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"The older you get, the less people care about you": The Sexual and Reproductive Health Management of Older Women with Disabilities in Canada During the COVID-19 Pandemic

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Abstract

Normative healthy aging frameworks promote later-life wellbeing through the maintenance of functional ability, moralizing autonomy, productivity, and sexual fitness, rendering disability, interdependence, and non-normative sexual lives signs of decline. How, then, do older women with disabilities experience sexual and reproductive health in later life? Drawing on six in-depth interviews with disabled women aged 50 to 63 in Canada during the COVID-19 pandemic and informed by intersectional feminist theory, we trace how sexual and reproductive health was managed amid health system strain, as intersecting ableism, ageism, sexism, and racism shaped whose needs were prioritized, deferred, or dismissed. We identify three interrelated sites through which this management unfolded: first, sexual inactivity during lockdown as a self- and medically prescribed risk management practice that affirmed identity and safety while deepening loneliness and desexualization; second, the devaluation and deferral of routine sexual and reproductive health care (e.g., cervical and breast cancer screening and menopause-related concerns); and, finally, hysterectomy amid pandemic triage protocols, where medical gatekeeping converged with racist histories of reproductive injustice to enact medical and colonial dispossession. We argue that sexual and reproductive health management during COVID-19 illuminates how aging with disability is lived through relations of care and constraint.

Keywords: *Disability; Healthy aging; Sexual subjectivity; Intersectionality; Ableism; Ageism; Racism; Sexism*

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Introduction

When the United Nations (UN) launched their "Decade of Healthy Ageing" in December 2020, societies were called on to reimagine how to foster well-being in later life. Yet the campaign's promotional video reveals troubling assumptions underlying global visions for healthy aging—the narrator cautions that if our health "declines" with age, "we may become disconnected and a burden to others" (UN Decade of Healthy Aging 2022). This message reinforces prevailing ageist and ableist assumptions about what it means to age well; namely, that overcoming the possibility of age-related disability is a moral virtue, and that people who need care are taxing to families and societies (Buch 2015; Kafer 2013; Nario-Redmond 2019). Such narratives hinge on a fantasy of the healthy (nondisabled, white, masculine, middle-upper class) subject, and overlook the ways in which colonialism, imperialism, capitalism, and social injustices cause and sustain the violent debilitation of disenfranchised communities (Puar 2017; Sterne 2021).

It was in this moral and political climate that COVID-19 was declared a global pandemic in March 2020. Older adults and people with disabilities were quickly identified as high-risk populations, with the risk of severe illness and death amplified by both age and disability (Brown et al. 2022; Kuper and Smythe 2023; Starke et al. 2021). As a mass disabling event, the pandemic transformed the sociodemographic landscape of aging. After the global public health emergency was declared over in 2023, adverse health effects of Long COVID continue to mean that more people are aging with disabilities (Hermans et al. 2025). At the same time, dominant healthy aging frameworks, such as those of the UN, continue to implicitly exclude or marginalize the experiences of older people aging with disabilities, especially older women.

The World Health Organization (WHO) defines healthy aging as the development and maintenance of "functional ability" into older age—mental and physical capacities including an "ability to walk, think, see, hear and remember" (World Health Organization 2020). This framing implicitly forecloses healthy aging from people aging with disabilities and people who acquire disabilities in older age. Earlier frameworks of successful aging were even more explicit, defining success as the "avoidance of disease and disability, maintenance of high physical and cognitive function, and sustained engagement in social and productive activities" (Rowe and Kahn 1997, 439). Critical aging scholarship has shown that these models reflect North American cultural ideals of individual autonomy, self-sufficiency, and productivity, stigmatizing disability, dependency, and mortality as moral failures; individuals are pressured to appear youthful, non-

disabled, and socially engaged while held personally responsible for failing to meet these inequitable ideals (Calasanti 2016; Calasanti and King 2021; Klein 2022; Lamb 2014; 2019; Minkler and Fadem 2002). Such models overlook how people with disabilities navigate aging in unique ways—for instance, by drawing on the lived experience of disability to prepare for the health challenges of aging, and by focusing on mitigating and managing (rather than avoiding) disability and disease in later life (Aubrecht et al. 2020; Molton and Yorkston 2017). While the contemporary healthy aging discourse now emphasizes social determinants like age-friendly environments and health care systems, public health rhetoric continues to position health as an individually achieved status rather than a relational, interdependent, and indeterminant social practice (Yates-Doerr 2020).

