AT THE INTERSECTION OF DISABILITY AND PREGNANCY:

AN EXAMINATION OF AUSTRIAN DISABILITY AND HEALTHCARE POLICIES, AND THEIR IMPACTS ON DISABLED PREGNANT PEOPLE

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Vienna, 26 May 2025

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ABSTRACT

An expansive and ever-evolving concept, disability has variously been conceived of as individual tragedy, punishment for personal moral failure, something to be fixed or cured, and the condition of being restricted by societal and environmental factors that do not sufficiently account for human variance, among many others. These varying conceptions of disability have translated to diverse policymaking approaches addressing the needs of disabled people. Of these conceptions, the social model, which sees disability not as a natural consequence of physical or mental attributes—often referred to as 'impairments' instead of disabilities—but rather as a result of the social and environmental circumstances that make those attributes problematic, has been the foundation undergirding much of the legislation regarding disability rights and accessibility around the world.

While disabled people face various challenges, their disadvantages can be compounded by intersecting factors such as race, class, and gender. This thesis focuses on the understudied confluence of the challenges faced by disabled people who may experience pregnancy, and evaluates whether Austrian legislation, infrastructure, and healthcare systems as they presently stand adequately address these challenges and enable sufficient accessibility. It is found that despite its many advancements, Austria still remains a largely inaccessible environment for disabled people who may experience pregnancy due to infrastructure, access, oversight, and training issues with the country's healthcare system and accessibility framework.

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Key Words: Disability, Pregnancy, Austrian Medical Framework, UNCRPD

CHAPTER 1: INTRODUCTION

People with disabilities, at an estimated 1.3 billion people comprising 16% of the global population, face significant barriers to accessing adequate healthcare.[1] The Disability and Development Report from the United Nations reported that persons with disabilities are 15 times more likely to rate their health as poor and 7 times more likely to lack access to healthcare.[2] This lack of accessibility extends to critical areas of healthcare, including sexual and reproductive health services, where people with disabilities, particularly women with disabilities, face even greater disparities. Significant challenges include physical barriers like inaccessible facilities and transportation, informational barriers such as a lack of tailored resources or alternative communication methods, and systemic issues like untrained healthcare providers and limited specialized services for people with disabilities.[3] In addition to these challenges, disabled people often lack autonomy in reproductive decisions as others frequently make these choices for them, limiting their ability to exercise their reproductive rights and freedoms.[4] In the context of pregnancy care, these obstacles can lead to delayed or inadequate care, compromising both parental and fetal health.[5]

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[1] World Health Organization, *Global Report on Health Equity for Persons with Disabilities,* 3.

[2] United Nations Department of Economic and Social Affairs, "Disability and Development Report 2024 Executive Summary," 6.

[3] *Disability and Development Report 2024*; Hansen et al., "Monitored but Not Sufficiently Guided – A Qualitative Descriptive Interview Study of Maternity Care Experiences and Needs in Women with Chronic Medical Conditions."

[4] United Nations Department of Economic and Social Affairs, 7.

[5] European Commission. Directorate General for Employment, Social Affairs and Inclusion., *Union of Equality*; United Nations Department of Economic and Social Affairs, *Disability and Development Report 2024 Executive Summary*; *Access to Health Services for Persons with Disabilities in the EU: Review and Commentary*.

Accessible prenatal care is essential to ensuring safe and equitable health outcomes for individuals with disabilities. The UN defines Sexual and Reproductive Health and Rights (SRHR) based on three core principles: the right to make decisions about sexuality and reproduction free from discrimination, coercion, and violence; the right to the highest attainable standard of sexual and reproductive health; and the right to access relevant services, goods, and information.[6] To recognize these rights, addressing these barriers experienced by people with disabilities through inclusive policies, disability-focused training, and improved infrastructure is critical to fostering equity, empowering individuals with disabilities, and promoting positive pregnancy outcomes.

To address and mitigate discrimination against people with disabilities, their rights are protected by international treaties that urge state signatories to address and protect these rights through national policy implementation. The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) acts as the international framework and basis for policies developed at the national level.[7] While this treaty does acknowledge that access to healthcare is a fundamental right and that women with disabilities are more disadvantaged and face more discrimination, women with disabilities continue to face heightened discrimination and stigma in healthcare settings, underscoring the need for robust legal frameworks and policies that prioritize their rights and needs.

As a signatory of the UNCRPD, Austria has implemented multiple frameworks to protect the rights of persons with disabilities and ensure access to healthcare through its compulsory social insurance model. These legal frameworks prohibit discrimination in daily life and the workplace

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[6] Dr. Carmel Shalev, "Rights to Sexual and Reproductive Health."

[7] *Convention on the Rights of Persons with Disabilities and Optional Protocol*.

and establish law enforcement measures for discrimination cases. However, despite Austria's social healthcare models and disability rights frameworks, critical gaps remain between the implementation and enforcement of these policies leading to the failure of ensuring equitable pregnancy care services for people with disabilities who can experience pregnancy.

This thesis will first determine the criteria against which the Austrian system can be evaluated— it will do this by defining disability as a sociological concept, instrumentalized to delineate who these policies should serve and to establish the perspective and approach these policies must take to do this effectively and appropriately. A brief review of international frameworks on disability rights, accessibility, and healthcare access will follow to establish the context within which the Austrian system has been instituted. This thesis will then delve into the unique challenges faced by disabled people who may experience pregnancy to establish what specific challenges these policies must attempt to mitigate. Following this, the case of Austria will be discussed, analyzed, and evaluated, assessing the extent to which Austrian healthcare and disability policies promote barrier-free access to prenatal and parental care for people with disabilities. The last section will identify key gaps between policy and implementation, discuss how Austria has reflected global policies and approaches at the national level, and evaluate their enforcement and effectiveness in practice, finally proposing solutions to address the identified issues. While primary surveys and interviews with stakeholders would have helped to strengthen this study's conclusions regarding policy implementation, such research is beyond the scope of this thesis, and it will instead use available data and otherwise highlight issues fundamental to Austrian policy and legislation.

