**Sexual Health: International Perspectives**

**HIV/AIDS and Disability**

**Abstract:**  Globally, one billion people with disabilities face additional barriers in the society that prevent equal participation in their human rights and fundamental sexual freedom which can impact their overall sexual health and wellbeing. Despite the advances in health services over the decades with a substantial decline of the new HIV infections, the exclusion of people with disabilities from mainstream HIV prevention campaigns can heighten risks of exposure to HIV/AIDS. The paper explores the impact of stigmatization and discrimination of people with disabilities from international perspectives based on the Millennium Development Goals and Sustainable Development Goals specifically on combating HIV/AIDS, through quality education and empowerment.

**Keywords:** HIV/AIDS; disability; public health; sexuality; human rights; education; United Kingdom

The concept of sexual health has evolved over the last forty years which led to the current definition by the World Health Organisation (WHO) as “a state of physical, mental and social well-being in relation to sexuality. This requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled” [1]. Social and public policies such as welfare and housing have been influential in promoting and improving health and wellbeing; and health inequalities research with the aim to increase opportunities for people who have experienced discrimination on the grounds of gender, race, age, sexuality, religion and disability.

There have been technological advances in health services over the years with international development initiatives such as Millennium Development Goals (MDG) with their poverty-reduction schemes and health improvements [2]. However, people with disabilities are systematically denied access to healthcare services, despite the mounting evidence highlighting the link between disability and poverty, thus putting them at higher risk of exposure to HIV/AIDS compared to the general population [3-4]. The mission of public health is to improve the health of all communities including preventing disability through advocacy, education, and outreach; and yet people with disabilities have limited access to quality health services due to stigmatization, and discrimination which are the violations of the 1948 Universal Declaration of Human Rights [5]. The aim of this paper is to explore the impact of HIV/AIDS on people with disabilities from the international perspectives based on the MDG and Sustainable Development Goals (SDG); specifically ‘Primary Education’, ‘Combat HIV/AIDS’, ‘Promoting gender equality’, and ‘Empowering women’. People with disabilities are among the least understood members of society with their experiences of disempowerment [6].

Human Immunodeficiency Virus (HIV) is “a virus that weakens and damages the immune system which is the body’s natural defence against illness” [7]. When a person gets infected with HIV, it will remain in the body for life, rendering it unable to fight off infections and diseases [8]. The transmission of HIV is acquired through sexual acts with an infected person; injection or infusion of contaminated blood; the sharing of needles or needle-stick injury from an HIV-con taminated needle. The infection can also occur through artificial insemination; and mother-to-child transmission [9]. If left untreated, it takes several years for HIV symptoms to progress to Acquired Immunodeficiency Syndrome (AIDS). Although there has been a behavioral change in response to AIDS, there is no cure. But HIV/AIDS is now converted from an acute terminal illness into a chronic condition with the integration of antiretroviral therapy (ART) into HIV care, which significantly extends the life expectancy and quality of life for people with HIV [10].

HIV continues to be a major international sexual health priority, with 35 million deaths from HIV/AIDS in the last 30 years, making it one of the most destructive infectious epidemics in recorded history [11]. According to global statistics, 36.7 million people are living with HIV, and 1.1 million people died from AIDS-related illnesses by the end of 2015 [12]. Epidemiologically, there has been a substantial decline of the new HIV infections with HIV care continuums since the MDG declaration in 2000, by 35 percent with 7.8 million lives saved in 15 years with effective ART treatment [13]. In 2014, the UNAIDS set three ambitious 90-90-90 target goals by 2020 where "90 percent of all people living with HIV will know their HIV status; 90 percent of all people with diagnosed HIV infection will receive sustained ART, and 90 percent of all people receiving ART will have viral suppression" [14]. Recently, UNAIDS revealed that 18.2 million people including 910,000 children have access to ART [15]. The statistics from PHE 2015 report on ‘HIV New Diagnoses, Treatment and Care in the UK’ have shown excellent results on those accessing and receiving HIV care, with 96 percent on ART; and 94 percent virally suppressed. The statistics put the UK ahead of time for two of the three target goals [16, 17]. Recently, the Healthcare Quality Improvement Partnership in collaboration with British HIV Association, Medical Foundation for HIV and Sexual Health, and Public Health England (PHE) suggests in their feasibility report that meeting these targets will require a concerted approach to over 15,000 people, including men who have sex with men (MSM) and Black Africans with undiagnosed HIV infection [18]. Moreover, the PHE report indicates that a total of 6,151 new HIV diagnoses in the UK were among MSM, heterosexuals including black and other ethnic minorities [16]. Unfortunately, there is no epidemiological data for people with disabilities in these reports, due to a common misconception that people with disabilities are sexually inactive which means that people with disabilities living with HIV/AIDS experience a double stigma preventing access to quality HIV care [19]. Additionally, the Office for Disability Issues has classed HIV infection as a progressive condition and automatically meets the disability definition under the Equality Act 2010 [20].