In high-income countries like Canada, health, aging, and disability are often treated as individual burdens rather than social, cultural, and relational experiences. Since the late 20th century, neoliberal ideals of individuality and a sense of personal responsibility have shaped global frameworks of health and healthy aging as moral projects of the self (Crawford 2006; Lamb 2014; 2019). This ethos has justified the dismantling of social services, income supports, and health care systems in ways that disproportionately harm older and disabled people (Buch 2015; McRuer 2018). The COVID-19 pandemic has further entrenched these inequities, intensifying ageism, ableism, and the social abandonment of older and disabled people through triage and rationing practices (Andrews et al. 2021; Cohen 2020; Klein 2022).

Healthy nondisabled aging subjects are imagined by global health campaigns as autonomous, agentive, and socially legible. Eligibility for social recognition and intelligibility is negotiated, in part, through sexual subjectivity—the ways in which people are constructed and construct themselves as sexual beings—which has long been tied to aging and health. In the 19th century, sexual decline was seen as an inevitable and even morally and spiritually beneficial aspect of aging; by the 20th century, it became pathologized as dysfunction that accelerates aging (Katz and Marshall 2003; Marshall and Katz 2002). Sexual activity came to signify vitality and resistance to decline, and individuals were encouraged to cultivate "sexual fitness" into old age through biomedical consumption, such as with Viagra and hormone replacement therapy (Katz and Marshall 2003; Marshall and Katz 2002). These practices privilege able-bodied, heterosexual, white, and wealthy subjects in monogamous couples, and a colonial system of compulsory sexuality—the idea that having sex is necessary for healthy aging, identity, and social belonging (Przybylo 2021). As "techniques of the self" (Foucault 1988, 98), sexual self-discipline, control, and the regulation of desire are central to the production of ethical and moral subjectivity. Individuals who fail to enact self-controlled, agential, and rational liberal subjects by adapting their behaviours in the pursuit of health and wellbeing can be vilified as failing to "embrace life" (Crawford 2006, 411).

Women's aging bodies are key targets in projects of sexual and reproductive health management; for example, the promotion of "anti-aging" cosmetic products, hormone therapies, and plastic surgeries that promise sexual vitality and desirability in later life (Bell 1987; Edmonds 2014; Katz and Marshall 2003; Marshall and Katz 2012; 2002; Leibing 2005; Lock 1998; Roberts 2002). While sexual activity can enhance wellbeing and counter the desexualization of older adults (Lindau and Gavrilova 2010; Patterson and Jehan 2024; Smith et al. 2019), its elevation as a moral and medical imperative marginalizes people who are sexually inactive or asexual (Paul and Paul 2021; Przybylo 2021). For older women with disabilities, this marginalization is intensified by ableist and sexist assumptions that desexualize them and render their sexual lives invisible (Esmail et al. 2010; Waxman 1994).

Similar to global trends, women in Canada are more likely than men to live with disability across the life course (Statistics Canada 2024). Although Canada's publicly funded universal health care system provides most sexual and reproductive health care services free at the point of care, women with disabilities continue

to encounter discrimination (Gibson and Mykitiuk 2012). During the COVID-19 pandemic, public health responses—including lockdowns, service reorganization, and the widespread suspension or deferral of non-urgent and elective care—substantially disrupted access to routine health services. Across Canada, scheduled procedures were postponed, generating significant backlogs and wait times, alongside marked declines in hospital admissions, emergency and primary care visits, including access to preventative sexual and reproductive health services (Baaske et al. 2022; Ibadin et al. 2023; Ledesma et al. 2024; Zeitouny et al. 2023). System-wide disruptions like clinic closures, staffing shortages, and visitor bans amplified pre-existing accessibility barriers for disabled people and disproportionately affected their access to sexual and reproductive health services (Evans et al. 2024; 2025; Liu et al. 2025). Yet little is known about the sexual and reproductive health experiences of older women with disabilities in Canada during this time.

This article examines the sexual and reproductive health experiences of older women with disabilities in Canada during the COVID-19 pandemic, a period of significant health system strain. Drawing on intersectional feminist theory (Crenshaw 1990), we analyze how sexual and reproductive health was self- and medically managed under conditions shaped by intersecting ableism, ageism, sexism, and racism. We argue that sexual and reproductive health management during the pandemic reveals how aging with disability is lived through relations of care and constraint.

Methods

This qualitative research was part of a community-engaged mixed-methods study on disability and sexual and reproductive health in Canada during the COVID-19 pandemic. As a community-engaged study, we collaborated with two disability organizations as research partners: the DisAbled Women's Network of Canada and ASE Community Foundation for Black Canadians with Disabilities. We convened an Advisory Committee that included clinicians, academics, and community members with disabilities to provide ongoing input. Peer researchers with disabilities were integral members of the core research team as experts by experience. Ethical approval was obtained from the University of Toronto (Protocol # 42194, approved January 21, 2022).

