



Contents lists available at ScienceDirect

## Disability and Health Journal

journal homepage: [www.disabilityandhealthjnl.com](http://www.disabilityandhealthjnl.com)

## Barriers and facilitators of sexual and reproductive health service utilization among young people with disabilities: A scoping review

Sumia Andleeb Abbasi<sup>a</sup>, Shumaila Batool<sup>b</sup>, Saba Nisa<sup>c</sup>, Zohra S. Lassi<sup>d,e</sup>, Salima Meherali<sup>c,\*</sup> 

<sup>a</sup> School of Nursing and Midwifery, The Aga Khan University, Stadium Road, Karachi, Pakistan

<sup>b</sup> Department of Nursing, University of Turku, Finland

<sup>c</sup> Faculty of Nursing, University of Alberta, Canada

<sup>d</sup> School of Public Health, University of Adelaide, Australia

<sup>e</sup> Robinson Research Institute, University of Adelaide, Australia

## ARTICLE INFO

## Keywords:

Sexual and reproductive health

Youth with disabilities

Barriers

Facilitators

Service utilization

## ABSTRACT

**Background:** Young people with disabilities (YPWDs), including those with physical and sensory impairments, face heightened risks of sexual, physical, and emotional violence. Despite having similar sexual and reproductive health (SRH) needs and rights as their non-disabled peers, YPWDs encounter multiple barriers to accessing SRH information and services.

**Objective:** To map and synthesize existing global evidence on SRH needs, barriers, and facilitators to SRH service utilization among YPWDs aged 10–24 years with physical and sensory disabilities.

**Methods:** A comprehensive search of multiple databases identified 2010 studies. After title, abstract, and full-text screening, 26 studies met inclusion criteria. Both quantitative and qualitative studies were reviewed. Two independent reviewers conducted screening and data extraction using a structured template to capture study characteristics, populations, SRH needs, and reported barriers or facilitators. The review followed PRISMA-ScR guidelines, and the protocol was registered with the Open Science Framework ([10.17605/OSF.IO/WJEPH](https://doi.org/10.17605/OSF.IO/WJEPH)).

**Results:** The review identified physical inaccessibility of healthcare facilities, lack of disability-friendly communication, financial barriers, and pervasive social stigma and discrimination as major obstacles to SRH service use. Gender inequality, cultural taboos, and experiences of sexual violence further restricted access. Facilitators included supportive family or caregiver networks, strong religious or community ties, lower disability severity, and the availability of affordable, disability-adapted SRH services and digital information platforms.

**Conclusions:** Improving SRH outcomes for YPWDs requires more than infrastructural changes, it demands addressing societal stigma, enhancing SRH education, and enforcing inclusive policies that prevent discrimination and violence.

## Introduction

The World Health Organization (WHO) defines young individuals as the population between 10 and 24 years.<sup>1</sup> Worldwide, approximately 1.3 billion people across all age groups live with a disability, representing a substantial proportion of the global population. According to the Centers for Disease and Control Prevention (CDC), “A disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities and interact with the world around them.”<sup>2</sup> The WHO recognizes two main approaches to classifying disabilities. The first is based on the type of

impairment, such as physical, sensory (including vision and hearing loss), intellectual, and mental disabilities.<sup>3</sup> The second uses the International Classification of Functioning, Disability and Health (ICF) framework, which takes a more holistic view by considering impairments, activity limitations, and restrictions in daily participation across both biological and social aspects of functioning.<sup>3</sup>

Globally, about 180–220 million youth experience disabilities, including physical and sensory impairments.<sup>4</sup> Young people with disabilities (YPWDs) constitute one of the most marginalized and economically disadvantaged groups within the global youth population.<sup>5,6</sup> Although intellectual and other forms of disabilities exist, such

\* Corresponding author. Faculty of Nursing, University of Alberta, Canada.

E-mail address: [meherali@ualberta.ca](mailto:meherali@ualberta.ca) (S. Meherali).

<https://doi.org/10.1016/j.dhjo.2026.102087>

Received 24 November 2025; Received in revised form 5 May 2026; Accepted 11 May 2026

Available online 15 May 2026

1936-6574/© 2026 The Authors. Published by Elsevier Inc. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

as autism spectrum disorder, dyslexia, depression, and aphasia, physical and sensory disabilities are more commonly reported and often have a great impact on daily functioning.<sup>7,8</sup> Physical disability refers to impairments that limit a person's movement or physical functioning, such as paralysis, limb loss, or muscular disorders.<sup>3,4</sup> Sensory disability involves the loss or impairment of the senses, primarily vision and hearing, for example, blindness or deafness.<sup>2,3</sup> Physical disabilities significantly affect mobility, daily functioning, and independence, often requiring youth to rely on others for routine activities.<sup>9</sup> Globally, physical inactivity associated contributes to an estimated 5.3 million deaths and healthcare costs of US\$53.8 billion per year.<sup>9</sup> Beyond functional limitations, youth with physical disabilities often face social stigma, exclusion, and discrimination, which can negatively impact their mental health, well-being, and quality of life.<sup>10,11</sup> Similarly, sensory disabilities, such as hearing or vision impairments, are among the most common types of disability, affecting approximately 13% of youth globally as compared to conditions like cerebral palsy which are less prevalent (around .2–.3%).<sup>7,8</sup> Youth with sensory disabilities face similar social and functional barriers, including challenges in completing daily tasks, navigating social interactions,<sup>12</sup> and being accepted within their communities, often leading to social isolation and marginalization.

Young people with disabilities have the same sexual and reproductive health (SRH) needs and rights as their peers, as SRH is a fundamental aspect of overall health and a basic human right.<sup>13</sup> Accessing SRH information and services by YPWDs, enable them to safeguard against sexually transmitted infections (STIs), prevent unsafe abortions and unintended pregnancies in a timely manner and reduce their vulnerability to sexual abuse and exploitation.<sup>14</sup> Moreover, SRH support also plays a critical role in fostering self-esteem, bodily autonomy, emotional well-being, and social inclusion, which are essential for the holistic development of young people with or without disability equally.<sup>13,14</sup> Despite these benefits, YPWDs face greater barriers to accessing accurate SRH information and services.<sup>15</sup> These issues are driven by inadequate healthcare infrastructure and the absence of inclusive policies, which limit the autonomy of YPWDs in making informed decisions about their SRH and needs.<sup>15,16</sup> Moreover, discrimination and misconceptions about their sexuality and ability to have sexual relationships further hinder their access to SRH resources.<sup>10,11</sup> These barriers among YPWDs lead to adverse SRH outcomes, such as reluctance to engage in intimate relationships and exclusion from SRH programs.<sup>14,15</sup> Moreover, YPWDs are more at risk of sexual abuse, and they require tailored support to navigate their SRH needs.<sup>10,11</sup> Because they often rely on caregivers, translators, or support persons for daily activities, their opportunities for privacy are limited.<sup>16,17</sup> This lack of privacy can prevent them from asking sensitive questions, disclosing abuse, or independently accessing SRH services, highlighting the need for support systems that ensure both accessibility and confidentiality.<sup>16,17</sup>

The high prevalence and significant social, health, and economic consequences of physical and sensory disabilities highlight the importance of addressing the needs of these youth, particularly to ensure equitable access to SRH information and services. Efforts to improve SRH services for YPWDs require a strong understanding of the barriers and facilitators that influence YPWDs access and utilization. These factors can vary significantly depending on cultural, national, and disability-specific contexts.<sup>18,19</sup> While previous reviews have examined SRH among people with disabilities broadly, they have rarely distinguished between disability types or youth in particular. This scoping review specifically focuses on young people with physical and sensory disabilities, who may face distinct accessibility and communication barriers. A scoping review approach allows for mapping the breadth of existing evidence across diverse contexts and identifying key knowledge gaps to inform more inclusive SRH policies, programs, and future research.

