Sexuality and Disability (2025) 43:2
https://doi.org/10.1007/s11195-024-09881-8

ORIGINAL PAPER

A Qualitative Study Exploring the Sexual Experiences of Women with Disabilities in Lagos, Nigeria

Obasanjo Afolabi Bolarinwa[1,2] · Clifford Odimegwu[1] · Blessing Iretioluwa Babalola[3] · Aliu Mohammed[4]

Accepted: 24 November 2024

Abstract
As of 2021, 1.3 billion people globally live with disabilities, with 80% in low-and-middle-income countries and 12.8% in Africa. Women with disabilities often face gender-based discrimination and limited sexual autonomy, impacting their sexual health. Despite global progress, there is limited research on the sexuality of women with disabilities in sub-Saharan Africa, particularly Nigeria. This study explores the sexual experiences of women with disabilities in Lagos, Nigeria. Using a qualitative approach, 24 women with disabilities, including blindness and mobility impairments, were interviewed to understand their experiences with sexual activity, autonomy, contraceptive use, risky behaviors, and sexual violence. The participants demographic shows that 67% of participants had physical disabilities, while 33% had visual impairments, with ages ranging from 20 to 45 and varying education and employment levels. Themes were generated around the experience of women with disabilities in sexual activities, modern contraceptive use, sexual autonomy, risky sexual behavior and sexual violence. Many participants did not see their disabilities as hindering sexual activity but faced challenges in relationships due to physical limitations and societal stigma. The study found mixed experiences with modern contraceptives, hindered by misconceptions and accessibility issues, and some women reported experiencing sexual violence and inadequate access to reproductive health resources and support. The findings underscore the need for targeted interventions, including improved access to contraceptives, public education to reduce stigma, and enhanced legal protections to support the sexual and reproductive health of women with disabilities in Lagos.

Keywords Sexual experience · Woman with a disability · Qualitative study · Lagos · Nigeria

✉ Obasanjo Afolabi Bolarinwa
bolarinwaobasanjo@gmail.com

[1] Demography and Population Studies Programme, Schools of Public Health and Social Sciences, University of the Witwatersrand, Johannesburg, South Africa

[2] Department of Public Health, York St John University, London, UK

[3] Demography and Social Statistics, Federal University Oye-Ekiti, Ekiti, Nigeria

[4] Department of Health, Physical Education and Recreation, University of Cape Coast, Cape Coast, Ghana

Published online: 11 December 2024

Abbreviations

COREQ	Consolidated Criteria for Reporting Qualitative Research
HIV	Human Immunodeficiency Virus
LMICs	Low- and Middle-Income Countries
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
WHO	World Health Organization

Background

According to the World Health Organization (WHO) and the World Bank's "World Report on Disability" (2021), around 1.3 billion people globally live with some form of disability, which represents about 16% of the global population. It is also widely acknowledged that the majority (around 80%) of people with disabilities live in low- and middle-income countries (LMICs) [1]. However, the specific percentage for Africa (12.8%) may vary depending on the source or data interpretation. WHO and other organizations do highlight that the prevalence of disability in low-income regions like Africa is significantly due to factors such as limited access to healthcare, higher rates of poverty, and greater exposure to disabling conditions like diseases and injuries [1]. Although the current prevalence estimates of persons with disabilities in Nigeria remain unclear [2], earlier estimation by the WHO [3] revealed that approximately 13.2% of the Nigerian population have some form of disability. With approximately 2 million persons with disabilities, Lagos state has the highest disability population among the 36 states in Nigeria [4].

Generally, persons with disabilities are described as those with long-term physical, sensory or cognitive impairment which, in the presence of certain individual and environmental factors, hinder their activity performance or societal functioning [3]. For instance, during the 2019 coronavirus disease pandemic, the effect of the virus was felt differently on the sexuality among persons with disabilities [5]. Whilst disability affects both men and women, the prevalence of disability remains higher among women [1]. Meanwhile, due to gender-based discrimination, victimization, and social prejudice [6], women with disabilities experience various inappropriate behaviors, including risky sexual behavior [7, 8], which predispose them to poor sexual and reproductive health outcomes [9–11].

Sexual experience can be described as a person's involvement in sexual activities or behaviors such as sexual intercourse [12]. Positive sexual experience promotes individuals' sexual and reproductive health [13, 14], and it is vital to the general well-being of people and the communities in which they live [15, 16]. However, the sexuality and sexual experience of women with disabilities is often neglected, largely because of the long-standing myth that characterizes women with disabilities as asexual and not sexually active [17–19]. Thus, women with disabilities continue to be marginalized and denied their sexual and reproductive health rights [20, 21], which predispose them to inappropriate sexual behaviors and associated sexual and reproductive health problems such as unintended pregnancies [22] and sexually transmitted infections (STIs), including HIV [7]. In this exploratory research, the term sexual experience is broadly conceptualized to include sexual exposure, sexual autonomy, modern contraceptive use, risky sexual behavior, and sexual violence. Evidence

suggests that women with disabilities have limited autonomy in decision-making regarding their sexuality and reproduction [23] and are more likely to be exposed to sex at an early age or have an early sexual debut [24, 25]. Besides, they are less likely to use modern contraceptives such as condoms [10]. Also, women with disabilities are increasingly exposed to sexual violence [26, 27] and risky sexual behavior, such as having multiple sexual partners, which increases their risk for HIV infection and other STIs [28].

Despite the increasing attention to the sexual and reproductive health of women worldwide [29], there continues to be limited research on the sexuality and sexual activities of women with disabilities [20, 30, 31], particularly in sub-Saharan Africa (SSA) [32]. Like in many LMICs, there is limited research data on disability issues in Nigeria [2, 33], which could affect the implementation of measures to safeguard the sexual and reproductive rights and sexual activities of persons with disabilities. Although the government of Nigeria has taken some measures, such as the enactment of the Disability Act 2018, to protect the rights of disabled persons, the law did not guarantee the sexual and reproductive rights of persons with disabilities [34]. Meanwhile, evidence suggests many women with disabilities in Nigeria are sexually active, and some are often exposed to inappropriate sexual experiences, including early sexual debut, multiple sexual partners, sexual violence, and risky sexual behavior [35]. Besides, the few available studies that investigated the issue of sexuality and sexual experience of persons with disabilities in Nigeria largely focused on adolescents and young adults, and they were mostly quantitative (e.g., Aderemi and Pillay [36]; Oladunni [35]; Olaleye et al. [37]). Thus, by exploring the sexual experiences of women with disabilities in Lagos, Nigeria, the current study seeks to enrich the evidence on the sexual experience of women with disabilities in Nigeria from a qualitative perspective.

Methods

Study Design

This qualitative study is grounded in the interpretivist research paradigm and adheres to the guidelines outlined by the Consolidated Criteria for Reporting Qualitative Research (COREQ) [38] to explore the sexual experiences of women with disabilities in Lagos, Nigeria.

Participant Recruitment

The qualitative in-depth interviews used purposive and convenience sampling techniques to select 24 women with disabilities in Lagos, Nigeria. The snowball sampling method was used to help recruit participants [39, 40]. Some participants were initially recruited through a local disability organization in Lagos, Nigeria. These participants then referred us to other individuals with similar disabilities, expanding our sample. The inclusion criteria specified women of reproductive age between 18 and 49 with disabilities, including blindness and mobility impairments (e.g., wheelchair users). The exclusion criteria were based on age and gender. The overall aim was to explore the sexual experiences of women with disabilities.

Data Collection

The researcher utilized a participant-oriented approach to conduct in-depth interviews with each participant in June 2024. These interviews, lasting approximately 20 to 30 min, were conducted in Yoruba, English, and Pidgin. Participants were free to schedule the time and location for the interviews based on their availability and convenience, with most interviews taking place at their homes.

Each session provided a platform for participants to share their personal experiences regarding their sexual lives and disabilities. The interviews explored various aspects, including demographic information, sexual activity, sexual autonomy, modern contraceptive use, risky sexual behavior, and experiences of sexual violence. The interviewer used prompts and probes to guide the conversation.

To ensure confidentiality, no identifying information was collected from participants, and each was assigned a unique identification code (Table 1). All interviews were audio recorded with the participant's consent.

