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Original Research Article

Challenging Ableism: Sexual and Reproductive Health Barriers for Women with Differently Abled Bodies

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Abstract: *Women with physical disabilities experience compounded marginalization due to ableism, gender inequality, and entrenched socio-cultural norms. These intersecting barriers severely limit their autonomy and access to sexual and reproductive health (SRH) services, particularly in low- and middle-income settings like Pakistan.* ***Objective****: To explore the lived experiences and challenges in accessing SRH services among married women with physical disabilities in Lahore, Pakistan.* ***Methods:*** *A qualitative phenomenological study was conducted from January to June 2024 in Lahore, Pakistan. Purposive sampling was used to recruit 15 married women aged 18–40 years with physical disabilities. In-depth semi-structured interviews were conducted in Urdu, audio-recorded, transcribed verbatim, and translated into English. Thematic analysis was performed using NVivo software, following Colaizzi's seven-step method. The study was grounded in the theoretical frameworks of social constructivism and intersectionality to examine how structural and attitudinal factors shape SRH experiences.* ***Results:*** *Participants reported numerous barriers to accessing SRH services, including negative societal attitudes, discriminatory healthcare practices, inaccessible facilities, and inadequate SRH education. The internalization of stigma, invisibility in SRH discourse, and lack of provider sensitization further marginalized these women. Many participants expressed that health systems neither addressed their specific SRH needs nor considered their lived realities.* ***Conclusion:*** *The study underscores the urgent need to integrate disability-sensitive approaches into SRH policies in Pakistan. Addressing structural ableism, gender discrimination, and socio-cultural bias is critical to ensuring equitable access to SRH services for women with disabilities. A more inclusive health policy framework, provider training, and community awareness are essential to improve SRH outcomes for this underserved population.*

Keywords: Sexual and Reproductive Health, Ableism, Gender Discrimination, Intersectionality, Social Constructivism, Socio-Cultural Norms.

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Introduction

Disability is a diverse term that includes a set of disabilities that restrict full participation in social, economic, and cultural activities (1). Because of one's disability, it affects the individual and the socio-environment and infrastructure within which the individual lives. The concern is much broader than health because it relates to identity and social inclusion. It also includes barriers to the quality of life of individuals with abilities (2). Identity and social inclusion serve to enrich an impairment, particularly for women. Our purpose was to look at the problems of women with physical disability.

For women with diverse needs, it represents an additional societal layer that defines their social roles and the quality of life, access to and availability of resources. Many women with diverse needs continue to experience "double discrimination" as a result of ableism and being female, thus heightening their need for social exclusion as well as essential resources including healthcare. (3). This study sought to understand the reproductive health issues specifically for women with diverse needs, along with how societal constructs and the absence of accessible healthcare facilities create gaps within reproductive healthcare. We issue violence, discrimination, abuse, and the growing gap of neglect that exists towards women with differently abled bodies, which calls for some form of action that seeks to address the interrelation of these multiple social aspects simultaneously.

As provided by the World Health Organization, approximately 16% of the world's population live with some form of disability, which includes women as a notable proportion of this demographic (4).

Though there has been some improvement in understanding the rights of people with disabilities on a global scale, women suffering from physical disabilities remain underappreciated. In Pakistan, this is further complicated by socio-cultural and institutional factors, despite the attempts made by the state to improve the conditions of persons with disabilities. The United Nations Development Programme (UNDP) estimates the disabled population in Pakistan to be around 6.2%, which could be more given differentiating standards and definitions of disabilities (5). Legal recognition for people with disabilities was first provided in The Person with Diverse Needs (Employment and Rehabilitation) Ordinance of 1981 and this was furthered in 2018 with the establishment of a National Council to address issues of disability as an integral part of national programs.

Obstructions in the fields of education, healthcare, and employment still exist, which reveals the lack of system change necessary for women with differently abled bodies to contribute fully to society.

Ableism refers to discrimination or prejudice against individuals with physical or mental disabilities, privileging those without disabilities (6, 7). Media often reinforces ableist stereotypes by depicting individuals with disabilities as dependent, inferior, or socially different, which hinders their integration. Moreover, social and physical infrastructures that fail to consider the needs of disabled individuals promote exclusion and reinforce a single-axis view of society (8). This marginalization is worsened by poverty linked to limited educational, employment, and healthcare access, restricting mobility and social growth.