Between May 2022 and March 2023, a medical anthropologist (Evans) and peer researchers (Ogbonna, Welsh, and Rego) conducted semi-structured interviews with 61 women and gender-diverse people with disabilities. Participants were recruited through community networks. Additional recruitment occurred through the distribution of flyers and an accessible video via email lists and social media platforms. Eligibility criteria included being 18 years of age or older; identifying as disabled or a person with a disability and/or d/Deaf; identifying as a woman and/or gender-diverse person;[1] and living and receiving health care in Canada. Informed consent was obtained from all participants, and disability-related supports (e.g., sign language interpretation) were provided as needed.

This article focuses on a sub-sample of six women with disabilities aged 50 to 63 years old (mean age 55.8 years). Most participants lived with combinations of physical, mental health, developmental, and sensory disabilities (n=4), while two reported physical disabilities only. All had chronic health conditions, and most used assistive devices (n=5). All identified as cisgender, heterosexual, and mothers of adult children; most were divorced (n=5), while one was single and never married. They identified as white (n=3), white and Indigenous (n=1), Indigenous (n=1), and Black (n=1). All had postsecondary education and experienced financial precarity. None held full-time employment; most volunteered (n=5), and some worked part-time (n=3). Most disclosed past experiences of gender-based violence (n=5). All names are pseudonyms and identifying details have been minimally altered to preserve anonymity while maintaining data integrity.

Interviews explored participants' sexual and reproductive health histories, their experiences accessing or attempting to access sexual and reproductive health care during the COVID-19 pandemic, and their recommendations for improving sexual and reproductive health services for people with disabilities. Participants were invited to discuss any sexual and reproductive health care-related experiences that felt important to them.[2] Interviews typically lasted 60-90 minutes and were conducted via Zoom or telephone; audio-recordings were professionally transcribed prior to being verified and deidentified by the research team. Transcripts were analyzed thematically using an inductive approach that emphasized collaborative interpretation through iterative discussions, reflexive comparison, and negotiated refinement of emerging themes, with close attention to participants' lived experiences.

Findings: Managing sexual and reproductive health amid risk, devaluation, and abandonment

We analyze older women with disabilities' experiences managing sexual and reproductive health care amid the disruptions and exclusions of the COVID-19 pandemic. Our findings identify three interrelated sites of sexual and reproductive health management—sexual inactivity, routine sexual and reproductive health care, and hysterectomy—that emerged from participants' narratives and illustrate how intersecting ableism, ageism, sexism, and racism contour experiences of aging and care.

Sexual Inactivity as Risk Management

Alanna was a 53-year-old Black woman living independently in a large city in Eastern Canada. She had multiple chronic illnesses and mental health disabilities, including posttraumatic stress disorder (PTSD), depression, and autoimmune conditions. With a graduate degree and a career in senior management, she was on a long-term disability leave. She explained that her pain was often minimized by the stereotype of the "strong Black woman," making it difficult to obtain referrals or appropriate treatment. "Black women—our disability is our problem," she said. "We're not entitled to be sick, we're not entitled to be on disability, we're not entitled to get accommodations or support for treatment. It makes us feel like we're lesser than."

Before the pandemic, Alanna underwent a hysterectomy due to fibroids, endometriosis, and adenomyosis, which induced surgical menopause and triggered severe depression and PTSD symptoms—"memories, experiences, pain, lots of strange things happening in my body." The hysterectomy and surgical menopause left her feeling "a mess." When she requested accommodations, such as working from home, she was denied. "I had a nervous breakdown, was denied long-term disability for almost a year, had no income, which made my health issues, menopause, everything, worse. And then, boom, COVID."

Alanna's gynecologist stopped seeing her because her care was not considered urgent during the pandemic. While framed through pandemic triage, Alanna's exclusion points to longer-standing hierarchies of medical urgency through which gendered and racialized chronic conditions are systematically deprioritized. She felt abandoned by health care systems: "Disability means, and COVID meant, you're even more isolated and alone."

Alanna chose to be sexually inactive to mitigate the risk of acquiring COVID-19. "If you didn't have anybody before COVID, having sexual relationships became risky for people like us with disabilities," she explained. For her, this decision was inseparable from broader conditions of structural racism and sexism:

> I still have lots of sexual feelings, but it feels safer to be [sexually inactive]. As Black women, we are perceived as being very sexual, especially through the history of slavery [...] or you get to be 'mammy,' which is the [desexualised] version of an older Black woman. I'm

> internally choosing what society has laid out for me, not because I am [asexual] but because I didn't get any care during this journey, this loss. [...] One of the deepest pains I'm carrying is the loss of my sexual identity, because of that hysterectomy and menopause. [...] I'm not old; I've just had a full hysterectomy and don't have a husband. And I have disabilities, so I guess it's a checked box—it's done.

