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Sexual and Reproductive Health Empowerment in Rural Angola

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Abstract

Background: This study focused on a community located in Sumbe, in the Kwanza Sul province of Angola. The community's limited resources significantly affect the healthcare of its residents. Local beliefs and traditions exacerbate this issue. Considering this scenario and a preliminary diagnosis by the research team, the Seigungo project aimed to evaluate the effectiveness of a training programme with different health-related modules. The module addressed in this study focused on sexual and reproductive health. **Methods:** This exploratory, quantitative, observational before-and-after study employed a descriptive-correlational analysis with a sample of 30 participants (n = 30) who finished the training programme. Statistical analysis was conducted using IBM® SPSS® Statistics, version 29.0. **Results:** The sexual and reproductive health literacy module of the implemented training programme proved effective. Considering the results before the training, 53.3% of the health promoters presented inadequate literacy levels, and after the training this number decreased to only 3.3%. **Conclusions:** Our findings demonstrate that education and community engagement may significantly improve the levels of literacy in sexual and reproductive health, which may result in better health decisions and outcomes.

Keywords: sexual and reproductive health; health empowerment; health education; health literacy; Angola

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1. Introduction

Sexual and Reproductive Health Literacy (SRHL) broadens the definition of Health Literacy (HL) by including knowledge, behaviour, and individuals' perceived ability to access, understand, and apply information for making informed decisions about their sexual health [1]. Low-SRHL concerns are most prevalent in poorer countries, particularly among younger individuals [1]. The literature indicates various consequences linked to limited SRHL. According to a cross-sectional study, three-quarters of adolescents in Ethiopia had insufficient SRHL. Literacy levels were highly correlated with sociodemographic characteristics, like income and access to sexual health information [2]. In Lao PDR, a study found that 65.5% of youths had inadequate SRHL, which was associated with limited SRH knowledge and poor functional health-literacy skills [1]. A review of 24 studies

from Sub-Saharan Africa found that young people had limited SRHL, poor sexual health practices, early sexual activity, teenage pregnancy, and STIs [3]. In Bandar Abbas, Iran, insufficient SRHL was also found, associated with different sociodemographic variables such as the level of education, emphasising the importance of literacy interventions [4]. Still, risky or non-risky sexual behaviours are not just the consequence of inadequate SRHL. They could also be associated with peer influence [5], future expectations [6], sensation-seeking [7,8], substance use [9], self-esteem and emotional status [10], parental monitoring and supervision [11], mental health [12], and cultural norms [13]. Furthermore, the absence of institutional support or adapted sexual education programmes could be linked with a higher prevalence of risky sexual behaviour [14]. Considering these factors, disseminating reliable information, along with ensuring its comprehension by the target population, is vital to addressing this plethora of challenges.

In this context, community health workers can bridge the knowledge gaps in their community since they are the go-to facilitators for adolescents and young adults in many vulnerable, rural, and hard-to-reach communities, with involvement in various health topics, including sexual and reproductive health [15]. In many communities in Angola, the weaknesses in SRHL are evident. The country presents high fertility rate, sexually transmitted infections, and the spread of HIV/AIDS [16]. A study conducted in a school in Lobito, Angola, by Batista et al. [17] showed that in a sample of 45 high school students, 93.3% indicated knowing some contraceptive method, with the male condom being the most well-known (62.2%). However, knowledge about other available methods was low. Only 17.8% of the students indicated knowing the calendar method, with just 17.8%, combined pill 15.6%, morning-after pill 13.3%, and injectables 8.9%. According to Girls Not Brides [18], 30% of Angolan girls are married before the age of 18 and 8% before the age of 15. This prevalent situation reinforces cycles of poverty and gender inequality, early motherhood, and constraints on access to future opportunities. With this, Angola continues to face one of the highest adolescent pregnancy rates in the world, representing serious health risks to adolescents and adults [19]. These challenges are intensified by limited resources in some communities, such as the access to health services, inadequate family planning, and the absence of effective health and sexual education. In these circumstances, strengthening SRHL is crucial because it empowers individuals to advocate for their rights, negotiate health systems, and make informed reproductive decisions. Angolan health authorities have acknowledged this problem and emphasises that in order to reverse the current situation, effective sexual and reproductive health information and education programmes must be put in place in addition to increasing school enrolment [20]. Given this scenario, it is anticipated that by developing sexual education initiatives, health promoters will have a positive impact on health education, resulting in better public health indicators, greater individual autonomy, greater social equity, and improved levels of sexual and reproductive health. This research is a component of a larger initiative in Gungo aimed at enhancing multiple aspects of health literacy among local health promoters. The training programme encompassed various health domains; however, this study specifically examines the sexual and reproductive health component. The objective was to evaluate the effectiveness of the training method in enhancing critical outcomes associated with sexual and reproductive literacy, such as positive sex education, contraception, and informed decision-making.

