

Sexual and Reproductive Health Rights among People with Disabilities in Juba County, South Sudan

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Cite this article as: Sebit Mustafa Sebit, Diana Joseph Wani Gore. Sexual and reproductive health rights among people with disabilities in Juba County, South Sudan. Texila Int J Public Health. 2026;14(3). <https://doi.org/10.21522/TIJPH.2013.14.03.Art016>

Received: 02.01.2025

Accepted: 27.02.2025

Published: 30.09.2026

Article Type: Original Research

Abstract The United Nations emphasizes inclusivity and leaving no one behind, advocating for universal health care, including sexual and reproductive health (SRH). However, the patterns of SRH rights among persons with disabilities remain poorly understood, with this group facing numerous barriers to accessing SRH services. We aimed to examine patterns of Sexual and Reproductive Health Rights (SRHR) among people with disabilities in South Sudan, focusing on Juba County. The study utilized qualitative methods for data collection, supplemented by in-depth quantitative secondary data. The researchers gathered qualitative data using key informant guides and observation. The study analyzed data using a master sheet. The findings revealed significant challenges in accessing SRH services, particularly in rural areas, where comprehensive services are scarcer than in urban centers. Men often mistrust family planning initiatives, viewing them as threats to their authority. Older individuals often exclude themselves from SRH relevance. Barriers such as stigma, discrimination, financial and physical constraints, limited perceived need, and gendered blame further hinder access. Gender-based violence, misconceptions, and negative associations exacerbate these challenges. Notably, comprehensive sex education in schools emerged as a critical intervention to foster liberal attitudes and self-control. In conclusion, the study underscores the exclusion of persons with disabilities from SRHR and highlights the urgent need for inclusive programs to address their specific needs. Limited access to services in rural areas, societal stigma, and misconceptions impede progress. Efforts should focus on promoting inclusive policies, enhancing awareness of SRHR for women with disabilities, and implementing comprehensive sex education. Addressing societal perceptions and fostering inclusivity are vital for advancing SRHR for persons with disabilities in South Sudan.

Keywords Barriers, Inclusivity, Persons with Disabilities, Sexual and Reproductive Health, South Sudan.

Introduction

Sexual and reproductive health rights (SRHR) represent an integral spectrum of civil, political, economic, social, and cultural rights that empower individuals to exercise autonomy over their sexuality and pursue a fulfilling sexual and reproductive life. These rights are enshrined in international human rights frameworks, including the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). Notably, several articles within the UN Convention on the Rights of the Child (UNCRC) are relevant to the reproductive rights of marginalized groups, including individuals with disabilities [1].

Despite the Universal Health Coverage (UHC) commitment to "leave no one behind," disability remains insufficiently addressed within the UHC agenda, even though it is a crucial component of inclusive development under the Sustainable Development Goals (SDGs). At the 2019 United Nations High-Level Meeting, global leaders reaffirmed their dedication to SDG 3.8, emphasizing equitable access to sexual and reproductive health (SRH) services and information for all, including those with disabilities [2].

The 1994 International Conference on Population and Development (ICPD) Program of Action highlights that reproductive health remains inaccessible to many due to inadequate knowledge of human sexuality, insufficient or poor-quality SRH services, discriminatory social norms, and negative attitudes towards women and girls, including those with disabilities. Furthermore, the limited agency of women and girls with disabilities over their sexual and reproductive lives exacerbates their marginalization. These factors collectively contribute to the disproportionately poor SRH outcomes experienced by persons with disabilities and underscore the need for inclusive and targeted interventions. In addition to general factors, specific issues related to the collective rights

of persons with disabilities, such as the principle of free, prior, and informed consent and respect for their cultural perspectives, must be acknowledged, protected, and fulfilled. This is essential to realizing the sexual and reproductive health and rights (SRHR) of disabled individuals [3].

High maternal mortality rates among people with disabilities are concerning, and although data on reproductive health and voluntary family planning in this group remain incomplete, evidence suggests lower rates of contraceptive use compared to the general population. A 2014 UN interagency statement led by WHO highlights the vulnerability of persons with disabilities to violence, including coercive sterilization, particularly in African countries like Congo and Ethiopia. Population policies in some nations have targeted women with disabilities from marginalized communities, leading to thousands undergoing sterilization without informed consent. Human rights bodies have emphasized that denying reproductive health information or failing to ensure free and informed consent for sterilization constitutes a violation of fundamental human rights and reflects multiple forms of discrimination based on gender and race [4].