For Alanna, being a single, postmenopausal Black woman with disabilities and a hysterectomy constrained her sexual subjectivity by limiting the socially sanctioned choices available to her. She asked, "How do you become sexual again [...] without being promiscuous?" Choosing sexual inactivity was the "safer" choice—not only because it reduced her risk of COVID-19 but also because it avoided being cast as a hypersexual Black woman. While sexual inactivity shielded Alanna from the "jezebel" stereotype, it also compromised her mental wellbeing and entangled her in new forms of desexualization that eroded her sexual subjectivity, resigning her to the "mammy" stereotype and a sense of social erasure.

This logic of self-management extended from sexual to mental health. "COVID meant I couldn't access my psychologist in person anymore," she explained. She began seeing a psychiatrist for medication management and to cope with intensifying distress related to childhood sexual violence, workplace trauma, and menopause. Because she "now had a psychiatrist," her psychologist ended their therapeutic relationship. "It was devastating," Alanna said. Before their sessions ended, her psychologist told her she "needed to do a lot more of this stuff on my own," framing recovery from sexual trauma as an individual responsibility. This reasoning reappeared in psychiatric care. When Alanna mentioned that she wanted to start dating again, her psychiatrist discouraged her: "Do you really think you should be dating right now? You should be working on yourself." Alanna felt "sad and not heard. I'm very lonely. I have no companionship." Sexual inactivity was prescribed as a condition for recovery—a strategy for managing mental and physical health that deepened social isolation.

Alanna's account reveals multiple pandemic-related losses of care—both gynecological and psychological support—that compromised her physical and psychological wellbeing as well as her intimate life. These compounding experiences took a severe toll on her mental health. "I made strides not to kill myself, which after going through this menopause, became a reality—wanting to kill myself. And I'm still here."

Alanna speculated that her sexuality may have felt less constrained had the quality of her post-surgical and menopausal care not been compromised by intersecting racism, ableism, sexism, and ageism. Her pain was dismissed and undertreated, leaving her feeling devalued by providers who "didn't care" about her. "I want the medical profession to understand that we exist as full persons—we are women, but there is something around being a Black woman with disabilities that disqualifies you from the full title of woman," she explained. "The older you get—as we know with age and women—the less people care about you."

Abstinence is prescribed to older women with disabilities through different logics of sexual risk management. While Alanna's sexual inactivity emerged through racialized desexualization, exacerbated by the withdrawal of care, Brenda was advised to practice abstinence in response to perceived risk-taking.

Brenda was a 58-year-old white woman living independently in an affordable housing complex in a city in Eastern Canada. She used a walker and described chronic pain and mobility limitations from past injuries, along with multiple chronic illnesses affecting her digestive and respiratory systems, and PTSD related to long-term trauma. Retired from a career in administrative support, she volunteered in her community and relied on disability income assistance. She reflected, "As I get older, I get worse, and I'm more in poverty."

After leaving an abusive marriage, Brenda described withdrawing emotionally and sexually as a form of self-protection. She said, "I didn't want any husband or boyfriend or anything," which she understood as a response to marital abuse and trauma from earlier sexual violence. At midlife, the losses accumulated. "I'm grieving a whole bunch of things," she explained. When her youngest child moved out, this grief intensified and precipitated a "midlife crisis" marked by a renewed engagement with her sexuality. "It was almost like a frenzy," she said. This period exposed Brenda to new forms of harm. She was targeted by an online romance scam that resulted in emotional and financial devastation. "I was romance scammed," she explained. "Then I almost killed myself. I walked in front of vehicles." In the aftermath, she engaged in sexual relationships she later understood as unsafe, describing her behavior as reflecting both a "sexual addiction" and "an addiction to being an online romance junkie." While she asserted control over some encounters, attempting "to mess with the scammers and report them," she experienced others as dangerous: "Some, I met them in person and had sex. That was bad. It was not safe."

When Brenda sought medical support, her sexual behavior was pathologized. Providers framed her sexual risk-taking as a symptom of her PTSD and advised her to stop all sexual activity as part of her recovery. Brenda felt it was more complicated than a diagnostic symptom. "I thought that maybe it wasn't just PTSD," she said. "I was told it was my PTSD, and I needed to stop doing what I was doing and look after myself better. I had to go on medication. I was followed by a psychiatrist for a while." Brenda was not provided any trauma-informed supports, like counselling; instead, she received medical prescriptions and behavioural directives for abstinence as the route to mental and emotional stability. COVID-19 public health directives reinforced this message. She recalled, "I did have a boyfriend during COVID, but I refused to have any sex. I'm a bit turned off, probably because of what happened. I don't feel very safe about all of it." Sex felt risky both emotionally and physically: "I didn't want to have anything else going wrong with my body because I'm doing something that possibility I shouldn't be doing, because maybe that puts me more at risk of getting COVID."

