



Health Equity

“It Would Have Been Nice to Have a Choice”: Barriers to Contraceptive Decision-making among Women with Disabilities


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A B S T R A C T

Introduction: Engaging in contraceptive decisions is an important part of reproductive health for women and other people with the capacity for pregnancy. However, not all individuals capable of pregnancy have equal access to information and/or opportunities to make fully informed decisions. The goal of this study was to understand barriers women with disabilities experience around contraceptive decision-making and whether these differ based on type of disability. **Methods:** We conducted focus groups with 17 reproductive age adult women (aged 18–45 years). Focus groups were homogenous with regard to disability type and consisted of one group for each of the following disability categories: 1) physical disability, 2) intellectual and developmental disabilities, 3) blind or low vision, and 4) Deaf users of American Sign Language. Data were collected in the Portland, Oregon, metropolitan area during 2016–2017. We analyzed focus group transcripts using content analysis.

Results: Barriers to informed contraceptive decision-making emerged in five main thematic areas: 1) lack of information in accessible formats, 2) incomplete information about contraceptive side effects, 3) limited clinician knowledge and relevant research specific to the care of women with disabilities, 4) taboos around discussing sexual activity, and 5) limited opportunities for shared contraceptive decision-making.

Conclusions: Women with disabilities faced numerous barriers to contraceptive decision-making. Although the barriers differed somewhat by disability type, many barriers were consistent across groups, suggesting commonalities associated with the experience of disability in the context of contraceptive decision-making. Increased attention to the reproductive health needs of people with disabilities is important for improving health care equity and quality.

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Over the past 30 years, the United States has made significant strides in civil rights for people with disabilities. Although major laws, such as the Americans with Disabilities Act, have resulted

in improved access to public spaces, services, and employment opportunities, progress in reproductive justice still lags (Wu et al., 2019). Reproductive justice encompasses the right to not have a child as well as the right to pursue pregnancy and parenthood if and when desired (Ross & Solinger, 2017). Women with disabilities continue to face reactions of surprise that they are sexually active (Alhusen, Bloom, Laughon, Behan, & Hughes, 2021; Iezzoni, Wint, Smeltzer, & Ecker, 2015) and astonishment and resistance to the idea that they might bear and raise children (Iezzoni et al., 2015; National Council on Disability, 2012).

The stigma surrounding procreation and parenthood for people with disabilities has contributed to a range of responses encompassing two extremes. At one extreme, active measures

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are taken to prevent any possibility of pregnancy. Across disability types, reproductive age women with disabilities are more likely to be sterilized than their counterparts without disabilities (Li et al., 2018; Wu et al., 2017). At the other end of the spectrum, the topics of sexuality and reproduction are simply ignored and women with disabilities are provided with little or no information about sexual health, pregnancy, or contraception (Holland-Hall & Quint, 2017; Namkung, Valentine, Warner, & Mitra, 2021). Both of these extremes may leave women and other pregnancy-capable people with disabilities vulnerable to sexually transmitted infections. The second approach also puts this group at increased risk of unintended pregnancy.

The limited research available indicates that women with disabilities are approximately as likely to be sexually active and to get pregnant as women without disabilities (Haynes et al., 2018; Horner-Johnson, et al., 2016). However, pregnancies among women with disabilities are more likely to be unintended (Horner-Johnson, Dissanayake, Wu, Caughey, & Darney, 2020). Unintended pregnancies include those that are unwanted (i.e., the woman did not want to be pregnant at that time or ever) and those that are mistimed (i.e., the woman wanted to be pregnant at some time in the future but not yet) (Finer & Zolna, 2016). When pregnancies are unintended, opportunities to prepare for the healthiest pregnancy possible are curtailed. That lost preparation time can present particular challenges for populations exposed to high levels of preconception health risks. Women with disabilities are one such population. For example, prior research has found that women with disabilities are significantly more likely than women without disabilities to experience modifiable preconception health risks such as smoking, obesity, depression, and inadequate social support (Horner-Johnson, Akobirshoeve, Amutah-Onukagha, Slaughter-Acey, & Mitra, 2021a; Mitra, Clements, Zhang, & Smith, 2016; Tarasoff et al., 2020). Research also has indicated that women with disabilities may be less knowledgeable about contraceptives than women without disabilities (Horner-Johnson et al., 2019).

