DISABILITY, CBR & INCLUSIVE DEVELOPMENT

Original Research Article

Knowledge, Attitude, and Utilization of Sexual and Reproductive Health Services among People with Disabilities

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ABSTRACT

Introduction and Purpose: Knowledge and attitude toward sexual and reproductive health play a crucial role in services utilization among people with disabilities. The purpose of this study was to assess the knowledge, attitude, and utilization of sexual and reproductive health services among people with disabilities in Kathmandu Valley.

Methods: The study was a quantitative, descriptive, and cross-sectional study. The total sample was 217, and a census was conducted to collect data from people with disabilities. The data were entered in EPI data 3.1 and exported to SPSS version 22 for further analysis. Descriptive and inferential statistics were used for data analysis.

Results: Of the 217 respondents, over half (54.8%) did not utilize sexual and reproductive health services (SRH), while 45.2% did. Among those SRH service users, more than two-thirds (66.3%) used family planning, and more than four-fifths (87.8%) sought those services from government health facilities.

Conclusion: This study revealed that slightly more than half did not utilize any sexual and reproductive health services, and the reason for not utilizing SRHS was the distance to facilities, as said by almost two-fifths of the respondents, while just over a third of the respondents mentioned no-disability-inclusive services.

Keywords: Utilization, Sexual and reproductive health, People with disability, physical disability, visual disability

INTRODUCTION

Approximately one billion people globally live with disabilities, and eighty percent of them reside in resource-limited settings (World Health Organization, 2015). Disability is influenced by both individual health conditions and environmental factors, encompassing a wide range of impairments, functional limitations, and participation restrictions (WHO, 2011). Despite international progress in health and human rights, persons with disabilities continue to face significant discrimination, marginalization, and social exclusion in many countries (Anderson & Kitchin, 2000; Stein, Stein, Weiss, & Lang, 2009).

Women with disabilities encounter even greater barriers, especially in relation to their sexual and reproductive health (SRH). Harmful stereotypes often depict them as asexual and unlikely to marry or bear children, leading to their exclusion from essential SRH services. These misconceptions contribute to their exclusion from essential healthcare services (Hridaya R Devkota, Kett, & Groce, 2019; Morrison et al., 2014). Compounding the issue, healthcare providers frequently lack the necessary training, equipment, and accessible information to provide inclusive SRH care. Social and economic factors further increase the vulnerability of women with disabilities. Economic dependence, social isolation, and assumptions that they are less likely to report abuse heighten their risk of experiencing violence, directly affecting their SRH rights and safety (Alexander & Taylor Gomez, 2017; Namatovu, Preet, & Goicolea, 2018; Subedi & Regmi, 2019). Despite prevailing myths, studies indicate that women with disabilities have similar levels of sexual desire and activity, as well as comparable needs for family planning, to their non-disabled peers (Alexander & Taylor Gomez, 2017; Emerson et al., 2014). However, their access to SRH services is often limited by lower socio-economic status, physical inaccessibility of health facilities, and the higher costs associated with care (Coppin et al., 2006; Hosseinpoor et al., 2013). People with disabilities have been reported to have poorer health outcomes due to multiple challenges, such as gender, a poor health care system, a lack of community support, and low economic levels (Kumi-Kyereme, Seidu, & Darteh, 2020; Ministry of Health and Population, 2019).

In Nepal, the prevalence of disability is 1.94%, with a higher rate among males (2.2%) compared to females (1.7%) (Central Bureau of Statistics Nepal, 2014). However, women with disabilities experience disproportionately poor health outcomes, largely due to gender-biased cultural norms that contribute to systemic discrimination and exclusion across multiple aspects of life (Hridaya Raj Devkota, Murray, Kett, & Groce, 2017). This group faces intersecting discrimination—both as women and as persons with disabilities—which leads to greater marginalization compared to either men with disabilities or non-disabled women (Anderson & Kitchin, 2000; Morrison et al., 2014).

