Comment

Bridging sexual and reproductive health service gaps for people with disabilities in conflict-affected zones in Africa

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Abstract

Sexual and reproductive health remains largely inaccessible to people with disabilities in Africa, and these inequities are magnified in conflict settings through displacement, disrupted services, and heightened violence. Despite global frameworks such as the Convention on the Rights of Persons with Disabilities and the Sustainable Development Goals, disability inclusion is often absent from humanitarian sexual and reproductive health responses. Drawing on examples from Nigeria and Uganda, this commentary illustrates the compounded vulnerabilities faced by women with disabilities, including the loss of assistive devices, stigma, and exclusion from planning. I propose five strategies to bridge these gaps: policy reform, inclusive service design, partnerships with Disabled Persons' Organisations, improved data collection, and capacity building for frontline workers. Ensuring disability-inclusive sexual and reproductive health in conflict-affected Africa requires empowering the voices of people living with disabilities. This is both a health and human rights imperative that demands urgent and coordinated action.

Keywords: Africa, sexual and reproductive health, disability, conflict-affected zones, health inequities

Introduction

Sexual and reproductive health is central to the well-being, dignity, and rights of individuals. However, people living with disabilities continue to experience systemic exclusion from sexual and reproductive health services (Kett et al., 2020). In Africa, where health systems are already strained, those with disabilities face profound structural, cultural, and institutional barriers to care. In conflict-affected settings, these inequities are magnified by displacement, disrupted health infrastructure, and heightened exposure to violence (Bolarinwa et al., 2025).

Despite global commitments such as the Convention on the Rights of Persons with Disabilities (CRPD) and Sustainable Development Goal (SDG) 3 (good health and well-being) (United Nations [UN], 2015, UN General Assembly, 2006). The sexual and reproductive health needs of people with disabilities remain largely absent from humanitarian responses in Africa (Kett et al., 2020, Bolarinwa et al., 2025). This commentary draws attention to these intersecting vulnerabilities, highlights examples from conflict-affected African countries, and proposes actionable strategies to bridge sexual and reproductive health service gaps for this neglected population.

Current gaps in sexual and reproductive health access for people with disabilities

Studies have indicated that people with disabilities in Africa often encounter physical, attitudinal, and communication barriers when seeking sexual and reproductive health

services (Kett et al., 2020, Ganle et al., 2016). These include inaccessible facilities, a lack of adapted information, and stigma from health workers. In conflict-affected settings, humanitarian interventions often adopt a "one-size-fits-all" approach that excludes disability-specific needs (Kett et al., 2020).

Across both conflict and non-conflict settings, evidence consistently shows that women with disabilities face entrenched barriers to accessing sexual and reproductive health services. In conflict-affected contexts such as the Boko Haram insurgency in Nigeria, displaced women in Borno State reported significant challenges in accessing the required services because of the conflict and similar experiences were experienced by women with disabilities which include inaccessible camp layouts, absence of sign language interpreters, and pervasive social stigma, all of which limited access to reproductive health clinics (Fatokun and Olise, 2024, Eleweke and Ebenso, 2016). Similar patterns are observed in Uganda, where survivors of sexual violence with disabilities encounter compounded barriers to psychosocial and reproductive health support, including a lack of assistive devices and discriminatory attitudes from healthcare providers (Human Rights Watch, 2010). These findings highlight how conflict exacerbates pre-existing structural and social inequalities, further marginalising disabled women.

Importantly, these barriers are not confined to humanitarian settings but reflect broader systemic issues in healthcare access. In Nigeria, participants in a study by Eleweke and Ebenso (2016) reported being "deprived of the opportunity to acquire services," citing discrimination, exclusion, and structural barriers within health systems. Likewise, in Uganda, Mulumba et al. (2014) document how communication barriers, particularly for deaf women, can have fatal consequences during childbirth, as the absence of appropriate support prevents effective interaction with healthcare providers. Together, these studies underscore a critical argument: whether in stable or crisis contexts, health systems remain inadequately equipped to meet the needs of people with disabilities, reinforcing inequities in access and outcomes.