CHAPTER 2: THEORETICAL AND GLOBAL LEGISLATIVE FRAMEWORK

The questions of what disability is, who is considered disabled, and what disabled people need, are fundamental to designing any policies relating to disabled people and disability. Institutions and policymakers naturally rely on an understanding of disability to inform the approach they take with regards to how they respond to disabled people. Whether disability policy is designed to include, or 'correct', is directly a consequence of whether disability is seen as an 'issue' to be solved, or a variation in being accommodated. Thus, to understand and identify points of critique with any policy framework addressing the needs of disabled people, these questions, and previous attempts to answer them, must first be understood.

While there exist various conceptions of disability in both theory and policy, most perspectives can be broadly split into two camps: one that sees disability as being an individual problem, and another that sees disability as being a state experienced by people arising from society's failure to account for human diversity.[8] While the former models designate disability as inherently being a material state of being, meriting an individualized response, the latter—social—models define it as a social condition and cultural signifier independent of one's physical attributes (referred to as impairments), that is imposed on people by virtue of their human variances and divergence from bodily or mental norms of being, and which merits a social transformation.

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[8] Oliver, "THE INDIVIDUAL AND SOCIAL MODELS OF DISABILITY."

The overarching individual model originated from the historical perceptions of disabilities as a moral desert. This is now referred to as the moral model of disability.[9] Here, disability is conflated with the divergent attributes of the person and is interpreted as being a result of an individual's moral failing or sin, a manifestation of evil, a test of faith, or a consequence of wrongdoing. In this framework, disability is viewed as a form of punishment meant to invoke shame in both the person affected and their family, and something intrinsically undesirable.[10] The locus of responsibility for disablement is thus placed within the disabled person. This assignment of responsibility to the disabled person continues with the moral model's spiritual successor— the medical model of disability. Here disability is seen as a flaw, or even a 'malfunction' caused by health issues which preclude 'normal' functioning, and as such must be corrected or cured.[11] It begins to become clear here how the model used to understand disability impacts how we choose to respond to it. If disability is an individual deficiency, then the solution must be to resolve the individual's perceived deficiencies.

On the other hand, if disability is viewed as an insufficiency on the part of society to appropriately account for varying—rather than malfunctioning or deficient—ways of being human, then the solution must be to make society more accessible to all kinds of bodies and minds. Here, the locus of responsibility for the condition of disablement is placed not within the individual and their attributes, but on the social and environmental conditions that lead to the restrictions and limitations they must face.[12]

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[9] Goodley, *Disability Studies*.
[10] Goodley, *Disability Studies*.
[11] Goodley, *Disability Studies*.
[12] Oliver, "THE INDIVIDUAL AND SOCIAL MODELS OF DISABILITY."

The individual model reinforces and promotes reliance on medical professionals and interventions and centers them as experts rather than considering the perspectives of disabled people themselves.[13] This model essentially views disabled people as aberrations rather than a minority group that has formed part of humanity since its inception. Such a framing positions disabled people as inherently inferior and is often considered to represent a paternalistic and patronizing view of disabled people. Despite this, the individual model of disability across its different forms has historically been the most persistent narrative around disability and remains prevalent in the public consciousness.

Concurrent with the origins of the disability rights movement in the 1970s, a gradual shift to the social model ensued, particularly in policymaking and activist circles. Developed and articulated by disabled people themselves as a direct rejection of the individual model, the principles underlying the social model were first introduced in 1976 in *The Fundamental Principles of Disability by the Union of the Physically Impaired Against Segregation* (UPIAS) as the 'social *definition* of disability'. The social model itself was first articulated as such by the disabled academic Mike Oliver in 1983.[14] When one begins to see disabled people as a human minority, it becomes clear that the lack of consideration for their needs, the control exercised over them, their infantilization and their exclusion from many aspects of public life, constitute a glaring civil rights issue [15] In fact, this failure is then not incidental, but systematic, indicating institutionalized discrimination against disabled people as a minority group.[16]

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[13] Goodley, *Disability Studies*.

[14] Mike Oliver, "The Social Model in Action: If I Had a Hammer," 18–31.

[15] Mike Oliver, "The Social Model in Action: If I Had a Hammer."

[16] Oliver, "THE INDIVIDUAL AND SOCIAL MODELS OF DISABILITY."

While the disability rights movement and the acknowledgement of the principles underlying the social model in broader society birthed the first federal civil rights laws to prohibit discrimination against people with disabilities such as the Americans with Disabilities Act of 1990 and brought forth important policy changes to promote the inclusion of disabled people in everyday life, it faces its own issues. For one, it can be argued that the social model's focus on the environmental conditions that can cause disablement disregards that the experience of 'impairment' itself can be painful, restrictive, or otherwise unpleasant entirely internally and independent of social or environmental circumstances.[17]

This issue is further exacerbated when you consider that the social model also tends to center the experiences of individuals with physical 'impairments', thus often overlooking the needs of those with other forms of disability such as mental health conditions or learning disabilities. Certain mental health conditions may not lead to disablement in public life or functional terms, but still impact one's subjective experience of, and cause significant disruption to, other aspects of one's lives which cannot be improved by social transformation. The same is the case for disabilities resulting from 'impairments' causing chronic pain or chronic fatigue, for example.

However, even the language of 'impairment' itself is flawed, implying deficit rather than neutral variance, emphasizing the view that there is such a thing as a 'normal' human and that the disabled form is in some way 'inferior'. This element of the social model aligns closely with the 'flaw' or 'malfunctioning' designations associated with the individual/medical model's basis. This problem is especially stark for many with congenital rather than acquired disabilities, and to those in, for example, the deaf and autistic communities who do not identify with the term 'impairment'.

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[17] Morgan, "Mad Studies and Disability Studies."

