Women with Disabilities: Addressing the Barriers to Adequate Sexual Health on a Global Level

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This essay was written for Writing in Psychology, taught by Dr. Cremens-Smith. The assignment was to write a 10-12 page research paper reviewing the research literature on their particular topic.

Women face a multitude of barriers to sexual health: including their gender, cultural norms, socioeconomic level, and any physical or mental disability that may exist. In many developed countries, these barriers have been addressed; however, in many developing countries they continue to be a hindrance to receiving adequate sexual healthcare (Burn, 2005; Smith, Murray, Yousafzai, and Kasonka, 2004; Yoshida, Li, and Odette, 1999). In some cultures, women are placed at a low-level in their social hierarchy, limiting their ability to access education and services related to their sexual health. Oftentimes, it is the male partner who makes the decisions regarding sexual health, including the use of condoms to prevent sexually transmitted disease. In some cultures, it is the norm to have multiple sex partners or coerced and unprotected sex (Burn, 2005; Fox et al., 2007; Smith, 2007). The latter happens frequently among the disabled female population, primarily because of the inequalities that exist within this subgroup of many cultures, namely in developing countries (Smith, 2007; Smith et al., 2004; Yoshida et al., 1999).

The United Nations and other governmental agencies have implemented policies in many developing countries, giving women with disabilities the same human rights protection as any other person. Unfortunately, these women are often unaware and unable to exercise these rights in practical ways (Burn, 2005; Glasier, Gulmezoglu, Schmid, Moreno and Van Look, 2006). For example, women, particularly those with disabilities, are not given the same educational opportunities as those without a disability. These women may encounter such issues as pregnancy and childbirth, sexually transmitted disease (including HIV/AIDS), and menopause with little or no education about how to cope with them (Smith et al., 2004; Yoshida et al., 1999). The literature addressing sexual health issues is readily available regarding women in general; however, it is more limited when it comes to women with disabilities. These women do exist; both in developed and developing countries and they have many sexual healthcare needs that warrant further investigation. These needs include education and access to services, assessment of behavioral patterns, and development of innovative ways to address their sexual health concerns (Doyal and Anderson, 2004; Glover-Graf and Reed, 2006; Kvam and Braathen, 2008; Milberger, 2002). The purpose of this paper is to review the literature and investigate the barriers that hinder the sexual health and well-being of women, while also looking at the common thread of violence that appears to be elevated among women with disabilities (Kvam et al., 2008; Milberger, 2002; Smith, 2007).

Inequalities and Violence

Understanding the inequalities that exist for women worldwide, including those of gender, cultural norms, socioeconomic levels, and disabilities is crucial in helping address the barriers that exist in accessing sexual healthcare services (Burn, 2005; Glasier et al., 2006). Many women experience not just one of these inequalities but multiple issues of inequality. In addition, there is a common thread of violence that occurs for many women throughout the world, particularly for women with disabilities (Glover-Graf et al., 2006;
This violence includes acts of sexual abuse, rape, and emotional abuse; all of these acts of violence play a role in the sexual health and mental well-being of all women, particularly those with a disability (Burn, 2005; Doyal et al., 2005; Fox et al., 2007; Glover-Graf et al., 2006; Milberger, 2002; Smith, 2007; Smith et al., 2004; Yoshida et al., 1999). Regardless of their age, socio-economic status, race, ethnicity or sexual orientation, women with disabilities are twice as likely to be victimized as a woman without a disability (Kvam et al., 2008; Milberger, 2002). One study of 7,027 Canadian women shows that women with disabilities have a 40% greater risk of encountering violence, particularly that of a severe nature (Smith, 2007). Despite greater occurrences and increased severity of abuse among those who are disabled, it is quite common for the abuse to go unreported due to fear of retaliation from their abuser (Glover-Graf et al., 2006; Kvam et al., 2008). For women with and without disabilities, the issue of violence continues to negatively impact their sexual health and general well-being (Glasier et al., 2006).

