**Disability Rights & Reproductive Justice: Improving Sexual and Reproductive Health Care Access for People with Disabilities in a Post-Dobbs World**

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JILLIAN: Thank you all for attending today. Today, we are going to do a presentation on "Access to Abortion and Reproductive Health Care for People with Disabilities in a Post-Dobbs World." My name, again, is Jillian MacLeod. My pronouns are she/her. I am the Reproductive Justice Legal Fellow at Disability Rights Education and Defense Fund. And today, I am wearing a, as a visual description, I'm wearing a gray sweater. I am a 26-year-old white woman. I forgot how old I was. I'm a 26-year-old white woman with short brown hair and I have gold earrings on and a blurred background. And I will pass it on to Amanda to introduce herself.

AMANDA: Everyone, my name is Amanda Spriggs-Reid, I use she/her pronouns, and I am an Equal Justice Works Fellow with Women Enabled International. As visual description, I am a 26-year-old East Asian woman with long black hair. I'm wearing a black blazer vest and I have a white background.

JILLIAN: And thank you, Amanda, for introducing yourself. So before we start, we wanted to do a quick poll to understand everyone's background. We designed this training to hopefully be helpful to people from a broad range of professional or personal backgrounds. So we're just hoping to share information about the rights of people with disabilities who are seeking reproductive and sexual health care. So you can either advocate for yourself if you are a person with a disability when you're seeking this care, or you may be able to aid and educate your clients if you work with individuals with disabilities. Okay, thanks everyone for participating. It looks like we've got a lot of, we've got 28% are law students or legal interns, 5% are direct legal services attorneys, 24% are disability advocates, 19% are sexual and reproductive health advocates, and 22% are other. So thank you everyone for participating and I will pass it to Amanda for moving on with the presentation.

AMANDA: Thanks, Jillian. So I'm going to go to the next slide and first, I'm gonna give people a second to look through the bullet points. So first, we just wanted to give an outline of what we're going to be covering today. The first section that I'm gonna be talking about is Disability 101, so that we're all on a similar knowledge level about some disability basics. Then, we'll cover why access to sexual and reproductive healthcare is important for disabled people. We'll cover both the historical context and the current context of these issues for the disability community. We'll cover legal responsibilities for providers and that will include LSC restrictions on participating in abortion litigation and proceedings, reasonable accommodations and supportive decision-making, effective communication, accessible facilities and medical equipment, and 2024 updated regulations. Then, we'll end the session with some resources for people who work with the disability community or disabled themselves in looking for some sexual and reproductive health information. And then we'll cover some questions. Next slide, please.

So as I mentioned, the first section is gonna be on Disability 101 and we wanted to start with defining what disability means and who we're talking about when we say people with disabilities. So the first definition is a legal definition under the Americans with Disabilities Act and Section 504. And that means, "A person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such impairment or a person who is perceived by others as having such an impairment." The Convention on the Rights for People with Disability is a United Nation Treaty on the rights of disability communities. So that definition uses, "Persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." And lastly, disability identity is, "a sense of self that includes one's disability and feelings of connection to or solidarity with the disability community." So people might fit under the legal definition of being a person with a disability under the ADA or Section 504, but not necessarily identify with the disability identity or vice versa. So we wanted to cover both. These are large and incredibly diverse populations in the disability community and that can sometimes be hard to define, but as we'll cover a lot in this section, it comes down to people's preferences and just asking if people prefer to identify as a person with a disability. Next slide.

I'll give people a second to read through some of the bullet points and then we'll go over some terminology. So on the left side of the slide, we have person first language. This terminology, it emphasizes the person and shows that a person is not defined by their disability. This is the traditional rule that many people use historically, it remains pretty common, especially for people with chronic illnesses and mental health or I/DD. Examples of using this would be a person with a disability, a person with down syndrome or a person with epilepsy. On the right side of the slide, we have identity first language. So that emphasizes that disability and identity are intertwined and it's preferred in certain communities among blind, Deaf and autistic people. So examples would be a disabled person, an autistic person, a Deaf person, or a blind person. And if you're unsure what someone prefers, you can always just ask. In advocacy spaces, I know that Women Enabled and DREDF, we use the terms interchangeably so that both schools of thought are represented. Next slide.

So some more terminology is boiled down to basically disability is not a bad word. So when you're trying to pick terminology, you're talking about the disability community. There's some terms that we don't use anymore or are offensive, so we don't use handicapped and that is because it is outdated. Instead, you could use disabled or a person with a disability, similar with wheelchair bound or confined to a wheelchair. This has a negative connotation and is an inaccurate description. Wheelchairs are a mobility device and can be a tool for freedom. So instead use a wheelchair user or person who uses a wheelchair. Differently abled, handi-capable or special are euphemisms that are condescending and we don't use those anymore. Use disabled, person with a disability, name of the disability such as like a person with CP or a person with an intellectual disability. Next slide.

Continuing on. So instead of saying suffering from MS or an HIV victim or afflicted with epilepsy, don't use these terms. They're very negative and disempowering and othering for many people. Instead, use a neutral term like a person with MS or a person living with HIV. Disability slurs. I feel like that should be obvious not to use, but in that box, avoid those terms, and just use person with a disability. They're offensive. They're rooted in eugenics and institutionalization. So use current language like intellectual disability, little person, person with dwarfism. Euphemisms like mind of a child, instead of doing that, describe concretely the impacts of an intellectual or developmental disability on a person's functioning. Take care with using disability nouns. Avoid using the mentally ill or the disabled, but you can know that some subgroups do use nouns. You don't need to be perfect, but just be thoughtful and respectful when you choose the language to talk about the disability community, there's definitely some lawyers in the room and as we know, language is very powerful and so we want to use terms that are empowering and respectful and accurate. Next slide.