WHO identifies disability as a global public health issue and a matter of human rights, and a development priority; because people with disabilities, throughout the lifespan, face extensive barriers to accessing health services, and have poorer health outcomes compared to the general population [21]. The World Disability Report 2011 estimates that 15 percent of the world’s population, or over one billion people, have some form of a disability which is the world’s largest minority [22, 23] [21]. The UN estimates that there are between 180 and 220 million youth with disabilities and between 76 and 85 percent of them live in developing countries receiving no treatment for serious mental disorders, compared to 35 and 50 percent in developed countries [24-25]. Consequently, the HIV prevention may become problematic in terms of learning and applying knowledge as well as communication. Moreover, depressive co-morbid is one of the factors that compromises adherence to ART [26]. The explicit exclusion of people with disabilities in the MDGs over the past 15 years is critical because the UNAIDS Gap report has identified people with disabilities as one of the twelve population groups excluded from access to ART, this is a missed opportunity which could have been prevented with disability awareness, inclusion and education [27]. The SDG will not achieve an effective global response to HIV/AIDS without including people with disabilities as illustrated in the ‘Global Development Goals: Leaving no one behind’ report [28].

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) states that, “persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments; which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” [29]. According to the Papworth Trust, only 17 percent of the disabilities in the UK are from birth (for example, Down Syndrome). Other disabilities are acquired through traffic accidents; violence and warfare; sports and risky activities or behaviours including substance misuse; chronic health conditions such as diabetes or Multiple Sclerosis (MS) and musculoskeletal disorders [23, 30]. And over 300 million youth live in countries affected by armed conflict and are at severe risk of violence, abuse, and injury [31, 21].

Traditionally, the concept of disability as viewed by the medical model sees individuals with disability as human tragedies requiring medical intervention by experts with their authoritative attitudes, to cure their disability or alleviating its worst effects [32]. The social model of disability replaced the medical model to represent a multifaceted system of social restrictions imposed on all areas of an individual’s life including sexual lives by a highly discriminatory society that has not adapted to those groups' needs by removing the barriers that deny inclusion and equal rights [10]. Scope, a disability charity in the UK, coined the term ‘disablism' in 2004 as "discriminatory, oppressive or abusive behaviour arising from the belief that disabled people are inferior to others" [33]. Disablism is the last prejudice to be tackled at different levels: social, institutional, and cultural [32]. People with disabilities face socio-cultural barriers that are more disabling than the impairments themselves as those barriers do not allow people with disabilities to participate as full members of society [34].

Disability is a widespread and complex phenomenon as it affects all societies including those who identify as lesbian, gay, bisexual, transgender (LGBT) with 16 percent of male and 14 percent female LGBT respondents stating that they have a form of disability [35]. The Stonewall Health Briefing on Disability found that almost half of lesbian and bisexual women at 46 percent and one in five gay and bisexual men (22 percent) have never been tested for sexually transmitted infections (STIs) and 27 percent of gay men never had an HIV test [35]. The reason for this is disablism which is homogenising this highly diverse group, failing to appreciate that they also are part of other key populations at risk of HIV exposure [36, 14, 37]. Additionally, intersectionality as the dimensions of disability such as sexuality and ethnicity, "can be ignored as their disability or impairment become the most prominent and relevant feature of their lives, dominating interactions" thus exacerbating health inequalities [10].

Sexual health is “an integral aspect of overall human health”, which involves managing sexual relationships and health care, negotiating sexual pressures, executing protective strategies such as unplanned pregnancies, and managing the moral stigma of STIs, sexual identities and social norms of acceptable sexual behaviour [38]. However, for people with disabilities, dealing with sexual and social relationships are often more complex, and can affect an individual’s wellbeing because they have sexual desires like everyone else and have different life experiences and support needs. Their needs require a multifaceted approach as every person has the right to feel good about their sexuality; have safe and consensual sex, based on mutual respect and agreement; and knowledge on how to protect oneself from HIV/AIDS.