Similar challenges exist in South Sudan, especially in Central Equatoria, where a significant portion of the disabled population lacks access to basic medical care. Many live in unstable environments with limited access to essential healthcare services. Structural inequalities, including gender disparities, significantly hinder the protection and exercise of SRHR and restrict access to services such as family planning and comprehensive sexual education. These barriers increase the vulnerability of persons with disabilities, placing their lives at risk, according to a WHO (2019) report [5].

Scholars note that South Sudan's prolonged conflict and insecurity have disrupted traditional social norms and mechanisms of

accountability, exacerbating risks of death and disability. This breakdown disproportionately affects women and children, who bear the long-term consequences.

Limited access to SRHR services exposes women and adolescent girls with disabilities to HIV/AIDS, with social, economic, and sexual exploitation further compounding the issue. Additionally, there is a substantial gap in information on sexually transmitted infections and HIV/AIDS within this group WHO, 2018. Contrary to common belief, communities of disabled individuals face a disproportionately high burden of HIV and other diseases. Available data link this to stigma, discrimination, lack of sexual education, inadequate access to contraception, high levels of sexual violence, and substance abuse [6].

This study aims to examine the Pattern of Sexual and Reproductive Health Rights Among People with Disabilities in South Sudan, focusing on Juba County, Republic of South Sudan.

Materials and Methods

Research Design and Setting: This study employed a qualitative descriptive survey approach using self-administered questionnaires, expert opinions, and observations. The design was chosen to gather accurate data on behaviors, beliefs, and knowledge regarding the sexual and reproductive health rights of people with disabilities in Juba County, Central Equatoria State, South Sudan.

Study Area: The research was conducted in Juba County, Central Equatoria State, the capital city of South Sudan, focusing on patterns of sexual and reproductive health rights among people with disabilities.

Study Population: The target population included individuals with disabilities in Juba County, with data gathered from knowledgeable respondents and stakeholders.

Sampling Technique: Simple random sampling was used to ensure a representative sample for qualitative generalization.

Sampling Procedure: Respondents were selected systematically from a compiled sampling frame. Eligibility was determined through careful review, and data were collected online and analyzed using Excel to present findings in tables and graphs.

Data Collection Methods: The researcher obtained university permission and explained the study's purpose to participants. Three primary methods were used:

Observation: Verified information and captured non-verbal insights.

In-depth Interviews: Facilitated face-to-face or phone interactions to gather comprehensive insights.

Structured Questionnaires: Distributed to target groups, including open- and closed-ended questions, to ensure consistent and accurate responses.

Data Processing and Analysis: Data Processing: Included cleaning, editing, coding, and organizing data during and after collection.

Data Analysis: Employed qualitative methods to thematically organize and evaluate data using analytical reasoning.

Quality Control: Validity: Ensured through expert review and pre-testing of questionnaires to refine content.

Reliability: Used the test-retest method with a similar population to identify ambiguities and enhance the research instrument.

Ethical Considerations: The study adhered to ethical guidelines from the University of Juba, ensuring confidentiality and voluntary participation.

Study Limitations: Key challenges included limited generalizability beyond Juba County. Other challenges included high transportation costs, weather disruptions such as rainfall, and some respondents' reluctance to provide information.

Results

The study reveals diverse perceptions, beliefs, and challenges related to Sexual and Reproductive Health Services (SRHS). A significant finding is the limited access to these services, which are primarily available in urban centers, leaving rural populations underserved. Additionally, SRHS is often perceived as a privilege reserved for specific groups, such as married individuals, excluding others, including persons with disabilities.

In South Sudan, persons with disabilities face important barriers to Sexual and Reproductive Health and Rights (SRHR) services. The 2021 Population Estimation Survey reported functional difficulties among the population, with women generally experiencing higher levels than men. In Aweil South, 65.3% of persons with disabilities reported difficulties accessing humanitarian services, while 79.1% reported that HIV/VCT services were unavailable [7, 8]. These findings highlight significant gaps in accessibility, information, and service delivery for persons with disabilities.

Men's attitudes toward family planning emerged as a key obstacle, with many viewing these programs as conspiracies to undermine their authority. This suspicion fosters resistance to contraceptive use, further limiting the adoption of SRHS. Age also influences perceptions, as older individuals (40+) often associate SRHS with sexually active youth (15–24), believing these services are irrelevant to them.

