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# Sexual and Reproductive Health Literacy among Persons with Disabilities in Sub-Saharan Africa: A Scoping Review

**Olufunke Victoria Aiyegbusi**
Department of Maternal and Child Health,
Faculty of Nursing Sciences, Achievers University, Owo, Ondo State, Nigeria.

**Adekemi Eunice Olowokere**
Department of Community-Public Health Nursing,
Faculty of Nursing Sciences, Obafemi Awolowo University, Ile-Ife, Nigeria.

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**Abstract:** *Sexual and reproductive health (SRH) literacy, the capacity to access, understand, appraise and apply SRH information, underpins autonomous decision-making. Persons with disabilities in sub-Saharan Africa (SSA) face disproportionate barriers to SRH information and services, yet the evidence on their SRH literacy has not been mapped. To map the available evidence on SRH literacy among persons with disabilities in SSA, describe its characteristics and identify gaps for research, practice and policy. A scoping review was conducted using the Arksey and O'Malley framework, refined by Levac and colleagues and the Joanna Briggs Institute, and reported according to PRISMA-ScR. PubMed, Scopus, Web of Science, African Journals Online and Google Scholar were searched. Peer-reviewed primary studies on SRH knowledge, information access or literacy among persons with disabilities in SSA were eligible. Findings were charted and mapped onto the four dimensions of health literacy (access, understand, appraise, apply), then synthesised thematically.Nineteen studies from eight countries (2013–2022) were included; seven were from Ghana. Hearing impairment was the most studied disability, while intellectual and psychosocial disabilities were rarely examined. Evidence clustered around access to and understanding of SRH information; only three studies touched on appraisal and none measured it directly. Knowledge was consistently partial, particularly for HIV prevention and contraceptive methods, and frequently failed to translate into protective practice. Communication barriers, provider attitudes, beliefs that persons with disabilities are asexual, gender and dependence on caregivers shaped literacy, and heightened exposure to sexual violence was reported. SRH literacy among persons with disabilities in SSA is low, unevenly studied and rarely measured as a distinct construct. Accessible, disability-specific SRH education, sign language-competent services and validated literacy measures are priorities.*

**Keywords:** sexual and reproductive health literacy; disability; health literacy; sub-Saharan Africa; scoping review

## INTRODUCTION

Health literacy is more than the capacity to read health information. Now it is understood as knowledge, motivation and competence to access, understand, appraise and apply health information

to make judgements and decisions in everyday life (Sørensen et al., 2012). Sexual and reproductive health (SRH) literacy, when applied to sexuality and reproduction, is the ability to access, understand and use information on puberty, contraception, pregnancy, sexually transmitted infections (STIs), sexual rights and protection from sexual violence. It is a prerequisite for informed and voluntary choices that reproductive autonomy relies on.

SRH literacy is low among the youth in sub-Saharan Africa (SSA). A regional synthesis of 24 studies revealed that information gaps, limited knowledge and practices, and lack of translation of knowledge into action remained prevalent, influenced by personal, interpersonal and structural factors (Amanu et al., 2023). Although research on adolescent SRH has grown in the region, it is still largely focused on HIV and a few countries (Ajayi et al., 2021). Programmes that enhance knowledge and uptake of contraceptive use among young people, such as school-based education or mHealth and youth-friendly services, rarely consider disabled people.

An estimated 1.3 billion people (one in six people worldwide) are living with a significant disability and many of them are experiencing avoidable health inequities (World Health Organization [WHO], 2022). The Convention on the Rights of Persons with Disabilities obliges States Parties to provide persons with disabilities with the same range, quality and standard of SRH programmes as other persons and to guarantee access to age-appropriate reproductive and family planning information (United Nations, 2006). In reality, people with disabilities in LMICs are often assumed to be asexual, not included in sexuality education and deprived of information that others are afforded (Carew et al., 2017).