Despite this, there remains a significant lack of information and attention regarding the sexual and reproductive health (SRH) needs of people with disabilities in Nepal. Government policies targeting women with disabilities often lack depth and practical implementation, and healthcare systems are ill-equipped to respond to their unique needs (Hridaya R. Devkota et al., 2019; Wilbur et al., 2021). Barriers to accessing SRH services include the physical inaccessibility of health facilities, lack of trained providers, economic hardship, and persistent societal stigma.

In resource-constrained settings like Nepal, SRH is integral to overall well-being and sustainable development. However, individuals with disabilities are often excluded from SRH discussions and services, largely due to the persistent misconception that they are not sexually active or do not require such care (Kallianes & Rubenfeld, 2014; Starrs et al., 2018). This neglect has perpetuated the invisibility of their SRH needs and rights in both health systems and broader policy frameworks.

Further studies are needed to understand the factors influencing SRH-related information and service utilization by Young People with Disabilities (YPWD)(Kassa, Luck, Bekele, & Riedel-Heller, 2016). Various factors impact the sexual and reproductive health of women with disabilities (Anderson & Kitchin, 2000; Groce, Kett, Lang, & Trani, 2011).

People with disabilities face poorer health outcomes due to challenges like gender disparities, inadequate healthcare systems, lack of community support, and economic difficulties (Emerson et al., 2009; Kumi-Kyereme et al., 2020). There is limited documentation analyzing how countries have formulated policies and solutions to meet the needs of people with disabilities (WHO, 2011). It is crucial to integrate people with disabilities into

sexual health promotion and service planning, requiring specialized policy and program interventions to address their unique challenges (Holdsworth et al., 2018).

There are just a few documents that compile and analyze how countries have built policies and solutions to meet the requirements of people with disabilities (Ministry of Health and Population Department of Health Services, 2019). It is critical to include people with disabilities in sexual health promotion and service planning, and specialized policy and program interventions are needed to address the negative sexual health outcomes that people with disabilities suffer disproportionately (Holdsworth et al., 2018).

Furthermore, it is critical to investigate the link between disability type and SRH service use, along with total disability status, to identify possible disparities in SRH service utilization among people with different disabilities (Mac-Seing, Zarowsky, Yuan, & Zinszer, 2022). Hence, this study will focus only on respondents with physical and visual disabilities, respectively.

These vulnerabilities underscore the pressing need for increased sexual and reproductive health education and care for people with disabilities. Universal access to SRH is recognized as a fundamental human right, aligning with sustainable development goals on good health, well-being, and gender equality. In this context, understanding the utilization of sexual and reproductive health services by people with disabilities is critical in Nepal.

The National Guideline for Disability Inclusive Health Services in 2019 prioritizes SRH services, with an even higher emphasis on SRH for women with disabilities in Nepal (Ahmed & Taneepanichskul, 2008). However, there is a notable gap in research, particularly in the inclusion of both genders with disabilities in studies targeting various areas to ensure fairness and equal opportunities. This study aims to include both genders with disabilities, making it a unique endeavor to assess the utilization of Sexual and Reproductive Health services among people with disabilities in the Kathmandu Valley.

Objective

The study aims to assess the knowledge, attitude, and utilization of sexual and reproductive health services among people with disabilities in the Kathmandu Valley.

METHODS

The dependent variable for this study was the utilization of SRH services.

Study setting

The study was conducted in five organizations working with visual and physical disabilities. The organizations in Kathmandu Valley are institutional as well as household-based. Out of the many organizations that support PWDs, only those focusing on people with physical and visual disabilities are considered as the study units, which comprise a total of nine organizations within the Kathmandu valley. Permission was granted from three organizations, where the estimated number of people associated with those organizations was provided. The sample organizations for the study are listed below:

Table 1: List of organizations providing study sample

S.N	Name of the organization	Eligible	Participated
1.	Blind Youth Association, Sukedhara	80	77
2.	Jawalakhel Wheelchair Sports Club	15	15
3.	B.I.An Institute, Jorpati	67	67
4.	Nepal Disabled Association (Khagendra Newlife Centre), Jorpati	40	40
5.	Sainik Purnasthapana Kendra, Bhandarkhal	20	18
	Total	**222**	**217**

Study Design

The study design was cross-sectional and carried out to assess the knowledge, attitude, and utilization of sexual and reproductive health services, as it allows for data collection at a single point in time, providing a snapshot of the current situation and enabling the identification of patterns and associations relevant to the study objectives. The selected method was quantitative, which examined the utilization of sexual and reproductive health services among people with visual and physical disabilities.