2. Materials and Methods

2.1. Study Design and Setting

This study adopted a descriptive-correlational methodology and was designed as exploratory, quantitative, and observational, evaluating the effectiveness of the aforementioned programme through a before-and-after comparison. The STrengthening the

Reporting of OBservational Studies in Epidemiology (STROBE) guidelines were followed in its execution [21]. The study was conducted in the Gungo commune, located in Kwanza Sul Province, Angola, in the city of Sumbe. The commune has an estimated population of 33,969 inhabitants, distributed across approximately 108 districts. Gungo has ten health centres, which are, however, in extremely poor condition and face a severe shortage of medical supplies. Due to the limited number of physicians and nurses, the community relies heavily on health promoters to address health-related issues. This challenging situation is evidenced by the early initiation of sexual activity among many adolescent girls in Angola, the elevated rates of early childbearing, and the restricted access to or utilisation of contraceptives, particularly in rural regions [16,17,19].

2.2. Training Model

The overall training consisted of approximately 360 h of theoretical and practical instruction organised into one-week, in-person, modular sessions. The training programme was developed in a careful manner, considering the vulnerable context of Gungo, and was adapted accordingly. In the sexual and reproductive model, the key topics of the training were preconception care, family planning, pregnancy, childbirth, puerperium care, and neonatal and paediatric care, which were among the crucial subjects covered. These subjects addressed the gaps found during the diagnostic phase. Five Portuguese doctors, three nurses, and one psychologist were part of the intervention team. A preliminary screening was conducted in October 2023, followed by theoretical and practical training in January 2024, and a post-training data collection was conducted in October 2024.

2.3. Data Collection

A field diagnostic evaluation was conducted prior to the project. The project itself began in 2022 and was carried out by the research team. Midwives and health promoters were interviewed, and alarming data was found, with a 44% neonatal/infant mortality rate and a 10% intrapartum maternal mortality rate over a 10-month recording period [22]. After recruitment via communication with local authorities, 30 health promoters were selected for the training programme. The eligibility criteria for participants were being above 18 years old, possessing literacy skills, and working as a health promoter in Gungo. To collect the data, two instruments were administered: a sociodemographic questionnaire to characterise the sample, and a 26-item questionnaire (pending publication) developed to assess four key domains: information search and access; understanding and thematic knowledge; critical evaluation of information and behaviour; practical application and safe decision-making. The questions were developed based on theoretical saturation derived from a relevant literature review and were subsequently adjusted by the authors and some experts in the field. Cultural adaptation and face validity were then assessed through a pilot test. In this article, we also evaluated the internal consistency of the instrument. The participants were instructed to answer the following questions using a five-point scale: 1 = Very easy; 2 = Easy; 3 = Difficult; 4 = Very difficult; and 5 = Don't know (Table 1).

For the score's operationalisation, the 26 items should be dichotomised: answers marked 'difficult', 'very difficult' and 'don't know' should be assigned a value of 0, while answers marked 'easy' and 'very easy' should be assigned a value of 1. The total score is obtained by summing the values of all items and reflects the level of sexual and reproductive health literacy of each participant. A score of 13 or above indicates 'adequate' sexual and reproductive health literacy, scores between 9 and 12 indicate 'problematic' sexual and reproductive health literacy, and scores of 8 or below indicate 'inadequate' sexual and reproductive health literacy. This instrument demonstrated strong internal consistency, with a Cronbach's alpha coefficient of 0.90 for the overall scale.

Table 1. Sexual and Reproductive Health Literacy Scale.