The findings will support the development of more inclusive, accessible, and informed SRH policies, programs, and future research.

## Objectives of the study

To explore the existing literature regarding barriers and facilitators of SRH services utilization among YPWDs (i.e., sensory and physical disabilities).

## Research question

What are the barriers and facilitators of SRH services utilization among young people with sensory and physical disabilities?

## Conceptual framework

In our scoping review of exploring the barriers and facilitators of SRH service utilization among YPWDs, we used the social model of disability as our guiding framework Fig. 1<sup>20</sup>. This model emphasizes the importance of empowering individuals with disabilities to live independently and fully engage in society. Building on the social model of disability and the independent living model, this framework outlines how various intersecting factors influence SRH service utilization among YPWDs.<sup>20</sup> These factors include individual elements such as personal beliefs and behaviors, social and community norms related to disability and sexuality, the accessibility of health services, institutional support systems, and structural barriers, such as legal frameworks and societal attitudes towards disability and sexual health.<sup>20</sup> By adopting this multidimensional approach, our review aims to offer a comprehensive understanding of the factors that either facilitate or hinder SRH service utilization among YPWDs.

## Methodology

We used the Joanna Briggs Institute (JBI) scoping review methodology.<sup>18</sup> The scoping review has gained traction in health research due to its effectiveness in mapping the breadth and depth of evidence and its ability to identify gaps in the literature on complex issues.<sup>18,19</sup> To ensure transparency and complete reporting in this scoping review, the PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews) reporting guidelines were used.<sup>21</sup> This review is registered with OSF (Open Science Framework), doi: [10.17605/OSF.IO/WJEPH](https://doi.org/10.17605/OSF.IO/WJEPH).

## Eligibility criteria

The Population, Concept, and Context (PCC) approach was used to determine the eligibility criteria. The **Population** includes YPWDs (Physical and sensory disability) aged 10 to 24 years, encompassing individuals of all gender identities, including male, female, and gender diverse individuals. The **Concept** focuses on the barriers and facilitators influencing the utilization of SRH services by this population. The **Context** includes studies conducted globally and published in English from 2010 to July 15, 2025. This review considered all study designs, including quantitative, qualitative, mixed-methods research, and grey literature such as reports and theses. Studies were excluded if they did not specifically address disability or if the information related to SRH service utilization outcomes was unclear or not separately reported.

## Data sources and search strategy

A systematic literature search was conducted by an experienced health sciences librarian (MK) to identify all relevant studies. Searches were performed in the following databases: Ovid MEDLINE, and the Cochrane Central Register of Controlled Trials, which host a wealth of peer-reviewed literature. Other crucial sources encompass EMBASE (Excerpta Medica), CINAHL (Cumulative Index to Nursing and Allied Health Literature), and PsycINFO (Psychological Abstracts). Additional evidence was gathered through other search methods, including hand

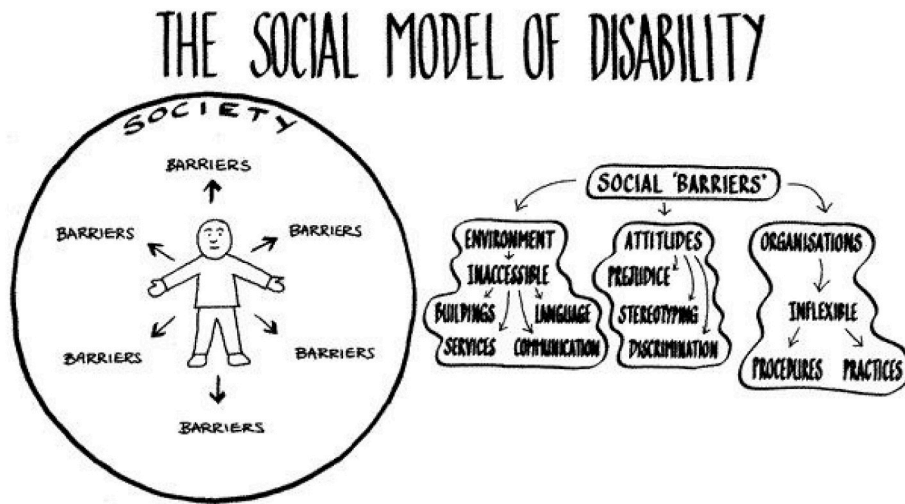


Fig. 1. Social model of disability

Adapted from University of Illinois Library. *Disability Theory* University of Illinois Library LibGuides, 11 Oct. 2024, <https://guides.library.illinois.edu/disabilitytheory>.

searches of reference lists and forward citation searches using Scopus for papers to be included in the scoping review. Lastly, the team examined grey literature on the topic using Google and Google Scholar, along with targeted searches of relevant organizational and governmental websites (see **Supplementary 1** for the complete search strategy).

**Study selection and screening**

We conducted a comprehensive search, including quantitative and qualitative studies and grey literature from the global context. We identified 2010 records from the databases, and all identified studies were imported into Covidence,<sup>22</sup> an online software for screening and

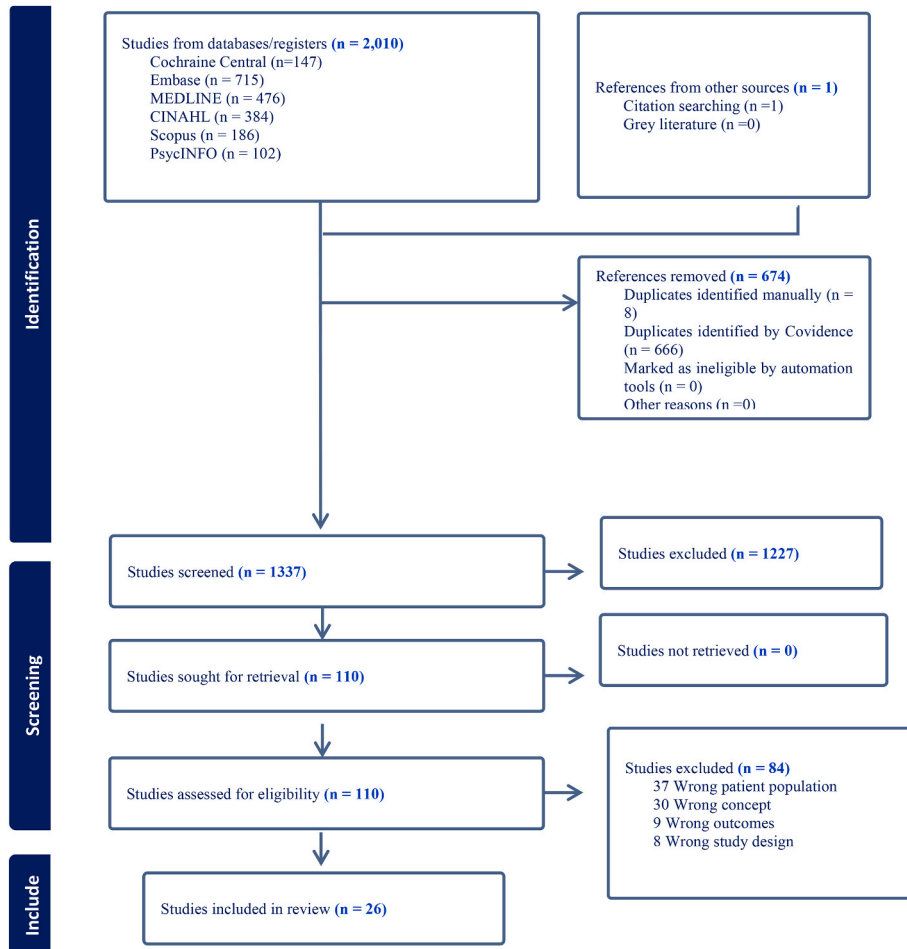


Fig. 2. PRISMA Flow diagram.