Gender Inequalities

According to the literature, women across many cultures are subject to male dominance in decision making (Burns, 2005; Doyal et al., 2004; Fox et al., 2007; Glasier et al., 2006). This is especially true regarding such issues as birth control, prevention and treatment of sexually transmitted disease, and other issues which affect a woman’s sexual health. In such countries as Ethiopia, Nigeria, and India, a woman’s body is considered to be the property of her husband (Burns, 2005). Men with such a mindset often think that if their wife is on birth control, either she is currently unfaithful or she will become unfaithful in the future (Burns, 2005; Fox et al., 2007). Yet these men oftentimes practice multiple partner sex, either through multiple marriage partners or extramarital relationships. All of the women these men are sexually active with are at a higher risk for various sexually transmitted diseases, including HIV/AIDS (Burn, 2005; Fox et al., 2007; Glasier et al., 2006; Smith et al., 2004). In Sub-Saharan Africa, young girls are five times more likely to contract HIV/AIDS because older men, infected with the disease, are taking younger girls as their wives and mistresses. Yet in this region, over half of these young girls could not name one method for preventing HIV (Burn, 2005). This clearly indicates that women are at a disadvantage when it comes to their sexual health decisions and because disabled women are placed at a lower position in the social hierarchy, they have even less control over such decisions (Burn, 2005; Glasier et al., 2006; Smith et al., 2004). Women who have a subordinate status in their social position are at a disadvantage because it is more difficult or even impossible for them to negotiate safer sex practices with their male partners (Burn, 2005; Dannerbeck and Muriuki, 2007; Glasier et al., 2006; Smith et al., 2004; Fox et al., 2007). This creates a barrier, making it more difficult for women to access sexual healthcare and implement healthy sexual behaviors. This is evidenced by increasing rates of HIV among women in countries that place women at a lower stratum of their social hierarchy (Fox et al., 2007).

Economic Dependence

Economic dependency on men also makes it easier for women to fall into the trap of exchanging sex for money or other basic needs, such as housing or food (Burn, 2005; Smith et al., 2004). It is also common for women with disabilities to remain in an abusive relationship because they depend on the abuser for support (Fox et al., 2007; Glover-Graf et al., 2006; Milberger, 2002; Smith, 2007). African women reported that economic and financial abuse and neglect have made a negative impact on their lives, including their health outcomes (Burn, 2005; Fox et al., 2007). For example, one woman reported that her partner communicated, “if you have sex with me, I will buy you whatever you want” (Fox et al., 2007, p. 589), tying financial support to sexual favors (a form of abuse), so even if a woman knows her partner is abusive or has a sexually transmitted disease she will oftentimes feel forced to comply to sexual behaviors that risk her health (Fox et al., 2007). Even in such developed countries as the United States and Canada, disabled women are oftentimes economically disadvantaged and their partner uses this to control care-giving. Glover-Graf and colleagues (2006) report that neglect is “the failure of a caretaker to provide necessary goods, services, or emotional care,” and these forms of neglect “can include intentional or unintentional acts of abandonment,
isolation, denial of food, health services, or attention” (Glover-Graf et al., 2006, p. 44). These types of conditions will, in turn, impact the ability of women to make decisions regarding issues of sexual health (Fox et al., 2007; Glover-Graf et al., 2006; Milberger, 2002; Yoshida et al., 1999). Research indicates that many women with disabilities find it very difficult to leave their present situations, even if abuse or violence is part of the relationship, because they lack the resources and social supports that women without disabilities have available to them (Glover-Graf et al., 2006; Smith, 2007).