Sexual inactivity during the pandemic was not always experienced as loss or constraint. Winona, a 50-year-old white and Indigenous neurodivergent woman living alone in a city in Eastern Canada, lived with multiple chronic illnesses and autoimmune disorders that contribute to pain, fatigue, and mobility challenges, along with developmental and sensory disabilities affecting her vision and hearing. When she was younger, she felt like a "defective, awful, and bad person" because she was not interested in sex; this negative self-image was reinforced by health care encounters.

During the COVID-19 pandemic, pandemic lockdowns and social distancing measures prompted Winona to embrace her lack of sexual desire as an expression of neurodivergence: "I've never been so damn glad to be neurodivergent and able to thrive by my own damn self." Under lockdown conditions Winona's sexual inactivity was socially sanctioned; instead of her behavior being marked as a deviant problem to be managed, it was aligned with public health norms. At the same time, she understood her experience as inseparable from society's desexualization of people with disabilities: "You're disabled? Oh, well, you're a non-sexual being.' I happen to be, but I know I'm in the minority."

As participants narratives demonstrate, sexual inactivity was variously chosen and prescribed during the pandemic. For some, it offered a sense of safety or affirmation; for others, any such protection came at the cost of loneliness and diminished sexual subjectivity. By positioning abstinence as a responsible way to manage risk, the pandemic intensified pre-existing dynamics of desexualization, delineating the boundaries of care, intimacy, and risk that felt possible for older disabled women. The next section explores how the social and medical logics that link sexual health, morality, and self-control also shaped how routine sexual and reproductive health care was navigated or avoided during the pandemic.

Devaluing Routine Sexual and Reproductive Health Care

During the COVID-19 pandemic, ongoing disability-related needs, service disruptions, and fears of exposure converged to render routine sexual and reproductive health care deferrable, negotiable, or expendable. This devaluation was imposed by health systems and taken up by participants themselves as a pragmatic self-management strategy under conditions of scarcity.

Irene was a 55-year-old white woman with physical and mental health disabilities living independently in an Atlantic Canadian city. She used a walker due to mobility limitations from osteoarthritis and lives with neurodevelopmental, mental health, and chronic health conditions. She depended on daily home care support, which became inconsistent during the COVID-19 pandemic. "There was definitely times when I had to go without workers," she explained. "That was hard—it still is. Even now, I don't have a steady worker." When she contracted COVID-19, she was left to manage alone since workers were unavailable. "I just had to make do," she said. Early during the pandemic, Irene's family doctor closed their practice. She was later accepted into a community clinic, but the care felt impersonal: "They're definitely not following up the way my family doctor did. I can't even get in to see them just to get a refill on my pills." Community program closures limited her social involvement: "I don't have places to go like I used to."

Irene focused on managing disability-related health concerns during the pandemic. Routine sexual and reproductive health care felt less urgent. "I don't have a lot of needs in that regard, I don't think—unless I was [sexually] active. I'm not active, I don't have a boyfriend, right?" When asked whether the pandemic affected her sexual and reproductive health, Irene hesitated. "Well, it has, because—well, I don't know—I could be having some issues there. I've had pain different times. I haven't had anything checked since my surgery," she said. Eight years had passed since her ovaries were surgically removed and, in that time, she had not had cervical or breast cancer screening, despite ongoing pelvic pain and a history of atypical cervical cells. "I can always mention I think it might be time to get a pap test," she said, "but I've got questions for [my doctors]. Other problems." As she spoke, her focus quickly shifted back to chronic illness management and more immediate medical concerns.

Like Irene, other participants similarly prioritized disability-related health care over sexual and reproductive health. Health system limitations, like short appointment times, meant they had to prioritize pressing issues. Despite wanting cervical and breast cancer screening as well as menopause-related care, Winona "didn't want to go for another appointment" or risk exposure to COVID-19. Anything sexual and reproductive health related "could go on the back burner," she explained. "It's just not prioritized." Sexual inactivity, combined with disability-related and chronic illness concerns, reduced the perceived urgency of routine sexual and reproductive health care, which was deferred indefinitely. When participants did seek care, negative encounters with providers reinforced a devaluation of their sexual and reproductive health.

