



Reproductive Health Matters

An international journal on sexual and reproductive health and rights

ISSN: 0968-8080 (Print) 1460-9576 (Online) Journal homepage: <http://www.tandfonline.com/loi/zrhm20>

The sexual and reproductive rights and benefit derived from sexual and reproductive health services of people with physical disabilities in South Africa: beliefs of non-disabled people

Xanthe Hunt, Mark T Carew, Stine Hellum Braathen, Leslie Swartz, Mussa Chiwaula & Poul Rohleder

To cite this article: Xanthe Hunt, Mark T Carew, Stine Hellum Braathen, Leslie Swartz, Mussa Chiwaula & Poul Rohleder (2017) The sexual and reproductive rights and benefit derived from sexual and reproductive health services of people with physical disabilities in South Africa: beliefs of non-disabled people, Reproductive Health Matters, 25:50, 66-79, DOI: [10.1080/09688080.2017.1332949](https://doi.org/10.1080/09688080.2017.1332949)

To link to this article: <https://doi.org/10.1080/09688080.2017.1332949>



© 2017 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group



Accepted author version posted online: 23 May 2017.
Published online: 05 Jul 2017.



Submit your article to this journal [↗](#)



Article views: 1333





View Crossmark data [↗](#)



Citing articles: 2 View citing articles [↗](#)

The sexual and reproductive rights and benefit derived from sexual and reproductive health services of people with physical disabilities in South Africa: beliefs of non-disabled people

Xanthe Hunt ^a, Mark T Carew ^b, Stine Hellum Braathen ^c, Leslie Swartz ^d,
Mussa Chiwaula,^e Poul Rohleder^f

a PhD Candidate, Department of Psychology, Stellenbosch University, Stellenbosch, South Africa.

b Research Fellow, Department of Psychology, University of East London, UK

c Research Manager, SINTEF Technology and Society, Trondheim, Norway

d Distinguished Professor of Psychology, Stellenbosch University, South Africa

e Chair, South Africa Federation of the Disabled (SAFOD), Gaborone, Botswana

f Reader in Psychology, University of East London, UK

Abstract: *There is a body of theoretical work, and some empirical research, which suggests that non-disabled people assume people with physical disabilities are not suitable romantic partners, do not have sexual drives or desires, or are not sexually active. It has also been proposed that people with physical disabilities face barriers to sexual healthcare access which are structural as well as social. The present paper explores non-disabled South Africans' beliefs concerning the degree to which non-disabled respondents enjoy sexual and reproductive rights, and benefit from sexual and reproductive healthcare, compared to people without disability. Using a survey, we asked 1989 South Africans to estimate the degree to which people with physical disabilities and people without disability have sexual rights, and benefit from sexual and reproductive healthcare services, respectively. Respondents were more likely to support the idea that the population without disability were deserving of sexual rights compared to people with physical disabilities. Respondents were more likely to rate the degree to which people with physical disability benefit from sexual and reproductive healthcare as less than that for people without physical disabilities. These findings provide some of the first empirical support that non-disabled people perceive people with physical disabilities as having fewer sexual and reproductive rights, and deriving less benefit from sexual and reproductive health services, than the population without disability. To have diminished sexual rights, and benefit less from sexual and reproductive healthcare, we suggest, evinces a negation of the sexual and reproductive needs and capacity of people with physical disabilities. DOI: 10.1080/09688080.2017.1332949*

Keywords: persons with physical disabilities, sexuality, sexual and reproductive health rights, sexual rights, reproductive healthcare, access, disability studies, South Africa

Introduction

There is a body of theoretical work, and some research, which suggests that non-disabled people assume that people with physical disabilities are not sexual or sexually active.^{1–10} Simultaneously, access to sexual and reproductive health services for people with physical disabilities is largely

neglected, and people with physical disabilities are generally excluded from sexual and reproductive health education.^{11,12}

Since the 1970s, the disability rights movement has fought for equality, access, and recognition for people with disabilities.¹³ Today, as authors such as Addlakha¹⁴ note, there is a recognition of the need to enhance educational and employment opportunities for people with disabilities, to address their exclusion from society, services, and

Supplemental data for this article can be accessed at <https://doi.org/10.1080/09688080.2017.1332949>.

institutions, and – amongst disability rights activists – to speak back to the dominant discourses of the non-disabled which have for too long portrayed people with physical disabilities unfavourably. Only in the past few decades, however, have the issues of sexual and reproductive health for people with physical disabilities been addressed in disability scholarship^{9,15–17} and, even more latterly, in relation to public health.^{18,19}

Indeed, recent years have seen a growing recognition of the sexual and reproductive rights of all people, which, since the World Report on Disability,²⁰ and the UN Convention on the Rights of People with Disabilities²¹ includes people with disabilities. In the years subsequent to this report, increased international attention has been given to issues of sexual and reproductive rights, and health, amongst people with disabilities, including people with physical disabilities. Indeed, amongst people with physical disabilities, issues of sexuality and sexual rights are inextricably linked with human rights and so should form a focus of disability activism: as Shakespeare²² notes, work around disabled sexuality:

*“should form part of a revisioning of the disability movement’s mission which encompasses identity and solidarity and rights and respect in every area of the lives of disabled people, and which builds an inclusive community of disabled and non-disabled individuals.”*²²

The drive for the inclusion of people with physical disabilities in contemporary efforts to improve sexual and reproductive health access is underlain by the prevailing wisdom in disability scholarship that the sexuality of people with physical disabilities has hitherto been nullified, with people with physical disabilities systematically excluded from conceptions of sexuality, from sexual health services, and generally considered to be – and treated as – lacking sexuality.

