

Original Article

## Exploring Reproductive Health Education Needs and Barriers Among Adolescent Girls with Disabilities: A Qualitative Study



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### ABSTRACT

**Background:** Adolescents with disabilities remain among the most marginalized populations in accessing reproductive health services. Structural inaccessibility, social stigma, and limited awareness among health providers perpetuate inequities that compromise their reproductive rights and well-being. This study aims to explore the reproductive health service needs, experiences, and barriers faced by adolescents with disabilities to inform the development of inclusive and responsive reproductive health programs.

**Methods:** A qualitative exploratory design was employed. Data were collected through in-depth interviews and focus group discussions with adolescents with various disabilities, their parents or caregivers, and key health workers. A total of 12 participants were purposively selected to represent diverse disability types and socio-demographic backgrounds. The Consolidated Criteria for Reporting Qualitative Research (COREQ) was applied in this research. Thematic analysis was conducted using an inductive coding approach to identify emerging patterns related to accessibility, service experience, and social attitudes.

**Results:** Four interrelated themes emerged from the analysis: (1) Limited access and barriers to reproductive health information; (2) Sociocultural stigma and silences surrounding sexuality; (3) Unmet educational and emotional needs; (4) Strategies and aspirations for inclusive reproductive health education. This theme indicated that adolescent girl with disabilities face significant structural and information barriers that limit their ability to access accurate and accessible reproductive health information, thereby increasing their vulnerability to misinformation and unmet health needs.

**Conclusion:** Adolescents with disabilities face multiple and intersecting barriers to accessing reproductive health services. Addressing these challenges requires systemic transformation through disability-sensitive training for health providers and a rights-based, inclusive education that reduces stigma and improves access.

**Keywords:** Adolescents; Disability; Reproductive Health; Sexual Health Education; Health Services Accessibility.

## Implications for Practice:

- Integrating disability-sensitive reproductive health education into school and community programs can improve knowledge, autonomy, and protection against sexual risks.
- Strengthening training for healthcare providers and educators can enhance inclusive communication, improve service quality, and reduce stigma in care delivery.
- Developing culturally adaptable, resource-sensitive interventions can support equitable access to reproductive health education in low-resource, diverse sociocultural settings.

## Introduction

Adolescents, the next generation, play an essential role in life (Romero et al., 2017). Adolescence is a vulnerable period marked by major changes in identity development towards adulthood (Vermeulen et al., 2022). Adolescence is a critical stage of human development characterized by rapid physiological, cognitive, and psychosocial transitions. Among the most crucial dimensions of this developmental phase is the acquisition of knowledge and competencies related to sexual and reproductive health (SRH) (Manze et al., 2022). Comprehensive reproductive health education equips adolescents with the capacity to understand bodily changes, develop autonomy in decision-making, and engage in healthy interpersonal relationships (Hallum-Montes et al., 2016). It also serves as a protective factor against early pregnancy (N. K. T. Agustini & Sagitarini, 2023), sexually transmitted infections, and gender-based violence (Tork & Al Hosis, 2015).

These adolescents are not only normal adolescents, but also adolescents with special needs or disabilities who have limited access to reproductive health information (Du et al., 2022). Adolescents at this stage have not yet achieved mental and social readiness, so they must face many existing pressures and conflicting social situations (Craig et al., 2022). Adolescents

will experience rapid physical changes during puberty, including the ability to carry out the reproductive process (Rodén et al., 2020). However, many adolescents with disabilities still do not understand reproductive health (Craig et al., 2022). Providing information and education for people with disabilities through appropriate educational media will help achieve a higher quality of life, one that is fairer and more prosperous, physically and mentally (Juanita et al., 2023).

Globally, the prevalence of disabilities is such that more than one billion people live with some form of disability, and approximately one in ten are adolescents (Susanti & Kurniasari, 2020). Despite global commitments to health equity, adolescents with disabilities are often left at the margins of reproductive health systems (Pérez-Curiel et al., 2023). They face unique challenges shaped by physical barriers, communication difficulties, and deep-seated social attitudes that perceive disability as a form of limitation rather than diversity (Matin et al., 2021).

This study addresses a significant research gap in understanding the reproductive health education needs of adolescents with disabilities, the existing program, curricula and evidence largely ignore how disability type, communication needs, caregiver roles, stigma and accessibility to enhance knowledge, attitudes, and access to service for this group, leaving policy makers and educators without actionable, evidence-based guidance to develop inclusive sexual and reproductive health education. Adolescents with disabilities are heterogeneous and have distinct learning and communication needs that standard sexual reproductive health curricula (Mathabela & Madiba, 2024). Studies across low- and middle-income countries have revealed that these adolescents with disabilities are more likely

to experience sexual abuse, unintended pregnancies, menstrual hygiene challenges, and limited access to health services compared to their non-disabled peers (Craig et al., 2022). Barriers are multifaceted, encompassing structural, sociocultural, and institutional dimensions. Structural barriers include inaccessible educational materials, the absence of trained teachers, and inadequate enforcement of policies (Brown et al., 2025). Sociocultural barriers are rooted in pervasive stigma, parental overprotection, and misconceptions portraying girls with disabilities as asexual or childlike (Craig et al., 2022), which often result in denial of sexuality education (Singh Shrestha et al., 2022). Institutionally, there is a lack of intersectoral collaboration between education, health, and social service systems. In Indonesia, for example, sexuality and reproductive health education are often integrated into general curricula without adaptations to accommodate learners with varying abilities (Kemenkes RI, 2018). Teachers report insufficient training and resources to deliver disability-sensitive content, while families often lack accurate information or confidence to discuss sexuality with their daughters with disabilities (Craig et al., 2022). Adolescent girls with disabilities often encounter sociocultural stigma surrounding sexuality, which contributes to restricted communication and limited access to reproductive health information. This limited access, in turn, increases the risk of misinformation, inadequate knowledge, and poor reproductive health outcomes. Thus, stigma, restricted access to information, and unmet health needs are interconnected factors shaping their reproductive health experiences.