When legislation adopts this understanding of disability as being linked to ‘impairment’, it often leads to policies and funding guidelines which prioritize based on perceived severity of impairment, again medicalizing the topic of disability and allowing others to position themselves as experts externally determining what disabled people need.

Further, the social model also does not sufficiently consider that there exist differences between disabled people such as age, gender, race, and sexual orientation, and that these factors affect how disablement manifests for people, even for those with similar disabilities. This, in fact, is why the needs of specific subgroups such as disabled women and other people who may experience pregnancy are often overlooked. The model also fails to consider that many may experience ‘disabled states of being’ in a sense at times, as experiences such as pregnancy often mimic the experiences of disablement and considering most disabilities are themselves acquired and often occur as a natural consequence of aging or participating in the regular activities of life. Beyond the question of what constitutes and originates disability as a concept, it is also important to determine what exactly comprises disablement, and whether this is a fluid or stagnant designation. If disablement is caused exclusively by external factors, then the presence of an ‘impairment’ is not inherently disabling, and as such, individuals can become non-disabled once social and environmental structures are transformed. However, as before, many feel that the disabled experience is far more complicated and wide-ranging and encompasses both the internal subjective experience and external barriers. Many thus find the experience of ‘impairment’, or even just ‘divergence’, intrinsically disabling regardless of social expectations or barriers and would value medical intervention, others disagree, and many hold both views at the same time for different disabilities.

While various new models have emerged within the fields of critical disability theory and mad studies, no single model can capture the sheer range of experiences, and the many different forms disability can take. In fact, Mike Oliver himself had intended for the social model not to be an all-encompassing theory of disability, but instead only a departure point for the eventual reframing of societal perceptions of disability and a tool for policymaking. However, any policy-making effort intending to serve disabled people must first acknowledge that the experience of disability and disablement can be different for all people, for different reasons, and these experiences and conceptions can often be conflicting. Thus, policy must be able to permit the intersection and confluence of multiple approaches of seeing and dealing with disability, rather than attempting to draw clean boundaries around what counts as disability, who is considered disabled, and what disabled people need.

Legislative Frameworks

Most current legislation is based on the social model, such as the UN Convention on the Rights of People with Disabilities (UNCRPD), the Americans with Disabilities Act (ADA), and the recent European Accessibility Act (EAA) among others.[18] Similar to protections based on race, sex, or religion, the ADA ensures equal access to employment, goods and services, public accommodations, transportation, and participation in state and local government programs. The ADA is structured to address the various areas of public life where participation may be hindered, to guarantee full inclusion and equal opportunity for individuals with disabilities.[19] The ADA was the first federal legislation that was enacted to protect the rights of people with disabilities and set

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[18] *Convention on the Rights of Persons with Disabilities and Optional Protocol*; ADA.Gov, “Americans with Disabilities Act of 1990, As Amended”; European Disability Forum, “European Accessibility Act Toolkit for Transposition.”

[19] ADA.Gov, “Americans with Disabilities Act of 1990, As Amended.”

a precedent globally. This act was the first step towards global recognition of the rights of people with disabilities, and what followed was international frameworks, regional frameworks like in the European Union, and those enacted at the state level. The most important and widely adopted disability rights framework came in the form of the UNCRPD in 2006.[20]

The UNCRPD was heavily influenced and inspired by the preceding Americans with Disabilities Act of the United States but took multiple important steps forward in the way it conceptualizes disability. This was the first global treaty to be created for the promotion and protection of the rights of people with disabilities. Its purpose is to ensure the full and equal enjoyment of human rights and fundamental freedoms for disabled individuals while emphasizing respect for their inherent dignity through autonomy, inclusion, and equality in all areas of life. The UNCRPD adopts and uses elements of the social model to define disabled people as being *"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"*.[21]

However, the convention does attempt to respond to some classical critiques of the social model and evolves its own interpretation. For example, there is clear improvement on issues of intersectionality, with the convention acknowledging the interactions of disability with gender, recognizing that women and girls with disabilities often face increased risks of violence and discrimination. The preamble of the convention underscores the diversity of people with disabilities and the need to integrate a gendered perspective into all efforts. This is particularly

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[20] *Convention on the Rights of Persons with Disabilities and Optional Protocol*.

[21] *Convention on the Rights of Persons with Disabilities and Optional Protocol*, 4.

significant, as women and girls with disabilities often experience greater disadvantages compared to their male counterparts and are frequently the focus of restrictive sexual and reproductive policies.[22] Women and others who may experience pregnancy are widely known to face challenges regarding access to reproductive healthcare and maternity care due to legislative restrictions and social and medical attitudes. Disabled individuals are similarly known to experience great difficulties accessing healthcare and widely report lacking access to healthcare.[23]

The confluence of these two factors creates a condition of multiple oppressions for disabled people who may experience pregnancy. Both the UN Convention on the Elimination of Discrimination Against Women (UNCEDAW) and the UNCRPD, in combination, aim to combat discrimination against women with disabilities and to actualize their full involvement and participation in society.[24] However, most countries still lack appropriate mechanisms to address the condition of multiple discriminations faced by women with disabilities, and further do not account for disabled people with other gender identities that may face similar gender-based violence and lack of access to reproductive and sexual or maternity-related healthcare. Thus, despite the availability of such international frameworks, there are still many glaring oversights, and it is clear most gender-related legislation ignores the perspectives and needs of disabled people. This is particularly concerning due to the history of forced sterilization of disabled people across the world.

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[22] World Health Organization and United Nations Population Fund, *Promoting Sexual and Reproductive Health for Persons with Disabilities*, 34.

[23] World Health Organization, *Global Report on Health Equity for Persons with Disabilities*; United Nations Department of Economic and Social Affairs, “Disability and Development Report 2024 Executive Summary,” 6.

[24] Federal Ministry Republic of Austria Social Affairs, Health, Care and Consumer Protection, “Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).”

