

“These attitudes are a pressure”: Women with disabilities’ perceptions of how stigma shapes their sexual health choices

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Abstract

Women with disabilities face numerous barriers to achieving sexual health on an equitable basis to others, including stigma about disability and sexuality. Yet, how specific stigmatising beliefs about disability and sexuality influence the choices women with disabilities make about their sexual health has not been studied widely. The present study sought to address this gap in the context of Sierra Leone. Semi-structured interviews were conducted with women with disabilities ($N = 32$) and women without disabilities ($N = 10$). Societal stigma of disability linked with witchcraft was seen as a deterrent to accessing sexual and reproductive health services. Stigma about women with disabilities as burdens and about childless women with disabilities as pitiable were perceived as sources of pressure on disabled women’s reproductive choices. Concurrently, women with disabilities rejected common stigmatising beliefs held about their lives. Results are discussed in terms of practical implications for healthcare providers and policymakers in Sierra Leone.

Keywords: disability, stigma, sexuality, sexual health, attitudes

Introduction

People with disabilities have been described as the most marginalised and vulnerable group within any population due to their inability to access health services, including sexual and reproductive health services on an equitable basis to people without disabilities (Braathen et al. 2016). More broadly, the right that people with disabilities have to sexual health (e.g. to freely express their sexuality, start a family, and obtain information and education about sexual health; (WHO 2009)) is in many contexts restricted by the environmental and social barriers that people with disabilities encounter. These include unaffordable costs, inaccessible physical infrastructure, inaccessible healthcare information, and negative attitudes from health providers towards disability and sexuality (Rohleder, Braathen and Carew 2018).

Although globally the evidence base concerning the barriers that people with disabilities face in accessing sexual and reproductive healthcare is sparse, particularly in low- and middle-income countries (Carew et al. 2017), there has been growing attention to the nature, magnitude and extent of these barriers in the empirical literature. Ganle et al. (2020) conducted a systematic review of research examining the barriers that people with disabilities face to obtaining sexual and reproductive healthcare. The review identifies disability stigma and discrimination from families, the community and healthcare providers as key barriers that constrain access to sexual and reproductive healthcare. Concerning women with disabilities specifically, a narrative review of literature covering the sexuality of women with disabilities in Africa illustrates how the intersection of disability and womanhood contributes to the negative societal perceptions they experience concerning their sexuality (Peta and Ned 2019). Many of the existing studies in this area are qualitative, bringing to the fore the discriminatory experiences that women with disabilities are subject to when seeking sexual and reproductive healthcare. For example, in Zimbabwe, Peta (2017) identifies how problematic attitudes of healthcare staff contribute to the exclusion of women with disabilities from sexual and reproductive healthcare. She found women with disabilities were viewed by health providers as damaged beings who were an inconvenience and therefore not worthy of treatment. These perceptions were themselves linked to wider beliefs about disability as caused by evil spirits or witchcraft.

Other studies from both Africa and more broadly (e.g. Nguyen, Liamputtong and Horey 2019) have shown that women with disabilities are explicitly discouraged from childbearing by healthcare professionals who question their capability as mothers or sexual partners (e.g. Smith et al. 2004; Rugoho and Maphosa 2017). Their experience and expertise about their own disabilities is also often ignored (Smeltzer et al. 2016). In one study by Ganle et al. (2016), women with disabilities encountered direct discrimination from maternal health nurses, with one woman being referred to as a pregnant cripple, while another was refused physical assistance. The findings of Ganle et al. (2016) also indicate that women with disabilities may deliberately avoid healthcare appointments due to experiencing or desiring to avoid negative attitudes from healthcare providers. Outside of healthcare centres, women with disabilities are often advised against or actively prevented from having families or seeking sexual and reproductive health services, by their families and the wider community (e.g. McKenzie 2013). Taken together, this evidence highlights how women with disabilities' opportunities to achieve active sexual and reproductive lives are often denied (Addlakha, Price and Heidari 2017) due to stigma about disability and sexuality. However, beyond healthcare access, there has been much less study of how stigma concerning disability and

sexuality influences the choices women with disabilities themselves make throughout their sexual lives. The present study addresses this gap within the context of Sierra Leone.