Audrey was a 56-year-old white woman with cerebral palsy who lived with her adult son in a city in Western Canada. She explained, "I don't have the best mobility and there's been a few times I've fallen." After years of financial struggle, she relied on disability income assistance. In need of more support, Audrey was frustrated by being repeatedly denied government-funded home care. A sense of being disbelieved extended into experiences with sexual and reproductive health. "I have a nurse practitioner," she said, "but they don't seem to take me seriously." Long before the pandemic, she had a tubal ligation[2] following childbirth. After her abusive ex-husband also began hitting their young children, she left with them for a shelter. The children were taken in and out of state care and she recalled how social workers deemed her an unfit parent: "They used my disability against me." Audrey was sensitive to further

judgement from social services and medical providers. She felt "embarrassed" during her last pelvic exam for cervical cancer screening a few years before the pandemic. Providers "insisted on doing the tests" for sexually transmitted infections against her wishes. This discouraged her from returning for future screenings, despite a family history of cancer.

Audrey's discomfort and mistrust reflected that of other participants. Alanna described her last cervical cancer screening as extremely painful. She felt reduced again to the stereotype of the "strong Black woman" as her family doctor dismissed her pain. She also felt diminished by the family doctor's assumption she was sexually inactive: "she made these comments that, 'you haven't had sex.' [...] I didn't tell her I wasn't having sex—she never even asked. It was a perception because I'd had a hysterectomy." Winona recalled a provider telling her it was "ridiculous" she felt pain during cervical cancer screening. Negative experiences made participants feel embarrassed, disbelieved, and patronized, leading many to avoid seeking future care.

Health system strain during the COVID-19 pandemic exacerbated routine sexual and reproductive health care deferrals. Brenda experienced a year-long delay in receiving an ultrasound for uterine prolapse. Alanna felt that her menopause-related concerns were more likely to be disregarded; she explained, "during COVID, [menopause] was seen as the least of my problems." Others avoided care to minimize COVID-19 exposure risk and to prioritize access for sicker patients. Winona delayed cervical and breast cancer screening because her clinic was "so overburdened," and because "every time I have to go to the hospital, it means I could be at risk" of acquiring COVID-19.

During the pandemic, routine sexual and reproductive health care was strategically deferred by participants and devalued by medical systems that treated these needs as secondary. Negative encounters, medical gatekeeping, and health system strain discouraged care-seeking, reinforcing participants' sense that sexual and reproductive health was not important for women like them. These dynamics also shaped how more invasive forms of care were experienced during the pandemic, as we discuss in the next section.

Hysterectomy as Dispossession

For Black and Indigenous participants, the devaluation of sexual and reproductive health during the pandemic materialized in experiences of having their reproductive organs removed through hysterectomy. Pandemic triage and medical gatekeeping rendered long-standing racialized, sexist, and ableist forms of reproductive injustice acutely visible in this irreversible intervention.

Pauline was a 63-year-old Indigenous woman from a small town in Western Canada. She lived with a degenerative neurological muscular condition and chronic illnesses including respiratory conditions and osteoarthritis, making life "a very painful existence at times." Her condition worsened in her 50s, after her divorce. "I've noticed a deterioration of my mobility, and the ability to do specific tasks. [...] I could just be an old lady that deteriorates, or it could be from the [disability]. Who knows?" She used mobility aids like a cane and walker, and lived with her adult son who supported her day-to-day. "I don't go out much unassisted, but you just learn to adapt." After a long career in community development, Pauline still took casual remote work to supplement insufficient disability income assistance. "I'm sure glad I have my faculties because you wouldn't be able to survive on [disability assistance] if you weren't clever."

Violent colonial histories shaped Pauline's sexual and reproductive health. "I'm the first generation that did not attend a residential school," she explained. "There was no discussion of healthy sexuality, of relationships. The discussions that we had were very Christian-based, very shame-based." Surrounded by

"a lot of unhealthy behaviour," she became a teenage mother—a consequence of "an environment where you don't feel any control over how your body is, or who shares it." Health system supports were limited. "My first pregnancy could have been avoided, but I was so afraid of the doctor to ask for birth control pills. And then his reluctance to give them to me—I was already pregnant when I finally got them." After her youngest child was born, providers failed to honour her request for tubal ligation. "We waited for four days, [and] it didn't happen. [...] It meant another ten years of worrying about being pregnant again."

Pauline underwent a hysterectomy during the COVID-19 pandemic due to uterine fibroids. She had previously declined the procedure because she already "had lots of surgeries." Over time, the fibroids grew, and a gynecologic oncologist recommended a hysterectomy to treat or prevent possible cancer. Yet Pauline's critical awareness of anti-Indigenous racism made her question the medical advice she received: "I was going, 'Is that Western medicine? Or is that acquiescing? Or is it true that I would be better off without a uterus full of fibroids?'" Her age was an additional factor; "I was not of childbearing age, that made the decision too." She situated her hysterectomy in colonial medical histories of forced sterilization:

> [Physicians] used to do [hysterectomies] to Indian[3] women all the time. Not just tie their tubes but take out the whole works. There isn't one female relative of my mom's family that had their uterus when they died. [Was my hysterectomy] because the fibroids were too overwhelming, or the doctors were too lazy, or 'you're not having any more babies'? You need your womb for health. Just because you stop having babies doesn't mean you don't need your parts to stay hormonally balanced.

