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Disability, Vulnerability and Sexuality: Sexual and Reproductive Healthcare Experiences of Young Persons with Disabilities in Dhaka City

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Persons with disabilities encounter unequal access to sexual and reproductive health services (SRH). However, improving access to SRH remains a public health challenge, especially for this population in Bangladesh. This study explores the SRH-related care experiences and quality of services provided to PWDs in Dhaka city, along with the narratives of their personal struggles and vulnerabilities in navigating SRH issues in a society where they are often unseen and unheard. The research involved fifty semi-structured in-depth interviews and two focus group discussions to assess the needs and challenges associated with SRH. Participants were selected using a network sampling method. The data were coded and classified using thematic analysis. The participants were generally young, with an average age of 22 (SD = 2.7). More than three-quarters (84.0%) of the respondents were visually impaired since birth, and 16% had been physically impaired for an extended period of time. The results show that persons with disabilities often lack awareness about their SRH needs, and they have limited access to sex education. Most participants were typically hesitant to seek SRH services due to a lack of understanding, stigma, discrimination and the perception that these services are not essential. Persons with disabilities highlighted the necessity for disability-inclusive built environments within healthcare facilities and the support from health assistants with greater inclusion of female healthcare workers.

Keywords: Sexual and Reproductive health; persons with disabilities; Dhaka; young persons with disabilities

Introduction

Ensuring access to sexual and reproductive health (SRH) continues to be a public health challenge, particularly for persons with disabilities. In Bangladesh, they experience several difficulties, such as discrimination in education, employment, and healthcare (Bangladesh Bureau of Statistics [BBS], 2015). Disability prevalence estimates in Bangladesh vary due to various methodologies, and the absence of reliable data pose challenges to the design of effective disability-inclusive development strategies and policies (Amin et al., 2020; Marella, 2015; Uddin et al., 2019). A recent national survey conducted by BBS with technical support from UNICEF, reveals that 2.8 percent of the population and 1.7 percent of children have at least one form of disability, as defined by the BBS (BBS, 2021). The actual number is of course much higher especially when considering Bangladesh's large population of 165 million. Various factors contribute to disability, with the most common causes reported being congenital conditions (41.09 percent), illness (36.35 percent), falls from trees or rooftops (12.27 percent), and road accidents (5.53 percent).

Despite the commitment of Bangladesh to the rights of persons with disabilities and signing international instruments to address SRH, they continue to experience multiple levels of challenges that make them a vulnerable group (Du et al., 2022). The Government of Bangladesh ratified the UNCRPD in November 2007 without any reservation and has since domesticated the Convention into its national laws including the 2013 Rights and Protection of Persons with disabilities (RPPD) Act, (Permanent Mission of Bangladesh, 2008). Most people in Bangladesh, including those with disabilities, are largely unaware of their SRH rights (Hasan, 2020) because of widespread insensitivity and ignorance regarding the SRH needs of persons with disabilities (Greaux et al., 2023; Nguyen et al., 2018). The lack of training for healthcare providers to deliver disability-inclusive services and the absence of accessible infrastructure and disability friendly equipment needed to support specialized care, and the scarcity of disability-integrated data at all levels makes it challenging to propose or implement disability-focused initiatives in the country (Amin et al., 2020).

Persons with disabilities are more vulnerable while accessing SRH information and services than other people for several reasons (Greaux et al., 2023; Ganley et al., 2020). They are seldom considered for SRH emergencies in many healthcare schemes. In many regions, these issues are exacerbated by poverty, limited resources, and healthcare barriers (Du et al., 2022). Earlier studies have highlighted the vulnerability of persons with disabilities where they are denied chances to exercise their rights, such as access to contraception and knowledge about SRH (Amin et al., 2020; Nguyen et al., 2018; Addlakha, et al., 2017; Percez-Curiel et al., 2023). Many people in Bangladesh see disability as a misfortune and mark of disgrace on the family, forcing many persons with disabilities to be institutionalized (Amin et al., 2020). Women with disabilities often face increasing social exclusion and marginalization worldwide. Chiwandire and Vincent (2021) conducted a systematic review of 24 qualitative studies and found that women with physical, sensory, and intellectual disabilities face intersecting socio-cultural stigma and abuse, financial and structural barriers to healthcare access due to poverty, inaccessible facilities and inadequate healthcare services. Previous research has highlighted how stereotypes and folk beliefs in society perpetuate an image of PWDs as ‘non-sexual’, indicating a low libido with a lack of interest in sexual activities (Callen, 2022; Anderson et al., 2000; Devkota, Kett & Groce, 2019). The primary misconception in society is that Persons with disabilities do not need SRH services as they are presumed to be sexually inactive (Shildrick, 2004). However, research delineates that persons with disabilities are just as sexually active as those without disabilities (Carew et al., 2020). Despite this fact, their sexuality has frequently been denied, and their reproductive rights were dismissed. They are stigmatized and excluded from the economies of desire and sexuality (Srinivasan et al., 2024).

There has been some research in Bangladesh highlighting the misconception that individuals with disabilities are non-sexual or not frequently sexually active, leading to the belief that they have fewer SRH needs or are less at risk of sexually transmitted infections (STIs). This myth persists in society, along with ongoing stigma and taboos surrounding both disability and sexuality (Lejzerowicz, 2017). Sexual desires are present among persons with disabilities as with every other person (Carter et al., 2022) and they can establish sexual and intimate relationships (Lam et al., 2025). However, research suggests that individuals with intellectual disabilities often lack access to educational and healthcare resources needed to make informed choices regarding their bodies, understanding intimacy and sexual relationships, and parenting if they wish to (Carter et al., 2022). Considering their high risk of abuse and emotional vulnerability, persons with disabilities may have an even greater need for comprehensive sex education and healthcare (Berger et al., 2022).

Women with disabilities face even greater obstacles than men, being particularly vulnerable to sexual and gender-based violence, which can profoundly affect their lives (Matin et al., 2021; Sharma et al., 2015; Benhura, 2016). They often experience social isolation and have fewer chances to participate in community activities. Additionally, they face a lack of respect, resources, decision-making power, and spaces that consider their needs. A lack of understanding about their health and well-being has led to increased segregation of women with disabilities from the general population. Challenges include a lack of accessible information and negligence of specific healthcare needs (Linton et al*.,* 2016; Mavuso et al., 2015; Dean et al., 2017).

There is an abundance of research that highlights that a higher level of education is related to an increased use of SRH services (Du et al., 2022; UNESCO, 2022). Higher education generally leads to a better understanding of health resources and a greater tendency to prioritize people's health. Education and SRH service utilization are closely related, underscoring the importance of accessibility and including educational opportunities for public health (Chennat, 2020). A recent study in Bangladesh revealed a link between higher education levels and increased use of SRH services (Du et al., 2022). Individuals with disabilities who had lower educational attainment were more likely to hold misconceptions and distrust SRH services. They had experienced mistreatment from SRH healthcare providers, which discouraged them from seeking these services in the future. (Du et al., 2022).