While research about the availability of reproductive healthcare and maternity care has been conducted in the past, and research regarding the accessibility of various healthcare services and public spaces exists as well, there is a severe lack of data regarding, and examinations of, current disability and maternity/reproductive care policy and how they respond to the unique challenges faced by disabled people who may experience pregnancy by virtue of their dual oppressions. This thesis attempts to fill this research gap for the case of Austria, through a legislative analysis of current policies and structures meant to address the challenges faced by disabled people who may experience pregnancy.

Challenges Faced by Disabled People Who May Experience Pregnancy

This section will specifically address the UN's Sexual and Reproductive Health and Rights' (SRHR) second and third core principles: "the right to the highest attainable standard of sexual and reproductive health and the right to access relevant services, goods, and information."[25] It will cover the common challenges faced by people with disabilities in accessing sexual and reproductive health care as reported globally, using this information to help set the broader scene of inaccessibility for the specific case study of Austria addressed later.

Women with disabilities, comprising 11% of those who may experience pregnancy, report frequently experiencing many challenges and barriers when accessing family planning and pregnancy care due to these issues.[26] Over 50% of women with disabilities lack access to essential reproductive and prenatal healthcare services, including family planning, skilled birth attendance, and timely postnatal care.[27] Furthermore, health disparities between those with and without disabilities show that postpartum emergency visits are significantly more common among women with disabilities. Rates are especially high among those with intellectual (49%), multiple (42%), physical (33%), sensory (30%) impairments, compared to 24% among women without disabilities.[28]

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[25] Dr. Carmel Shalev, "Rights to Sexual and Reproductive Health."
[26] Byrnes and Hickey, "Perinatal Care for Women With Disabilities," 1.
[27] "Disability and Development Report 2024," 7.
[28] "Disability and Development Report 2024," 92-93.

In many countries, SRHR facilities are physically inaccessible and lack barrier-free features and diverse communication methods like braille, audio options, or better signage.[29] Globally, many women with disabilities report that the essential equipment needed for pregnancy care services, such as examination tables, scales, and baby care items, is not adapted to their needs.[30] Furthermore, the facilities themselves are often inaccessible: rooms, restrooms, and washrooms are not designed for those who use mobility aids such as wheelchair users.[31] Data from 2022 shows that worldwide, 42% of doctors' offices, 29% of pharmacies, and 15% of hospitals were not accessible for wheelchair users.[32] Women with sensory impairments struggle to navigate healthcare spaces without assistance, and those with speech or hearing impairments experience communication difficulties unless accompanied by someone who can support them.[33] This then forces people with disabilities to rely on others to accompany them to appointments, which in turn compromises confidentiality, particularly problematic in the context of sexual and reproductive health care.[34]

There is a consistent stigma that disabled people should not be or are incapable of having sex. This belief prevails even though disabled people are reported to be equally as sexually active as others.[35] This stigmatization often leads healthcare providers to deny people with disabilities access to sexual and reproductive health information and services, and instead discourage them

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[29] United Nations Department of Economic and Social Affairs, *Disability and Development Report 2024 Executive Summary*.
[30] Hansen et al., “Monitored but Not Sufficiently Guided – A Qualitative Descriptive Interview Study of Maternity Care Experiences and Needs in Women with Chronic Medical Conditions.”
[31] *Disability and Development Report 2024*; Hansen et al., “Monitored but Not Sufficiently Guided – A Qualitative Descriptive Interview Study of Maternity Care Experiences and Needs in Women with Chronic Medical Conditions.”
[32] United Nations Department of Economic and Social Affairs, “Disability and Development Report 2024 Executive Summary,” 6.
[33] Hansen et al., “Monitored but Not Sufficiently Guided – A Qualitative Descriptive Interview Study of Maternity Care Experiences and Needs in Women with Chronic Medical Conditions”; *Disability and Development Report 2024*.
[34] “Disability and Development Report 2024,” 124.
[35] “Disability and Development Report 2024,” 119-120.

from any sexual activity.[36] Healthcare providers lack knowledge about how physical disabilities interact with pregnancy, this often means that pregnancy care providers fail to seek out the additional information needed to support them effectively.[37] Instead of addressing disability-related concerns, healthcare providers tend to focus solely on the pregnancy, overlooking the broader needs that arise at the intersection of disability and parental care.[38] The services that providers should offer would ideally encompass education and counselling on sexuality and contraception, prenatal and postnatal care, infertility treatments, safe abortion access, and prevention and treatment of STIs and reproductive tract infections.[39] Unfortunately, due to the lack of education and experience, providers feel unprepared and lacking confidence in their ability to support women with physical disabilities, and conversely, pregnant people looking for adequate care are left confused and mistreated by a system that says it encompasses everyone's needs. This overall lack of accessible infrastructure and assistance from healthcare providers and personnel limits disabled people’s ability to receive adequate pregnancy care and they often feel caught between being treated as dependent patients and needing to advocate for themselves.[40] They are frequently forced to rely on their own knowledge, seeking out information and strategies to ensure effective communication with healthcare providers.[41]

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[36] “Disability and Development Report 2024,” 124.

[37] Hansen et al., “Monitored but Not Sufficiently Guided – A Qualitative Descriptive Interview Study of Maternity Care Experiences and Needs in Women with Chronic Medical Conditions.”

[38] Hansen et al., “Monitored but Not Sufficiently Guided – A Qualitative Descriptive Interview Study of Maternity Care Experiences and Needs in Women with Chronic Medical Conditions.”

[39] “Disability and Development Report 2024,” 114.

[40] Hansen et al., “Monitored but Not Sufficiently Guided – A Qualitative Descriptive Interview Study of Maternity Care Experiences and Needs in Women with Chronic Medical Conditions.”

[41] Hansen et al., “Monitored but Not Sufficiently Guided – A Qualitative Descriptive Interview Study of Maternity Care Experiences and Needs in Women with Chronic Medical Conditions.”