The public's perceived need for SRHS is generally limited to fertility issues, with many individuals seeking these services only to confirm reproductive health status. Gendered perceptions also play a role; married women advocating for SRHS, particularly family planning, are often viewed as disrupting family harmony. In cases where women seek family planning secretly, they risk blame and domestic violence from their partners.

Persons with disabilities face significant exclusion, as some members of the public believe SRHS should not be extended to them, considering them burdensome regarding marriage, childbirth, and service access. Furthermore, social stigma prevents many individuals from seeking SRHS information and services. This stigma is compounded by low awareness and negative perceptions, leading to widespread resistance to these services.

The study also highlights how hyper-masculinity limits SRHS uptake. Disputes over these services can result in gender-based violence, as some men reject medical advice and services out of fear of being labeled as sexually dysfunctional. Misconceptions further hinder SRHS access, with some associating these services with encouraging abortion among young women or imposing restrictions on personal behaviors such as smoking and alcohol consumption.

To address these challenges, the study recommends integrating comprehensive sex education into school curricula to promote informed and liberal attitudes toward sexuality, emphasizing self-control. Persons with disabilities face additional barriers to accessing SRHS, including discrimination from service providers, lack of information, geographic and financial constraints, violations of dignity, and physical and communication barriers. Addressing these issues is critical for ensuring equitable and inclusive access to SRHS.

Discussion

This study aimed to explore patterns, perceptions, and barriers related to Sexual and Reproductive Health and Rights (SRHR) among persons with disabilities in Juba County, South Sudan. Findings from qualitative interviews with key informants and community participants demonstrate that SRHR is influenced by social norms, gender relations, disability-related stigma,

geographical access, misinformation, and limited awareness. Although sexuality is a fundamental human need and a component of human rights, participants indicated that SRHR is frequently regarded as a private or restricted matter, particularly for married people, with persons with disabilities often excluded from reproductive health decision-making and services. This finding is consistent with Pérez et al. [9], who emphasize that sexuality and emotional and physical intimacy are fundamental aspects of human wellbeing.

The findings further demonstrate substantial barriers to SRHR services among persons with disabilities in South Sudan. The 2021 Population Estimation Survey documented functional difficulties among the population, with several forms of disability reported more frequently among females than males [7]. Similarly, an assessment in Aweil South found that 65.3% of persons with disabilities experienced difficulties accessing humanitarian services, while 79.1% reported that HIV and voluntary counselling and testing services were unavailable [8]. These findings support the present study by demonstrating that disability intersects with physical accessibility, inadequate information, service availability, and socioeconomic constraints to limit access to SRHR-related services.

Negative attitudes toward family planning emerged as an important social barrier. Some participants described family planning as a threat to male authority or as an externally imposed intervention intended to reduce population growth. Such perceptions may contribute to resistance to contraception and child-spacing practices. Although the specific social and cultural context differs, this finding is consistent with earlier UNFPA evidence that suspicion among men can undermine acceptance of family-planning programmes and position men as important determinants of contraceptive decision-making [8]. In the South Sudanese context, these perceptions suggest that family-planning interventions

need to engage men and community leaders rather than focusing exclusively on women.

Geographical inequality was another important finding. Participants perceived comprehensive SRHR services as more readily available in urban centres than in rural communities. This may reflect differences in health-facility availability, staffing, transport, affordability, and information. Olujide et al. [9] reported similar findings, identifying lack of awareness, perceived poor service quality, negative provider attitudes, and cost as barriers to utilization. Thus, improving physical availability alone may not be sufficient; service quality, provider attitudes, affordability, and community awareness also require attention.

Age-related perceptions also influenced SRHR utilization. Some participants aged 40 years and above perceived SRHR as primarily relevant to adolescents and young adults aged 15–24 years. This perception may result in older adults being overlooked in reproductive health programming despite continuing needs related to contraception, sexual health, sexually transmitted infections, and reproductive health information. Although interventions targeting adolescents and young men are important for promoting gender-equitable behaviours, SRHR programmes should adopt a life-course approach that responds to the needs of different age groups [8].