Past work has used the term asexuality to describe this state of affairs. The word asexual in this literature has been used to describe the assumption that people with disabilities experience a “relative absence or insufficiency of sexual interest, biologically and socially described function, and interpersonal sexual engagement”.⁴ Recently, important research and campaigning has resulted in the recognition of asexuality as a sexual orientation, and this recognition must lead us to qualify our use of the term in the present paper. People with disabilities are generally seen

as not having any sexuality, including sexual agency or choice, drives or desires, rather than having made the choice to identify as asexual of their own volition. Thus, we limit our use of the term asexuality in the present paper. Instead, we refer to the described lack of sexuality which societies tend to ascribe to people with physical disabilities.

Although there is some empirical research evidencing that people with physical disabilities are considered by non-disabled people to be less sexual, we know of little research investigating if they are viewed as having diminished sexual rights. (Important work has been done with samples of healthcare providers, see for instance Lee et al,²³ and Rueda, Linton and Williams,²⁴ but none that we know of with the population without disability.²⁰) In the main, the literature concerning societal attitudes towards the sexuality of people with physical disabilities suggests that people with physical disabilities are viewed as less sexual than non-disabled people.^{10,25–29} The beliefs, and the consequent attitudes, of the non-disabled have been proposed to have consequences for people with physical disabilities.^{30–33} These include reticence to date people with physical disabilities, and so negative romantic appraisals of people with physical disabilities by non-disabled people,^{5,27,29,34–36} the exclusion of people with physical disabilities from family planning clinics,⁷ and possibly even increased risk for sexual violence against people with physical disabilities.³⁷ Indeed, there is much evidence of an elevated rate of sexual violence perpetrated against women with physical disabilities when compared to non-disabled women.³⁸ One of the reasons put forward for this sorry fact is that – again, due in no small measure to societal attitudes – women with physical disabilities lack social experience and sexual education.²⁶ Further, and ironically, Hanass-Hancock⁸ found that in South Africa, women with physical disabilities are particularly vulnerable to HIV through the threat of sexual abuse precisely because they are perceived to be asexual and virgins. It is thus proposed that people with physical disabilities not only face barriers to sexual and reproductive healthcare access which are structural (such as inaccessible healthcare provider offices), but also those which are social (such as attitudes).³⁹

Some work has suggested that it is the negation of the sexuality of people with physical disabilities that results in a lack of sex education for people

with physical disabilities. Several studies have shown that the misconception that people with physical disabilities lack sexuality (including sexual agency or choice, drives or desires) and so are sexually inactive, has resulted in a paucity of sex education for students with disabilities.^{12,40} Two additional South African studies have found that educators lacked the knowledge and – particularly – confidence to successfully teach sexual education to adolescents with disabilities,^{41,42} whilst another has drawn attention to the fact that almost nothing is known about how, or even if, the HIV and sexual health promotion strategies implemented in South Africa are implemented amongst youth with disabilities.⁴³ More generally, access to sexual health services for people with physical disabilities is largely neglected, often due to attitudinal barriers encountered by people with physical disabilities, including towards women with physical disabilities trying to access reproductive healthcare services, and contraception.^{15,44–51} Yet more work has suggested that people with physical disabilities, especially women, have greater unmet health needs than women without disability, and reduced access to health information, screening, prevention, and care services in the realm of sexual and reproductive health.^{2,52–54} The exclusion of people with physical disabilities from sex education,^{11,12,55} and sexual and reproductive healthcare, is a human rights as well as a public health issue. Empirically investigating whether people with physical disabilities are indeed considered by the population without disability to have fewer sexual rights is imperative. It is equally important to explore whether it is generally believed that people with physical disabilities will benefit less from sexual and reproductive healthcare than will members of the population without disability.

The present study

As noted, many have argued that people with physical disabilities face daunting attitudinal barriers in their attempts to realise their sexual and reproductive rights and to benefit from sexual and reproductive healthcare. It is especially important to explore attitudinal barriers (if these do, in fact, exist) in the African context. In this context, where healthcare services are already often scant or oversubscribed, any additional barriers faced by people in their attempts to derive benefit from sexual and reproductive health services

might be insurmountable. There is almost no empirical evidence for these attitudinal barriers in Africa, although their existence could have dire consequences for people with physical disabilities, including increased risk for HIV. The present article examines a sample of non-disabled South Africans' estimations of the degree to which people with physical disabilities enjoy sexual and reproductive rights, and benefit from sexual and reproductive healthcare services, compared to members of the population without disability.