In Pakistan, the roots of ableism lie in cultural beliefs and misinformation. Disabilities are often perceived as divine punishment or personal misfortune, contributing to the stigmatization and isolation of affected individuals (5). These views, often supported by religious interpretations, alienate people with disabilities from cultural and social activities and deny them basic rights and opportunities.

When gender intersects with disability, the social barriers multiply. Women with disabilities experience unique challenges that non-disabled women and disabled men do not. This intersection often results in higher rates of gender-based violence and reproductive control due to deeply ingrained societal prejudices (9). These women frequently experience 'double marginalization,' where they are stigmatized both for being women and for being disabled, leading to limited access to education, employment, and healthcare (10).

One critical area of concern is access to sexual and reproductive health services. Women with physical disabilities often encounter inaccessible healthcare facilities—such as examination rooms not designed for wheelchair users—and healthcare professionals who lack the training to address their specific needs (11). This results in delays, inadequate treatment, and a general lack of support. Misguided beliefs about the reproductive capacity and parenting abilities of disabled women further limit their access to family planning and maternal health services (12, 13). Social attitudes compound these issues, as many women with disabilities are discouraged from seeking reproductive healthcare out of fear of judgment or discrimination (1). These societal barriers often prevent them from exercising autonomy over their bodies and making informed health choices. Moreover, many sexual health education programs fail to include the specific needs of differently abled women, leaving them vulnerable to sexual abuse, unintended pregnancies, and sexually transmitted infections (2).

The vulnerability of disabled women to sexual and intimate partner violence is well-documented. Studies have shown that women with physical disabilities are more likely to suffer from sexual violence than those without disabilities (14). This risk is exacerbated by inadequate reporting mechanisms and a lack of accessible support services, increasing their susceptibility to mental health disorders such as depression and PTSD.

Legislative frameworks have not adequately addressed the reproductive health rights of women with disabilities. Although some policies exist, they often restrict rather than support access to necessary services (15). Therefore, there is an urgent need to reform laws to explicitly support the healthcare and reproductive rights of women with physical disabilities.

Despite growing global awareness, there remains a significant research gap in Pakistan regarding the sexual and reproductive health of women with physical disabilities. Most studies overlook the intersectional challenges these women face and fail to address the cultural and infrastructural barriers they encounter. This study, focusing on women in Lahore, aims to fill this gap by exploring their lived experiences in a local context. By doing so, it will provide critical insights for developing policies, promoting social inclusion, and advocating for reproductive rights. Understanding the intersection of gender and disability in Pakistan is key to building a more inclusive and equitable society.

Research Questions:

- How do ableism and intersecting factors of gender, disability, and socio-cultural norms shape the unique challenges and barriers encountered by women with differently abled bodies in accessing sexual and reproductive health services in Pakistan?
- How do women with physical disabilities navigate and cope with the challenges related to their sexual and reproductive health?

Conceptual Framework

Women with differently abled bodies face interconnected challenges in sexual and reproductive health (SRH), significantly influenced by ableism a societal construct fostering discrimination against individuals with disabilities. These challenges are compounded by gender discrimination, limiting access to SRH services, education, and rights. Social constructivism highlights that disability is not an individual flaw but a socially constructed concept shaped by cultural norms and biases, often perpetuating stereotypes and stigma. Intersectionality further reveals how overlapping identities, including gender, disability, and class, intersect to create unique experiences of oppression, leaving women with differently abled bodies particularly vulnerable to gender-based violence and systemic marginalization in healthcare settings.

Barriers to accessing SRH services isolate these women, limiting personal and professional growth opportunities. Addressing these challenges requires inclusive policies and interventions that tackle ableism and gender discrimination while considering intersecting identities. Future research must explore these dynamics to promote equitable access and empower women with differently abled bodies in SRH contexts.

Methodology

This study employs a qualitative research design to explore the sexual and reproductive health (SRH) challenges faced by married women with physical disabilities, focusing on the impact of ableism on their experiences. The phenomenological approach was adopted to capture the lived experiences of these women, emphasizing the social, cultural, and systemic barriers they encounter. Purposive sampling was used to recruit 15 participants aged 18 to 40, ensuring a diverse range of experiences and perspectives. To reduce potential bias, researcher bracketing was employed by setting aside personal assumptions through reflexive journaling. This ensured the participants' lived experiences remained the primary focus of the study.

This sampling strategy enabled the inclusion of women from different socio-economic backgrounds and life stages, offering a nuanced understanding of how physical disabilities intersect with SRH challenges and societal biases rooted in ableism.