To better support the health of women and infants, women with disabilities need full access to contraceptive information and methods that allow them to determine if and when to get pregnant. Yet little is known about the specific barriers women with different types of disabilities encounter when attempting to obtain contraceptive information. The purpose of this qualitative study was to conduct an initial exploration of the experiences of women with disabilities in finding, understanding, and using contraceptive information. We also considered differences and commonalities in barriers to informed contraceptive decision-making experienced by women with sensory (vision or hearing), intellectual, and physical disabilities.

Materials and Methods

We used a multiple-category focus group design, collecting data from adult women of reproductive age (eligible age range: 18–45 years) with different types of disabilities, allowing comparisons across categories (Krueger & Casey, 2015). The project was guided by an advisory council of six women representing a range of disability types, including physical disability, intellectual and developmental disabilities (IDD), blind/low vision, and Deaf/hard-of-hearing. Advisory council members participated actively in designing the focus group guide, recruiting participants, conducting focus groups, and reviewing the findings.

Participants and Recruitment

We purposively recruited women to ensure prior experience with seeking contraceptive information and/or making contraceptive decisions as well as representation of each of the following disability categories: 1) physical disability, 2) IDD, 3) blind or low vision, and 4) Deaf users of American Sign Language. We used multiple recruitment modalities, including 1) study opportunity postings on our university website, 2) postings on the craigslist classified advertising website, 3) fliers posted in disability resource centers and sexual health resource centers on college campuses, 4) fliers for disability service and advocacy organizations (e.g., support services brokerages serving individuals with IDD, centers for independent living) to share with their clientele in hard copy and/or electronically, 5) emails to listservs of disability groups, 6) sign language videos posted on social media groups for Deaf users, and 7) emails to participants in a prior survey of women's health who had indicated willingness to be contacted about future study opportunities.

Women who were interested in participating contacted study staff. Staff answered questions about the study and collected data on age, race and ethnicity, type of disability, insurance coverage, and prior and/or current contraceptive use. Women who met the eligibility criteria regarding age, having one of the types of disability described elsewhere in this article, and having contraceptive experience were scheduled for a focus group.

Focus Group Guide

The advisory council assisted in developing the focus group guide, which consisted of broad questions and follow-up probes to gain insight into women's experiences with seeking and obtaining contraceptive information and participating in contraceptive decisions. Advisory council members reviewed an initial list of topics suggested by the research staff and suggested additional topics to include. The advisory council also prioritized topics to address and reviewed multiple drafts of the guide, providing detailed input on specific wording of questions and probes. The guide addressed participants' sources of information about contraceptives, ease or difficulty of finding the contraceptive information they needed, and experiences with contraceptive decision-making.

Data Collection

Focus groups were conducted in the Portland, Oregon, metropolitan area in 2016 and 2017. We organized focus groups to be homogenous with regard to type of disability. The size of our participant pool enabled us to hold one focus group for each type of disability. Each focus group included three to six participants and lasted approximately 2 hours. Each group was held in a community location easily accessible and familiar to participants.

We sent consent forms and focus group questions to participants in advance of focus group meetings. We discussed these materials with participants individually and ensured that participants were able to describe in their own words the key aspects of the study required for consent (e.g., study purpose, how their answers to focus group questions would be used, possible risks of participating, and that no one would be upset if they chose not to participate). At the beginning of each focus group, we reviewed the consent form, answered any question participants had about the study, and collected signed consent forms.

We emphasized that women could choose whether or not to answer each question and could discontinue their participation at any time. Participants received a \$40 gift card to thank them for their time. Study procedures were reviewed and approved by the Oregon Health & Science University Institutional Review Board.

Project staff and advisory council members co-facilitated the focus groups. Because all of our Deaf participants used sign language as their primary means of communication, the focus group for Deaf women was conducted in American Sign Language, with voice interpretation. All members of each focus group participated actively in the conversations. If needed, moderators asked if a participant who had not yet spoken in response to a particular question had anything to add; these prompts yielded responses that added further detail to what had already been said and/or raised new points.