Sexual and reproductive health services for persons with disabilities in Bangladesh are limited, primarily focusing on pregnancy-related care, maternal and neo-natal care, family planning, and a small range of screening and treatment options for STIs. Despite global advancements in understanding of the SRH and general health needs of PWDs, only a few organizations in

Bangladesh are actively working to develop comprehensive SRH services (Hasan, 2020). Consequently, Persons with disabilities are among the least likely to access such care. Moreover, there is a limited understanding of the experiences of PWDs in relation to SRH information and service delivery (Uddin et al., 2019). Sexual and reproductive health has not been identified as a priority area for providing information and support among PWDs in Bangladesh (Du et al., 2022).

Recent studies have signaled that the infrastructural and attitudinal barriers that persons with disabilities face when accessing SRH services. In a comprehensive study from Nepal, Singh et al. (2024) identified multifaceted challenges such as inaccessible facilities, healthcare providers' negative attitudes and the perpetuation of socio-cultural stigmas. Similarly, Zahra et al. (2025) explored biases within healthcare systems in Pakistan and highlighted how cultural norms and institutionalized discrimination enhance the marginalization of women with disabilities in SRH spaces. The physical barriers to accessing SRH services creates stressful situation for persons with disabilities as the built environment is not designed to consider their needs and does not always ensure their universal inclusion (Becker et al., 1997). The physical layout of healthcare facilities is often not adapted to the needs of people with disabilities, further marginalizing and excluding them (Anderson et al., 2000).

Several studies have indicated the transformative potential of Comprehensive Sexuality Education (CSE). Silempa (2025) delineates that targeted CSE in Zimbabwe significantly improved the SRH related awareness and health-care seeking behavior in women with disabilities. This reinforcement on CSE is further emphasized by Devkota et al. (2025), whose scoping review reveals a darker side of society whereby adolescents with intellectual disabilities are left vulnerable and exposed to sexual abuse with limited knowledge of their sexual and reproductive rights.

Intersectionality remains a critical analytical lens across these studies. The qualitative study by Zahra et al. (2025) and the regional review by Morcelle (2025) argue that experiences of SRH exclusion are influenced by intersecting identities; such as gender, disability status, and geographical location- and call for policies rooted in equity rather than equality. Morcelle (2025) also identifies pathways to SRH justice, advocating for universal design, inclusive policy frameworks, and leadership of persons with disabilities in healthcare reform.

Finally, advocacy and systemic reformations are central in recent publications. The editorial letter by Shrivastava, Bobhate, and Nair (2025) provides an urgent call to exacerbate reproductive health access through inclusive training of healthcare professionals. Overall, studies highlight the need for a shift away from a medicalized, deficit-oriented view of disability towards a justice-oriented approach emphasizing a person-centered model of care. The critical areas for reform include comprehensive sexuality education and inclusive training for healthcare professionals, policy integration, youth-centered programming, and ensuring an inclusive environment and infrastructure for persons with disabilities.

This study aims to explore the sexual and reproductive healthcare experiences of persons with disabilities in Dhaka city both in terms of the accessibility of facilities and the quality of services they are provided with. It also aims to investigate how healthcare facilities in Dhaka city produce social spaces for persons with disabilities and reflect dominant cultural ideals while navigating through their personal stories and struggles to access SRH.

Methods

Study design and study setting

A qualitative approach was adopted providing the opportunity to delve deep into the experiences of persons with disabilities and provide a better understanding of their needs, challenges, and the healthcare services and infrastructure accessible to them. The study included fifty in-depth interviews and two focus group discussions (FGDs) to explore the needs and challenges related to their sexual and reproductive health.

The study was conducted in Dhaka Metropolitan City and included persons with disabilities living in the residential halls of educational institutions such as the University of Dhaka, Eden College, Bodrunnessa College, Dhaka College and Government Teachers Training College. Participants were also recruited from public and private housing provided by disability welfare organizations (e.g. Imam Foundation, Baptist Mission Hostel for Visually Impaired Girls). Dhaka Metropolitan City was chosen due to its higher known population of persons with disabilities compared to other cities.

Study population and sampling

A network sampling technique was employed to align with the qualitative study's research objectives. Data was collected from five purposively selected educational institution halls and two housing hostels supported by disability welfare organizations. Initially, student organizers collaborating with disability groups on the University of Dhaka campus were contacted, and they provided a list of all persons with disabilities currently living and studying in Dhaka city. Persons with physical and visual disabilities were selected to participate in the study, including both married and single men and women of reproductive age.

The volunteers were contacted as they had the key information regarding the list of all students with disabilities living in Dhaka city and enrolled in various educational institutions. Subsequently, all the enlisted persons with disabilities were contacted through phone calls, and those who consented to participate in an interview were added to the final list of participants.

In Bangladesh, most hostel living arrangements are made for girls with visual disabilities, and accommodation through institutional arrangements is not available for persons with disabilities with cognitive and physical impairments. The initial recruitment phase involved a network sample of PWDs who were personally known to the research team members and were current students in tertiary institutions. In the second phase, NGOs focused on the welfare of persons with disabilities and providing services for them in Dhaka city, collaborated with the research team to expand the network. One of the welfare organizations denied to give us access to persons with disabilities living under their arrangements. Later we continued recruiting participants who gave us consent and conducted the interviews face to face until thematic saturation was reached.

Demographic characteristics and sample description

Table 1 below summarizes the demographic characteristics of the respondents. 30 women and 20 men participated in the study. The participants were generally young, with an average age of 22 years. Most (around 28 participants) fell within the 20-25 age range, 14 participants in the 15-20 age group, and about 8 participants were in the 25-30 age range. 39 participants had attained or were pursuing a university degree; 7 participants indicated they had obtained a college degree, and 4 participants had a school certificate. The distribution of respondents' religion varied within the sample, 44 participants were Muslims, while 6 participants reported to be Hindu. 42 participants were visually impaired since birth, and 8 had been physically disabled for a long period of time. Overall, 28 participants reported they were single at the time of data collection, 12 stated they were in a relationship, and 10 reported they were married. The majority of the married participants (8) said that they had no child, whereas only 2 participants reported to have one child.

Table 1: Demographic characteristics of the respondents (n=50)

Characteristics	**Value**
Age (in year)	
15-20	14
20-25	28
25-30	8
Mean = 22.08, SD = 2.704, Range = 5	
Sex	
Male	20
Female	30

Education	
College level	7
School level	4
University level	39
Religion	
Islam	44
Hinduism	6
Nature of disability	
Visual impairment	42
Physically challenged	8
Relationship status (n=50)	
Single	28
Married	10
Currently in a relationship	12
Number of children (n = 10)	
0	8
1	2

Data collection

Fifty face-to-face semi-structured interviews were conducted. An invitation letter explaining the purpose of the study and what would be expected of participants was emailed to the head of the disability foundation. It included contact information for the research team and a consent form, which was reviewed and discussed with the participants at the beginning of the interview sessions. A pre-test was conducted to understand the sensitivity of the topic and preparedness of the participants in participating in the study. The participants who participated in the pre-test were later excluded from the main list of the interviewees. All heads of educational institutions endorsed the research team's proposal to carry out the interviews, while one welfare foundation refused to cooperate. A final list of potential participants who consented were shortlisted. A meeting was arranged at their preferred time and location. Data was collected by the researcher at the respondents' residential premises, in the guest rooms and the waiting corridors of the residential halls. Each interview lasted around two and half hours.