data management. Two independent reviewers (SA, SI) conducted the title and abstract screening, followed by full-text review to determine inclusion. Any disagreements between the two reviewers were first resolved through discussion. For the few cases where consensus could not be reached, a third reviewer (SM) made the final decision, ensuring consistency and rigor in study selection. After title/abstract and full-text screening, a total of 26 studies were included in the review, which met the eligibility criteria (PRISMA flow diagram, Fig. 2). A total of 84 studies were excluded, including 37 due to wrong patient population (e.g., adult populations or individuals without disabilities), 21 for wrong concept (i.e., the study did not address the main topic of interest), 9 for wrong outcomes, and 8 for wrong study design (e.g., review articles rather than primary studies). Data extraction was also carried out independently by two reviewers using a standardized Word template, capturing key information relevant to the review objectives, including authorship, publication year, country of origin, study design, participant demographics, sample size, sampling methodology, study settings, identified barriers and enablers, and key findings. For studies reporting age ranges extending beyond 10-24 years, we extracted only data relevant to the 10-24 age group whenever available. If age-stratified results were not provided, the study was included only if the majority of participants fell within the target age range.

Two reviewers then independently coded the data using a deductive approach informed by the social model of disability, identifying barriers and facilitators reported in the studies. Codes were compared, and discrepancies were resolved through discussion. Through an iterative process, similar codes were grouped into six barrier categories and corresponding facilitator categories. The categories were refined and finalized collaboratively by the review team to ensure they accurately reflected the data.

### Operational definitions

- Young people: The World Health Organization defines young people as individuals aged between 10 and 24 years.<sup>1</sup>
- Disability: For this scoping review, physical and sensory disabilities was adapted from WHO and previous literature defined as *“the problem or limitation in the body functions and daily activities of an individual that are related to motor impairments (such as muscular, neurological, or skeletal systems) and sensory impairments (such as blindness, deafness, neuropathy, and anosmia).”*<sup>2</sup>
- The definition of SRH by WHO was used: a person's right to a healthy body and the autonomy, education, and healthcare to freely decide whom to have sex with and how to avoid sexually transmitted infections or unintended pregnancy.<sup>23</sup>

### Findings/results

A total of 26 studies were included in this scoping review, exploring barriers and facilitators to SRH services among YPWDs (Table 1). The majority of which (23 studies) were conducted in low- and middle-income countries (LMICs), including Ethiopia, Fiji, Ghana, Nepal, Nigeria, Tanzania, the Philippines, and Zambia. Only three studies originated from high-income countries (HICs), two from the United States and one from Germany<sup>24–26</sup>. This distribution reflects that the existing evidence on SRH access among YPWDs is predominantly generated in LMIC settings, where structural, sociocultural, and health system challenges related to disability and SRH access have been more frequently examined. The methodological designs varied across the included studies. Quantitative surveys dominated (n = 14), including large-scale facility- or community-based cross-sectional surveys<sup>24–36</sup>. Qualitative designs (n = 9) explored lived experiences through interviews, focus groups, and participatory approaches<sup>37–45</sup>. Three studies adopted mixed-methods approaches, combining surveys with interviews or focus groups for triangulation<sup>46–48</sup>. The included studies collectively represented a quantitative sample size of 21,454

participants and a qualitative pool of 667 participants. The largest study was a U.S. school-based survey with over 7000 adolescents with physical disabilities.<sup>24</sup> Across the studies, a range of disability types were included. Hearing impairments were the most frequently studied (n = 20)<sup>26,30–45,47,48</sup>. Visual impairments were also common (n = 15)<sup>25,26,30–37,41,44–46,48</sup>, followed by physical disabilities (n = 11)<sup>24,25,27,29,33,35–37,39,41,46</sup>.

### Barriers to SRH utilization among young people with disabilities

There are six main categories of barriers identified from the included studies:

#### 1. Communication Barriers

Communication barriers are consistently identified as a major obstacle to accessing SRH services among YPWDs across the included studies<sup>26,32,35,38,42–44,46</sup>. For instance, a study in Nigeria found that 40.5% of hearing-impaired girls experienced communication challenges, largely due to the lack of interpreters, leading to feelings of embarrassment and concerns about confidentiality.<sup>16,44</sup> Similar issues were reported in other studies, which emphasized the absence of sign language and interpreters as key barriers to accessing SRH care.<sup>43,46</sup> Moreover, the exclusion of sign language from SRH curricula further limits access to vital information, particularly for marginalized groups such as YPWDs, including gender diverse individuals.<sup>38</sup> Deaf learners cannot fully engage with material in their primary language and cultural context. This also compounds barriers already faced by marginalized groups, such as stigma, discrimination, and a lack of inclusive, culturally tailored resources.<sup>38</sup> Apart from this, in some contexts, teachers were reported as unprepared to provide age-appropriate sexual health education for disabled youth, and there is no standardized approach to integrating disability into SRH curricula.<sup>29,30</sup> Additionally, many adolescents had not discussed SRH topics with their parents and were unaware of available SRH services.<sup>45,48</sup> Barriers such as shyness, fear, and misinformation were found to contribute to low contraceptive use among YPWDs.<sup>29,34</sup> This gap in accessible communication, especially in educational and healthcare settings, disproportionately affects YPWDs (hearing impairments),<sup>35,44</sup> indicating a broader systemic issue in the delivery of inclusive SRH services for YPWDs.<sup>29,33,43</sup>

#### 2. Health System Barriers

Health system-related limitations emerged as frequently reported barriers to accessing SRH services among YPWDs.<sup>29,33,37,39,40,46</sup> Multiple studies identified logistical and facility-level challenges faced by YPWDs (physical and sensory impairments). These included barriers such as physically inaccessible health facilities, often located far from where they live, lack of assistive support (such as mobility aids), and the absence of necessary accommodations to meet their specific needs within healthcare settings, such as accessible pathways including ramp.<sup>29,39,46</sup> Moreover, YPWDs frequently face transportation challenges and high service costs that hinder their access to SRH services.<sup>28,36,37,39,43,46,48</sup> Furthermore, barriers including long travel distances, inaccessible facilities, and unaffordable fees further complicate the SRH accessibility<sup>33,34</sup>. Moreover, negative attitudes and discriminatory behavior by healthcare providers, such as impatience with communication barriers, lack of empathy, and unwillingness to engage, were consistently reported, contributing to feelings of anxiety and mistrust among YPWDs.<sup>36,40</sup> These systemic shortcomings were particularly evident in school, university and healthcare settings, where inaccessible environments and a lack of support services left many students with disabilities underserved and excluded from essential SRH information and care.<sup>32</sup>

