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Original Research Article

SEXUAL AND REPRODUCTIVE HEALTH OF PEOPLE WITH DISABILITIES: AN ASSESSMENT OF FAMILY PLANNING PRACTICE AND NEED IN GUSAU, ZAMFARA STATE, NORTHWEST NIGERIA.

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Author's contributions

This study was a collaborative effort of the authors. The authors reviewed and approved the final version of the manuscript for publication.

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ABSTRACT

People with disabilities continue to experience significant challenges in accessing sexual and reproductive health (SRH) services, despite global declarations that guarantee their universal right to the same quality and standard of care without discrimination. However, there is a dearth of research in our region on this issue. This study aims to understand the family planning practices and needs of people living with disabilities in Gusau, Zamfara State, Northwest Nigeria. This is a qualitative exploratory methods that gather data from people with disabilities about their experiences and use of family planning methods. The study included key informant interviews with 8 representatives (both male and female) and 8 focus group discussions (FGDs) among various categories of people with disabilities. The transcribed and translated findings from the interviews and FGDs were analyzed using descriptive thematic analysis. The respondents generally expressed a high level of awareness and utilization of family planning (FP) services, with many preferring modern methods due to their effectiveness and safety**.** Most married people with disabilities actively use family planning methods, while it is less common among unmarried individuals with disabilities. Women with disabilities frequently use contraceptive implants, injectables, and pills, whereas men often use withdrawal and condoms. Common reasons for using family planning include limiting family size, economic hardship, child spacing, and promoting the health of PWDs and children. Non-use is often due to disability-related reasons such as needing more children for assistance, lack of knowledge, fear of side effects, and misconceptions. Barriers included communication challenges, stigmatization, and lack of disability-friendly services. Respondents called for government intervention, including free services, interpreters, and better accessibility to encourage greater participation in FP programs. Persons with disability actively use family planning methods, with married persons utilizing them more frequently than unmarried individuals. Among married women, implants, injectables, and pills are the predominant methods, while men typically opt for withdrawal and condoms. A comprehensive approach to recognizing the diverse challenges faced by people with disabilities is necessary. Health workers should be trained in skills and ethics to meet their needs. Sexual and reproductive health (SRH) information must target people with disabilities and correct public misconceptions about disability and reproduction. Policies should improve SRH access for people with disabilities, including economic empowerment, free family planning services, enhanced communication, and making facilities disability-friendly.

Key words: Family planning, Nigeria, Disability, Barriers, Qualitative

INTRODUCTION

Contraceptive use among persons with disabilities (PWDs) remains a major public health concern due to the persistent discrimination and social exclusion they experience compared with their non-disabled peers (Ross & Frankenberg, 1993; Dickson *et al.,* 2018). When contraception is required, methods should be appropriately matched to the individual's physical and cognitive abilities, health status, lifestyle, and personal preferences, as well as those of their partner (Ross & Frankenberg, 1993; Dickson *et al.,* 2018). However, access to family planning (FP) information and services remains limited, resulting in low utilization of contraceptive services among PWDs (Shiwakoti *et al.,* 2021).

According to the World Health Organization (WHO) and the International Labour Organization (ILO), approximately 10% of the global population lives with some form of disability (World Health Organization & World Bank, 2011). An estimated 80% of PWDs reside in low- and middle-income countries, including about 60 million in Africa and 29 million in Nigeria as of 2018 (World Health Organization & World Bank, 2011; National Population Commission [NPC] & ICF, 2019). Disability does not inherently affect fertility; however, in sub-Saharan Africa, PWDs face substantial barriers to accessing sexual and reproductive health (SRH) services. These barriers are largely driven by misconceptions surrounding the sexuality of PWDs, who are often erroneously perceived as asexual or unlikely to marry or bear children (Shiwakoti *et al.,* 2021; Anderson & Kitchin, 2000). Consequently, contraception remains among the least utilized reproductive health services by PWDs (Alemu & Fantahun, 2011).

Addressing SRH needs among PWDs is critical to promoting health, wellbeing, and the realization of fundamental human rights (Ross & Frankenberg, 1993). Despite having reproductive health needs similar to those of the general population—such as child spacing and fertility limitation—PWDs frequently encounter unmet needs due to inadequate information, physical inaccessibility, and limited service availability (Ross & Frankenberg, 1993; Dickson *et al.,* 2018). Health facilities often lack disability-friendly infrastructure, while healthcare services frequently fail to provide essential communication supports, such as sign language interpreters, for persons with hearing impairments (Shiwakoti *et al.,* 2021).