So we're gonna cover, so the models of disability, first off would be the medical model of disability. This has disability is a medical problem that would be treated as other medical problems and cured if possible. The disability is located squarely within the individual, and responsibility is placed on the individual to quote unquote, "overcome their disability." A charity model of disability thinks of disability and people with disabilities as deserving our support and care as an act of charity and an exception of people who are left out would be people that have stigmatized disabilities or who are viewed as causing their disability. And a charity model views people with disabilities as an object of charity, not empowered whole people. Both of these models are outdated and offensive and not empowering of the disability community or the principles of disability justice. So next slide.

What we would use instead is the social model of disability. So a social model separates impairment, a person's bodily or functional limitations that result directly from a medical condition from disability, which is a socially constructed disadvantage. This disadvantage arises from multiple factors including environmental, attitudinal, structural, and economic barriers. Foundational tenets of the social model is that impairment is no negative connotation and is just seen as a natural part of human diversity. Impairment cannot be used as an excuse to deny or restrict people's rights. It is everyone's responsibility to remove socially constructed barriers. People with disabilities need rights and justice, not charity or to be cured with a medical model. Next slide, please.

We also want define ableism for people. Ableism is discrimination, prejudice or social prejudice against people with disabilities. And it manifests in various forms from individual attitudes towards systematic practices that disadvantage or discriminate against people with disabilities. So some examples of ableism are attitudinal ableism. This is negative attitudes or stereotypes or assumptions about the capabilities and worth of people with disabilities. An example is believing that a person with a disability can be a good parent. That is a very harmful negative stereotype and definitely not true. There are great parents with disabilities out there. Institutional ableism as an example, are policies, practices, and societal structures that disadvantage people with disabilities. So an example of that would be lack of medical school training on treating patients with disabilities. And this structural oversight in medical training results in harms and medical bias against people with disabilities. To go to the next slide, we'll also cover accessibility versus reasonable accommodations.

So accessibility is the degree to which a product, device, service or environment is available to as many people as possible. True accessibility occurs when a space is always 100% of the time welcoming to people with disabilities versus reasonable accommodations. And reasonable accommodations or adaptations that are made to environments, programs, policies, and/or technology upon the request of the individual with a disability without imposing a disproportionate or undue burden. We'll talk about reasonable accommodations a lot more later in the webinar, but accessibility is related to groups and having a space or service be accessible to everyone without putting it on the disabled person to ask for access. Whereas a reasonable accommodation is related to the individual and those accommodations can vary by person to person, but it's put on the individual to ask to get that, to make a service or a space accessible to them. So this is similar to the contrast between disability rights versus disability justice, disability rights, or some involve like the legal rights and laws that protect disabled people, whereas justice is a little bit more of a holistic vision for the disability community. If we go to the next slide, we're going to the principles of disability justice.

So the principles of disability justice, these were put together by the organization Sins Invalid, who do amazing work, advocating for the disability community and creating really beautiful disabled art. So the first of these is intersectionality. In the words of Audre Lorde, "We do not live single-issue lives." So ableism coupled with white supremacy, supported by capitalism, underscored by heteropatriarchy, render the vast majority of the world invalid. All issues and social justice interconnect and having a holistic view of justice is very important to achieve the vision of disability justice. The principle of leaderships of those most impacted, we are led by those who know the most about these systems. So the voices that we should be highlighting in the disability justice movement are the members of the disability community who are most impacted by these issues and have the most lived experience with them. Anti-capitalist politic, so in an economy that sees land and humans as components of profit, an anti-capitalist politic challenges that view of productivity and the devaluation of non-conforming minds and bodies. Commitment to cross movement organizing. Shifting how social justice movements understand disability and contextualize ableism, disability lends itself to politics of alliance. So similar to intersectionality working together to realize disability justice with other social movements. Recognizing wholeness, people have inherent worth outside of commodity and capitalist notions of productivity. Each person is full of history and life experience. Sustainability, pacing ourselves individually and collectively to be sustained in the long term. Our embodies experiences guide us toward ongoing justice and liberation. Commitment to cross disability solidarity. We honor the insights and participation of all of our community members, knowing that isolation undermines collective liberation. So the diversity of the disability community is broad, but we realizing disability justice for everyone. Interdependence, we meet each other's needs as we build toward liberation, knowing that state solutions inevitably extend into further control over lives. Collective access, bringing flexibility and creative nuance that goes beyond an able-bodied or able-minded normativity to be in community with one another. Collective liberation, no body or mind can be left behind. In the disability justice movement, we should be moving together to accomplish the revolution that we require together. Going to the next slide.

These interconnect very strongly with the principles of reproductive justice. Reproductive, these, like, reproductive justice was coined similarly to by SisterSong, which is a Black-led reproductive justice organization in the South, in the United States, in Atlanta. Reproductive justice is defined as the human right to maintain personal bodily autonomy, have children, not have children, and parent our children in safe and sustainable communities. Both disability justice and reproductive justice share the themes of intersectionality, centering those that are most marginalized, solidarity across movements, issues and identities, and focus on access and commitment to dismantling systems of oppression.