The conceptual and theoretical framework of Erikson's Psychosocial Theory, particularly the developmental stage of Identity versus Role Confusion, is used to explain adolescents with

disabilities' reproductive health education needs. During this stage, individuals develop a sense of identity, including aspects related to sexuality and personal values. For adolescent girls with disabilities, limited access to accurate reproductive health information and prevailing sociocultural stigma may hinder health identity information, leading to confusion, reduced self-efficacy, and challenges in understanding their reproductive health rights and needs. Psychosocial theory emphasizes that providing accessible, developmentally appropriate reproductive health education is essential for supporting identity formation, fostering healthy relationships, encouraging self-advocacy, and promoting safety. Therefore, understanding psychosocial development is critical in designing sexual reproductive health education programs that meet the unique needs of adolescents with disabilities.

Reproductive sexual education for adolescents with disabilities rarely receives attention from educators (Singh Shrestha et al., 2022). Reproductive sexual education is essential for them, as adolescents with disabilities generally experience the same developmental stages of sexual drive as adolescents in general (Roden et al., 2020). Adolescents experience rapid individual changes, including those with disabilities (Pérez-Curiel et al., 2023). During puberty, adolescents with disabilities often experience social problems, including public-private errors and stranger-friend errors. Public-private errors are characterized by touching genitals, lifting skirts, playing with genitals in public to achieve satisfaction, and even undressing in public (Goli et al., 2020). Stranger-friend errors are characterized by sudden, careless kissing or hugging (Matin et al., 2021).

Contradictory findings regarding the needs of sexual reproductive health in

adolescents with disabilities, whether adolescents with disabilities possess comparable sexual reproductive health knowledge to their peers or experience significantly greater information deficits, and research alternately reports strong demand for sexual reproductive health information or expresses need depending on disability type and communication context ([Mathabela & Madiba, 2024](#)). Caregiver or teacher roles are likewise inconsistently portrayed, with some evidence identifying them as key facilitators of sexual reproductive health learning and other studies presenting them as major barriers due to overprotective beliefs or stigma ([Kuumuori et al., 2020](#)). These inconsistencies largely arise from heterogeneous disability categories, non-standardized assessment tools, and varying levels of curriculum accessibility across studies ([Mesiäislehto & Katsui, 2021](#)). Consequently, there is no coherent, evidence-based understanding of what content, delivery methods, or support systems are most appropriate for adolescents with different disabilities ([Tanabe et al., 2015](#)). This critical gap hinders the design of effective, inclusive reproductive health education interventions. It underscores the need for rigorous, context-sensitive research that clarifies educational needs and identifies strategies that genuinely improve reproductive health outcomes for adolescents with disabilities.

These social problems can place them in risky situations, such as sexual exploitation or legal problems ([Mitchell et al., 2023](#)). The lack of sexual education for adolescents with disabilities makes them more susceptible to manipulation, often making them targets of sexual harassment and sexual exploitation ([Goli et al., 2020](#)). Therefore, reproductive sexual education media for adolescents with disabilities is urgently needed ([Gudlavalleti, 2018](#)).

Existing reproductive sexual education media for adolescents with disabilities have not been able to improve adolescents' understanding of reproductive sexual health ([Goli et al., 2020](#)). Current media are still general and not intended for adolescents with disabilities. Targeted educational media can provide increased knowledge and understanding for message recipients ([Tork & Al Hosis, 2015](#)). Providing health education can increase a person's knowledge, especially adolescents with disabilities ([Craig et al., 2022](#)). In this case, good knowledge regarding reproductive sexual health will increase adolescent awareness, which will have an impact on preventing reproductive sexual harassment in individuals with disabilities. Understanding the reproductive health service needs of adolescents with disabilities is not simply a question of health care provision ([Mesiäislehto & Katsui, 2021](#)). By exploring their lived experiences, this study aims to shed light on how health systems can evolve into truly inclusive systems that view adolescents with disabilities not as passive recipients of care but as active participants and rightful agents of their own reproductive health ([Du et al., 2022](#)). This gap highlights the need for more inclusive approaches in both practice and policy. Integrating disability-sensitive reproductive health education into school curricula, ensuring accessible information formats, and equipping educators and healthcare providers with appropriate skills are critical steps to address these inequities. At the policy level, stronger implementation of inclusive education and health frameworks is required to ensure that adolescents with disabilities are not overlooked. Addressing these gaps is essential to reducing stigma, improving access to information, and promoting equitable reproductive health outcomes.

This study aimed to explore the reproductive health service needs of

adolescents with disabilities from their own perspectives. It aims to illuminate how they perceive, seek, and experience reproductive health services, the barriers they encounter, and the changes they believe are necessary to make these services more inclusive (Du et al., 2022). By amplifying their voices, this research contributes not only to health policy but also to the broader pursuit of reproductive justice, the right of every individual, regardless of ability, to access information, exercise autonomy, and participate fully in decisions about their own body and future.

## Methods

### Study Design

This study used a qualitative descriptive approach with an exploratory design. The exploratory design used in this study aims to provide an in-depth understanding of reproductive health education and services for adolescents with disabilities. A qualitative descriptive design was selected as it allows for a comprehensive, straightforward summary of participants' experiences in their own terms, making it particularly suitable for informing practice and policy. This approach is appropriate when the aim is to obtain a rich description of phenomena without extensive theoretical interpretation and to focus on participants' perspectives. Researchers will explore the perceptions of policymakers, health care providers, and people with disabilities themselves. The Consolidated Criteria for Reporting Qualitative Research (COREQ) was applied in this research. The guideline was applied by reporting the research team's characteristics and roles, detailing the sampling and recruitment procedures, describing the use of interviews and data collection settings, and outlining the coding, theme development, and inclusion of verbatim participant quotations. This ensured transparency and enhanced the

rigor and credibility of the study. The research was conducted in Denpasar, Bali, Indonesia, an urban setting with diverse sociocultural influences that shape perceptions of disability and sexuality. Cultural norms in this context often position discussion of sexuality as sensitive or taboo, particularly for adolescent girls and individuals with disabilities. These sociocultural factors may influence participants' access to reproductive health information, their willingness to seek information, and their overall experiences. Variations in access to inclusive education and disability-sensitive health services in Denpasar may further affect the availability and quality of reproductive health education.