Moreover, PWDs experience unique and intersecting barriers to FP services, including stigma, discrimination, and negative attitudes from healthcare providers (Shiwakoti *et al.,* 2021; Anderson & Kitchin, 2000; Alemu & Fantahun, 2011). They are also at an increased risk of unsafe abortion, often linked to social isolation, sexual violence, and limited access to contraception (International Labour Organization, 2004; Anderson & Kitchin, 2000). Studies conducted in Africa have identified limited knowledge of FP methods and fear of side effects as major deterrents to contraceptive uptake among PWDs (Alemu & Fantahun, 2011). Given their heightened vulnerability to abuse, PWDs may have greater needs for SRH education and care than persons without disabilities. However, SRH services for PWDs remain largely neglected, resulting in poorer health outcomes compared with non-disabled populations (Adhikari, 2019). While substantial progress has been made in addressing the reproductive health needs of PWDs in high-income countries (Ross & Frankenberg, 1993), evidence from low-income settings—particularly in sub-Saharan Africa—remains limited. Available studies suggest that PWDs in this region face increased risks of unintended pregnancies, unsafe abortions, and socioeconomic vulnerability, largely due to inadequate institutional and social support (Adhikari, 2019).

In Nigeria, there is a paucity of studies examining the barriers to contraceptive use among PWDs, creating significant gaps in understanding the factors influencing FP uptake within this population. This underscores the need for focused research to inform disability-inclusive family planning policies and programs.

Therefore, this study aims to assess family planning methods, needs and practices among persons with disabilities in Gusau, Northwest Nigeria, and to identify factors contributing to low utilization of family planning services.

Specifically, it assesses. Utilization of Family planning among persons living with disabilities in Gusau, Barriers and opportunities for family planning service utilization among persons living with disabilities in study area, The attitude and beliefs of persons living with disabilities towards using family planning methods in study setting.

MATERIALS AND METHODS

Study Design

This is a qualitative exploratory methods [KIIs and FGDs] to gather data from person with disabilities about their need, experiences and use of family planning methods. Participants were purposefully sampled to represent different disability groups (Person who are blind, deaf, dumb, Persons with physical disabilitiesd and suffer deformities from Hansen or other diseases). The study included key interviews with 8 representatives (both male and female of different groups) and 8 focus group discussions (FGDs) among various categories of people with disabilities (both male and female or married and unmarried).

Study settings

This study was conducted in Gusau metropolis, state capital of Zamfara state, Northwest Nigeria predominantly inhabited by Muslims of the Hausa and Fulani ethnicity.

Methodology and Material

Various groups of persons with disabilities are predominantly domiciled in the capital, Gusau, due to greater means of livelihood and support. They mostly live in cluster communities according to their disability type with domicile areas named accordingly Anguwar [settlement] for blind, majar kutari etc. Associations are formed based on disability types to coordinate the affairs of the group and advance their welfare and concerns.

These associations' structures naturally become the entry point for the research activities. Prior to the research, discussion was undertaken with leaders of each disability group involved in the study. The engagement with the group of officers helped raise awareness about the research and its objectives. It also provided identification of group representatives to gain an initial overview of the group's views through key informant interviews and helped refine the focus of the upcoming FGDs.

Data collection for the research took place between February 2022 to March 2022. The data were collected from 10 am to 5pm

Sampling

The key informants for the interviews are officials or designate representatives of the different disability groups [Male and female]. Overall 8 key interviews were conducted. Participants for the FGDs were purposively selected in collaboration with association leadership in all 8 FGDS [male and female groups were conducted involving the People who are blind, deaf, or have other physical disabilities.

Study procedure

Study team

The data collectors were healthcare providers and sociologists experienced in conducting KIIs and FGDs. The entire data collection process was supervised by the researchers to maintain quality and consistency.

This well-structured approach questionnaire allowed for comprehensive data collection, ensuring that the perspectives of different disability groups and genders were accurately captured during the study.

Duration of interviews

The overall data collection process spanned one month. The FGDs were audio-recorded to capture the discussions accurately. The predominant language, Hausa, was used for communication during the FGDs. Interviews were held with auditory and visual interpretation at Anguwar [settlement] and majar kutari [settlement]

Participant recruitment

Four disability centers were visited for the study. Participants with different disabilities were identified and confirmed through their individual associations. They were recruited after appropriate sensitization and permission from relevant authorities in these centers.

Key informant interviews (KIIs), with representatives of each disability group, were used to explore their understanding of family planning needs and practices. The interviews were conducted in the members' association offices to ensure easy delivery for participants and allowed them to carry out the discussion freely

The focus group discussion (FGDs]

The focus group discussion (FGDs) formed separately from the different segments of the assessed population (women and men; married/cohabited and unmarried/not cohabited). For the FGD, the participants were divided based on their disability and gender status. Each FGD consisted, an average of six (6) to ten (10) women or men with disabilities.

Data collection tool procedure

Data was collected using key informant and focus group discussion guides which were developed from literature search and experts' consultation that align with our study objective and context. The tools were pre-tested in a non-study LGA [Bugundu LGA]. Interview guides for FGDs and KIIs were translated into local languages. Data collection commenced with KII which allow for refinement of the FGD guide. Key informant guide elicited information on the following key issues: (1) knowledge of sexual and reproductive health. Need of family (2) family planning utilization, (3) barriers and facilitators for family planning service utilization, and (4) attitudes and behaviours of participants towards using different family planning methods.