For Pauline, a hysterectomy was markedly different from tubal ligation, which she had once requested. Tubal ligation symbolized agency and control, while having her uterus taken reflected medical and colonial dispossession. Her uterus was imbued with cultural and personal meaning: "I treasured my womb. I treasured all my parts. It's a cultural thing too, to look after yourself."

Anti-Indigenous racism and pandemic health system strain compromised Pauline's hysterectomy care. Her surgery was delayed and, after the procedure, she was discharged early despite not having recovered fully. "I asked, 'Can you keep me in one more day? I feel like hell.' But I had to go." She explained, "It was because of the beds being required for COVID that I wasn't able to recuperate in the normal amount of time." She developed a serious blood-borne infection and had a traumatic outpatient experience—the hospital "had me lying in the hallway for like 12 hours," before sending her home. The infection worsened before eventually being diagnosed and treated. Pauline reflected, "I think in better times, we would've had the time to sit and talk about my options, or I would have had more time to convalesce, or just take out the [fibroids]. There was no cancer—after all was said and done."

Pauline linked her treatment to intersecting ageism, ableism, and racism of health care providers "trying to care in the face of COVID." She said, "I really think it was my age, and my disability and my race that also impacted my care. Not enough to paint a picture to take it to court, but enough to know that it was there. It was right under the surface." Hospital triage practices intensified a sense of abandonment:

> You get triaged as to how well you might survive. I don't know if my body would have been on the 'save' list in my condition at the time, and that's not a very comfortable thought to live with. [...] I was older and disabled, in pain. And I was Native. [...] If you're just an old Indian woman with a uterus no longer there, where are you on the pecking order? A disabled old woman.

Like Pauline, Alanna experienced hysterectomy as a loss of reproductive and sexual subjectivity. "I'm grieving," she explained. "The grieving is, I can't have kids, even though I didn't want any more, couldn't have any more. A man's not going to want me anymore." She described this hysterectomy-induced "loss of my sexual identity" as "one of the deepest pains I'm carrying." A hysterectomy was especially difficult as a Black woman with disabilities, when "you already feel lesser than," she explained. Also, like Pauline, Alanna had initially refused a hysterectomy until providers gave her no other choice. She connected her experience to medical racism and the structural devaluation of Black women's reproductive health:

> We have a very large percentage of Black women that get hysterectomies, that have fibroids, and very little conversation about all the other reproductive things that we have, like endometriosis. [...] The only thing they talk about with us is how many babies we have, and then you can't have babies because you have fibroids.

For both Pauline and Alanna, hysterectomy became a site of medical and social reckoning with racialized, gendered, and ableist devaluation, exacerbated by pandemic conditions. The physical loss of reproductive organs materialized ongoing processes of medical and social desexualization and erasure for older racialized women with disabilities—experienced as a loss of identity and negation of personhood. As Alanna put it, "we don't exist in the world of sexual health." For Pauline, hysterectomy marked not only the end of fertility but also the end of the self. "Reproductive health goes to when you stop reproducing," she said. "If your organs are gone, then you're gone."

Discussion

Through practicing sexual inactivity, deferring routine sexual and reproductive health care, and experiences of hysterectomy, older women with disabilities negotiated intersecting regimes of risk, responsibility, and neglect. Participants' experiences show that sexual and reproductive health management during COVID-19 was constituted through relations of care and constraint, as women were compelled to self-manage risk while navigating health systems that treated their sexual and reproductive concerns as secondary. Their accounts demonstrate how dominant healthy aging frameworks that privilege functional capacity, autonomy, and sexual fitness fail to account for the experience of older women with disabilities, reproducing exclusionary boundaries of what it means to age well.

Sexual inactivity was both self- and medically prescribed, shaped by the constraints of the COVID-19 pandemic, provider directives, social scripts, and racist stereotypes. Sexual inactivity mitigated risk of COVID-19 infection and aligned with public health directives in Canada that positioned social isolation as a moral imperative. Yet even before the COVID-19 pandemic, providers had promoted sexual inactivity to some women as a strategy for managing mental health disabilities—a "technique of the self" (Foucault 1988), wherein normative subjectivities are governed and produced through practices of self-management.