### Research Team and Reflexivity

The research team consisted of three lecturers with nursing backgrounds. The research team holds a Master's in Nursing. It has prior experience in qualitative research and adolescent health, with female researchers, which was considered important given the sensitivity of discussing reproductive health topics with adolescent girls. The researchers adopted strategies to create a safe and supportive environment during data collection. Participants were informed that their responses would remain confidential and that there were no right or wrong answers. Interviews were conducted in a respectful and non-judgmental manner to minimize differences between researchers and participants. Researchers maintained professional distance from participants, with no prior personal relationships, to minimize bias. Participants served as sources of information in this study. To further enhance reflexivity, researchers kept journals of reflexivity, engaged in regular peer debriefings, and collaboratively reviewed and cross-checked data interpretations. These steps aimed to

ensure transparency and trustworthiness in reflecting on how researchers' backgrounds and interactions might influence data collection and analysis.

### **Participants**

A total of 29 adolescent girls with disabilities participated in this study. Participants were recruited using a purposive sampling strategy to ensure inclusion of individuals with relevant experience in reproductive health education. The subjects of this study were 12 informants, divided into three categories: health services providers (two informants), teachers (two informants), and people with disabilities and their families (eight informants). Informants were selected using purposive sampling, ensuring they could provide the desired information and meet the suitability and adequacy requirements for this study. The selection of these informants was based on inclusion criteria: adolescent girls aged 15-19 years, able to communicate their experiences and willing to participate in this study, and who also represented a diverse disability population and varied levels of access to reproductive health education and services. Data collection was conducted from July to September 2024. A purposive sampling strategy was used to recruit participants with relevant experiences. Recruitment continued until data saturation was achieved, defined as the point at which no new themes or insights emerged from the interviews, thereby justifying the sample size in line with qualitative research.

The process of selecting informants with disabilities at Special Need School 3, Denpasar, would then be selected based on recommendations from management and previous persons with disabilities. During the recruitment process, 29 individuals were approached, of whom 8 agreed to participate and 11 declined or were excluded. Reasons for refusal or

nonparticipation included difficulty communicating with others, lack of interest, time constraints, and discomfort discussing sensitive topics. Therefore, the initial research approach was carried out by the researchers, who established good relationships and coordinated with the management of Special Need School 3 Denpasar. For informants with disabilities who have difficulty communicating (Deaf and Mentally Impaired) during the interview process, they were accompanied by family and volunteers who understand and can use sign language. In addition, to improve data quality, a Focus Group Discussion (FGD) was also conducted with eight (8) family members of persons with disabilities, consisting of three (3) autistic family members, three (3) deaf and hard of hearing family members, and two (2) mentally disabled family members.

Participants were fully informed about the study aims and procedures before providing written consent. No incentives were offered for participants.

### **Data Collection**

This study used primary data collected through several methods, including in-depth interviews, focus group discussions (FGDs), and observation conducted in a private, quiet setting, such as a designated room in the school or the participant's home. The data collection process encompassed several important aspects, including the selection of research informants, the location and timing of data collection, the researcher's skills and knowledge, and research ethics. The first step was selecting research informants, which involved identifying appropriate potential informants who met the criteria and needs. Specifically, to select informants with disabilities, the researcher collaborated with SLB Negeri 3 Denpasar's management to identify those who met the research needs.

Before conducting the interviews, the researcher agreed with the informants on the time and location of the in-depth interviews, tailored to their availability. The interview duration with each informant ranged from 20 to 45 minutes. The researcher provided background, objectives, and benefits, and some information about the research, before conducting the in-depth interview. This was followed by the researcher, informant/guardian, and witness signing an informed consent form. In-depth interviews were conducted with persons with disabilities, except for informants with intellectual disabilities (mentally impaired). The interview guide was developed based on previous literature and covered the following domains: knowledge and understanding of reproductive health; sources of reproductive health; perceived barriers to accessing education and services; cultural and family influences; and preferred methods and materials for learning about reproductive health.

The interviews were recorded using a mobile phone recorder and documented in photographs and several videos. Throughout the in-depth interviews, all informants were very cooperative and informative in answering every question posed by the researcher. As part of efforts to improve data quality, researchers also conducted field observations and focus group discussions (FGDs) with families of people with disabilities. The researcher is the research instrument, serving as a data-collection tool. Another primary data collection tool is an in-depth interview guide designed to meet the research objectives. The next data collection instrument is an FGD guide, which guides the FGD implementation. The same applies to the in-depth interview guide.

The interview guide consisted of open-ended questions exploring participants' experiences. Example prompts included:

“What have you learned so far about changes that happen in the body during adolescence?” “Have you received any information about sexual reproductive health? (probe: what topics, in what form, who taught them)”, “is it easy or difficult for you to get information about reproductive health? Why?” (probes: materials not in accessible format, embarrassment, lack of privacy, or community challenges), “what makes it harder for adolescents with disabilities to learn about reproductive health?” (probes: stigma, care giver restriction, inaccessible schools, lack of trained teachers), “how do you like to learn a new thing?” (probes: pictures, videos, someone talking to you, one by one, group with friends).

All interviews were audio-recorded with participants' consent and transcribed verbatim. The primary researchers conducted the transcription, and the research team checked the transcripts for accuracy to ensure consistency with the original recordings. In addition to interviews, nonverbal cues and contextual observations, including participants' expressions, pauses, and environmental factors, were noted during and immediately after the interviews. These observations were recorded as field notes and used to complement and enrich the interpretation of the interview data.

To ensure accuracy and respect for participants' perspectives, a brief, accessible member-checking process was conducted. At the end of each interview, the researcher provided a simple verbal summary of the participant's responses, using clear language and visual supports. Participants were asked whether the summary was correct and were given the chance to confirm, correct, or add to their responses. This process ensured accuracy and strengthened the credibility of the findings. Data saturation was determined during the iterative process of data

collection and analysis. Saturation was considered reached when no new codes, categories, or themes emerged from the interviews, and additional data no longer contributed new insights to existing patterns. This point indicated that further interviews were unlikely to change the thematic structure of the findings.