FGD guides

Major theme explored in the FGD guide included knowledge and use of family planning methods, accessibility FP facilities and services, family planning use among PWDs, attitudes and behaviour of participants towards using different family planning methods. Health providers attitude to PWDs use of FP services, barriers and facilitators for family planning service utilization and recommendations to improve services

Data collection procedure

One data collection team was attached with each FGD. Each team had a moderator, a note taker/Recorder, and interpreter. Team members were of same sex with respondents to allow participant to express themselves freely. Supervision and quality assurance were provided by the authors

The FGDs were conducted at four different disability residents of their leaders, fostering confidence in the process and ensuring representation from various segments of the assessment population.

Methods:

Data Analysis and Rigor

Data were analyzed using a thematic analysis approach as described by Braun and Clarke (2021). This method was selected for its flexibility and suitability for exploring experiences, perceptions, and contextual factors influencing sexual and reproductive health (SRH) and family planning among persons living with disabilities (PWDs). The analysis adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) to enhance transparency and methodological rigor.

Step-by-Step Analytic Process

The analysis followed a systematic, iterative process:

Data Familiarization:

All in-depth interviews (IDIs) and focus group discussions (FGDs) were audio-recorded, transcribed verbatim, and anonymized using unique identification codes linked to disability categories. The research team repeatedly read the transcripts and listened to audio recordings to gain immersion and an overall understanding of the dataset.

Initial Coding:

Two trained qualitative researchers independently conducted line-by-line open coding on a subset of transcripts. This involved identifying meaningful units of text related to SRH knowledge, family planning practices, access to services, and lived experiences of PWDs.

Development of Coding Framework:
An inductive–deductive coding strategy was adopted. Inductive codes emerged directly from participants' narratives, while deductive codes were informed by the study objectives, interview guides, and existing literature. An initial codebook was developed and refined through team discussions.

Theme Development:
Codes were clustered into categories and subsequently organized into higher-order themes by examining patterns, similarities, and differences across transcripts. Data from different disability groups and FGDs were pooled and compared to identify both cross-cutting and subgroup-specific themes.

Review and Refinement of Themes:
Themes were reviewed in relation to the coded data and the full dataset to ensure coherence, internal consistency, and clear distinctions between themes. Themes were refined, merged, or redefined as necessary.

Defining and Naming Themes:
Final themes were clearly defined and named to reflect their core meanings and relevance to SRH and family planning among PWDs. Representative verbatim quotations were selected to illustrate each theme and ensure that findings remained grounded in participants' voices.

Coding Strategy and Use of Software

Data management and analysis were facilitated using NVivo qualitative data analysis software. NVivo was used to store transcripts, organize and retrieve coded segments, compare coding across disability categories and FGDs, and document analytic decisions. The software supported a transparent audit trail, including records of codebook development, coding iterations, and analytic memos.

Inter-Coder Reliability

To enhance consistency and dependability, inter-coder reliability was addressed through independent coding by two researchers. Coded transcripts were compared, and discrepancies were discussed until consensus was reached. This iterative process informed refinement of the coding framework and strengthened analytic rigor.

Subgroup and Comparative Analysis

A subgroup analysis was conducted to examine themes across different categories of disabilities and FGDs. This comparative approach enabled identification of unique experiences, as well as shared barriers and facilitators, related to accessing SRH and family planning services among PWDs.

Final Themes

The final thematic framework comprised the following major themes:
(1). Knowledge of sexual and reproductive health and family planning among PLWDs. (2). Accessibility of SRH and family planning facilities and services. (3). Utilization of family planning methods among PLWDs. (4). Barriers and facilitators to family planning service utilization. (5). Attitudes and behaviours of PLWDs and healthcare providers toward family planning. These themes structured the presentation and interpretation of study findings.

Several strategies were employed to enhance trustworthiness:

Credibility: Transcript validation through independent transcription by a trained transcriber with lived experience of disability. Use of verbatim quotations to support interpretations. Prolonged engagement with the data through repeated readings and iterative analysis

Dependability: Independent coding by multiple analysts. Detailed documentation of analytic decisions and code revisions

Maintenance of an audit trail was done using NVivo

Confirmability: Reflexive discussions among the research team to minimize individual bias

Systematic linkage between raw data, codes, and final themes: These procedures align with COREQ recommendations regarding data analysis, researcher reflexivity, and reporting transparency.

Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) were conducted with four distinct PWD groups: the deaf, the blind, the Persons with physical disabilitiesd, and individuals with deformities resulting from leprosy. A total of 8 interviews and 8 FGDs were conducted, with male and female respondents targeted separately for each group. The age group of participants ranged of 15-42 years. All participants were within the reproductive age group.

RESULTS

Theme 1: Knowledge and Awareness of Family Planning

Subtheme 1.1: General Awareness across Disability Groups

Overall, participants demonstrated moderate to high awareness of family planning, particularly among Persons with physical disabilitiesd, deaf, and blind respondents. Awareness was highest among Persons with physical disabilitiesd participants and deaf respondents, reflecting increased exposure to health information. Blind men frequently discussed family planning with their spouses and sought professional advice. However, Women who are blind expressed a preference for larger family sizes, often viewing children as social and economic support.

In contrast, persons affected by leprosy and unmarried PWDs reported comparatively lower knowledge and awareness, although some improvement was noted.