Study Tools

A semi-structured questionnaire was developed based on the study objectives and variables under the guidance of subject experts. A questionnaire was developed in English and then translated into Nepali without changing the meaning of the sentences used in the questionnaire, and then retranslated back to English. The study tool comprised three components: socio-demographic variables, service-related factors, and utilization-related factors. The tools used in utilization factors, where attitude-related statements were retrieved from "Sexual and Reproductive Health of Young People with Disability in Ethiopia: A Study on Knowledge, Attitude and Practice: A Cross-Sectional Study" by Tigist Alemu Kassa (Kassa et al., 2016), were in English and were translated into Nepali. Based on a modification of Bloom's cut-off points from Nahida's KAP-Study (2007), there were 10 variables to assess knowledge on SRH (Ahmed & Taneepanichskul, 2008). Pretesting was done among 22 people residing in the Bhaktapur district. Reliability and validity of the data collection tool were ensured by an extensive review of the literature and pretesting of the tools to check consistency under the guidance of subject experts.

Study Sample

A total of 217 eligible participants from five organizations were included in the study. Individuals with visual and physical disabilities were included as a unit. Overall, Kathmandu Valley has more than 25 disability-related NGOs working to make life easier for people with disabilities by making them self-reliant through awareness and skill development programs. Out of the many organizations that support PWDs, only those supporting people with physical and visual disabilities were the study units, which comprised a total of nine organizations within the Kathmandu Valley. Permission was granted by five organizations, for which an estimated number of people associated with each was provided.

Eligibility Criteria

Inclusion Criteria: Participants included in the study were individuals aged 18 to 45 with physical or visual disabilities residing in the Kathmandu Valley, whether in their own homes, rented accommodations, hostels, or rehabilitation centers for persons with disabilities (PWDs). Only those who were able to communicate fluently in the Nepali language were eligible. Disability status was identified using the organizations they were registered in and the disability card they were provided with.

The age range of 18 to 45 years was chosen to focus on individuals within the legally recognized age of adulthood and reproductive age group, ensuring ethical autonomy for informed consent and better comparability of sexual and reproductive health (SRH) needs. While menarche may begin around age 15, individuals under 18 are legally minors, and involving them would raise additional ethical considerations regarding assent and vulnerability. This range also allows for the inclusion of both men and women with disabilities, ensuring a more inclusive and gender-balanced understanding of SRH service knowledge, attitudes, and utilization.

Exclusion Criteria: People who were registered in the selected organizations and had disabilities other than physical and visual disability were not included in the study.

Data Collection Procedure

Data were collected through face-to-face interviews using a semi-structured questionnaire. Before data collection, formal permission was obtained from the relevant organizations by submitting an official letter issued by the affiliated academic institution. Once approval was granted, rapport-building activities were conducted to establish trust and ensure a comfortable environment for participants.

Interviews were conducted individually in a private setting to maintain participants' privacy and confidentiality. All interviews were carried out in the Nepali language, with consideration for the comfort, communication preferences, and accessibility needs of individuals with physical or visual disabilities.

Informed verbal and written consent was obtained from each participant before the interview. Participants were informed about the purpose of the study, their voluntary participation, the right to withdraw at any time, and measures taken to ensure confidentiality. No personal identifiers were recorded, and all responses were anonymized. The study adhered to ethical principles of respect, beneficence, and justice.