Data Analysis

The interview sessions were audio-recorded and transcribed verbatim for analysis, following the reflexive thematic analysis framework [41, 42]. This analytical approach was

Table 1 Demographic information of participants

Participant assigned number	Age	Disability type	Level of education	Marital status	Working status
Participant 1	28	Physical disability	Secondary	Married	Working
Participant 2	42	Physical disabilities	Not educated	Married	Working
Participant 3	32	Visual disability	Not educated	Married	Not working
Participant 4	22	Physical disability	Secondary	Married	Not working
Participant 5	29	Physical disability	Secondary	Unmarried	Working
Participant 6	27	Visual disability	Secondary	Married	Not working
Participant 7	33	Visual disability	Secondary	Married	Not working
Participant 8	41	Physical disability	Secondary	Married	Working
Participant 9	30	Physical disability	Primary	Married	Working
Participant 10	42	Physical disability	Primary	Unmarried	Working
Participant 11	35	Visual disability	Primary	Married	Working
Participant 12	45	Visual disability	Higher	Ever married	Not working
Participant 13	45	Physical disability	Higher	Married	Working
Participant 14	40	Physical disability	Primary	Unmarried	Working
Participant 15	35	Physical disability	Higher	Unmarried	Working
Participant 16	40	Physical disability	Higher	Married	Working
Participant 17	20	Physical disability	Primary	Unmarried	Not working
Participant 18	30	Physical disability	Primary	Married	Not working
Participant 19	33	Visual disability	Not educated	Unmarried	Not working
Participant 20	20	Physical disability	Not educated	Unmarried	Not working
Participant 21	35	Physical disability	Not educated	Married	Not working
Participant 22	40	Visual disability	Not educated	Married	Not working
Participant 23	20	Physical disability	Primary	Unmarried	Not working
Participant 24	38	Visual disability	Higher	Married	Working

selected for its flexibility, which allows for the integration of the researcher's subjectivity in knowledge production on the sexual experience of women with disabilities. This has been effectively used in studies previous studies to explore both similarities and differences in participants' perspectives and experiences [43, 44].

The analytical process began with familiarization with the dataset. OAB, who conducted the interviews, led the analysis with support from BB. The transcripts were read multiple times to gain immersion and a deeper understanding of the data beyond its surface meaning. Using NVivo, the data was then coded through both inductive and deductive methods, grounding the codes in the data and relevant literature [45].

Themes were developed from these codes by searching, categorizing, and refining. The goal was to identify patterns of shared meanings rather than simply summarizing data domains. To prevent over-saturation in the results, responses with similar themes were carefully managed [41, 42].

Focus on Sexual Experiences

This analysis specifically focused on the sexual experiences of women with disabilities, exploring how their disabilities influenced their sexual activity, autonomy, use of modern contraceptives, engagement in risky sexual behaviors, and experiences of sexual violence. The thematic analysis uncovered detailed insights into the challenges and adaptations in their sexual lives, as well as the emotional and relational dynamics involved. Through this detailed thematic analysis, a comprehensive understanding of the participants' sexual experiences was achieved, highlighting the intersection of disability and sexuality. This approach ensured that the voices and experiences of women with disabilities were accurately and respectfully represented, contributing valuable knowledge to the field of sexual health research (Fig. 1).

Personality Statement

This study acknowledges the potential influence of the researcher's position on the process and outcomes. Careful steps were taken to minimize power imbalances by adopting a participant-centred approach and prioritizing participants' voices. Reflexive practices were employed throughout to ensure that the experiences of women with disabilities were respectfully represented. The study aims to authentically reflect their sexual health experiences and contribute to advancing their rights.

Results

Demographic Information of Participants

Table 1 below presents the demographic classification of the study participants. The table provides demographic information for 24 participants, focusing on age, disability type, education level, marital status, and working status. The participants' ages range from 20 to 45 years, with a higher percentage in the age group 30 to 39 at 38%. In terms of disability type, a majority of the participants (67%) have physical disabilities, while the remaining 33%

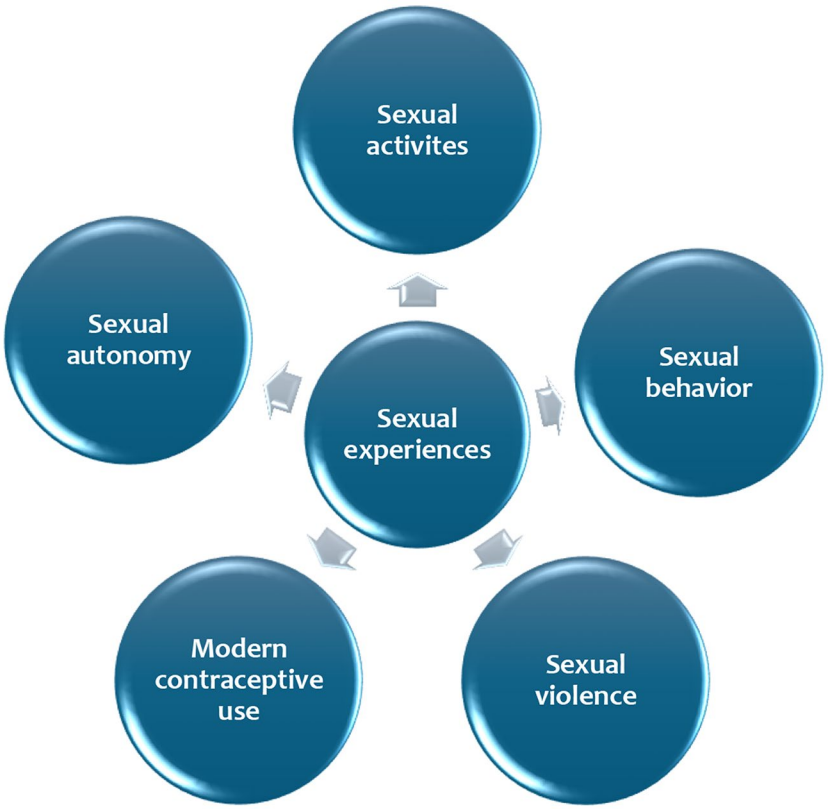

Fig. 1 Sexual experience operationalization among women with disabilities

have visual disabilities. Regarding educational attainment, 25% of the participants have not received any formal education, while primary education accounts for 29%, secondary education for 25%, and higher education for 21%. Marital status reveals that 63% of the participants are married, 33% are unmarried, and 4% are not currently married. When it comes to working status, there is a balanced distribution, with 50% of the participants currently working and 50% not working.

Emerging Themes from Sexual Experiences of Women with Disabilities

The themes and sub-themes that came out from this study were compiled in Table 2. Three major themes emerged in this study, which guided the result section; these include sexual experiences of women with disabilities, sexual challenges experienced by women with disabilities and recommendations to improve the sexual experiences of women with disabilities.

Table 2 Summarized themes, sub-themes and codes

Themes	Sub-themes	Codes
Sexual experiences of women with disabilities	Disability and sexual activities	Sexual-activity
	Desire and use of modern contraceptives	- Contraceptive non-use - Modern contraceptive use and desire - Contraceptive discontinuation - Not needed
	Understanding sexual autonomy in the context of disability	- Don't Know - Not applicable - Sexual choice right is personal. I cannot be forced - Sexual agreement or consent obtained before sexual activity - Relationship between a man and a woman - Sexual agreement among couples based on mutual understanding
	Experiences with risky sexual behavior with unfamiliar partners	- Experienced in the past - Not experienced
	Experiences of sexual violence related to disability	- Not experienced it - Forceful sex - Attempted rape - Forceful sex-suggestive statement - Sexual harassment
Sexual challenges experienced by women with disabilities	Challenges in pursuing sexual relationships and intimacy due to disability	- Difficulty in sexual intention or activity communication - Difficulty with raising legs and adjusting during sexual intercourse - Discrimination or stigmatization in the initiation of sexual activity - No effect - Hindering marriage desire - Abandonment by partner - Painful sex with partner - Not sexually active - Unable to do different styles - low self-esteem
	Challenges in accessing and using modern contraceptives	- Suitable experience with accessing contraceptive - suitable experience with using modern contraceptive - Difficulty in accessing modern contraceptive - Unsuitable experience with using modern contraceptive - No experience - Difficulty in accessing the health facility for modern contraceptive
	Barriers to asserting sexual autonomy and strategies for navigation	- Assertive facing no barrier - Disability - Forceful sexual experience - No barrier - Not applicable - Inability to satisfy the sexual style needs of the man - Deprivation of sexual rights - prevention of partner from promiscuity by consenting to sexual request against will
	Barriers to accessing support for sexual violence as a woman with a disability	- Disability - Bad judgement from others - Not experienced - Not applicable - Strong but unsatisfied sexual urge - No supporter - Perpetrators not found - Parent's support