Given the sensitivity of the topic, ethical considerations were prioritized throughout the research process. Participants were fully informed about the study's objectives, procedures, and potential risks, and their consent was obtained voluntarily. Confidentiality was maintained by anonymizing data and using pseudonyms in reporting. Discussions were conducted with cultural sensitivity and an understanding of the specific needs and vulnerabilities of women with differently abled bodies. Researchers provided a supportive environment, addressing potential distress and sharing information about local support resources. The study protocol received ethical approval from the relevant review board to ensure compliance with established ethical standards. This research aims to uncover the complexities of SRH challenges experienced by differently abled women and to highlight the role of ableism in shaping their access to healthcare, contributing valuable insights to public health, disability studies, and gender studies literature.

This research on ableism and the experiences of women with differently abled bodies in Lahore is important because it reveals distinct aspects of their experiences within a particular culture. This study enhances informed policy at the intersection of gender and disability, aids social inclusion initiatives, empowers women with physical disabilities, informs healthcare policies, adds to the global research on disabilities, advocates on their behalf, and develops education policies. Understanding the challenges posed by societal norms for women with differently abled bodies in Lahore is critical for fostering inclusivity and challenging norms in this neglected area of study.

Results

The data on sexual and reproductive health (SRH) challenges faced by women was analyzed through thematic analysis, based on transcribed interviews and audio recordings. Using an inductive approach, key research questions were explored, revealing patterns and themes related to SRH barriers. The analysis highlighted issues such as limited healthcare access, social stigma, and reproductive autonomy restrictions. These findings underscore the significant impact of cultural and economic constraints on women's SRH, emphasizing the need for targeted interventions to address these challenges.

The data analysis, performed by a single coder, identified two primary themes with related sub-themes, shedding light on the complex SRH issues faced by women in socio-culturally constrained environments.

Theme 1: Systemic Barriers to Sexual and Reproductive Health Access

This theme analyzes the sociocultural obstacles of women with differently abled bodies in Pakistan to access sexual and reproductive health services

(SRHS). The analysis points out the lack of infrastructural development within healthcare services, the absence of policies and legal frameworks, the inadequacies of telehealth services, and the absence of reproductive health education for these women. Women with differently abled bodies face huge difficulties with mobility in the clinics with little or no ramps and elevators, as well as other adaptive devices. This situation makes it impossible for many physically disabled women to consult care providers, much less receive treatment. "I once visited a clinic in my locality for a gynecological examination, and I regretted the trip because I needed assistance to reach the consulting room. The place is a maze and there is not a single ramp for wheelchair users. I'm really ashamed that I have to depend on other people." In another case, a participant spoke about not being able to access a seated position on the examination table because of how high it was and a simple lack of other people meant she ended up not going through with the check-up. "After I finally made it to the doctor's, I was told I needed to step up on the examination table. I had to miss the check-up that day," she said, describing how her hospital needed to attend to a different patient and aid them in ascending the high stairs that led to the clinic.

Health policy gaps incorporate numerous legal issues, including accessibility difficulties. "I feel utter disregard as being a member of a social group whose needs are being overlooked by governments." The absence of legal frameworks surrounding the provision of reproductive health services leaves women with disabilities having to depend on the charity of particular healthcare professionals. "We have no policy which guarantees these services are provided them at the expense of unhelpful doctors or generous, helpful clients." Policy design dictates the interplay between accessibility and telehealth aids, which can lead to problems for women with deformities.

Numerous women expressed their dissatisfaction with telehealth due to technological illiteracy, smartphones, and internet infrastructure, particularly in rural settings. "I was so optimistic when I heard about telehealth services. But when I tried to use it, I realized it's not that easy…They assume everyone can handle a smartphone, but that's not the case for me. Half the apps they recommend, I don't know how to use." For rural women, where resources are hard to come by, telehealth has not been accessible or useful from a resource perspective. "It's like they rolled out telehealth for the educated urban elite, not for people like us. The majority of us in rural areas do not have smartphones or Wi-Fi. So, what's the point of offering these services?"

At last, a common gap in the narratives of women with various disabilities was reproductive health education. Many women reported that healthcare providers did not offer sexual health, family planning, or maternal care services, either because providers assumed they did not require such services, or due to societal perception that disabled people are asexual or indifferent to family life.

"Society has this misconception regarding a person's disability whereby they tend to disregard the need for a person with a disability to know about family planning. As if we somehow overlook having relationships and family matters." One participant explained a doctor's dismissal of her questions regarding contraceptive options. "When I asked my doctor about contraception, she just laughed and said, 'Why do you need this information?' That was so humiliating… Why treat me differently just because I am in a wheelchair?"

