A Life-Course Analysis of the Exclusion and Denial of Agency Among Women with Disabilities

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Abstract— Agency is the capacity to exercise autonomy and shape one's life, is systematically denied to women with disabilities due to socially constructed barriers, but it rather blamed it to their impairments. This article employs a life-course framework to analyse how systemic exclusion, rooted in gendered norms and ableism, restricts agency for women with disabilities across three stages of their life: childhood, adulthood, and old age. It examines how the agency of women with disabilities—a fundamental human right—is systematically restricted by legal, social, and cultural barriers. Utilizing the social model of disability and an intersectional, life-course approach, the analysis argues that such restrictions stem not from individual impairments but from structural factors including discriminatory policies, inaccessible infrastructure, and pervasive stigma. By tracing challenges across their life, the study highlights how structural ableism, intersecting with gendered norms, undermines autonomy and perpetuates exclusion. Drawing on secondary data, we map structural barriers across key domains: personal decision-making (education), economic participation (unemployment), accessibility (social space and community participation), political participation and bodily autonomy (sexual health). The article concludes with policy recommendations for economic justice, healthcare reform, and political equity, advocating a shift from a paternalistic medical model to a human rights framework that centres the voices of women with disabilities and transforms theoretical rights into lived realities.

Keywords— Agency, Women with Disabilities, Intersectionality, Ableism, Ageism.

I. INTRODUCTION

Agency as defined as the capacity to make choices, pursue interests, and shape one's life is a fundamental human right, yet for women with disabilities, one of the marginalised sections, this right is often systematically restricted and denied through a combination of legal, social, and cultural barriers (Arstein-Kerslake, 2019; Elkhateeb & Peter, 2019; Ngwena, 2018; Pacheco et al., 2024). Disability is not merely a medical condition but a socially constructed experience shaped by barriers and restrictions such as discriminatory policies, inaccessible infrastructure, and stigma (Goodley, 2021). In this context, accessibility is not just about physical environments access but it also includes access to education, healthcare, employment, and political participation. The intersection of gender and disability creates a unique form of oppression, where women face double discrimination due to societal norms that devalue both their femininity and their bodily differences (Hirschmann, 2012). This article argues that the restricted agency of women with disabilities is not rooted in their impairments but in social structures that perpetuate exclusion that worked throughout their lifetimes—from childhood to old age.

The social model of disability, argues disability is a product of societal failure rather than individual deficit (to qualify on abled body norm), provides a critical lens for understanding this dynamic (Oliver, 1990; Oliver et al., 1983). For example, girls with disabilities are frequently excluded from education due to attitudinal discrimination against girl child (Hui et al., 2018) and lack of inclusive (and safe) infrastructure, limiting their future in all aspect (economically and social autonomy) (Bakhshi et al., 2017). In adulthood, women with disabilities face wage gaps, unemployment, and restricted sexual rights, or no sexual agency, reflecting systemic inequities in capitalist market system, safety-net policies, and healthcare system. By the time reaching to the twilight years, ageism compounds disability-related exclusion, leaving older women economically vulnerable and socially isolated (Mikton et al., 2021; Garrido et al., 2023; Dahlberg et al., 2020; Yang et al., 2018). These life-stage barriers illustrate how structural ableism, the systemic devaluation of disabled

lives, intersects with gendered norms to erase agency, especially in case of women with disabilities.

Central to this analysis is intersectionality, a framework that highlights how overlapping identities (e.g., gender, disability, caste) amplify marginalization. For instance, cultural taboos in some regions silence women with disabilities from participating in public events, reinforcing their invisibility in policy-making (Srinivasan et al., 2024). Similarly, international developmental organisations often treat gender and disability as separate issues, neglecting the unique needs of women at this intersection.

This article adopts a life-course approach to map how exclusion transmit and evolves across three stages of women with disabilities' life:

1St stage - Childhood: Overprotection, educational neglect, and social stigma.

2nd stage- Adulthood: Economic marginalization, restricted bodily autonomy, and political erasure.

3rd stage- Older Adulthood: Healthcare inequities and dependency cycles.

By focusing the voices of women with disabilities and leveraging analysis from scholarly works, this work underscores the urgency of dismantling structural barriers through inclusive policies and intersectional advocacy (Hirschmann, 2012).