Hypotheses

On the basis of past research,

- (1) we hypothesise that participants would estimate that people with physical disabilities have fewer sexual and reproductive rights than the population without disability and
- (2) we hypothesise that participants would estimate that people with physical disabilities benefit less from sexual and reproductive healthcare than the population without disability.

Method

Research design

The present study entails a cross-sectional survey, administered amongst the population without disability.

Materials

We measured participant beliefs regarding the sexual and reproductive health rights and benefit derived from sexual and reproductive healthcare services of people with physical disabilities and people without disability, using a survey administered to members of the population without disability. In the introduction to the survey, a person with a physical disability was defined as “someone with a physical impairment that has a substantial and long term adverse effect on the person’s ability to perform normal day to day activities e.g., walking, eating, going shopping” (p.4).⁵⁶ Questionnaire items were identified through focus group discussions with people with physical disabilities and from a literature review. People with physical disabilities (invited with the assistance of the Southern Africa Federation of the Disabled (SAFOD), the umbrella body for national disabled people’s organisations in the region) took part in focus group discussions during

a planning workshop at the start of the project. These groups focussed in part on identifying and formulating questions to be included in the survey, and survey items were checked with participants prior to the survey's being finalised. The survey was translated into Xhosa, Zulu, and Afrikaans, and available online in these languages, as well as in English. All translations were back-translated by home language speakers, to ensure accuracy.

The survey included demographic questions (age, gender, race, home language, and education). The Washington Group Short Set of questions, which is being used in many contexts globally,^{57,58} was used to identify people with disabilities amongst the survey participants. These items include questions regarding the respondent's functioning in terms of seeing, hearing, ambulating, cognition, self-care, and communication. The survey included open and closed questions measuring beliefs about disability and sexuality, and attitudes about the sexual and reproductive health rights and healthcare, of the two populations: people with physical disabilities and the population without disability. This paper reports on findings primarily from this last measure. There are substantial qualitative data from the open-ended questions, which are reported on in detail elsewhere.⁵⁹

We employed a continuum of percentages to elicit respondents' beliefs about different facets of the sexual and reproductive rights and degree to which benefit was derived from sexual and reproductive healthcare services, of people with physical disabilities. Respondents were requested to move a sliding button (online), or point to a spot (pen and paper) on a continuum from 0% to 100% to indicate what percentage of people with physical disabilities certain statements apply to. These items are described below. Each item was prefaced by the statement "Please indicate what % of people with physical disabilities the following statements apply to. You can do this by marking on the line below the number between 0 and 100 that best represents your view."

- (1) [indicate the] % of people with physical disabilities that are capable of expressing sexuality.
- (2) [indicate the] % of people with physical disabilities for whom expressing sexuality is a basic human need.
- (3) [indicate the] % of people who have physical disabilities that should be allowed to have children

- (4) [indicate the] % of people with physical disabilities who benefit from sexual healthcare services (e.g., HIV testing) in your area.
- (5) [indicate the] % of people with physical disabilities who benefit from reproductive healthcare services (e.g., pregnancy screening) in your area.
- (6) [indicate the] % of people who benefit from sexual education services (e.g., classes providing information about HIV) in your area

At a later point in the survey, respondents were asked to respond to the same set of items, but regarding their beliefs about the sexual and reproductive health rights and benefit derived from sexual and reproductive healthcare services of the population without disability. The rights items were constructed to tap into respondents' beliefs (expressed as an estimation) about who should or could potentially have sexual and reproductive rights. The items concerning benefit derived from sexual and reproductive healthcare, and were designed to elicit the respondent's perception about the needs and benefit to be derived from the access of people with physical disabilities to services. Taken together, they paint a coherent picture about (a) whether people without disability believe people with physical disabilities should be less sexual, but also (b) whether people without disability believe that people with physical disabilities *do or should* benefit less from sexual and reproductive health services (see Supplementary data).

Sampling

The survey respondents were recruited through social media (such as a dedicated Facebook page) and other social networks. A *Qualtrics* survey link was also advertised on two of South Africa's top news sites, one which caters mostly to Xhosa- and Zulu-speaking readers,* and has over 1,274,856 unique users, and one which caters to English-speaking readers, and has over 3,104,185 unique users.⁶¹ Permission was also obtained from the institutional planning departments of two large urban universities in South Africa, in

*isiXhosa and isiZulu are two of South Africa's 11 official languages. These indigenous languages are spoken mostly by Black South Africans. isiXhosa is the home language of 22.7% of the population, and isiZulu, 16%, making them the two largest language groups in the country.⁶⁰

Gauteng and the Western Cape, to distribute the survey amongst students.

The survey was also administered by hand-trained data collectors in two peri-urban settlements in the Western Cape, Langa, and Khayelitsha. This was to avoid biasing the sample towards educated, literate people with access to computers. The pen-and-paper respondents were selected at convenience by the data collectors who recruited people for the survey from busy areas (markets, taxi ranks, through their own social networks) in the respective locations. All respondents had to be at least 18 years of age or older in order to complete the questionnaire (due to the sexual nature of some of the content).