Illustrative quote: "Utilization is increasing because people now understand family planning." (FGD, Persons with physical disabilitiesd men)

Subtheme 1.2: Traditional versus Modern Methods

Across disability groups, there was a clear transition from traditional methods to modern contraceptive methods, driven by perceived safety and effectiveness. Deaf and Participant who are blind described abandoning herbal methods in favor of hospital-based services.

Illustrative quote: "People no longer use herbs; modern methods are safer." (KII, blind man)

Table 1: Knowledge and Awareness of Family Planning by Disability Group

Disability Group	Awareness Level	Key Observations
Physical disability	High	Strong knowledge and high utilization
Deaf	High	Improved awareness; shift to modern methods
Blind (men)	High	Joint decision-making with spouses
Blind (women)	Moderate	Desire for more children limits uptake
Leprosy-affected	Low–moderate	Evolving awareness
Unmarried PWDs	Low	Limited exposure to FP information

Theme 2: Preferred Family Planning Methods

Subtheme 2.1: Preference for Modern Methods

Modern methods—including injectables, implants, and pills—were widely reported. Injections were favored for convenience, while implants were valued for longevity. Withdrawal was preferred by some men. Negative experiences, such as abnormal bleeding, influenced method choice in a few cases.

Illustrative quote: "Most people prefer injections because they are easy." (FGD, blind men)

Table 2: Preferred Family Planning Methods by Gender and Disability

Group	Preferred Methods	Reasons

Persons with physical disabilitiesd women	Implants, injections	Convenience, availability
Persons with physical disabilitiesd men	Withdrawal	Perceived safety
Deaf women	Implants	Fewer side effects
Blind couples	Injections	Provider recommendation
Leprosy-affected	Modern methods	Shift from ineffective traditional methods

Theme 3: Family Planning Decision-Making

Subtheme 3.1: Joint Spousal Decision-Making

Decision-making was largely collaborative, with couples discussing options and often deferring to healthcare providers' recommendations. Women's health concerns and the burden of frequent pregnancies were central to decisions.

Illustrative quote: "We discuss and follow hospital advice." (KII, Persons with physical disabilitiesd man)

Table 3: Decision-Making Patterns

Pattern	Description
Joint decision-making	Most common across groups
Provider-guided choice	Strong influence of health workers
Male-led consensus	Reported among blind and deaf men

Theme 4: Attitudes and Reasons for Family Planning Use

Subtheme 4.1: Economic and Health Motivations

PWDs widely viewed family planning as necessary due to financial hardship, unemployment, and health risks associated with frequent pregnancies. While Participant who are blind desired larger families, economic realities encouraged spacing.

Illustrative quote: "Life is expensive; we cannot care for many children." (FGD, blind men)

Subtheme 4.2: Variations by Marital Status and Disability

Unmarried individuals—especially among the deaf—often opposed family planning, though attitudes shifted after marriage or childbirth. Some persons affected by leprosy resisted family planning due to perceived ease of childbirth.

Table 4: Attitudes toward Family Planning

Group	Dominant Attitude
Married PWDs	Positive
Unmarried Participants who are deaf	Negative/neutral
Women who are blind	Mixed
Leprosy-affected	Mixed to negative

Theme 5: Barriers and Provider Attitudes

Subtheme 5.1: Provider Attitudes and Client Experiences

Participants reported generally positive attitudes from healthcare providers, including kindness and prioritization. However, stigmatization from non-disabled clients discouraged service utilization.

Illustrative quote:

"Health workers are kind, but other patients stigmatize us." (FGD, deaf women)

Subtheme 5.2: Disability-Related Barriers

Key barriers included:

- Poor facility navigation for the blind
- Communication barriers for the deaf
- Lack of interpreters
- Misconceptions about contraceptives

Table 5: Barriers to Family Planning Access

Barrier	Affected Group
Communication	Deaf
Physical navigation	Blind
Misconceptions	Deaf, leprosy-affected
Stigma	All groups

Theme 6: Sources of Family Planning Services

PWDs accessed family planning primarily from public hospitals and clinics within Gusau metropolis, including FMC Gusau, King Fahad Hospital, and selected PHCs.

Theme 7: Recommendations from Participants

Subthemes

1. Free or subsidized services
2. Priority care without queuing
3. Disability-friendly services
4. Provision of interpreters
5. Government intervention and employment of PWDs
6. Awareness creation and peer involvement

Illustrative quote: "If services are free and we are treated first, more people will come." (FGD, mixed groups)

Table 6: Participant-Driven Recommendations

Recommendation	Expected Outcome
Free FP services	Increased utilization
Priority service	Reduced access barriers
Disability-friendly services	Increase General Awareness and conducive environment
Interpreters	Improved communication
Inclusive staffing	Better responsiveness
Awareness programs	Improved knowledge

Analytical Summary

Using thematic synthesis and matrices, the findings demonstrate that while knowledge and acceptance of family planning among PWDs are improving, structural, communication, and social barriers continue to limit equitable access. Disability-specific strategies are therefore essential to improving SRH outcomes.