Stigma toward Disability and Sexuality

Negative attitudes toward disability and sexuality are global in scope, including the incorrect perception among the general population that women with disabilities are unable to have sexual intercourse, give birth or are otherwise disinterested in forming meaningful sexual relationships (Nario-Redmond 2010; Reimer-Kirkham et al. 2022; Rohwerder 2018). These perceptions co-exist with the equally incorrect assumption that some people with disabilities, (e.g. those with intellectual impairments) are hypersexual and will act on their uncontrollable sexual urges given the slightest opportunity (e.g. Mavuso and Maharaj 2015). Other frequently encountered misperceptions include the view that people with disabilities are a financial burden or too much work to form a romantic relationship with, because of their perceived needs for personal care and economic support (e.g. Hunt et al. 2018; Marini et al. 2011). Some studies have also identified a hierarchy of disability acceptability, whereby people with some types of disabilities are more stigmatised than others. This includes within the area of sexual and reproductive health. For instance, Ip et al. (2022) found that both Australian and Hong Kong youth were more open to dating people with physical impairments, compared to those with intellectual impairments. Problematic attitudes are also espoused by the family members of people with disabilities. Kahonde, McKenzie and Wilson (2018) found in South Africa that the family caregivers of young adults with intellectual impairments did not prioritise support for their sexual autonomy alongside other needs.

Myths about why people are born or become disabled underpin disability stigma globally and are key drivers of why people with disabilities are shunned and excluded from many facets of society. One of the most entrenched and long-standing community beliefs about the cause of disability is that it is the result of parental misdeeds (e.g. Njelesani et al. 2017), the misdeeds of the person themselves in the past life (Olkin 2002), or caused by witchcraft, demons or evil spirits (e.g. Groce and McGeown 2013). In some cultures including in West Africa children with disabilities may be viewed as supernatural beings or demons themselves (Njelesani et al. 2017). Because of this, people with disabilities experience dehumanisation from within their communities from birth with often devastating and life-threatening consequences, including being abandoned or even murdered during childhood (Njelesani et al. 2017; Rohwerder 2018). Both children and adults with disabilities are also at an increased risk of experiencing violence and abuse compared to children and adults without disabilities (Fang et al. 2022 Hughes et al. 2012), with the risk further elevated for girls and women with disabilities and for those with intellectual and sensory impairments (UNESCO and Leonard Cheshire, 2021).

The consequences of Disability and Sexuality Stigma for Health

Displays of disability stigma do not fall solely under the purview of the general public but are regularly espoused by professionals such as healthcare providers. An analysis using a diverse sample of over 25,000 healthcare providers showed that while providers may hold positive explicit attitudes towards disability, their internalised attitudes show a moderate bias against people with disabilities (Van Puymbrouck, Friedman and Feldner 2020). These findings corroborate the commonplace perception among people with disabilities that they are

discriminated against, whether subtly or explicitly, when accessing and engaging with healthcare.

Yet, what has not, to our knowledge, been widely studied is how specific stigmatising beliefs about disability and sexuality influence women with disabilities' choices in their sexual lives. LaPierre, Zimmerman and Hall (2017) have identified disability stigma as a factor in the decision-making of US women with disabilities about whether to become pregnant. However, the influence of specific stigmatising beliefs on women with disabilities' choices in relation to accessing sexual and reproductive health services, as well as the choices they make in their broader sexual lives are poorly understood, particularly in low- and middle-income contexts.

This is important as no woman makes decisions about her sexual and reproductive health in a vacuum, including women with disabilities. Decisions to start a family, use contraception or to seek an abortion are all influenced by the economic resources that she has recourse to and the degree to which it is seen as acceptable or desirable for a woman of her background to have a child, or choose not to. The importance of having children in order to be seen as a respectable adult, and the role children play in supporting parents as they age, are also important factors affecting many women's decision as to whether to have children. It is crucial to Because of this, and in the context of Sierra Leone, the present study sought to understand, through qualitative inquiry, the following research question:

How are different stigmatising beliefs about disability and sexuality perceived by women with disabilities to influence the choices they make in their sexual and reproductive lives?