II.   UNDERSTANDING AGENCY AND DISABILITY

2.1. Social Model of Disability: Contrast with Medical Model

The social model of disability, pioneered by scholars like Oliver (1990, 1983, 2013), reframes disability not as an individual medical deficit but as a consequence of socially constructed barriers such as inaccessible infrastructure, discriminatory policies, and exclusionary cultural practices (Flynn, 2024). This contrasts sharply with the medical model of disability, which locates disability within the individual's body, framing it as a pathology requiring correction or cure (Kim, 2021). For instance, while the medical model might focus on mobility impairment person physical limitations and try to correcting it, the social model critiques societal and (infra-) structural failures that 'disabled' the individual from realising the humanhood (Flynn, 2024; Kim, 2021). This paradigm shifts underscores disability as a product of systemic inequality - ableist system- rather than personal limitation, emphasizing societal responsibility for, change, inclusion (Yılmaz, 2024; Flynn, 2024).

The determination of whether individuals with certain disabilities require comprehensive caregiving, particularly concerning their agency, remains a subject of significant debate. Relying solely on the medical model to make such decisions can conflict with human rights principles and individual freedoms.

The medical model of disability focuses on impairments and often emphasizes care and treatment, potentially leading to paternalistic approaches that limit personal autonomy. In contrast, the human rights model emphasizes the inherent dignity and autonomy of individuals with disabilities, advocating for their active participation in decisions affecting their lives. (Sedova, 2024; O'Shaughnessy, 2022)

Overemphasis on the medical model may result in decisions that, while well-intentioned, inadvertently infringe upon the rights and freedoms of disabled individuals. This approach can lead to systemic exclusion and agency denial, contradicting the principles of equality and self-determination central to human rights frameworks. (Sedova, 2024; O'Shaughnessy, 2022)

Therefore, it is crucial to balance necessary support with respect for individual autonomy, ensuring that caregiving practices align with human rights standards and promote the freedom and dignity of persons with disabilities.

2.2. Agency vs. Structure: Societal Barriers to Autonomy

Agency is often constrained for disabled individuals by structural barriers. For example, inaccessible public transport limits freedom of movement, while ableist employment policies perpetuate unemployment rates as high as 80% for disabled women in low-income countries (Yılmaz, 2024; Abidi & Sharma, 2014). These barriers are reinforced by attitudinal stigma, such as assumptions that disabled people are "incapable" of decision-making and are not fast enough to keep pace with non-disabled persons. The UN Convention on the Rights of Persons with Disabilities (CRPD, 2006) highlights this tension, advocating for legal frameworks to dismantle institutional ableism. However, implementation gaps persist; only 28% of ASEAN countries, for instance, enforce disability-inclusive public transport policies (Sil et al., 2023). Such systemic neglect illustrates how structure often overrides agency, relegating disabled individuals to dependency cycles.

2.3. Intersectionality: Gender and Disability Compounding Discrimination

Intersectionality, a concept rooted in Black feminist theory (Crenshaw, 1989), reveals how overlapping identities like gender and disability amplify marginalization (Flynn, 2024). Disabled women face compounded discrimination: they are multiple times more likely to experience violence than non-disabled women and are often excluded from sexual health services due to stereotypes of asexuality or

incompetence (Flynn, 2024; Powell & Stein, 2016). For example, forced sterilization of disabled women in Latin America reflects patriarchal control over their bodily autonomy (Yılmaz, 2024). Similarly, in education, girls with disabilities are disproportionately denied schooling due to gendered expectations of caregiving and fears of "contamination" in classrooms (Brinkman et al., 2023; Psaki et al., 2022). These inequities are exacerbated by intersecting identities like race or caste; Dalit women with disabilities in India face exclusion rates higher than their upper-caste counterparts (Brinkman et al., 2023).

III. LIFE STAGES AND BARRIERS

3.1. Childhood:

3.1.1. Family Dynamics: Overprotection and Limited Personal Decision-Making

Families of children with disabilities often adopt "overprotective" behaviours due to societal stigma and structural neglect, restricting children's autonomy in critical areas like education and social participation. For instance, parents may limit decision-making opportunities, such as school choices, fearing discrimination or safety risks in ableist environments (Odeh & Lach, 2024; Sarman & Tuncay, 2024). This dynamic is exacerbated by cultural norms that equate disability with incapacity, leading to paternalistic attitudes that prioritize protection over empowerment. A study analysing family involvement in educational choices found that inadequate communication between schools and families and socio-economic disparities further marginalize children with disabilities, as parents struggle to advocate for their needs amidst systemic barriers (Yildirim, 2024). Additionally, families caring for children with disabilities frequently experience social isolation, which reinforces insular parenting practices and reduces exposure to inclusive community networks (Baumgardner, 2019). These patterns reflect broader structural failures, such as lack of respite care and financial support, which heighten parental stress and perpetuate overprotection or over-caring, and cycles of dependency (Sarman & Tuncay, 2024).