To explore the factors contributing to challenges in accessing SRH services as well as experiences of stigma and discrimination, focus group discussions were held with PWDs in private meeting rooms at hostel locations, chosen for their accessibility and familiarity of the place. The focus groups were organized based on the type of disability and gender, with each session consisting of six to eight participants and lasting around two hours. All the in-depth interviews and the focus group sessions were audio-recorded and professionally transcribed.

A semi-structured questionnaire was used for in-depth interviews. The questionnaire was composed of three sections: The first section included socio-demographic data such as age, residence, education, employment, marital status, consanguinity. The second section provided information on contraceptive use as well as knowledge and sources of information on SRH, including sexual and gender-based violence against women with disabilities. The third section contained details on stigma and prejudice, as well as the needs, challenges, and barriers to accessing SRH services. During the interviews, participants were queried about the barriers they encountered in accessing SRH services at hospitals, their experiences with stigma and discrimination, and their opinions about the critical issues with Bangladesh's public healthcare infrastructure and services related to sexual and reproductive health. A guide was used for focus groups, including general questions and follow-up prompts to explore participants' experiences with SRH services, including their sexuality, vulnerabilities and experiences of stigma and discrimination.

Data analysis

All interviews were recorded digitally with participants' consent and then professionally transcribed to ensure no important information was omitted. The transcribed data were translated into English, carefully reviewed for accuracy, and analyzed using thematic analysis, whereby a coding system was employed to identify themes inductively. These themes were carefully reviewed, validated, and cross-checked to ensure the study's credibility. Independent open coding was performed for the focus groups, after which similar quotes were grouped together. Preliminary codes were then applied and organized into categories and themes. Information was triangulated from multiple sources to enhance the reliability of the collected data.

Ethical approval

Ethical clearance was obtained from the Research Ethics Committee of the Faculty of Social Sciences in January 2023. Permission from the relevant institutes (disability welfare organizations) was acquired prior to carrying out the study. To ensure their confidentiality and maintain ethical standards of persons with disabilities, informed consent was ensured prior initiating the study. All details regarding the study were included in the consent form and explained to participants during the initial ice-breaking sessions. A confidentiality clause was included guaranteeing their anonymity and confidentiality. The study was carried out following the ethical standards of the WHO and Earl Babbie's (2020) research guide. The confidentiality statement in the consent form was read aloud to the participants, and verbal consent was obtained from participants with special care taken, keeping in mind that the participants were persons with disabilities. This was to protect their dignity, privacy and autonomy throughout the research process so that they could unhesitatingly share their stories without sensing any harm. They were told that if they felt uncomfortable or did not want to continue the discussion, they could withdraw themselves from the interview at ant time. They were also informed that any identifiable details such as their institution, names of hospitals, will be generalized and the records will be kept by specifying a code to them. All other names and traces will be removed from the transcribed data, and they would remain unrecognizable. After five years, all of the data will be destroyed including the coded numbers attached to their forms, field notes, all the transcribed information and audio recordings. All these were written in the consent form and verbally read to them, ensuring it was understandable to them. To ensure anonymity, each participant's form was identified by a unique number so none of the collected information could be traced back to anyone. Additionally, pseudonyms were used to denote to ensure their identities would remain unrecognizable in the future.

After consent was provided and the comfort of the participants ensured, we started the interview process. Some of the participants were safely escorted to their residential halls after the interviews ended by the research team.

Results

Several broad themes emerged, reflecting participants' experiences related to the needs, challenges and barriers in accessing SRH services. The first theme delves into the deeply personal experiences of PWDs within the societal structure of Bangladesh, where they encounter inequity and prejudice due to the persistence of misconceptions about disability and sexuality. The second theme highlights the absence of a support system and resources, which exacerbates the knowledge gap. The third theme captures their internal struggles, recounting feelings of helplessness and experiences of gender-based violence. The fourth theme addresses the regional contexts and societal norms, illustrating the discriminatory attitudes of healthcare professionals towards them. The other themes reveal narratives of discomfort encountered while seeking SRH treatments, the ongoing struggles against sexual abuse and the challenges they face due to gender-based violence. The findings emphasize the necessity for policy changes, greater inclusivity, compassionate care from female health professionals, and psychosocial and financial support systems for victims of gender-based violence, intimate partner violence, and sexual assault from caregivers. The sections below provide a detailed exploration of these themes.

Prevailing myths and realities about disability and sexuality

In Bangladesh, particularly in rural areas, numerous myths and beliefs about persons with disabilities persist, leading to widespread misconceptions and stigma. These myths can lead to the isolation, exclusion, and ridicule of persons with disabilities, particularly women. For example, a commonly held belief in rural communities is that if either of the parent has a form of disability, it is due to the negative karma [actions] of their ancestry, or that their parents may have committed sins, resulting in ongoing suffering for subsequent generations. Women with disabilities face greater stigma than men, often being criticized for their physical disabilities. Additionally, PWDs are frequently judged stereotypically. One of the women participants expressed how:

> Typically, non-disabled people are not very concerned about their own sexual and reproductive health, so why would they consider ours? They assume that we do not have feelings, do not need to reproduce, cannot create families, and are incapable of taking on responsibilities. (Rakhi, 21-year-old woman with visual impairment)

A participant with a visual impairment shared his experiences of being ridiculed by his peers on campus for being in a relationship with a girl. He recounted his experiences in this way:

> They used to call me 'kana' [a one-eyed person]; how do you sense your girl when you are unable to see her? (Mohiuddin, 21-years old)

In rural communities, various superstitious treatments for increasing sexual vigor of men and treating STIs with herbs is common. For example, in Gazipur, some *Kabiraj* (traditional healers) use herbal remedies to treat physical weakness in young men. However, their lack of knowledge about sexual and reproductive health often leads them to prescribe inappropriate medication, which can further impair their sexual urges and performance. Commenting on the impact of these myths on sexual and reproductive health in Gazipur, one participant remarked:

> In Gazipur, where I live, 'Sripurer Bodhi' [tablet of Sripur] or 'Shahi Halwa' [herbal energy booster sweet dessert] a herbal remedy, is prescribed by rural doctors to address physical weakness in men with lower sexual vigor. These remedies, often provided as sweetened desserts, are mixed with substances like Viagra, which provide an initial energy boost but gradually weaken the body over time. These medicines have significant side effects, yet rural people continue to use them without any awareness of the harmful consequences or any scientific validation. (Shahid, a 26-year-old man with physical impairment)

This shows that young men with physical disabilities are at risk of reproductive health issues and other related social challenges due to inadequate comprehensive sex education.