Data Management and Analysis

The collected data were checked and rechecked to reduce probable errors. After proper coding, data were entered into the Epi-Data software on the same day of data collection. The dataset in EpiData was then exported to SPSS version 22, and further analysis was carried out. Simple statistical measures, such as percentage, mean, standard deviation, and frequency, were used for descriptive analysis, while to measure the association between dependent and independent variables, the Chi-square test was done with a p-value less than 0.05 ($p\text{-value}<0.05$) for a significant level. Utilization of SRH was the dependent variable, defined as the use of any of the following SRH services: family planning, maternal and newborn care, sex education and care during menstruation, reproductive and pregnancy rights, safe abortion service, obstetric and gynecological services, breast and cervical cancer services, awareness on sexual and gender violence, and drug abuse. Independent variables of the study consisted of socio-demographic characteristics, service-related factors, and utilization-related factors.

Ethical Consideration

Ethical approval for the study was obtained from the Institutional Review Committee (IRC) of CIST College, Kathmandu, Nepal (Ref: IRC/183/078/079). In addition, formal permission was sought and granted from the relevant organizations involved in the study by submitting a written request letter from the college.

Following institutional approval, the researchers provided a brief self-introduction and explained the objectives of the study to potential participants. Informed written and verbal consent was obtained after clearly informing participants about the voluntary nature of their participation, their right to refuse or withdraw at any time without penalty, and the assurance that no foreseeable physical or emotional harm would result from their involvement.

Participants were assured of their right to ask questions at any point during the interview process. The study strictly adhered to the ethical principles of justice, respect for human dignity, and the protection of physical and emotional well-being. All data collected were kept confidential, and interviews were conducted in a private setting to maintain participant privacy.

RESULTS

Findings

This section presents findings of the study. A total of 217 people with disabilities were included in the study. Findings include socio-demographic characteristics, service-related factors, and utilization-related factors, knowledge of SRH and attitude-related

statements, along with their association with utilization of sexual and reproductive health services among people with disabilities.

Socio-demographic Characteristics

Out of 217 people with disabilities aged 18-45, the median age was 30. About 52.5% were between 18-30 years old, and 47.5% were between 31-45 years old. The majority were male (58.1%) and Hindu (71.4%). Ethnically, 46.1% were Brahmin/Chhetri and Janjati, while 3.7% were Dalit. Over half (53.5%) were unmarried, and 36.4% had secondary education, with only 5.5% able to write their names. More than half (54.8%) were self-employed, and 29.5% were unemployed.

Most participants (64.1%) had physical disabilities, 27.6% were completely blind, and 8.3% had partial blindness. Nearly all (95.9%) had a disability card, and 59.0% of those with cards had a 'b' grade.

Among these, 55.3% lived in rented accommodations, and 2.8% were in rehabilitation centers. Of those living in their own or rented houses, 78.7% were in nuclear families, and only 2.4% were in extended families. About 63.1% received good family support, 13.8% had poor support, and 30.9% faced family discrimination.

Table 2: Socio-demographic characteristics of respondents

Variables	Frequency	Percent
Co-morbidities (MR)		
Diabetes	8	14.8
Thyroid dysfunction	14	25.9
Hypertension	24	44.7
Heart diseases	4	7.4
Asthma	6	11.1
Kidney disease	3	5.6
Utilization of SRH Services		
SRH service users	98	45.2
SRH service non-users	119	54.8
Used SRH services (MR)		
Family planning	65	66.3
Maternal and newborn care	9	9.2
Sex education and care during menstruation	28	28.6
Reproductive and pregnancy rights	3	3.1
Safe abortion services	3	3.1
Awareness of sexual and gender-based violence and drug abuse	11	11.2
Reason for not utilizing SRH services		
No need to seek services	32	26.9
Distant facility	45	37.8
No disabled-inclusive services	42	35.3
Problem with the availability of SRH services		
Never a problem	32	32.7
A little problem	53	54.1
A big problem	13	13.3
Experience with the last received SRH services		
Completely respected	17	17.3
Neither respected nor disrespected	59	60.2
Completely disrespected	22	22.4
Ease of understanding information		
Easy	20	20.4

Neither easy nor difficult	52	53.1
Difficult	26	26.5
Ease being understood by healthcare providers		
Easy	26	26.5
Neither easy nor difficult	48	49.0
Difficult	24	24.5

Utilization-related factors

As shown in Table 2, 44.7% of people with disabilities experienced hypertension, and 25.9% had thyroid disorders, indicating the presence of significant co-morbidities within this population. More than half (54.8%) did not access sexual and reproductive health (SRH) services. Among SRH users, 66.3% utilized family planning, and 87.8% visited government facilities. Non-users often cited distance (37.8%) and lack of disability-inclusive options (35.3%) as barriers.