#### 3. Sociocultural Barriers

**Table 1**  
Data extraction table of included studies.

SR#	Author(s), Year	Study Design	Study Title	Age (Yrs)	Gender	Country/Region	Sample Size	Type of Disability	Barriers Identified	Key Findings/Outcomes
1	Aderemi et al., 2014	Facility-based survey	Predictors of voluntary HIV counselling and testing services utilization among people with disabilities in Addis Ababa, Ethiopia	15–49	Both (Male&Female)	Addis Ababa, Ethiopia	Convenience (n = 412)	Physical/Mental/Intellectual	Living with parents; type of disability; sparse predictors, religion, lack of comprehensive HIV knowledge	HIV testing prevalence 53.2%.
2	Alemu & Fantahun, 2011	Cross-sectional survey	Sexual and reproductive health status and related problems of young people with disabilities in selected associations of people with disability, Addis Ababa, Ethiopia.	15–19	Both (Male&Female)	Addis Ababa, Ethiopia	Systematic (n = 384)	Physical	Social Stigma, low Socio economic status, poor SRH awareness, low contraceptive use, vulnerability to sexual abuse/ commercial sex, Gender disparities, Poor access to health, Poor education	Unintended pregnancy 62.5% (50% abortions), risky sex, STIs 25.3%, SRH utilization 33.3%, Multiple partners 58.6%, casual sex 20.7%, commercial sex partners 18%, HIV service utilization (33.1%-55.5%)
3	Alriksson-Schmidt et al., 2010	YRBS national survey	Are adolescent girls with a physical disability at increased risk for sexual violence?	15–19	Female	U.S.A	n = 7193	Physical	Forced sex/sexual violence, lack of school health, physical limitations, gender disparities	Girls with disabilities had higher forced sex (19.6% vs 9.4%), AOR 1.57.
4	Arulogun et al., 2013	Cross-sectional	Experiences of girls with hearing impairment in accessing reproductive health care services in Ibadan, Nigeria.	11–24	Female	Ibadan, Nigeria	Purposive (n = 167)	Hearing	Communication barriers 40.5%, lack of interpreters, unemployment, financial barriers, lack of confidentiality, faced embarrassment 36.7%, felt anxiety	85.6% willing to use inclusive services. Employment increased access.
5	Biggs et al., 2023	Cross-sectional (online)	Access to Reproductive Health Services Among People with Disabilities.	15–49	Both LGBTQAI	US	Probability (n = 6841)	Vision, Hearing, Communication, Mobility	Logistical barriers (50.7%), access barriers (49.9%), multiple disabilities worsened access, medical mistreatment (49.6%)	High disparities, esp. communication disability (65.1%), ADL disability (75.3%).
6	Botfield et al., 2021	Pre/post survey	Sexuality education for primary school students with disability in Fiji.	15–19	Both (Male&Female)	Fiji	Schools (n = 60)	Mixed disabilities	Lack of disability-inclusive sexuality education, unprepared teachers, Limited access to SRH content	Improved knowledge of consent/ boundaries via inclusive CSE project.
7	Burke et al., 2017	Qualitative peer-to-peer	A qualitative study to explore the barriers and enablers for young people with disabilities to access sexual and reproductive health services in Senegal.	18–24	Both (Male&Female)	Senegal	FGDs/IDIs (n = 144)	Visual, Hearing, Physical	Conservative norms, financial barriers, fear of stigma, Gender disparity, Poor SRH accessibility, negative attitude towards contraception, misconceptions, unreliable sources of SRH information, sexual violence and its effects	SRH access hindered, need for provider training and policy reforms.
8	Devkota et al., 2018	Mixed methods	Are maternal healthcare services accessible to vulnerable group? A study among women with disabilities in rural Nepal.	15–49	Female	Rural Nepal	Survey (n = 354) + IDIs	Physical, Hearing, Visual	Poor accessibility, Poor infrastructure (lack of ramps, narrow doorways), lack of transport, bad roads, poor provider attitudes) neglect, rudeness, disrespect), financial costs, Lack of Disability-Friendly Equipment: lack of adapted beds, toilets, and other disability-specific equipment. Lack of trained staff and inadequate information	63% physical disabilities. Need culturally acceptable and inclusive SRH services.
9	Gomez & Geneta, 2021	Qualitative	Curbing the Risks: Toward a Transdisciplinary Sexual Health	19–24	Both (Male&Female)	Philippines	Purposive (n = 6)	Hearing	Lack of trained educators, poor accessibility, limited funding, Lack of disability based online	Unique Deaf LGBTQ + sexual experiences, highlight inclusive program needs.

(continued on next page)

Table 1 (continued)

SR#	Author(s), Year	Study Design	Study Title	Age (Yrs)	Gender	Country/Region	Sample Size	Type of Disability	Barriers Identified	Key Findings/Outcomes
10	Kassa, 2014	Cross-sectional survey	Literacy Program for Young Adults Who are Deaf and LGBT+. Sexuality and sexual reproductive health of disabled young people in Ethiopia.	10–24	Female) (LGBTQ+) Both (Male& Female)	Ethiopia	Probability (n = 426)	Hearing, Mobility, Visual	sign language resources, Lack of curriculum developers Low contraceptive use, rape (first intercourse), risky behaviors (casual sex, commercial sex, multiple partner), substance use, unintended pregnancy, STIs and abortion, Low SRH awareness and knowledge	Mobility impairment (41.5%), followed by visual (23.0%) and hearing impairments (19.2%).
11	Jacobs et al., 2023	Qualitative case study	Perceptions of youth-friendly sexual and reproductive health services in selected Higher and Tertiary Education Institutions of Zambia: A qualitative study on the perspectives of young people and healthcare providers.	18–24	All incl. LGBTQ+	Zambia	HTEIs (n = 112)	Mobility	Unfavorable infrastructural design, high cost, long waits, non-inclusive staff, Low supplies, Poor staff attitude	Systemic gaps remain in higher education. Affordability will improve accessibility
12	Kassa et al., 2016	Cross-sectional	Sexual and reproductive health of young people with disability in Ethiopia: a study on knowledge, attitude and practice: a cross-sectional study.	10–24	Both (Male& Female)	Addis Ababa, Ethiopia	n = 426	Mobility, Visual, Hearing	Low SRH/HIV awareness, poor parent communication, stigma, Negative attitude towards SRH, Low awareness about SRH facility	Awareness of SRH s64.6%, Parents rarely discussed SRH (77.9%), .21 .65 % anticipate HIV risk
13	Kumi-Kyereme, 2021	Cross-sectional	Sexual and reproductive health services utilization amongst in-school young people with disabilities in Ghana.	10–24	Both (Male& Female)	Ghana	Special schools (n = 2114)	Hearing, Visual	Location of YPWD-distance from SRH facility, Care needs, insurance, financial barriers, communication Issues, Low awareness of SRH/HIV and facility	51.9% sexually active (marital status, living in an orphanage, growing up in a family with separated parents, and being Orthodox or other Christians), Awareness of SRH s64.6% Parents rarely discussed SRH (77.9%). Poor knowledge preventing HIV.21 .65 % anticipate HIV risk, low usage rate of SRH services among YPWD
14	Mprah, 2013	Mixed methods	Exploring Knowledge and Attitudes Towards HIV/AIDS among Deaf People in Ghana.	>18	Both (Male& Female)	Ghana	Purposive (n = 179)	Hearing	Low HIV/AIDS knowledge, stigma, gender inequality	SRH utilization 70%, (male 67%). Blind versus deaf utilization (OR = 1.45, 95% CI = 1.26–3.11)
15	Mprah et al., 2022	Qualitative (FGDs + IDIs)	Barriers to utilization of sexual and reproductive health services among young deaf persons in Ghana.	>19	Both (Male& Female)	Ghana	Purposive (n = 60)	Hearing	Comm. challenges, negative provider attitudes, inaccessible information of SRH, low confidence, financial issue	Occasionally depending on health care workers, peers' dependable source for information,
16	Mesfin, 2021	Cross-sectional (institutional)	Disparities in Sexual and Reproductive Health Service Utilization and Associated Factors among Adolescents with and without Disability in Southern Ethiopia	15–19	Both (Male& Female)	Southern Ethiopia	Multistage (n = 422)	Visual, Hearing, Physical	Lack of awareness, neglect from health care worker, societal stigma, forced sex, substance use, young age (9th/10th grade), early sexual debut, behavioral issues (self-arm, substance abuse, forced sex)	Disabled youth as sexually active as peers; unmet SRH needs.
17	Mesiäisleshto et al., 2021	Qualitative MEBS	Disparities in Accessing Sexual and Reproductive Health Services at the Intersection of Disability and Female Adolescence in Tanzania.	10–19	Female	Tanzania	Purposive (n = 136)	Physical, Hearing, Visual, Albinism, Intellectual	Discrimination, staff neglect, inaccessibility, and confidentiality issues. Communication issues, patient blaming	SRHR utilization 32.2%. Good peer/HCP discussion improved use.