Adjacent questions have been answered in previous syntheses. A systematic review revealed health system and individual-level barriers to SRH services for persons with disabilities in SSA (Ganle et al., 2020). A scoping review of women with disabilities in SSA identified 17 studies, with the majority focussing on contraceptive use, with none addressing sexual autonomy (Bolarinwa et al., 2024). A global review of interventions in LMICs revealed that there is limited evidence of evaluated SRH interventions for people with disabilities (Hameed et al., 2020). None of these reviews examined SRH literacy as such: whether persons with disabilities can reach SRH information, understand it, judge its trustworthiness and use it. Mapping the evidence through a literacy lens can show which competencies have been studied, for whom and where, and can guide accessible education and services. This review therefore asked: what evidence exists on SRH literacy among persons with disabilities in SSA, and what gaps remain?

## METHODS

### *Study design*

The review followed the five-stage scoping framework of Arksey and O'Malley (2005), incorporating the refinements of Levac et al. (2010) and the Joanna Briggs Institute (JBI) guidance (Khalil et al., 2016; Peters et al., 2020). Reporting adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR; Tricco et al., 2018). A scoping design was chosen because the literature is heterogeneous in design, population and outcome, and the aim was to map the extent and nature of evidence rather than to estimate an effect.

***Review question and eligibility criteria***

The question was framed with the Population–Concept–Context (PCC) mnemonic (Table 1). Studies were included if they (a) involved persons with physical, sensory, intellectual or psychosocial disabilities, or professionals delivering SRH education to them; (b) reported on knowledge, awareness, information sources, comprehension, appraisal or use of SRH information or services; (c) were conducted in one or more SSA countries; (d) were primary studies using quantitative, qualitative or mixed methods; and (e) were published in English in peer-reviewed journals. Studies outside SSA, studies not reporting disability-specific findings, reviews, editorials, commentaries, conference abstracts and studies without accessible full text were excluded. Reviews identified by the search were used to contextualise findings but were not charted as evidence.

**Table 1: Population–Concept–Context framework guiding the review**

| Component | Definition applied in this review |
|---|---|
| Population | Persons with any disability (physical, visual, hearing, intellectual, psychosocial or multiple), any age or sex; teachers or providers delivering SRH education to them |
| Concept | SRH literacy: accessing, understanding, appraising and applying SRH information (contraception, pregnancy, STIs/HIV, sexual rights, sexual violence) |
| Context | One or more countries of sub-Saharan Africa |
| Review question | What evidence exists on SRH literacy among persons with disabilities in sub-Saharan Africa, and what gaps remain? |

*Note.* SRH = sexual and reproductive health; STIs = sexually transmitted infections.

***Information sources and search strategy***

PubMed, Scopus, Web of Science, African Journals Online (AJOL) and Google Scholar were searched. The search combined three concept blocks with Boolean operators: ("sexual health literacy" OR "reproductive health literacy" OR "sexual health knowledge" OR "reproductive health information" OR contracept *OR "HIV knowledge") AND (disab* OR "hearing impair*" OR deaf OR "visual impair*" OR blind OR "intellectual disab*" OR "physical disab*") AND ("sub-Saharan Africa" OR the names of individual SSA countries). Multi-database searching was used because disability and SRH research from the region is often published in regional journals that are poorly indexed (Bolarinwa et al., 2024). Reference lists of included studies and relevant reviews (Ganle et al., 2020; Hameed et al., 2020) were hand-searched.

***Study selection***

Records were exported to a reference manager and de-duplicated. Titles, then abstracts, then full texts were screened against the eligibility criteria, and reasons for full-text exclusion were recorded. In the selection process, 102 records were identified, 56 remained after de-duplication, 25 full texts were assessed, and 19 studies were included.

***Data charting***

A charting form, piloted on three studies, captured author and year, country, design, sample, disability type, SRH domain and key findings. Each finding was also coded deductively to one or more of the four literacy dimensions of the Sørensen et al. (2012) model: accessing information (information sources, communication channels), understanding it (knowledge and comprehension), appraising it (judging credibility and personal relevance, including risk perception) and applying it (use of services and protective practices).

***Synthesis***

Charted data were summarised descriptively and then synthesised thematically. Codes generated inductively from study findings were grouped into candidate themes, reviewed against the charted data and refined (Braun & Clarke, 2006). Consistent with scoping review methodology, formal critical appraisal was not undertaken (Peters et al., 2020), but study design and sample size are reported so that readers can weigh the evidence.