Additionally, the distribution of fake medications by village doctors affects their sexual and reproductive health. Therefore, it is crucial to provide comprehensive sex education and ensure the dissemination of proper SRH knowledge to young men to raise awareness about SRH.

Lack of awareness and resources

Focus group discussions with the participants suggest that visual disabilities leave young women more vulnerable and naive to exploitation and discrimination. Many are forced to live in welfare institutions, where they become overly trusting and easily preyed upon due to their limited awareness of harsh realities. According to one participant:

> Young boys and girls who were separated from their families are often naive and emotionally vulnerable. As a result, they struggle to discern between appropriate and inappropriate touch, seduction and manipulation, good and bad intentions, or love and lust. The innocence and lack of exposure make them an ‘easy prey’ for sexual exploitation. Persons with disabilities are especially vulnerable to manipulation into physical relationships, often leading to violent abuse, rape, or coerced sex, with those who are visually impaired being at even greater risk. (Disha, a 20-year-old woman with visual impairment)

There are no Braille books or audio resources available for executing SRH-related initiatives tailored for Persons with disabilities; there is also a lack of SRH-related materials to help raise awareness about SRH complications or provide information on sexual orientation and gender identity, resulting in lacking essential knowledge. However, merely increasing awareness of SRH and Comprehensive Sexuality Education (CSE) is insufficient. There is a pressing need to train girls with disabilities and provide facilities for delivering SRH and CSE in welfare organizations. Participants emphasized the importance of hosting SRH workshops, seminars, and training in hostels or living settings, where girls with visual impairments can gain practical knowledge on how to manage SRH issues. As one of the participants stated,

> Not many people think about us, and there aren't many organizations in our country that use Braille or audio materials and tapes to provide us with essential resources. These things are needed now more than ever. Since we live in institutions, most of us lack access to this kind of "outside world" knowledge. We primarily engage in close-knit interactions, living in a compact, tight-knit community, maintaining strong connections with one another. If training, workshops, and seminars were organized in the hostels or even in students’ residential halls, we would gain more hands-on knowledge about sexual and reproductive health. (Ainan, a 19-year-old woman with physical impairment)

Stigma, gender roles and SRH-related experiences of persons with disabilities

The stigma of disability is one of the most widespread obstacles hindering persons with disabilities from attaining equal rights and opportunities. Societal stigmatization and prejudices reinforce gender constructs, strengthen patriarchal values, and widen the gender gap and inequality. This stigmatization makes women feel more vulnerable, portraying them as weak and dependent. The patriarchal mindset places women with disabilities in an even more vulnerable position. As one participant commented:

> Woman who are physically challenged or visually impaired are often referred to as "nobody", and their fundamental rights are frequently overlooked. Men often perceive them as ‘useless’ and question their reproductive health. As a result, they may seek to spend time with them but do not consider long-term partnerships. (Anita, a 23-year-old woman with visual impairment))

There are prevalent prejudices and false beliefs regarding the reproductive abilities and sexual needs of persons with disabilities. Many people inaccurately believe that they are incapable of conceiving or parenting and frequently disregard their inherent sexual desires and longings. These misconceptions foster stigma and infringe upon the rights of persons with disabilities to experience intimacy, family life, and control over their own bodies. As one participant emphasized:

> We struggle to function effectively in cohabiting relationships, and as a result, we are unable to have children. Society views us as incapable of raising a child. (Mitu, a 25-year-old woman with visual impairment)

Young men with disabilities often fear entering into a long-term relationship like marriage and parenthood due to prejudices they encountered earlier in life. This negative attitude on family decisions is particularly prevalent among those who have recently experienced break-ups. A participant reflected on this issue:

> Of course, I am hesitant to get married and have children because I believe my disability might prevent me from finding a potential partner. (Anowar, a 26-year-old man with physical impairment)

Participants reported concerns regarding common misbeliefs in our society that a woman’s disability, regardless of the type of disability, can be passed on to her child and has genetic implications. The pregnancy and childbirth experiences of women with disabilities are frequently perceived as an extra strain on the family and community by society at large. The marginalization and targeting of women with disabilities is more pronounced in society. A man with a disability expressed his views on these stark social realities:

> Nobody would blame me if I father a child who eventually becomes visually impaired. Conversely, if a woman gives birth to a physically challenged child, she often faces societal isolation, exclusion, and taunts. People tend to blame her, saying, "You are disabled—that's why you gave birth to a disabled child. (Rinku, a 24-year-old man with physical impairment)

One of the factors influencing the life of persons with disabilities and discouraging them from seeking assistance for SRH issues is their fear of social stigma. Additionally, they could hear derogatory remarks regarding their sexual performance, which might make them less confident. As one participant recounted:

> Men with disabilities face many challenges due to poor health. We often do not share our sexual concerns with others, and if we do—even with close friends—they mock us and question about our ability to engage in sexual activity. Moreover, we often lack access to information within our families, as male family members, such as fathers or older brothers, do not always discuss these topics or share their experiences with us. (Rakib, a 25-year-old man with physical impairment)

This narrative indicates that men with disabilities face significant challenges related to poor health and limited access to sexual health information. They often remain silent about their concerns and within families and peer circles they feel isolated sparing them of essential knowledge and support.

Regional realities and healthcare providers' attitudes towards persons with disabilities

Regional circumstances considerably influence various dimensions of individual's life experiences, including education, knowledge, and health opportunities. Individuals with disabilities residing in urban regions receive more comprehensive sex education and sexual and reproductive health services than those living in rural settings. Our research highlighted through focus group discussions that individuals residing in disadvantaged areas often lack awareness of SRH. As a result, they frequently do not have access to these healthcare services. One participant stated how:

> It is easy for educated individuals to gather information about sexual and reproductive health, but those living in peripheral areas often have limited education and exposure, therefore, they remain unaware about their reproductive health. SRH topics are covered in secondary school curricula, but people in marginalized or underprivileged areas often do not have the opportunity to continue their education, leaving them uninformed. (Karim, a 21-year-old man with visual impairment)

In various government-run medical facilities, marginalized and vulnerable persons with disabilities are often overlooked, resulting in potential delays in accessing health care services, including emergency care. Despite relying on government hospitals for cost-free medical services, persons with disabilities, as well as socioeconomically disadvantaged individuals, frequently encounter disrespectful behavior- such as inappropriate negative comments and disrespectful attitudes by healthcare personnel, particularly nurses and support staff. Additionally, some public sector physicians prioritize their private practices, making them unavailable to respond promptly to medical emergencies within government-operated facilities. Consequently, it is individuals with disabilities or those from marginalized and underprivileged backgrounds who disproportionately suffer from these circumstances. Insights gleaned from participants have yielded significant findings that can provide valuable inputs to improve awareness. Findings from FGDs indicate that healthcare professionals harbor biases toward individuals with disabilities. This was clear in the narrative of Kirti, a 24-year-old woman with a physical disability:

> This is a common practice in our government hospitals, where healthcare providers often show bias towards patients without referrals or connections. In these settings, lobbying is frequently used to secure a spot, causing healthcare professionals to prioritize lobbied patients while neglecting others, particularly those who are marginalized and vulnerable.