Study Context

The West African country of Sierra Leone has a population of approximately 7 million, of whom 1.3% are estimated to be people living with disabilities (Statistics Sierra Leone 2017), although this is likely e an underestimate due to lack of a good quality disability data measure (Ossul-Vermehren, Carew and Walker 2022). Sierra Leone is one of the poorest countries in the world, with approximately two-thirds of the population estimated to be living with multi-dimensional poverty (Statistics Sierra Leone 2019). In Sierra Leone, many people with disabilities live together in separate small communities, many of which originated as refugee camps for injured victims of the Sierra Leonean Civil War 1991-2002 (Conteh and Berghs 2004).

According to the Sierra Leone Demographic Health Survey [SLDHS] 2019, one quarter (25%) of currently married women aged 15-49 have an unmet need for family planning services, and approximately one fifth (21%) of married women use any form of contraception (Statistics Sierra Leone and ICF 2019). Good quality data on the family planning needs of women with disabilities in Sierra Leone is lacking, but since the SLDHS data points to a high rate of unmet need among women in general, it is plausible to suggest this may be accentuated among women with disabilities since they face additional difficulty accessing healthcare in many contexts internationally (Peta and Ned 2019).

Methodology

Study Design

This study adopted a qualitative design and used in-depth semi-structured interviews to gain an understanding of how women with disabilities experience stigma about disability and sexuality, and their perceptions of how this stigma influences the choices they make in their sexual lives. Ethical approvals for the study were secured from the MSI Reproductive Choices Ethics Review Committee (033-20AA), the Sierra Leone Ethics and Scientific Review Committee, and University College London (1967/008).

Procedure

Data collection took place in three urban and peri-urban communities located within the Western Urban and Western Rural districts of Sierra Leone, which encompass the capital, Freetown, and the surrounding area. These communities were areas where MSI Reproductive Choices' country team, Marie Stopes Sierra Leone (MSSL), had recently provided sexual and reproductive health outreach services and in which a national organisation, the Sierra Leone Union of Persons with Disabilities (SLUDI) had identified a high proportion of disabled women in residence. At the time of the outreach, women with disabilities were informed about the forthcoming research study. A few days after outreach had taken place at each site, the research team visited each site to invite women with disabilities who had accessed the outreach health services and shown interest in the study to participate. A small group of women without disabilities in these communities was also invited to participate to shed light on whether the sources of stigma women with disabilities identified were disability specific or held more generally within Sierra Leonean society.

Prior to the fieldwork a workshop was held in Sierra Leone in which all members of the research team participated, alongside MSSL, SLUDI and other organisations of persons with disabilities. The purpose of the collective discussion was to ensure that all members of the research team understood intersectional issues that affected women with disabilities and could therefore ensure that the voice and agency of participants was preserved in the research study. The research team received additional disability training from MTC and training in safeguarding from MSSL. Semi-structured interviews lasting about one hour were conducted with each participant in Krio by two female study co-authors (HKK & TF) and written consent was obtained. Questions on stigma focused on the content of stigmatising beliefs about disability and sexuality (e.g. 'What are some general beliefs about disability and disabled people within communities around where you live?') and its perceived impact on women with disabilities (e.g. 'Do the attitudes we have been talking about impact the way that you get sexual and reproductive healthcare like family planning? Please share why/why not.'). Interviews were audio recorded, transcribed and translated into English. Data were collected between March and June 2021 in line with national and local COVID19 policies and procedures.

Participants

Forty-two semi-structured interviews were conducted. About three-quarters of the participants were women with disabilities ($N = 32$), while the remainder were women without disabilities ($N = 10$). Of the women with disabilities, two had visual impairments, while the remainder had physical impairments. The over-representation of women with physical impairments in our sample reflects the fact that the majority of people with disabilities residing in the three communities accessed by the study had physical impairments. Most

participants were single mothers/caregivers living with their children and without a partner or spouse ($N = 24$; 58%), while the remainder were living with their partner or spouse and their children ($N = 18$; 42%). Of the single mothers/caregivers, many participants spontaneously spoke of having a “night husband” within the interview. This refers to the common practice of men visiting women with disabilities at night to use them for sex but being embarrassed to be seen with them during the day (Bangura et al. 2021).