Table 2 (continued)

Themes	Sub-themes	Codes
Recommendations to Improve the sexual experiences of women with disabilities	Suggested recommendation to improve sexual activities and relationships	- Need time to move - Restoration of sight - Not applicable - No idea - Media sensitization against sexual stigmatization and abandonment or stigmatization among women with disabilities - Nothing can stop it - Use of drug - More healthcare treatment
	Improving accessibility of modern contraceptives for women with disabilities	-Home or personalized service - Provision of service in close any facility - More pharmacies or clinics to buy it - Change of contraceptive method - Awareness creation - Not needed or not applicable - making health facilities more accessible to women with disabilities with friendly roads - Modern contraceptives to be given free of charge - Can get it from the chemist or medical personnel - Send people to buy it for me
	Strategies to overcome barriers to sexual autonomy	- Prayer - Security agency - Shouting for help - Partners relationship - Walking equipment - Sexual education for men against forceful sex -No response or no idea or not applicable - No challenge - Re-orientation of the non-disabled that disability does not hinder sexual satisfaction - Marriage - Being careful of places they visit to avoid being taken advantage of - doing what the men want, nothing can be done - God's intervention - Ability to walk
	Measures to support and prevent sexual violence against women with disabilities	

Sexual Experiences of Women with Disabilities

Women with disabilities revealed various sexual experiences. They described the effect of disability on their sexual activities, desire for and use of modern contraceptives, understanding of sexual autonomy, experiences with risky sexual behavior and sexual violence.

Disability and Sexual Activities

Some participants reported that disability did not affect their sexual activity, while some participants opined that disability affected their sexual activity. The participants who opined that disability did not affect their sexual activity gave this report with the perception of

sexual activity as sexual intercourse practice, while other participants reported other ways in which their disability affected their sexuality.

A participant whose disability did not affect her sexual activity but affected her work life said, *"it did not affect it. I cannot do some work like fetch water, but I do other things; as I said am not married. I have a boyfriend, but it did not affect" (Participant 17).*

A participant who opined that her disability affected her marital or sexual relationship life because it affected her ability to re-marry or engage in sexual relationships but did not affect her sexual activity said, "My husband *is dead, so it doesn't affect me. I wish to get married, but because of this condition…., but am believing in God" (Participant 12).*

However, some of the participants reported that their disability affected their sexual activity. The participants reported effects such as pain, inability to do different sexual styles, inability to be sexually effective and sexual discrimination. One of the participants who usually experience pain during sexual intercourse said, *"It used to affect me o, sometimes when my husband says that we should have sexual intercourse, it usually pain" (Participant 18).*

A participant said her disability does not allow her to do several sexual styles; she said, *"It affects me because we cannot do different styles; my husband does complain" (Participant 21).* Another participant said, *"it affects me, as in I cannot able to do it very well" (Participant 4)*.

Desire and use of Modern Contraceptives

Participants in this study expressed their desire to use modern contraceptives, reflecting a range of experiences, including those who desired and those who did not desire to use contraceptives, as well as those who used and those who did not use them. The reasons for participants' desire and use of contraceptives were also reported. Participants gave reasons for not using modern contraceptives, including fear of negative consequences from contraceptive use, not having a current need for it either because they are not yet married or because they desire more children, high cost of modern contraceptives, and use of the traditional method.

A participant who desired to use a modern contraceptive but is not currently using it because of the fear that it may complicate her disability said, "*Yes, I wish to use it, but because of my leg, I am not sure because it may complicate my leg problem. I am afraid that is why I did not use it so that it will not lead to another thing" (Participant 21).*

Participants reported contraceptive non-use despite their desire to use it because they did not currently need it. A participant who is not using modern contraceptives because she is not married said, *"I am not married yet, so I can't say that I am going to use it; maybe if I am married now, I can say that if I can make use of it or not but for now, I don't have any need" (Participant 15).* Another participant who is not using because she is not married said, *"I know about it, but I can't do it because I am not yet married. I wish to use it after I have had like three or four kids" (Participant 19).*

A participant who desired to use but complained about modern contraceptives being expensive said, *"Yes, the modern contraceptive that me I know is the drug that we use to buy like postinor or something like, Yes I desire to use it, but now it is somehow expensive" (Participant 5).*

A participant who does not use modern contraceptives but uses traditional methods said, *"Which one is contraceptive? You know my leg I don't use to go out always, I use all this local method" (Participant 1).*

In addition, a participant who did not desire to use contraceptives because of the rumour that contraceptive use may cause infertility or delayed fertility, which has instilled fear into her, said, *"I did not desire to use it o, because I used to hear that if a person uses modern contraceptives, it may stop you from having children later in the future am not married, but due to my closeness with married people that it causes delay" (Participant 17). This participant is not yet married and most likely has not found a need to use it.*

Participants further reported contraceptive discontinuation. A participant who had discontinued the use of modern contraceptives but did not state contraceptive use desire said, *"I have used one before. I think they call it T junction. It usually blocks such that sperm will not be able to enter. That is the one I can talk about, and that was many years back" (Participant 13).*

Another participant who had discontinued modern contraceptive use but stated future contraceptive use desire said, *"I have used it before. Yes, I desire to use modern contraceptive" (Participant 22).*

A participant who uses it sometimes but complained about her disability condition said, *"I do use it sometimes because of my condition."... She further said, "I sometimes see it to use sometimes" (Participant 23). This participant is inconsistent with the use of modern contraceptives.*

Understanding Sexual Autonomy in the Context of Disability

Participants' perspectives on sexual autonomy were presented in this section. Sexual autonomy was defined as the right to decide about and freely engage in sexual activity in a sexual relationship. This was defined from different perspectives of the right to make sexual decisions, sexual negotiation, sexual capability, and normal activity in a sexual relationship.

A participant who defined sexual autonomy as the right to sexual activity decision based on interest said, *"This is the right one has when it comes to sexual activities between husband and wife; if my husband is interested and I am also interested, I will do it with him" (Participant 11)*. Another participant with a similar understanding as participant 11 said, *"The person I am dealing with must understand that the strength of the normal person is not what I will have; there are some things that they will be able to do easily that will be difficult for me. Yoruba usually say an adage that a pig will get to Oyo, but it will take time. So if you want to have sexual intercourse, if my body takes it, I will do it, but if my body did not take I will not do it; you can't force me" (Participant 14).*

Another participant who has the understanding of sexual autonomy as a right to sexual activity decision but with an additional perspective of sexual negotiation, agreement, or consent said, "Yes if there is no agreement between you and a person as an individual, it is impossible to have a sexual something or is that not the question you are asking? Apart from rape, there must be consent; for my own condition, I know what is right and what is wrong" (Participant 16). This reflects the ability to negotiate for sex and choose when to have sexual intercourse or not.

Experiences with Risky Sexual Behavior with Unfamiliar Partners

Risky sexual behavior was operationalized as being involved in sexual activity with someone the person does not know well or a stranger. The participants reported their risky sexual experiences to include forceful sexual intercourse or rape and sexual harassment. However, the emphasis here is on being involved in sexual activity with strangers.