## RESULTS

***Characteristics of included studies***

The 19 included studies were published between 2013 and 2022 (Table 2). Ghana contributed seven studies (Badu et al., 2019; Kumi-Kyereme, 2021; Mprah, 2013; Mprah, Duorinaah, et al., 2022; Mprah, Opoku, et al., 2022; Nketsia et al., 2022; Obasi et al., 2019), followed by Nigeria, Ethiopia, Uganda and South Africa with two each, and Senegal and Zimbabwe with one each. Two studies were multi-country (Tanabe et al., 2015; Tun et al., 2016). No study came from Central Africa or the Francophone Sahel beyond Senegal. Seven studies were quantitative, eight qualitative and four mixed-methods. Sample sizes ranged from 21 visually impaired women (Badu et al., 2019) to 2,114 students in schools for the deaf and blind (Kumi-Kyereme, 2021).

Six studies focused exclusively on deaf or hard-of-hearing participants, one each on visual, physical and intellectual impairment, nine on mixed disability groups, and one on teachers in special schools (Chirawu et al., 2014). Only one study explicitly included persons with psychosocial (mental) impairments (Mac-Seing et al., 2020). Seven studies concerned adolescents or young people and five concerned women or girls only. HIV and contraception were the most frequent SRH topics; menstruation, fertility awareness, safe abortion and sexual rights were rarely addressed.

**Table 2: Characteristics and key findings of included studies (n = 19)**

| Author (year) | Country | Design; sample | Disability | Literacy dimension(s) | Key findings |
|---|---|---|---|---|---|
| Aderemi et al. (2013) | Nigeria | Comparative cross-sectional; 300 learners with intellectual disability, 300 without | Intellectual | Access, understand, apply | Lower HIV transmission knowledge (52.9% vs 70.4%); less information from parents, teachers and print; inconsistent condom use universal among sexually active learners with disability |
| Arulogun et al. (2013) | Nigeria | Descriptive survey; 167 girls | Hearing | Access, apply | Communication (40.5%) and cost (10.8%) main barriers; 36.7% embarrassed to ask questions through an interpreter; 85.6% would use deaf-friendly services |
| Mprah (2013) | Ghana | Sequential mixed methods; FGDs and survey of 152 | Hearing | Understand | Only 3 of 13 contraceptive methods known by about 70% of adults and 60% of students |
| Ahumuza et al. (2014) | Uganda | Qualitative; 40 adults, 10 key informants | Physical | Access | Inaccessible facilities, negative provider attitudes, cost and beliefs that disabled people should not be sexually active; women more affected |
| Chirawu et al. (2014) | South Africa | Cross-sectional pilot survey; 99 | Teachers of learners with four | Access | Teachers positive and confident but materials and professional preparation inadequate; sexual behaviour topics avoided |