Education and Employment

Women with disabilities are more likely to be undereducated and unemployed (Glover-Graf et al., 2006; Kvam et al., 2008; Smith, 2007). This gap in education and employment for women with disabilities appears to be worldwide; however, until recently there has been little research on how these gaps affect these women and their living conditions (Glover-Graf et al., 2006). The limited research that is available indicates that because these women are often times dependent on someone else to take care of their daily needs, they are less likely to report the incidence of violence that can compromise their sexual health and well-being (Fox et al., 2007; Milberger, 2002). One Zambian woman disabled by HIV/AIDS says, “I don’t want to just sit there and be on benefits, I want to be useful,” indicating that while many women feel dependent on others, they would prefer to be self-sufficient (Doyal et al., 2005, p. 1733). Despite their willingness to work and be self-sufficient, employment opportunities are lacking for disabled women, yet these women continue to see education and employment as tools for their own empowerment (Kvam et al., 2008; Milberger, 2002; Smith, 2007). With over 60 million disabled people in Africa, the effect of disability on individuals is becoming an area of further research. Generally, their living conditions are poorer, with very little opportunity for women with disabilities to further their education or become employed (Kvam et al., 2008), giving them a sense of hopelessness and decreased self-efficacy.

Stereotypes of Disabilities

Women with disabilities not only experience economic and physical barriers to accessing health care, but they also experience “attitudinal barriers that go deeper than a lack of understanding of a disabled person’s sexuality or desire for motherhood” (Smith et al., 2004, p. 124). These attitudinal barriers contribute to a further decrease in their levels of self-esteem (Smith et al., 2004). ERRONEOUS beliefs about the cause and transmission of disability perpetuate negative stereotypes, leading women to feel more insecure about their disability. For example, in “Abuse against Women with Disabilities” by Noreen M. Glover-Graf and Bruce J. Reed, women in general are less valued, shown by the inequality that exists in pay and status. However, women with disabilities are even further stigmatized as “dependent” and even “asexual” due to their disabilities (Glover-Graf et al., 2006, p. 43). While it is a common false assumption that disabled women are not sexually active, many are (Glover-Graf et al., 2006; Kvam et al., 2008; Smith, 2007; Smith et al., 2004; Yoshida et al., 1999). Therefore, they are also facing such issues as pregnancy, birth, and sexually transmitted disease. Failure to provide sexual health education and services for disabled women should be further investigated, as it is crucial for these women to have equal access. Previous research indicates that a lack of governmental involvement and biased attitudes of healthcare providers both play a role in insufficient access to sexual health education and services for women with disabilities (Burns, 2005; Glasier et al., 2006; Glover-Graf et al., 2006; Yoshida et al., 1999).

Governmental Policies

While the United Nations and other governmental agencies have instituted policies regarding the rights of both women in general and women with disabilities, these policies are rarely carried out in day-to-day living (Burn, 2005; Gill, Kirschner, Reis, 2004; Glasier et al., 2006). Oftentimes, a lack of education about their rights causes many women to continue to be treated unequally (Burn, 2005; Gill et al., 2004; Glasier et al., 2006; Kvam et al., 2008). While women with disabilities are identified as a group with needs for reproductive and sexual healthcare, these needs are oftentimes not met (Fox et al., 2007; Smith, 2007; Smith et al., 2004; Yoshida et al., 1999). Because of the barriers of gender inequality, cultural norms, poverty, and physical inaccessibil-
they will run into. This fear is legitimatized as several women share their experiences of how they encounter surprise by others who are shocked “that someone like them can get pregnant” (Smith et al., 2004, pg. 124). Accessing sexual healthcare is further hindered by poverty, as women often cannot afford the ‘hidden costs’ of prenatal care and a safe childbirth delivery (Smith et al., 2004). Public health clinics are seen as one way to help meet the needs of women in regards to their sexual healthcare (Smith et al., 2004). However, these clinics are difficult to access if one has limited resources and social supports. Unfortunately, this is oftentimes the case, particularly regarding women with disabilities (Gill et al., 1994; Smith et al., 2004).