Analysis

We audio-recorded focus group sessions and had the recordings professionally transcribed. The first author reviewed each transcript for accuracy and removed identifying information. The resulting transcript files were analyzed by the first three authors using conventional content analysis (Hsieh & Shannon, 2005). We conducted independent open coding of the first focus group, then met to discuss initial arrangement of codes into categories to create a codebook. As we analyzed additional focus groups, we added new codes when needed, refining and reorganizing the codebook after each iteration. Subsequent focus groups transcripts were coded independently using the most recent codebook. After coding each focus group transcript, we met to compare assignment of codes; where we disagreed, we reviewed the transcripts and discussed applicable codes until we reached consensus. After all transcripts were coded, we reviewed the codes together to determine clustering of codes into higher order themes. We then examined the emergence of themes across focus groups to identify key themes in common for multiple groups, as well as themes that were unique to certain groups. We maintained an audit trail of transcripts with initial and revised codes, codebook iterations with explanations of codes and reasons for additions or changes to the code list, decisions regarding coding disagreements, and rationale for how codes were grouped into broader themes.

Results

Participant Characteristics

Of 27 women who responded to recruitment announcements, three were ineligible owing to age, six either did not respond to messages about scheduling or were unavailable for any possible focus group meeting time, and one was scheduled for a focus group but did not attend. Thus, across the four focus groups, a total of 17 women participated. Participants ranged in age from 26 to 45 years. Most participants identified their race and ethnicity as White, non-Hispanic and most were publicly insured (Table 1). With the exception of the IDD group participants, all participants had at least some college education. Participants in the IDD group had mild intellectual disabilities; in some cases, these were in combination with other developmental disabilities (e.g., autism, cerebral palsy).

Table 1
Participant Characteristics (N = 17)

| Characteristic | Median (Range) or Frequency (%) |
|----------------------------|---------------------------------|
| Age, years | 35 (26–45) |
| Race and ethnicity | |
| White, non-Hispanic | 15 (88%) |
| American Indian | 1 (6%) |
| Asian | 1 (6%) |
| Education | |
| Graduate degree | 2 (12%) |
| College degree | 9 (53%) |
| Some college, no degree | 2 (12%) |
| High school diploma | 3 (18%) |
| 8th grade | 1 (6%) |
| Health insurance | |
| Medicaid only | 4 (24%) |
| Medicare only | 3 (18%) |
| Medicaid and Medicare | 5 (29%) |
| Medicaid and private | 1 (6%) |
| Medicare and private | 2 (12%) |
| Private only | 2 (12%) |
| Disability type | |
| Physical | 6 (35%) |
| Hearing | 3 (18%) |
| Vision | 4 (24%) |
| Intellectual/developmental | 4 (24%) |

Summary of Themes

Five main themes emerged regarding barriers to contraceptive decision-making. Themes included inaccessible information formats, incomplete information about contraceptive side effects, lack of clinician knowledge and research to guide care for women who are not “typical,” taboos around discussing sexual activity, and limited opportunities for shared contraceptive decision-making.

Inaccessible information: “Doctor language is like in one ear and out the other”

Women with sensory disabilities and women with IDD raised the inaccessibility of commonly used information formats as a barrier to their contraceptive decision-making. Printed copies of written information were useless for women who were blind, as illustrated in the following quote:

So, with the birth control pills they give you these pieces of paper, y’know. It’s like... how am I gonna read this? So I, all those years that I took birth control, I saw a lot of different changes in my body and I had no idea and I wonder if I would have been able to read those pieces of paper that they gave us, would I have even chosen that?

Written information was challenging for Deaf women when it was presented during an appointment, because women could not simultaneously absorb the written content and follow the spoken conversation. As one Deaf woman said, “I don’t have time to read the paperwork because I have to watch the interpreters.” Deaf women also noted barriers to comprehension owing to the high reading level of medical documents. According to a Deaf participant, “Some Deaf people have lower reading levels and some of those brochures have a lot of tough English plus tough medical terms. I’d have to ask someone what some of the words meant.”

Complex language, whether written or spoken, was problematic for women with IDD. One participant with IDD stated, “I don’t bother asking if it’s going to be a verbal answer because I’m

not going to understand it anyway.” Another said, “Doctor language is like in one ear and out the other. You can’t understand that terminology, you know. It’s not where we grew up.”

Incomplete information: “No one told me there might be side effects”

Women reported having experienced a variety of side effects they attributed to contraceptives, including serious side effects such as blood clots. More mild side effects included breast tenderness, mood swings, and repeated yeast infections. Across groups, women felt that they had not been given enough information about potential side effects associated with contraceptives. One blind woman said, “I don’t think that the people, the OB/GYNs, the gynecologists, whoever they are, I don’t think they inform anyone enough about what kind of, what’s gonna happen to your body.” A Deaf woman recalled, “After I took the pills for a while I remember getting some side effects. I was surprised because no one told me there might be side effects.” A participant with IDD described the lack of warning she received about potentially dangerous side effects:

I was just not given a lot of information about it. I wasn’t told that there was like a lot of women coming forward having problems with it [Yaz]. I found out after I was already taking it and I was like, I was really kind of upset that they didn’t tell me.