Analytic strategy

To investigate the underlying factor structure of the measured items, an exploratory factor analysis was first conducted. Specifically, we employed a direct oblimin rotation.[†] Subsequently, we tested whether a significant difference existed between respondents' beliefs about the sexual and reproductive rights, and benefits of sexual and reproductive health services of people with physical disabilities, compared to the non-disabled population. On an exploratory basis, we also tested whether these beliefs varied according to participant gender. Specifically, we ran two mixed ANOVAs[‡] with participant beliefs (i.e., concerning either rights or benefits of sexual and reproductive healthcare) about each target group as the repeated measures factor and gender (male and female) as the between subjects factor.

Sample

The sample consisted of 1989 respondents. One hundred and twenty-five respondents who met the Washington Group criteria for having a

disability using the recommended cut-off i.e., a response of “a lot of difficulty” or “cannot do at all”⁵⁸ on any question were excluded, so the remaining group were people who were not disabled, according to the Washington Group methods. The mean age of the remaining 1864 respondents was 26 years (SD = 9.23), and the age range was 18–76 years old. There were approximately equal numbers of males (44%) and females (56%). Racially, the sample consisted of 45.1% Black African, 40% White, 8.6% Coloured, and 4.5% Asian or Indian, people, as well as 1.8% who self-identified as “other”. Of the participants, 51.5% held a school leaving certificate. In South Africa (total population estimated at 54,490,000), 67.5% of the population identify as Black and only 21.6% as White. In terms of education, according to the South African Census,⁶³ the percentage of people aged 20 or older with a school leaving certificate is 28.5%. Therefore, our sample has a higher number of White respondents and is better educated than the general population.

Our final sample contained 1741 respondents who participated in the survey online, while 123 filled out the pen-and-paper versions. The survey was open from March 2016 until September 2016.

We ran the below analyses separately for each sub-group and found that the results were not significantly different. Therefore, we report findings for the total sample below.

Results

The mean and standard deviations of the beliefs items are summarised in [Table 1](#).

Factor structure of the beliefs items

The factor analysis with direct oblimin rotation created two distinct factors (eigenvalues of 2.838 and 2.319; criteria to retain factors are eigenvalues of >1, and the clustering of items into factors were easily interpretable.⁶⁴ That is, items 1, 2, and 3 loaded onto one factor (“sexual and reproductive health rights”) and items 4, 5, and 6 loaded onto a second factor (“benefit from sexual and reproductive health services”). [Table 2](#) shows the factor loadings, which are the strength of association between each factor and the measured items. The same two-factor solution was apparent in the non-disabled population items and the correlation between factors was medium in size, $r = .497$, which confirmed that the direct oblimin rotation was appropriate.

[†]Factor analysis is a data reduction technique used to group measured items into a few latent (unobserved) easily interpretable factors. Factor rotation is a technique used in factor analysis to discriminate between the factors. The type of rotation applied here, direct oblimin, is advised when factors are expected to correlate.⁶²

[‡]ANOVA is a technique used to analyse differences between group means.⁶² The type of model is mixed, because participants give repeated observations on our dependent variable (“beliefs”), while, concurrently, we also wished to examine if these beliefs differed between two independent groups (males and females).

Table 1. Means and standard deviations of belief items

Item	People with physical disabilities (%)	Non-disabled population (%)
Capacity to express sexuality <i>[indicate the] % of people with physical disabilities that are capable of expressing sexuality.</i>	61.47 (SD= 30.47)	72.49 (SD= 26.21)
The need to express sexuality <i>[indicate the] % of people with physical disabilities for whom expressing sexuality is a basic human need.</i>	66.21 (SD= 31.00)	73.03 (SD= 26.81)
The right to reproduction <i>[indicate the] % of people who have physical disabilities that should be allowed to have children.</i>	74.22 (SD= 29.99)	74.38 (SD= 27.34)
Benefit from sexual healthcare <i>[indicate the] % of people with physical disabilities who benefit from sexual healthcare services (e.g., HIV testing) in your area.</i>	61.80 (SD= 34.25)	70.25 (SD= 29.42)
Benefit from reproductive healthcare <i>[indicate the] % of people with physical disabilities who benefit from reproductive healthcare services (e.g., pregnancy screening) in your area.</i>	59.04 (SD= 34.32)	69.60 (SD= 29.41)
Benefit from sexual education services <i>[indicate the] % of people who benefit from sexual education services (e.g., classes providing information about HIV) in your area.</i>	60.26 (SD= 35.47)	69.07 (SD= 30.92)

Given that two clear factors were observed (the higher numbers for each item clearly lay in one column, and not the other), we subsequently averaged the rights and benefit from services items together for each target group (i.e., people with physical disabilities and the non-disabled population) to create four constructs. These constructs indicated good reliability ($\alpha = .75-.91$) and were found to be normally distributed (i.e., skewness <1.16 and kurtosis <1.47 ; below respective cut-offs of 3 and 8 recommended by Kline.⁶⁵

ANOVAs: difference in beliefs between people with disabilities and the non-disabled population

With a sufficiently large sample size, inferential tests will almost always produce significance, even when these differences are too small to have practical relevance.⁶⁶ Therefore, in considering the below

results, we also interpret the effect size (partial η^2 ; i.e., the magnitude of the difference), according to Cohen's⁶⁷ criteria (small: .0099; medium: .0588; large: .1397.⁶⁸

