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Original Research Article

Sexual and reproductive health experiences of young adult women with hearing impairment: a qualitative study

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ABSTRACT

Background: Adolescence is a time of rapid change. For young people who are deaf or hard of hearing, this period can be even more challenging. The aim of this study is to understand the sexual and reproductive health experiences of young women with hearing impairment.

Methods: A qualitative exploratory study was conducted using in-depth interviews with 53 participants including young adult women with hearing impairment, their mothers, teachers, psychologists, and healthcare providers. Data were collected using category-specific interview guides. Thematic analysis was used to identify barriers in accessing sexual and reproductive health (SRH) knowledge and services.

Results: The study identified several challenges. Young women in our study struggle to communicate, preventing them from asking questions and understanding answers. Many times, they get no information about their bodies, health or relationships. However, this study shows that when young people receive accessible language, guidance and encouragement, their confidence and ability to seek help improve greatly. Many feel alone or left out. But the study also found that when young people are given the right words, signs and support, they start to feel better about themselves. We identified four central themes namely, communication barriers; information gaps; physical, emotional, social consequences and systemic challenges.

Conclusion: The findings highlight the urgent need for SRH education and services for hearing-impaired people. There is a need to ensure that young people have the right language, information, and support, as this is fundamental to equity, wellbeing, and human rights.

Keywords: Reproductive health, Hearing impairment, Adolescence

INTRODUCTION

Adolescence is a defining period of human development — a time of rapid physical growth, cognitive expansion, and social transformation. This stage lays the foundation for lifelong health. Accurate sexual and reproductive health (SRH) information is vital then. Without it, adolescents risk misinformation, unsafe practices, and exploitation. This critical transitional period that includes

the biological changes of puberty and the need to negotiate key developmental tasks, such as increasing independence and normative experimentation.¹⁻³ Reproductive health is an important area of concern in adolescent health. Reproductive health and sexuality were always a sensitive subject, and this is especially so when it is for adolescents.⁴ World Health Organization (WHO) defines young adults as those between 15-24 years. Reproductive health problems of young adult girls occupy a special space in the

spectrum of reproductive morbidity among women of all ages. This is because of the physical nature of the problems which are so unique, special, and specific for the age group, and also because of the associated psychological factors which are very important in the growth and psychological remodelling of someone in the transition between childhood and womanhood. Young adult girls face more risks and challenges than ever before in reproductive health. It's particularly important to protect these girls against many reproductive health problems emerging in catastrophic manner. Many adolescent girls in this vital life phase (visible physical maturation) are denied the skills and resources to protect and advance themselves in reproductive and sexual health.

The chances of sexual or physical abuse are considerably more in the case of individuals with any kind of disability. Reports indicate that 83% of females and 38% of the males who have developmental disabilities are sexually abused.⁵ 40% of females with physical disability are sexually assaulted. Out of those who are faced with sexual assaults 49% of those with developmental disabilities are assaulted 10 times or more. Only 3% of the sexual assaults are ever reported by those with developmental disabilities. 90% of the perpetrators of these assaults are those in the family, acquaintances or caregivers. The victims of the assaults are not able to understand these as abusive behaviour or the consequences of these assaults. Hence, they are not able to sometimes react or respond appropriately. These alarming statistics indicate the need for education and preparation of the individuals with disabilities against sexual harm.

Hearing impairment is a disability which imposes a lot of restrictions on understanding different aspects of life, because of the barriers in communication. Persons with hearing impairment have limited vocabulary and are behind in language. They communicate mostly through gestures and sign language. In India the lack of a standard sign language similar to American sign language (ASL) or British sign language (BSL) adds to the difficulty in communication. Especially sexual reproductive health issues are less likely to be communicated to the deaf population not only because of difficulty of communicating, but also because of the inherent stigma prevailing in our society to communicate about it even to normal people. The limitations imposed by the impairment, combined with the environment to which they are exposed, may not be conducive to normal development and understanding about reproductive topics and issues. So, while on the one hand adolescents and young adults with hearing impairment face the same developmental needs and tasks that confront hearing adolescents and young adults, yet their passage through normal developmental stages may become more complicated. This is because the basic deprivation due to deafness is not just the sensory one of sound, but also the acquisition of communication skills. Young adults with disabilities are no less likely to be sexually active than their peers. They have the same social and sexual development cycle as their peers and they need information about sexuality,