### **Data Analysis**

The research data were analyzed using thematic analysis (Green et al., 2021). Braun & Clarke (2006) define thematic analysis as a data analysis method aimed at identifying patterned themes within the data collected by the researcher (Sirwan Khalid Ahmed, 2025). First, the researchers familiarized themselves with the data by reading and re-reading the interview transcripts. Second, initial codes were generated systematically across the dataset to identify meaningful units related to the research objectives. Third, codes were grouped into potential themes based on patterns and similarities. Fourth, themes were reviewed and refined to ensure coherence and consistency with the coded data and the overall dataset. Fifth, themes were defined and clearly named to capture their essence and in sixth phase, the findings were organized and reported with supporting verbatim quotations from participants.

Data management and coding were conducted manually, primarily by the lead researchers, with regular discussion among the research team to review codes and themes and ensure consistency and credibility in the interpretation of the data. The triangulation methods used in this study are method triangulation and source triangulation. Triangulation was conducted by combining data collected through various methods, including in-depth interviews, observations, and focus group discussions (FGDs). Meanwhile, source triangulation was conducted by comparing

and cross-checking data from multiple sources.

### **Trustworthiness and Rigor**

Trustworthiness was enhanced through triangulation of interviews and observation, member checking, audit trails, and peer review. To ensure rigor, this study applied established criteria of trustworthiness, including credibility, dependability, confirmability, and transferability. Credibility was enhanced through prolonged engagement with the data, iterative data analysis, and the use of verbatim participant quotations to support the findings. Dependability was ensured by maintaining a clear, systematic description of the research process, including data collection and analysis procedures, thereby enabling transparency and potential replication. Confirmability was addressed through reflexive practices and regular discussions among the research team to minimize researcher bias and ensure that the findings were grounded in the data. Transferability was supported by providing detailed descriptions of the study context, participants, and findings, enabling readers to assess the applicability of the results to other settings.

### **Ethical Consideration**

This study was conducted with a strong emphasis on ethical integrity. Before data collection, participants were informed of the research's purposes, the voluntary nature of their involvement, and their right to withdraw at any time without consequences. Written informed consent was obtained from all participants. Confidentiality and anonymity were maintained throughout the study by using pseudonyms and securely storing all data. The research adhered to the ethical principles of respect for persons, beneficence, and justice outlined. The Institute of Technology and Health Bali has

approved the ethical considerations for this study under number 03.0263/KEPITEKES-BALI/VI/2024. All procedures followed standard ethical principles, such as informed consent and the right to withdraw, consistent with exempt research guidelines for minimal-risk student interviews. In addition, formal permission to conduct the study was obtained from relevant institutions, including the participating school (Special Need School 3 Denpasar) and the Public Health Center 3 North Denpasar.

## Results

The informants in this study included 11 individuals from diverse backgrounds. In Table 1 below, the youngest age was 14 years old; all the informants were female; the policy maker's educational background was magister's; the health provider and teachers' educational backgrounds were bachelor's; and the adolescent girl with disabilities was in a special needs school.

**Table 1.** The characteristics of the informants

Participant Code	Gender	Age (years)	Education level	Work setting	Additional information
I01	Female	52	Magister	Public Health	Policy maker
I02	Female	50	Bachelor	Primary Health Care	Health provider
I03	Female	45	Bachelor	Special Need School 3 Denpasar	Special need school teacher
I04	Female	40	Bachelor	Special Need School 3 Denpasar	Special need school teacher
I05	Female	14	Special Need School	Special Need School 3 Denpasar	Adolescent girl with disabilities
I06	Female	16	Special Need School	Special Need School 3 Denpasar	Adolescent girl with disabilities
I07	Female	15	Special Need School	Special Need School 3 Denpasar	Adolescent girl with disabilities
I08	Female	16	Special Need School	Special Need School 3 Denpasar	Adolescent girl with disabilities
I09	Female	15	Special Need School	Special Need School 3 Denpasar	Adolescent girl with disabilities
I10	Female	18	Special Need School	Special Need School 3 Denpasar	Adolescent girl with disabilities
I11	Female	17	Special Need School	Special Need School 3 Denpasar	Adolescent girl with disabilities
I12	Female	16	Special Need School	Special Need School 3 Denpasar	Adolescent girl with disabilities

**Table 1** describes the characteristics of the informants involved in this study. All participants were female and comprised a diverse group of stakeholders, including one policymaker, one health provider, two special needs school teachers, and eight adolescent girls with disabilities. The adolescent participants were aged 14-18 years and enrolled in Special Need School 3

in Denpasar, while the other informants ranged in age from 40 to 52 years and held at least a bachelor's degree. This composition of informants reflects a multi-perspective approach, capturing both experiential insights from adolescents and professional health education needs and barriers in this study.

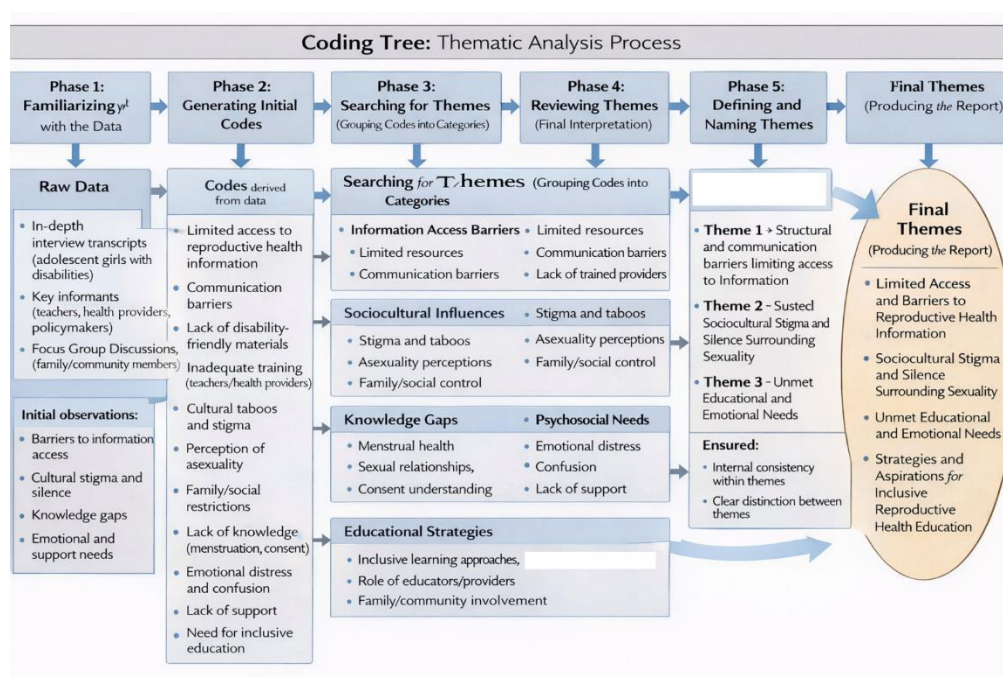
**Table 2.** The characteristics of the Focus Group Discussion Participants