Analysis

Responses were analysed using thematic analysis (Braun and Clarke 2006). For the purposes of the study, a top-down approach to the thematic analysis was taken, where the analysis was driven by the specific research question under study (Maguire and Delahunt 2017). First, the corpus of transcripts was read and re-read. Two of the study co-authors did the initial coding of the data (HKK & TF), focused on stigma-related content within the interviews. These same co-authors grouped the data into initial themes and subthemes, which were then refined on collective review also involving MTC and NG. . Pseudonyms have been assigned to participants to protect confidentiality.

Findings

The analysis generated three themes, each comprising two subthemes. Each of the three main themes reflected a different facet of stigmatising beliefs about disability and sexuality: namely, the causes of disability; the characteristics of women with disabilities; and the lives of women with disabilities. Sub-themes reflected the specific beliefs under these different facets of stigma. The themes and sub-themes are shown in Table 1.

[Table 1 about here]

Not all of the women who participated in this study thought each of the beliefs in Table 1 was true and not all perceived their choices to be personally influenced by stigma. For instance, some women with disabilities (as well as non-disabled women) spoke about the impact of stigmatising beliefs on their friends and neighbours (i.e. women with disabilities in the wider community). Additionally, in many cases different stigmatising beliefs were found to be interlinked. For example, a frequent connection was made by participants between disability caused by witchcraft and women with disabilities being a source of shame to others.

Stigmatising Beliefs about the causes of Disability

This theme encompasses stigmatising beliefs about the causes of disability which participants noted were prevalent in Sierra Leone.

Disability as caused by Witchcraft

Participants frequently described the societal perception that disability was linked to witchcraft:

‘Some people, they believe that it due to witchcraft. Also, some people say people with disabilities are witches or wizards.’ (A, Single mother of three, visual impairment)

‘As for me, my mother told me I suffered from fever when I was a child and was diagnosed with typhoid. I was transferred to a native herbalist and sorcerers told my parents that witches wanted to eat me but because they couldn’t succeed, they cast this spell on me.’ U, Single mother of four, physical impairment

Some women with disabilities believed this to be true themselves because of what they were told by family and the community:

‘My own disability is an action of my stepmother. I was told she was responsible for me being a disabled. I was told my stepmother turned into a cat and attacked me where I was a baby sleeping. When my mother went to sorcerers to find out, she was told that my stepmother actually wanted to eat me.’ J, Married caregiver of seven, physical impairment

Belief that disability was caused by witchcraft and that people with disabilities were witches or somehow under spells was described by participants as the key reason why people with disabilities were shunned and excluded from wider society in Sierra Leone. One direct consequence of this prevalent perception was that some women with disabilities shy away from accessing sexual and reproductive health services:

‘People do not get close to us and some say we are disabled because we are witches. That is the reason women don’t come forward [for sexual and reproductive health services]... Nurses say we are witches and rude.’ H, Single caregiver of two, physical impairment

‘Another thing is that health workers [at hospitals] are very rude to us. They shout at us that we should not give birth because of our disability. This is why some of our colleagues don’t go for healthcare for fear of this negative attitude. P, Single mother of one living in family home, physical impairment

As the participants have explained, there was a widespread expectation that the general community and healthcare providers themselves would treat women with disabilities who go for sexual and reproductive healthcare badly, therefore leaving some women reticent to access services. At the same time, this perception was sadly often based on direct experience. Belief that disability is caused by witchcraft also precipitated other types of stigmatising beliefs, discussed under later themes.