To conclude, the reasons for such access constraints to sexual and reproductive health services for women with disability in Pakistan are fundamentally rooted in systemic ableism, socio-economical disparities, and deepened gendered inequalities. The absence of healthcare infrastructure that caters to these women, coupled with weak policy frameworks, limited telehealth services, and the absence of reproductive healthcare further segregate these women. Inadequate policy framing along with healthcare system build-up, along with changing perceptions of society is needed for women with disability to be enabled access to sexual and reproductive health rights and services.

Theme 2: Social and Interpersonal Dynamics in Healthcare Experiences

This theme explores how social factors shape the healthcare experiences of women with differently abled bodies in Pakistan, particularly focusing on interactions with healthcare providers, societal biases, cultural and religious beliefs, and support networks. These dynamics significantly affect both access to and the quality of healthcare that women with differently abled bodies receive.

Interactions with Healthcare Providers and Medical Biases

Several participants reported biased and dismissive interactions with health service providers. At times, healthcare practitioners did not comprehend the specific requirements of women with differently abled bodies, or some of them even had preconceived notions regarding their reproductive health.

Recalling her experience with a healthcare provider, one participant stated,

The doctor kept on asking me why I would want information on family planning. Because I have a disability, he seemed to think I'd never get married or have a family. It's as though they don't view us as women with the same needs and rights.

Multiple women reported feeling patronized during consultations, which from then on made them uncomfortable and caused medical distrust. A participant noted,

Sometimes I feel like I have to justify my choices to the doctors. I mean, they're either too careful and think I can't handle some of the treatments or they completely disregard my concerns. I don't know what to say – it's frustrating.

Dynamics such as these without sympathy or understanding contributed to women feeling disengaged and reluctant to pursue services.

Stigma and Societal Misconceptions

Society's stigma towards disability and women's reproductive health further marginalizes women with differing abilities. Many reported that their reproductive decisions were disregarded by those around them, including healthcare workers and community members.

As one participant recalled,

Those around me assume that due to my disability, I should just forgo marriage or having children. They think granting me a family is asking for trouble as if it's not my right.

Such societal attitudes stripped women of control over their lives and imposed unwarranted shame regarding reproductive health. Some participants described family and community members actively discouraging them from pursuing marriage or starting a family, perceiving it as an unreasonable notion. A single participant shared,

Some of my relatives tell my parents that I'm a burden and that if I marry, I'll just be a burden to someone else. They don't think I should even think about a normal life.

These are the changes that perpetuate the social complexity concerning women with disabilities by reinforcing the misconception that women with different abilities are devoid of the prospect of ordinary familial or reproductive life.

Cultural and Religious Beliefs Affecting Health Choices

The women in Pakistan face additional challenges regarding reproductive health due to cultural and religious frameworks concerning disability as these frameworks limit choices affiliated with marriage and childbirth.

"In my village, there is this belief that if a disabled woman gets married, people think her children are going to be disabled too. It is viewed as a punishment". This is how one woman explained the phenomenon. With the integration of abstract faith practices and traditional customs, women's discretion over reproduction was at times hindered. Even though some participants gained solace in the teachings of faith, many others found these interpretations caste restrictions. As one participant remarked:

Some people say I'm disabled because that's their God's plan, and I am meant to stop longing for a better life. Religion is used as reasoning for why I should not aspire to try and have a family and that's the 'right' decision.

Such attitudes are in dire need of change when shaped through these religious and cultural lenses as they make women feel that pregnancy is an urge that clashes with expectation which pushes them further in search for assistance with reproductive health.

Support Networks and Advocacy Resources

Support networks and advocacy organizations proved to be essential in challenging societal stigma and promoting inclusive healthcare. Women accessing these networks felt more empowered and confident navigating the healthcare system.

One woman shared,

I joined a local support group for women with differently abled bodies, and it changed everything for me. Knowing I wasn't alone made me stronger. I could talk about things like family planning without feeling judged.

Support groups offered a safe space for women with differently abled bodies to share experiences, seek advice, and advocate for their rights. Through these groups, many women connected with healthcare providers who understood their unique needs. One participant commented,

"An NGO helped me find a doctor who doesn't judge. I finally have a healthcare provider who listens to me. It took a long time to find that support, but now I know some people care."

While advocacy organizations played a crucial role in promoting inclusive healthcare, resources remained limited, particularly in rural areas, where access to disability-specific support was scarce.