So to go to the next slide and the next topic of our webinar, why is access to sexual and reproductive healthcare so important for disabled people? Of course, for the same reason that non-disabled people need access to these services, like abortion, to protect their lives, their health and their autonomy. This might seem obvious, but pervasive ableism and paternalism towards disabled people in our society influences many people's views that people with disabilities are not inherently sexual beings with the same preferences, hopes and dreams around building or not building families as non-disabled people.

So to go to the next slide, we use the definition of sexual and reproductive healthcare or sexual and reproductive health that the World Health Organization and the United Nations Population Fund uses. So they define it as, "a state of complete physical, mental and social well-being in all matters related to the reproductive system, it implies that people are able to have satisfying and safe sex lives, the capability to reproduce and the freedom to decide if when, and how often to do so." Maintaining sexual and reproductive health requires access to accurate information about sexual and reproductive health, safe, effective, affordable, and accepted contraception choices. If a contraception choice is stigmatized, it makes it more difficult to access it. Information about sexually transmitted infection prevention, access to abortion, and once pregnant, access to skilled healthcare providers and services that can support safety, well-being, and good outcomes. Obviously, people with disabilities need access to those things just like people who are non-disabled.

On the next slide, we wanted to just briefly define what abortion is since it's such a hot topic in the United States and can sometimes be talked about kind of abstractly. So medication abortion is also known sometimes as the abortion pill, can consist of either one or two- different medications called mifepristone and misoprostol to end a pregnancy until 10 weeks. 63% of the abortions in the United States are medication abortions. And a little bit later, we'll talk about a recently decided Supreme Court case related to medication abortion where both DREDF and Women Enabled filed an amicus brief. In-clinic abortions are also sometimes called surgical or procedural abortions. These are medication or these are medical procedures that can be done in one of a couple of ways. You can have an aspiration abortion or dilation and curettage or a D&C abortion. There's also dilation and evacuation. D&Es are normally in the second trimester, whereas the other options are usually in the first trimester. To the next slide, please.

And so some important statistics about why SRH healthcare is so important for the disability community. People with disabilities have similar rates of sexual activity and pregnancy as non-disabled people. Disabled people have similar fertility desires as non-disabled people. Disabled people are less likely to receive comprehensive sex education as non-disabled people. And in another study, women with disabilities were significantly more likely to experience reproductive coercion or sexual violence than non-disabled people.

And to continue that in the next slide, disabled people are less likely to receive cervical and cancer screenings, prenatal care and family planning services than non-disabled people. And pregnant people with disabilities are at a higher risk for nearly all adverse outcomes during pregnancy, including six times the risk for thromboembolism, nearly four times the risk for cardiovascular events, three times the risk for infection and two times the risk for severe preeclampsia. People with disabilities are also 11 times more likely to die during childbirth than those without disabilities. Of course, people with disabilities can have fully safe and happy pregnancies, and this slide is not meant to imply that pregnancy is less desirable or possible with people with disabilities. Instead, all of these factors that we're talking about here make up a context where people with disabilities may be making decisions about whether or not they can or want to continue a pregnancy. And it's important to be aware of these studies and statistics in a context of sexual and reproductive health. So in light of these health risks and these other socio-economic barriers, it's especially important that people with disabilities have access to a full range of reproductive healthcare options, including abortion. And then next, I'm gonna turn it over to Jillian.

JILLIAN: Hi, everyone. I also wanted to note that Fabiola noted in the Q&A or the chat that medication abortion can also be provided in clinics. So I just wanted to note that before I start, but we'll move on to the next slide for historical context.

And it's important for us to discuss this historical context in terms of the access to sexual and reproductive health care for people with disabilities in the United States because this history informs the ways that people with disabilities interact with the healthcare system today. Next slide.

So one piece of this historical context is the Buck versus Bell Supreme Court case, which was decided in 1927. And in this Supreme Court case, the court held that the "feeble minded," quote unquote, could be sterilized against their will for the quote, "protection and health of the state," unquote. Justice Holmes also wrote quote, "three generations of imbeciles are enough," unquote. And unfortunately, Buck has never been explicitly repealed. Obviously, as you all saw in our discussion about language and terminology, this terminology is extremely ableist and is rooted in eugenics. And after Buck, 70,000 Americans were forcibly sterilized and the practice continues in some states today. Women of color were more likely to be involuntarily sterilized than white women. And 31 states and Washington DC still have laws on the books that allow for sterilizations. And here on the slide, we have a photo of the plaintiff in this case, Carrie Buck. She's the one with the short dark hair and she's next to her mother, Emma Buck. And Carrie was forcibly institutionalized and her institution attempted to sterilize her against her will and the court held that that was constitutional. Next slide.