The Sustainable Development Goal 4 is ‘Ensure inclusive and quality education for all’ which is a key determinant of productivity and wellbeing throughout an individual’s lifespan [39]. However, education for disabled children is a low priority [3]. According to UNESCO, 98 percent of disabled children in developing countries do not receive school education, and 99 percent of disabled girls are illiterate which is viewed not only as a human rights issue but also social justice issue [40-41]. Educators are at the forefront to address this problem; however, there is little understanding of the knowledge, attitudes, and teaching practices of educators of disabled children in regard to sexuality education [42]. There are little awareness and risk perception among people with disabilities about HIV/AIDS, partly due to the failure of formal sexual health education programs that are congruent with different disabilities; for example, 78 percent of individuals with disability in South Africa believe that their risks of acquiring HIV were small. Their lack of awareness exposes them to HIV risk factors including substance abuse. Therefore they are less likely to have access to interventions [14].

The greatest barrier to inclusion of children with disabilities in quality education is segregation, stigma, and prejudice. Therefore, a disability rights-based approach would require the provision of meaningful sexual and reproductive health education to all individuals with disabilities in mainstream and special schools as mandatory [43]. However, for people with hearing impairment and people with learning disabilities, additional facilities such as highly visual sex education packages that match their learning abilities would be needed to address the health-related SDGs effectively and making SDG 4 for inequality as a central issue would make a significant impact globally [44, 45].

Sexuality is often a key element of deepest and most visceral oppression for people with disabilities [46, 47] because of the combination of stigma; social; physical and attitudinal barriers lead to poor access to sexuality and reproductive health education [36]. Internationally, there is a continuing lack of fundamental social acceptance that people with disabilities are sexual beings with the right to express their sexuality and to form relationships. Individuals with learning disabilities often have poor negotiating skills, language deficits and communication difficulties which heightened their risk of unprotected sex and being in unsafe situations and risk of exploitation. The common assumption that confronts people with disabilities is not only that they are asexual, but they are hypersexual [48, 47]. This erroneous assumption heightens their susceptibility to sexual abuse, trafficking, and exploitation, for example, ‘virgin rape' in sub-Saharan Africa where HIV-positive individuals specifically targeted disabled virgins, with the belief they can rid themselves of the virus by having sexual intercourse with virgins [24]. They are under the assumption that people with disabilities are less able to communicate with service providers and because of lack of protection, they are more vulnerable to sexual violence which can have legal implications as they are not able to access to ART treatment [48].

The Sustainable Development Goal 5 is ‘Gender Equality’ to empower all women and girls and to reduce sexual violence [39]. Women are disproportionately at risk of HIV particularly in sub-Saharan Africa, due to a combination of socio-cultural, economic, and biological factors. Therefore, it is of great importance to consider how to address the unmet needs of children and young people with disabilities as they are at increased risk of becoming HIV-positive as well as "engaging in the offending behaviour, particularly if they lack understanding of concepts like consent” [22]. Female Genital Mutilation/Cutting (FGM/C) which in itself would put them at significant vulnerability and risk of HIV transmission through the use of the same surgical instrument without sterilisation between girls who undergo female genital mutilation together, as well as bleeding during sexual intercourse because of FGM/C. Moreover, there is an increased prevalence of genital herpes in FGM/C which also is another risk factor in the transmission of HIV [49-50]. With adolescent girls spending most their time in a school setting, it is important that school health professionals are mindful of these issues [51] which would ultimately meet the sustainable development goal 3 of promoting health and wellbeing of all people at all ages.

The Sustainable Development Goal 10 is ‘Reduced Inequalities’ within countries by promoting the social, economic and political inclusion and removing discriminatory laws, policies and practices that prevent people with disabilities from quality access to health services [39]. The organizational barriers in accessing healthcare services include scarcity of services, failure to make reasonable adjustments for low literacy and communication barriers for people with hearing impairment and people with learning disabilities, and disablist assumptions among healthcare professionals.

From an ethical perspective, individuals with disability, particularly those with disabilities, were regarded as victims of their condition and a burden on society and public services, which “will encourage paternalistic attempts to deprive the disabled with a capacity of their autonomy” [6]. The Convention on the Rights of Persons with Disabilities recognise that persons with disabilities have the right to the highest attainable standard of health including informed consent, raising awareness of the human rights, dignity, autonomy without discrimination, by taking all appropriate measures to ensure accessibility for disabled individuals to health services including sexual and reproductive health and public health programs [29]. This involves dissemination of health information; planning and monitoring implementation of facilities by identifying and eliminating obstacles and barriers to information and communication technologies and other services in sign language, braille and in plain language for learning disabilities [29].