A participant who experienced risky sexual behavior in the form of uncomfortable touch from someone she did not know said: *"I think that it is like I said before, it was when I was young everybody has a boyfriend that use to move about with people I don't really know, you boys when they say things that you want to hear you will want to follow them, when you now follow them you don't know them very well, next thing you are shouting you want to tell them not to touch something like that" (Participant 5).*

However, the majority of the participants did not experience risky sexual behavior. A participant said, *"It has never happened before" (Participant 22).* Another participant said, *"it is not possible for me to go out with someone I do not know well" (Participant 15).*

Experiences of Sexual Violence Related to Disability

Participants' sexual violence experiences were reported in this section to include those who had sexual violence experiences and those who never experienced it. Participants who experienced sexual violence reported issues that included: physical assault, sexual rape and uncomfortable bodily touch. The participants who reported sexual violence were victims of the violence and not perpetrators. A participant who experienced sexual harassment of sexually related physical assault and attributed it to her disability was assaulted by a man with a disability. She said, *"Yes, that was a long time when I was not married that I went to Lagos, so where they put us in a hostel, they mix us men and women. The guys used to say that I am being too arrogant "na today e go happen and I was na today ke" but you know I don't have leg and if I seat on the floor am already ok, and these people are more hefty than me. That was the only thing I did that year because they hold me by my neck" (Participant 16).*

Another participant who experienced rape also attributed it to her disability. She was of the opinion that her physical disability made it difficult for her to escape from the incidence of rape or get assistance. She said, *"If I were not disabled and nothing was wrong with me, the one that happened to me would not happen; because of my leg, I don't have any energy to shout, and the people that were supposed to assist me in the area did not show up. If I have legs and am complete, the thing that happens to me will not happen*"…… She experienced rape when she was younger, and her experience was narrated thus: *"This thing you ask me is very bad; you want to make me remember something bad, when I was around seventeen years, my mummy usually do farm work, there is this boy behind our house, it is the person that forcefully has carnal of me. This really caused a lot of problems that even turned into a police case. Since then, I have been somehow" (Participant 20).*

Women with disabilities who experienced sexual violence were, therefore, victims of the various violence which were perpetrated by other persons, either with a disability or not. The occurrences were blamed on their disability. The participants were of the opinion that such sexual violence would not have happened if they were not with disability.

However, participants who did not experience sexual violence gave their reports. A participant said, *"No, it has never happened to me" (Participant 11).* Another participant who

did not experience sexual violence reported her ability to engage in sexual activity freely without being coerced, and she said, *"It has never happened to me; if I want to date, I will date" (Participant 22).*

Sexual Challenges Experienced by Women with Disability

The study participants described various sexual challenges experienced by them with regard to sexual activity, accessing and using modern contraceptives, asserting sexual autonomy, exposure to risky sexual behavior and accessing support against sexual violence.

Challenges in Pursuing Sexual Relationships and Intimacy due to Disability

The participants narrated their experiences with regard to how disability affected their sexual relationships as they mentioned sexual difficulties such as the inability to do different sexual styles, difficulty with movement during sexual activity, and difficulty in establishing a while; a few participants reported that disability did not affect their sexual relationships.

A participant who experienced difficulty with ease of movement during sexual intercourse said, *"The only challenge is that the leg will not allow me to move easily" (Participant 5).*

Further, participants expressed the negative effect of disability on their relationship formation. A participant narrated how her disability hindered her from establishing another sexual relationship. She said, *"I could not get another man since my accident; it only me and my son that have been together"... She earlier said that before I had this accident that injured my leg, I gave birth to my son with a man, he said he is no longer interested in me and left, but before he left I already have a child for him" (Participant 10).*

Another participant explained how disability hindered her from establishing another relationship. She said, *"My husband is late, so it doesn't affect me. I wish to get married, but because of this condition, but am believing in God" (Participant 12).*

However, some participants opined that disability did not affect their sexual activities or relationships. One of the participants with this opinion said, *"I don't have any challenge; if my husband brings anything when it comes to sex, I will readily answer him" (Participant 13). This participant feels confident and capable of optimal performance sexually regardless of her disability. Another participant said, "I don't really have any challenge" (Participant 15).*

Challenges in Accessing and Using Modern Contraceptives

Myriads of factors such as disability, high cost of modern contraceptives, distance to health facilities, bad road accessibility, and unhealthy blood discharge were factors that discouraged participants from using modern contraceptives. Prominent among these challenges is their disabilities. A participant expressed difficulty in getting modern contraceptives due to disability; she said, *"I have issues using contraceptives ooo, because I cannot see and I don't go out so it is difficult so it is difficult to get it is always very hard" (Participant 7). Another participant with a similar experience said, "It is just for prevention now; it is not that easy for me, so most time, if I want to get it like that, I will rather send someone to help me get it at the pharmacy store or the hospital" (Participant 24).*

Furthermore, factors such as the high cost of contraceptives, distance to health facilities and bad road access were mentioned as challenges to the utilization of modern contraceptives. A participant expressed difficulty in accessing the pharmacy due to far distance and issues with the staircase; she said, *"It's just the affordability; it is expensive now, but if you go to a pharmacy, you will get it there because the pharmacy is far and to get to their entrances the stairs, that is the only thing to get it" (Participant 5).*

In addition, unhealthy discharge of blood was also reported as a factor that discouraged the continuation of the use of modern contraceptives. A participant who has used modern contraceptives but prefers local contraceptives due to her unsuitable experience said, *"I think I try it sometimes, maybe because I am used to the herbal or normal contraceptive way, but so I don't get myself that day, so I bought like one sachet so because it is the tablet I did not use it again the day I use it I saw blood, and you know how pad cost now I cannot be buying pad every time, but the other local way of preventing childbearing am using it" (Participant 1).*

However, a participant reported ease of getting modern contraceptives and that her disability does not hinder her from getting them at the hospital; she said, *"It is very easy to get na, in as much as you get to the hospital and explain yourself to the Doctor, of course, my challenge does not affect me to getting to the hospital" (Participant 15).*

Barriers to Asserting Sexual Autonomy and Strategies for Navigation

*D*isability limits participants from doing several sexual styles as they would want to, thereby leading to negative sexual consequences such as sexual rights deprivations from partners. A participant who faces such a barrier *said, "That one is very plenty and has different forms, you know we that are special, as a man he might have something that he desires, but due to the disability, the person might not get it, especially in terms of a different style but since I can't be able to do it. He might deprive me of my right by not wanting to have anything to do with me and go outside, so he has deprived me of my right by going outside" (Participant 16).*

In addition, disability limited participants from getting marital partners, being a challenge to sexual autonomy as expressed by a participant. She said, *"Generally, I face a lot of challenges. I can't walk, and I can't go anywhere; it is my parent that help me, nobody except them. I need help; you know, before any man can marry someone, it will be very difficult" (Participant 20).*

However, not all the participants reported having any challenges or barriers with expressing their sexual autonomy, as some do not have any challenges. A woman said, *"No, I don't have such challenges" (Participant 17).*

Barriers to Accessing Support for Sexual Violence as a Woman with a Disability

The barriers that women with disability face in accessing support or resources to address incidents of sexual abuse include abuse and misunderstanding from other people as well as their disability. A participant who experienced abuse from other people said,*"...Some people will abuse me" (Participant 4).*

Another participant who experienced misunderstanding from other people said, *"The barrier I face is that people in the community will not understand how you are feeling. They*

will be judging you. Kilon wa kire (what is she looking for about)? What is the person that leg is paining looking for? Those are the things I can say I face people use to say different things" (Participant 5).

A participant who experienced a barrier due to her disability said, "Yes, it is because of my disability because I cannot see, so only stay see doing nothing if anybody enters, I won't be able to know till I started feeling them touching me, there is no support except the one my husband is providing" (Participant 3).

Recommendations to Improve the Sexual Experiences of Women with Disability

Study participants recommended possible solutions to various sexual challenges reported in the study. Solutions such as government assistance, police involvement and involvement of other people are major recommendations in the study.

Suggested Recommendation to Improve Sexual Activities and Relationships

Two major recommendations emerged for the improvement of sexual activities and relationships among women with disability. Firstly, the government should help in re-orienting persons without disability that women with disabilities are sexually similar to other women without disability. A participant who recommended this said, *"We will have to beg the government to assist those of us with a disability who don't usually see men that like us; I also know that it how it will affect the male flocks too will not see women they like to marry*, *so the government should try and do things that will make the people see us as the same*, *they also need to do the right thing so that we ourselves will stop thinking" (Participant 10).*

Secondly, the government should conduct media sensitization to stop the stigmatization and abandonment of people with disabilities. The participant who recommended it said, *"Government need to do a lot*, *they need to go to media houses*, *newspaper publications that they should stop the stigmatization and the issues of abandoning people with disabilities" (Participant 9).*

Improving Accessibility of Modern Contraceptives for Women with Disabilities

In order to enable improved accessibility to modern contraceptives among women with disabilities, it was recommended that lifts should be made available in all health facilities to enhance easy passage among women with disabilities; health facilities where modern contraceptives can be purchased should be made available; modern contraceptives should be given free of charge, and there should be the creation of awareness for modern contraceptive in the hospitals.