Some healthcare professionals display extraordinary rudeness toward individuals with disabilities, as evidenced by a participant's account of mistreatment by a physician. This young woman, diagnosed with Polycystic Ovarian Syndrome (PCOS) and Endrometrioma in her ovaries, recounted an instance of inappropriate conduct by the attending physician during a medical consultation, which further compounded her distress:

> The doctor treated me very inhumanely because of my illness. It is a reproductive health concern, but he mistreated me, remarking, “Are you married? Why are you experiencing such complications at such an early stage as a visually impaired young woman? (Bithi,a 18-year-old woman with visual impairment)

Another participant shared her experience highlighting the difference in treatment between public and private hospitals even by the same doctors:

> I went to a doctor at a public hospital, and he did not treat me well or take the time to listen to me. However, when I met the same doctor in a private setting, his behavior changed; he was much more attentive and considerate. (Tarin, a 22-year-old woman with visual impairment)

These experiences of young women with disabilities underscore their vulnerability for the absence of patient-centered attentiveness by the healthcare providers, as well as the influence of geographic disparities and structural injustices on their situations.

Women in healthcare: ensuring their availability

The importance of ensuring the availability of female healthcare providers for women with disabilities was mentioned by participants. Nearly all participants (men and woman) suggested that women healthcare providers should be available to address the SRH concerns of persons with disabilities. As one participant stated:

> In Bangladesh, there should be more women healthcare providers to offer sexual and reproductive health services to young women with disabilities, and there should be a separate department dedicated to sexual and reproductive health in all hospitals. (Bashir, a 21-year-old man with physical impairment)

Many persons with disabilities have expressed the need for a female health assistant or volunteer in healthcare centers to help them manage their appointments. One female participant highlighted the importance of having a compassionate female health assistant or volunteer aid during physical tests and doctor visits, noting that proper assistance can make navigating the hospital more manageable. She stressed the need for compassionate treatment:

> We need a compassionate female health assistant or volunteer appointed to help us during physical tests and assist in doctors' and test rooms, as it is very confusing to ask for help and navigate the area without guidance. (Tatan, a 21-year-old woman with visual impairment)

The lack of support can lead to frustration and discourage individuals from seeking healthcare, potentially causing them to neglect their health.

Sensitivity and discomfort

Inappropriate touching of the body of a person with disability by medical professionals is a serious violation of trust and respect. Such actions can lead to significant emotional distress and feelings of vulnerability among patients who may already face challenges in expressing their discomfort. Healthcare providers must maintain a high standard of professionalism, ensuring that all interactions are conducted with sensitivity and consent. Training and awareness about the unique needs of persons with disabilities can help prevent such incidents, fostering an environment where patients feel safe and respected during their medical care. A woman with a visual impairment brought attention to a concerning issue prevalent in many hospitals in Bangladesh, where persons with disabilities are sometimes used as cases for educational purposes by interns and junior doctors. She recounted an incident in which she was admitted to a hospital for abdominal pain and was subsequently examined by a group of male intern doctors under the directive of a senior doctor for practical experience. She found this practice troubling:

> I felt like a "guinea pig" during physical exams. Allowing interns and junior doctors to conduct individual assessments was humiliating and violated my privacy. I had to endure the discomfort of multiple individuals touching my lower abdomen. This experience was degrading and a breach of my personal space. (Tarin, an 18-year-old woman with visual impairment)

The presence of such an environment may cause persons with disabilities to feel anxious, and they may be more sensitive to medical examinations and screenings. Moreover, before any screening tests, their consent should be obtained and check if they are comfortable with the medical processes, which will eventually help to diminish their doubts. Empathy should be practiced in such sensitive cases.

Experiences of sexual violence and problematic services for persons with disabilities

Several participants experienced institutional abuse as well as sexual abuse from close relatives prompting them to request psychological evaluations related to sexual behaviors. One woman was sexually abused at home by her own maternal grandparent, while others faced abuse from staff and caretakers in the hostels:

> I experienced deep depression for approximately three to four years. A close relative who was supposed to take care of me, sexually abused and harassed me, touching me inappropriately. He took advantage of my disability; since I was unable to move my hands and legs, I could not resist his advances. During that time, I felt utterly helpless. To this day, I have not shared this with my parents, as I fear that disclosing this incident will strain their relationship. That perpetrator was, in fact, my ‘nana’ [maternal grandfather]. (Paromita- 20-years-old woman with physical impairment)

During a focus group discussion, a participant recounted instances of young girls with visual impairments being exploited within their institutions. At times, they are not secure in facilities operated by welfare organizations:

> I have come across instances of visually impaired girls who were raped by the caregivers in the hostel, including a case involving a male hostel supervisor, and I am aware of a situation where a visually impaired girl was taken to an influential and powerful man in Madaripur to fulfill his bizarre fetish. (Abu Bakar- a 20-year- old man with visual impairment)

Another participant in the focus group recounted more stories:

> I am aware of a few young women from a specific institution where they faced sexual abuse from male teachers during their young age, yet they felt compelled to remain silent for an extended period. They only shared their experiences after graduating from the school. The fear of having to leave the school kept them away from reporting the abuse, as it provided them with housing, support, education, and all other essential needs. Such experiences are profoundly traumatic for them, as when girls encounter such situations at a young age, they often lose interest in studies and struggle to reach their full potential. (Arif-a 24-year-old man with visual impairment)

These narratives highlight the helplessness of women with disabilities in their surroundings, where they should have felt secure and protected from sexual exploitation; faced violations. They were victimized by those who were meant to care for them, accentuating their vulnerability. Nearly all the participants in the study recommended establishing policies to guarantee both physical and mental safety of PWDs.

Sexual assault support services are not available in Bangladesh for persons with disabilities, especially those who have experienced it or may experience it in the future. Currently, there are no services available to reduce the harmful effects of sexual abuse on PWDs. More painful details emerged on gender-based violence against women with disabilities, who did not receive any counselling or related social services. Women with disabilities described their experiences and expressed a need for crisis intervention, counseling, information, and resources:

> There should be counseling sessions for healthcare professionals and others involved, as this issue is psychological. I believe that psychological assessments for sexual behavior should be a requirement across all job sectors in our country. Victims of sexual assault must undergo counseling to deal with their traumatic experiences. (Joyita, a 20-years-old woman with physical impairment)

A married woman with visual impairment shared her tragic story of intimate partner violence (IPV); marital rape and physical abuse by her non-disabled partner. She explained how she was unable to escape that abusive relationship as she wasn't mentally prepared and financially independent. Moreover, she was encouraged to stay silent by her in-laws who would manipulate her:

> They would tell me: "Whichever body-part of yours is beaten by your husband will shine in Akhirah (after-life). It's a virtue to stay obedient and remain silent to the abuses of your husband".