Sexual rights beliefs

There was a significant difference in attributions of sexual rights to each group, $F(1, 1862) = 141.89$, partial $\eta^2 = .07$. Specifically, participants believed 67.28% of people with physical disabilities have sexual rights, compared to 73.30% of the non-disabled population. There was also a significant gender difference $F(1, 1862) = 16.75$, $p < .001$, partial $\eta^2 = .009$, with male participants attributing less sexual rights ($M = 68.02\%$) to both target groups, compared to females ($M = 72.01$) and a significant interaction was also observed between attributions of sexual rights and gender, $F(1, 1862) = 4.01$, $p = .046$, partial $\eta^2 = .002$. However, as the

Table 2. Factor loadings of the items

Item	People with physical disabilities		Non-disabled population	
	Rights	Benefit	Rights	Benefit
Capacity to express sexuality	.800		.880	
The need to express sexuality	.884		.854	
The right to reproduction	.552		.389	
The benefit derived from sexual healthcare		.888		.893
The benefit derived from reproductive healthcare		.934		.904
The benefit derived from sexual education services		.858		.841

magnitude of these differences (i.e., the effect size) are too small to be practically relevant (i.e., both partial $\eta^2 \leq .0099$; Cohen, 1969; see above) we do not probe the interaction further.

Benefit of sexual and reproductive healthcare beliefs

There was a significant difference in attributions of the benefit of sexual and reproductive healthcare to each group, $F(1862) = -252.77$, $p < .001$, partial $\eta^2 = .120$, with participants reporting that 60.36% of people with physical disabilities benefit from sexual and reproductive healthcare services, compared to 69.62% of the non-disabled population. There was a significant gender difference, $F(1, 1862) = 9.12$, $p = .003$, partial $\eta^2 = .005$, with male participants attributing less benefit of sexual and reproductive healthcare services ($M = 62.82\%$) to both target groups compared to females ($M = 66.64\%$). However, according to Cohen's (1969) criteria the magnitude of the effect size is too small to be practically relevant (see above). There was no interaction between attributions of benefit to be derived from services to sexual and reproductive healthcare and gender, $F(1, 1862) = .502$, $p = .479$, partial $\eta^2 < .001$.

Discussion

We hypothesised that non-disabled respondents would estimate the sexual and reproductive rights, and degree to which individuals benefit from sexual

and reproductive healthcare, of people with physical disabilities to be less than those deemed appropriate to the population without disability.

We found that respondents estimated the sexual and reproductive rights of the population without disability to be greater than those appropriate to people with physical disabilities, and were more likely to estimate the degree to which people without disabilities benefit from sexual and reproductive healthcare services as greater than that of people with physical disability.

Given the size of the dataset in the present study, we expected that even negligible effects would obtain significance. It is therefore imperative to interpret the effect sizes for each test. The magnitude of the observed difference in sexual rights beliefs and benefit from sexual and reproductive healthcare services were medium. The size of these effects suggest a practically meaningful difference in the estimations of South Africans without disability of the sexual rights and benefit derived from sexual and reproductive healthcare of people with physical disabilities and the population without disability (Cohen, 1969). There were small, statistically significant differences between genders, but these were too small in terms of effect size to be practically meaningful and so are not discussed in depth (i.e., $< .0099$; Cohen 1969). However, it is noteworthy that, while past work has indicated that females tend to have more positive attitudes towards people with physical disabilities when it comes to dating

and relationships than do males,^{35,60,69} it does not appear that these differences hold for beliefs about sexual rights and the degree to which individuals benefit from sexual and reproductive healthcare services.

Simply put, there is a significant medium effect for the differences between means of respondents' estimation of the sexual rights of people with physical disabilities and the population without disability. There is also a significant large effect for the differences between means of respondents' estimation of the degree to which individuals benefit from sexual and reproductive healthcare services for people with physical disabilities and the population without disability.

With respect to rights, the findings can be interpreted against the backdrop of the work of such authors as Kim,⁷⁰ Crawford and Ostrove,²⁶ and many more^{2,5,6,71–73} concerning the so-called myth of asexuality amongst people with physical disabilities, as well as that of Kim⁷⁰ concerning societal anxiety about reproduction amongst people with physical disabilities. (This phrasing has been used in past work. We interpret its meaning as lacking sexual agency and desire, and being less sexual than non-disabled people, rather than ascribing to asexuality as a sexual orientation and identity.) If we return to the items of which this construct is composed, this empirical and theoretical frame becomes useful in making sense of the sentiments which might be underlying this finding.