A particularly important finding was the perception that SRHR is primarily necessary for people experiencing fertility problems. Participants reported that some community members seek services mainly to confirm whether they have reproductive problems and discontinue care when they perceive themselves as healthy. This is consistent with evidence from Renk County, where social norms, stigma, and perceptions about fertility influenced family-planning utilization [10]. Recent evidence from Jonglei also found limited reproductive-health knowledge and

very low contraceptive use, highlighting gaps in preventive SRH engagement [11]. Therefore, SRHR should be understood as a continuum of preventive, promotive, and curative services, rather than services required only when illness or infertility occurs.

Gender and patriarchal norms were also prominent in the findings. Some participants reported that SRHR is perceived as primarily a woman's responsibility, while women who initiate discussions about family planning may be viewed as challenging male authority or family decision-making. Such norms can restrict women's reproductive autonomy and contribute to conflict within relationships. Women who use contraception covertly may also face risks if their partners discover their actions. This finding is consistent with evidence from Boyce et al. [12], which documented covert contraceptive use among women who feared opposition from partners and used strategies to conceal their family-planning practices. These findings highlight the importance of couple communication, male engagement, confidentiality, and protection from gender-based violence within SRHR programmes.

The study also identified pervasive misconceptions concerning the sexuality and reproductive capacity of persons with disabilities. Some participants believed that SRHS should not be prioritized for persons with disabilities because they were perceived as incapable of marriage, pregnancy, or independent reproductive decision-making. Such attitudes reinforce disability-related discrimination and can deny persons with disabilities their right to make informed decisions about sexuality, relationships, contraception, pregnancy, and childbirth. Ganle et al. [13] reported that women with disabilities have sexual and reproductive needs comparable to those of women without disabilities, challenging assumptions that disability eliminates sexual desire, sexual

activity, or the need for family-planning services.

The perception of persons with disabilities as dependent or burdensome was another important barrier. Participants described persons with disabilities as requiring additional care and therefore being unsuitable for marriage or childbearing. Similar findings were reported by Akasreku et al. [14], who documented negative social perceptions of persons with disabilities, including the perception that disability constitutes a physical, social, or economic burden on families. Such beliefs can restrict opportunities for relationships, marriage, pregnancy, and access to reproductive health services.

Provider attitudes were also identified as a potential barrier. Participants described discriminatory or judgmental interactions between health workers and women with disabilities, including questioning why women with disabilities become pregnant. Such attitudes may discourage future health-service utilization and undermine trust in healthcare providers. Akasreku et al. [14] similarly identified negative societal attitudes and misconceptions surrounding pregnancy among women with disabilities. Ganle et al. [13] further emphasized attitudinal barriers among health and social-service providers, as well as physical barriers within healthcare facilities.

The findings additionally indicate an association between SRHR-related disagreements and gender-based violence. Participants reported that disagreements concerning contraception and reproductive-health decisions may result in conflict and violence, particularly where patriarchal norms and male control are strong. This is consistent with evidence from South Sudan showing that women who use contraception without their partner's consent may face threats, physical violence, verbal abuse, or divorce [15, 16]. Similar evidence from South Sudanese refugee communities in Uganda found that male opposition to family planning and gendered

decision-making contributed to conflict and SGBV [17]. These findings demonstrate the importance of gender-transformative approaches, couple communication, violence prevention, and confidential SRHR services that protect the reproductive autonomy and safety of both women and men.

Misconceptions about the purpose of SRHR services were also evident. Some participants associated SRHR with promoting abortion among young women or with attempts to regulate personal behaviours such as alcohol and tobacco use. Similar findings have been reported in South Sudan, where family planning has sometimes been associated with fears of reduced fertility, opposition to cultural expectations, and concerns about its effects on family and community values [15, 18]. Such perceptions may contribute to community resistance and reduce acceptance and utilization of reproductive-health programmes. Comprehensive, accurate, and culturally appropriate health education is therefore essential to improve understanding of the purpose, benefits, risks, and rights associated with SRHR.

The study further identified limited disability awareness within communities and health services. Stigma and misconceptions about disability may result in women and girls with disabilities receiving inadequate information or inappropriate treatment. This highlights the need for disability-inclusive SRHR programming, including accessible information, trained healthcare providers, accessible facilities, communication support, confidentiality, and respect for dignity and informed consent

Gender-based violence results from disagreement over SRHS services. Likewise, Ganle et al. [13] found that negative public attitudes towards PWDs and their sexuality issues, stigma and discrimination against disabled patients/clients, sexual violence and abuse at the community level, and lack of community or family support networks to

enable PWDs to access SRH services and information [19].