Disability as caused by Injections

Participants noted that another common perceived cause for disability was the receipt of injections:

‘In the community, other people believe injection is the cause of poliomyelitis.’ Z, Married caregiver of four, physical impairment

“What I know, some people become disabled because of injections received as infants.” M, Single caregiver of three, non-disabled

This stigmatising belief was distinct from others in the analysis in that the target of the stigma was not women with disabilities, but something else (i.e. injections). Complications from injections are very rare but can cause disabilities. However, participants described fear and distrust in Sierra Leone society because disabilities are perceived as a common result of receiving an injection. Many study participants cited injections as a cause of their own disability:

‘My right foot is my problem. My mother told me I was born without any disability. When I was young, I fell sick and was given an injection which resulted in my right foot being paralysed.’ D, Single caregiver of five, physical impairment

‘People believe that disability is caused by witchcraft. Others believe people become disabled because of taking injections in the wrong vein. I became disabled because of the injection.’ P, Single mother of one living in family home, physical impairment

One participant explained how this belief in particular might impact women with disabilities’ desire to access family planning:

“Other people say their disability is as a result of injections.... This is the reason many persons with disability are phobic to injections... Some of us don’t like taking injections because of the fear we have.” D, Single caregiver of five, physical impairment

Stigma about the Personalities of Women with Disabilities

This theme encompasses stigmatising beliefs about the characteristics and personalities of women with disabilities.

Women with Disabilities as Sexually Promiscuous

Several participants commented that women with disabilities were seen in Sierra Leone society as having uncontrollable and disinhibited sexual urges:

‘Able bodied people don’t like us. Able bodied women refer to us as sex maniacs.’ J, Married caregiver of seven, physical impairment

‘People normally say women with disabilities are more sexually active because they had nothing to do other than sex for pleasure.’ W, Single mother of one, physical impairment

However, participants with disabilities were keen to emphasise that they were just like women without disabilities in terms of their thoughts, feelings and desires. They discussed possible structural reasons for the misperception that women with disabilities have heightened sexual desire. One driver was the fact that women with disabilities sometimes have large families, but this was recognised as arising from their exclusion of family planning services, and not from heightened sexual desire:

‘There are some elements of truth in it because [women with disabilities] have many children... because they are not using family planning commodities.’ I, Mother of three living with boyfriend, physical impairment

Other women with disabilities suggested that broader stigma about disability and sexuality itself influenced how women with disabilities behave:

‘One of the reasons why women with disability have multiple sex partners is because men without disability are not proud of them.’ F, Engaged mother of five, physical impairment

‘[Some people believe] there is nothing we can offer men except sex, but it is the wrong perception... some women living with disability are only going the extra mile to satisfy their partner’s sexual desires, but they really do not have a high urge for sex.’ D, Single caregiver of five, physical impairment

Women with Disabilities as Troublemakers.

Healthcare professionals in Sierra Leone are also influenced by disability stigma, and consequently view women with disabilities as undeserving of services:

‘Most of the nurses believe that persons with disability are trouble-makers.’ R, Married caregiver of six, physical impairment

These perceptions may be due to the wider stigma directed towards women with disabilities as sexually promiscuous, as affected by spells, or as otherwise shameful individuals who should not get pregnant. However, women with disabilities shared that the very act of their asking for services and particularly accessibility accommodations was perceived as rude and troublesome by some healthcare workers.

‘[Healthcare workers] often make statements like “It is due to your rude behaviour, that is why God created you this way” or statements like “God created you disabled because of your attitude.” They refer to us as difficult to deal with... I am an example. When I was pregnant, the first nurse that was called told us that she will not be able to provide me services.’ (H, Single caregiver of two, physical impairment)

Participants with disabilities cited these negative attitudes as a key reason why women with disabilities avoided sexual and reproductive health services:

‘All these negative words are pulling away women with disabilities from accessing health services. Women with disabilities will just prefer to stay at home, never mind the outcome!’ V, Single mother of three, physical impairment

Stigma about the Lives of Women with Disabilities

This theme encompasses stigmatising beliefs about the lives of women with disabilities.