In 2003, Crawford and Ostrove²⁶ reported on a variety of prejudicial beliefs held by non-disabled people, which people with physical disabilities experienced. These included beliefs amongst non-disabled people that people with physical disabilities were “universally intellectually challenged”, lacking sexuality, and helpless and incompetent.²⁶ These beliefs well encapsulate both facets of our findings concerning the sexual rights of people with physical disabilities: firstly, people with physical disabilities are *desexualised* (with fewer sexual needs and diminished sexual capacity, items 2 and 1), and secondly, people with physical disabilities are considered unlikely, even incapable or unsuitable, parents (item 3). However, the findings of Crawford and Ostrove's²⁶ study were based on accounts from women with physical disabilities of stereotypes which they had encountered. A subsequent study by Nario-Redmond²⁵ drew on the accounts of non-disabled people, but the sample was smaller than that of

the present research. Our findings also support these authors, and further suggest that people with physical disabilities are seen as having diminished sexual rights.

According to Kim,⁷⁰ the perception of people with physical disabilities as lacking sexuality and the denial of the rights of people with physical disabilities to have children are underpinned by a single social representation with its roots in fear and prejudice. Kim⁷⁰ argues convincingly that people with physical disabilities are popularly desexualised, a process which is built upon societal discomfort with the idea of disability “reproduction and contamination” (483).⁷⁰ That is, societal fear regarding the “abnormal” sexuality of people whose bodies are not typical underlies the imperative to desexualise people with physical disabilities, for fear that their sexuality – if it were to be acknowledged – would be somehow monstrous and uncomfortably different, and their offspring somehow genetically or otherwise tainted. The sexuality, and offspring, of people with physical disabilities cannot be normal, and people with physical disabilities, therefore, must not be sexual and must refrain from child-bearing. Such social representations of people with physical disabilities as desexualised and unsuitable or unlikely parents might very well underlie the significant effects for the differences between non-disabled respondents' estimation concerning the sexual rights of people with physical disabilities and the population without disability.

This study also provided some of the first empirical evidence that people with physical disabilities are believed to derive diminished benefit from sexual and reproductive healthcare compared to non-disabled people. However, we suggest, against the backdrop of the sentiments revealed in the rights questions, these findings reveal an underestimation, or negation, of the sexuality of people with physical disabilities, as identified in the literature. Imposing a lack of sexuality on people with disabilities relies on typifying them as requiring neither reproductive healthcare and contraception, nor sex education; as much as it does believing that they do not have the same rights to bear children. Our findings for people with physical disabilities are relative to the general population. Considering the multitude of ways that people can benefit from sexual and reproductive health services as above, our reading of this finding, in light of the attitudes evident in the rights items, is that the pervading societal attitude is to

assume that sexual and reproductive services benefit one group more than another. The implication is that this reflects a differing attitude toward each group.

Anderson and Kitchin⁷ note that:

“cultural ideologies [regarding the sexuality of people with physical disabilities] work to legitimate material and discursive discriminatory practices, such as exclusion from family planning clinics, sex education and sexual health, by suggesting that current social relations are common sense and natural (rather than constructed and negotiable); that the lifestyles, practices, minds and bodies of non-disabled people are the ‘norm’ and those of disabled people are deviant and undesirable”.

As people with physical disabilities are taken to lack sexuality, the need for sex education, and sexual and reproductive healthcare services for people with physical disabilities, is overlooked, suggesting that the findings in the present research might be indicative of ideas about the sexuality of people with physical disabilities which underlie this lack.^{11,12}

Beyond statistical significance, the findings of the present study make a noteworthy contribution to current understandings of attitudes towards, and beliefs about, the sexuality of people with physical disabilities. A major contribution of this paper is that it presents empirical evidence that non-disabled people consider people with physical disabilities not only to not be sexual, but also to have fewer sexual rights and benefit less from sexual and reproductive healthcare than the population without disability.

Limitations

The present study has three major limitations: the first concerns the representativeness of the sample, the second, the nature of the sample, and the third, the phrasing of the items which constitute the benefit derived from services factor.

Regarding the first, as noted, our sample includes a greater proportion of White respondents, and is better educated than the general population in South Africa. Thus, due caution must be taken in generalising the findings of this research to the population of South Africa as a whole. This study involves non-probability survey research, and so our goal, from the outset, was more accurately described as diversity, as opposed to representativeness. However, despite our

attempts to sample from different sectors of the South African population, including individuals without access to computers, and people from different language groups and provinces, our sample still suffers from over-representation of the country's minority (well-educated Whites). As such, we did not analyse our data by race or education as it was unlikely that the findings would reflect differences within the true population. Still, given the exploratory nature of the study, the lack of strict generalisability does not diminish the contribution made by the findings here: that a substantial difference exists between a sample of non-disabled South Africans' beliefs concerning the degree to which individuals benefit from sexual and reproductive services for people with physical disabilities, and the population without disability, and that this difference implies a negation of the sexuality of people with physical disabilities. It should be noted that a convenience sample is also prone to selection bias, and so our pen-and-paper sample could be biased towards people known to the data collectors. However, during training of the data collectors, emphasis was placed on approaching as random a selection of people as possible from busy areas in their communities, rather than from their social networks.