reproduction, contraception, STI/HIV/AIDS prevention, and healthy lifestyles behaviors. But most parents don't have the requisite knowledge and skills to have been subject to repeated incidents of violence, including rape and sexual abuse, resulting in multiple pregnancies and births.⁸

Studies have derived information like caregivers of children with hearing impairment also reported several challenges, including communication barrier, emotional distress, and financial burden. One of the common addressing mechanisms were problem-focused strategies, for example, using alternative communication methods, and social support strategies, for example, seeking social interaction.⁹ Some recent studies proved that most women were aware of SRH services. There were significant disparities in access. Lack of communication skills, language and cultural barriers, and also stigma was identified as significant barriers for obtaining SRH services.¹⁰ The deaf adults were more aware of and concerned about their health issues than their hearing counterparts. Sometimes, they experienced discrimination and social stigma related to reproductive or sexual health, which affected their ability to access information and services related to reproductive health.¹¹

The above discussed barriers or challenges point towards the involvement of developmental, social and communication factors that shape SRH outcome in adolescents with hearing impairments. They often face significant barriers in accessing right information and services thus becoming vulnerable to exploitation and health outcomes. The existing gaps show us the need for a more inclusive and sensitive approach to SRH education. A large majority of adolescents and young adults, particularly the girls, have little to no knowledge on human sexual/reproductive organs, menstruation and problems associated with that, reproductive tract infections and its long-term health implications and other reproductive health related issues. The problems of young adult girls are predominantly sexuality related and hence need a different approach and more experience in community sexuality related issues. Considering the great need for sexual reproductive health awareness of the young adult girls with hearing impairment, the present study intends to address the problem in detail.

METHODS

It is an exploratory qualitative study, guided by an interpretivist paradigm and employed a general inductive approach to data analysis. The study was conducted at the Child Development Centre and the National Institute of Speech and Hearing in Thiruvananthapuram, Kerala from February 2023 to August 2023. Semi-structured, in-depth interviews were conducted to explore stakeholders' perspectives on sexual and reproductive health knowledge and experiences. Young adult women with hearing impairment (aged 17 years and above) enrolled at NISH were purposively selected, along with their mothers, teachers, special educators, psychologists, and clinicians.

Data collection continued until data saturation was reached; in total of 53 in depth interviews were completed: 10 with young women, 14 with mothers, 19 with teachers or special educators, 8 with psychologists, and 2 with doctors. Interview guides, specific for each category, were prepared and reviewed by experts. Trained female interviewers, fluent in the local language and sign language, conducted the interviews. Before collecting data, the research team considered their own views on gender, disability, and sexuality and stayed aware of these throughout to reduce bias. Audio recordings were made with participants' informed consent. After the interviews, participants received counselling and referrals if needed. The CDC Institutional Ethics Committee approved the study (Approval No. [01/CDC/2018]). Audio recordings were transcribed and translated into English, then checked for accuracy. Thematic analysis followed the guidelines of Braun and Clarke (2006). Researchers began by listing main concerns, then coded for repeated ideas and experiences. They compared findings across all participant groups to find common themes.

This process identified four main themes. Each theme highlighted important barriers that affect the sexual and reproductive health of young women with hearing impairments.

RESULTS

In the present study we have completed 53 interviews which includes young women with hearing impairment, special teachers, and mothers of young adults with hearing impairment, psychologists and clinicians. Among these, the details of participants and sociodemographic and clinical characteristics of 10 young adult women with hearing impairment are summarized in Table 1.