(continued on next page)

Table 1 (continued)

SR#	Author(s), Year	Study Design	Study Title	Age (Yrs)	Gender	Country/Region	Sample Size	Type of Disability	Barriers Identified	Key Findings/Outcomes
18	Mills, 2020	Qualitative	Navigating sexual and reproductive health issues: Voices of deaf adolescents in a residential school in Ghana.	15–19	Both (Male&Female)	Ghana	School-based (n = 25)	Hearing	Communication barriers, unsafe sex, normalized forced sex, provider neglect, privacy and confidentiality compromised, discrimination and stigma, sexual violence and exploitation, unsafe sex, type of disability, financial issues, Poor accessibility	Policy must address disabled girls' SRH, and provider empathy is needed.
19	Ngilangwa et al., 2016	Cross-sectional (mixed)	Accessibility to sexual and reproductive health and rights education among marginalized youth in selected districts of Tanzania.	10–24	Both (Male&Female)	Tanzania	Purposive (n = 398)	Visual, Hearing	Cultural stigma, poor parent communication, inaccessible SRH services, unsafe information sources, and financial barriers, negative attitude of health care workers, unemployment, Unsupportive facilities, poor knowledge, stigma, fear/shyness	High unwanted pregnancies, unsafe abortions, complications.
20	Obasi et al., 2019	Cross-sectional	Sexual and reproductive health of adolescents in schools for people with disabilities.	15–19	Both (Male&Female)	Ghana	Systematic (n = 357)	Intellectual, Hearing, Visual		Peer educators' primary source of SRHR information for 36.7% Radio was the second most popular mass media 69.6%STDs and HIV/AIDS information access 55.1% awareness of SRHR-related laws 46.3%communicate with parents/guardians HIV/AIDS was the most discussed SRHR topic National HIV targets for reaching disabled populations have not been fulfilled
21	Saulo et al., 2012	Qualitative interviews	Access to healthcare for disabled persons. How are blind people reached by HIV services?	>17	Both (Male&Female)	Uganda	Purposive (n = 17)	Visual	Provider communication issues, harassment at health facility, poor services, societal stigma, dependency, issues of confidentiality and discrimination, lacked direct, accessible HIV-related content for blinds	
22	Shehu et al., 2023	Community cross-sectional	Youths with disabilities: Utilization and predictors of Youths Friendly Reproductive Health Services in Dessie City Administration, North East Ethiopia, 2021: A cross-sectional study	15–19	Both (Male&Female)	NE Ethiopia	Systematic (n = 817)	Visual, Physical, Hearing	Infrastructural gaps, poor accessibility to services, communication gaps/language barriers, social stigma, poor provider attitudes and knowledge, poor confidence, and sexual exploitation, poor sources of information	Blind rely on others for HIV info. Abstinence prioritized.
23	Suariyani et al., 2020	Qualitative	Reproductive Health Services for Adolescents with Hearing Impairment in Indonesia: Expectations and Reality.	16–17	Both (Male&Female)	Indonesia	Purposive (n = 10)	Hearing, Visual	Low literacy, young age, parental dependence, lack SRH knowledge,	58% utilized youth-friendly SRHS
24	Wienholz et al., 2016	Cross-sectional	Sexual Experiences of Adolescents with and Without Disabilities: Results from a Cross-Sectional Study	12–18	Both (Male&Female)	Germany	Schools (n = 410)	Physical, Visual, Hearing	Gender disparities, poor SRH education, communication barriers need based services (information sources and services specific for blind), social stigma, poor facilities, gender disparities, parental overprotection and lack of SRH communication, early	Online info (YouTube/Google) primary SRH sources.

(continued on next page)

Table 1 (continued)

SR#	Author(s), Year	Study Design	Study Title	Age (Yrs)	Gender	Country/Region	Sample Size	Type of Disability	Barriers Identified	Key Findings/Outcomes
25	Zelege et al., 2024	Cross-sectional	Sexual and Reproductive Health Services Utilization and Associated Factors among Disabled Students in Selected Public Universities of Ethiopia	15–25	Both (Male&Female)	Ethiopia	Random (n = 581)	Visual, Physical, Hearing	sexual onset, service in availability communication issues stigma, lack of disability-friendly facilities. Misconceptions around contraceptives Gender disparities -poor access for women, bad touch was common Breach of confidentiality in clinics. Maltreatment by HCWs Negative community attitudes. Poor wheelchair-friendly infrastructure. Negative attitudes of friends. Lack of family care/support. Fear of discussing SRH with parents. Low motivation to seek SRHSs. Lack of SRH knowledge. Poor socio-demographic status	36.2% used SRHS. Stable relationship & age predicted activity.
26	Mathabela et al., 2024	Qualitative descriptive		10–24	Both (Male&Female)	South Africa	Purposive (n = 27)	Physical		Public health strategies & education urgently needed.

Sociocultural norms and stigma were consistently identified as significant barriers to accessing SRH services among YPWDs.<sup>31–34,37,41,43,45</sup> Conservative community attitudes and low parental literacy levels contribute to persistent gender disparities and limited awareness of SRH issues.<sup>31,32</sup> Stigma surrounding premarital sex fosters secrecy, misinformation, and fear among YPWDs, which in turn discourages open communication and help-seeking behaviors.<sup>32,37</sup> Moreover, societal stigma, combined with factors such as early sexual activity, often leads to neglect and inadequate support from healthcare providers.<sup>33</sup> For example, providers may avoid discussing SRH needs with young people perceived as “inappropriate or underage” clients.<sup>33</sup> Additionally, cultural taboos and silence around sexuality within families, such as parents avoiding conversations about puberty or contraception, limit SRH knowledge among youth with disabilities, particularly those living with their families.<sup>41,44</sup> These sociocultural dynamics create an environment where YPWDs remain vulnerable to poor SRH outcomes due to a lack of information and supportive services.

