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Intersection of medicalization and reproductive autonomy: Challenging the barriers faced by women with disabilities

Mili Grace Kurian
PhD Research Scholar, M G University, Kottayam, Kerala, India

Bindumol V C
Associate Professor, Principal in Charge, Government Law College, Trivandrum, Kerala, India
Email: books.bvc@gmail.com

***Abstract*---**This paper explores the medicalization of disability and its detrimental effects on the reproductive autonomy of women with disabilities. Medicalization frames disability as a medical condition that requires intervention, often leading to the assumption that disabled individuals are incapable of making informed reproductive decisions. Drawing on case studies of women with disabilities, including those with muscular dystrophy, cerebral palsy, and psychiatric conditions, the paper highlights how medicalized views result in coercive reproductive practices such as forced sterilization, limited access to assisted reproductive technologies (ART), and the pathologization of pregnancy. These practices are rooted in harmful stereotypes about disabled women's ability to parent and a lack of understanding within healthcare systems. By analyzing these issues, the paper critiques how medicalization reinforces discriminatory attitudes and institutional barriers, restricting disabled women's Reproductive rights. It calls for a shift toward a rights-based, inclusive approach to reproductive healthcare that upholds the autonomy of women with disabilities, advocating for policy reforms to ensure informed consent, equitable access to reproductive services, and the

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Corresponding author: *Kurian, M. G.; Email: kurianmili6@gmail.com*
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dismantling of medicalized frameworks that undermine disabled women's reproductive agency.

***Keywords*---**Intersectionality, Medicalization, Pathologization, Reproductive Autonomy, Reproductive Justice.

1. Introduction

The case of Ora Mor-Yosef highlights the complex interplay of reproductive technology, disability rights, and societal attitudes. Ora, a woman with severe muscular dystrophy, pursued motherhood through surrogacy using donated ovum and sperm. Despite successfully initiating this process, the child was taken into foster care after birth, and Ora was denied custody (Rothler, 2017). Another incident involves a woman with a mobility impairment who sought access to in vitro fertilization (IVF). Despite having the financial resources and medical clearance to pursue the procedure, she was denied services by multiple clinics. One fertility specialist openly questioned her ability to parent due to her disability, stating, "We have to consider the well-being of the potential child."(Casebolt, 2020). Then there is the experience of Maria, a woman with cerebral palsy who sought access to in vitro fertilization (IVF). Despite her determination to become a mother, Maria faced scepticism from healthcare providers who questioned her ability to care for a child. She described being subjected to invasive questioning and a lack of physical accommodations at the clinic, which made the process both emotionally and physically exhausting. Maria's story highlights the pervasive biases and structural barriers that women with disabilities encounter when seeking ART (iezzoni et al., 2015). In 2012, the case of Mary Moe, a pregnant woman with a psychiatric disability, highlighted significant concerns about reproductive autonomy and legal guardianship. Moe's parents sought court approval to assume guardianship to compel her to undergo an abortion, despite her strong opposition rooted in religious beliefs. The trial court controversially granted the parents co-guardianship, authorizing coercive measures to carry out the abortion and even ordered her sterilization to prevent future pregnancies. However, the appellate court later reversed the decision, criticizing the sterilization order as procedurally unjustified and unsupported by any party involved (Powell, 2021)