Adolescence is a critical time for their psychosocial and sexual development, and conversely, expose adolescents with disabilities to the risk of HIV infection [52]. The key point of sex education as a part of the solution to concerns about the sexualization of children as there is a correlation between educational level and sexual health outcomes. The evidence shows that quality sex education delays sexual activity for adolescents by making appropriate choices which lead to the reduction of STIs rates and teenage pregnancies and promote condom use and adherence to ART [53]. Recent research by British Pregnancy Advisory Service found a lack of deaf awareness in health services impacts on people with hearing impairment’s sexual health where they are less likely to be asked about contraceptive use increasing their HIV risk [54]. Moreover, public health interventions often are not designed to include people with disabilities, for example; radio campaigns are inaccessible to people with hearing impairment; and funny, fast-paced advertisements on safer sex are lost on some individuals with learning disabilities [55].

The gap in the global policies and sexual health services where people with disabilities are neglected or excluded in new and existing programs and campaigns has legal implications because it is a form of discrimination on multiple levels. In the UK, the House of Commons Education Committee (HCEC) recently stated that all state primary and secondary schools teach sex and relationships education as part of personal, social, health and economic education (PSHE) as mandatory. The PSHE is a solution to concerns about the sexualization of children and to reduce risks of STIs and teenage pregnancies [56]. However, specialist schools are overlooked in the report, increasing the vulnerability of children with disabilities to HIV risks. Furthermore, parents often are reluctant to discuss sexuality and HIV with their disabled children, making it difficult to strike a balance between protecting their children from rejection and vulnerability to sexual abuse, and allowing them to explore and develop wider personal and social relationships by not talking about sex [36, 57]. Consequently, overprotection hinders children from reporting what they cannot say, for example, distinguishing sexual behaviours when receiving assistance with their hygiene [58].

The structured education about sexual health and relationships is rarely a part of the school curriculum, and the training of healthcare providers to deal with children with disabilities are inadequate which means that their needs remain almost entirely overlooked [59]. However, there is an international collaboration between deaf film productions and people with disabilities in Ghana with HIV awareness videos such as ‘Protect Yourself!" from the UK for Deaf individuals in sign language which was well received within the deaf community [60]. This is essential to address the cross-cutting issues faced by people with disabilities in sexual reproductive health education which are critical barriers in the lives of disabled adults and youths [61].

The SDGs are viewed as a ‘Herculean’ task with their 17 goals, 169 targets, and 230 indicators compared to the MDGs eight goals, 18 targets, and 48 indicators [62]. The MDGs were criticised for their lack of attention to health inequities particularly for people with HIV, for example, there was uneven progress regarding overall national indicators where those with better income benefitting more from health improvement, while some sections of the population faced marginalisation [45].

Recently, PHE’s the National HIV Prevention Innovation Fund awarded £600,000 to support thirteen successful voluntary-led projects targeting high-risk groups including ethnic minorities, people with hearing impairment and LGBT people in England, by offering innovative ways of delivering HIV prevention to reverse the high incidence of new HIV diagnoses [63]. Moreover, new and existing sexual health policies and initiatives can be adapted to accommodate people with disabilities and their carers by involving them as stakeholders in decision-making, to ensure that their appropriate measures in line with the CRPD and the Disability Discrimination Act 1995 to maximise the accessibility of the HIV/AIDS services [3]. However, evidence has shown that it does not always happen in practice.

This paper has highlighted a great betrayal of human rights, social justice and the gaps where people with disabilities are overlooked or excluded from global HIV/AIDS policies, putting them at serious risk of HIV/AIDS. The need for a disability-inclusive approach, rather than a blanket approach is crucial to overcoming this oversight by mainstreaming this population group, taking the whole of them into account, including their sexual orientation, and increase HIV/disability epidemiological data for decision-making to empower people with disabilities on their sexuality; and to enjoy equality which is a basic human right. The healthcare professionals are at the forefront in their role in health promotion and HIV prevention services if we wish to meet the targets of SDGs universal goals for the period up to 2030. Then people with disabilities would not be an 'afterthought' when taking an integrated approach to sexuality and HIV/AIDS information for effective sexual health interventions.

**Compliance with Ethical Standards**

**Ethical approval:** This article does not contain any studies with human participants performed by any of the authors and is based on available literature.

**Conflict of Interest:** The authors declare that they have no conflict of

interest.

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