CHAPTER 3: THE CASE OF AUSTRIA

Austria's Policies and Frameworks

This section will discuss the specific case of Austria and how disabled people who may experience pregnancy are treated within its healthcare system. First, Austria's legal frameworks regarding the rights of people with disabilities will be outlined, followed by a discussion of an Austrian case study that highlights the negative experiences individuals have faced within this system. After this, Austria's legal relationship to disability and its exclusionary nature is analyzed. The main component of this section will consist of a critique of the Austrian system discussing the improvements needed to ensure true equality between disabled and non-disabled people's available rights and health access.

(i) Historical Development

International conventions outline and provide guidelines for the essential rights and legal protections that should be vested in people with disabilities. However, countries often have their own terms within which they have ratified agreements formulated on the international level, and many have their own framework on the rights of people with disabilities on the national level. Taking this into consideration, it is important to outline the policies and frameworks formulated at the international level that outline the rights of people with disabilities and then focus on the specific case of Austria. By citing exact legislations and enforcement mechanisms, this section argues that while Austria is, in some ways, exemplary at securing basic rights for people with disabilities, little is spelled out regarding those with multiple oppressed identities. For example, the rights of an important sub-demographic, people with disabilities who may experience pregnancy, and as such face multi-layered discrimination and stigma.

In assessing the experiences of disabled people who may experience pregnancy, an important layer of legislation can be the regional authorities. Frameworks at the regional, federal, and international levels have varied jurisdictions and impacts that affect the daily experiences of people with disabilities. A ‘good’ framework would employ resources from all three levels and should complement, in unison, legislation and directives made at all three tiers.

(ii) Concepts and Models

International frameworks such as the UNCRPD acknowledge that access to healthcare is a fundamental right, and that women with disabilities experience more disadvantages and discrimination.[42] However, despite widespread adoption of this convention globally, less than 38% of countries have gender equality or disability specific laws with specific protections for women with disabilities, only 27% of countries include specific legal protections for women with disabilities, and only 14% protect their parental rights.[43] Austria is a signatory to the UNCRPD and Optional Protocol and has made various commitments towards recognizing the rights and protections of people with disabilities. Most significantly, Austria is one of the few countries with constitutional anti-discrimination protections for people with disabilities.[44] The constitution guarantees equality for all nationals and prohibits discrimination based on birth, sex, social status,

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[42] *Convention on the Rights of Persons with Disabilities and Optional Protocol*.

[43] United Nations Department of Economic and Social Affairs, “Disability and Development Report 2024 Executive Summary,” 8-9.

[44] *Disability and Development Report 2024*; WORLD Policy Analysis Center, “Constitutional Equal Rights of People with Disabilities.”

religion, or disability and mandates the equal treatment of disabled and non-disabled persons across all aspects of daily life, and the removal of existing inequalities.[45]

Austria's constitution also outlines its healthcare model by establishing the country as a welfare state, which implies an obligation to provide healthcare services to all of its residents.[46] To complement this constitutional provision, Austria has developed a compulsory social insurance model through various social security and health insurance laws that work in combination to protect the right to healthcare.[47] Theoretically, these antidiscrimination and healthcare legal frameworks should work together as guidelines to inform the state on how to protect the rights of, and equally include, people with disabilities both within daily life and its healthcare sector.

Using the constitutional outlines as a basis, Austria has created key national instruments for protecting and implementing the rights of people with disabilities that fall under three federal acts: the Disability Employment Act, the Federal Disability Act, and the Federal Disability Equality Act.[48] 'Disability' in all three pieces of legislation is defined as the "effect of a not only temporary physical, mental or psychological functional impairment or impairment of the sensory functions that are suitable to making participation in working life (BEinstG) and/or life in society (BBG and BGStG) more difficult."[49] It is important to note that there are key differences between this definition and the one outlined in the UNCRPD, which presents a split from the social model's conception of disability as outlined in the convention which will be discussed further in a later section. Together, these laws and guidelines prohibit discrimination in daily life and employment, as well as establish enforcement mechanisms by defining the role and authority of the disability

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[45] Austria: Federal Constitutional Law. Article 7.
[46] "The Austrian Health Care System."
[47] "The Austrian Health Care System," 40.
[48] oesterreich.gv.at, "Allgemeines zur Gleichstellung von Menschen mit Behinderungen."
[49] "National Action Plan on Disability 2022–2030," 14.

lawyer.[50] Such enforcement mechanisms, to a degree, ensure the rights and dignity of people facing discrimination due to disability, where violations are penalized, punished, and discouraged.

Per the commitments to the UNCRPD, Austria has created a National Action Plan on Disability, which is used as a resource and guide for the implementation of the UNCRPD commitments, and has also provided multiple policy recommendations to address current issues.[51] In the specific issue of prenatal care for people with disabilities, the Austrian National Action Plan recognizes that women with disabilities face greater disadvantages in healthcare settings and that the resources for accessing sexual and reproductive services are inadequate.[52]

(iii) Frameworks on Accessibility

The accessibility of the built environment is important to consider at the intersection of disability and health and ensuring equitable access to healthcare services. To address barriers of the structural environment, the various federal-level acts mentioned above attempt to prohibit discrimination against people with disabilities within public life by requiring the removal of structural, physical, and digital barriers that limit access to public services. Within Austrian law, accessibility is defined as a space "usable by people with disabilities in the usual way, without particular difficulty and, in principle, without outside help."[53] This is followed by various standards of barrier-free guidelines for accessible buildings and facilities that are outlined in ÖNORMEN standards (guidelines for accessible buildings and facilities) and the OIB Guideline 4 (part of six regulations harmonizing structural engineering established by the Austrian Institute

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[50] oesterreich.gv.at, "Allgemeines zur Gleichstellung von Menschen mit Behinderungen."
[51] "National Action Plan on Disability 2022–2030."
[52] "National Action Plan on Disability 2022–2030."
[53] "(Bundes-Behindertengleichstellungsgesetz – BGStG)." Translated from German to English.