These outcomes underscore the persistent prejudices and negative assumptions about the parenting capabilities of individuals with disabilities, which often influence legal and institutional decisions. The intersection of autonomy and reproductive healthcare is a critical area of inquiry, particularly when addressing the unique challenges faced by women with disabilities. Despite advancements in reproductive healthcare and technology, women with disabilities continue to encounter significant barriers that impede their ability to exercise full reproductive autonomy. These barriers are multifaceted, encompassing societal attitudes, systemic healthcare inequities, and legal and ethical dilemmas (Matin et al., 2021). Reproductive autonomy is a fundamental right, encompassing the ability to make informed decisions about one's reproductive health free from coercion, discrimination, or undue influence (Purdy, 1996). For women with disabilities, achieving this autonomy often involves navigating a complex landscape of physical, social, and institutional obstacles. Historically, these women have faced stigmatization, discriminatory policies, and limited access to reproductive healthcare, including ART (Rothler, 2017). Such inequities not only infringe upon their rights but also perpetuate broader social injustices. Assisted reproductive technologies offer transformative potential to support reproductive choices and overcome certain biological barriers to conception and childbearing. However, the accessibility and inclusivity of these technologies remain problematic for women with disabilities. Challenges include physical inaccessibility of clinics, lack of provider training and awareness, and biases that question the parenting capabilities of women with disabilities (Iezzoni et al., 2021). Moreover, ethical concerns regarding informed consent, affordability, and equitable access to ART further complicate this landscape. This paper explores the systemic barriers faced by women with disabilities in accessing Assisted Reproductive Technologies (ART), emphasizing how the medicalization of disability exacerbates discriminatory attitudes, reinforces physical and institutional inaccessibility, and perpetuates societal biases about parenting capabilities. By situating these challenges within a reproductive justice framework, the paper advocates for equitable access, respect for reproductive autonomy, and the deconstruction of medical and societal narratives that marginalize women with disabilities in their pursuit of parenthood and reproductive health.

2. Materials and Methods

This study employs a desk-based research design, relying on secondary data analysis to explore the intersection of medicalization and reproductive autonomy. The approach focuses on synthesizing existing literature, legal documents, and publicly available datasets to identify key themes and trends. Drawing exclusively from secondary sources, the research ensures a comprehensive review of available materials such as Peer-reviewed journal articles on medicalization, reproductive autonomy, and disability as well as Articles from interdisciplinary fields such as bioethics, sociology, law, and disability studies. Legal and Policy Documents like the National and international laws, court rulings, and policies related to reproductive rights, ART, and disability rights have been referred to. Examples include rulings like Mary Moe's case and guidelines from bodies like WHO or UNCRPD. Additionally reports from organizations advocating for disability rights and reproductive health (e.g., WHO, Guttmacher Institute) and News articles and documented personal narratives illustrating real-world experiences of medicalization and its impact on reproductive autonomy have also been referred to.

Limitations

- Dependence on secondary data may restrict the exploration of current trends or lived experiences not yet documented in the literature.
- Potential bias in the original data sources could influence the findings.
- Limited availability of disaggregated data specific to disabled individuals' experiences with reproductive health.

Objectives of the Methodology

1. Provide a comprehensive understanding of the relationship between medicalization and reproductive autonomy.
2. Identify systemic barriers and societal attitudes as reflected in existing literature and cases.
3. Highlight gaps in current research and propose areas for future investigation.

3. Results and Discussions

3.1. Reproductive Autonomy and Disability

The intersection of reproductive autonomy and disability represents a critical dimension of social justice and healthcare equity. Reproductive autonomy is defined as the right to make informed and independent decisions about one's reproductive health, including whether and when to have children (Purdy, 2006). For people with disabilities, achieving reproductive autonomy requires addressing significant obstacles, including:

1. **Stigma and Stereotypes:** Society frequently questions the reproductive desires and parenting capabilities of disabled individuals, perpetuating myths that they are unfit to be parents (Powell and Stein, 2016)
2. **Healthcare Inequities:** Physical inaccessibility, lack of provider training, and insufficient accommodations hinder disabled individuals from receiving adequate reproductive healthcare (Iezzoni et al., 2021).
3. **Legal and Policy Barriers:** Laws and institutional policies often fail to protect the parenting rights of disabled individuals, leading to practices such as custody removals based on disability status alone.(Powell and Stein, 2016) The cases mentioned earlier stand as examples for the same.

3.1.1 The Medicalization of Disability

The concept of medicalization refers to framing disability primarily as a medical problem requiring intervention, rather than as a natural variation of human experience. While medicalization can provide access to necessary treatments, it often reinforces the view of disabled individuals as dependent and incapable of autonomy.(DasGupta, 2020). Key Manifestations of Medicalization in Reproductive Autonomy of Women with Disabilities:

a) **Sterilization and Contraceptive Decisions:** Historically, women with disabilities have been subjected to forced sterilization or coerced into using contraception due to the belief that they should not have children. This stems from a medicalized view that people with disabilities are inherently unfit for parenthood, which disregards the individual's reproductive rights and autonomy. In some cases, women are seen as unable to care for a child because of their disability, leading to paternalistic decisions about sterilization or birth control without their full consent (Patel, 2017). Women with disabilities often face medical pressure to make reproductive choices that are not based on their own desires, but on societal assumptions about their capabilities as parents. These pressures often manifest as suggestions for permanent contraception or sterilization, particularly for women with intellectual or developmental disabilities. The medical community has sometimes viewed these women as lacking the capacity for informed decision-making, undermining their autonomy and right to choose.(Devkota et al., 2019)

b) **Lack of Accessible Reproductive Healthcare:** Women with disabilities may also face barriers to accessing reproductive health care, not only due to physical inaccessibility of healthcare settings but also due to a lack of medical professionals' understanding of their specific health needs (Silvers et al., 2016). Medicalization in this context occurs when these women are treated as passive recipients of care, rather than active participants in their reproductive decisions. For example, women with mobility impairments may have difficulty accessing gynaecological exams or may be denied reproductive services based on assumptions about their sexuality or fertility (Silvers et al., 2016).

c) **Pathologization of Pregnancy:** When women with disabilities do become pregnant, their pregnancies are often pathologized and are often terms 'Risky Mothers' (Frederick, 2017). Medical professionals may approach these pregnancies with a high level of caution, viewing the pregnancy as high-risk, even when there is no clinical basis for doing so. This can lead to unnecessary medical interventions and can undermine the woman's control over her own body and reproductive decisions. It may also result in increased surveillance of the pregnancy, often with the assumption that the woman may not be able to properly care for herself or her child, a belief rooted in the medicalization of disability.

d) **Exclusion from Reproductive Decision-Making:** Medical professionals may also exclude women with disabilities from the decision-making process regarding their own reproductive care.(Devkota et al., 2019) This exclusion is a direct result of medicalized views that these women are not capable of making sound reproductive decisions. For instance, in cases of pregnancy termination, women with disabilities may face external pressure from healthcare providers or family members who question their ability to care for a child or manage a pregnancy, further diminishing their reproductive autonomy.

The medicalization of disability manifests in the reproductive autonomy of women with disabilities in multiple ways, including forced sterilization, lack of accessible healthcare, pathologization of pregnancy, and exclusion from reproductive decision-making. These practices reflect broader societal biases and assumptions about disability, which view disabled individuals as dependent or incapable. Ensuring reproductive autonomy for women with disabilities requires dismantling these medicalized perspectives and promoting a more inclusive, rights-based approach to reproductive healthcare that respects their agency and autonomy.

3.2 Reproductive Justice Framework and Medicalization Of Disability

Reproductive justice is a framework that expands beyond reproductive rights, integrating social justice issues to ensure all individuals have the right to make decisions about their reproductive health. It emphasizes not only the right to have children, not have children, and parent in safe environments, but also addresses the intersecting factors of race, class, gender, and ability that shape reproductive choices and access to resources.(Onwuachi-Saunders et al., 2019).The reproductive justice framework offers a vital perspective to challenge the medicalization of disability, which often disregards the rights and capabilities of disabled women in making reproductive choices.

An intersectional approach is essential when considering the reproductive justice of disabled women. Disability interacts with other identities—such as race, class, and gender—to create compounded barriers that hinder their reproductive autonomy (Fletcher et al., 2023). Disabled women of color, for instance, face multiple layers of discrimination, including racism, sexism, ableism, and classism. Key challenges include:

a) **Healthcare disparities:** Disabled women, especially those from marginalized racial or ethnic backgrounds, face barriers in accessing adequate reproductive healthcare due to systemic racism and economic disparities. These women often encounter healthcare providers who may harbour prejudices or lack the knowledge to provide the specific care needed for their disabilities. Healthcare systems are often inaccessible to women with disabilities, particularly those from minority racial backgrounds, exacerbating health disparities (Matin et al., 2021).

b) **Social stigmas and stereotypes:** Disabled women of color often face stigmatization not only for their disability but also due to their race and gender. This can result in reproductive healthcare professionals making assumptions about their sexuality, reproductive desires, and abilities to parent (Matin et al., 2021). Stereotypes about disabled women's sexuality and their perceived inability to parent often shape healthcare providers' responses, resulting in decisions made on behalf of these women without their input.

c) **Economic barriers and coercive practices:** Disabled women, particularly those from low-income backgrounds, are disproportionately affected by policies that control their reproductive decisions (Horner-Johnson et al., 2021). Economic constraints may limit their ability to access healthcare, while systemic barriers often result in the forced sterilization or coercion into contraception. Disabled women in poverty are particularly vulnerable to the medicalization of their bodies, where their reproductive rights are compromised under the assumption that they lack the resources or capability to raise children.