Conclusion

We examined the difference between non-disabled people's estimation of the sexual and reproductive health rights, and benefit derived from sexual and reproductive healthcare services, of people with physical disabilities. Non-disabled respondents showed greater endorsement of the sexual and reproductive rights of the population without disability than those of people with physical disabilities, and were more likely to rate the benefit derived from sexual and reproductive healthcare of the population without disability as greater than people with physical disabilities. In synchrony, these findings, we propose, are attributable to non-disabled people's beliefs about the sexuality of people with physical disabilities: that people with physical disabilities are seen as having diminished sexual needs and diminished benefit to be derived from accessing sexual and reproductive healthcare services, and that reproduction amongst people with physical disabilities is deemed less desirable and less possible than reproduction amongst non-disabled people.

Examining the content of societal beliefs about the sexuality of people with physical disabilities in South Africa yields important insights into why issues of access to sexual and reproductive health-care services for this population continue to go unaddressed: if people with physical disabilities are desexualised, their need and capacity for sexuality diminished in the eyes of the public, and their suitability/ability for reproduction called into question, it is little surprise that they may encounter neglect in service provision.

This paper is the first of which we know to examine whether non-disabled people think people with physical disabilities possess the same sexual rights and benefit from sexual and reproductive healthcare in the same way as the population without disability. Our findings suggest that they do not, and, in fact, may perceive people with physical disabilities to be less sexual than non-disabled people. This latter possibility, raised by the present findings, calls for qualitative inquiry into the beliefs of non-disabled people about the sexuality of people with physical disabilities. Such work, which would explore the constructions of sexuality amongst people with physical disabilities, their capacity to be partners, parents, and sexual agents, would yield clarifying insights which would add nuance to the findings presented here.

Acknowledgements

This paper was conducted as part of the applied research “The myth of asexuality? Disability stigma as a barrier to sexual relationships in South Africa” led by the University of East London, in partnership with the Southern African Federation of the Disabled, SINTEF Technology and Society and Stellenbosch University.

Funding

The financial assistance of the International Foundation of Applied Disability Research (FIRAH) and the National Research Foundation (NRF) of South Africa is hereby acknowledged. Opinions expressed and conclusions arrived at are those of the authors and are not necessarily to be attributed to FIRAH or the NRF.

ORCID

Xanthe Hunt  <http://orcid.org/0000-0001-7531-6665>

Mark T. Carew  <http://orcid.org/0000-0002-1377-2910>

Stine Hellum Braathen  <http://orcid.org/0000-0002-3968-1873>

Leslie Swartz  <http://orcid.org/0000-0003-1741-5897>

References

- Burlink K, Tarvydas VM, Maki DR. Human sexuality and disability: a holistic interpretation of rehabilitation counseling. *J Appl Rehabil Couns*. 1994;25:10–16.
- De Loach CP. Attitudes toward disability: impact on sexual development and forging of intimate relationships. *J Appl Rehabil Couns*. 1994;25:18–25. Available from: https://www.researchgate.net/publication/232518788_Attitudes_toward_disability_Impact_on_sexual_development_and_forging_of_intimate_relationships
- Farrow J. Sexuality counseling with clients who have spinal cord injuries. *Rehabil Couns Bull*. 1990;33(3):251–259. Available from: <http://psycnet.apa.org/psycinfo/1990-23569-001>
- Sandahl C. Queering the Crip or Crippling the queer? Intersections of queer and Crip identities in solo autobiographical performance. *GLQ J Lesbian Gay Stud*. 2003;9:25–56. Available from http://muse.jhu.edu/login?auth=0&type=summary&url=/journals/journal_of_lesbian_and_gay_studies/v009/9.1sandahl.html
- Milligan M, Neufeldt A. The myth of asexuality: a survey of social and empirical evidence. *Sexuality and Disability*. 2001;19:91–109. doi:10.1023/A:1010621705591
- Shakespeare T, Gillespie-Sells K, Davies D. The sexual politics of disability. London: Cassells; 1996.
- Anderson P, Kitchin R. Disability, space and sexuality: access to family planning services. *Soc Sci Med*. 2000;51:1163–1173. doi:10.1016/S0277-9536(00)00019-8
- Hanass-Hancock J. Interweaving conceptualizations of gender and disability in the context of vulnerability to HIV/AIDS in KwaZulu-Natal, South Africa. *Sexuality and Disability*. 2009;27:35–47. doi:10.1007/s11195-008-9105-9
- McKenzie J. Disabled people in rural South Africa talk about sexuality. *Culture Health Sexuality*. 2013;15:372–386. doi:10.1080/13691058.2012.748936
- Vilchinsky N, Werner S, Findler L. Gender and attitudes toward people using wheelchairs: a multidimensional