#### 4. Knowledge and Awareness Gaps

Low levels of SRH awareness among YPWDs were widely documented across studies.<sup>29,30,34,42,43,45,47</sup> A key contributor to this gap is the generally low level of education and poor literacy among YPWDs.<sup>29,29,42,45,46</sup> For example, students with sensory impairments, such as those with hearing and vision difficulties, often have a limited understanding of HIV/AIDS<sup>42,47</sup> because educational materials and teaching methods are not accessible to them, such as the absence of sign language interpretation or visual aids.<sup>43,47</sup> This lack of accessible information also contributes to misconceptions and stigma toward HIV-positive YPWDs.<sup>42</sup>

#### 5. Violence and exploitation

Sexual violence represents a significant barrier preventing YPWDs from accessing SRH services.<sup>28,31,33,37,40</sup> High rates of forced sex, such as the 19.6% reported among physically disabled girls in the U.S., exacerbate vulnerabilities and complicate care-seeking.<sup>28</sup> Early sexual debut, rape, and unintended pregnancies, particularly among girls with hearing or multiple impairments, further increase the need for SRH support while simultaneously creating challenges in accessing it.<sup>31,33</sup> For example, fear of judgment, trauma, and negative reactions from parents or healthcare providers also deters adolescents from seeking help, leaving many without adequate protection or services.<sup>37,40</sup>

#### 6. Intersectional Vulnerabilities

Youth with intersecting identities, such as being gender diverse individuals, from low-income backgrounds, or having multiple disabilities, face compounded barriers to accessing SRH services.<sup>28,38,42</sup> For instance, physical and sensory YPWDs gender diverse youth often lack tailored SRH services that address their specific needs, resulting in significant gaps in care.<sup>38,39</sup> A large-scale study from the United States highlighted that gender diverse individuals frequently experience medical mistreatment, including being mocked, humiliated, or neglected by healthcare providers.<sup>25</sup> This mistreatment contributes to poorer quality of care and, in some cases, leads to consideration of self-managed abortions due to inadequate access to supportive services.<sup>25</sup> Discrimination was also found to intersect with factors such as gender, age, and disability, further marginalizing YPWDs in various contexts.<sup>42</sup> Additionally, YPWDs, especially illiterate females in conservative communities face multiple layers of disadvantage that restrict their SRH access and awareness.<sup>28,32</sup>

## Facilitators of SRH service utilization among young people with disabilities

This review identified several key factors that contribute to improved utilization of SRH services among YPWDs across the 26 included studies.

Comprehensive HIV knowledge was found across various studies to be linked with safer choices about contraceptives and increased access to SRH services among YPWDs, such as better understanding of prevention methods and risks.<sup>27,42,44</sup> Similarly, family support, such as living with a spouse or extended family members, was associated with higher utilization of SRH services by providing emotional and practical assistance.<sup>27</sup> Moreover, one study conducted in Ethiopia highlighted that religious affiliation, particularly Christianity,<sup>27</sup> was associated with greater SRH awareness compared to other religions, possibly due to faith communities promoting health education and open discussions on sexual health.<sup>28</sup> Furthermore, awareness of sexual violence risks among high school female students and improved accessibility of services for hearing-impaired individuals were frequently noted as important enablers.<sup>28,36</sup> Practical considerations, such as convenient campus hours and proximity to health facilities, also supported greater SRH service use.<sup>39</sup> Affordability, particularly low service costs, emerged as a key determinant in several studies.<sup>28,42,44</sup> Moreover, the role of family and caregiver support for females, especially for menstrual hygiene management, was emphasized as critical in facilitating access to SRH services among YPWDs.<sup>44</sup> Lastly, the increasing accessibility of online reproductive health information was identified as a valuable resource contributing to improved SRH awareness and utilization among YPWDs.<sup>27</sup>

## Discussion

This scoping review synthesized existing literature on SRH service utilization among YPWDs, identifying a range of barriers and facilitators influencing their access to care. The findings reveal that despite growing attention to the SRH needs of YPWDs, significant gaps persist in ensuring equitable access to information, education, and services. Our findings suggest that YPWDs face multifaceted and compounding challenges that not only restrict their access to essential SRH services but also put them at increased risk of health inequities, sexual violence, and systemic exclusion. These results align with and extend previous studies conducted in both low- and high-income countries.<sup>9,11,13,14</sup>

A recurring and critical issue identified in this review is the lack of access to appropriate and inclusive SRH education. This aligns with earlier research showing that many YPWDs are excluded from sexual health education in schools, often due to ableist assumptions or cultural discomfort with discussing sexuality in relation to disability.<sup>10-12</sup> The early denial of SRH knowledge leaves youth unprepared to make informed decisions about their bodies and relationships, increasing their vulnerability to exploitation, unsafe sexual practices, and preventable health issues.<sup>14</sup> This exclusion perpetuates a cycle of disempowerment, where YPWDs are unable to exercise their rights or seek help when needed.<sup>49,50</sup> Moreover, communication barriers are another substantial obstacle, particularly for those with sensory or physical disabilities. The lack of braille materials, sign language interpreters, and appropriately trained healthcare providers limits not only the quantity of care available to YPWDs but also its quality and safety.<sup>33</sup> Such communication gaps were also observed in other studies, including in Ethiopia and Ghana, where healthcare providers were often unequipped to interact effectively with disabled patients.<sup>33,34</sup> These findings suggest that health systems, as they currently operate, are largely unprepared to meet the diverse needs of young disabled populations.

Physical inaccessibility also emerged as a major deterrent to service utilization. Many healthcare facilities lack basic accommodations such as ramps, wide doorways, adjustable examination tables, or accessible toilets. These challenges are echoed across the literature and represent a form of environmental exclusion that reinforces inequality.<sup>14,49,50</sup>

Moreover, the geographical placement of SRH services is often located far from residential areas, and the associated transportation challenges further compound the inaccessibility problem.<sup>32</sup> Several studies from LMICs have emphasized that many YPWDs rely on companions for mobility, which not only doubles transport costs but also adds logistical and emotional strain.<sup>32,36,46</sup> The impact of such physical exclusion is profound.<sup>50,51</sup> It not only limits timely access to critical services such as contraception, antenatal care, or STI screening, but also reinforces feelings of invisibility, dependency, and disempowerment among disabled youth.<sup>51</sup> Beyond limiting service use, some studies also noted that inaccessible environments contributed to feelings of exclusion and dependence among youth with disabilities. Together, these findings suggest that physical infrastructure and the design of healthcare environments play an important role in shaping the accessibility of SRH services for YPWDs. While this review primarily revealed numerous barriers to access to SRH services among YPWDs, several facilitators were also identified, offering important direction for future interventions. Factors such as family support, access to accurate HIV and contraceptive information, youth-friendly and disability-adapted services, and affordable or free care emerged as significant enablers. These findings are consistent with studies from Ethiopia and the Philippines, which similarly report that supportive family environments and targeted health education improve the uptake of SRH services among YPWDs.<sup>30,38</sup> Notably, access to comprehensive and accessible SRH information empowers YPWDs to make informed decisions, mitigating risks such as unintended pregnancies or STIs. Studies have shown that when SRH education is inclusive, using sign language, braille, or plain language, it increases health-seeking behavior and promotes safer sexual practices.<sup>51,52</sup> Likewise, affordable and accessible healthcare facilities, when combined with trained providers and inclusive design, reduce logistical and psychological barriers to care.<sup>28,36</sup> Additionally, digital tools were identified in some studies as promising facilitators, offering discreet and flexible access to SRH resources.<sup>26</sup> However, these tools must be designed with accessibility in mind, such as screen-reader compatibility, captioning, and user-friendly interfaces or risk reinforcing digital exclusion. These facilitators underscore the need for inclusive, multi-level approaches that address both structural and informational barriers to improve SRH outcomes for YPWDs.