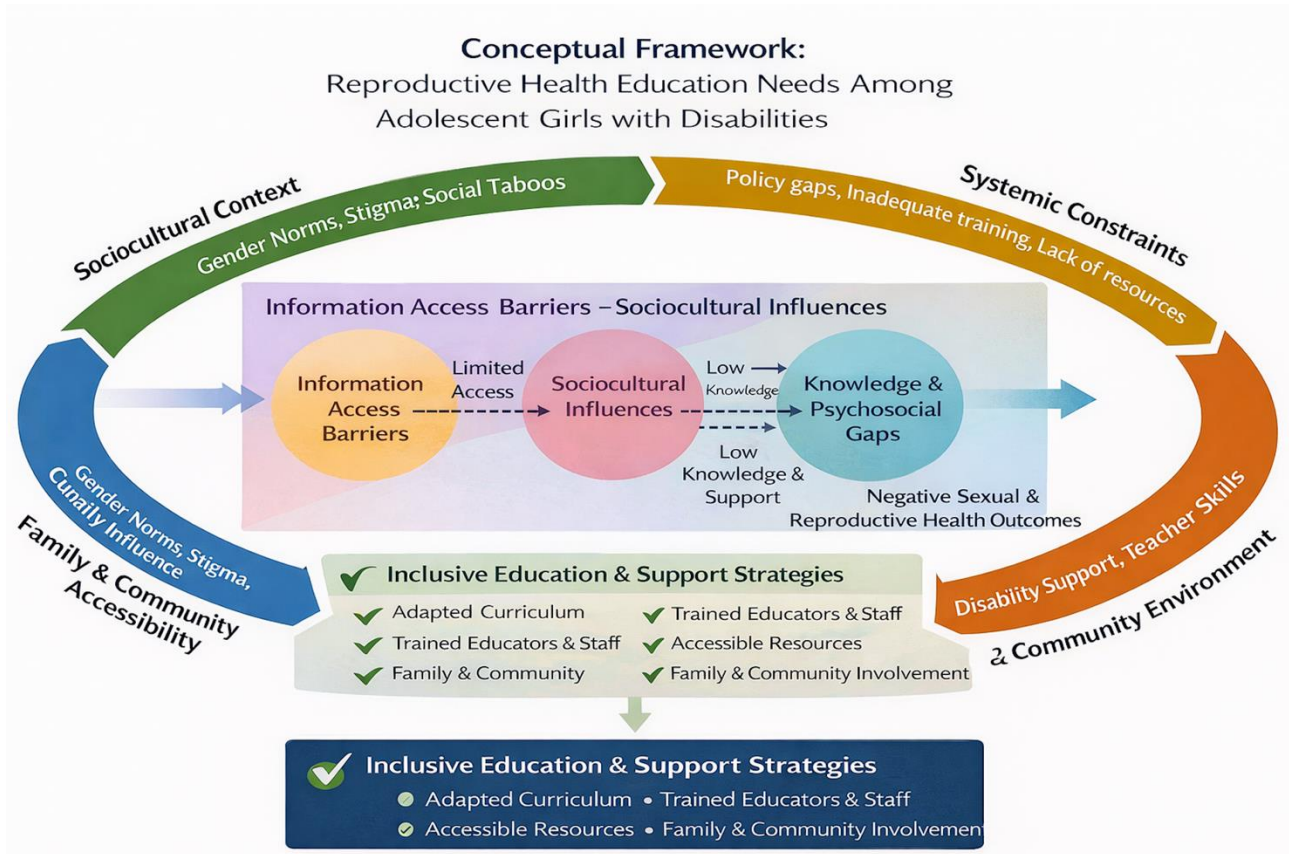
Participant Code	Gender	Age	Education level	Work setting	Additional information
P01	Male	29	Senior High School	Self employee	Family member with disabilities
P02	Male	49	Senior High School	Self employee	Family member
P03	Female	35	Senior High School	Housewives	Family member
P04	Male	41	Diploma	Self employee	Family member
P05	Female	34	Diploma	Self employee	Family member
P06	Female	50	Senior High School	Housewives	Family member
P07	Female	46	Elementary School	Housewives	Family member
P08	Female	34	Senior High School	Housewives	Family member

**Table 2** presents the characteristics of the participants in the focus group discussion. The participants were eight family members of persons with disabilities, including both male and female participants. They ranged in age from 29 to 50 years and had diverse educational backgrounds, primarily at the senior high school level, with some holding diploma qualifications and one with an elementary

education. In terms of occupation, participants were mainly self-employed or homemakers. This diversity in age, education, and occupation reflects varied family and community perspectives, which are important for understanding the social and environmental factors influencing reproductive health education for adolescent girls with disabilities.



**Figure 1.** Coding tree of Reproductive Health Education Needs Among Adolescents with disabilities



**Figure 2.** Conceptual Framework of Reproductive Health Education Needs Among Adolescents with disabilities

*Theme 1: Limited Access and Barriers to Reproductive Health Information*

*Sub-theme 1.1: Lack of Inclusive Educational Materials*

Interviews revealed that there are no specific Reproductive Health Education modules or teaching materials for people with disabilities. Furthermore, the materials are not suitable for adolescents with disabilities' cognitive abilities. Visual media are unsuitable for visually impaired adolescents.

*"I never received an explanation about menstruation at school, so I was afraid when I first started menstruating." (Informant 8)*

*Sub-theme 1.2: Inadequate training and awareness among teachers and health educators*

The lack of reproductive health education for adolescents with disabilities can also be influenced by several factors, one of which is the ability of teachers to provide reproductive health education. Currently, many teachers still haven't received training on reproductive health, especially for adolescents with disabilities. This can be a barrier to providing information about reproductive health to adolescents with disabilities.