3.1.2. Education: Low Enrolment and Lack of Inclusive Infrastructure

Children with disabilities face stark educational inequities, particularly in low- and middle-income countries (LMICs), where enrolment rates remain as low as 10%. UNESCO data highlights that exclusion is driven by attitudinal barriers (e.g., teachers' biases) and systemic gaps like inaccessible classrooms and untrained staff. For example, only 28% of ASEAN countries enforce disability-inclusive policies for public infrastructure, leaving schools without ramps, Braille materials, or adaptive technologies. (Odeh & Lach, 2024)

Bronfenbrenner's Ecological Framework — it is a comprehensive model for understanding human development within the context of the systems that influence an individual's environment. This framework has been widely adopted across various fields, including education, social work, and public health, to explore the complex interactions between individuals and their environments — reveals how barriers operate across multiple levels (Crawford, 2020):

- Micro-system: Bullying by peers and teacher neglect in classrooms.
- Meso-system: Poor collaboration between families and schools.
- Macro-system: Weak enforcement of inclusive education laws.

These challenges are compounded for girls with disabilities, who are often denied schooling due to gendered stereotypes and disability. Even when enrolled, children with disabilities faced difficulties with inclusive school curriculum which perpetuates their exclusion from meaningful learning experiences. (Baumgardner, 2019; Paul et al., 2022)

3.1.3. Stigma and Peer Isolation

Social exclusion begins early, with children with disabilities facing stigma that labels them as "abnormal" or "burdens." Studies show they are more likely to experience loneliness than their peers, often excluded from playgroups and activities related to children (Koller & Stoddart, 2021). This isolation is reinforced by societal attitudes that prioritize "fixing" the child through medical treatment or social skills training rather than addressing environmental barriers like inaccessible playgrounds or prejudiced peer groups; neglecting systemic changes to promote acceptance (Koller & Stoddart, 2021). Families also internalize this stigma, with parents reporting feelings of shame or guilt that limit their child's social interactions (Baumgardner, 2019; Sarman & Tuncay, 2024). The voices of children with disabilities (of whatever kind; along with Parents of Children with Disabilities) are notably absent in research and policy, with only 3 out of 54 studies in a major review including their perspectives (Odeh & Lach, 2024). This erasure perpetuates cycles of invisibility, denying them agency in shaping inclusive social environments.

3.2. Adulthood:

3.2.1. Economic Agency

Women with disabilities face profound economic marginalization, rooted in systemic ableism and gendered

capitalist labor market inequalities. According to the International Labour Organization (ILO), the employment rate of women with disabilities globally is significantly lower than that of non-disabled men. Only about one-fifth of women with disabilities are employed, while more than half of non-disabled men have jobs. Wage gaps are not merely labor market failures but reflect societal devaluation of disabled lives. Even when employed, women with disabilities face wage disparities. In low-income countries, they earn significantly less—about a fifth to a third less than non-disabled men for comparable work. They are often relegated to informal jobs without social protections. (Statistics on Women - ILOSTAT, 2024)

This underemployment is exacerbated by workplace discrimination, such as inaccessible infrastructure and employer biases that equate disability with lower productivity. For example, a 2023 ILO report highlights that 80% of employers in Southeast Asia perceive hiring women with disabilities as a "risk," perpetuating occupational segregation into low-skilled roles like domestic work or piece-rate labor.

3.2.2. Personal & Sexual Rights: Reproductive Health Access and Forced Sterilization

Women with disabilities are routinely denied autonomy over their bodies, facing both systemic neglect in healthcare and human rights violations. Forced sterilization remains a pervasive practice globally, justified under paternalistic rationales of "protecting" women with disabilities from pregnancy or menstruation-related problems and suspected rape or sexual violence (Serrato Calero et al., 2021; Patel, 2017). A 2020 meta-synthesis found that 30–50% of women with intellectual disabilities in Europe and North America have been sterilized without consent, often under guardianship regimes that override their legal agency (Serrato Calero et al., 2021). Forced sterilization—framed as "medical necessity"—is a tool of gendered control, denying women bodily autonomy under the guise of care.

Reproductive healthcare access is equally fraught. Only 35% of women with disabilities in Sub-Saharan Africa receive adequate sexual health services, including contraception or prenatal care, due to physical inaccessibility (e.g., clinics without ramps; inaccessible public transport to reach center) and provider biases (e.g., Nurse discrimination) (Botsou et al., 2023). Medical professionals often withholding information about reproductive choices or pressuring women into irreversible procedures like hysterectomies (Neetu et al., 2024; Powell & Stein, 2016).