for Building Technology).[54] In the case of healthcare facilities, the ÖNORMEN standard ÖNORM B 1601 contains the "planning principles for barrier-free healthcare facilities, assisted living and working spaces."[55] OIB guidelines are updated every four years, approved by the OIB General Assembly, and incorporated into state building regulations.[56] However, these standards are mere guidelines, not federally mandated across all of Austria, and are instead up to the regional authorities to be made obligatory.[57]

(iv) Frameworks on Pregnancy Care

In Austria, pregnancy is protected through comprehensive legal, financial, and healthcare measures. Under the Maternity Protection Act, pregnant people are protected in the workplace from termination with entitlement to parental leave and supplemental income on top of childcare allowance.[58]

In accordance with Austria's compulsory social insurance model, the Austrian government has strict policies when it comes to pregnancy care support in the context of healthcare. The public healthcare system fully covers pregnancy-related medical care through the Parent-Child Pass.[59] This pass provides a structured schedule of mandatory medical check-ups for both the pregnant person and the child, starting in early pregnancy and continuing until the child is five years old. This includes five scheduled examinations, including additional allowances for specific cases, and

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[54] "National Action Plan on Disability 2022–2030"; oesterreich.gv.at, "General information on barrier-free construction."
[55] oesterreich.gv.at, "General information on barrier-free construction."
[56] oesterreich.gv.at, "General information on barrier-free construction."
[57] The Austrian Disability Council, *Response to the List of Issues*.
[58] oesterreich.gv.at editorial team and Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection, "Was Ich Vor Der Geburt Zu Beachten Habe."
[59] oesterreich.gv.at editorial team and Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection, "Was Ich Vor Der Geburt Zu Beachten Habe."

midwife consultations encompassing ultrasounds, blood tests, and developmental screenings during pregnancy to help ensure early detection of health issues. On top of the examinations provided by the government, government social organizations like Frühe Hilfen provide extra support to families and individuals.[60] However, what is missing from the pregnancy care framework is the ability to easily find knowledgeable providers and accessible facility options for people with disabilities.

(v) Experiences of Pregnant Disabled People in Austria

In the specific context of Austria, there have been very few studies done on the experiences of parents with disabilities during pregnancy care. The most recent study, done between 2013 and 2015, "*Experiences of Austrian Mothers with Mobility or Sensory Impairments During Pregnancy, Childbirth*", found that women with disabilities experience challenges or barriers primarily due to social stigma, communication, a lack of transparency and information, and limited professional support during pregnancy, childbirth, and postpartum care.[61]

The women interviewed during this study reported experiencing social stigma regarding their decision to start a family, marked by discriminatory attitudes and a lack of support for their life choices, especially around parenting. Many reported frequent violations of personal space and a constant feeling of being monitored or controlled. These experiences damaged their self-confidence and sense of autonomy. Communication challenges with healthcare professionals were

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[60] oesterreich.gv.at editorial team and Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection, "Was Ich Vor Der Geburt Zu Beachten Habe."

[61] Schildberger et al., "Experiences of Austrian Mothers with Mobility or Sensory Impairments during Pregnancy, Childbirth and the Puerperium."

due to time constraints and a lack of accommodation in the form of different communication methods, such as sign language interpreters for those with sensory impairments.[62]

These barriers led to fear, uncertainty, and discomfort due to limited understanding and preparedness. These communication challenges also led to a major concern regarding transparency and clear and accessible information, making the overall environment frequently fail to ensure privacy and adequate support. Women with sensory disabilities also expressed a need for more detailed information and the necessary interventions for their pregnancy care. This left the women feeling unprepared for medical procedures, and an increase in distressing and embarrassing situations.[63]

Furthermore, many healthcare professionals appeared inexperienced and uncertain when dealing with women with disabilities, further reducing the women's trust and self-assurance. This issue was further exacerbated by staff shortages and time constraints, leading to minimal time spent with patients. The limited knowledge and comfort of professionals in caring for pregnant women with disabilities often prevented adequate communication and care. Additionally, it was reported that alternative, non-institutional services were either unknown or inaccessible to many women due to poor accessibility.[64]

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[62] Schildberger et al., "Experiences of Austrian Mothers with Mobility or Sensory Impairments during Pregnancy, Childbirth and the Puerperium."

[63] Schildberger et al., "Experiences of Austrian Mothers with Mobility or Sensory Impairments during Pregnancy, Childbirth and the Puerperium."

[64] Schildberger et al., "Experiences of Austrian Mothers with Mobility or Sensory Impairments during Pregnancy, Childbirth and the Puerperium."

CHAPTER 4: CRITIQUE OF THE AUSTRIAN SYSTEM AND POLICY RECOMMENDATIONS

Medical vs. Social Model

The Austrian framework does not reflect the UNCRPD's understanding of disability through the lens of the social model. Instead, Austria predominantly relies on the medical model of disability within many aspects of its legal framework. This is glaringly apparent in the verbiage used to define disability, framing disability as an 'impairment', or fault, of a person's body, which then 'impedes' participation in society.[65] This frames disability as an individual issue, rather than as a social issue created by environmental and systemic barriers. This ignores the impacts that social barriers have on disabled people as a marginalized group. Relying on the medical model of disability impacts the formulation of a legal framework that can adequately respond to the social and environmental barriers with which a social issue like disability is approached.[66] These notions have permeated Austrian society and take an active role in shaping the cultural norms and how people interact with disability as a social issue. To remedy this, Austria should take a top-down approach and shift the legal framing of disability from the medical model to the social model. Approaching disability as a social issue would recognize the importance of removing structural barriers as a priority for better the lives of disabled people and dramatically transform how the challenges faced by people with disabilities are responded to.

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[65] "(Bundes-Behindertengleichstellungsgesetz – BGStG)." German to English translation.

[66] The Austrian Disability Council, *Response to the List of Issues*.