These social and interpersonal dynamics illustrate how societal views, healthcare provider attitudes, and support networks influence the reproductive health experiences of women with differently abled bodies. The biases and misconceptions they face hinder their autonomy and access to compassionate care. Despite these challenges, supportive networks offer hope for a more inclusive healthcare system. However, systemic reforms and continuous advocacy efforts are needed to ensure women with differently abled bodies can exercise their reproductive rights with dignity and respect.

Theme 3: Personal Autonomy, Identity, and Psychological Well-being

This theme examines the reproductive freedom, identity, and ableism in healthcare dynamics troubling women with different-abled bodies in Pakistan. It also elucidates how these women reconstruct their self and sexual identities along with the family planning paradigm while demonstrating their resistance to social silencing.

Empowerment in Reproductive Decision-Making

For many women with differently abled bodies, making independent decisions regarding their reproductive health is a significant step toward autonomy. Despite societal limitations, several women shared how gaining control over their reproductive choices allowed them to feel empowered.

One participant explained, "When I decided to use contraceptives, my family wasn't supportive at first. But I knew it was my right. It felt empowering to make that choice on my terms." Empowerment often meant confronting societal expectations and asserting their rights, despite limited support or information from healthcare providers.

Another participant shared, "In my community, there's this idea that if a blind woman has a child, the child will also be blind. My own family didn't support my marriage because of these assumptions. Now, as a married woman with a disability, people say my husband married me because he's 'a good man,' not seeing that I'm capable of building a family."

These stories underscore the struggle many women face in accessing reproductive information and support while showing their determination to make their own choices despite systemic barriers.

Navigating Identity and Sexuality

For women with differently abled bodies, navigating identity and sexuality is complex and often influenced by societal stigmas. Participants shared how their disabilities affected their sense of femininity, desirability, and sexual agency.

One woman shared, "People don't see us as sexual beings. They think because I'm in a wheelchair, I can't have a normal relationship. But I am a woman too; I have feelings and desires just like anyone else." Such perceptions create emotional challenges, forcing women to redefine their identity within a society that often dismisses their sexuality. This lack of acceptance can lead to internalized stigma, making self-acceptance difficult.

Another participant shared, "Growing up, I never saw women like me in media. I felt invisible. It took me years to accept myself and understand that I could have a relationship, that I could be loved."

Emotional and Psychological Effects of Ableism in Healthcare

Systemic ableism in healthcare often leads to psychological distress for women with differently abled bodies. Many participants recalled feeling dismissed or marginalized by healthcare providers, impacting their mental health.

One participant recalled, "I remember going to a gynecologist who wouldn't even look at me. She didn't take my concerns seriously just because of my disability. It felt humiliating." This form of ableism creates emotional distress, reinforcing the belief that their voices and needs are less important, often resulting in stress and anxiety.

Another participant shared, "Every time I go to the doctor, I feel like I have to fight to be heard. Sometimes, I just don't want to go anymore. It's not worth the stress."

Challenges in Parenthood and Family Planning

Women with differently abled bodies often face skepticism and healthcare barriers when pursuing parenthood. Many reported their desire for children being questioned by family and healthcare providers.

One woman shared, "I always wanted to be a mother, but people told me it would be too hard, that I couldn't take care of a child. Even doctors discouraged me. But I know I can be a good mother but doctors told me to avoid having a child."

Another participant shared, "When I told my family I wanted to adopt, they said I was crazy. They think a disabled woman can't raise a child. But I know I have the love and strength to do it."

The theme of Personal Autonomy, Identity, and Psychological Well-being highlights the resilience of women with differently abled bodies in Pakistan as they navigate reproductive health, identity, and family planning. Despite societal ableism and healthcare barriers, these women assert their autonomy in decision-making, challenge stereotypes about their sexuality, and overcome stigma. Their experiences reveal a struggle for self-acceptance and empowerment, underscoring the need for a more inclusive and supportive healthcare system.

Discussion

The intersection of disability, gender, and sexual and reproductive health (SRH) represents one of the most marginalized and overlooked areas in healthcare policy and practice. For women with disabilities, the challenges they face in accessing SRH services are deeply embedded in systemic ableism and socio-cultural prejudices. These barriers hinder access to essential health services and perpetuate the marginalization of disabled women in matters related to their bodies and reproductive autonomy (16).

Research further emphasizes the importance of promoting autonomy in sexuality and reproductive care, particularly for individuals with intellectual and physical disabilities. Inclusive care models must prioritize informed consent and person-centered communication to address the unique health needs of these populations (17).