A participant who recommended that health facilities should have lifts so that women with a disability can use them instead of staircases said, *"The solution is that we already know of buildings that have been built*, *but the new building should have where wheelchairs can pass. Even those that are using crutches can pass easily because there are some places that immediately there is water their people on crutches cannot pass there*, *but if they put lift where there is staircase it will be convenient" (Participant 14).*

A participant recommended having more pharmacies where it can be gotten and also recommended it being given to women with disability by many hospitals; she said, *"How it*

can be made easily available is when there are more pharmacies/chemists that we can easily buy it. The only one I know very well is postinor, but people are saying that there are other ones, the ones they use to insert or something, so if you can use that too, it will be better. Many hospitals can be giving us" (Participant 7).

A participant recommended that if modern contraceptives are free, then it will encourage more use. She said, *"It is in the hospital. I will use it more if it is free in the hospital" (Participant 19).*

Another participant recommended creating awareness for women with disability in the hospital; she said, "*I feel there should be awareness for the disability people like us like that maybe like in the hospital, they can just tell us or inform us, and there is a way they can convey us there and give it to us"* (Participant 24).

Strategies to Overcome Barriers to Sexual Autonomy

Based on the findings from this study, certain recommendations were given to overcome barriers to sexual autonomy. These recommendations include giving sexual orientation to men to stop sexual coercion against women, promoting understandable relationships among partners, ensuring self-protection strategies such as not engaging in risky movement and locking women with disability in the house when others are not around, as well as seeking the assistance of other people including the law enforcement agents and provision of walking aids.

It was recommended that men should be given sexual orientation so as to stop sexual coercion against women with disability. A respondent said, *"If they can help us talk to our men, especially since we are visually impaired, they should not be forcing us to have sex" (Participant 6).*

Further, it was recommended in this study that cordial relationships among partners should be encouraged to ensure the sexual autonomy of women with disabilities. A participant has this to say, *"I think relation, the way the two partners relate assuming maybe there is conflict in the house and my husband come around that he needs sex, sometimes I don't use to say no sometimes I look at the circumstances, I will just manage myself and pray that God will help me so for that time and pray that God will help me to do it. It thinks it is by relationship" (Participant 1)*. This participant recommends good relationships among partners.

In addition, to ensure sexual autonomy among women with disabilities, self-protection or safety measures were recommended. A participant recommends that parents or caretakers should take self-safety measures as well as safety and preventive measures. She said, *"In my own opinion, I think disabled people should mind where they go to in the sense that, if you are in a place where you can't readily get help, people will take advantage of you easily, then the parent has a lot to do it. I think I remember when I was young, my parent believed that it was safer to lock me up at home, so when they locked me inside, anybody who knew where they normally kept the key could come to me or just finger my brain and get to me and want to take advantage of me so we must have ways of knowing our right and able to prevent the occurrence" (Participant 13).*

Another participant recommended seeking help from other people, including the law enforcement agent, as a way of asserting your sexual autonomy. She said, *"Sexual harassment, sexual violation, people can touch you anyhow when they know that you cannot run,*

you cannot do anything, and you don't have power over yourself; they can harass you anyhow they like. By shouting or calling others for help, calling people that are older than you for help, I think that is the only thing that we can do or by informing the police… by reporting to the police and by calling people around us, people living around us elders, community leaders they can help us by doing that" (Participant 2).

Lastly, a participant recommended finding the solution to her disability through walking support to easily access the hospital for support as what will solve the issue of sexual autonomy. She said, *"Number one thing that I think can help me now is to get crutches or a machine that can easily allow me to move really fast and can easily access the hospital so that if anything like that happens, I know where to lay complain and meet the doctor or anybody in the hospital they can help me to do that" (participant 5).*

Measures to Support and Prevent Sexual Violence against Women with Disabilities

The measures that can be taken to support women with disabilities who have experienced sexual violence and to prevent such from occurring in the future are reported by the participants. The recommendation centres around four major themes, which are the recommendation for people's support, the recommendation for the government's support, the police's involvement and the creation of a platform for sexual orientation for people not to perpetrate sexual violence against women with disabilities.

It was recommended that families should provide adequate support systems for women with disabilities. A participant said, *"It is the family that I will still beg for their support is very important. Family should bring them closer; even the ritualist can take advantage of such persons, so they should preach and talk to the person. It is the family that is important even in some cases, if the husband wants to stay, they might be making jest of the husband of a blind person; in terms of money and caring, it is better among those their eye problem started since birth, but all in all God knows about everything, they should not talk bad to us, some people will talk down on you till you start thinking of committing suicide, all in all, the family has very important" (Participant 11).*

It was further recommended that women should socialize with other people to prevent sexual violence. A participant said, *"They should have courage enough to just put away what happened; the people should encourage them because it can cause depression because the person will think that with their condition, the people surrounding them need to cheer them up, and they should keep their hand busy they should not just seat down not doing anything. If you are sitting down and not doing anything you will have time to be thinking bad thoughts and this and that, if you are busy and you have good people surrounding you, I hope you fair well from there you will see a good person who can pick you for there and also do not look less on yourself because what has gone has gone and let count it has past so you start afresh" (Participant 15).*

It was further suggested that the government should enact laws that would protect women with disabilities from experiencing sexual violence, execute justice, find solutions to disability and build houses for women with disabilities to ensure the protection of women with disabilities against sexual violence. A participant who suggested that the government should enact laws that will protect women with disability from sexual violence said, *"The almighty should assist us have we don't have a good government; if we have a good government and we have special care and special care for people that are physically challenged, we will not*

be facing what we are facing sexual violence, those who are able to are facing it talk less of physically challenge if their law that bides these things, they will not want to violet the law and say this girl because of her condition and take advantage over her but because their no law and anywhere there is no law there is no offence and they will continue to suffer someone the best thing is that anybody that had physical challenge should have people around and support structure so that if there is any problem can be quickly called upon. So it the law that actually matters sha" (Participant 16).

A participant who recommended that the government should execute justice said, *"If that kind of thing happens, the government should do the right thing, and justice should be served so that it will not happen again; that kind of people that cannot work as women it is not polite for a woman to be begging from household to household so if a woman has all they need that kind of things cannot happen" (Participant 18).*

A participant who recommended the government's assistance with finding a solution to her disability, which she said would be a solution to her sexual violence experience, said, *"I beg the government, if he can help us, people that are disabled like us, we will be very happy. They can help us; If the eyes can see very well, we will not have all these challenges, something bad wants to happen we will see" (Participant 19).*

A participant recommended that the government should build houses for women with disabilities so as to aid their livelihood and protection against sexual violence. She said, *"What I think the government can do is that they can build houses for people like us, and they help us get things we need and put people that can monitor and assist us so that we won't face sexual violence again" (Participant 20).*

Furthermore, societal support for women with disabilities was recommended. A participant said, *"What I think is that people should be around, and the community should stay with them, and they need enough security so that people will not take advantage of them" (Participant 10).*

It was further recommended that participants should raise the alarm for people's support against sexual violence. A participant recommended raising the alarm to alert people and also involve the police. She said, *"That kind of person needs to let people know what happened; she should let people around know by creating an alarm, if possible, the person can go to the police station to report" (Participant 14).*

The involvement of the police was suggested, and more serious action should be taken on the issue by the police. She said, *" I think, people that are disabled like me, when we go to the police station, they should not say because we have eye challenge they should not take our matter seriously" (Participant 7).*

It was also recommended that a forum should be created for the enlightenment of people towards stopping sexual violence against women with disability. She also recommended the government's support. She said, *"I feel there should be more awareness towards the sexual harassment towards the disability, they should create a forum to inform people that should not harass these people because they are disabled and all that I feel our government too should do something toward it also" (Participant 24).*

Another woman suggested something similar to what was suggested by participant 24. She said, *"It is by supporting us by letting people know not to take advantage of us by providing for us. I like said I don't work; I normally go around with my stick sometimes. I may fall sometimes, and a lot of things happen; let's assume there is support from the government; the harassment won't be much; there will be more, like me, that I can't see I need to*

go out to another street to beg in another to have money and little change along that said I face many challenges it would have been better" (Participant 3).