Gaps in Implementation and Enforcement

While Austria has several federal legal frameworks intended to address the rights of people with disabilities, including anti-discrimination and some accessibility measures, there are significant gaps in regulatory oversight regarding the implementation, compliance, and enforcement. These laws are scattered across several different frameworks, with the assumption that they will work together comprehensively to address the inequalities faced by disabled people within Austria. Furthermore, while Austria is a signatory of the UNCRPD, the nine regions of Austria are not equally bound by the convention. For example, the Governor of Vienna stated publicly that only the federal state of Austria ratified the UNCRPD, not the regions, so therefore, since each region of Austria did not ratify the convention, they do not have to be concerned with the obligations of the convention.[67] Because each tier of governance within this system has its own priorities, polices and jurisdiction with little cooperation between them, this has resulted in the different tiers of governance as unable to cohesively work together in recognizing the rights of disabled people.

Accessibility of the Built Environment and Enforcement Mechanisms

Another major shortcoming of Austria's legal framework is the absence of mandatory accessibility guidelines for barrier-free design in the built environment. Instead of a comprehensive understanding of barrier-free design, the Austrian legal framework aims to address structural

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[67] The Austrian Disability Council, *Response to the List of Issues*.

barriers of the built environment through antidiscrimination laws against disabled people, through the prohibition of both direct and indirect forms of discrimination. This includes both physical and social barriers. Within Austria’s disability rights laws, the structural environment must be accessible and usable without outside assistance. However, the obligation to remove barriers does not apply if doing so would impose a “disproportionate burden,” which is assessed based on factors like cost, available funding, and the impact on those affected.[68] In such cases, only “reasonable accommodations” are required.[69] The allowance for such exceptions creates loopholes and negatively impacts enforcement mechanisms. This exception gives businesses, landlords, and public institutions flexibility to cite financial or practical constraints, weakening Austria’s universal design approach by allowing entities to avoid full compliance.[70]

Furthermore, Austria’s legislative responsibility is split between the federal government and the regions, making construction law a competence of each region and limiting the federal government's authority to mandate structural accessibility. While some regional building laws include accessibility provisions, these mainly apply to new construction or major renovations, not existing buildings.[71] This limits efforts to address the structural barriers that are seen as the true source of disablement within the Social Model. By failing to prioritize the removal of environmental obstacles, Austria's laws make little acknowledgment of how physical infrastructure restricts the full social participation of disabled people. This essentially grants compliance with barrier-free standards as optional or dependent upon the business or person constructing new buildings, rather than on regional or federal authorities.

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[68] “(Bundes-Behindertengleichstellungsgesetz – BGStG).”
[69] “(Bundes-Behindertengleichstellungsgesetz – BGStG).”
[70] *Overview About the Cross-Sectional Issue of Disability in Austria*.
[71] *Overview About the Cross-Sectional Issue of Disability in Austria*. 58.

There are minimal penalties or regulatory bodies that regulate and enforce the built accessibility of private or public establishments. The enforcement mechanism is dependent on individuals who report that their rights are being discriminated against, for example, a disabled person who files a complaint that a building is not barrier-free for them. This means that enforcement is highly reliant on individual complaints of discrimination, making it an individual issue, rather than on a restructuring of understanding to view disability as rooted within society. These anti-discrimination laws stem back into the medical model of disability and reflect how disablement is seen as an individual problem rather than a societal issue. For example, if one feels that the structural environment of a hospital doesn't meet their needs, it is their responsibility to report this to the authorities as an act of discrimination. This lack of a unified, binding framework for accessible design continues to hinder meaningful progress toward a social understanding of disability.

Accessibility in the Context of Healthcare Facilities

The lack of coordination in accessibility measures is especially evident in the Austrian health.[72] Many building regulations lack clear accessibility requirements targeted at hospitals, clinics, and medical professionals with a little to no legal obligation or consequences if they fail to provide accessible and inclusive services. While state hospitals and larger facilities have generally implemented accessibility well, smaller providers, such as general practitioners, specialists, and private clinics, often fall short. (see appendix 3).[73] A study done on the accessibility of Austrian Obstetric Departments found that, while basic physical accessibility in Austrian obstetric

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[72] The Austrian Disability Council, "Response to the List of Issues."

[73] Schildberger et al., "Chancengleiche Versorgung in der Geburtshilfe – Eine quantitative Erhebung zur Barrierefreiheit an geburtshilflichen Abteilungen in Österreich."

departments, such as barrier-free sanitary facilities, is present in most cases, more specific features are lacking.[74] Without official guidelines of what barrier-free design is, there is a lack of understanding or knowledge among healthcare workers on how to make their clinics accessible. As a result, accessibility is typically self-reported by the healthcare facilities themselves, leading to inaccurate accessibility assessments and information, and inadequate accommodations for individuals with varying disabilities, such as blindness, deafness, or mobility impairments. This is especially problematic for those seeking pregnancy care, as few specialized clinics exist, and resources to support individuals navigating pregnancy with a disability are limited and difficult to find.

Despite existing accessibility standards for healthcare facilities, compliance is inconsistent due to limited awareness, restricted access to the guidelines, and a lack of legal enforceability, like the general accessibility issues faced with any infrastructure. Accessibility guidelines are not mandatory in architectural education, leaving many professionals and architectural students unfamiliar with universal design principles. If healthcare is to be recognized as a basic universal human right to all as defined by the compulsory social insurance model, then it should be recognized as such through barrier-free design, so everyone has equitable access to receive care. Codifying ÖNORMEN as the law would establish universal design under federal authority, ensuring nationwide regulation, public accessibility, and legal enforcement. This would also mandate its inclusion in architectural curricula, outlining consistent application of accessibility standards, and promoting broader awareness and recognition of disability as an issue of the social environment.

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[74] Schildberger et al., “Chancengleiche Versorgung in der Geburtshilfe – Eine quantitative Erhebung zur Barrierefreiheit an geburtshilflichen Abteilungen in Österreich.”