Other eugenic policies adopted in the United States during the 20th century include forced institutionalization and segregation, which is still occurring in some contexts today. Limitations on the ability of people with disabilities to get married and have sex before the age of 45, which were an attempt to essentially prevent people with disabilities from procreating and having children. And to some extent, people with disabilities still do not have marriage equality because many people with disabilities rely on SSI in order to receive their life supporting or life sustaining care. And there are income limits on SSI eligibility. So people with disabilities, if they were to marry their partner, would sometimes lose access to that life sustaining care because with their partner's income, they would no longer be eligible. So people with disabilities still do not have marriage equality today. Further, there is a history of kind of an entanglement between the history, or sorry, there's an entanglement between the abortion access advocacy and discussions of disability historically. So in the pro-choice movement in the 1960s and '70s, disability was used as a major justification for people needing access to abortion care. And much of this rhetoric was ableist in that it assumed that disability was an inherently bad thing or that the quality of life of all people with disabilities was automatically worse. And of course, it is essential to support the bodily autonomy of pregnant people, but using this ableist rhetoric to do that is not the answer. And more recently, the anti-choice camp has co-opted the language of disability rights to argue for restricting access to abortion care. But this still prevents people from exercising their bodily autonomy. So instead of quote unquote "reason bans" on abortion, pregnant people should be provided with neutral, scientifically accurate resources and community resources about how to support their child with a disability before they make a decision about how they want to proceed with a pregnancy. Next slide.

And next we'll talk a little bit about the current context of access to reproductive and sexual health today for people with disabilities. Next slide.

So first, we'll do a bit of an overview of the Supreme Court cases that affect the legal landscape of abortion access today because this is closely related and part of sexual and reproductive healthcare access. So in 2022, the court decided Dobbs versus Jackson Women's Health Organization, which stripped Americans of their federal constitutional privacy right to an abortion. And currently, 3 million women with disabilities live in states that have banned or are likely to ban abortion since Dobbs. And the next case is FDA versus the Alliance for Hippocratic Medicine, which was released a couple of weeks ago. And the Alliance for Hippocratic Medicine, the plaintiff in the case was an anti-abortion group, challenging the FDA's decision to remove unnecessary restrictions on access to the abortion medication mifepristone, which Amanda mentioned earlier. But on June 13th, the Court actually dismissed the case on standing, meaning that current access to medication abortion remains unchanged. But the decision did not protect mifepristone in any way because new parties could still challenge access in the future. And the Supreme Court released another decision actually this morning in Moyle versus the United States. And the legal issue in that case was whether a federal law called EMTALA or the Emergency Treatment and Labor Act preempts or overrides state abortion bans. And the court actually dismissed the case today for being quote unquote "improvidently granted" and sent it back to the lower courts to decide the issue on the merits. And so this was still in some ways a bit of a harmful decision because although the court essentially dismissed the case and didn't further limit access, they kicked the issue down the road. And yeah, essentially they kicked the issue down the road and several of the conservative justices showed a lot of disdain for abortion advocates and people who need access to abortion care. Justice Jackson wrote in her descent quote, "Today's decision is not a victory for pregnant patients in Idaho, it is a delay, while this court waddles and the country waits, pregnant people experiencing medical conditions remain in a precarious position as their doctors are kept in the dark about what law, what the law requires. The court had a chance to bring clarity and certainty to this tragic situation and we have squandered it." Next slide.

And next we'll talk a little bit about socio-economic barriers that people with disabilities face when seeking sexual and reproductive healthcare. So the cost of an abortion and sometimes the necessary travel to the appointment can be prohibitive for many patients. And people with disabilities are two times more likely to live below the federal poverty line than non-disabled people. They're also three times more likely to be unemployed and these disparities are worse for people of color. So Black people with disabilities are almost 55% more likely to live below the poverty line compared to white people with disabilities. And among Black and Latino people with disabilities, there is also a 50% higher unemployment rate than white people with disabilities. In addition, one in 10 people with disabilities lack health insurance, which can contribute to the cost of an abortion being prohibitive. And even if someone has insurance, if they have federally funded insurance, things like the Hyde Amendment can actually still limit coverage and cause them to not have insurance coverage for an abortion. And we'll talk about that a little more later. And next slide.

Next, travel barriers are a huge problem for people with disabilities. As I mentioned previously, 3 million disabled women of reproductive age, which is about 52.3% of all disabled women in the U.S., live in the 26 states that ban or are likely to ban abortions since Dobbs. Some common transportation barriers that people with disabilities face are needing to rely on others for transportation, which can sometimes cause privacy problems if that person does not want to disclose to others that they're interested in having an abortion or that they're seeking contraceptive help. And in addition, public transit can be very inaccessible for some people and paratransit services can be insufficient. So paratransit services are often underfunded. People report having their paratransit drivers coming late to pick them up, which can be a problem in terms of getting to an appointment at a particular time. In addition, paratransit doesn't often travel across county lines. So if you need to get to an appointment in a different county or in a different state, that's not an option. And in addition, inaccessible ride share services are a problem. So discrimination against people who have service animals is a big problem for ride share services. And some ride share services may not be accessible to people who use mobility aids like wheelchair users. In addition, air travel can be inaccessible and very expensive. And all of these barriers compound and can result in less access to care. So people with disabilities are more likely to report experiencing logistical barriers like arranging transportation to a reproductive healthcare appointment than non-disabled people. And that rate is 50.7% of disabled people versus 29.7% of people without disabilities face logistical barriers. And next slide.