DISCUSSION

This study presents significant insights into the knowledge, practice, and needs of family planning among individuals with disabilities in Gusau, Zamfara State, and Northwest Nigeria. Thus, bridging gaps arising from paucity of comprehensive data regarding the knowledge, practice and family planning needs of persons with disabilities in sub-Saharan Africa, specifically in Nigeria. The study also sheds light on the barriers, opportunities and attitudes of service providers towards family planning for these marginalized groups such as disabled individuals. The age of participants in this study ranged from 15 to 42 years, which falls within the globally recognized reproductive age range of 15–49 years (World Health Organization, 2018).

The study revealed varying levels of knowledge and awareness of family planning among people with disabilities (PWDs). Compared to lower knowledge levels reported among persons with disabilities in Ethiopia (Mekonnen *et al.,* 2020) and barriers identified in Ghana (Seidu *et al.,* 2021/2023), this study found higher awareness among Persons with physical disabilitiesd and Participants who are deafs. These findings also reflect broader global trends in expanding contraceptive access documented by Family Planning 2020 (2019). This study examined awareness, utilization, decision-making, motivations, and barriers related to family planning (FP) among people with disabilities (PWDs), highlighting important within-group variations across disability types. Overall, the findings reinforce existing evidence that PWDs are not a homogeneous population and that their reproductive health needs and experiences differ substantially depending on disability type, social context, and access to tailored services.

Awareness and Knowledge of Family Planning

Persons with physical disabilitiesd and Participants who are deafs demonstrated relatively high awareness and understanding of family planning methods. This finding aligns with studies suggesting that individuals with mobility or hearing impairments may have increased contact with health facilities or disability-focused organizations, thereby enhancing exposure to reproductive health information (Mekonnen *et al.,* 2019; Seidu *et al.,* 2020). Targeted communication initiatives, particularly those using visual or sign-language-based approaches, may also explain the improved knowledge observed among Participants who are deafs, as reported in earlier studies on accessible sexual and reproductive health (SRH) communication (Ganle *et al.,* 2020; World Health Organization [WHO], 2011).

In contrast, Women who are blind in this study were less likely to utilize family planning services. While some participants associated non-use with personal or emotional motivations—such as viewing children as a form of social or practical support—similar tendencies have been indirectly reported in qualitative studies examining reproductive intentions among visually impaired women in low-resource settings (Groce *et al.,* 2014; Hanass-Hancock & McKenzie, 2017). Rather than presenting this as an entirely novel phenomenon, these findings may reflect broader structural gaps in tailored counseling and psychosocial support for Women who are blind, particularly in contexts where disability-related vulnerabilities intersect with poverty and limited access to assistive services.

Participants affected by leprosy also showed lower utilization of family planning, largely attributable to stigma and social exclusion. This is consistent with earlier evidence demonstrating that stigma surrounding leprosy continues to limit access to SRH services, despite medical advances in treatment (Seidu *et al.,* 2020; Tsutsumi *et al.,* 2007). Unmarried PWDs exhibited minimal knowledge of family planning, underscoring the persistent assumption—shared by both communities and healthcare providers—that unmarried individuals, particularly those with disabilities, are not sexually active. Similar observations have been reported across sub-Saharan Africa, where marital status strongly mediates access to FP information and services (Mekonnen *et al.,* 2019; UNFPA, 2018).

Knowledge and Utilization of Family Planning Methods

Implants, injectables, and oral contraceptive pills were the most commonly known family planning methods across disability categories. This pattern aligns with findings from other studies among people with disabilities and reflects the method mix commonly promoted in public-sector family planning programs in Nigeria and similar contexts (Solanke *et al.,* 2021; World Health Organization [WHO], 2019). However, comparisons with Nigeria Demographic and Health Survey (NDHS) data should be interpreted cautiously, as national surveys often underrepresent people with disabilities and do not fully account for the structural barriers they face.

Implants emerged as the most frequently used modern contraceptive method, consistent with earlier research highlighting their convenience, long duration of action, and reduced need for frequent facility visits—an important consideration for individuals with mobility or communication challenges (Solanke *et al.,* 2021). Traditional methods, including herbs and beads, were occasionally reported but were largely discontinued due to perceived ineffectiveness or health concerns. Condoms and calendar methods were the least utilized, echoing findings from prior studies that attribute low uptake to negotiation challenges, misinformation, and limited provider engagement with PWDs (Seidu *et al.,* 2020; Ganle *et al.,* 2020).

Although overall contraceptive knowledge among PWDs appeared lower than that reported in national surveys, participants described increasing awareness and utilization over time. This trend aligns with broader global observations from initiatives such as Family Planning 2020, which emphasize gradual improvements in contraceptive access among marginalized populations when inclusive policies and targeted interventions are implemented (FP2020, 2018).

Decision-Making Dynamics in Family Planning

Decision-making around family planning among PWDs in this study was largely characterized by spousal communication, mutual respect, and shared responsibility. Persons with physical disabilities men and their partners often reached consensus after receiving professional advice, even when initial preferences differed. Participants who are deaf described early misunderstandings that were gradually resolved through improved communication and increased access to information, reinforcing evidence that accessible SRH communication enhances joint decision-making (Ganle *et al.,* 2020; WHO, 2011).