The thematic analysis led to the identification of several themes and subthemes which are presented in Table 2. A detailed description of the same is presented below.

Communication barriers

Across all participant groups, communication emerged as the most fundamental barrier. Family members acted as informal interpreters, raising ethical concerns and limiting young women's autonomy. Both teachers and mothers reported the absence of standardized signs for key SRH terms such as “menstruation” or “uterus,” forcing them to rely on improvised gestures and metaphors that often led to misunderstanding. These communication gaps were prominently visible in healthcare settings. Clinicians acknowledged that a young woman’s hearing impairment sometimes overshadowed clinical judgment, leading to assumptions rather than thorough examination.

One gynaecologist shared, “When I see a deaf girl with irregular periods, I sometimes assume its stress or a hormonal issue without doing a full diagnosis, as communication takes long.” This shows that

communication failures do more than limit young women socially—they can put them at real medical risk. Symptoms may be minimized or overlooked because of time pressures and unconscious biases, leaving their health concerns insufficiently addressed.

Table 1: Details of study participants (n=53).

Characteristics	Variables	N (%)
Participants category	Young adult women	10 (18.9)
	Mothers	14 (26.42)
	Special teachers	19 (35.8)
	Psychologists	8 (15.1)
	Gynecologists	2 (3.8)
Sociodemographic and clinical characteristics of young adults with hearing impairment (n=10)		
Age (years)	17-19	7 (70)
	20-22	3 (30)
Education status	Intermediate or diploma	8 (80)
	Graduate	2 (20)
Socio economic status	Upper middle	1 (10)
	Lower middle	4 (40)
	Upper lower	3 (30)
	Lower	2 (20)
Type of family	Nuclear	5 (50)
	Joint	5 (50)
Menarche age (years)	12-13	9 (90)
	14-15	1 (10)
BMI category	Underweight	3 (30)
	Normal	7 (70)
PCOS	Present	1 (10)
	Absent	9 (90)

Lack of SRH vocabulary in ISL highlights how the lack of standardized sexual and reproductive health vocabulary in Indian Sign Language restricts both expression and access to accurate SRH knowledge. Teachers reported struggling to teach SRH content due to a lack of sign-language vocabulary for biological or emotional terms. Mothers, in turn, confessed that even with love and concern, they lacked the tools to communicate about sexuality. “My daughter asks questions I can’t answer — not because I don’t care, but because I don’t have the words,” shared a mother.

These linguistic gaps fostered avoidance and discomfort, replacing dialogue with silence. Both educators and parents described relying on gestures, metaphors, or avoidance — strategies that perpetuated confusion rather than clarity.

Information gap

A major finding was the severe lack of sexual and reproductive health (SRH) information, which led to both emotional and physical difficulties. Instead of experiencing puberty as a natural stage of growing up,

many young people found it shocking, confusing, and frightening. The stories shared by young adults, mothers, and teachers showed a common pattern: SRH information was almost completely missing. This was not just about skipped lessons—it was a widespread silence that affected

how girls felt, how they behaved socially, and even their physical health. For many young women, puberty did not unfold gradually. It arrived suddenly and without explanation, leaving them scared and unsure about what was happening to their bodies.

Table 2: Themes and subthemes identified through the interview.

Theme	Subthemes	Illustrative quotes
Communication barriers	Lack of SRH vocabulary in ISL, informal interpretation and loss of autonomy	“We have signs for boy and girl, but not for menstruation or uterus.” — Teacher “I depend on my mother to explain to the doctor — but I don’t want her to hear everything.” — Young woman
Information gap	Fearful menarche and unprepared puberty, misinformation from peers	I thought I was injured — nobody told me.” — Young woman “You can’t get pregnant if it’s your first time.” — Young women
Physical, emotional, and social consequences	Normalised pain and self-management, emotional disconnection from the body	“I just use hot water and wait — pain is normal.” — Young woman “When you cannot name what’s happening inside you, your body becomes something to fear, not to understand.” — Psychologist
Systemic challenges	Policy–practice gaps, lack of trained interpreter	“On paper it sounds great — in reality nothing reaches them.” — Doctors “I never learned how to communicate with deaf adolescents in training.” — Doctors