Next, we'll talk a little bit about health systems barriers, which can impact access to care. So until November, people with disabilities were generally not included as a disparity group in federally funded research on health disparities. So this meant that there was less of an understanding about the barriers that people with disabilities faced and therefore, potentially less funding to help overcome those barriers or help address those barriers. And people with disabilities were designated as a health disparities population very recently in 2023. In addition, ADA compliance enforcement is lacking and also, federal insurance like Medicare or Medicaid can cause problems with access to sexual and reproductive healthcare. So 58% of people with disabilities under the age of 65 rely on federal insurance, which is Medicare or Medicaid compared to only 14% of people under the age of 65 without a disability. And this translates to about 900,000 pregnancy capable people on Medicare who have a disability. And 29% of these people rely on Medicare alone. But because those benefits are designed for people over 65, contraception access is very restricted and it's only covered for a medical indication, which is essentially it's only covered if it's going to be addressing some other medical issue. And I know some of you may be familiar with the Hyde Amendment, but the Hyde Amendment also prohibits the use of federal funds in the provision of abortion care unless the life of the mother is in danger or the result of rape or incest. And because Medicare is federally funded insurance, that means that there is a limitation on coverage for abortion. And in states where the state doesn't offer additional funds to cover abortion, like in California, the state will offer those additional funds. In states with bans or states that don't offer those additional funds, people can have no insurance coverage for abortion care, which is a big problem because many people with disabilities are on federal insurance. Next slide.

And so once people with disabilities get to the clinic, there are also more barriers to adequate healthcare. Inaccessible facilities are a major barrier. A recent survey of specialty offices found that nearly a quarter of practices said their practices would not be accessible to a patient with a mobility disability. And gynecology offices had the highest rate of inaccessibility with 44% of clinics physically inaccessible. And in the same study, only 9% of clinics had an adjustable exam table and 29% said they would just examine the patient in their wheelchair, which would be considered substandard care if the exam is not usually done in a seated position. So lack of accessible medical equipment is definitely a barrier. Another barrier is lack of provider and staff knowledge about their legal obligations and lack of training on caring for disabled patients. So physicians in one study noted they had a lack of knowledge and skills concerning care for people with disabilities and especially mentioned their lack of patient transfer skills. There also seems to be a lack of understanding of ADA requirements and what their obligations were to provide accommodations. And some providers even cited providing accommodations as being burdensome or as a quote, "personal choice" as opposed to a legal obligation. Further, there are studies showing that there are lots of staff and provider biases against people with disabilities. One provider in a study referred to people with disabilities as a quote "entitled population" and multiple providers who reported trying to transfer disabled patients, sorry, multiple providers in that study also reported trying to transfer disabled patients out of their care. Additionally, multiple qualitative studies suggest that providers frequently assume that disabled patients are asexual and sometimes hesitate to discuss sexual health or rely on a caregiver to communicate as opposed to communicating directly with a patient, which can make it really hard to take an appropriate sexual history and can also cause privacy problems. And then we'll move to the next slide.

And all of these barriers compound to limit overall care access. A 2023 study looked at barriers to accessing reproductive care, which was defined as a pap smear or family planning. So it was a limited study for people with disabilities. And the barriers discussed in the study were logistical barriers defined as finding transportation, getting time off work, finding childcare access barriers, like finding a place that offers reproductive health services, finding a place where they felt comfortable, finding a place that spoke their language, cost barriers like paying for the appointment or finding a place that accepts my insurance. Privacy barriers, like getting services without telling someone that they didn't to tell or interpersonal relationship barriers like a partner or family member not wanting them to go to the appointment. And the study found that people with disabilities were significantly more likely to experience every single type of barrier than non-disabled people. So nearly 70% of all disabled participants had experienced one or more barriers, compared to 43% of non-disabled patients. And unfortunately, there are a lack of studies on the barriers that people with disabilities face when seeking abortion care specifically, but DREDF and Women Enabled International are currently facilitating a survey of people with disabilities who have sought abortion care to try to better understand this landscape and also try to develop guidance documents for providers to help increase access to care for people with disabilities. And we will drop a link to that survey in the chat if you're interested in taking it or if you're interested in sharing it with anyone you know. Next slide.

So next we'll talk about the legal responsibilities of healthcare providers when providing sexual and reproductive healthcare. So it's helpful for you to understand these legal responsibilities so that if you are a person with a disability, you can better advocate for yourself by understanding your rights or if you're an advocate or lawyer who works with people with disabilities, you can inform them of their rights and help facilitate their access to care. And first, before we move on, we want to talk a little bit about restrictions on organizations that are funded by the Legal Services Corporation or LSC. So if any of you work at an organization funded by LSC, this is applicable to you. And so essentially, the relevant regulation says that organizations funded by LSC may not provide legal assistance with respect to any proceeding or litigation which seeks to procure a non-therapeutic abortion or to compel any individual or institution to perform an abortion or assist in the performance in abortion or provide facilities for the performance of an abortion contrary to the religious beliefs or moral convictions of such individual or institutions. So essentially, people who work for legal services or organizations funded by LSC may not participate in any proceeding or litigation seeking to procure an abortion. That being said, there are no special restrictions on educating clients, training them, or providing legal information concerning this access or even referring them to someone who can help with the issue that they're facing. Also, LSC funded organizations can in engage in proceedings and litigation representing or advocating for clients seeking other types of reproductive and sexual health services that are not abortion. Next slide.

