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Equity in Crisis: Access to Sexual and Reproductive Health Services for Young Women with and Without Disabilities during a Pandemic

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Introduction

The COVID-19 pandemic posed unprecedented challenges to global healthcare systems, interrupting routine services and exacerbating existing inequalities in access to care. Among the most significantly impacted were Sexual and Reproductive Health and Rights (SRHR) services, which are essential to the well-being and autonomy of young women. Within this demographic, young women with disabilities faced heightened vulnerability due to systemic barriers that predated the pandemic but were magnified during the crisis. This report explores the disparities in access to SRHR services among young women with and without disabilities during the pandemic, examining the intersection of gender, disability, and healthcare access in times of crisis. Before the pandemic, young women with disabilities already encountered numerous obstacles to accessing SRHR services, including physical inaccessibility, stigmatization, limited provider training, and a lack of inclusive health information. The onset of the pandemic further disrupted service delivery by restricting mobility, limiting in-person consultations, and reallocating healthcare resources to emergency response. For young women without disabilities, these disruptions were significant but not always insurmountable. However, for those with disabilities, the compounding effects of societal, infrastructural, and informational barriers created a situation of acute marginalization [1].

Description

A multi-country qualitative and quantitative research approach was employed to assess the impact of the pandemic on SRHR service access for young women aged 15–30, with and without disabilities. Data collection involved online surveys, in-depth interviews, and focus group discussions with healthcare providers, policymakers, disability rights advocates, and young women from both groups. The study spanned urban and rural settings to capture a diverse range of experiences and contexts. The research aimed to identify systemic gaps, understand lived experiences, and propose actionable recommendations for more inclusive SRHR service provision in future public health emergencies. Findings revealed a pronounced disparity in access to SRHR services between young women with and without disabilities. During the height of lockdown measures, many healthcare facilities either suspended or limited non-emergency SRHR services such as contraception counseling, STI testing, antenatal care, and safe abortion services. Telehealth emerged as an alternative mode of service delivery, but its accessibility was inconsistent and often inadequate for women with certain disabilities, particularly those with hearing, visual, or cognitive impairments. Internet connectivity, digital literacy, and affordability further limited the effectiveness of telehealth among marginalized populations [2].

Young women with disabilities often lacked accessible communication formats such as sign language interpretation, screen-reader-compatible content, or easy-to-understand language versions of vital health information. This exclusion from crucial information significantly impacted their ability to make informed decisions regarding their sexual and reproductive health. Additionally, public health messaging frequently failed to consider disability-inclusive language or representation, contributing to feelings of invisibility and neglect among disabled young women. Many participants reported that healthcare providers lacked adequate training to communicate effectively with young women with disabilities. This communication gap often led to misdiagnosis, overlooked consent procedures, and a general disregard for autonomy. Instances were cited where women with intellectual or psychosocial disabilities were denied SRHR services based on assumptions about their capacity or sexual activity. In contrast, young women without disabilities, while also facing challenges such as service delays and reduced confidentiality in telehealth settings, generally experienced more continuity in care and fewer discriminatory interactions [3].

Transportation emerged as another significant barrier for women with disabilities. Pandemic-related restrictions severely limited public transportation options, and many accessible transport services were either suspended or rerouted to support COVID-19 logistics. This particularly impacted rural women, who often had to travel long distances to access SRHR services even under normal circumstances. The added logistical challenges during the pandemic made it nearly impossible for many young disabled women to seek timely care, resulting in unplanned pregnancies, untreated infections, and heightened mental health distress. Social stigma and isolation were amplified during the pandemic, affecting the mental health and self-esteem of young women with disabilities. Lockdowns confined many to homes where they faced neglect or abuse, with limited avenues for seeking help. In some cases, family members served as gatekeepers, either intentionally or inadvertently restricting access to SRHR information or services. This dynamic reinforced dependency and limited opportunities for self-directed health decisions [4].

Community-based support systems, such as youth centers, disability advocacy groups, and sexual health education programs, were either paused or shifted to online formats that were not always accessible. This disrupted peer networks and informal support systems that play a crucial role in SRHR education and empowerment. The absence of these networks further marginalized young women with disabilities and created a gap in services that was difficult to bridge through formal healthcare systems alone. Policy responses during the pandemic rarely prioritized disability inclusion in SRHR service continuity plans. While many governments issued broad directives to maintain essential health services, few outlined specific strategies for ensuring access among people with disabilities. This oversight reflected a broader pattern of exclusion in health policy planning and emergency preparedness. Where policies did exist, implementation was often weak due to limited training, inadequate funding, and a lack of accountability mechanisms [5].

Conclusion

In conclusion, the pandemic exposed and intensified deep-rooted inequities in access to sexual and reproductive health services for young women, particularly those with disabilities. While all young women faced challenges, the intersection of disability and gender placed an undue burden on disabled individuals, who encountered greater service disruptions, higher risks of rights

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violations, and fewer avenues for redress. The lessons from this crisis must inform future strategies to build resilient, inclusive health systems that uphold the rights and dignity of all people, regardless of ability. Ensuring that no one is left behind in times of crisis requires proactive, inclusive planning, grounded in human rights and informed by the lived experiences of those most affected.

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Conflict of Interest

No conflict of interest.

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