*"Indeed, we haven't received specific training on reproductive health for adolescents with disabilities; we only explain our basic understanding of reproduction," (Informant 3).*

### *Sub-theme 1.3: Physical and Communication Barriers*

The obstacles faced include limited health education activities and the difficulty of finding human resources, particularly in the field of sign interpreting. The diverse circumstances of adolescents with disabilities naturally require different treatment, necessitating specialized communication skills.

*"The students here have different needs, so some understand when explained, while others don't, even running away during counseling." (Informant 4)*

### *Theme 2: Sociocultural Stigma and Silence Surrounding Sexuality*

#### *Sub-theme 2.1: Perceptions of Asexuality and Infantilization*

The disabilities experienced by adolescents sometimes change parents' understanding of their children. Parents of adolescents with disabilities often assume that they don't have sexual needs and often consider them to be children who don't need to learn about sexuality.

*"They shouldn't know about that (sexuality), it's for adults." (Informant 9)*

#### *Sub-theme 2.2: Cultural and Religious Taboos*

The reality in society, where discussions about sexuality and reproduction are still considered taboo, makes reproductive health education difficult. The feeling of shame around discussing sexuality creates an uncomfortable environment for adolescents who want to learn about it.

*"Usually, we never talk about sex at home. We're embarrassed; they say little kids shouldn't know about it." (Informant 10)*

### *Sub-theme 2.3: Fear and Social Control from Family or Caregivers*

The condition of adolescents with disabilities requires closer supervision from their caregivers, resulting in developmental limitations, such as restrictions on leaving the house and restrictions on socializing with the opposite sex.

*"Not allowed to date, not allowed to get close or kiss" (Informant 7)*

### *Theme 3: Unmet Educational and Emotional Needs*

#### *Sub-theme 3.1: Insufficient Knowledge on Menstrual Health and Bodily Changes*

Interviews with adolescents revealed that some still lack knowledge of self-care during menstruation, lack understanding of personal hygiene, and many still lack understanding of normal bodily changes experienced by adolescents. The most common reason cited was embarrassment about asking adults.

*"Suddenly, I had a really bad stomach ache and didn't dare report it to the teacher, and then blood came out of my skirt" (Informant 12)*

#### *Sub-theme 3.2: Lack of Information on Sexual Relationships and Consent*

Teenagers with disabilities do not understand the meaning of sexual intercourse, do not understand the right to refuse, and do not understand the risks of sexual violence, as stated in the following statement:

*"I didn't know that touching someone's body without permission was considered sexual harassment" (Informant 7)*

*Sub-theme 3.3: Emotional Needs and Desire for Peer Support*

The psychological development of adolescents between normal and disabled adolescents is generally similar. They feel a desire to share with their peers, want to talk about their experiences, and feel safe when socializing. Therefore, they still need support from friends to talk and share experiences.

*"If you have a friend you can talk to, that's great, right, ma'am?" (Informant 6)*

*Theme 4: Strategies and Aspirations for Inclusive Reproductive Health Education*

*Sub-theme 4.1: Preferred Learning Approach*

The health education approach offered to adolescents with disabilities requires some adjustments to their specific circumstances. The media used should not be written modules, but rather visual learning in the form of hands-on practice, health education videos, and modules in Braille and sign language. Simple and repetitive explanations should also be provided.

*"I understand better if there are videos and pictures" (Informant 5)*

*Sub-theme 4.2: Role of Parents and Peer Educators*

Adolescents with disabilities do indeed have weaknesses in socializing and gaining an understanding of health education. Therefore, to improve their understanding of reproductive health, they require support from parents. These peers serve as educational facilitators, and the disability community can provide education and counseling on reproductive health.

*"If my mother knew how to explain it, maybe I would understand about sex"*

*(Informant 12)*

*Sub-theme 4.3: Expectation Toward Policy and Institutional Support*

We provide education in accordance with the curriculum. However, we do need a specialized curriculum for people with disabilities, skills development for special needs teachers, and disability-friendly facilities.

*"There's limited training for teachers here, but we also want the lessons to be tailored to our needs here." (Informant 3)*

**Figure 1** illustrates the thematic analysis structure as a coding tree, showing the relationships among main themes, subthemes, and related codes regarding reproductive health education needs among adolescents with disabilities. Meanwhile, **Figure 2** presents a conceptual framework that integrates key factors—such as barriers to information access, sociocultural stigma, unmet educational needs, and inclusive education strategies—that interact in shaping their experiences and needs. Together, these figures highlight that the challenges faced are multidimensional and require a comprehensive and inclusive systemic approach.

**Discussion**

This study explored the reproductive health education needs of adolescent girls with disabilities and identified four interrelated themes: (1) limited access and barriers to reproductive health information, (2) sociocultural stigma and silence surrounding sexuality, (3) unmet educational and emotional needs, and (4) strategies and aspirations for inclusive reproductive health education. Together, these themes highlight how structural, sociocultural, and pedagogical barriers shape the lived experiences of adolescent



girl with disabilities and restrict their right to accessible, comprehensive reproductive health education.

The findings revealed that adolescent girls with disabilities face multiple layers of exclusion from reproductive health education due to the lack of inclusive learning materials, inadequate teacher preparation, and communication barriers. These barriers persist not simply because of resource limitation, but because disability is often not prioritized within the mainstream reproductive health and education system, which is designed around non-disabled assumptions of learning, communication, and bodily autonomy. These results are in line with research stating barriers at the individual level, such as lack of information, lack of support to seek sexual reproductive health, improper care from family, and negative attitudes of non-disableds ([Mathabela & Madiba, 2024](#)). Barriers resonate with prior studies that identified disability-blind curricula, inaccessible health facilities, and untrained educators as key contributors to reproductive health inequity among persons with disabilities ([Brown et al., 2025](#)). A key contradiction emerges here: while policies may formally promote inclusive education, the implementation system still operates on standardized, non-adaptive models of teaching and healthcare delivery. This is the gap between policy intent and lived reality. In practice, inclusion becomes symbolic rather than functional.