Several participants described their first menstruation as a moment of shock and fear. One 19-year-old shared, “I thought I was hurt... bleeding meant I had done something wrong.” Such reactions highlight how, without prior explanation, girls are left to interpret bodily changes as signs of injury, wrongdoing, or illness. These early misunderstandings often stayed with them, becoming deeply rooted associations of shame and secrecy. Mothers and teachers acknowledged that discussions about menstruation rarely occurred beforehand, unintentionally placing girls in situations where their first encounter with puberty was surrounded by confusion rather than clarity.

Since families and schools did not provide proper SRH education, young people mostly learned from their friends. Young women often turned to their peers for comfort and answers. While these friendships were supportive, they also spread incomplete or incorrect information, which sometimes led to risky misunderstandings and harmful actions. Teachers said they often spent a lot of time correcting wrong information—or “un-teaching”—things students had learned from friends or incomplete social media posts. This shows that when young people don’t get proper information, they easily start believing untrue or harmful ideas.

The mothers felt guilty and understood their part in the problem. Many admitted that they had stayed silent about important topics, just as their own mothers had done. “My mother never talked to me about this, and I see I’ve done the same to my daughter,” one mother said, realizing how hard it is to break these patterns. In many families, not talking about such topics was seen as being modest,

protective, or simply following tradition. But over time, this silence became a cycle where avoiding uncomfortable conversations was passed down just as strongly as any family belief or value.

Over time, this silence weakened girls’ confidence, limited their sense of control, and influenced how they saw their own place in society. The refusal to talk about SRH—often defended as modesty, care, or cultural tradition—ended up working against them. Instead of offering safety, the silence allowed misinformation to spread, reduced self-esteem, and prevented young women from gaining the independence and clarity they needed to manage their health responsibly and confidently.

Physical, emotional, and social consequences

The lack of SRH knowledge and communicative support had a visible effect on well-being. Young women frequently normalized severe menstrual pain and coped alone using hot water, rest, or improvised remedies instead of seeking professional help.

Normalized pain and self-management refer to the participants describing the tolerance of severe menstrual cramps, irregular cycles, and infections in silence. “Pain is normal, I was told... so I just stay in bed with hot water,” stated a participant. Clinicians confirmed this trend, often seeing patients only when problems became severe. This normalization of suffering reinforces a passive relationship with one’s own body.

Psychologists noted that the lack of language to describe bodily sensations led to emotional disconnection and doubt about one's own body. Because the girls could not express what was happening and did not feel confident to speak up, they were at higher risk of being abused. This created a cycle where the girls stayed silent because they didn't have the words or confidence to speak up.

Parents and doctors shared the same fear: the silence about SRH might look like safety from the outside, but actually, it increased risk. It prevented girls from recognizing harmful situations, understanding when something was wrong, or telling anyone about it.

In reality, the silence that families believed would protect young women ended up doing the opposite. It created a quiet space where fear, confusion, and vulnerability grew. Many girls found they could not speak up—even when something felt wrong—because they had never been given the words or confidence to express their discomfort.

This silence slowly shaped their behaviour in the world. Without language to describe their feelings, they doubted themselves, mistrusted their instincts, and hesitated to seek help. Even simple tasks—like asking a question at the clinic or saying they felt unsafe—became difficult.

Over time, the lack of communication affected much more than their health. It made it hard for them to set boundaries, say “no,” or understand when a situation crossed the line. Without the ability to express what they needed or what made them uncomfortable, standing up for themselves felt nearly impossible. What was meant to protect them instead left them facing important health and social situations without guidance, clarity, or a voice of their own.