And so first, we'll talk about the relevant disability rights laws. So first is the Americans with Disabilities Act or the ADA, which is a federal civil rights law that prohibits discrimination on the basis of disability in everyday activities or public life. And privately owned entities or private hospitals or clinics are covered by Title III as places of public accommodation. And publicly owned and operated entities are covered by Title II as quote, "public entities." And Section 504 of the Rehabilitation Act of 1973 or for short, Section 504, is a federal law that prohibits discrimination on the basis of disability by employers and organizations that receive federal financial assistance. And further, Section 1557 of the Affordable Care Act or for short, Section 1557, is a federal law that prohibits discrimination on the basis of race, color, national origin, age, disability, or sex in health programs or activities that receive federal financial assistance. So for example, if a clinic receives Medicaid or Medicare funding, they can be covered under multiple of these disability rights laws. Next slide.

So a sexual or reproductive health clinic has essentially three different buckets of responsibilities in terms of providing care to people with disabilities. The ADA Section 1557 and Section 504 generally prohibit discrimination against people with disabilities and require medical providers to make their services and programs available in an accessible manner. And this can include, first, providing reasonable accommodations, second, ensuring effective communication, and third, having accessible facilities and equipment. Next slide.

So first, what are reasonable accommodations? The definition of a reasonable accommodation is a change to the usual way of doing things to include people with disabilities and provide equal opportunity for them to benefit from your services or from the clinic services. And it is discrimination to fail to provide reasonable accommodations to disabled patients unless doing so will fundamentally alter the nature of the services or benefits provided or result in a quote unquote "undue burden." So a fundamental alteration and an undue burden are kind of terms of art, but a fundamental alteration is essentially something that changes the essential nature of the program or service or activity. And an undue burden is a significant difficulty or expense. So both are generally a pretty high bar. Also, undue burden is considered in light of an entity's entire budget. So that contributes to why that can be a high bar for a clinic to reach when arguing that they don't have to offer reasonable accommodations. Next slide, please.

And this slide has a non-exhaustive list of pretty much of a number of reasonable accommodations, but pretty much anything could be consider, that could be considered reasonable is a possible reasonable accommodation and a patient is an expert in their needs and what accommodation will make services most accessible to them. So some examples of a common reasonable accommodations in this context are reserving additional time for an appointment. This can allow time for physically transferring a patient from their wheelchair onto an exam table, for example. It can allow time for engaging with interpreters or for checking understanding. In addition, a reasonable accommodation can be made for allowing a support person to be present at an appointment or allowing the person with a disability to utilize supported decision-making during their appointment, which we'll talk about a little bit later. In addition, providers can perform pelvic exams in alternative positions. Providers can move items that might block the path of travel for a wheelchair user. In addition, providers can reserve an appointment room that has accessible equipment. They can allow time for breaks during the appointment. They can turn down the brightness of exam room lights if someone has sensory sensitivities. They can also provide a written outline of the information being discussed in the appointment to help the person understand. Or they can also wear a mask if the patient requests one, if that's not already their basic policy. But really the possibilities around reasonable accommodations are pretty endless. Next slide.

And next we wanted to introduce the topic of supported decision-making, which can be considered a reasonable accommodation and supported decision-making maybe helpful for people with I/DD when making decisions about their medical care. As a reminder, I/DD means intellectual or developmental disabilities. And so this can be a reasonable accommodation, as I said in the sexual and reproductive healthcare context, including during abortion appointments. And if you have a constituent or a patient, or sorry, a yeah, a patient or a client with I/DD who you think might be a good fit for this tool, you can provide them with information about it. So supported decision-making is an individualized arrangement in which a disabled adult chooses one or more people they trust as supporters to help them understand, communicate, make or act on their own choices. And supported decision-making can look different for each person. It can be formal as in written, or it can be an informal agreement between two people who have just decided that they want to use supported decision-making. And it can help strengthen a person's capacity for making decisions and avoid the need for a conservator to be involved in decision-making. And it's recognized under California law, which is cited here. And just for a little bit of context, some caretakers of people with disabilities may seek guardianship in order to exert control over a disabled person's reproductive health decisions. And obviously, this can prevent some disabled people from exercising their bodily autonomy and supported decision-making is a less restrictive alternative to reliance on conservators and guardians. Usually in California, conservatorship is the correct term, in other states, they use guardianship as the correct term. But 84 states mandate that less restrictive alternatives are used before a guardianship is put in place. And 22% of states name supported decision-making as one of those options that should be considered before putting a conservatorship in place. So it's good to be aware of this tool and not assume that a person with a disability needs a conservator to be involved in their decision-making. Next slide, please.

So this slide is a comparison between supported decision-making and conservatorship and supported, during the supported decision-making, a disabled person makes their own choices, but receives help from supporters in the process. And the disabled person chooses their own supporters and supported decision-making can help strengthen their capacity to make these decisions on their own and avoid the need for a conservatorship. And this is compared with a conservatorship where a conservator makes the choices for the person with the disabilities sometimes without consulting them, the conservator is appointed by the court and can only be removed by a court. And the conservator's decisions must be approved by a court. Next slide, please.

And because this is closely related to the topic of capacity, we wanted to talk a little bit about capacity. And really capacity is a spectrum. It's not a yes or no question, it can change with context, topic, emotional and physical state. An individual may have capacity to make medical or mental health decisions without understanding every single aspect of a diagnosis or a treatment. And capacity is flexible and it can be strengthened by things like plain language, reasonable accommodations, supported decision-making, and really capacity to make decisions should be assessed with the person's preferred supports in place. Next slide, thank you.