On a Scale from Very Easy to Very Difficult, How Easy Would You Say It Is for You to	**1**	**2**	**3**	**4**	**5**
Information search and access					
1. Find information about sexual and reproductive health.					
3. Find information about citizenship education and gender equality.					
6. Find information about the importance of emotions in sexuality.					
10. Find information about how the female/male reproductive system works.					
12. Find information about the various forms of sexual abuse and exploitation.					
14. Find information about the various forms of dating violence.					
15. Find information about the use of contraceptive methods.					
18. Find information about the prevention of sexually transmitted infections (STIs).					
24. Find information on how emergency contraception works.					
25. Find information on the importance of sexual and reproductive health monitoring (breast cancer screening, cervical cancer screening, testicular cancer screening, STI screening).					
Understanding and thematic knowledge					
2. Understand information about sexual and reproductive health.					
4. Understand the importance of citizenship education and gender equality.					
7. Understand information about the importance of emotions in sexuality.					
8. Understand the importance of individual responsibility in promoting sexual and reproductive health (informed and safe choices).					
11. Understand information about how the female/male reproductive system works.					
16. Understand information about the use of contraceptive methods.					
19. Understand the importance of information about STI prevention.					
21. Understand the physical, psychological and social impact of teenage pregnancy.					
Critical evaluation of information and behaviour					
5. Assess the importance of respect for others and gender equality.					
13. Assess the importance of preventing sexual abuse and exploitation behaviours.					
Practical application and safe decision-making					
9. Use information to make informed and safe choices about sexuality.					
17. Use information about contraceptive methods safely.					
20. Use information to prevent STIs.					
22. Use information to prevent teenage pregnancy.					
23. Use information to prevent unwanted pregnancy.					
26. Use the information to carry out regular sexual and reproductive health monitoring.					

2.4. Ethical Considerations

The study was approved by the Ethics Committee of the Instituto Politécnico de Viseu on 24 April 2025 (Reference N°19/SUB/2025), following strict adherence to ethical and deontological procedures. The research followed the guiding principles of the Declaration of Helsinki. Ethics approval was granted after data collection because Gungo does not have an ethics committee, and the study had to follow the schedule established with the Portuguese trainers; this explains the later approval date. To clarify this point, although the ethical approval was after the data collection, all ethical procedures were undertaken. A

written informed consent form was included as part of the survey, and a local researcher provided a brief, culturally appropriate verbal explanation to ensure participants fully understood the study. All collected data were kept confidential and secure, and participation was entirely voluntary.

2.5. Statistical Analysis

Statistical analysis was performed using Statistical analysis was conducted using IBM® SPSS® Statistics software, version 29.0, IBM Corp., Armonk, NY, USA, to characterise, describe, and conduct inferential analysis of the collected data. Descriptive statistics were applied to calculate absolute frequencies (n), percentages (%), measures of central tendency (Mean—M), and the measure of dispersion (Standard Deviation—SD). Cronbach's Alpha (α) was used to assess the internal consistency of the instrument. The following reference values were considered for interpretation: >0.9 Excellent; 0.8–0.9 Good; 0.7–0.8 Acceptable; 0.6–0.7 Questionable; 0.5–0.6 Poor; <0.5 Unacceptable.

The choice of statistical techniques was influenced by the nature and characteristics of the variables involved. Prior to any analysis, the normality assumptions were confirmed. The data did not follow a normal distribution ($p < 0.05$), as pointed by the skewness and kurtosis values, as well as the value of the Shapiro–Wilk test statistic and its p-value. Inferential statistics were conducted using non-parametric tests, specifically the Wilcoxon test to compare the means of a quantitative variable between two paired groups. In order to assess whether there were any differences between participants based on gender, marital status, age and years of work experience after completing the training programme, the Mann–Whitney U test and Spearman's rank correlation coefficient were used. A p-value of <0.05 was considered statistically significant.

3. Results

3.1. Sample Characteristics

The sample consisted of 30 participants, most of whom were men (60%), with a mean age of 45.57 ± 10.86 years (range 24–64 years). Most participants were single (53.3%) and had completed 6 years of formal education (26.7%). A significant proportion were displaced from their usual residence (80%) and lived with other family members (70%). The participants had on average 13.82 ± 8.47 years of work experience (range 1–36 years) (Table 2).

Table 2. Sociodemographic background.

Variables	n	%
Sex		
Male	18	60
Female	12	40
Marital status		
Single	16	53.3
Married or cohabitating couples	14	46.7
Level of education		
Primary education		
3 years	1	3.3
4 years	2	6.7
6 years	8	26.7
Secondary education I cycle		
8 years	4	13.3
9 years	4	13.3

Table 2. *Cont.*

Variables	n	%		
Secondary education II cycle				
11 years	2	6.7		
12 years	2	6.7		
13 years	2	6.7		
Higher education				
Bachelor's degree	5	16.7		
Displaced from usual residence				
Yes	24	80		
No	6	20		
Household				
Living alone	2	6.7		
Living with the family of origin	6	20		
Living with other family members	21	70		
Other	1	3.3		
	M	**SD**	**Min**	**Max**
Age	45.5	10.9	24	64
Years of work experience	13.8	8.5	1	36

Regarding the characterisation of the participants' reproductive and sexual backgrounds, it should be noted that most of the sample (80%) reported having had sex in the last year, primarily within a relationship (80%). The most used methods of contraception were the pill (93.3%) and condoms (56.7%). While 10% of the sample said they had already had a sexually transmitted infection (STI), half (50%) did not know if they had (Table 3).