Another woman with IDD said, “Well they never educated me on it anyways. They didn’t tell me anything about it. But it just caused me a bunch of health issues.”

Although some women tried multiple different contraceptives in an effort to avoid side effects, other women were unaware of alternate possibilities. As one Deaf woman said, “I didn’t know that there were any other options so I just kinda put up and I kept taking the pill.” As a counter example, another Deaf woman shared a positive experience with being well informed about what to expect after IUD insertion:

Well the first month they told me that I might have some body changes, and it might not be awful but I might have bleeding maybe for the month, a little bit of cramps. And I did have some... I was thinking if that pain was gonna continue for a few more months I was gonna say, ‘Get it out I didn’t want it any longer.’ But it was really nice, it was just one month which they warned me about, and then it seemed like as soon as the time hit for that month to be over, then it was done.

Lack of clinician knowledge: “We’re not sure what’s gonna happen”

Women with physical disabilities, in particular, discussed a lack of clinician knowledge about how different contraceptives might affect them. One woman with a physical disability observed, “I think doctors just get overwhelmed by all of the other medical issues associated with my disability, so they don’t feel like they really know what, like how it will affect me, you know?” Another participant in the physical disability group who had encountered similar uncertainty from clinicians characterized it this way: “We’re not sure what’s gonna happen. Like a level of—it’s not—I don’t feel that confident. I don’t know what’s gonna happen with you.” A third participant in this group highlighted the lack of applicable research to inform clinicians:

And the truth is, most studies of these drugs don’t include women with disabilities in the pool of people that—Right? —It’s like, okay, healthy women from the ages of dadadada, we’re gonna try out this treatment in. So I don’t even know how the doctors can be informed, because nobody’s even looking at the research on how it would affect women in our situations.

Taboos: “It was not really something talked about at home”

Women with disabilities indicated limited preparation for contraceptive decision-making and referred to sex and contraception as taboo topics not generally discussed. Women described these taboos as limiting their access to contraceptive information, especially during adolescence. As one blind participant said:

I didn’t really explore birth control options until I got into college because it was not really something talked about at home. And so I asked my girlfriends in the dorm, where do I go? Who do I talk to? Don’t tell mom, type thing.

Similarly, one of the Deaf participants said:

My family don’t talk about sex or anything or birth control at all. I wasn’t sexually active until my 20s. By that time I was kinda readying, considering things, and I was like I didn’t wanna talk to my mom about it. I didn’t feel comfortable enough with my doctor to open up that discussion either about any options I might have about birth control. So I kinda would look at ads, and TV, and brochures, and magazines to get information.

Another Deaf participant noted how barriers related to taboos and embarrassment have an additional layer for women who rely on interpreters: “I didn’t want to talk to a doctor or my family about any of those. With the doctor, you have to go in there with an interpreter, someone you don’t even know, and talk about things.” Only one woman—a participant in the focus group for Deaf women—specifically described having good access to information and support early in her life: “Before I had my first boyfriend I remember my mom said, ‘When you’re ready I’ll help you get birth control.’”

Limited opportunities for shared decision-making: “It would have been nice to have a choice”

Women had mixed experiences with opportunities for shared decision-making around contraception. Several participants described limited input regarding contraceptive methods or the use of contraceptives at all. For example, one blind woman said, “There was no discussion as to, well, which one do you think is gonna work? They just put me on one.” A Deaf woman commented, “I noticed my doctor did not ask me a lot of questions, didn’t ask me my goals. He just asked if I wanted the birth control and I said, ‘Sure, I don’t know, okay.’”

Participants with IDD indicated particularly low involvement in contraceptive decision-making. As one woman in this group said, “They just wrote me out a prescription and said ‘Here.’” Another woman with IDD described a similar lack of input and reflected on how she wished things had been different:

It was pretty much the doctor telling me ... I really didn’t have an option... it was just like, you’re going to do this, and I’m like, okay, I trust you. Now I have help and stuff and I really wish that I’d been more involved. It would have been nice to have a little bit more information and a choice.