| Author (year) | Country | Design; sample | Disability | Literacy dimension(s) | Key findings |
|---|---|---|---|---|---|
| | | teachers, 10 special schools | disability types | | |
| Tanabe et al. (2015) | Kenya, Uganda (and Nepal) | Participatory qualitative | Mixed, refugees | Understand, access | Uneven awareness of anatomy, family planning and STIs; provider disrespect most painful barrier; violence risk highest with intellectual impairment |
| Kassa et al. (2016) | Ethiopia | Cross-sectional; 426 young people | Mixed | Access, understand, appraise | 96.7% had heard of HIV but 88% had poor prevention knowledge; 21.6% perceived HIV risk; 77.9% never discussed SRH with parents |
| Tun et al. (2016) | Ghana, Uganda, Zambia | Qualitative FGDs; 76 adults living with HIV | Physical, visual, hearing | Access, apply | No accessible materials or interpreters; delayed testing; disability-tailored NGO services improved experience |
| Burke et al. (2017) | Senegal | Qualitative, peer-led; 17 FGDs, 50 interviews, aged 18–24 | Physical, visual, hearing | Understand, access, apply | Very low knowledge and use of SRH services; reliance on companions undermined confidentiality; rape reported, especially among deaf women |
| Gichane et al. (2017) | South Africa | Mixed methods; 42 women | Hearing | Access, apply | 96% attended antenatal care but relied on writing; limited interpretation and some mistreatment |
| Rugoho & Maphosa (2017) | Zimbabwe | Qualitative; 23 women | Mixed | Access | Negative provider perceptions, no sign language interpreters, cultural beliefs that disabled women are not sexually active |
| Badu et al. (2019) | Ghana | Qualitative; 21 women | Visual | Access, understand, apply | Knowledge centred on intercourse, family planning and STIs; none had used a condom or contraceptive; lack of family support limited access |
| Obasi et al. (2019) | Ghana | Cross-sectional; 280 adolescents aged 15–19 | Hearing, visual, intellectual | Access, understand | 67.1% good SRH knowledge; teachers main source (63.9%); low awareness of long-acting methods; visual vs intellectual AOR 2.37 |
| Mac-Seing et al. (2020) | Uganda | Qualitative intersectional; 32 interviews, 2 FGDs, facility observations | Physical, sensory, mental | Access | Gender, disability and violence intersected to restrict access; physical, attitudinal and communication barriers in public and private facilities |
| Mekonnen et al. (2020) | Ethiopia | Cross-sectional; 397 adults | Mixed | Understand | 47.3% good HIV knowledge; 46.9% good STI knowledge; men more knowledgeable (AOR 1.60) |
| Kumi-Kyereme (2021) | Ghana | Cross-sectional; 2,114 students aged 10–24 | Visual, hearing | Apply | About 7 in 10 had ever used SRH services; blind students more likely than deaf students to use services |
| Mprah, Duorinaah, et al. (2022) | Ghana | Qualitative; 60 young people | Hearing | Access | Negative health worker attitudes and individual-level barriers at the point of service |
| Mprah, Opoku, et al. (2022) | Ghana | Sequential mixed methods; 288 survey, 60 qualitative | Hearing | Access, understand, appraise | Dissatisfaction owing to absent interpreters; participants guessed what nurses meant and distrusted information they could not understand |
| Nketsia et al. (2022) | Ghana | Sequential mixed methods; 288 survey, 60 qualitative | Hearing (women) | Understand, appraise | Little knowledge of contraceptive methods; religious beliefs shaped how SRH information was interpreted |

*Note.* AOR = adjusted odds ratio; FGD = focus group discussion; NGO = non-governmental organisation; SRH = sexual and reproductive health; STI = sexually transmitted infection.

***Distribution of evidence across literacy dimensions***

Coding against the four dimensions showed a marked imbalance. Sixteen studies reported on access to SRH information or services, eleven on understanding (knowledge), seven on application (service use or protective practice), and only three on appraisal. No study used a validated SRH literacy instrument; knowledge was measured with study-specific questionnaires that covered narrow topics, usually HIV and contraception. Four themes emerged from the synthesis.

***Theme 1: Partial and fragmented SRH knowledge***

Knowledge was consistently incomplete. Awareness was often high while functional understanding was low: among young people with disabilities in Addis Ababa, 96.7% had heard of HIV, yet 88% had poor knowledge of how to prevent it (Kassa et al., 2016). In North Shewa, fewer than half had good knowledge of HIV (47.3%) or of other STIs (46.9%) (Mekonnen et al., 2020). Nigerian learners with intellectual disability scored substantially lower on HIV transmission knowledge than their non-disabled peers (Aderemi et al., 2013). Contraceptive knowledge was narrow. Deaf Ghanaians knew only three of 13 methods well (Mprah, 2013), deaf women had little knowledge of contraceptive methods (Nketsia et al., 2022), and adolescents in special schools knew condoms but rarely implants or intrauterine devices (Obasi et al., 2019). Refugees with disabilities had uneven understanding of reproductive anatomy, family planning and STIs (Tanabe et al., 2015). Where knowledge was relatively good, as in Obasi et al. (2019), it varied with age and disability type, with learners with intellectual disability faring worst.