Women with Disabilities as Shameful Burdens

All participants noted that disability was perceived as a source of shame in Sierra Leone, leading women with disabilities to be shunned within communities. These attitudes were espoused by men directly, or else were perceived to influence men to abandon otherwise worthwhile relationships:

‘When [father of first child and I] were in love, when I visited him, his friends would mock him about me. This was why he abandoned me. He became discouraged because of his friends’ mocking.’ Z, Married caregiver of four, physical impairment

The shame arises from myths about the causes of disability, like witchcraft, but also from the perception that women with disabilities are a burden and cannot support themselves and:

‘The last guy I fell in love with abandoned me after I helped him secure a job ... his relatives supported him and they boldly told me they will not allow their brother to marry a woman with a disability because I am not able to do anything on my own.’ O, Caregiver of nine living with boyfriend, physical impairment

Participants with disabilities noted that they were often treated as “night-wives” by their partners. Additionally, when they became pregnant, many women with disabilities experience being abandoned:

‘Men we considered to be our fiancé will only visit us at night to have sex with us and when we are pregnant, they deny and abandon us because they are ashamed to associate themselves with us. The responsibilities of children increase our disability and this is very painful, it more than death.’ K, Single caregiver of one living in family home, physical impairment

Some women with disabilities described abandonment by men as a motivation to access family planning, so as to mitigate the risk of unwanted pregnancy and solo child-bearing responsibilities:

‘In my own case, I will not allow any man to play on me again. I will continue on contraceptives to be safe from unwanted pregnancies.’ G, Single caregiver of four, physical impairment

Pity for Childless Women with Disabilities

While being a single mother was considered an undesirable situation for women in general, participants both with and without disabilities attributed particular stigma to childless women with disabilities:

‘Women with disabilities without a child are [seen as] pathetic.’ B, Married caregiver of five, physical impairment

‘I honestly think women with disabilities who don’t have children are pitiful.’ L, Married mother of one, non-disabled

For women with disabilities being childless was viewed as a particular burden because having children would provide them with the necessary support with day-to-day activities, without which disabled women need to find costly and inconvenient alternatives:

‘Women with a disability who have children are far better than those without children because their children help reduce their burden by helping them with chores like fetching water, sending them to buy something at a far distance etc.’ T, Married mother of seven, physical impairment

‘Those who don’t have children on their own have to pay if they require any service from other children.’ V, Single mother of three, physical impairment

Participants explained that the reason why women with disabilities had to rely on their own children for support was partly due to societal stigma about disability:

‘Family members don’t associate with their relatives who are persons with disability. They shun relations and that is very prominent in our society. Women with a disability who don’t have children are in a more difficult situation.’ C, Married mother of two, physical impairment

Ultimately, participants saw disability stigma and the familial and community ostracism it precipitated as the major reason why women with disabilities sought sexual and reproductive health services:

‘These attitudes are a pressure on women who don’t have children. They go for D and C [dilation and curettage]so that they can have their children.’ E, Caregiver of one living with boyfriend, physical impairment¹

¹ Dilation and curettage is a medical procedure used to remove tissue from the inside of the uterus. For some women in Sierra Leone, if they have been trying to get pregnant but with no success, they will have this procedure to clean the womb (sometimes due to an earlier unsafe abortion) to enable them to get pregnant.

‘These attitudes make me feel like having more children. Whatever happens to me, only my children will come to my aid.’ S, Single caregiver of three, physical impairment

Discussion

Findings from this study suggest that Sierra Leonean women with disabilities perceive the choices they make about their sexual health, such as whether or not to access family planning, to be influenced by stigma about disability and sexuality in a myriad of ways. First, stigmatising beliefs related to the causes of disability deter women with disabilities from seeking sexual and reproductive health services. Notably, the perception that disability is caused by witchcraft underpins the widespread societal ostracism and alienation that women with disabilities experience. Second, we identified stigmatising beliefs about the personalities of women with disabilities, specifically that they are sexually promiscuous and trouble-makers. Yet, women with disabilities strongly refuted these characterisations, highlighting instead (for example) that what appears as a woman’s choice (e.g. having multiple sexual partners) is actually the result of poor treatment and abandonment by Sierra Leonean men who themselves espouse widespread stigmatising beliefs about women with disabilities.

Our findings unpack stigmatising beliefs about the lives of women with disabilities and their consequences. Specifically, women with disabilities are seen as shameful burdens, which encourages men to abandon them when they fall pregnant, leaving them with children they cannot care for alone. At the same time, women with disabilities need support with day-to-day activities like personal care. Their children are often the sole providers of this support, because women with disabilities are shunned by their family and the wider community. The attitudes reported by the women with disabilities in this study are, as one informant put it, ‘a pressure.’ Moreover, this pressure is complex as women with disabilities in Sierra Leone face conflicting demands both to have children and to abstain from child-bearing. These pressures were perceived as a reason why women with disabilities seek or are deterred from sexual and reproductive health services, as well as the type of treatment sought.