“Some men fear being declared sexually dysfunctional because of refuse medical advice and services due to hyper-masculinity.”

Our findings agree with (Ganle et al.) [13] findings, arguing that actual barriers or challenges PWDs face in accessing sexual and reproductive health services. Such barriers should relate to access to or use of sexual health education and information, family planning, contraception, abortion, ANC, health facility childbirth, and PNC services, as presented below.

“Some members associated SRHS with things like encouraging abortion among young women, dislike SRHS because they fear restriction from smoking and taking alcohol.”

“This refers to the development of various sex education that should be integrated into all the school syllabi that should reflect the liberal sexual attitudes that should emphasis more on self-control than the typical case.”

Evidently, there is a dearth of knowledge regarding impairments in society, which results in views that are unfavorable to those who have disabilities. The majority of medical staff tend to discriminate against women and girls with disabilities when it comes to sexual and reproductive health services; this is one of the factors that affect access to these services for women and girls with disabilities. For instance, nurses in some clinics enquire as to why women with disabilities became pregnant. Women and girls with disabilities may be deterred from using sexual and reproductive health services by such views. Similarly, according to [14], there are generally negative societal attitudes towards pregnant PWDs. The evidence suggests that a degree of prejudice and misconceptions exists towards the pregnancy of women living with disabilities. Generally, there is a public perception that

women living with disabilities cannot have a safe motherhood experience and are capable of transferring their disability to an unborn child of another pregnant woman.

The study further identified limited disability awareness within communities and health services. Stigma, discrimination, and misconceptions about disability may result in women and girls with disabilities receiving inadequate information or inappropriate treatment. This is consistent with evidence from South Sudan showing that persons with disabilities face inaccessible health facilities, negative attitudes from health workers, and inadequate accessible health information [20]. These findings highlight the need for disability-inclusive SRHR programming, including accessible information, trained providers, communication support, confidentiality, and respect for dignity and informed consent.

Overall, the findings demonstrate that barriers to SRHR among persons with disabilities in Juba County are multidimensional, involving stigma, discrimination, gender norms, misinformation, poverty, geographical barriers, limited-service availability, inadequate provider capacity, and restricted reproductive autonomy. Evidence from South Sudan similarly identifies social exclusion, stigma, and structural barriers as major constraints to access to essential services [20, 21]. A rights-based and disability-inclusive approach is therefore needed, including community awareness, engagement of men and community leaders, improved provider competencies, accessible facilities and information, and integration of disability inclusion into existing SRHR programmes.

Conclusion

The study demonstrates that persons with disabilities in South Sudan experience significant social, cultural, informational, and health-system barriers to Sexual and

Reproductive Health and Rights (SRHR). The findings are consistent with evidence from South Sudan and comparable settings showing that disability-related stigma, gender inequality, provider attitudes, inadequate accessibility, and misconceptions can restrict reproductive autonomy and utilization of SRHR services. Addressing these barriers requires integrated, rights-based and disability-inclusive interventions that promote gender equality, informed decision-making, accessible information, confidentiality, and equitable access to quality SRHR services. Further research should examine the role of community leaders, healthcare providers, families, and organizations of persons with disabilities in improving SRHR knowledge, acceptance, and service utilization, including the relationship between SRHR access and gender-based violence. Collaboration among government, NGOs, disability organizations, and communities is essential to strengthen inclusive and equitable SRHR services in South Sudan.

Conflict of Interest

The authors declare no conflict of interest.

Acknowledgements

The authors thank the University of Juba, Texila American University, and the Ministry of Health, Republic of South Sudan, for their support during data collection. Special thanks are extended to the participants, experts, professionals, disability aid organizations, government agencies, and other stakeholders for their valuable contributions and collaboration.

Ethical Approval

The authors obtained ethical approval from the relevant institutional authorities before data collection. The authors obtained informed consent from all participants and ensured confidentiality and voluntary participation.

Data Availability

The data supporting this study's findings are available from the corresponding author upon reasonable request.

Funding

This study received no specific funding from any public, commercial, or non-profit organization.