A third participant with IDD talked about being pressured to initiate contraceptive use when she did not actually want to:

My OB/GYN, kind of was demanding the issue that I get on birth control and he was saying, 'You need to try this, you need to be on this, because otherwise you're going to be multiplying like crazy.' And so I wasn't too happy, and now I'm like, I want more children and they're not popping out as quickly as I wished they would.

However, women also presented examples of actively participating in the decision making process. For instance, a participant with physical disability said, "My gynecologist was very open to what I had to say, gave me a lot of options." A blind woman described a similarly positive experience:

I actually set up an appointment to meet with my gynecologist beforehand to inquire more about it and I actually had questions for her about what I read online and she was really—she's a great gynecologist and really helpful and didn't just tell me, well, this is so much easier because you don't have to remember to take a pill. She didn't push anything away, she was really straightforward.

One woman with IDD also had a clinician who discussed contraceptive decisions with her, with particular attention to safety:

I brought my issues up with my primary care physician and she was really helpful, because I have cerebral palsy and I have epilepsy and so certain medications that I take affect what type of birth control I can take.

One Deaf participant who recounted both limited and more in-depth involvement in decisions at different points in her life explained her preference for being actively engaged in the decision-making process: "At Planned Parenthood they do ask you a lot more questions. That's one of the reasons I'm more comfortable with them because we're both on the same page. We both go through the questions and we understand each other."

Discussion

To our knowledge, this study is the first to explore common themes as well as distinct barriers to contraceptive decision-making encountered by women with different types of disabilities. Our participants faced numerous barriers to engaging in informed decisions about contraceptive use and method selection. They faced a lack of information in accessible formats, incomplete or missing information about contraceptive side effects, insufficient clinician knowledge and contraceptive research to guide care of women with disabilities, taboos around discussing sexual activity and contraception, and limited opportunities for shared contraceptive decision-making. The majority of these broad themes emerged in common across disability groups; however, some specific information barriers varied by type of disability. For women with sensory disabilities or IDD, the inaccessible formats of contraceptive information (e.g., hard copy only; complex language) served as a key barrier. For women with physical disabilities, a distinct theme was the lack of relevant research to guide information tailored to their needs.

Our findings are consistent with and add further depth to earlier studies that have touched on reproductive health care experiences of women with only one type of disability per study. For example, women with IDD have indicated that their

gynecologists used language they did not understand, did not provide information about risks and side effects of contraceptives, and provided no opportunity for women to choose what type of contraceptive to use (Dotson, Stinson, & Christian, 2003; McCarthy, 2009; Walmsley et al., 2016). Women with physical disabilities have described clinicians' lack of knowledge about disability and its effects on reproductive health, and difficulty obtaining reliable information about contraceptive options and risks (Becker, Stuijbergen, & Tinkle, 1997; Kalpakjian et al., 2020; Nosek et al., 1995; Nosek, Howland, Rintala, Young, & Chanpong, 2001). Less information has previously been available about contraceptive experiences of women with sensory disabilities. Our findings indicate that women in these groups struggled to obtain information in accessible, understandable formats and did not always feel fully informed or engaged in contraceptive decision-making. The barriers we identified highlight continued gaps in achievement of reproductive justice for women with disabilities.

Not all of the issues identified by our participants are necessarily unique to women with disabilities but may have an added layer for those with disabilities. For example, women in the general population commonly experience side effects they did not anticipate, and this is a primary reason for contraceptive method switching and discontinuation (Castle & Askew, 2015). However, women with disabilities face additional challenges to being fully informed about side effects when information is presented in inaccessible formats, as some of our participants described. Similarly, taboos about sexual activity can restrict the contraceptive information available to many adolescents, especially if school-based sexual education is limited to abstinence-only programs (Treacy, Taylor, Abernathy, 2018). These taboos are even stronger for those with disabilities, who face ongoing stigma as a legacy of the eugenics movement and entrenched ableism (Stevens, 2011; Horner-Johnson, Klein, Campbell, & Guise, et al., 2021b). Teenagers with disabilities are often excluded from school-based sexual health education entirely (Holland-Hall & Quint, 2017) and may be less likely than their counterparts without disabilities to receive contraceptive information from their parents (Cheng & Udry, 2003; Krupa & Esmail, 2010; Pownall, Wilson, & Jahoda, 2020). Moreover, clinicians may not ask about or be comfortable discussing contraceptive needs if they erroneously believe such discussions are irrelevant to women with disabilities (Alhusen et al., 2021; Kalpakjian et al., 2020).