## Implications

Overall, the findings of this review point to a critical need for disability-inclusive, youth-centered, and rights-based approaches to SRH service delivery. Inclusive training for healthcare providers, development of accessible infrastructure, implementation of clear non-discrimination policies, and the integration of SRH content into disability-focused education curricula are essential steps. Furthermore, SRH policies must be designed and evaluated with the active participation of disabled youth themselves, ensuring that their lived experiences inform service design. Failure to address these systemic barriers is not just a matter of poor service provision; it represents a broader neglect of human rights, health equity, and social justice. Without urgent and coordinated action, the SRH needs of YPWDs will remain unmet, reinforcing cycles of vulnerability, dependence, and poor health. Therefore, a multisectoral response involving healthcare, education, technology, legal systems, and community support is imperative to promote full inclusion and dignity for YPWDs.

## Strengths and limitations

One of the key strengths of this scoping review is its comprehensive global scope, incorporating studies from both high-income and low- and middle-income countries. This global inclusion offers a broad and diverse perspective on the barriers and facilitators affecting SRH service utilization among YPWDs, allowing for more generalizable insights. The review also followed a systematic and rigorous methodology, guided by

established frameworks for scoping reviews, enhancing its transparency and reproducibility. Furthermore, findings were contextualized within existing literature, allowing for meaningful comparisons and deeper understanding of patterns across different settings.

Despite its strengths, the review has some limitations. Most notably, it included only studies published in English, which may have excluded relevant research published in other languages. This language restriction potentially limits the diversity of cultural and regional perspectives represented, particularly from non-English-speaking countries. Finally, although the assessment of methodological quality or risk of bias was not done and is not typically required in scoping reviews, the absence of such appraisal may limit the ability to evaluate the robustness and reliability of individual study findings. Moreover, this review has excluded certain groups, including individuals with mental health disabilities, intellectual or learning disabilities, and those who are neurodivergent. This limits the review's comprehensiveness, as these groups may face distinct barriers to SRH access. Furthermore, although the review included studies from both LMICs and HICs, majority were conducted in LMIC settings. This uneven distribution may limit the generalizability of the findings, as structural, sociocultural, and health system challenges differ across contexts.

## Conclusion

In conclusion, this study highlights barriers and facilitators in the SRH service utilization among YPWDs. The review identified common barriers to SRH service use among young people with disabilities, including physical inaccessibility, limited disability-inclusive communication, financial constraints, and social stigma. Gender inequality, cultural taboos, and experiences of sexual violence were also reported. Facilitators included supportive family or caregiver networks, community or religious support, lower disability severity, and access to affordable, disability-adapted services and digital information. Most studies were conducted in LMICs, suggesting that the evidence largely reflects these contexts. A comprehensive, cross-cultural approach is necessary to ensure that YPWDs have access to appropriate healthcare and support, while also fostering societal changes to reduce discrimination. The findings advocate for a collaborative effort across sectors to promote inclusivity and improve SRH services for this underserved population. Future research should focus on identifying effective strategies to overcome these barriers and enhance the well-being of YPWDs.

## CRedit authorship contribution statement

**Sumia Andleeb Abbasi:** Writing – original draft, Software, Formal analysis, Data curation. **Shumaila Batool:** Writing – original draft, Software, Methodology, Formal analysis. **Saba Nisa:** Writing – review & editing, Formal analysis. **Zohra S. Lassi:** Writing – review & editing, Supervision, Methodology, Conceptualization. **Salima Meherali:** Writing – review & editing, Supervision, Methodology, Conceptualization.

## Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.dhjo.2026.102087>.