Among SRH users, 54.1% faced service availability issues, 22.4% felt disrespected, 26.5% found information hard to follow, and 24.5% struggled to communicate with providers. Awareness of SRH rights and methods was low; 37.8% knew about family planning, with condoms being most recognized (98.6%) and the calendar method least known (6.9%). While 92.6% had heard of STIs, including HIV/AIDS, 79.7% lacked knowledge about HIV testing and counseling.

Table 3: Utilization-Related Characteristics of SRH Services Among PWDs

Variables	Frequency	Percent
Co-morbidities (MR)		
Diabetes	8	14.8
Thyroid dysfunction	14	25.9
Hypertension	24	44.7
Heart diseases	4	7.4
Asthma	6	11.1
Kidney disease	3	5.6
Utilization of SRH Services		
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Experience with the last received SRH services		

Completely respected	17	17.3
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Completely disrespected	22	22.4
Ease of understanding information		
Easy	20	20.4
Neither easy nor difficult	52	53.1
Difficult	26	26.5
Ease being understood by healthcare providers		
Easy	26	26.5
Neither easy nor difficult	48	49.0
Difficult	24	24.5

Level of Knowledge on SRH

In this study, 41.5% of people with disabilities had poor knowledge of sexual and reproductive health (SRH), while only 9.7% had good knowledge (Figure 1). Knowledge levels were classified as poor (<50%), moderate (50-79%), and good (80-100%), based on modified Bloom's cut-off points from Nahida's KAP-Study (2007).

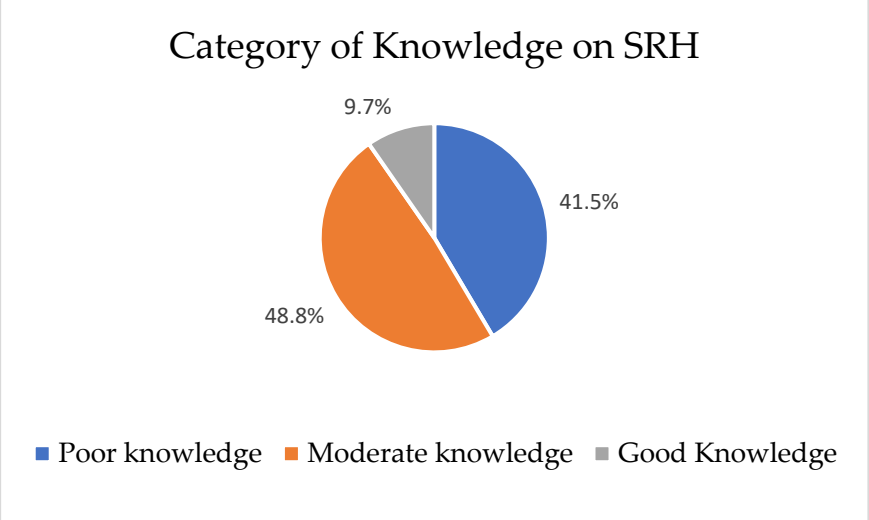

Figure 1: Level of SRH Knowledge Among Study Participants

Attitude-related statements

In this study, just over half (50.7%) of the respondents had a positive attitude toward sexual and reproductive health (SRH) issues, agreeing that HIV can be contracted the first time someone has sex. However, only 12.4% disagreed with the idea that you cannot tell if someone has HIV just by looking. Most participants (89.9%) believed that having multiple sex partners increases the risk of HIV, which reflects a favorable attitude.