References

- [1]. United Nations Committee on Economic, Social and Cultural Rights. General Comment No. 22 (2016) on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights). Geneva: United Nations; 2016. E/C.12/GC/22.
- [2]. Mac-Seing M, Zarowsky C, D'Ambruoso L. Disability and sexual and reproductive health service utilisation in Uganda: an intersectional analysis of demographic and health surveys between 2006 and 2016. *BMC Int Health Hum Rights*. 2022;22:7.
- [3]. United Nations. Report of the International Conference on Population and Development: Cairo, 5–13 September 1994. New York: United Nations; 1995.
- [4]. World Health Organization, Office of the United Nations High Commissioner for Human Rights, UN Women, UNAIDS, UNDP, UNFPA, UNICEF. Eliminating forced, coercive and otherwise involuntary sterilization: an interagency statement. Geneva: WHO; 2014.
- [5]. World Health Organization. HIV/AIDS [Internet]. Geneva: WHO; [cited 2019 May 28]. Available from: <https://www.who.int/features/qa/71/en/>
- [6]. World Health Organization. Call to action to the global community: attaining universal health coverage through sexual and reproductive health and rights and HIV linkages. Geneva: WHO; 2018.
- [7]. National Bureau of Statistics. Population Estimation Survey (PES) 2021. Juba: Republic of South Sudan; 2021.
- [8]. International Organization for Migration. Disability Access and Inclusion Survey: Aweil South County, South Sudan. IOM DTM; 2023.
- [9]. Pérez-Curiel P, Vicente E, Morán ML, Gómez LE. The right to sexuality, reproductive health, and found a family for people with intellectual disability: a systematic review. *Int J Environ Res Public Health*. 2023;20(2):1587. <https://doi.org/10.3390/ijerph20021587>
- [10]. Ahmed WAM, Shokai SB, Abduelkhair IH, Boshra AY. Factors affecting utilization of family planning services in a post-conflict setting, South Sudan: a qualitative study. *AIMS Public Health*. 2015;2(4):655-66. doi:10.3934/publichealth.2015.4.655
- [11]. Lawry LL, Gabor R, Katele J, et al. Mixed-methods reproductive health knowledge, attitudes and practices survey of IDPs, returnees and host communities in Jonglei State, South Sudan. *BMJ Open*. 2025;15(1):e083905. doi:10.1136/bmjopen-2024-083905.
- [12]. Hartmann-Boyce J, Lindson N, Butler AR, McRobbie H, Bullen C, Begh R, et al. Electronic cigarettes for smoking cessation. *Cochrane Database Syst Rev*. 2022 Nov 17;11(11):CD010216.
- [13]. Ganle JK, Baatiema L, Quansah R, Danso-Appiah A. Barriers facing persons with disability in accessing sexual and reproductive health services in sub-Saharan Africa: a systematic review. *PLoS One*. 2020;15(10):e0238585. <https://doi.org/10.1371/journal.pone.0238585>
- [14]. Akasreku BD, Habib H, Ankomah A. Pregnancy in disability: community perceptions and personal experiences in a rural setting in

Author Contributions

The authors contributed to the study conception, methodology, data collection, analysis, interpretation of findings, and preparation and review of the manuscript. All authors approved the final manuscript.

Ghana. J Pregnancy. 2018;2018:8096839. <https://doi.org/10.1155/2018/8096839>

[15]. Scott J, Averbach S, Modest AM, Hacker MR, Cornish S, Spencer D, et al. An assessment of attitudes toward gender inequitable sexual and reproductive health norms in South Sudan: a community-based participatory research approach. *Conflict Health*. 2013;7:24. doi:10.1186/1752-1505-7-24.

[16]. Using vignettes to gain insights into social norms related to voluntary family planning and gender-based violence in South Sudan. *Glob Health Sci Pract*. 2024.

[17]. They will say you want to make their home die: a mixed methods study to assess modern family planning use in partnered South Sudanese refugee and host populations in Northern Uganda. *BMC Womens Health*. 2022.

[18]. Kane S, Kok M, Rial M, Matere A, Dieleman M, Broerse JEW. Social norms and family planning decisions in South Sudan. *BMC Public Health*. 2016;16:1193. doi:10.1186/s12889-016-3839-6.

[19]. World Health Organization, United Nations Population Fund. Promoting sexual and reproductive health for persons with disabilities: WHO/UNFPA guidance note. Geneva: WHO; 2009. ISBN 9789241598682.

[20]. UNICEF South Sudan. The situation of children and women in South Sudan 2018–2020: situation analysis. Juba: UNICEF; 2021.

[21]. Ministry of Gender, Child and Social Welfare, Republic of South Sudan. National Disability Action Plan 2021–2030. Juba: Government of South Sudan; 2021.