Discussion

This study describes the sexual experiences of women with disabilities in Lagos, Nigeria. Findings from the current study affirm previous findings in Nigeria [35, 46] and elsewhere [47–49], which suggested that most women with disabilities are sexually active and have similar sexual needs and desires as those without disabilities. However, the sexuality and sexual experiences of women with disabilities in Nigeria, like in many countries in SSA, are often neglected or ignored due to the long-held perception that women with disabilities are asexual or sexually inactive [17, 18]. For instance, Okotie and Jolly [46] reported that women with disabilities in Nigeria continue to be discouraged from getting intimate or expressing their sexual desires. Such suppression of sexual feelings could have a negative impact on the well-being and quality of life of women with disabilities [48].

Meanwhile, some participants reported limitations in sexual activity due to their inability to assume certain sex positions such as "doggy" or "touch your toe", pain during sex, and sexual discrimination, which affected their sexual relationships. Evidence suggests that women with limiting disabilities, especially those with missing limbs [50] and those with difficulties in mobility [51], tend to have challenges in pursuing or maintaining intimate relationships due to their inability to meet the sexual desires or demands of their partners [52]. Therefore, aside from using sexual therapeutic aids to enhance the sexual activity of women with disabilities [52], educating male partners on the physical limitations of women with disabilities and empowering them to provide physical support during sex could promote sexual satisfaction of both partners and safeguard their sexual relationships. Also, as suggested by many participants in the present study, there is a need to educate the general public, especially men, on the sexuality and sexual needs of women with disabilities in order to minimize stigma and sexual discrimination against women. This could promote sexual activity and enhance the ability of women with disabilities to form healthy sexual relationships.

Consistent with findings from previous studies [53–55], most of the participants in this study reported not using any form of contraception, and some had no desire to use modern contraceptives. Participants' accounts of their non-use of contraceptives include difficulties in getting access to contraceptives, fear of unknown complications, cost, and the desire to have children. For instance, some participants with physical and visual impairments recounted how challenging it was to get contraceptives from pharmacies or healthcare facilities due to distance and difficulties in using the staircase. Unfriendly physical health infrastructure, such as pharmacies and hospitals that can only be accessed through staircases [56], and long travel distances to access healthcare, including contraception services [57], are known to contribute to the low utilization of contraceptives among women with disabilities. Besides, participants' narratives revealed poor contraceptive knowledge, as some believed that the use of modern contraceptives could lead to bareness and other unknown health complications.

Interestingly, none of the participants associated the use of contraceptives with the prevention of STIs. Thus, aside from highlighting the limited contraceptive knowledge among

the participants, which could contribute to the low utilization of contraceptives among women with disabilities in Nigeria [35, 58], the current findings also suggest that there could be an exposure of the participants to STIs, including HIV. Therefore, targeted interventions are needed to improve the contraceptive knowledge of women with disabilities and increase their access to sexual and reproductive health services, including access to HIV counselling and testing [35, 59].

Despite having the same sexual autonomy or rights as persons without disabilities, individuals with disabilities are often disregarded by society when expressing their sexuality and sexual desires [20]. In this study, we found that most of the participants had good knowledge of sexual autonomy/rights, describing the concept as the liberty to choose sexual partners and engage in consensual sex regardless of being disabled. Nonetheless, participants reported difficulties in asserting their sexual autonomy/rights, which they attributed to limitations in mobility, excessive dependence on their partners for physical and financial support, as well as negative societal attitudes towards the sexuality of women with disabilities. Evidence suggests that increased dependence on others prevents many women with disabilities from asserting their sexual and reproductive rights, promoting sexual abuse [60, 61]. Thus, there is a need for societal education on the sexual and reproductive rights of women with disabilities as well as empowerment of women with disabilities on how to assert their sexual and reproductive rights, including seeking help from the appropriate authorities such as law enforcement agencies and health providers.

Furthermore, most participants reported that they did not engage in risky sexual behaviors (i.e., having sexual activities with an unfamiliar person). However, some suggested they were sexually exploited or abused by unfamiliar persons. These sexual exploitations and abuses occurred largely due to the limiting nature of victims' disabilities (e.g., missing limbs) and social isolation (e.g., staying alone at home) [60, 61], highlighting the need for interventions that protect women with disabilities from sexual predators and abusers. Similar to the findings from a previous study in Nigeria [35], some participants reported experiencing sexual violence and coercion, including rape and sexual harassment. In the same vein, Ekenedo and Albert [62] found that sexual violence against persons with disabilities in Nigeria largely occurs due to dependence on others for support, poverty, and social isolation. Meanwhile, most of the victims of sexual violence and coercion reported difficulties in accessing support or seeking justice mainly due to their inability to identify perpetrators (due to visual impairment), societal prejudice, and victim blaming, thus emphasizing the need for increased social protection of women with disabilities in Nigeria.

Strengths and Limitations

This study describes the sexual experiences of women with disabilities in Lagos, Nigeria, enabling us to have detailed insight into women's sexual activity, modern contraception use, risky sexual behaviors, and sexual violence and coercion. Therefore, the current findings enhance our understanding of the sexual experiences of women with disabilities from a qualitative perspective. However, the current study has some limitations. Although women's sexual experiences with regard to their sexual activity, contraceptive use, and risky sexual behavior may vary by disability type [47], the current study did not segregate participants' experiences based on disability type, which could affect the interpretations of our findings. Also, the concept of risky sexual behavior was operationalized as having sexual activities

with an unfamiliar person, although the concept encompasses multiple sexual activities, including engaging in unprotected sex, having multiple sexual partners, and having sex under the influence of alcohol or drugs, among others [35, 63, 64]. Further, because of the socially undesirable nature of certain forms of sexual experiences, such as risky sexual behavior and sexual violence, as well as their associated stigma in society, some of the participants are likely to underreport their experiences.

Policy and Practical Implications

The current findings have important policy and practical implications. First, whilst most of the women with disabilities were sexually active, some had limitations in expressing their sexuality, which had a negative impact on their sexual relationships. Therefore, it is incumbent on various stakeholders and policymakers to implement measures that enhance the sexual activity or functioning of women with disabilities. This may include providing sexual aids to women with disabilities when needed and sensitizing male partners to understand the physical limitations of the women and the need to provide physical support during sexual intercourse.

Also, the majority of the women with disabilities did not use any form of contraception, highlighting their increased exposure to sexual and reproductive health problems, including HIV infections. Therefore, it is important to implement measures that address barriers to access and use of contraceptives among women with disabilities. These may include improving contraceptive knowledge among women with disabilities and increasing their access to sexual and reproductive health services, providing disability-friendly pathways at hospitals and pharmacies, having more community pharmacies, and making contraceptives free for women with disabilities.

Further, whilst some of the women with disabilities were sexually exploited or abused by unfamiliar persons, others experienced sexual violence and coercion, largely due to mobility limitations, dependence on others for support, and social isolation. Therefore, aside from empowering women with disabilities to assert their sexual autonomy, it is important to implement measures that protect them from sexual exploitation, risky sexual behaviors, and sexual violence and abuse.

Conclusion and Recommendations

The current study highlights the sexual experiences of women with disabilities in Lagos, Nigeria. Whilst the majority of the participants were sexually active, some experienced various challenges in expressing their sexuality, including the inability to assume certain sex positions to meet their partners' sexual demands or expectations, difficulties in getting access to contraception, inability to assert their sexual rights, the experience of sexual violence and exploitations. Therefore, considering the importance of positive sexual experience on the health and well-being of women with disabilities, it is important for stakeholders, including governmental and non-governmental organizations, to institute stringent measures that address the sexual and reproductive health needs of women with disabilities in Nigeria. These interventions should be targeted at promoting positive sexual experiences among women with disabilities by improving their sexual functioning, particularly among

those with limiting disabilities, enhancing access and the use of contraceptives, providing avenues to assert sexual autonomy and preventing exposure to risky sexual behaviors and sexual violence and abuse.