Sexual Health Concerns

Sexually transmitted infections are on the rise worldwide, and while the literature appears consistent on this fact, it does not adequately address the issue of prevention and treatment for those with disabilities (Dannerbeck et al., 2007; Doyal et al., 2004; Fox et al., 2007; Glasier et al., 2006). There are limited studies reporting women with disabilities and HIV/AIDS, but these do not always address the incidence of sexually transmitted disease in general (Kvam et al., 2008; Smith et al., 2004). Regarding women with disabilities, the literature also seems to lack information on the availability of education and services for such issues as menstruation, menopause, or ovarian cysts. Therefore, more research is needed to ensure that these issues of sexual health are being addressed in populations of disabled women. There also appears to be a lack of research on the prevalence of sexual abuse among young women with disabilities. According to Glover-Graf and colleagues (2006), one reason that the issue of sexual abuse may not be studied as often is that it is a sensitive issue and especially women and children are hesitant to disclose such abuse. If a woman is disabled, she may be less likely to report abuse as it is oftentimes committed by a caregiver or intimate partner (Glover-Graf et al., 2006). A more subtle form of sexual abuse occurs when a man tells a disabled woman he loves her and will marry her for sex, but then leaves once she becomes pregnant or after the man has had his sexual needs met (Kvam et al., 2008; Smith et al., 2004). However, these women oftentimes admit that they respond
to any affection because they do not think they are capable of gaining the affections of a respectable man (Glover-Graf et al., 2006; Kvam et al., 2008; Smith et al., 2004). This is especially common in Africa (Kvam et al., 2008), although it also happens in such developed countries as the United States (Glover-Graf et al., 2006). Oftentimes, these women feel inferior and they perceive unhealthy sexual advances as expressions of love and acceptance (Glover-Graf et al., 2006; Smith et al., 2004). Also, some women with disabilities may have impaired judgment which leaves them more vulnerable to physical or sexual abuse (Glover-Graf et al., 2006). Because the research indicates consistently that women with disabilities are more likely to experience all forms of violence, including sexual violence, it appears increased screening and interventions are needed to help these women overcome the barriers presented by these volatile incidents (Fox et al., 2007; Glasier et al., 2006; Glover-Graf et al., 2006; Kvam et al., 2008; Milberger, 2002; Smith, 2007; Smith et al., 2004).

Models for Intervention

There are different models that can be used to examine the issues involving women with disabilities and their sexual health, and while Yoshida and colleagues (1999) distinguish the biomedical model of the disability as one which deals only with the physical impairment of the disability, they focus on the importance of the biopsychosocial model. This model looks at the well-being of the complete person: biological, psychological, and social. Using this model to replicate similar studies would help to identify ways to address the barriers, reduce inequalities, and enable both women with and without disabilities to access sexual healthcare, reduce violence, and improve their general well-being. One weakness of Yoshida and colleagues (1999) is its limited size; however, future replications could be useful in investigating the issues involved in the overall health and well-being of women with disabilities.

Conclusion

The literature (Glover-Graf et al., 2006; Milberger, 2002; Smith et al., 2004 and Yoshida et al., 1999) draws attention to the importance of increasing intervention strategies including advocacy activities for women with disabilities. These activities should also include those helpful in deterring and preventing partner and caregiver violence (Glover-Graf et al., 2006; Smith, 2007). There is also an indicated need for an increase in community awareness and dissemination activities to educate healthcare providers and the general public about the sexual health needs of women with disabilities (Glover-Graf et al., 2006; Yoshida et al., 1999). These recommendations are easier to implement in countries where gender and social hierarchy are not major hindrances. In countries where these hindrances occur, it is more difficult to overcome social and cultural norms in order to remove the barriers that exist for women with disabilities (Gill et al., 1994; Smith, 2007; Smith et al., 2004; Yoshida et al., 1999).

In the quest to find solutions that address the complex sexual health issues of women with disabilities, it should not be forgotten that these women are simply that, women. While ensuring that the services developed fit the unique needs of this group, their need to be identified and accepted as "normal" should also be considered (Gill et al., 1994; Smith et al., 2004). Further research will help in gaining a greater understanding of the perceived sexual health needs of women with disabilities. Most importantly, it will assist in the development of effective strategies that will provide adequate education and equal access to services for women with disabilities. This would include strategies to meet not only the physical or sexual health needs of women with disabilities, but their psychological and social needs as well. Addressing the psychological and social needs of women with disabilities will provide them with increased self-worth and social support, which will in turn assist them in making healthier decisions regarding their sexual health.
References