Furthermore, poor intersectoral collaboration between health and education institutions perpetuates fragmented service delivery ([Pandia et al., 2024](#)). This emphasizes weak intersectoral collaboration between education and health systems. This fragmentation helps explain why reproductive health education remains inconsistent. The education system may provide theoretical content without adequate support from the health system,

while health services may lack educational continuity or accessibility. Reproductive health education for adolescents with disabilities must be provided sustainably and gradually, and be tailored to their intellectual capacity ([Pandia et al., 2024](#)).

Sexual and reproductive health education must cover at least basic reproductive health education, including reproductive organs, physical growth and psychological development, self-adaptation, critical thinking, and the fulfilment of reproductive rights ([Juanita et al., 2023](#)). Teachers often lack both the content knowledge and pedagogical confidence to discuss sensitive reproductive topics. At the same time, health providers are not trained to communicate effectively with individuals with sensory or intellectual impairments ([Brown et al., 2025](#)). Teachers' lack of confidence and health providers' limited communication training further reinforce exclusion. The underlying reason is not only a lack of training, but discomfort and cultural taboos surrounding adolescent sexuality and disability. Health reproductive education for adolescents with disabilities should be adjusted to more fundamental and practical elements because they might face difficulty understanding abstract concepts. This finding reinforces the argument that effective reproductive health education for persons with disabilities requires a systemic approach integrating disability-awareness training into teacher education and healthcare professional curriculum ([Taghizadeh et al., 2024](#)). From a psychosocial perspective, access to information is central to fostering personal competence and identity. Adolescents in this study described significant barriers to reproductive health information, ranging from physical inaccessibility to a lack of adapted learning materials. The absence of appropriate educational support reinforces dependency and undermines their ability to

form a positive self-concept during a critical development period. Adolescents in this study experience dependency not merely as a function of impairment, but as a social produced condition reinforced by restricted knowledge systems. This is important because it challenges a common assumption that dependency is inherent to disability; instead, it is often reinforced through institutional gatekeeping of information.

A pervasive theme in this study was the strong sociocultural stigma surrounding disability and sexuality. Many participants reported that their families and communities perceive them as asexual, childlike, or incapable of engaging in romantic or sexual relationships. Such infantilization reflects deep-rooted social taboos and gendered stereotypes that strip adolescent girls with disabilities of sexual agency and bodily autonomy (Pérez-Curiel et al., 2023). This infantilization reflects deeply embedded gender norms and cultural assumptions that equate sexuality with physical normality, maturity and independence, thereby excluding adolescent girl with disabilities from socially recognized sexual subjectivity. As a result, their bodies are simultaneously rendered visible as disable yet invisible as sexual beings, producing a form of symbolic exclusion that strips them of sexual agency and bodily autonomy. Religious and cultural taboos further constrain open dialogue about reproductive health. Breaking down the stigma that exists in society is certainly not easy (Matin et al., 2021). Research shows that stigma and discriminatory behavior can actually be overcome through continuous outreach regarding the needs and rights of people with disabilities as citizens according to the principle of equality (Singh Shrestha et al., 2022). A key contradiction emerges while silence is culturally constructed as safeguarding morality and preventing premature sexual activity, it is simultaneously increases

vulnerability by depriving adolescents of accurate knowledge, critical awareness and protective skill.

Furthermore, through synergy from various parties, especially support from champions, access to health services for people with disabilities can be increased (Mesäislehto & Katsui, 2021). However, another contradiction emerges while structural intervention aim to promote inclusion, community-level beliefs often continue to produce exclusionary attitudes, meaning that institutional change does not automatically translate into cultural change. Discussions of menstruation, sexuality, and relationships are often considered shameful, resulting in silence both at home and in schools. Similar findings were reported where fear, moral anxiety, and parental overprotection limited girls' access to information (Pérez-Curiel et al., 2023). In the current study, participants narratives reflected a sense of internalized shame and self-censorship, which may lead to misinformation, fear of bodily functions, and vulnerability to sexual abuse. Therefore, sociocultural stigma does not only restricts access to reproductive health education but also undermines **psychological empowerment**, the capacity to claim knowledge, make choices, and assert boundaries (Matin et al., 2021). Challenging these stigmas requires culturally sensitive advocacy and community-based education that normalize discussions of reproductive health and affirm the sexual rights of persons with disabilities (Singh Shrestha et al., 2022). Adolescents are developmentally characterized by identity exploration and increasing autonomy. Yet, for girls with disabilities, social conditions actively suppress these developmental processes, producing delayed or constrained psychosocial maturation rather than supporting it. According to psychosocial theory, the strong sociocultural stigma

surrounding sexuality, especially for adolescents with disabilities, creates a climate of silence, shame, and surveillance. When caregivers and communities view disabled adolescents as asexual or incapable of making informed choices, they inadvertently limit adolescents' psychosocial opportunities for exploration and self-understanding (Kuumuori et al., 2020). This silencing disrupts the normal developmental tasks of adolescence, such as establishing autonomy and negotiating emerging sexuality. While dominant cultural narratives frame restriction and silence as protective strategies for adolescent girl with disabilities, these same practices systematically reduce access to knowledge, weaken autonomy, and increase vulnerability. This contradiction underscores the need to reconceptualize protection not as withholding information, but as enabling informed agency within supportive and inclusive environments.

The third theme captures the substantive knowledge gaps and emotional vulnerabilities of participants. Many lacked basic understanding of menstruation, hygiene management, sexual consent, and protection from abuse (H. Hermawan, 2021). This indicates reduced access to both formal school-based instruction and informal family education. This absence of structured information is not incidental. However, it reflects cultural discomfort with discussing sexuality, particularly for unmarried girls and persons with disabilities, where sexuality is often perceived as inappropriate or unnecessary. A contradiction emerges between protection and vulnerability. While restrictions on sexuality education are often justified by caregivers and institutions as protective, they in fact increase risk by delaying understanding of bodily changes, consent, and boundaries. Lack of knowledge about bodily changes during puberty often leads to anxiety and confusion (Du et al.,

2022). Limited knowledge of consent significantly increases susceptibility to coercion and abuse, particularly among girls with sensory or intellectual disabilities (Brown et al., 2025). Importantly, this vulnerability is not inherent but structurally produced through restricted access to rights-based education, communication barriers, and social norms that discourage open sexual dialogue. In many cultural contexts, silence around sexuality is maintained through ideals of modesty and family honor, which unintentionally create informational voids filled by misinformation and power imbalances. Beyond knowledge deficits, participants expressed strong emotional needs for safety, empathy, and peer support.