Systemic challenges

Although policies were in place, they were not always put into practice effectively. Participants proposed several solutions, including ISL-based digital tools, deaf peer educators, specialized SRH training for interpreters, and structured programmes to build parents' skills.

Policy–practice gaps highlight the gap between existing policies and their implementation in practice. Healthcare and education professionals described systemic neglect — inadequate training, lack of interpreters, and absence of institutional accountability. “We have inclusion policies on paper, but no interpreters in hospitals. We are told to ‘manage somehow,’” stated a doctor. “Teachers are expected to explain menstruation without even a proper sign for the uterus — how?” questioned one educator.

Many mothers shared a strong desire to move beyond simply “protecting” their daughters. They wanted to be active, informed partners in their daughters' education. As one mother said, “Don't exclude us—train us.” We want to guide our daughters, not just protect them. Their voices highlighted that parents are not barriers to SRH learning;

they are potential allies who simply need the right support, training, and resources to help their daughters confidently and safely navigate these topics

DISCUSSION

This study provides one of the first detailed qualitative insights into the SRH experiences of young adults with hearing impairment in India. The findings show that inaccessible communication is not a minor gap—it is a core barrier affecting health, dignity, and agency. Across participants, accounts, silence appears institutionalized and misunderstanding normalized.

A central insight from this research is that communication itself is a form of healthcare. When communication breaks down, everything else—confidentiality, consent, diagnosis, and trust—breaks down with it. This reflects international findings that deaf people often experience lower health literacy, dissatisfaction with services, and higher medical error.¹² In India, practices such as triadic consultations, where family members speak for deaf women, seems like support, but actually takes away their autonomy. Clinicians also described diagnostic overshadowing, where a person's disability is used to explain symptoms that should be examined separately.¹³ Taken together, these issues echo claims that unequal communication constitutes structural discrimination.¹⁴ But the problem reaches far beyond clinical spaces. Families, schools, and peer networks together create an “ecosystem of silence.” Cultural taboos transferred from mothers to daughters become ingrained as a lack of knowledge. This reflects global research showing that deaf women's sexual health concerns are often denied or feared.¹⁵

In India, however, silence is further intensified by linguistic deprivation: many SRH terms simply do not exist in accessible sign- language forms. Teachers and parents repeatedly shared that they could not explain even the basics—one teacher remarked, “We have a sign for ‘boy’, but not for ‘menstruation’.” As a result, relationships that should offer support instead become sites of confusion, worry, and emotional strain. The consequences are embodied in young women lived experiences—unmanaged pain, fear during menstruation, confusion about bodily changes, and reliance on silence or home remedies. These reflect global findings linking poor SRH education among disabled adolescents with vulnerability, mental distress, and poorer health outcomes.¹⁶ Yet the study also revealed small acts of resistance: caregivers wanting to learn, teachers improvising visual tools, and clinicians acknowledging systemic failures—showing that silence can be challenged.

The policy implications of this study are urgent and impossible to ignore. Programs like RKSK have expanded adolescent health services across India, but they still leave out many young people with disabilities.^{17,18} To truly include deaf adolescents, we need to rethink how SRH information is created and delivered—shaping it through

Deaf perspectives, moving from a mindset of simply protecting them to actively involving them, and building digital and peer-led sign-language platforms where they can learn privately, safely, and without stigma.^{19,20} These changes reflect the commitments of the UN Convention on the Rights of Persons with Disabilities, which upholds every person's right to information and control over their own body. The study also provides an important insight by showing that sexual and reproductive health for deaf young women is, at its core, an issue of epistemic justice. They are not just denied information; they are often not seen as reliable or knowledgeable about their own bodies. It is important to restore autonomy, make sure interpreters are available when needed, include deaf educators in teaching roles, and create policies that truly reflect their perspectives and rights. Overall, the challenges faced by hearing-impaired youth are not personal failings; they result from larger structural inequalities. The barriers are not in their bodies, but in the systems that do not support them. Improving access to sexual and reproductive health means recognizing that communication is a right, not a privilege.