This study has several limitations. Our data consisted entirely of information self-reported by women; thus, our findings reflect the perceptions and memories of the participants and may be subject to recall bias. Participants were self-selected, and those with strong feelings or opinions about their experiences may have been more likely to participate. We were only able to conduct one focus group for each broad category of functional disability rather than continuing until we reached data saturation. Further, the majority of our participants were non-Hispanic White and well-educated. Therefore, our findings may not be representative of the full range of women's experiences with contraceptive decisions and access to contraceptive information. Many women with disabilities have more than one marginalized identity and/or more than one type of disability (Haynes et al., 2018; Horner-Johnson, Akobirshoeve, et al., 2021a). These women may experience even greater barriers to obtaining information and participating in contraceptive decisions, as they may be simultaneously impacted by two or more different types of barriers. Additional research is needed to understand the

potentially additive effects of the barriers these multiply-marginalized women may encounter.

Implications for Practice and/or Policy

Our findings point to the need for more contraceptive information in accessible formats. The content should be in clear, nontechnical language. To maximize accessibility, information can be provided in multiple modes, including electronic documents that are compatible with text-to-speech screen reader software, and videos with sign language interpretation. Accessible information should be provided early in life through sexual health education that fully includes students with disabilities and accommodates their learning needs (Horner-Johnson, Senders, et al., 2021c). In health care settings, providing accessible resources through patient portals and showing people how to find and use them would help to ensure that pregnancy-capable individuals with disabilities have access to accurate information to guide contraceptive decisions.

Additionally, there is a critical need for research on safety and effectiveness of various forms of contraceptives in people with different types of disabilities (Farr, Folger, Paulen, & Curtis, 2010; Fromson, 2021; Kaplan, 2006; Zapata et al., 2016). Such research is challenging because results may differ by diagnosis, combinations of diagnoses, extent to which diagnoses impact functioning, and other medications participants may be using (Farr et al., 2010; Kaplan, 2006; Zapata et al., 2016). The number of women in each such subcategory is small relative to the overall population (e.g., McKenzie, Milton, Smith, & Ouellette-Kuntz, 2016; Zapata et al., 2016). Therefore, targeted funding is needed to support multisite trials that can accrue sufficient numbers of women—as well as trans men and nonbinary people—to provide reliable data that can guide care of people with disabilities.

Last, our results indicate opportunities to better involve people with disabilities in the contraceptive decision-making process. It is important to recognize that most women with disabilities can get pregnant (Horner-Johnson et al., 2016; Signore, Spong, Krotoski, Shinowara, & Blackwell, 2011) and many desire to do so (Bloom, Mosher, Alhusen, Lantos, & Hughes, 2017). Routine health visits should address family planning, contraceptive needs and preferences, and preconception counseling; however, this may be impacted by clinician biases (Horner-Johnson, Klein, et al., 2021b). In previous studies, women have reported that clinicians treated them as if they were asexual and expressed surprise that they might need contraceptives (Alhusen et al., 2021; Becker et al., 1997; Kalpakjian et al., 2020; Nosek et al., 1995). Such biases could be reduced through increased education (Horner-Johnson, Klein, et al., 2021b; Iezzoni et al., 2021). Currently, few clinicians receive instruction in addressing reproductive health needs of people with disabilities (Smeltzer, Blunt, Marozsan, & Wetzel-Effinger, 2015; Taouk, Fialkow, & Schulkin, 2018); addressing this gap would improve clinician readiness to engage people with disabilities in discussions about contraceptive options and decision-making.

Given the limited sexual health education they may have received as adolescents (Holland-Hall & Quint, 2017; Namkung et al., 2021), women and other pregnancy-capable people with disabilities may need additional support or resources to help them think through their choices and evaluate the available options. In certain situations, supported decision-making may be helpful, particularly for women with IDD. Supported decision-making would engage one or more additional people of the

woman's choice in helping her reach and communicate a decision, rather than making the decision for her (Center for Public Representation, n.d.). Interactive shared decision-making tools may be another useful resource to help women and other pregnancy-capable individuals identify their priorities and weigh alternatives, provided such tools are designed to be fully accessible and address the unique questions people with disabilities may have. Importantly, women with disabilities need access to the same opportunities as those without disabilities to prepare for and practice reproductive decision-making skills through comprehensive sexuality education beginning at an early age (American College of Obstetricians and Gynecologists, 2016).

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