## References

- World Health Organization. Adolescent and Young Adult Health. Geneva: WHO; [cited 2026 March 24]. Available from: <https://www.who.int/health-topics/adolescent-health>.
- Prevention CfDca. Disability and health overview [cited 2024; Available from: <https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html>]; 2023 February.
- (WHO), W.H.O. *International Classification of Functioning*. Disability and health (ICF). Available from: <https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health>; 2021–2025. Accessed September 3, 2025.
- United Nations, Department of Economic and Social Affairs, Division for Inclusive Social Development. Youth with disabilities. New York: United Nations; [cited 2026 March 24]. Available from: <https://www.un.org/development/desa/youth/youth-with-disabilities.html>.
- Lindsay S, Leo S, Phonepraseuth J, Cao P. A systematic review of racial health disparities among children and youth with physical disabilities. *Disabil Rehabil*. 2025 Jul 3;47(14):3484–3506.
- King T. Bullying and health inequalities for children and adolescents with disability. *Lancet Child Adolesc Health*. 2024 Feb 1;8(2):90–91.
- Allerton LA, Welch V, Emerson E. Health inequalities experienced by children and young people with intellectual disabilities: a review of literature from the United Kingdom. *J Learn Disabil*. 2011 Dec;15(4):269–278.
- Olusanya BO, Smythe T, Ogbu FA, Nair MK, Scher M, Davis AC. Global prevalence of developmental disabilities in children and adolescents: a systematic umbrella review. *Front Public Health*. 2023 Feb 16;11, 1122009.
- Tan V, Lim J, Akksilp K, Chow WL, Ma S, Chen C. The societal cost of modifiable risk factors in Singapore. *BMC Public Health*. 2023 Jul 4;23(1):1285. <https://doi.org/10.1186/s12889-023-16198-2>. Erratum in: *BMC Public Health*. 2023 Oct 16;23(1):1844. doi: 10.1186/s12889-023-16271-w. PMID: 37403019; PMCID: PMC10318651.
- Chatzitheochari S, Butler-Rees A. Disability, social class and stigma: an intersectional analysis of disabled young people's school experiences. *Sociology*. 2023 Oct;57(5):1156–1174.
- Kumar S, Lata S, Verma S. Psycho-social outcomes of disability-related stigma and social exclusion among people with physical disabilities: a systematic review. *Hellenic J Psychol*. 2024 Dec 2;21(3):281–301.
- Denche-Zamorano A, García-Gil MÁ, Mendoza-Muñoz M, Barrios-Fernandez S. Sadness and loneliness in adolescents with physical, sensory or health problems in low/middle-income countries. *Children*. 2023 Jun 1;10(6):996.
- Benoit C, Mellor A, Premji Z. Access to sexual rights for people living with disabilities: assumptions, evidence, and policy outcomes. *Arch Sex Behav*. 2023 Nov; 52(8):3201–3255.
- Seidu AA, Malau-Aduli BS, McBain-Rigg K, Malau-Aduli AE, Emeto TI. A mixed-methods study of the awareness and functionality of sexual and reproductive health services among persons with disability in Ghana. *Reprod Health*. 2023 Oct 31;20(1):162.
- Qi W, et al. Knowledge level and access barriers related to sexual and reproductive health information among youth with disabilities in China: a cross-sectional study. *Reprod Health*. 2023;20(1):84.
- Ganle JK, et al. 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.
- Secor-Turner M, McMorris BJ, Scal P. Improving the sexual health of young people with mobility impairments: challenges and recommendations. *J Pediatr Health Care*. 2017 Sep 1;31(5):578–587.
- Tricco AC, et al. A scoping review on the conduct and reporting of scoping reviews. *BMC Med Res Methodol*. 2016;16:1–10.
- Samaan Z, et al. A systematic scoping review of adherence to reporting guidelines in health care literature. *J Multidiscip Healthc*. 2013;169–188.
- Mladenov T. The social model of disability, the independent living, and the idea of 'care'. *Критика и хуманизъм*. 2021;3(55):9–24.
- Page MJ, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *Br Med J*. 2021;372.
- Covidence Systematic Review Software, Veritas Health Innovation, Melbourne, Australia. Available at: [www.covidence.org](http://www.covidence.org).
- World Health Organization. Sexual Health. Geneva: World Health Organization; [cited 2026 March 24]. Available from: [https://www.who.int/health-topics/sexual-health#tab=tab\\_1](https://www.who.int/health-topics/sexual-health#tab=tab_1).
- Alriksson-Schmidt AI, Armour BS, Thibadeau JK. Are adolescent girls with a physical disability at increased risk for sexual violence? *J Sch Health*. 2010;80(7):361–367.
- Biggs MA, et al. Access to reproductive health services among people with disabilities. *JAMA Netw Open*. 2023;6(11). p. e2344877-e2344877.
- Wienholz S, et al. Sexual experiences of adolescents with and without disabilities: results from a cross-sectional study. *Sex Disabil*. 2016;34:171–182.
- Aderemi TJ, et al. Predictors of voluntary HIV counselling and testing services utilization among people with disabilities in Addis Ababa, Ethiopia. *AIDS Care*. 2014;26(12):1461–1466.
- Alemu T, Fantahun M. Sexual and reproductive health status and related problems of young people with disabilities in selected associations of people with disability, Addis Ababa, Ethiopia. *Ethiop Med J*. 2011;49(2):97–108.
- Botfield JR, et al. Sexuality education for primary school students with disability in Fiji. *Health Educ J*. 2021;80(7):785–798.
- Kassa TA, et al. Sexual and reproductive health of young people with disability in Ethiopia: a study on knowledge, attitude and practice: a cross-sectional study. *Glob Health*. 2016;12:1–11.
- Kassa TA, et al. Sexuality and sexual reproductive health of disabled young people in Ethiopia. *Sex Transm Dis*. 2014;41(10):583–588.
- Kumi-Kyereme A. Sexual and reproductive health services utilisation amongst in-school young people with disabilities in Ghana. *African Journal of Disability (Online)*. 2021;10:1–9.
- Mesfin Y. Disparities in sexual and reproductive health service utilization and associated factors among adolescents with and without disability in southern Ethiopia. *Sci World J*. 2021;2021:1–8.
- Obasi M, et al. Sexual and reproductive health of adolescents in schools for people with disabilities. *Pan African Medical Journal*. 2019;33(1).

35. Shehu EY, et al. Youths with disabilities: utilization and predictors of youths friendly reproductive health services in dessie city administration, North East Ethiopia, 2021: a cross-sectional study. *Health Sci Rep.* 2023;6(7), e1386.
36. Zeleke FT, et al. Sexual and reproductive health services utilization and associated factors among disabled students in selected public universities of Ethiopia. *Sex Disabil.* 2024;1–17.
37. Burke E, et al. A qualitative study to explore the barriers and enablers for young people with disabilities to access sexual and reproductive health services in Senegal. *Reprod Health Matters.* 2017;25(50):43–54.
38. Gomez MGA, Geneta ALP. Curbing the risks: toward a transdisciplinary sexual health literacy program for young adults who are deaf and LGBT+. *Sex Disabil.* 2021; 39(1):195–213.
39. Jacobs C, et al. Perceptions of youth-friendly sexual and reproductive health services in selected higher and tertiary education institutions of Zambia: a qualitative study on the perspectives of young people and healthcare providers. *PLOS Glob Publ Health.* 2023;3(11), e0002650.
40. Mathabela B, Madiba S, Modjadji P. Exploring barriers to accessing sexual and reproductive health services among adolescents and young people with physical disabilities in South Africa. *Int J Environ Res Publ Health.* 2024;21(2):199.
41. Mesiäislehto V, Katsui H, Sambaiga R. Disparities in accessing sexual and reproductive health services at the intersection of disability and female adolescence in Tanzania. *Int J Environ Res Publ Health.* 2021;18(4):1657.
42. Mills AA. Navigating sexual and reproductive health issues: voices of deaf adolescents in a residential school in Ghana. *Child Youth Serv Rev.* 2020;118, 105441.
43. Mprah WK, et al. Barriers to utilization of sexual and reproductive health services among young deaf persons in Ghana. *Afr J Reprod Health.* 2022;26(12):58–66.
44. Saulo B, Walakira E, Darj E. Access to healthcare for disabled persons. How are blind people reached by HIV services? *Sexual & Reproductive Healthcare.* 2012;3(1):49–53.
45. Suariyani NLP, et al. Reproductive health services for adolescents with hearing impairment in Indonesia: expectations and reality. *J Prev Med Publ Health.* 2020;53 (6):487.
46. Devkota HR, et al. Are maternal healthcare services accessible to vulnerable group? A study among women with disabilities in rural Nepal. *PLoS One.* 2018;13(7), e0200370.
47. Mprah WK. Exploring knowledge and attitudes towards HIV/AIDS among deaf people in Ghana. *Disability, CBR & Inclusive Development.* 2013;24(2):22–39.
48. Ngilangwa DP, et al. Accessibility to sexual and reproductive health and rights education among marginalized youth in selected districts of Tanzania. *The Pan African Medical Journal.* 2016;25(suppl 2).
49. Goulden A. 'A lot of social workers don't seem to understand or realize the harm that they cause': disabled young people's experiences with sexual well-being in social work practice. *Br J Soc Work.* 2025 Mar;55(2):644–662.
50. Davies A, O'Leary S, Prioletta J, Shay B, Bryan M, Neustifter O. *Sexuality Education for Disabled Children and Youth in Ontario, Canada: Addressing Epistemic Injustice Through School-Based Sexuality Education.* Children & Society; 2024 Mar 10.
51. Bauer SE, et al. Disability and physical and communication-related barriers to health care related services among Florida residents: a brief report. *Disability and health journal.* 2016;9(3):552–556.
52. Hameed S, Maddams A, Lowe H, Davies L, Khosla R, Shakespeare T. From words to actions: systematic review of interventions to promote sexual and reproductive health of persons with disabilities in low-and middle-income countries. *BMJ Glob Health.* 2020 Oct 15;5(10).