Appendix 1: Ethical Approval Letter

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Bolarinwa

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H24/04/07**
PROJECT TITLE	Disability and sexual health: Understanding the sexual behaviour of women with disabilities in sub-Saharan Africa
INVESTIGATOR(S)	Mr O Bolarinwa
SCHOOL/DEPARTMENT	Social Sciences/
DATE CONSIDERED	19 April 2024
DECISION OF THE COMMITTEE	Approved Risk Level: Low
EXPIRY DATE	22 May 2027
DATE 23 May 2024	**CHAIRPERSON** (Professor J Watermeyer)

cc: Supervisor : Prof C Odimegwu

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **A SIGNED COPY** returned to the Secretary electronically. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure be contemplated from the research procedure as approved I/we undertake to submit an amendment of the protocol to the Committee. **I/we agree to completion of a regular progress report. For Minimal and Low Risk studies, this is due annually on 31 December. For Medium and High Risk studies, this is due twice annually on 30 June and 31 December.**

Obasanjo Bolarinwa
Signature

24/05/2024
Date

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Supplementary Information The online version contains supplementary material available at https://doi.org/10.1007/s11195-024-09881-8.

Acknowledgements We would like to express our gratitude and appreciation to the participants who contributed to this study.

Author Contributions OAB and CO conceived and designed the study. OAB and AM drafted the manuscript and conducted the methodology, and AOB and BIB performed the analysis. CO supervised the overall study development and critically reviewed the manuscript for methodological and intellectual content. All authors read and approved the final version of the manuscript before submission.

Funding Open access funding provided by University of the Witwatersrand.
There is no specific funding received for this study.

Data Availability All data generated and analysed are included in this article.

Declarations

Ethics Approval and Consent to Participate Ethical clearance for this study was granted by the Human Research Ethics Committee (Non-Medical) at the University of Witwatersrand, dated April 19, 2024, with ethical number H24/04/07 (Appendix 1). Potential participants were provided with an information sheet to review before giving verbal consent. Those who agreed to participate were then asked to provide informed consent before the interviews began. This consent process ensured that participants understood their involvement was entirely voluntary, with welfare services available if needed due to the sensitive nature of the questions and the participants' social status (disability). It was emphasized that participants could withdraw from the study at any time without any consequences. Additionally, participants were informed that the study results would be published in an anonymous form in academic journals. All data collection processes and methods used in this study adhered to the ethical principles outlined in the Declaration of Helsinki [65].

Consent for Publication Not applicable.

Competing Interests The author declares no competing interests.

References

1. World Health Organization [WHO]: Global Report on Health Equity for Persons with Disabilities. World Health Organization (2022)
2. Martinez, R., Vemuru, V.: Social Inclusion of Persons with Disabilities in Nigeria: Challenges and Opportunities. World Bank Blogs (2020)
3. World Report on Disability: [https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/world-report-on-disability]
4. Lagos state persons: with disabilities community [https://cdinclusionafrica.org/tag/lagos-state-person-with-disabilities-community/]
5. Rabie, A.M.: COVID-19 and sexual dysfunction in men: SARS-CoV-2 in the testes. Sexologies. **30**, e141–e148 (2021)

6. Higgins, D.: Sexuality, human rights and safety for people with disabilities: The challenge of intersecting identities. Sex. Relatsh. Therapy. **25**, 245–257 (2010)
7. De Beaudrap, P., Mouté, C., Pasquier, E., Tchoumkeu, A., Temgoua, C.D., Zerbo, A., Mac-Seing, M., Beninguisse, G.: Burden of and risk factors for sexual violence among women with and without disabilities in two sub-saharan African countries. Global Health Action. **15**, 2077904 (2022)
8. Ledingham, E., Wright, G.W., Mitra, M.: Sexual violence against women with disabilities: Experiences with force and lifetime risk. Am. J. Prev. Med. **62**, 895–902 (2022)
9. Aslan, E., Yılmaz, B., Acar, Z.: Reproductive health, sexual function and satisfaction levels in women with physical, hearing, and visual disabilities. Sex. Disabil. **39**, 595–608 (2021)
10. Mavuso, S.S., Maharaj, P.: Access to sexual and reproductive health services: Experiences and perspectives of persons with disabilities in Durban, South Africa. Agenda. **29**, 79–88 (2015)
11. Bolarinwa, Odimegwu, C., Tapera, T.: Improving the sexual health of women with disabilities in sub-saharan Africa: A scoping review of published studies. Reproductive Health. **21**, 1–13 (2024)
12. Romo, L.F., Lefkowitz, E.S., Sigman, M., Au, T.K.: A longitudinal study of maternal messages about dating and sexuality and their influence on latino adolescents. J. Adolesc. Health. **31**, 59–69 (2002)
13. Mitchell, K.R., Lewis, R., O'Sullivan, L.F., Fortenberry, J.D.: What is sexual wellbeing and why does it matter for public health? Lancet Public. Health. **6**, e608–e613 (2021)
14. Udigwe, I.B., Adogu, P.O., Nwabueze, A.S., Adinma, E.D., Ubajaka, C.F., Onwasigwe, C.: Factors influencing sexual behavior among female adolescents in Onitsha, Nigeria. Open. J. Obstet. Gynecol. **4**, 987 (2014)
15. Narasimhan, M., Say, L., Allotey, P.: Three decades of progress and setbacks since the first international conference on population and development. *Bulletin of the World Health Organization* 102:226. (2024)
16. Starrs, A.M., Ezeh, A.C., Barker, G., Basu, A., Bertrand, J.T., Blum, R., Coll-Seck, A.M., Grover, A., Laski, L., Roa, M.: Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission. Lancet. **391**, 2642–2692 (2018)
17. Groce, N.E., Rohleder, P., Eide, A.H., MacLachlan, M., Mall, S., Swartz, L.: HIV issues and people with disabilities: A review and agenda for research. Soc. Sci. Med. **77**, 31–40 (2013)
18. Peta, C., McKenzie, J., Kathard, H., Africa, A.: We are not asexual beings: Disabled women in Zimbabwe talk about their active sexuality. Sexuality Res. Social Policy. **14**, 410–424 (2017)
19. Kim, E.: Asexuality in disability narratives. Sexualities. **14**, 479–493 (2011)
20. Addlakha, R., Price, J., Heidari, S.: Disability and Sexuality: Claiming Sexual and Reproductive Rights, vol. 25, pp. 4–9. Taylor & Francis (2017)
21. Frohmader, C., Ortoleva, S.: The sexual and reproductive rights of women and girls with disabilities. In *ICPD International Conference on Population and Development Beyond*. (2014)
22. Seidu, A.-A., Malau-Aduli, B.S., McBain-Rigg, K., Malau-Aduli, A.E., Emeto, T.I.: Sexual lives and reproductive health outcomes among persons with disabilities: A mixed-methods study in two districts of Ghana. Reproductive Health. **21**, 69 (2024)
23. Holness, W.: Informed consent for sterilisation of women and girls with disabilities in the light of the convention on the rights of persons with disabilities. Agenda. **27**, 35–54 (2013)
24. Lee, R.L.T., Yuen Loke, A., Hung, T.T.M., Sobel, H.: A systematic review on identifying risk factors associated with early sexual debut and coerced sex among adolescents and young people in communities. J. Clin. Nurs. **27**, 478–501 (2018)
25. Perez-Curiel, P., Vicente, E., Moran, M.L., Gomez, L.E.: The right to sexuality, reproductive health, and found a family for people with intellectual disability: A systematic review. Int. J. Environ. Res. Public Health. **20**, 1587 (2023)
26. Mailhot Amborski, A., Bussieres, E.-L., Vaillancourt-Morel, M.-P., Joyal, C.C.: Sexual violence against persons with disabilities: A meta-analysis. Trauma. Violence Abuse. **23**, 1330–1343 (2022)
27. Plummer, S.-B., Findley, P.A.: Women with disabilities' experience with physical and sexual abuse: Review of the literature and implications for the field. Trauma. Violence Abuse. **13**, 15–29 (2012)
28. Groce, N., Izutsu, T., Reier, S., Rinehart, W., Temple, B.: Promoting sexual and reproductive health for persons with disabilities: WHO/UNFPA guidance note. (2009)
29. Sully, E.A., Biddlecom, A., Darroch, J.E., Riley, T., Ashford, L.S., Lince-Deroche, N., Firestein, L., Murro, R.: Adding it up: investing in sexual and reproductive health 2019. (2020)
30. WHO: Promoting sexual and reproductive health for persons with disabilities: WHO/UNFPA guidance note. (2009)
31. Bolarinwa, O.A., Odimegwu, C., Adebisi, Y.A.: Leaving no one behind: Addressing the sexuality of people with disabilities. Int. J. Equity Health. **23**, 129 (2024)
32. Ganle, J.K., Baatiema, L., Quansah, R., Danso-Appiah, A.: Barriers facing persons with disability in accessing sexual and reproductive health services in sub-saharan Africa: A systematic review. PloS One. **15**, e0238585 (2020)