***Theme 2: Inaccessible information channels and communication***

The channels through which youngest people learn about SRH were narrowed or closed. Parents rarely discussed SRH with their children with disabilities (Kassa et al., 2016), and learners with intellectual disability received less information from parents, teachers and print media than their peers, although radio and television reached both groups similarly (Aderemi et al., 2013). Mass media and teachers were therefore pivotal sources (Kassa et al., 2016; Obasi et al., 2019), but teachers in South African special schools, while willing, lacked adapted materials and training and avoided topics concerning sexual behaviour (Chirawu et al., 2014).

In health facilities, the absence of sign language interpreters was the most frequently reported barrier (Gichane et al., 2017; Mprah, Opoku, et al., 2022; Rugoho & Maphosa, 2017; Tun et al., 2016). Deaf women relied on writing during antenatal care and delivery (Gichane et al., 2017), and others guessed what nurses meant (Mprah, Opoku, et al., 2022). Even where interpreters were present, more than a third of deaf girls in Ibadan felt too embarrassed to ask questions through a third party (Arulogun et al., 2013). Dependence on relatives or companions to reach services, a recurring finding among visually and physically impaired participants, compromised confidentiality and limited independent information-seeking (Badu et al., 2019; Burke et al., 2017).

***Theme 3: Weak appraisal and a gap between knowledge and practice***

Few studies explored how persons with disabilities judge SRH information, but the available evidence suggests difficulty. Only 21.6% of young Ethiopians with disabilities perceived themselves to be at

risk of HIV (Kassa et al., 2016). Deaf Ghanaians distrusted information they could not fully understand (Mprah, Opoku, et al., 2022), and religious beliefs shaped how deaf women interpreted contraception and abortion (Nketsia et al., 2022).

The translation of knowledge into protective behaviour was weak. Visually impaired women who could describe family planning and STI prevention had never used a condom or contraceptive (Badu et al., 2019). Among sexually experienced Nigerian learners with intellectual disability, condom use with partners was universally inconsistent (Aderemi et al., 2013). Persons living with disability and HIV often delayed testing until they were ill (Tun et al., 2016). Service use was not uniformly low: about seven in ten Ghanaian students in schools for the deaf and blind had used SRH services, but deaf students used them less than blind students (Kumi-Kyereme, 2021), again pointing to communication as the limiting factor.

***Theme 4: Structural, sociocultural and gendered determinants and vulnerability***

Literacy was embedded in social and structural conditions. Beliefs that persons with disabilities are, or should be, sexually inactive were reported in Uganda and Zimbabwe (Ahumuza et al., 2014; Rugoho & Maphosa, 2017), and negative or disrespectful provider attitudes were documented in nearly every qualitative study (Burke et al., 2017; Mac-Seing et al., 2020; Mprah, Duorinaah, et al., 2022; Tanabe et al., 2015). Physical inaccessibility and cost compounded these barriers (Ahumuza et al., 2014; Arulogun et al., 2013). Gender intensified disadvantage: women reported every barrier more often than men in Kampala (Ahumuza et al., 2014), women living with HIV faced greater caregiving constraints (Tun et al., 2016), and in Northern Uganda gender, disability and conflict-related violence intersected to restrict access (Mac-Seing et al., 2020). Male respondents also had higher odds of good HIV knowledge than female respondents in Ethiopia (Mekonnen et al., 2020).

Low literacy coincided with heightened vulnerability. Rape was reported among young women with hearing impairment in Senegal (Burke et al., 2017), the risk of sexual violence was greatest for refugees with intellectual impairment (Tanabe et al., 2015), and a high proportion of sexually experienced girls with intellectual disability in Nigeria reported a history of rape (Aderemi et al., 2013). Enablers were also identified. Disability-tailored services offered by non-governmental organisations, and in Uganda by government facilities, improved HIV care experiences (Tun et al., 2016), and most deaf girls in Ibadan said they would use services designed for deaf clients (Arulogun et al., 2013).

## DISCUSSION

This review has mapped 19 studies of SRH literacy for people with disabilities in SSA. Three results are noteworthy. First, the evidence is focused on the access and knowledge aspects of literacy, with the appraisal aspect, arguably the most important in an environment of misinformation, almost unstudied. Second, the evidence base is geographically limited and is largely about deaf people, in Ghana, with intellectual and psychosocial disabilities being virtually absent. Third, knowledge was incomplete and did not consistently lead to protection across settings and designs.