Discussion

The research indicated that participants sought access to SRH services in government and private hospitals. However, they expressed experiences of uninviting attitudes and discrimination from healthcare staff and service providers. These findings are aligned with Goffman's (1963) theory on stigma, demonstrating how social labeling and ingrained stereotypes lead to the marginalization of persons with disabilities, especially regarding SRH needs. Participants shared feelings of shame, invisibility, or being judged when trying to communicate their SRH needs, often internalizing societal views that depict them as non-sexual or unable to engage in intimate relationships. These individuals frequently internalize this stigma, resulting in feelings of contempt, diminished self-worth, and hesitation to voice their SRH issues. This stigma further discourages them from pursuing SRH services, as they fear judgment, discrimination, or a lack of compassion from healthcare professionals. Studies (see Callen, 2022; Anderson et al., 2000; Devkota, Kett & Groce, 2019) have highlighted how stereotypes and socially stigmatizing beliefs impact persons with disabilities in seeking sexual and reproductive healthcare. Recent studies further reflect an intensification of real cases where they are indeed in dire need of SRH (Sing et al., 2024). The findings of this study, too, suggest and emphasize that their sexuality should not be an issue of abjection (Kristeva,1982), and through this lens, we found that they are rendered abject in society as their bodies and desires do not confirm to normative beliefs about their sexualities. SRH of persons with disabilities should be regarded as a concerning social issue and society should reinforce positive affirmations, thoughtful the active inclusion of such persons in matters of SRH.

Consequently, many remain underserved and excluded from essential health education and care, perpetuating cycles of marginalization and adverse health outcomes. Just as we have seen in the focus group discussion, where participants documented mistreatment by healthcare providers, persons with disabilities were almost ignorant about comprehensive sexuality education and were in the dark about their sexual and reproductive health concerns. Moreover, they were silenced and discouraged from seeking medical advice from their peers. Women with visual impairments, in particular, faced tremendous challenges in navigating their sexual and reproductive health problems when they actually opted for medical services and visited medical centers. There, they faced attitudinal barriers and misbehavior from the healthcare practitioners, nurses and stuffs, also one of them felt humiliated during physical examinations. Some of them faced class barriers and regional prejudices where private practices and lobbying played the upper hand in treatment. Studies also show relevance here. A similar study was conducted in 2025 by Zahra, et al., in Pakistan where they explored how cultural norms and institutionalized discrimination enhance the marginalization of women with disabilities in SRH spaces.

Most participants in this study indicated that the policy of government and private facilities and infrastructure was inadequate for meeting the needs of persons with disabilities. This absence of inclusivity in social infrastructure leads to the marginalization of PWDs from vital social support and healthcare resources, thereby maintaining situations of deprivation. This lack of inclusive infrastructure in the capital city not only restricts movement but also perpetuates exclusion, dissuading them from pursuing necessary services, including those associated with SRH.

The study emphasizes a considerable deficiency in the resources necessary to guarantee fair access for persons with disabilities. Respondents noted the lack of preferential access in service facilities, insufficient financial assistance, and a scarcity of accessible tools like Braille and audio materials and availability of sign languages. Studies (see Linton et al., 2016; Mavuso et al., 2015; Dean et al., 2017) found how persons with disabilities face multiple challenges including lack of resources, respect, decision making power, and spaces that consider their voices. They also lack accessible information and constantly face negligence by healthcare providers. In addition, our study also highlights the absence of volunteer aid and lack of accommodating attitudes by service providers, further obstructing the capacity of persons with disabilities to access crucial services, and utilize them especially in the area of SRH.

The cases of institutional abuses and sexual abuse in the household, reports of intimate partner violence and gender-based violence found in the study suggest a need to integrate a strict policy, enact and enable laws to enforce their security. To secure their mental health and provide SRH related knowledge and information, psychological counselling and therapy are encouraged by the participants. Young girls with disabilities are typically placed in hostels alongside other individuals with impairments, which results in a reduced ability to recognize the abuse they may face during their formative years, consequently diminishing their decision-making capacity that could help empower them. This vulnerability often leads them to become victims of coercive relationships with authority figures and opportunistic individuals who exploit their disabilities. Strict government measures should be taken as well as regular monitoring in the welfare institutes to prevent such horrific instances where humanity is violently violated.

Moreover, we found that scarce information on SRH for persons with disabilities and ignorance of healthcare professionals increased fears, leaving many women unable to make informed decisions. Unpleasant experiences in the past, made it difficult for individuals to discuss SRH concerns with doctors. Additionally, lack of information makes it hard to learn about reproductive health issues. Many young men and women knew what they needed to know but did not know where to get it. Knowledge gaps hampered their decision-making capacity. Communication about reproductive health was most typically encountered during clinical interactions. Its ease or difficulty could be influenced by factors such as the opinion of a person with a disability about a healthcare provider's reluctance to initiate a talk or the reluctance of a person with a disability to introduce a topic. In this context, all stakeholders must be engaged in disability management to enhance medical rehabilitation, improve service delivery, and advocate for the rights of persons with disabilities (Uddin et al., 2019). To effectively integrate individuals with disabilities into society, it is crucial to establish an inclusive, disability-friendly education system, promote disability-positive messages in mainstream and social media, and advocate for the specific SRH needs of this population. Additionally, it is essential to dispel misinformation, counter prejudice, and break the silence surrounding disabilities through the widespread dissemination of non-judgmental knowledge. Instilling societal respect for individuals with disabilities by preventing stigmatization and fostering a supportive environment is imperative.

Addressing misconceptions, such as the erroneous belief that individuals with disabilities lack sexual needs, is crucial for raising awareness and cultivating a positive perspective on disabilities. Currently, urban spaces are not inherently accessible, but are often purposefully designed to segregate individuals with disabilities, thereby perpetuating their social isolation. It is essential to create inclusive physical environments that offer supportive messages to individuals with disabilities. Many of them lack awareness about their SRH needs. Access to comprehensive sex education is limited. They often avoid seeking SRH services due to insufficient knowledge and a belief that such services are not beneficial. The reasons for the limited knowledge and awareness surrounding SRH are varied. Notably, several contributing factors include the absence of comprehensive sex education tailored to the living situations of persons with disabilities, a lack of training focused on SRH awareness for them, insufficient policies or advocacy efforts regarding the SRH of persons with disabilities, the unavailability of accessible informative resources for them, strict institutionalization, and sometimes institutional abuse and structural injustices faced by persons with disabilities, as found in this study.