Table 3. Reproductive and sexual background.

Variables	n	%
Sexual intercourse in the last year		
Yes	24	80
No	6	20
Sexual intercourse in the context of a relationship		
Yes	24	80
No	6	20
Use of contraceptive methods		
Use of condom		
Yes	17	56.7
No	13	43.3
Use of the pill		
Yes	28	93.3
No	2	6.7
Use of vaginal ring		
No	30	100
Implant		
Yes	1	3.3
No	29	96.7
Coitus interruptus		
Yes	1	3.3
No	29	96.7
Other		
Yes	2	6.7
No	28	93.3
Sexual intercourse in the last year with a condom		
Always	2	6.7
Often	5	16.7
Rarely	4	13.3

Table 3. *Cont.*

Variables	n	%
Never	13	43.3
Not applicable	6	20
Sexual intercourse associated with alcohol consumption		
Rarely	5	16.7
Never	25	83.3
Had a Sexually Transmitted Infections (STIs)		
Yes	3	10
No	12	40
I don't know	15	50

Non-existent Sexual and Reproductive Health literacy levels prior to implementation of the training programme per item.

At least 50% of the sample marked all items as 'don't know', with the exception of items 3 and 5. The most prevalent items (>80%) were items 24, 25, and 26 (Table 4).

Table 4. Initial assessment using the Sexual and Reproductive Health Literacy Scale.

Sexual and Reproductive Health Literacy Scale	Don't Know n/%
1. Find information about sexual and reproductive health.	15; 50%
2. Understand information about sexual and reproductive health.	17; 56.7%
3. Find information about citizenship education and gender equality.	14; 46.7%
4. Understand the importance of citizenship education and gender equality.	15; 50%
5. Assess the importance of respect for others and gender equality.	12; 40%
6. Find information about the importance of emotions in sexuality.	20; 66.7%
7. Understand information about the importance of emotions in sexuality.	21; 70%
8. Understand the importance of individual responsibility in promoting sexual and reproductive health (informed and safe choices).	18; 60%
9. Use information to make informed and safe choices about sexuality.	16; 53.3%
10. Find information about how the female/male reproductive system works.	21; 70%
11. Understand information about how the female/male reproductive system works.	20; 66.7%
12. Find information about the various forms of sexual abuse and exploitation.	20; 66.7%
13. Assess the importance of preventing sexual abuse and exploitation behaviours.	22; 73.3%
14. Find information about the various forms of dating violence.	22; 73.3%
15. Find information about the use of contraceptive methods.	17; 56.7%
16. Understand information about the use of contraceptive methods.	16; 53.3%
17. Use information about contraceptive methods safely.	17; 56.7%
18. Find information about the prevention of sexually transmitted infections (STIs).	14; 46.7%
19. Understand the importance of information about STI prevention.	16; 53.3%
20. Use information to prevent STIs.	16; 53.3%
21. Understand the physical, psychological and social impact of teenage pregnancy.	22; 73.3%
22. Use information to prevent teenage pregnancy.	17; 56.7%
23. Use information to prevent unwanted pregnancy.	18; 60%
24. Find information on how emergency contraception works.	25; 83.3%
25. Find information on the importance of sexual and reproductive health monitoring (breast cancer screening, cervical cancer screening, testicular cancer screening, STI screening).	25; 83.3%
26. Use the information to carry out regular sexual and reproductive health monitoring.	24; 80%

3.2. Effectiveness of the Training Programme Implementation

Before their participation in the training programme, 63.3% of the participants demonstrated inadequate or problematic levels of sexual and reproductive health literacy. After the intervention, the proportion of participants with adequate literacy increased significantly, from 36.7% to 96.7% ($p < 0.001$) (Table 5).

Table 5. Levels of sexual and reproductive health literacy.

	Prior to Attending the Training Programme		After Completing the Training Programme		*p*
	n	**%**	**n**	**%**	
Inadequate	16	53.3	1	3.3	
Problematic	3	10	0	0	
Adequate	11	36.7	29	96.7	
Total score	M = 10.0; SD = 7.57		M = 22.93; SD = 4.57		<0.001

Legend—M: mean; SD: standard deviation.