Women with physical disabilities encounter numerous structural and attitudinal barriers when seeking SRH services. These include physically inaccessible healthcare facilities, the absence of adaptive medical equipment, and a general lack of professional training among healthcare providers to handle disability-specific reproductive health needs (18). In many cases, examination rooms and diagnostic tools are not designed for wheelchair users or women with mobility impairments, making it difficult to undergo even basic medical procedures.

Furthermore, the negative attitudes and implicit biases of some healthcare providers significantly affect the quality of care. Assumptions that women with disabilities are asexual, incapable of bearing or raising children, or

uninterested in relationships persist, further marginalizing them in health discussions and decision-making processes (19). These ableist beliefs often result in inadequate or withheld reproductive health information and services, denying women with disabilities their right to comprehensive healthcare.
There is an urgent need for inclusive health policies that recognize the unique experiences and needs of women with disabilities. Such policies should include mandatory disability-awareness training for healthcare providers and the adaptation of healthcare infrastructure to accommodate physical limitations (20). Efforts should also focus on promoting respectful, non-discriminatory communication and consent practices tailored to women with disabilities.
In addition, reproductive health education must be inclusive of women with disabilities. Tailored health education that considers their physical, emotional, and psychological realities can empower them to make informed decisions about their bodies and reproductive choices (10). When SRH education acknowledges their rights and capacities, it counters ableist stereotypes and strengthens their agency in navigating healthcare systems.
Cultural perceptions regarding the maternal abilities of women with disabilities further compound these challenges. Societal beliefs often view women with physical impairments as incapable mothers. This stigmatization not only questions their capacity to care for children but also discourages them from pursuing motherhood or seeking SRH services altogether (5). It is essential to dismantle these stereotypes by showcasing real-life narratives of successful parenting by women with disabilities. Positive representation through media, education, and public discourse can help shift societal perceptions and reduce stigma.
Community-based support systems, including peer advocacy groups, play a critical role in bridging the gap between women with disabilities and healthcare services. These platforms provide a space for women to share experiences, advocate for their rights, and access relevant information about available health services. Through workshops, awareness campaigns, and direct engagement with healthcare institutions, such initiatives can create an environment where disabled women feel empowered and supported.
Despite these challenges, many women with physical disabilities demonstrate resilience in navigating their SRH needs. Their narratives reflect resistance to social exclusion and a drive to assert their rights. This highlights the importance of involving disabled women in healthcare planning, policy formulation, and service delivery. Their participation ensures that policies are not only inclusive but also grounded in lived experience, thereby making healthcare systems more responsive and equitable. Ultimately, the inclusion of women with disabilities in SRH discourse must go beyond tokenism. It requires systemic change from policy to practice to ensure their health rights are respected and fulfilled. Inclusive SRH services can only be achieved when healthcare systems actively dismantle ableist structures and embrace diversity in health experiences and needx

Conclusion

Women with differently abled bodies face unique sexual and reproductive health problems that need urgent attention. Systemic issues such as spatial barriers, insufficient educational materials, and rampant neo-ableism within the healthcare system often limit their access to critical services and the ability to make choices regarding their reproductive healthcare. These barriers impact women with disabilities as they attempt to claim their rights and control over their bodies. Such problems call for inclusive advocacy specifically tailored to women with disabilities. Educating healthcare professionals as well as society at large is essential in refuting many of the erroneous notions about disability and reproductive health. Additionally, social policies must foster and provide support structures that incorporate women with disabilities into governance processes to grant them the requisite respect and attention to their divergent needs. When society starts to understand the rights and capabilities of women with disabilities, it would enable to design
policies that guarantee non-discrimination towards obtaining essential information, services, or even products. Through a collaborative effort, society can create an ecosystem that encourages women with disabilities, thus enhancing their welfare and respecting their self-determination on issues about their sexual and reproductive health.

Declarations

Data Availability statement
All data generated or analysed during the study are included in the manuscript.
Ethics approval and consent to participate
Approved by the department concerned. (IRBEC-MMS-033-24)
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Conflict of interest

The authors declared the absence of a conflict of interest.

Author Contribution

SBZ (MPhil Sociology)
Manuscript drafting, Study Design,
NN
Review of Literature, Data entry, Data analysis, and drafting articles.
AI
Conception of Study, Development of Research Methodology Design,

All authors reviewed the results and approved the final version of the manuscript. They are also accountable for the integrity of the study.

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