Awareness and Training

Beyond the inadequate infrastructure of the built environment, there exists a lack of adequate training and awareness among healthcare providers on how to care for patients with disabilities or accommodate their specific needs. Trained staff and support services are limited, with 19% having diversity management training, 14% of staff having sign language skills, and only 13% providing antenatal classes for disabled women.[75] It has also reported that current structural and organizational conditions in obstetric settings are often not suitable for providing individualized, flexible care to women with physical disabilities. Due to the rarity of such cases, professionals often feel unprepared and insecure, leading to hesitation or inappropriate medical decisions. Specific gaps in knowledge include how to position women with motor disabilities, instruct blind women in newborn care, manage paraplegic women's needs during labor, and handle disability-specific medications or anesthetics. These uncertainties can cause professionals to feel awkward, ashamed, or to unintentionally pathologize the pregnancy.[76] While the Ministry of Social Affairs offers a brochure service and database with information on a range of topics, including gynecological and pregnancy care for disabled patients, this resource is not widely known or accessible.[77]

Reflective, empathetic, and diversity-aware attitudes are seen as essential for respectful, inclusive maternity care. The healthcare professionals in the study emphasized the need for targeted training, access to clear guidelines, and ongoing education to strengthen both their medical skills and confidence in caring for patients with disabilities. They also called for systemic

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[75] König-Bachmann et al., "Health Professionals' Views on Maternity Care for Women with Physical Disabilities."
[76] König-Bachmann et al., "Health Professionals' Views on Maternity Care for Women with Physical Disabilities."
[77] Bundesministerium Soziales, Gesundheit, Pflege und Konsumentenschutz, "Broschürenservice."

improvements, including centralized information resources, enhanced communication strategies, and formal frameworks for interprofessional collaboration.[78] A centralized, publicly available database of accessible healthcare providers, including those specializing in pregnancy care for people with disabilities, would be a crucial step toward improving healthcare access and ensuring equitable treatment.

Intersectional Barriers

Existing laws presently do not contain any specific legal frameworks to adequately address intersecting identities which may impact equitable healthcare access for reproductive healthcare services such as pregnancy and postpartum care for people with disabilities. Instead, pregnancy care and access depend on broad anti-discrimination laws and state-level regulations, which often fail to address the unique challenges faced by people with disabilities in reproductive healthcare settings. Additionally, monitoring and accountability mechanisms are weak, meaning that violations of accessibility and discrimination often go unreported or unaddressed. Without a centralized body or enforcement agency responsible for evaluating and ensuring compliance with disability-inclusive healthcare policies, accessibility remains inconsistent across healthcare facilities. This results in unequal healthcare experiences, where some individuals may find inclusive care while others encounter systemic barriers.

Disability-inclusive pregnancy and postpartum healthcare services may not be widely available in the public healthcare system, forcing individuals to seek private care, which is financially inaccessible for many. Individuals who are migrants, especially those without stable

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[78] König-Bachmann et al., "Health Professionals' Views on Maternity Care for Women with Physical Disabilities."

residency status, may struggle to navigate the healthcare system due to a lack of accessible information and discrimination as well as additional challenges like language barriers and legal restrictions beyond disability. Instead of simply accounting for multiple oppression in policy, there must also be steps taken to prevent such discrimination and oppression occurring in the first place, through public education and awareness campaigns.

Data Deficiency

This system and laws have no centralized disaggregated data on the number of people living with disabilities, nor on how many seek pregnancy care to rely upon. There is a lack of firsthand accounts from pregnant individuals with disabilities regarding their experiences and the barriers they face in accessing reproductive healthcare services in Austria. Without this information, it is difficult to assess the gaps in healthcare access, allocate resources effectively, or develop targeted policies to address the specific needs of disabled individuals, particularly those who are pregnant.[79] To fully evaluate and address the needs of people with disabilities in Austria, comprehensive data collection is essential.

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[79] The Austrian Disability Council, *Response to the List of Issues*.

CHAPTER 5: CONCLUSION

Disabled individuals and people who may experience pregnancy both experience nuanced and often intersecting forms of oppression. Those who belong to both categories are thus especially vulnerable, and many of their needs remain unmet and unconsidered by international frameworks and national legislation. These issues extend to the case of Austria despite its socialized model of healthcare and associated legislative agenda.

The way disability has been conceptualized in international frameworks does not seem to be reflected in Austrian legislation. Thus, while Austria is a signatory to conventions such as the UNCRPD and aims to align Austrian society with its stated goals, its approach is fundamentally flawed. Following an overview of research documenting the challenges faced by disabled people who may experience pregnancy both generally and in Austria, a thorough analysis of existing data and an examination of Austrian policies was conducted which has substantiated the view that Austria's current disability rights framework, in combination with its health care model, does not adequately address the barriers lying at the intersection of disability and reproductive rights. Thus, to create an accessible environment especially for those experiencing multiple oppressions, Austria must overhaul much of its disability and healthcare policies.

Specific challenges faced by disabled individuals in Austria range from infrastructural and informational barriers to undertrained staff and lack of specialized accessible equipment. Beyond transforming its approach from a medical model to a social model of disability more closely aligned with the principled espoused by the UNCRPD, Austria must ensure it develops strict requirements for accessibility of public spaces, and create appropriate oversight, compliance, and enforcement mechanisms. Austria must also tackle its lack of data on disabled people, as this is essential to developing targeted policies and frameworks, especially those which may help address barriers faced by those who face compounded disadvantages such as lower socioeconomic status or migrant backgrounds.

Austria must also seek to ensure that healthcare facilities are accessible, and staff is trained on how to treat patients with disabilities, in addition to offering specialized treatment plans tailored to disabled patients' specific circumstances and considering disabled perspectives in mandated maternity plans. Ultimately, while Austria has taken steps to enable accessibility and counter ableism, disabled residents, especially women and people who may experience pregnancy, still face numerous challenges and a largely inaccessible environment. However, by implementing some reforms to respond to the identified issues, Austria can move toward a healthcare system that ensures equal access, dignity, and high-quality care for individuals with disabilities, particularly those in need of reproductive and maternity services, both within healthcare facilities and otherwise.

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