3.3. Future Implications

The continued medicalization of disabled women, particularly in the context of reproductive justice, poses significant implications for their autonomy, rights, and social inclusion. The medicalization process, which often frames disability as something to be fixed or controlled, frequently results in the denial of disabled women's reproductive rights, reinforcing harmful stereotypes and limiting their ability to make informed, autonomous decisions about their bodies and family planning.

1. **Loss of Reproductive Autonomy:** One of the most pressing implications is the erosion of reproductive autonomy for disabled women. Medical professionals, under the assumption that disabled women are incapable of making informed decisions, may subject them to coerced sterilizations, forced contraception, or restrictions on their reproductive choices. (Patel, 2017)
2. **Compounded Discrimination:** The ongoing medicalization of disability, when combined with other forms of discrimination (such as racism, classism, and sexism), further marginalizes disabled women, particularly women of color and those from low-income backgrounds (Brinkman et al., 2023). The failure to

recognize and address these intersecting forms of oppression exacerbates their vulnerability to coercive reproductive practices and contributes to unequal access to reproductive healthcare. As a result, disabled women may face additional barriers to accessing the care they need, including prenatal care, family planning, or abortion services.

3. **Stigmatization and Stereotyping:** The medicalization process often involves the pathologization of disabled women's bodies, reinforcing stereotypes that they are either asexual or incapable of responsible parenting (Frederick, 2017). This stigmatization reduces their visibility as individuals with reproductive desires, further perpetuating harmful misconceptions about their sexuality and capacity for motherhood. These negative stereotypes can lead to exclusion from reproductive health services and support systems, leaving disabled women without the resources or opportunities to explore their reproductive options freely.
4. **Institutional and Legal Barriers:** The ongoing medicalization of disability may also contribute to legal and institutional practices that limit disabled women's reproductive rights (Fletcher et al., 2023). For example, laws and policies in some regions may permit or encourage forced sterilization, involuntary contraceptive use, or the denial of reproductive health services for women with disabilities(Patel, 2017). These practices further entrench a system that disregards disabled women's reproductive justice, keeping them under the control of medical authorities and other gatekeepers of reproductive health.
5. **Perpetuation of Disempowerment:** Lastly, if the medicalization of disabled women continues unchecked, it will perpetuate a cycle of disempowerment. Disabled women will remain disenfranchised from decisions that directly affect their lives, including their reproductive choices (Devkota et al., 2019). This systemic disempowerment reinforces the broader societal narrative that disabled individuals, particularly disabled women, are dependent on others, rather than capable of making their own decisions and having full control over their reproductive futures.

Therefore, the continued medicalization of disabled women undercuts their rights to reproductive autonomy, perpetuates harmful stereotypes, and exacerbates social inequalities. A shift toward a reproductive justice framework that affirms the rights of disabled women to make autonomous decisions about their bodies is essential to ensuring that they are fully included in reproductive rights discourse and are able to exercise their reproductive freedoms without coercion or discrimination.

3.4 Suggested Policy Changes and Legal Reforms to Combat The Medicalization Of Women With Disabilities

Examining the intersection of disability, gender, and reproductive justice is essential to recognize the harmful effects of the medicalization of disabled women. This process, which frames disability as something that needs to be fixed or controlled, severely impacts their reproductive autonomy and perpetuates harmful stereotypes about their sexuality, parenting abilities, and overall agency. In light of the multiple implications outlined—such as the loss of reproductive autonomy, compounded discrimination, stigmatization, institutional barriers, and the disempowerment of disabled women—this paper outlines several policy changes and legal reforms that could help to combat these issues such as:

1) **Enforcing Reproductive Autonomy and Informed Consent Laws**
   To address the loss of reproductive autonomy, it is critical to establish and enforce laws that guarantee informed consent and decision-making capacity for disabled women. Policies must mandate that all medical professionals, including those in reproductive healthcare, undergo training on the reproductive rights of disabled individuals, and the importance of recognizing their capacity to make informed decisions. Additionally, informed consent laws should require that disabled women are not coerced or pressured into sterilization, forced contraception, or other reproductive interventions. These laws should be clear in prohibiting the medical practice of assuming that disabled women lack decision-making abilities based on their disability status alone. Legal frameworks should also include provisions for third-party advocacy to ensure that the voices of disabled women are heard and respected in reproductive decision-making processes (Furgalska and de Londras, 2024).
2) **Intersectional Anti-Discrimination Policies**
   The compounded discrimination disabled women face due to the Intersectionality of race, class, and disability must be addressed through comprehensive anti-discrimination policies. The formulation of policies should integrate disability rights with anti-racism, anti-sexism, and anti-classism frameworks, which would allow for better access to inclusive reproductive healthcare. Specifically, policies should ensure equal access to prenatal care, family planning, and abortion services, regardless of socioeconomic status or racial identity. Governments should implement targeted programs that cater to the unique needs of disabled women of color and those from low-income backgrounds, ensuring that reproductive healthcare services are accessible, affordable, and free from discrimination.
3) **Combating Stigmatization and Stereotyping through Public Education and Legal Protections:**
   To combat the stigmatization and pathologization of disabled women's bodies, national and local governments should implement public education campaigns to challenge harmful stereotypes that portray disabled women as either asexual or incapable of responsible parenting. These campaigns should aim to shift societal attitudes by showcasing the diverse reproductive experiences and desires of disabled women. In parallel, legal reforms must ensure that reproductive health providers are held accountable for discriminatory practices based on these stereotypes. Legal protections should guarantee that disabled women are not excluded from Reproductive Health Services or treated as lesser-than in their desires for parenthood.
4) **Legislation to End Coercive Reproductive Practices:**
   Legal reforms should be aimed at eliminating coercive reproductive practices such as forced sterilization or involuntary contraception. In many regions, laws that allow for the sterilization or contraceptive use of disabled women without their consent continue to persist (Patel, 2017). Reforms should specifically criminalize these practices and provide legal avenues for disabled women to challenge any medical decision that violates their reproductive rights. Moreover, legislation must ensure that all forms of reproductive healthcare, including family planning, prenatal care, and abortion services, are available to disabled women without discrimination. Courts must prioritize the autonomy

of disabled women in matters of reproduction, safeguarding their right to make decisions about their bodies and families.

5) **Empowerment through Legal and Social Support Systems:**
The systemic disempowerment of disabled women can be addressed by creating a legal and social infrastructure that supports their autonomy. This could include establishing legal support services that assist disabled women in advocating for their reproductive rights. Additionally, social programs should provide resources that enable disabled women to make autonomous reproductive choices, such as access to counselling services, peer networks, and financial support. By creating spaces for disabled women to voice their concerns and assert their rights, we can work to dismantle the broader societal narrative that positions them as dependent or incapable of making decisions about their reproductive futures.

6) **Promoting a Reproductive Justice Framework:**
Finally, the most comprehensive policy shift would involve a movement toward a reproductive justice framework that acknowledges and affirms the reproductive rights of disabled women. This framework should include the recognition that reproductive justice is not only about the right to bear children or access abortion but also about the broader context of social and economic conditions that enable disabled women to exercise reproductive autonomy. The framework should prioritize the removal of structural barriers, ensure equitable access to healthcare, and promote policies that support the reproductive health of disabled women across the life course. This includes addressing the societal, economic, and institutional challenges that prevent disabled women from fully participating in decisions about their reproductive health.

4. Conclusion

The continued medicalization of disabled women presents a serious threat to their reproductive autonomy, reinforcing harmful stereotypes and exacerbating existing inequalities. Through targeted policy changes and legal reforms, we can ensure that disabled women are empowered to make autonomous decisions about their bodies and reproductive futures, free from coercion and discrimination. The path forward must center on a reproductive justice framework that respects the rights, dignity, and agency of disabled women, recognizing their capacity for informed decision-making and their right to fully participate in reproductive healthcare without fear of exclusion or stigmatization.

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