Amid pandemic conditions, sexual inactivity as a risk mitigation strategy reflected a neoliberal impetus to assume personal responsibility for health. Abstinence was promoted by clinical guidance and infection prevention discourse in ways that reproduced ableist, ageist, and sexist imaginaries, desexualizing women with disabilities and collapsing care, risk, and moral responsibility. Expectations for self-management were racialized, grounded in long histories of slavery, colonization, and reproductive injustice that pathologized the sexuality of racialized and Mad women (Appignanesi 2011; Davis 2019; Laganá et al. 2013; Pinto 2014; Roberts 1997; Showalter 1987). Prescriptions of abstinence deepened social isolation—already more prevalent in disability communities and amplified by the pandemic (Emerson et al. 2021; Jenkins et al. 2021). Sexual inactivity became a technique for negotiating safety, autonomy, and social legibility.

The COVID-19 pandemic magnified systemic neglect of women with disabilities' sexual and reproductive health (Evans et al. 2024; 2025; Liu et al. 2025). Participants prioritized chronic illness and disability management over routine preventive care, in part because health system strain required them to triage their own needs. Women and providers alike devalued routine sexual and reproductive health care, especially for those presumed sexually inactive. This exemplifies "epistemic injustice" (Fricker 2007; Ho 2022), whereby the experiences of older women with disabilities are erased within sexual and reproductive health knowledge systems oriented toward pregnancy and childbirth. In Euro-American contexts, where reproductive capacity is intertwined with women's social value and menopause symbolizes the end of reproductive life (Greenhalgh 1995; Lock 1995), routine care was rendered irrelevant to women situated outside this sexual economy. When participants did seek care, they encountered dismissal or patronization, reinforcing medical mistrust and disengagement from care. Their experiences reflect how menopause-related care and chronic reproductive health conditions are routinely treated as low priority and tolerable despite their physical and psychological effects, disproportionately impacting Black women and other women of colour (Katon et al. 2023; Zahn et al. 2024).

Hysterectomy was a visceral site where medical devaluation intersected with racism, ableism, and ageism. Performed ostensibly to preserve health and longevity, hysterectomy rendered pregnancy a material impossibility—this ontological loss concretized broader social processes of devaluation. Disabled and racialized women have long been subject to reproductive violence through eugenic practices like forced sterilization (Davis 2019; Nuriddin et al. 2020; Serrato Calero et al. 2021; Roberts 1997). Invasive hysterectomy procedures are more common for racialized women compared to white women (Pollack et al. 2020; Robinson et al. 2017), and racialized women's pain is disproportionately underestimated and undertreated (Ruben and Stosic 2024). Exacerbated by pandemic triage conditions that discriminated against older and disabled people (Andrews et al. 2021; Cohen 2020; Klein 2022), Alanna and Pauline's experiences of hysterectomy registered medical and colonial dispossession inflected by anti-Black and anti-Indigenous racism that negated sexual and reproductive subjectivity, threatened a sense of self, and marked exclusion from the realm of full womanhood and reproductive personhood.

Conclusion

The sexual and reproductive health experiences of older women with disabilities during the COVID-19 pandemic reveal how aging is shaped by intersecting systems of ableism, ageism, sexism, and racism. Practices of self- and medical management constrain possibilities for sexual and reproductive subjectivities: sexual inactivity was a strategy of moralized risk mitigation that promised health and safety but also exacerbated desexualization and isolation; routine care was treated as nonessential, reproducing ableist, racist, and ageist hierarchies of care; and hysterectomy enacted medical and colonial dispossession in the lives of racialized women with disabilities, performed in the name of care. This study's small sample limits generalizability; however, detailed accounts offer insights into the complexity of aging, disability, gender, and race. Future research should examine how disabled women navigate sexuality and reproductive health across the life course and within different health care systems.

While sexual and reproductive health disparities predate COVID-19, the pandemic magnified them. Women with disabilities are paradoxical subjects of healthy aging frameworks—targets for medical intervention yet excluded from the promises of sexual vitality and longevity. Models of aging that privilege functional capacity and autonomy ultimately obscure the sexual and reproductive lives of women aging with disabilities, underscoring the need to center interdependence and inclusion across the life course.

Notes

1. In this article, women and/or gender-diverse persons include cisgender women, transgender women, transgender men, Indigenous Two-spirit persons (i.e., a queer gender, sexual, and spiritual identity culturally specific to Indigenous people across Turtle Island including Canada), and non-binary, genderqueer, gender non-conforming, or gender questioning persons.
2. Participants were given a $40 CAD honorarium and a list of sexual and reproductive health resources after interviews.
3. "Indian" and "Native" are terms with colonial origins used historically in Canada and the United States to refer to Indigenous communities of Turtle Island. Today, these communities are usually referred to as Indigenous, First Nations, Inuit, and/or Métis. However, some people continue to self-identify as Indian, NDN, and/or Native, and have reclaimed these identities.

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