Findings in this study suggest that stereotypical views and societal biases about disability and mean persons with disabilities as non-sexual or uninterested in sexual matters, lead to many remaining unaware of and with no access to essential information. They frequently hesitate to pursue medical help and professional guidance because of the stigma surrounding their sexuality and the taboos linked to its expression. Moreover, the inappropriate conduct and negative attitudes exhibited by certain healthcare providers, contribute to silencing the voices of persons with disabilities and perpetuating perilous stereotypes. Access to educational and healthcare resources is crucial for addressing bodily changes or hormonal and psychological issues related to SRH, unintended pregnancies, and STI infections if raped or sexually abused. Lacking access to these opportunities and resources can significantly influence their sexual and reproductive health as well as their overall wellbeing.

The absence of effective monitoring and planning in public-private initiatives aimed at enhancing SRH awareness for persons with disabilities hinders disability organizations and other groups from effectively campaigning for SRH awareness, community mobilization, knowledge sharing, and behavior changing communication related to SRH. As a result, persons with disabilities residing in group settings or with family members remain uninformed about their SRH needs. Moreover, the differences across regions highlight the importance of recognizing and responding to the unique local circumstances that individuals experience to improve their well-being and health results.

This study suggests that educational institutions should implement a campaign to raise awareness about SRH services and comprehensive sex education for persons with disabilities. It advocates for focused interventions, the establishment of relevant policies, and initiatives aimed at raising awareness to support the rights of persons with disabilities. To effectively address their SRH requirements, individuals with disabilities need partnerships between the public and private sectors, alongside a supportive social environment for the provision of these services. Persons with disabilities highlighted the need for healthcare facilities to be accessible and the infrastructure to be more inclusive. Additionally, they were largely unaware of the existing policies regarding sexual and reproductive health rights. As a result, they urged for the formulation of laws or policies to safeguard the sexual and reproductive health rights of persons with disabilities.

This study indicates a need for gender-specific healthcare providers, a specialized healthcare department, improvements in infrastructure, removal of structural and attitudinal barriers, and dedicated support personnel for individuals with disabilities. The study participants highlighted the importance of receiving support from peers, family members, and educators when pursuing SRH assistance. We have looked at Goffman's theory of stigma to analyze how societal stigma and prejudice prevent persons with disabilities from fulfilling their SRH needs and seeking SRH services. Findings highlight how their SRH needs are abjected in the society largely, hence, fulfilling the notion of abjection from the perspective of Kristev (1982). Future research should focus on the marginality of persons with disabilities especially women with disabilities based in lower and middle income countries in the global south. It should also explore indigenous and subaltern perspectives, voices too often suppressed under the normative perspectives of the privileged. The intersection of sexuality, disability and health with multifaceted social issues such as cultural variations, class barriers, structural and infrastructural injustices, collective consciousness shaped by regional realities, gender, race and ethnicity, diaspora and migration, can open up novel approaches to addressing the social problems by connecting people and minimizing barriers and bringing forth an emergent inclusive policy.

Conclusions

To accommodate the diverse needs of this group, comprehensive sex education, healthcare access, and social collaboration are recommended. Families, friends, and peers should be empathetic and supportive to prevent persons with disabilities from feeling isolated and vulnerable when they seek sexual and reproductive health information and services. An empathetic understanding and supportive environments leads to a healthier and more empowered lifestyle for individuals with disabilities, helping them to comprehend their bodies, make informed choices, and find appropriate supportive resources.

Finally, it is essential to address the SRH needs of Persons with disabilities to ensure their overall well-being. Access to information, services, and resources related to sexual and reproductive health can be limited for them due to physical, social, and attitudinal barriers. Providing inclusive, accessible, and non-discriminatory healthcare is crucial for empowering individuals to make informed decisions regarding their bodies and relationships.

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Conflicts of interest

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References

Addlakha, R., Price, J. & Heidari, S. (2017). Disability and sexuality: claiming sexual and reproductive rights (editorial). *Reproductive Health Matters*, 25(50), 4-9.

Amin, A., Das, A. S., Kaiser, A., Azmi, R., Rashid, S.F. & Hasan, M.T. (2020). Documenting the challenges of conducting research on sexual and reproductive health and rights (SRHR) of persons with disabilities in a low-and-middle income country setting: lessons from Bangladesh. *BMJ Global Health*, 5(12). Available at: https://doi:org10.1136/bmjgh-2020-002904.

Anderson P & Kitchin R. (2000). Disability, space and sexuality: access to family planning services. *Soc Sci Med*, 51(8), 1163-73.

Bangladesh Bureau of Statistics (BBS) (2021). Report on national survey on persons with disabilities (NSPD) 2021. Dhaka: Ministry of Planning, Statistics and Informatics Division, Bangladesh Bureau of Statistics.

Bangladesh Bureau of Statistics (BBS) (2015). Disability in Bangladesh: Prevalence and Pattern. Population Monograph: Vol. 5. Dhaka. Ministry of Planning, Statistics and Informatics Division. Available at: http://203.112.218.65:8008/WebTestApplication/userfiles/Image/PopMonographs/disabilityFinal.pdf.

Becker, H., Stuifbergen, A. & Tinkle, M. (1997). Reproductive Health Care Experiences of

Women with Physical Disabilities: A Qualitative Study. *Arch Phys Med Rehabil,* 78(12), S26-33.

Babbie, E. R. (2020). *The practice of social research* (15th ed.). Cengage Learning.

Benhura, A. (2016). Displaced and Dispossessed: Sexual and Reproductive Health Rights for Women in Hopley, Zimbabwe. *Oriental Anthropologist*, 16(2), 215-227.

Berger, G., Aresu, A. & Newnham, J. (2022), *Sexual and Reproductive Health and Rights for All: Disability Inclusion from Theory to Practice.* Women's Integrated Sexual Health 2 Action Project (WISH2ACTION). France: Humanity & Inclusion.

Callen, K. (2022). Disabled sexualities: A theoretical review of sociological approaches and a call to problematize the normative/non-normative dialectic. *Sexualities*, 25(5-6), 502-522.

Carew, M. T., Braathen, S. H., Hunt, X., Swartz, L. & Rohleder, P. (2020). Predictors of negative beliefs toward the sexual rights and perceived sexual healthcare needs of people with physical disabilities in South Africa. *Disability and Rehabilitation*, 42(25), 3664–3672.

Carter, A. I., Strnadová, C., Watfern; Pbdani, R., Bateson, D. Loblinzk, J. Guy, R. & Newman, C. (2022). The Sexual and Reproductive Health and Rights of Young People with Intellectual Disability: A Scoping Review. *Sexuality Research & Social Policy: A Journal of the NSRC* 19(1), 372–390.

Chennat, S. (2020). Disability studies: The context. In S. Chennat (ed). *Disability Inclusion and Inclusive Education* (pp.1-19). Singapore: Springer.