Among participants affected by leprosy, mutual spousal support for family planning was commonly reported, reflecting adaptive coping strategies in the context of chronic illness and social marginalization. These findings are consistent with studies emphasizing the importance of male involvement and couple-based approaches in FP programming for disabled populations (Mekonnen *et al.,* 2019; Seidu *et al.,* 2020). Collectively, the results highlight the value of inclusive FP services that engage both partners and accommodate diverse communication needs.

Motivations for Family Planning Use

The primary motivations for FP use among PWDs included financial constraints, child spacing, limiting family size, and safeguarding maternal and child health. These drivers broadly mirror those observed in the general population, though their implications may be amplified among PWDs due to higher levels of economic vulnerability and health-related challenges (National Population Commission [NPC] & ICF, 2019; Seidu *et al.,* 2020). Rising living costs, limited employment opportunities, and the physical demands of pregnancy were frequently cited as reasons for prioritizing family planning.

While some women who are blind expressed a preference for larger families, this finding will be interpreted within the broader context of limited social support systems and inadequate access to rehabilitative or assistive services. Similar reproductive intentions have been discussed in qualitative disability research, where children are perceived as sources of emotional security or assistance later in life (Groce *et al.,* 2014). This underscores the need for integrated interventions that combine FP counseling with disability support services, rather than framing such preferences as anomalous.

Negative perceptions of family planning among a minority of participants who are deaf and individuals affected by leprosy were linked to cultural beliefs and misconceptions, echoing findings from earlier studies in comparable contexts (Ganle *et al.,* 2020; Seidu *et al.,* 2020). These patterns reinforce the importance of culturally sensitive and disability-inclusive education strategies.

Barriers to Access and Provider Attitudes

Experiences with FP service provision varied considerably. Some participants with physical disabilities reported positive experiences, including prioritization and free services, consistent with evidence that disability-sensitive practices can enhance satisfaction and uptake (WHO, 2011). However, others described inadequate accommodations, particularly for mobility and communication needs, highlighting inconsistencies in implementation.

Participants who are deaf faced persistent communication barriers due to the absence of sign language interpreters, a challenge widely documented in SRH research involving hearing-impaired populations (Ganle *et al.,* 2020; WHO, 2011). Participant who are blind encountered navigational difficulties within health facilities and reported receiving advice that was not sufficiently tailored to their needs. Stigmatization by other clients and, in some cases, health workers discouraged service utilization, reinforcing stigma as a critical structural barrier (Seidu *et al.,* 2020; Solanke *et al.,* 2021).

These findings suggest that while some providers demonstrate good practice, systemic gaps in training, infrastructure, and stigma reduction persist. Addressing these barriers requires comprehensive disability-inclusive health system strengthening, as advocated in previous studies (WHO, 2019; UNFPA, 2018).

Health Facilities as Trusted Access Points

Participants consistently identified specific hospitals as trusted sources of family planning services, reflecting the central role of accessible and inclusive health facilities in improving SRH outcomes for PWDs. Similar reliance on well-equipped facilities has been reported elsewhere, particularly where services include physical accessibility adaptations and communication support (Solanke *et al.,* 2021; Ganle *et al.,* 2020). Strengthening these facilities and expanding disability-friendly services at lower levels of care may further improve equitable access to family planning.

RECOMMENDATION

The findings of this study underscores the obligation of health systems to ensure that persons with disabilities (PWDs) can exercise their sexual and reproductive health and rights (SRHR) on an equal basis with others. These recommendations align with principles of inclusiveness, autonomy, equity, non-discrimination, privacy, and dignity, as articulated in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and global SRH guidelines.

1. Financial Protection and Equity in Access

PWDs emphasized the need for free or subsidized family planning services, reflecting the disproportionate economic burden they face. From a rights-based perspective, financial barriers constitute a form of structural discrimination that undermines equitable access to healthcare. Governments and health financing bodies should implement financial risk-protection mechanisms, including fee waivers and social health insurance exemptions, to ensure that inability to pay does not impede access to family planning services. Ethical principles of justice and equity require that prioritization mechanisms be implemented transparently and without stigma.

2. Meaningful Inclusion of PWDs in Health Programs

Participants advocated for the active inclusion of educated and skilled PWDs in healthcare planning, implementation, and evaluation. Meaningful participation promotes self-determination and empowerment, ensuring that services are responsive to lived experiences. In line with ethical commitments to respect for autonomy and participatory justice, health systems should engage PWDs as co-designers, peer educators, and advisors in SRH programs.

3. Disability-Friendly and Respectful Care Environments

The call for kind, respectful, and priority treatment highlights the ethical obligation of healthcare providers to uphold human dignity and non-maleficence. Disability-friendly services should extend beyond physical accessibility to include respectful communication, reasonable accommodations, and provider training on disability rights and inclusive care. Such environments reduce fear, stigma, and avoidance of care among PWDs.