Consequently, there remains a significant gap in the literature at the intersection of disability and conflict across Africa. This area is underexplored, making it difficult to capture and represent the authentic voices and lived experiences of people with disabilities who have been displaced by conflict.

Compounded vulnerabilities in conflict zones

Conflict settings exacerbate existing inequalities for people with disabilities:

i. Displacement and loss of support systems: In Western Darfur, women with physical disabilities reported losing assistive devices during displacement, leaving them dependent on family members to access health services, including sexual and reproductive health care (Trani and Cannings, 2013).
ii. Increased risk of sexual and gender-based violence: In Ethiopia's Tigray region, reports highlight widespread sexual and gender-based violence during the conflict, with women facing heightened risks due to displacement, lack of safe shelters, and the breakdown of protection systems (Amnesty International, 2021).
iii. Invisibility in humanitarian planning: In the Central African Republic, disability was rarely included in needs assessments or health cluster responses, rendering people with disabilities invisible in sexual and reproductive health programming (Kett et al., 2020).

These compounded vulnerabilities illustrate how disability intersects with conflict-related risks to produce double exclusion; being left out both as a conflict-affected population and as a marginalised group within that population.

Pathways to bridging the gaps

1. Policy reform and accountability

Disability must be explicitly mainstreamed in African governments' and humanitarian actors' sexual and reproductive health policies. For example, Uganda's National Policy on Disability offers a model for integrating disability into health services (Republic of Uganda Ministry of Gender Labour and Social Development, 2023), though implementation gaps persist. Regional bodies such as the African Union could require all humanitarian sexual and reproductive health interventions in conflict-affected states to include disability-specific measures, aligning with CRPD obligations.

2. Inclusive service design

Practical steps, such as accessibility audits of refugee camp health posts, the provision of sign language interpretation, Braille materials, and disability-friendly infrastructure, are essential. For example, in South Sudan, some NGOs have piloted mobile health clinics that specifically target people with disabilities, providing a replicable model for other fragile contexts. This inclusive design should be rolled out in all conflict zones in Africa.

3. Community engagement and co-design

Partnerships with Disabled Persons' Organisations (DPOs) can ensure that interventions reflect the lived realities of people with disabilities. In Nigeria, collaboration between humanitarian actors and local DPOs has enabled adapted sexual and reproductive health messaging for women with hearing impairments. Expanding such models across African conflict zones could improve inclusivity.

4. Research and evidence generation

A major gap in the literature is the lack of disaggregated data on sexual and reproductive health among people with disabilities in conflict settings. This absence of robust evidence limits the visibility of their needs and constrains the development of targeted, inclusive interventions. Current research and humanitarian monitoring systems often overlook disability-specific variables, resulting in incomplete and non-representative findings. Addressing this gap requires deliberate efforts by donor agencies and research institutions to prioritise disability-inclusive data collection. Emerging initiatives, such as the disability-inclusive tools piloted by the United Nations Population Fund in the Democratic Republic of the Congo, demonstrate promising approaches that could be scaled up to strengthen the evidence base across the region.

5. Capacity building of frontline workers

Training health workers on disability rights and inclusive care is important. Evidence from Northern Uganda indicates that providers trained in disability inclusion exhibit improved attitudes and provide better service to women with disabilities (Smythe et al., 2025). Scaling such training to conflict-affected settings is essential.

Conclusion

People with disabilities in conflict-affected zones in Africa represent one of the most excluded groups in global health. Bridging sexual and reproductive health service gaps for them is not merely a health systems challenge; it is a justice and human rights imperative. Governments, humanitarian agencies, and donors must commit to inclusive sexual and reproductive health policies, adapt service delivery, and engage directly with people with disabilities in programme design to ensure that their voice is at the central of the development. Without such action, progress towards universal health coverage and the SDGs will remain incomplete.

Ensuring disability-inclusive sexual and reproductive health in conflict-affected Africa requires bold leadership, multi-sectoral collaboration, and investment in inclusive humanitarian responses. Only then can the double exclusion faced by this population be replaced with dignity, equity, and justice.

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