The partial knowledge is similar to what was reported by young people in the overall SSA (Amanu et al., 2023) but the mechanisms are different. The primary barriers for people with disabilities are the cultural taboos and the lack of sex education for all young people, as well as communication channels

that are not accessible to people with disabilities and assumptions that they do not need SRH information. Ganle et al. (2020) termed these as barriers to services; this review demonstrates the same barriers exist upstream, where information is first acquired. Learners with intellectual and sensory impairments are disadvantaged in the case of information that relies on parents, teachers or written materials, while broadcast media are able to reach them more evenly (Aderemi et al., 2013). The mass media and disability adapted school curricula are therefore worthy of consideration as avenues for SRH literacy.

The knowledge–practice gap is related to the literacy framework itself because knowing information is not enough to put it into practice (Sørensen et al., 2012). For people with disabilities, access to the application is dependent on being able to reach a facility, private communication with a provider and being treated with respect. Where companions or interpreters are required, confidentiality is broken and questions are not asked (Arulogun et al., 2013; Burke et al., 2017). Literacy programs that focus only on individual knowledge are thus unlikely to be effective unless they are also physically, linguistically and attitudinally accessible.

The lack of research on appraisal is a very significant gap. With the proliferation of information in SRH via mobile phone and social media, credibility is paramount. The low perceived risk of HIV (Kassa et al., 2016) and distrust of poorly understood clinical information (Mprah, Opoku, et al., 2022) indicates that appraisal skills are underdeveloped but were not measured. Likewise, a validated instrument for SRH literacy does not exist, and thus the operationalisation of the concept of "knowledge" has been done in a very limited way and is not comparable between countries and disability groups.

The results also show intersecting disadvantage. Women and girls with disabilities were likely to experience additional barriers and sexual violence, as identified by a regional scoping review of women with disabilities (Bolarinwa et al., 2024) and consistent with global evidence on sexual lives of persons with disabilities in LMICs (Carew et al., 2017). Persons with intellectual disability seemed the least informed and most vulnerable to violence, but were only represented in three studies. This aligns with the fact that there is a lack of evaluated SRH interventions for people with disabilities globally (Hameed et al., 2020).

***Implications for practice and policy***

If empowered, nurses, midwives and other providers are well positioned to strengthen SRH literacy. There is a need for training in disability inclusive communication and basic sign language; provision of certified interpreters and private consultation services; production of disability adapted comprehensive sexuality education materials in Braille, audio, sign language video and easy-read formats; and integration of disability adapted comprehensive sexuality education in the special and inclusive schools with materials and in-service training for teachers (Chirawu et al., 2014). Information can be co-designed and shared with organisations of persons with disabilities like national association of the deaf (Mprah, Duorinaah, et al., 2022). There is a need to disaggregate data by disability in national SRH policies and health information systems to monitor progress.

***Research priorities***

Future studies should create and validate SRH literacy instruments for various impairments; study the appraisal dimension of SRH including digital SRH information; involve persons with intellectual and psychosocial disabilities; involve men with disabilities; and assess literacy interventions with experimental or quasi-experimental designs in Central, Francophone and Lusophone Africa.

***Strengths and limitations***

This review used an explicit health literacy framework to structure the heterogeneous evidence and the reporting of methods was done in line with PRISMA-ScR. Several limitations apply. There may be a bias in the selection of English language peer-reviewed publications, which may not have included Francophone and Lusophone studies and disability organisations' grey literature. Few studies reported an actual measure of literacy, so findings had to be interpreted when they were mapped to the dimensions of literacy. In line with scoping methodology, the quality of the studies was not formally assessed, and the results reflect the amount of evidence, not its strength.

## CONCLUSION

The SRH literacy rate of PWD in SSA is low and is not well studied. The evidence indicates some understanding, limited information flows, limited connections between knowledge and practice, and gender vulnerability, but little about the way persons with disabilities evaluate information and virtually nothing about persons with intellectual or psychosocial disability. To realize the promises of the Convention on the Rights of Persons with Disabilities, accessible SRH education, communication-competent services, and validated literacy measures and intervention research involving persons with all types of disability will be necessary.

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