And who can benefit from supported decision-making? Really anyone can benefit from supported decision-making. When you think about it, we all talk to people that we trust when we're making important decisions, but supportive decision-making may be especially helpful for people who need additional help with identifying and weighing options, understanding the risks and benefits of those options, choosing between them, communicating their choice or acting on their choice. And it's important to remember that a person who has a guardian or conservator in a different part of their life, for example, their finances may still be competent to make decisions about their medical care with or without support through supported decision-making or some other mode of support. Next slide, please.

So next we'll move on to the second bucket of requirements for providers offering care to people with disabilities. And that is effective communication. So under the ADA Section 504 and Section 1557, medical providers are required to ensure effective communication with disabled patients. And this may include the provision of auxiliary aids and services. So ensuring effective communication may require qualified interpreters, which can be done in person or through video remote interpreting or VRI, real-time captioning, particularly for video telemedicine, assistive listening devices and systems like a hearing loop or a pocket talker. Effective communication can also be insured through offering written materials in alternative formats such as Braille materials or large print materials. Further, a provider can offer written notes that summarize the information provided and using plain language can be a big part of ensuring effective communication. Next slide, please.

And the third bucket is ensuring that a provider's facilities and medical equipment are accessible. So the ADA and Section 504 require that medical providers give disabled people full and equal access to their facilities and medical equipment. And government providers that receive federal money must make their programs as a whole accessible to and usable by individuals with disabilities. And non-discrimination in this area includes removing architectural barriers and acquiring accessible medical equipment, which is now required under the new Section 504 regulations, which Amanda will go over in a couple of minutes. And further where barrier removal would be an undue burden like we discussed recent or previously, a provider is required to make services available through alternative locations or methods. So that might look like, for example, if a provider's services can be offered via telemedicine and that would offer an equal opportunity for a person with a disability if their facilities are inaccessible and it would be an undue burden to make their facilities accessible, video telemedicine could be an option for providing an alternative method. Next slide, please, and I'll hand it back over to Amanda.

AMANDA: Hi, everyone. I will give you guys a second to look over these slides. The new regulations have a lot of new information on them. So I'm gonna be going over some of the new regulations that were released this spring in, that would apply for the disability community accessing reproductive and sexual healthcare. The first one being Section 504, which was released on May 9th and that will go into effect July of this year so, part of these new provisions prohibit the provision denial or limitation of medical treatment based on bias, stereotypes about an individual's disability. They also would prohibit judgements that a person with a disability would be a burden, including but not limited to caregivers, families or society, or a belief that the life of a person with a disability is less value than a person without a disability or that the life, person with a disability is not worth living. In practice, this can look like, for example, it would now, it's prohibited for a provider to deny someone STI screenings or contraceptive methods if they normally would be providing those same services to a person without a disability because of a stigmatized or stereotyping belief about person with a disabilities sexual activity. The regulations also prohibit discrimination in child welfare, which includes decisions based on stereotypes or generalizations about a child with a disability or that a parent or caregiver with a disability cannot safely care for a child. Then the regulations also update web kiosk and mobile accessibility requirements. So for web accessibility, the final rule defines what accessibility means for websites and mobile applications and requires compliance with specific technical standards, which are the web content accessibility guidelines. And that requirement begins in May 11th, 2026 for people that have 15 or more employees and by May 10th, 2027 for organizations that have fewer than 15 employees. This is especially important for telehealth provision of sexual and reproductive healthcare. Telehealth platforms need to be accessible. The new regulations also incorporate the U.S. Access Board's 2017 Standards for Accessible Medical Equipment or Medical Diagnostic Equipment that is required to go into effect for newly acquired MDE if the covered entity uses MDE, then 10% of the units being no less than one must meet the standard. And within two years, covered entities must have at least one exam table and one weight scale that meet the standards, provided that they use that type of equipment and that could include reproductive healthcare clinics. Some other, some other parts of the regulations that have been updated that are not on the scale, just to go over super quickly because the regulations are very long and excitingly in depth. Mobility devices, recipients must allow the use of wheelchairs and manually powered mobility aids. It has updated service animals, recipients must permit the use of trained service animals except under certain limited circumstances. All of these regulations will hopefully result in much better experiences for people with disabilities interacting with the medical system and with providers that are more accessible. Next slide.

The next regulation I'm gonna be talking about with the new Section 1557 regulation. So on April 26, HHS has finalized their rule for non-discrimination in health programs and activities that goes into effect July 5th. This requires covered healthcare providers, insurers, grantees, and others to let people know that language assistance and accessibility services are available to patients at no cost. And covered entities are also required to train their staff on these policies and procedures. So like we talked about earlier, one of the barriers is that sometimes providers are not even aware or understand their obligations. And the new 1557 regulations will require these providers to train their staff and make people aware that these services are available. But it also clarifies that health programs and activities offered via telehealth must be made in, accessible to individuals with limited English proficiency and individuals with disabilities. It also clarifies that the protections against discrimination by codifying Section 1557 prohibition against discriminating based on sex and that that includes LGBTQI patients. It also clarifies that sex discrimination includes discrimination on the basis of sex stereotypes such as sex characteristics including intersex traits and pregnancy or related conditions. So discrimination on the basis of pregnancy is not allowed. There are also updates to applying these non-discrimination protections to patient care decision support tools in the healthcare sphere. And that can include the use of artificial intelligence and machine learning. Things like patient care decision support tools can include things like brochures even, these need to be accessible to patients so that they can make informed decisions about their health care with their doctors. And then the last regulation I'm gonna cover on the next slide.