4. Accessible Communication and Informed Decision-Making

Requests for interpreters reflect critical communication barriers faced by individuals with hearing impairment and visually impaired individuals. Providing sign language interpreters, accessible information formats (Braille, large print, audio), and assistive technologies is essential for informed consent and autonomous decision-making. Failure to provide such accommodations compromises ethical standards of informed choice, privacy, and confidentiality, particularly in sensitive areas such as family planning.

5. Government Accountability and Inclusive Health Workforce

Participants called for stronger government leadership in providing free healthcare and employing PWDs within health facilities. Employing PWDs as staff or focal persons not only enhances service responsiveness but also promotes equity, representation, and social inclusion. Ethically, this reflects a commitment to structural inclusion and anti-discrimination within health systems.

6. Ethical Use of Identification and Prioritization Systems

While labeling patient files to facilitate timely care was suggested, such practices must be implemented with caution. Any identification system should respect privacy, confidentiality, and patient consent, avoiding stigmatization or involuntary disclosure of disability status. Ethical service delivery requires that prioritization mechanisms be discreet, voluntary, and aligned with data protection standards.

7. Rights-Based Health Education and Information Access

The call for increased family planning awareness underscores the right of PWDs to accurate, accessible, and comprehensive SRH information. Education initiatives should be tailored to different disability groups and delivered through inclusive channels. Involving educated PWDs, including individuals with blind, as educators supports peer-led approaches that respect autonomy and enhance trust.

8. Community-Based Leadership by PWDs

Empowering PWDs to serve as focal persons and community providers for family planning aligns with principles of community ownership and participatory ethics. Peer-led dissemination strengthens credibility, enhances uptake, and supports sustainable behavior change while reinforcing the agency of PWDs as rights holders rather than passive beneficiaries.

9. Promotion of Self-Care and Choice-Centered Family Planning Methods

The promotion of self-administered injectables and other self-care family planning options supports autonomy, privacy, and convenience, particularly for PWDs who face mobility or access barriers. Consistent with WHO self-care guidelines, such approaches should be offered alongside adequate counseling and voluntary choice, ensuring that no method is promoted coercively.

10. Tailored and Integrated Care for Specific Disability Needs

The recommendation to link family planning services with sight restoration interventions reflects the ethical principle of holistic, person-centered care. Tailored service integration acknowledges the diverse needs of PWDs and promotes equity by addressing intersecting health challenges that may affect SRH decision-making.

These recommendations collectively highlight that exclusion of PWDs from family planning services is not merely a service delivery gap but a violation of fundamental human rights. Ethical family planning programs must ensure voluntary, informed, and confidential access to services, free from coercion, stigma, or discrimination. Policymakers and healthcare providers have a moral and legal responsibility to operationalize inclusive, rights-based frameworks that uphold the SRHR of PWDs.

Limitations

Despite its strengths, this study has some limitations that must be acknowledged.

1. Although our study had a diverse set of participants, the study focused on disability-support groups that may miss some people with disabilities in the community and is localized to a specific region in Nigeria, which may limit the generalizability of its findings to other regions or countries with different socio-cultural contexts and healthcare systems.
2. The authors also acknowledge the possibility of information bias created by the sign language interpreters to interpret for respondents who had a hearing impairment, language barriers and the limitations associated with self-reported data.
3. The author also admitted that sample size and diversity of disabilities among participants may not fully capture the range of experiences and needs of PWDs in family planning across broader populations.
4. The study is cross-sectional, providing a snapshot in time without tracking changes in knowledge, attitudes, or practices over time. Longitudinal data could offer more insights into how these factors evolve.

CONCLUSION

In this study, the knowledge, attitude, and practice of people with disability about FP methods were relatively better compared to previous report in some other studies. Due attention should be given to ensure that disabled people are well informed about FP methods through training of health. This study underscores the crucial need for inclusive and accessible family planning services tailored to the unique needs of PWDs in Gusau, Zamfara State. Despite a relatively high level of knowledge and awareness among some disability groups, significant barriers persist, including financial constraints, communication challenges, and the need for disability-friendly healthcare environments. The study highlights the importance of government intervention, free or subsidized services, and the inclusion of PWDs in healthcare programs. Addressing these issues through targeted policies and practices can significantly improve family planning outcomes for this marginalized group. The findings serve as a call to action for policymakers and healthcare providers to prioritize the needs of PWDs, ensuring equitable access to family planning services.

Conflict of Interest:

We declare no conflict of interest

Ethical consideration

Ethical approval was sought from the state's research ethic committee. Permission was obtained from the disability support organizations and each participant. Informed consent was obtained from the participant before participating in the study. Anonymity, confidentiality and privacy was maintained as the interview was carried out in a private area for each focus group member. The nature, purpose and process of the study was explained to the participants. They were informed that they might not necessarily benefit directly from the study but that the result of the data will be used to try and contribute to improvement in service provision for PWD attending the facility and thus improve universal and equitable access to healthcare. Participants continuously remained of their right to withdraw from the study at any time and were reassured that refusing to participate in or withdraw from the study would not disadvantage them in any way.