Additional sub-analyses were performed which demonstrated that there were no differences between the participants after completing the training programme with regard to gender (Mann–Whitney U test = 88.5, $p = 0.38$), marital status (Mann–Whitney U test = 112.0, $p = 1.00$) and to years of work experience ($\rho = 0.32$, $p = 0.09$). Age was moderately and positively associated with higher levels of sexual and reproductive health literacy, and this relationship was statistically significant ($\rho = 0.47$, $p = 0.009$).

4. Discussion

According to our research, the SRHL of local health promoters who participated in the training statistically significantly improved when a structured training programme was introduced. Before the intervention, it was found that over 50% of the participants lacked sufficient SRH literacy. After the training, this number decreased substantially, and the percentage of participants with adequate literacy increased from 36.7% to 96.7%. The presented results show that context-adapted training may improve the ability to share and disseminate essential knowledge, to support safe decision-making in sexual and reproductive health.

Previous approaches, in different contexts, demonstrate the importance of training health promoters to improve not only SHRL but HL in general. A study setting in rural Niger found that young married women who were visited by trained community health workers were more likely to use modern contraception, highlighting the positive impact of training community health workers [23]. In their work, Parellada Pena and Teixeira [24] identified capacity-building initiatives for health service providers, focused on areas such as family planning, childbirth and childhood care, and HIV, highlighting the potential of these trainings to strengthen skills. However, the authors identified the need for more assessments to prove their impact. Recognising the importance of training, Pathfinder International [25] developed a supplementary training module in West Africa for community agents, reinforcing the role of promoters as credible sources of information, empowering them to address topics such as family planning, pregnancy, and healthy spacing of pregnancies.

The training model developed by our team reveals the need for educational strategies that are sensitive to the cultural, social, and economic specificities of the communities, and are capable of engaging local health promoters. Furthermore, educating trainers and health promoters can constitute a strategic approach for a more effective dissemination of sexual health practices. The results presented also emphasise the need to integrate continuing education strategies for these health promoters into public policies. The evidence obtained

in this study, along with previous literature, demonstrates the positive impact of training community health workers on sexual and reproductive health outcomes [23,25], justifying the investment in continuing education in sexual and reproductive health. Prioritising rural areas and strengthening access to healthcare can contribute to reducing identified problems, such as the high prevalence of teenage pregnancy, and improving decision-making regarding sexual health, a challenge identified in recent reports [19].

Limitations and Suggestions

This study presents some limitations. The instrument used has not been formally validated to date. The internal consistency analysis (Cronbach's alpha) is reported here; however, the instrument was previously developed theoretically and culturally adapted to the Gungo context, considering local traditions and community approaches to sexual and reproductive matters. Linguistic considerations were necessary, as the questionnaire was initially created in European Portuguese, and it was important to ensure a comprehensive understanding among participants. Future studies should focus on formally validating the instrument and studying its other psychometric properties (e.g., validity, reliability, and responsiveness). Other methodological limitations should also be acknowledged. The study's small sample size could have been larger, even though it met the minimum requirement and allowed statistically significant differences to be found. Also future research could evaluate long-term knowledge retention and the impact of changes in health promoters' practices on the community's sexual and reproductive health.

5. Conclusions

The results presented suggest that continued investment is necessary to develop training models for health promoters, community workers, facilitators, and multipliers, particularly in vulnerable communities in Angola. The training of these health promoters and the replication of the model through local agents are also considered sustainable strategies to ensure medium- and long-term impact. Over time, these trainees are expected to be able to disseminate and promote knowledge among the members of the Gungo municipality, contributing to changing risky behaviours related to sexuality, shifting mindsets, and overcoming deep-rooted prejudices. It is essential to provide the skills to communicate clearly, non-judgementally, and culturally sensitively. Future interventions should also create safe spaces within communities and institutions where open research on issues such as sexuality, relationships, prevention, and informed decision-making can take place. The experience in Gungo demonstrates that it is possible to significantly improve SRHL through well-structured training programmes based on a multidisciplinary and participatory approach. Replicating this model in other Angolan communities could contribute to the development of more literate and capable health promoters, ultimately improving public health indicators, reducing risk behaviours, and promoting healthy and responsible sexual practices. Health promoters with higher literacy levels can create more open environments for discussing sexuality, reducing stigma, and increasing the participation of men and women in health education programmes, with lasting health gains.

Investing in sexual and reproductive health is investing in the health and well-being of a population.

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Abbreviations

The following abbreviations are used in this manuscript:

HL	Health Literacy
SRHL	Sexual and Reproductive Health Literacy
STIs	Sexually Transmitted Infections

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