33. Khan, F., Owolabi, M.O., Amatya, B., Hamzat, T.K., Ogunniyi, A., Oshinowo, H., Elmalik, A., Galea, M.P.: Challenges and barriers for implementation of the World Health Organization Global Disability Action Plan in low-and middle-income countries. J. Rehabilitation Med. (Stiftelsen Rehabiliteringsinformation) 50. Vol 4(2018)
34. Chilaka, O.: An Appraisal of the sexual and Reproductive rights of women with disability in Nigeria. Available SSRN 4481102 (2021) (PrePrint)
35. Oladunni, T.M.: Sexual behavior and practices among adolescents with disabilities in Southwest Nigeria. Sex. Disabil. **30**, 289–299 (2012)
36. Aderemi, T.J., Pillay, B.J.: Sexual abstinence and HIV knowledge in school-going adolescents with intellectual disabilities and non-disabled adolescents in Nigeria. J. Child. Adolesc. Mental Health. **25**, 161–174 (2013)
37. Olaleye, A.O., Anoemuah, O.A., Ladipo, O.A., Delano, G.E., Idowu, G.F.: Sexual behaviours and reproductive health knowledge among in-school young people with disabilities in Ibadan, Nigeria. Health Educ. **107**, 208–218 (2007)
38. Tong, A., Sainsbury, P., Craig, J.: Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. Int. J. Qual. Health Care. **19**, 349–357 (2007)
39. Andrade, C.: The inconvenient truth about convenience and purposive samples. Indian J. Psychol. Med. **43**, 86–88 (2021)
40. Parker, C., Scott, S., Geddes, A.: Snowball sampling. *SAGE research methods foundations* (2019)
41. Braun, V., Clarke, V.: Reflecting on reflexive thematic analysis. Qualitative Res. Sport Exerc. Health. **11**, 589–597 (2019)
42. Braun, V., Clarke, V.: Using thematic analysis in psychology. Qualitative Res. Psychol. **3**, 77–101 (2006)
43. Jordan, A., Parchment, A., Gauntlett-Gilbert, J., Jones, A., Donaghy, B., Wainwright, E., Connell, H., Walden, J., Moore, D.J.: Understanding the impacts of chronic pain on autistic adolescents and effective pain management: A reflexive thematic analysis adolescent–maternal dyadic study. J. Pediatr. Psychol. **49**, 185–194 (2024)
44. Gainforth, H.L., Shwed, A., Giroux, E.E., Hoekstra, F., McKay, R.C., Schaefer, L., Sibley, K.M., Kaiser, A., McPhail, L., McBride, C.B.: Transforming research systems for meaningful engagement: A reflexive thematic analysis of spinal cord injury researchers' barriers and facilitators to using the integrated knowledge translation guiding principles. Disabil. Rehabil. **2024**:1–9
45. Azungah, T.: Qualitative research: Deductive and inductive approaches to data analysis. Qualitative Res. J. **18**, 383–400 (2018)
46. Okotie, E.S., Jolly, S.: Feeling 'Happy, loved, cherished, desired'and 'Hopeful for the future': Disabled women in Nigeria Talk about sex and pleasure. Sex. Disabil. **42**, 85–99 (2024)
47. Haynes, R.M., Boulet, S.L., Fox, M.H., Carroll, D.D., Courtney-Long, E., Warner, L.: Contraceptive use at last intercourse among reproductive-aged women with disabilities: An analysis of population-based data from seven states. Contraception. **97**, 538–545 (2018)
48. Moin, V., Duvdevany, I., Mazor, D.: Sexual identity, body image and life satisfaction among women with and without physical disability. Sex. Disabil. **27**, 83–95 (2009)
49. Morales, E., Gauthier, V., Edwards, G., Courtois, F.: Women with disabilities' perceptions of sexuality, sexual abuse and masturbation. Sex. Disabil. **34**, 303–314 (2016)
50. Ward Khan, Y., O'Keeffe, F., Nolan, M., Stow, J., Davenport, J.: Not a whole woman: An interpretative phenomenological analysis of the lived experience of women's body image and sexuality following amputation. Disabil. Rehabil. **43**, 251–261 (2021)
51. Holdsworth, E., Trifonova, V., Tanton, C., Kuper, H., Datta, J., Macdowall, W., Mercer, C.H.: Sexual behaviours and sexual health outcomes among young adults with limiting disabilities: Findings from third British National Survey of sexual attitudes and lifestyles (Natsal-3). BMJ open. **8**, e019219 (2018)
52. Nery-Hurwit, M.B., Kalpakjian, C.Z., Kreschmer, J.M., Quint, E.H., Ernst, S.: Development of a conceptual Framework of sexual well-being for women with physical disability. Women's Health Issues. **32**, 376–387 (2022)
53. Alhusen, J.L., Bloom, T., Laughon, K., Behan, L., Hughes, R.B.: Perceptions of barriers to effective family planning services among women with disabilities. Disabil. Health J. **14**, 101055 (2021)
54. Beyene, G.A., Munea, A.M., Fekadu, G.A.: Modern contraceptive use and associated factors among women with disabilities in Gondar City, Amhara Region, North West Ethiopia: A cross sectional study. Afr. J. Reprod. Health. **23**, 101–109 (2019)
55. Tenaw, Z., Gari, T., Gebretsadik, A.: Sexual lives of reproductive-aged people with disabilities in Central Sidama National Regional State, Ethiopia: A mixed-methods study. BMC Public. Health. **23**, 1550 (2023)

56. Lagu, T., Hannon, N.S., Rothberg, M.B., Wells, A.S., Green, K.L., Windom, M.O., Dempsey, K.R., Pekow, P.S., Avrunin, J.S., Chen, A.: Access to subspecialty care for patients with mobility impairment: A survey. Ann. Intern. Med. **158**, 441–446 (2013)
57. Ganle, J.K., Otupiri, E., Obeng, B., Edusie, A.K., Ankomah, A., Adanu, R.: Challenges women with disability face in Accessing and Using Maternal Healthcare Services in Ghana: A qualitative study. PLoS One. **11**, e0158361 (2016)
58. Zandam, H., Mitra, M., Mitra, S.: Awareness and access to mass media sources of information about modern family planning methods among women with disabilities in Nigeria: An analysis of 2018 demographic and health survey. Front. Global Women's Health. **3**, 746569 (2022)
59. Bolarinwa, O.A., Adebisi, Y.A., Ajayi, K.V., Boutahar, R.: Sexual and reproductive health rights in the era of artificial intelligence. Lancet. **404**, 120–121 (2024)
60. Agaronnik, N., Pendo, E., Lagu, T., DeJong, C., Perez-Caraballo, A., Iezzoni, L.I.: Ensuring the reproductive rights of women with intellectual disability. J. Intell. Dev. Disabil. **45**, 365–376 (2020)
61. De Beaudrap, Mouté, C., Pasquier, E., Tchoumkeu, A., Temgoua, C.D., Zerbo, A., Mac-Seing, M., Beninguisse, G.: Burden of and risk factors for sexual violence among women with and without disabilities in two sub-saharan African countries. Global Health Action. **15**, 2077904 (2022)
62. Ekenedo, G., Albert, J.A.: Prevalence and correlates of sexual violence among persons with disabilities in Rivers State, Nigeria. Int. J. Health Wellness Soc. **12**, 13 (2021)
63. De Beaudrap, P., Beninguisse, G., Pasquier, E., Tchoumkeu, A., Touko, A., Essomba, F., Brus, A., Aderemi, T.J., Hanass-Hancock, J., Eide, A.H.: Prevalence of HIV infection among people with disabilities: A population-based observational study in Yaoundé, Cameroon (HandiVIH). Lancet HIV. **4**, e161–e168 (2017)
64. Kassa, T.A., Luck, T., Birru, S.K., Riedel-Heller, S.G.: Sexuality and sexual reproductive health of disabled young people in Ethiopia. Sex. Transm. Dis. **41**, 583–588 (2014)
65. Salako, S.: The declaration of Helsinki 2000: Ethical principles and the dignity of difference. Med. L. **25**, 341 (2006)