ANNEX 1:

Focus Group Discussion Guide - Assessment on Family Planning Needs of Persons living with disability

I. Introduction – 5 Minutes

- Provide a brief introduction on family planning needs assessment, purpose and process.
- Explain that you will ask the group to spend a few minutes identifying their current family planning needs, practice, attitudes and belief in using different family planning methods, and barriers and opportunities to access family planning services,
- Emphasize that their input is vital in helping to identify and prioritize needs, create solutions, and plan for services.
- Explain that you are not trying to evaluate or judge anyone's opinions or experiences, but rather to capture the thinking of as many people as possible.
- Ask if there are any questions before you begin. Answer questions and then begin with the facilitation questions.
- Major Talking Points:
- The study is interested in assessing the current family planning practice, needs and associated barriers and opportunities of persons living with disability.

The assessment looks at the following three broad categories:

1. The current family planning practices and decision-making
2. The extent of current family planning is needed
3. The attitude and beliefs of persons living with disability with different family planning use
4. Barriers and opportunities for family planning service utilization among people living with disabilities.

The information will be helpful in identifying the family planning practice and needs of persons living with disability and recommends ways for better future service delivery for persons living with disability.

The discussion will require no more than 45 minutes.

1. FGD Participant Demographics (5 minutes)

Would you please introduce yourself and respond to the following questions?

Number [ ] sex: [ ] age: [ ] Marital status: [ ] Types of disabilities: [ ] Family Planning Use: [ ] Name of Your Association: [ ] Membership Status: [ ]

2. Family Planning Practice: (10 minutes)
   - Would you please tell us which family planning practice do you use?
   - What method have you used in the past and why do you choose it?
   - Would you tell us which method do you prefer? Why?
   - Is your views different among females and males? How? Why?
   - Where were you offering the method?
   - How do you see the current family planning service utilization among persons living with disability compared with former times? Why?

3. Family Planning Need: (10 minutes)
   - Would you please tell us about family planning needs among people living with disabilities?
   - Is your views different among females and males? How? Why?
   - Is there any preference in different family planning (contraceptive) method use? Which method/s is/are mostly preferred? Why?
   - Is there any difference in contraceptive method preference between:

1) Males and females?
2) Married and unmarried?
3. How much do you think is the unmet needs of family planning among persons living with disability?

4. Service Providers and Quality of Service Received (10 minutes)
   - Where do persons living with disability receive family planning services? Why?
   - Looking from the perspective of disability how do you judge the family planning service being rendered? Why?
   - What do you think service providers should do to fulfil the family planning needs of persons living with disability?

5. Attitude and Behavior (10 minutes)
   - Would you tell us the attitude and behavior of people living with disabilities in using different family planning methods? Why?
   - Is there any difference in attitude and behavior between:

1) Males and females?
2) Married and unmarried?

6. Barriers and Opportunities (5 minutes)
   - What do you think are barriers for persons living with disability in obtaining family planning services? Why?
   - What opportunities do you think people will have for people living with disabilities to obtain quality family planning service? Why?

7. Do you have any additional comments or suggestions?

Thank You!!

ANNEX. II

CONSENT FORM

This research, Sexual and Reproductive Health of Women with Disability: An Assessment of Family Planning Practice and Need in Gusau, Zamfara State, Northwest Nigeria, will be carried out in accordance with the ethical guidelines of FMC, Gusau and your consent will be needed for eligibility to participate in the study

Before you decide if you would like to take part or not, please read the following carefully.

WHAT IS THE STUDY ABOUT?

The study aims to assess family planning practice and the needs of people living with different types of disabilities. Findings/ information from this study will assist in drawing attention to quality of family planning service provision, help in improving provision of family planning methods and practice, understand the family planning need of people living with disabilities, addressing the barriers and challenges associated with their family planning need, in designing SRH policy for people living with disabilities and to guide interventions in our resource constrained environment.

WHAT WILL BE DONE IF YOU PARTICIPATE IN THIS STUDY?

People living with different disabilities and their family planning practice and need will be the focus of the study. Different focus groups will be created. Each interview will last about 45-50 minutes. Key informant interviews with participants in each focus group by the facilitator will take place in each to ensure visual and auditory privacy. During each of the interviews, data will be recorded by taking handwritten notes and audio recording of the interviews. At the end of the interview, debriefing will be carried out and some quotations will be read back to the participants, especially on some important points.

Necessary steps will be taken to secure transcripts and data sources in a secure place.

WILL THE INFORMATION BE CONFIDENTIAL? YES

Anonymity, confidentiality and privacy will be maintained as the interview will be carried out within a focus group discussion following advance booking. The information collected during this study will be stored and analyzed without including your unit and position. The results of the study will be published in medical literature and may be used in health policy formulation, but your identity will not be revealed.

WRITTEN CONSENT FORM

I………………..… (Initials please) have read and understood all the information given to me about my participation in this study and I have been given the opportunity to discuss it and ask questions. All my questions have been answered to my satisfaction and I voluntarily agree to take part in this study. I understand that I will receive a copy of this signed written informed consent form. I authorize the release of my information and interview the investigator, regulatory authorities and ethical committee as may be required.

Signature of participant …………………Date…………….
Initials of participants ………..……….
Signature of investigator ………………………… Date………………
Initials of investigator …………………

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