More than half (51.6%) disagreed with the notion that using condoms indicates distrust in a partner, showing a positive attitude. Around 20% supported early premarital sex for boys and 18% for girls, which was less favorable. About a third did not agree that a wife can refuse unprotected sex if she wants to use a condom, and another third believed discussing condoms with young people encourages promiscuity, which were also less favorable views. Overall, most respondents had a positive attitude towards SRH issues.

Table 4: Assessment of Attitudes toward SRH Services among Persons with Disabilities

Attitude Statements	People With Disability, n (%)	
	Favourable attitude	Unfavourable attitude
A person can get HIV the first time he or she has sex	110(50.7)	107(49.3)
By looking carefully, one can know if someone has HIV	190(87.6)	27(12.4)
A person having multiple sex partners has a high risk of acquiring HIV	195(89.9)	22(10.1)
Using a condom is a sign of not trusting your partner	112(51.6)	105(48.4)
Early age premarital sex for boys is supported	174(80.2)	43(19.8)
Early age premarital sex for girls is supported	178(82.0)	39(18.0)
A wife has a right to refuse unprotected sex with her husband if she wants to use a condom, but her husband does not	145(66.8)	72(33.2)
Discussing condoms or contraceptives with young people promotes promiscuity	144(66.4)	73(33.6)

Association between socio-demographic characteristics and utilization of SRH services among PWDs

Out of 12 variables, only one variable i.e., occupation, was associated with utilization of SRH services by p-value (0.024), having a moderate relationship with Cramer's V of 0.227.

Table 5: Utilization of SRH Services by PWDs in Relation to Socio-demographic Factors

Occupation	SRH service user, n (%)	SRH services non-user, n (%)	p-value	Cramer's V
Unemployed	28(43.07%)	37(56.92%)	0.024*	0.227
Business	2(11.1%)	16(88.9%)		
Self-employed	61(51.3%)	58(48.7%)		
Service	7(46.66%)	8(53.33%)		

$p<0.05$, *Likelihood ratio,

Association of service-related factors and utilization of SRH services among PWDs

Out of 6 variables, two variables were significant with the utilization of SRH services by PWDs: annual household income with p-value=0.037, having a weaker relationship with Cramer's V of 0.172, and distance between SRH facility and residence with p-value=0.047, having a weaker relationship with Cramer's V of 0.168.

Table 6: Association between Service-related Factor and Utilization of SRH Services among PWDs

Variables	SRH service users, n (%)	SRH service non-users, n (%)	p-value	Cramer's V
Annual Household Income				
Less than 1 lakh	13(29.5%)	31(70.5%)	0.037	0.172
1-10 lakhs	85(50.86%)	88(49.13%)		
Distance between the SRH facility and the residence				
1-8 KM	42(56.8%)	32(43.2%)		
9-16 KM	42(39.3%)	65(60.7%)	0.047	0.168
17-25KM	14(38.9%)	22(61.1%)		

DISCUSSION

This study provides valuable insights into the knowledge, attitudes, and utilization of sexual and reproductive health (SRH) services among people with disabilities (PWDs) in the Kathmandu Valley. The findings reveal significant gaps in SRH service utilization, knowledge, and attitudes among this population, underscoring the need for targeted interventions to improve SRH outcomes for PWDs.

Over half of the respondents (54.8%) did not utilize SRH services. This underutilization can be linked to the lack of disability-inclusive services and the distance to facilities. Similar structural barriers were identified in another study, where women with disabilities cited distant facilities and inaccessible infrastructure as major obstacles to using SRH services (Shiwakoti et al., 2021). A recent study in Kathmandu reported that only 47.6% of women accessed family planning services, supporting the findings of the present study (Singh et al., 2024).

Although disability identity cards are intended to improve health and other social services, many PWDs still face barriers. In Ilam district, even cardholders reported difficulties, including poor physical access, negative provider attitudes, and lack of awareness about available SRH services (Shiwakoti et al., 2021). This suggests that formal recognition alone is insufficient to ensure access.

