

SEXUAL AND REPRODUCTIVE HEALTH RIGHTS OF PERSONS WITH DISABILITIES

The World Health Organization estimates that 15 per cent of the world's population have a disability and that a higher prevalence of disability occurs among people in lower-income countries. Persons with disabilities can have widely varying needs and experiences, depending on factors such as whether they have experienced their disability from birth or later in life, or if they live independently or not. However, all have sexual and reproductive health needs and rights, yet it is an area that can be neglected in health and development policy, and the barriers preventing access to these rights can be widespread. It is therefore crucial to recognise and challenge these barriers in order to provide essential sexual and reproductive education that not only includes disease prevention, but also relationships, fertility desires, and pleasure.

Exclusion from services

Persons with disabilities (PWD) have the same sexual and reproductive health rights (SRHR) needs as other people. Yet they often face barriers to information and services. A main cause of barriers to PWD accessing SRHR services is not the disability itself, but the ignorance and outdated attitudes of researchers, NGOs, health-care and service providers, and communities. It is the assumptions made by researchers, NGOs, and people within communities about women with disabilities' SRHR needs which can leave women with disabilities excluded from vital services. Assumptions include:

- The desexualisation of PWD – the view that PWD do not have sex, are not sexually attractive, have no sexual desires, are considered a-sexual or sometimes hypersexual, and that SRHR is not a priority. The result is that PWD often do not receive any sex education and that sexual vocabulary is not included in sign language in many countries. If there is any sex education it is focused on disease prevention and not pleasure.
- Limits on family life of PWD – the opinion that PWD do not have fertility desires or interests in long-term relationships, and are therefore denied the right to establish relationships and to decide whether, when, and with whom to have a family. In some cases, PWD are subjected to forced sterilisations, forced abortions, or forced marriages.

Consequences of this lack of access to services and sex education mean that PWD are more likely to experience physical, emotional, and sexual violence and other forms of gender-based violence and mental health issues. They are also more likely to become infected with HIV and other sexually transmitted infections (STIs).

It is important to note that just as no one individual is the same as another, each person with disability will have different experiences in relation to SRHR and the issues above can vary depending on the type of disability, whether physical or mental and whether it has been experienced since childhood or later in life.

A context of wider gender inequality

Sexual abuse, dehumanisation, and violence against women with disabilities must be seen in the context of the wider pattern of gender inequality and social norms. With regards to reproductive health, the children of women with disabilities can also face lower survival rates due to lack of access to health services, and female children can be more adversely affected.

Emergency and humanitarian crises

All of the issues detailed above are compounded in an emergency/humanitarian crisis situation. Research shows that forced marriages and rapes are socially unacceptable in most crises (Uganda, Nepal, Kenya). Particular challenges faced by PWD that may be worse in a crisis setting include:

- Shunning and blaming of women at health services, for example for being pregnant.
- Exclusive parallel services and insufficient services.

Recommendations

- Establish partnerships with organisations of PWD while recognising the incredible diversity among PWD. Not all PWD are able or willing to attend PWD groups.
- Pay particular attention to PWD in institutions.
- Recognise that the sexual health rights of PWD include the right to pleasure and intimate relationships. This includes paying attention to people who acquired a disability later in life (war veterans, traffic or work accidents) as part of rehabilitation.
- Increase the capacity and the competencies of disabled people's organisations.
- Conduct research to strengthen the evidence base and evidence-based solutions.

The following principles should also be applied:

Sexual literacy: Improve evidence-based knowledge and understanding, which includes learners' understanding of the diversity of constructions and valuations of sexuality, sexual health and sexual pleasure, and show tolerance for differences.

Sexual confidence/competence: Focus on confidence and competence to build self-esteem and communication skills, and feel empowered to support PWD to make informed choices about sex but also wider sexual health and rights issues.

Sexual solidarity: Work with PWD with specific sexual health problems, including victims/survivors of sexual assault and those whose sexual rights are being denied or violated. All people should be treated with respect and dignity.

Being sex critical: Being 'sex critical' means to critically engage with dominant social and cultural norms about sexuality and disability in order to be critical of these norms too. Being critical does not mean disagreeing with the dominant social norms about sex, sexuality, and disability within a community. Health professionals need to be able to identify what is considered 'normal' and 'abnormal', 'good' and 'bad' within their community and think about whose interests these categories serve. Who has the power to define what is 'normal' and 'good'?

Further reading

WHO/UNFPA (2009) *Promoting Sexual and Reproductive Health for Persons with Disabilities*, WHO/UNFPA Guidance Note, Geneva: World Health Organization

Starrs, A.M. et al. (2018) 'Accelerate Progress Sexual and Reproductive Health and Rights for All: Report of the Guttmacher-Lancet Commission', *The Lancet*, [http://dx.doi.org/10.1016/S0140-6736\(18\)30293-9](http://dx.doi.org/10.1016/S0140-6736(18)30293-9) (advance online publication)

Credits

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