These findings corroborate those detailed in existing studies which have highlighted the importance of addressing stigmatising beliefs about disability and sexuality as necessary for the provision of equitable and disability-inclusive sexual and reproductive healthcare in sub-Saharan (Ganle et al. 2020) and West Africa (e.g. Ganle et al. 2016). Studies in this area have commonly investigated disability stigma as a barrier to accessing sexual and reproductive health services (e.g. Nguyen Liamputtong and Horey 2019 ; Rugoho and Maphoso 2017), identifying stigma as a key issue alongside other barriers such as unaffordable costs, inaccessible physical infrastructure and a dearth of healthcare information (Rohleder, Braathen and Carew 2018). The present study extends this line of investigation by elucidating, how, according to the perceptions of women with disabilities, stigma about disability and sexuality affects the choices they make about their sexual health.

These findings is widely shared should allow healthcare providers and other key stakeholders (e.g. the Sierra Leonean Ministry of Health) to better recognise and understand why women with disabilities in Sierra Leone may access services or else be deterred from doing so. Notably, the findings highlight the value that stigma interventions targeted at entire communities as well as specific targeting of health professionals hold for achieving equitable and sexual health. For instance, the negative attitudes about disability and sexuality displayed by healthcare providers are often cited as a reason why women with disabilities do not access

family planning (Ganle et al. 2016; Peta 2017). Yet, these findings suggest that because Sierra Leonean women with disabilities are stigmatised by their families and community, they may also feel undue pressure to have children as a means of securing household support. For these women, even if they can access health care and family planning services and the attitudes of providers are inclusive, disability stigma is still likely to exert a meaningful impact on the choices they make. At the same time, the study findings also highlight the need to shift the specific beliefs held by women with (and without) disabilities (i.e. that injections cause disability) that may deter them for accessing services.

Limitations

In terms of the study's limitations, all but two of the women with disabilities who participated in this study were women with physical disabilities. It is therefore possible and indeed likely that the issues and experiences raised do not fully capture the situation of other women (e.g. women with sensory or intellectual impairments). For example, some studies have suggested that women with sensory or hearing impairments are more vulnerable to sexual violence relative to women who have other impairment types (Fraser and Corby 2019). In addition, the present study was conducted in urban and peri-urban areas of Sierra Leone. It is plausible that the stigma about disability and sexuality impacts the sexual health choices of Sierra Leonean women with disabilities living in rural areas in different ways. Future research should address these gaps in representation.

Conclusion

The constraints that women with disabilities experience are not unique. All women globally face social and economic pressures that influence the choices they feel able to make about their sexual health. However, our findings highlight in the context of Sierra Leone, areas in which the choices of women with disabilities may be unduly influenced by stigma about disability and sexuality. Further research is needed to fully understand the impact of such forms of stigma on sexual health. For example, the belief that injections cause disability may deter some non-disabled Sierra Leonean women from using injectable contraceptives, and distrust of injections may be considerably more prevalent among women with disabilities, perhaps because of their belief that their lives have already been severely affected by them. This is concerning because injectable contraceptives are a very important modern contraceptive option. More broadly, research should examine how beliefs and stigma about disability and sexuality influences the choices women with disabilities feel able to make about their sexual health in other settings, contexts and cultures.

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Declaration of Conflicting Interests

The authors declare no competing interests.

Data Availability

The data that support the findings of this study are available on request from the corresponding author, MTC. The data are not publicly available due to their containing identifying information that could compromise the privacy of research participants.

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Table 1. Thematic table of stigmatising beliefs

Themes		
Stigma about the causes of disability	Stigma about the personalities of women with disabilities	Stigma about the lives of women with disabilities
Subthemes		
Disability as caused by witchcraft	Women with disabilities as sexually promiscuous	Women with disabilities as a source of shame
Disability as caused by injections	Women with disabilities as troublemakers	Pity for childless women with disabilities