This study, guided by an interpretivist qualitative approach using IDIs, allowed an in-depth contextual understanding of SRH experiences of young adult women with hearing impairment. Inclusion of multiple stakeholders provided a detailed, layered understanding of the issues and enabled data triangulation. Sample size was decided to the point of data saturation. Development of interview guide and data analysis done by a multi-disciplinary team of researchers, independent coding and taking team consensus before finalizing themes and subthemes enhanced rigour and minimized researcher bias. Thematic analysis using Braun and Clarke's approach ensured transparency, while triangulation across researchers of different disciplines enhanced credibility. Back validation done. Interviews were conducted in sign language, and checked for its accuracy in translation by members of the deaf community helped ensure accuracy in translations and reflected participants' meanings. This approach respects the realities of deaf participants and offers a level of accuracy, respect, and cultural sensitivity that is rare in disability research. For future research, the study encourages the use of more community-led methods.

This study has some limitations. Being a single site study, the subjective experiences of participants may differ in other states, language or culture and hence cannot be generalizable to all deaf youth in India. As the interviews with women having hearing impairment were conducted by a person known to them; this familiarity might have influenced participant's willingness to disclose all sexual and reproductive health related concerns. However, interviews were conducted in sign language, and checked for its accuracy in translation by members of the deaf community which helped ensure accuracy in translations and reflected participants' meanings.

This approach respects the realities of deaf participants and offers a level of accuracy, and cultural sensitivity that is rare in disability research. For future research, the study encourages the use of more community-led methods.

CONCLUSION

This study highlights a major, often-ignored problem: the SRH struggles of young adults in India. By listening to young women, mothers, teachers, doctors, and therapists, we see a whole system in which silence is created by communication gaps, cultural taboos, and official neglect. The core issue isn't that these individuals don't know things, but that the system shuts them out, denying them the right words, tools, and safe places to learn about and care for their own bodies. Fundamentally, this isn't a problem caused by disability; it's a problem of a lack of accessibility. The inability to talk about periods, sex, or consent is not a fault of the deaf community—it's a fault of systems that refuse to speak their language. The study clearly shows that the lack of accessible SRH education and health care is not an accident but an injustice. When people can't communicate, true consent is impossible; when education is not accessible, people cannot be truly empowered. The lessons from this study go beyond just disability and health. They challenge us to look at our society's values—how we decide whose voices matter and whose experiences we believe. Solving the SRH needs of hearing-impaired youth requires a complete shift in thinking: moving from token gestures of inclusion to real communication equality, from silence to open conversation, and from vulnerability to self-determination. In the end, the findings confirm a simple truth: communication is the first step to healing. When we give young people the words, signs, and confidence to understand their bodies, we do more than prevent illness—we restore their dignity. By finally listening to those who have been ignored for too long, this study rightly frames sexual and reproductive health as a matter of justice, compassion, and human rights.

Recommendations

Based on the findings of this study several implications for policy and practice are identified. There is a need to institutionalise regular SRH awareness programmes for children and young adults with hearing impairment to be conducted at least twice a year in schools, training centres, and community settings where they are enrolled. Dedicated counsellors who are proficient in sign language and skilled in disability-sensitive counselling could be appointed to enable trust based, peer-like communication and open discussion of doubts and concerns. In addition, disability-inclusive SRH content into existing SRH curricula, ensuring that concepts are adapted to the cognitive, linguistic, and experiential needs of learners with hearing impairments. The involvement of trained sign language experts is essential to facilitate effective communication during healthcare interactions and to deliver SRH education using accessible methods,

including sign language, visual aids and simplified explanations. Dedicated time should be allocated for group or individual sessions, recognising that even short, focused interactions can significantly improve understanding, confidence, and disclosure of sensitive issues. Promoting sign-language-based awareness sessions as a standard practice, may further enhance better comprehension, encourage openness, and allow multiple SRH concerns to be addressed effectively.

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