3.2.3. Political Participation: Exclusion from Decision-Making

Women with disabilities are grossly underrepresented in political spheres, both as voters and leaders. According to United Nations Department of Economic and Social Affairs (2018) Less than 2% of elected officials globally are women with disabilities, reflecting barriers such as inaccessible polling stations, lack of assistive voting technologies, and discriminatory nomination processes.

Women with disabilities report lower voter turnout than the general population due to inaccessible ballot formats and transportation (Stum, 2021). Even within disability advocacy movements, their voices are often sidelined: disability-related policy consultations in the EU excluded women with intersecting marginalized identities (e.g., racialized or low-income women) (Christoffersen, 2022).

3.3. Twilight Years:

3.3.1. Healthcare Access: Ageism and Disability Discrimination

Older women with disabilities face compounded barriers in healthcare due to ageism and ableism, which intersect to undermine their access to quality services. Studies reveal that healthcare providers often dismiss their symptoms as "normal aging," leading to delayed diagnoses and inadequate treatment (Hand & Ihara, 2024; Rogers et al., 2015). For instance, older women with mobility impairments are less likely to receive preventive care compared to non-disabled peers, partly due to inaccessible facilities and providers' biases (Abou-Abbas et al., 2024; Matin et al., 2021). Ageist attitudes among healthcare workers—such as assumptions that older patients are "less deserving" of intensive care—exacerbate disparities (Fernández-Puerta et al., 2024). These inequities are rooted in systemic failures, including lack of disability-adapted equipment and training for geriatric care (Rogers et al., 2015; Matin et al., 2021).

3.3.2. Economic Vulnerability

Economic insecurity in later life is heightened by exclusion from pension systems. Globally, women with disabilities are less likely to receive pensions than men, and those who do often face reduced benefits due to fluctuating work histories from caregiving or underemployment. In low-income countries, older women with disabilities often depends on family support or informal work (Tefera et al., 2018). This dependency perpetuates cycles of poverty, violence and negligence. Pension systems often fail to account for disability-related costs and market inflation. (Deegan, 1985)

3.3.3. Social Isolation

Reduced mobility and societal stigma isolate older women with disabilities, severing their social networks. Transportation barriers—such as lack of wheelchair-accessible public transit—limit participation in community

activities, while ageist stereotypes paint them as "burdens" rather than contributors (Garrido et al., 2023; Yang et al., 2018). Additionally, cognitive impairments or sensory disabilities (e.g., hearing loss) amplify communication challenges, deepening loneliness (Yang et al., 2018). Social isolation correlates with poorer mental health outcomes, including depression, which affects older women with disabilities more compared to non-disabled peers.

IV.   CONCLUSION

The social model's emphasis on societal-structural change, when integrated with intersectional analysis, offers a comprehensive framework for enhancing agency among individuals with disabilities. Policies should prioritize inclusive design, such as universal accessibility standards, and challenge gendered stereotypes through educational reforms. As the World Health Organization asserts, "disability is a human rights issue"—one that necessitates systemic, rather than individual, solutions. By centring disabled voices in policymaking, societies can dismantle barriers that conflate impairment with incapacity, reclaiming agency as a universal right.

The challenges faced by disabled children (in our case, Girl Child) underscore the urgent need for policies that empower families, reform educational systems, and challenge discriminatory norms to ensure equitable childhoods for all. In adulthood, the exclusion of women with disabilities often results from the intersection of structural ableism, patriarchy, and economic inequality.

4.1. Policy Recommendations

- Economic Justice: Enforce disability inclusion guidelines, including workplace quotas for women with disabilities.

- Healthcare Reform: Criminalize non-consensual sterilization and train providers on disability-inclusive sexual health protocols.

- Political Equity: Adopt universal design in electoral processes and establish special funds to support leadership initiatives for women candidates with disabilities.

- By implementing these measures, societies can transform agency from a theoretical concept into a lived reality for women with disabilities.

In Older age, the exclusion of women with disabilities Pathways to Equity:

- Healthcare Reform: Mandate age- and disability-inclusive training for providers, coupled with universal design standards for medical facilities.

- Pension Justice: Implement gender-responsive pension reforms and disability-adjusted benefits.

- Community Integration: Develop accessible public spaces and peer-support networks to combat isolation.

Addressing these intersecting barriers will uphold the dignity and agency of all age women with disabilities, ensuring their life are characterized by equity rather than exclusion.

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