Feelings of shame and isolation reflect a psychosocial gap in education, where affective and relational support is absent. This undermines autonomy development, as adolescents are expected to navigate puberty without emotional guidance. Caregiver dependency further intensifies this tension as support systems often function simultaneously as gatekeepers of information. Therefore, reproductive health education must encompass not only informational content but also affective learning that nurtures self-esteem, confidence, and autonomy (Pandya et al., 2024); (Singh Shrestha et al., 2022). The unmet emotional needs identified here underscore the importance of integrating **psychosocial support and peer-led approaches** into inclusive education programs (Du et al., 2022).

Peer educators with disabilities can serve as relatable role models who challenge stigma, foster mutual trust, and facilitate open discussion about sexuality and reproductive health (Agustini, 2022). Psychosocial theory highlights the importance of emotional support in navigating development transitions. Without trusted adults or peers to validate

their experiences, adolescents may struggle with identity confusion or diminished self-esteem ([Mesiäislehto & Katsui, 2021](#)). Adolescent with disabilities often face vulnerability because they depend more on others for daily support ([Mathabela & Madiba, 2024](#)). The finding show that vulnerability is not only informational but also emotional and relational, produced through the intersection of cultural silence, institutional exclusion and overprotective care.

Despite the barriers they face, participants articulated clear aspirations for inclusive, accessible, and empowering reproductive health education. They expressed preference for participatory, visual, and experiential learning ([Susanti & Kurniasari, 2020](#)) methods such as videos, illustrations, and hands-on demonstrations, rather than lecture-based instruction. Visual media should be used to facilitate better understanding among adolescents with disabilities ([B. Hermawan, 2020](#)). Creative learning methods and visual media can stimulate adolescents' attention, interest, and understanding ([Sriasih et al., 2023](#)). This reflects the universal design for learning principle, which emphasizes a multimodal, flexible pedagogy to meet diverse learner needs ([Susanti & Kurniasari, 2020](#)). Contradiction emerges within the cultural context, while sexuality education is often restricted due to norms of modesty, shame and moral protection, which particularly for adolescent girls.

Participants simultaneously demand more open, structured, and visible forms of learning. This cultural silence intended to preserve morality directly conflict with adolescents expressed need for clarity, visibility and guided exposure to reproductive knowledge. This tension illustrates how protective cultural norms can inadvertently suppress the very competencies they aim to safeguard. Participants also highlighted the crucial role

of parents, peers, and community organizations in providing ongoing support. Family involvement was identified as both a challenge and an opportunity, while some parents perpetuated silence, others were viewed as potential allies if equipped with appropriate knowledge and communication skills. Information provided by parents is essential to ensure that adolescents receive accurate information related to reproductive health. In addition sexual and reproductive health information should be provided from early childhood ([Wibowo et al., 2019](#)). Strengthening parental capacity through inclusive community education programs may therefore bridge the gap between school and home-based learning ([Mathabela & Madiba, 2024](#)). Participants' calls for supportive educators, accessible materials, peer engagement, and structured sessions reflect an aspiration for psychosocial empowerment rather than passive information delivery. However, implementation required more than technical adaptation, it demands institutional willingness to integrate disability and gender perspectives into education and health systems ([Kuumuori et al., 2020](#)). Their suggestions for accessible materials, supportive educators, peer engagement and structured reproductive health sessions indicate an aspiration for psychosocial empowerment ([Mathabela & Madiba, 2024](#)). The findings show that adolescents are not passive recipients of care but active agents with clear educational expectations. Their aspirations expose a structural mismatch, while cultural framework prioritize silence and protection, adolescents prioritize visibility, participation and autonomy.

### Implications and limitations

Implications: This study highlights the need for disability-inclusive sexual reproductive health education that is accessible, tailored, and integrated into

both health and education systems. Nurses, teachers, and caregivers require specialized training to communicate effectively with adolescents with disabilities. Policymakers should strengthen inclusive education policies and support mechanisms, while researchers should develop accessible SRH tools and examine subgroup-specific needs. Limitations include potential underrepresentation of certain disability groups, communication barriers, social desirability bias, and contextual differences across settings. Reliance on caregivers or interpreters may have influenced data, and cultural sensitivities may have limited openness. These factors constrain generalizability and may affect interpretation of findings

### Relevance to Practice

The findings of this study have clear and immediate relevance for nursing and healthcare practice. Adolescents with disabilities often face significant barriers to accessing accurate and developmentally appropriate reproductive health information, making practitioners central to closing this gap. Nurses, school health personnel, and community health workers play a critical role in ensuring that sexual reproductive health education is inclusive, accessible and responsive to the diverse needs of this population.

### Conclusion

In conclusions, this study has provided valuable insights into four themes related to reproductive health services need for adolescent girl with disabilities and found persistent barriers including limited access to information, sociocultural stigma, fragmented support systems, and unmet emotional needs, alongside a strong demand for inclusive, visual and participatory learning with greater involvement of families, peers, and educators. This findings show that

exclusion is shaped not only by structural limitation but also by cultural norms that promote silence around sexuality. A key contradiction emerges: this silence is often intended as protection yet ultimately increases vulnerability by limiting knowledge of consent, body autonomy, and self-protection, while participants simultaneously demonstrate, through clear aspirations, a desire for more accessible and empowering education. The study highlights the need for reproductive health education that moves beyond information delivery towards a rights-based, inclusive approach that addresses both structural barriers and sociocultural stigma, so that protection does not become exclusion.

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### CrediT Authorship Contributions Statement

**Ni Komang Tri Agustini:** Conceptualization, Methodology Supervision, Writing-Original Draft

**Putu Noviana Sagitarini:** Formal Analysis, Writing-Review and Editing, Funding Acquisitions

**Ida Ayu Ningrat Pangruating Diyu:** Investigation, Resources, Data Curation, Project administration

### Conflicts of Interest

The authors declare that they have no known competing financial interest or personal relationships that could have appeared to influence work reported in this paper

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