This last one is the new HIPAA regulations. On April 22nd, HHS released a finalized rule for the HIPAA Privacy Rule to Support Reproductive Healthcare Privacy. And it went into effect this week on June 25th. This prohibits the use or disclosure of protected healthcare information by a covered healthcare provider health plan or health clearing house or their business associates for the following activities. So these covered entities cannot provide protected healthcare information to conduct a criminal, civil, or administrative investigation into or to impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive healthcare where such healthcare is lawful under the circumstances in which it was provided or the identification of any person for the purpose of conducting such investigation or imposing liability. That's very long. So to give a concrete example of that, if a patient were to travel out of state to receive abortion care in a state where abortion is legal, in that person's home state, a law enforcement officer could not investigate the person who obtained the out-of-state abortion by subpoenaing that doctor that was out of state. The healthcare provider does not have an obligation to disclose protected healthcare information about that person's abortion procedure because it was lawful in the state where the person obtained. Also importantly, the regulation creates a presumption that reproductive healthcare provided by a person that was not the covered entity was receiving the request was lawful. This means that if an officer or investigator wants to try and get this protected healthcare information, it's on them to prove that the healthcare that was obtained was unlawful. Unfortunately, this regulation doesn't cover some circumstances of pregnancy criminalization that are very common, such as criminalization for substance use during a pregnancy. It also does not cover protective healthcare information when a person potentially had a self-managed abortion, it's unclear if that would be covered under the term of lawful. So this HIPAA regulation is helpful, but it's a very specific circumstance where it would be utilized. And that's generally if someone's gonna be traveling to a state where abortion is legal and getting that healthcare from a state where the abortion would be illegal. And at the bottom of these slides is the citation for these regulations. And then going to the next slide, this last page is just some resources that we gathered in case you are a person with a disability who wants to access information about reproductive healthcare or you have clients that you work with that might need this information.

So the first couple of resources are directories of abortion funds and other support services or abortion providers. It's definitely important to be giving people resources with verified information so that clients don't potentially get misleading or untrue resources or resources from pregnancy crisis center that are posing as places that might give people abortion services, but then once they show up to the clinic, that is not a service that they provide. Some of these pregnancy crisis centers can be very deceiving and confusing for people. So we wanna make sure that people have resources that are true reproductive healthcare clinics. These include the National Network of Abortion Funds, Abortion Finder, and I Need an A. And then All Options Talkline is a free peer counseling support network for anyone at any stage in or after their pregnancy. And pro or Exhale Pro-Voice is a free talkline for people who might need emotional support after having an abortion. And lastly, the If/When/How Repro Legal Helpline provides free confidential legal services for all areas of reproductive life, including abortion, pregnancy loss, and birth. And then I think that we can move to the next slide and the last area of our webinar, which is Q&As.

JILLIAN: And I can start with this first question. And actually, before I get to answering this question, I wanted to note that Fabiola Kerian entered into the chat, "Thanks so much for your work on this panel. Just sending this to the host and panelists to generally suggest using more gender neutral language and to avoid using terms like mothers, which people seeking abortions don't always consider themselves to be." And Amanda replied, "Hi Fabiola, thank you so much for the important reminder. We will do our best to clarify that when we are using a gendered term, it is because that term is used in the study we are citing and we agree about the importance of gender neutral language." Definitely agree about avoiding terms like mother and that all people who utilize these services regardless of gender. So thank you, Fabiola, for raising that. Apologies for not clarifying that earlier. We did our best to use gender neutral language throughout the presentation and if we did use gendered language, it's usually because we were referencing some type of study that used gendered language. So thank you for bringing that up, Fabiola. And our first question is by Joshua and they asked to clarify because I'm not sure I understood your point about MDE accessibility. A portion of all newly acquired MDE must be accessible, but of existing MDEs within facilities only weight scales and examining tables must be retrofitted so they can be accessible. So I can answer this, essentially, the regulations are definitely a little bit wordy and confusing, but going forward after July 8th, 2024, if a provider's office acquires a new piece of medical diagnostic equipment, all of the pieces that they acquire must be accessible until they reach a certain scoping requirement. So for facilities that specialize in treating mobility disabilities or treating mobility conditions, 20% of their MDE of each type must be accessible. But if they're a facility that doesn't specialize in treating mobility disabilities, only 10% of their general medical diagnostic equipment of each type must be accessible. So until they reach that point, each new piece of equipment that they acquire must be accessible. But the problem with this is that there isn't necessarily a compliance deadline for all types of MDE. So for example, if a provider doesn't replace their mammography machine, sorry, I always have trouble with that word, but they're machine for doing mammograms, if they don't replace that for the next five years, then they're not required to have it be accessible because they haven't acquired a new piece yet. But for exam tables and weight scales, providers who use exam tables and weight scales must acquire at least one of each by July 8th, 2026. So there is a compliance deadline for exam tables and for weight scales. So hopefully, that answers your question. Are there any other questions? It doesn't look like we have any other questions. I also want to note that DREDF is actually currently working on a document to help inform people of the new MDE regulations and the requirements for providers. So hopefully, that will be released soon and you can keep an eye out, but thank you so much for attending. If you'd like to contact either Amanda or I, please feel free. And thank you so much to our interpreters as well and to my co-presenter, Amanda.

AMANDA: Thank you all so much for joining. It was so great being able to talk with all of you.