International evidence echoes these findings. In Uganda, SRH service utilization was not significantly associated with disability types, indicating that systemic and social factors may play a greater role than the nature of disability (Mac-Seing et al., 2022). In Pakistan, women with disabilities were less likely to utilize ANC, delivery, and PNC services from skilled health service workers (Mahmood, Hameed, & Siddiqi, 2022). These studies highlight the need for policies that address physical, institutional, and attitudinal barriers, rather than relying solely on disability certification.

Occupational status was also found to be associated with SRH service utilization. Self-employed respondents were more likely to access services compared to those who were unemployed or engaged in other forms of employment. This may be due to greater financial independence and flexible schedules. A previous study similarly found that employed women with disabilities were significantly more likely to use SRH services (Shiwakoti et al., 2021). Although the study did not isolate self-employment, it enforced the role of economic empowerment in improving healthcare access.

The study also uncovered a concerning lack of SRH knowledge among PWDs. Only 9.7% of respondents have good knowledge, while the majority had poor (41.5%) or moderate (48.8%) understanding. Awareness of specific topics such as family planning, reproductive rights, and prevention was limited, and misconceptions were common. In contrast, a study conducted among women with disabilities found a significant association between SRH knowledge and service utilization (Shiwakoti et al., 2021). This difference may be due to the gender and educational profile of respondents. The heavy reliance on informal sources like TV/Radio and friends further indicates a need for reliable and accessible SRH education tailored to PWDs.

Attitudes toward SRH services were mixed. While many participants expressed positive views, such as acknowledging the importance of condom use and the risks of multiple sex partners, negative attitudes were prevalent. A substantial number believed that discussing contraception with young people encourages promiscuity. Support for early premarital sex among boys and girls also reflected entrenched cultural norms that may drive risky sexual behavior. While this study found generally favourable attitudes, a similar KAP study in Ethiopia reported predominantly unfavourable attitudes, possibly due to differences in SRH knowledge levels (Kassa et al., 2016).

The study identified multiple barriers to SRH service utilization, including the distance to facilities and the lack of disability-inclusive services. Participants also reported

issues related to service availability, providers' respect, and communication challenges. Negative experiences, such as feeling disrespected or misunderstood, can further discourage the service use. Training health care providers to deliver respectful, inclusive care is therefore critical. A systematic review in sub-Saharan Africa similarly found that physical, attitudinal, and informational barriers significantly hinder access for people with disabilities. The review emphasized the lack of providers and the confounding effect of stigma, both of which contribute to inadequate service delivery (Ganle, Baatiema, Quansah, & Danso-Appiah, 2020). Moreover, the stigma surrounding disability further exacerbates these challenges, making it difficult for individuals to seek out and receive the care they need.

This is an organization-based cross-sectional study. Therefore, individuals who are not affiliated with any organization were excluded, and the findings of this study cannot be generalized to the community setting. Additionally, recall bias may have occurred due to the long time interval, especially among individuals whose period of frequent sexual and reproductive health service utilization has already passed due to age.

CONCLUSION

In conclusion, this study sheds light on the critical challenges faced by PWDs in accessing SRH services in Kathmandu Valley. The gaps in knowledge, negative attitudes, and barriers to service utilization identified in this research underscore the urgent need for comprehensive interventions aimed at improving SRH outcomes for this vulnerable population. Addressing these issues through policy reforms, education, and improved service delivery will be essential in ensuring that PWDs can fully realize their sexual and reproductive health rights.

RECOMMENDATIONS

The findings of this study have several implications for policy and practice. First, there is a need for targeted educational campaigns to improve SRH knowledge among PWDs, with a focus on addressing misconceptions and providing accurate information through accessible formats. Second, healthcare facilities must be made more accessible to PWDs, both in terms of physical accessibility and the availability of disability-inclusive services. Third, healthcare providers should receive training to enhance their ability to communicate effectively with PWDs and deliver respectful and responsive care to their needs. Lastly, policies should be developed to address the socio-economic barriers that prevent PWDs from accessing SRH services, including measures to support their financial independence and reduce the distance to healthcare facilities.

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Data availability statement: The data supporting the findings of the study are available from the corresponding author on reasonable request.

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