Chiwandire, D., & Vincent, L. (2021). Barriers to accessing healthcare services for women with disabilities in low- and middle-income countries: A systematic review. *BMC Women's Health, 21*(1), 44. Available at: https://doi.org/10.1186/s12905-021-01189-5

Du, K. C., Mohosin, A. B., Amin, A. & Hasan, T. (2022). Influence of education on sexual and reproductive health service utilization for persons with disabilities in nationwide Bangladesh: an explanatory sequential mixed-methods study, *Reprod Health*, 19 (46). Available at: https://doi:org/10.1186/s12978-022-01352-7.

Dean, L., Tolhurst, R., Khanna, R. & Jehan, K. (2017). You're disabled, why did you have sex in the first place? An intersectional analysis of experiences of disabled women with regard to their sexual and reproductive health and rights in Gujarat State, India. *Global Health Action*, 10. Available at: https://doi:org/10.1080/16549716.2017.1290316.

Devkota, H. R., Kett, M. & Groce, N. (2019). Societal attitude and behaviours towards women with disabilities in rural Nepal: pregnancy, childbirth and motherhood. *BMC Pregnancy Childbirth*, 19(20). Available at: https://doi:org/10.1186/s12884-019-2171-4

Devkota, A., Robards, F., & Zablotska-Manos, I. (2025). Relationships and consent education for adolescents with intellectual disability: A scoping review. *Youth*, 5(1), Article 22. Available at: https://doi.org/10.3390/youth5010022

Ganle, J. K., Baatiema, L. Quansah, R. & Danso-Appiah, A. (2020). Barriers facing persons with disability in accessing sexual and reproductive health services in sub-Saharan Africa: A systematic review. *PLoS ONE,* 15(10), 1-12.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon & Schuster, Inc.

Greaux M., Moro M. F., Kamenov K. Russell A. M. & Cieza A. (2023). Health equity for persons with disabilities: a global scoping review on barriers and interventions in healthcare services. *Int J Equity Health,* 22 (236). Available at: https://doi:org/10.1186/s12939-023-02035-w

Hasan, M. T. (2020). Sexual and Reproductive Health and Rights (SRHR) of Persons with disabilities in Bangladesh. Dhaka: BRAC James P. Grant School of Public Health.

Kristeva, J. (1982). *Powers of Horror: An Essay on Abjection* (L. Roudiez, trans.). New York: Columbia University Press.

Lam, A. Y. K., Yau, M., Franklin, R. C. & Leggat, P. (2025). Expressing Sexuality in Silent and Weep: Experience of Chinese People with Intellectual Disabilities and Parents. *Journal of Applied Research in Intellectual Disabilities*, 38(1), 1-12.

Lejzerowicz, M. (2017). Identity and its reconstruction and disabled people, *International Journal on Disability and Human Development*, 16(1), 19-24.

Linton, K. F., Rueda, H. A., Williams, L. R., Sandoval, A. & Bolin, S. (2016). Reproductive and Sexual Healthcare Needs among Adults with Disabilities as Perceived by Social Workers. *Sexuality and Disability*, 34(2), 145–156.

Matin, B. K., Williamson, H. J., Karyani, A. K., Rezaei, S., Soofi, M. & Soltani, S. (2021). Barriers in access to healthcare for women with disabilities: a systematic review in qualitative studies. *BMC Women's Health*, 21(44), 1-23.

Marella, M., Huq, N. L., Devine, A., Baker, S. M., Quaiyum, M. A. & Keeffe J. E. (2015). Prevalence and correlates of disability in Bogra district of Bangladesh using the rapid assessment of disability survey. *BMC Public Health*, 15, 867.

Mavuso, S. S., & Maharaj, P. (2015). Access to sexual and reproductive health services: Experiences and perspectives of persons with disabilities in Durban, South Africa. *Agenda*, 29(2), 79–88.

Morcelle, M. (2025). 2025 Landmines and pathways in the fight for sexual and reproductive health care equity for people with disabilities. *National Health Law Program*. Available at: https://healthlaw.org/2025-landmines-and-pathways-in-the-fight-for-sexual-and-reproductive-health-care-equity-for-people-with-disabilities/

Nguyen, T. T. A., Liamputtong, P., Horey, D. & Monfries, M. (2018). Knowledge of Sexuality and Reproductive Health of People with Physical Disabilities in Vietnam. *Sexuality and Disability*, 36(1), 3–18.

Percez-Curiel P., Vicente E., Moran M. L. & Gomez L.E. (2023). The Right to Sexuality, Reproductive Health, and Found a Family for People with Intellectual Disability: A Systematic Review. *Int J Environ Res Public Health*, 20(2), 1-29.

Permanent Mission of Bangladesh (2008). Brief Rights Account of actions taken by the Government of Bangladesh for the Protection of and Promotion of Services for the Persons with disabilities in Bangladesh. Geneva: Permanent Mission of Bangladesh and UNHCR.

Sharma, R., Singh, A. J., Suri, A. J. & Kaur, S. (2015). Barriers Faced by Women with Disabilities in Access to Sexual and Reproductive Healthcare: Experiences from North India, *Int. J. Preven. Curat. Comm. Med*, 1, 69-73.

Shildrick, M. (2004). Silencing Sexuality: "The Regulation of the Disabled Body". In J. Carabine (ed.). *Sexualities* (pp. 123-156). Belfast: OU/Policy Press.

Srinivasan, P., Karah, H. & Srinivashan, S. (2024). Disability, culture and erased sexuality: curated raw narratives of disabled women with significant impairments in India. *Culture, Health & Sexuality*, 26, 623-637.

Shrivastava, S. R., Bobhate, P., & Nair, N. (2025). Facilitating access of disabled persons to avail reproductive healthcare. *Asian Pacific Journal of Reproduction*, 14(1), 47-48. Available at: https://journals.lww.com/apjr/fulltext/2025/01000/facilitating_access_of_disabled_persons_to_avail.7.aspx

Silempa, S. (2025). Effect of comprehensive sexuality education on access to sexual reproductive health services among women with disabilities: A case of Bulawayo, Zimbabwe. *International Journal of Research and Innovation in Social Science*, 9(2). Available at: https://dx.doi.org/10.47772/IJRISS.2025.9020216

Singh, R., et al. (2024). Accessibility and utilization of sexual and reproductive health services among people with disabilities in Nepal. *Sexuality & Disability,* 42, 717-733.

Uddin, T., Islam, M., Rathore, F. & O'Connell, C. (2019). Disability and Rehabilitation Medicine in Bangladesh. *The Journal of the International Society of Physical and Rehabilitation Medicine,* 2(4), 168-177.

UNESCO (2022). Global Education Monitoring Report 2020: Inclusion and Education: All Means All. France: UNESCO.

United Nations (2008). Convention on the Rights of Persons with Disabilities. New York: United Nations.

Zahra, S. A., Noreen, N., & Imran, A. (2025). Challenging ableism: Sexual and reproductive health barriers for women with differently abled bodies. *Biological and Clinical Sciences Research Journal*, 6(5). Available at: https://doi.org/10.54112/bcsrj.v6i5.1740