- perspective. *Rehabil Couns Bull.* 2010;53:163–174. doi:10.1177/0034355209361207
11. Cheausuwantavee T. Sexual problems and attitudes toward the sexuality of persons with and without disabilities in Thailand. *Sexuality and Disability.* 2002;20:125–134. doi:10.1023/A:1019830411534
12. Seidel A, Wienholz S, Michel M, et al. Sexual knowledge among adolescents with physical handicaps: a systematic review. *Sexuality and Disability.* 2014;32:429–441. doi:10.1007/s11195-013-9326-4
13. Hurst R. The international disability rights movement and the ICF. *Disability Rehabil.* 2003;25:572–576. doi:10.1080/0963828031000137072
14. Addlakha R. How young people with disabilities conceptualize the body, sex and marriage in urban India: four case studies. *Sexuality and Disability.* 2007;25(3):111–123. <http://doi.org/10.1007/s11195-007-9045-9>
15. Fine M, Asch A. Disabled women: sexism without the pedestal. In: Deegan MJ, Brooks NA, editor. *Women and disability: the double handicap.* New Brunswick: Transaction Books; 1985. p. 6–22.
16. Gibson BE, Mykitiuk R. Health care access and support for disabled women in Canada: falling short of the UN convention on the rights of persons with disabilities: a qualitative study. *Womens Health Issues.* 2012;22:e111–e118. doi:10.1016/j.whi.2011.07.011
17. Shuttleworth R, Mona L. Disability and sexuality: toward a focus on sexual access. *Disability Stud Q.* 2002;22:2–9. doi:10.18061/dsq.v22i4.368
18. Ahumuza SE, Matovu JK, Ddamulira JB, et al. Challenges in accessing sexual and reproductive health services by people with physical disabilities in Kampala, Uganda. *Reprod Health.* 2014;11(1):S26. doi:10.1186/1742-4755-11-59
19. Albert B, Hurst R. Disability and a human rights approach to development: briefing paper; 2005. Available from: <http://hpod.org/pdf/human-rights-approach.pdf>
20. World Health Organization. World report on disability. Geneva: WHO; 2011.
21. United Nations [Internet]. Convention on the rights of persons with disabilities. United Nations; 2006. [cited 2017 March 13]. Available from: <http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>
22. Shakespeare T. Disabled sexuality: toward rights and recognition. *Sexuality and Disability.* 2000;18(3):159–166. doi:10.1023/A:1026409613684
23. Lee K, Devine A, Marco MJ, et al. Sexual and reproductive health services for women with disability: a qualitative study with service providers in the Philippines. *BMC Women Health.* 2015;15(1):e178.
24. Rueda HA, Linton KF, Williams LR. School social workers' needs in supporting adolescents with disabilities toward dating and sexual health: a qualitative study. *Children Sch.* 2014;36(2):79–90.
25. Nario-Redmond MR. Cultural stereotypes of disabled and non-disabled men and women: consensus for global category representations and diagnostic domains. *Br J Soc Psychol.* 2010;49:471–488. doi:10.1348/014466609X468411
26. Crawford D, Ostrove JM. Representations of disability and the interpersonal relationships of women with disabilities. *Women Ther.* 2003;26:179–194. doi:10.1300/J015v26n03_01
27. Olkin R, Howson LJ. Attitudes toward and images of physical disability. *J Soc Behav Personality.* 1994;9:81–96. Available from: <https://www.uwlax.edu/urc/jur-online/PDF/2010/grames-leverentz.pdf>
28. Trieschmann RB. *Spinal cord injuries: psychological, social, and vocational rehabilitation.* 2nd ed. New York: Demos; 1988.
29. Yoshida KK. Intimate and marital relationships: an insider's perspective. *Sexuality and Disability.* 1994;12:179–189. doi:10.1007/BF02547904
30. O'Dea SM, Shuttleworth RP, Wedgwood N. Disability, doctors and sexuality: Do healthcare providers influence the sexual wellbeing of people living with a neuromuscular disorder? *Sexuality and Disability.* 2012;30:171–185. doi:10.1007/s11195-011-9235-3
31. Sakellariou D. If not the disability, then what? Barriers to reclaiming sexuality following spinal cord injury. *Sexuality and Disability.* 2006;24:101–111. doi:10.1007/s11195-006-9008-6
32. Sakellariou D, Algado SS. Sexuality and disability: a case of occupational injustice. *Br J Occup Ther.* 2006;69:69–76. Available from: https://www.researchgate.net/profile/Salvador_Algado/publication/233652926_Sexuality_and_Disability_A_Case_of_Occupational_Injustice/links/00b7d52d3cea09433a000000.pdf
33. Siebers T. A sexual culture for disabled people. In: McRuer R, Mallow A, editors. *Sex and disability.* Durham: Duke University Press; 2012. p. 37–53.
34. Hahn H. The social component of sexuality and disability: some problems and proposals. *Sexuality and Disability.* 1981;4(4):220–233. doi:10.1007/BF01103307
35. Marini I, Chan R, Feist A, et al. Student attitudes toward intimacy with persons who are wheelchair users. *Rehabil Res Policy Educ.* 2011;25(1–2):15–25. doi:10.1891/216866511805001109
36. Marini I, Wang X, Etzbach CA, et al. Ethnic, gender, and contact differences in intimacy attitudes toward wheelchair users. *Rehabil Counseling Bull.* 2013;56(3):135–145. doi:10.1177/0034355212456605
37. Astbury J, Walji F. The prevalence and psychological costs of household violence by family members against women with disabilities in Cambodia. *J Interpersonal Violence.* 2014;29(17):3127–3149. doi:10.1177/0886260514534528

38. Stromsness M. Sexually abused women with mental retardation: hidden victims, absent resources. In: Holcomb L, Willmuth ME, editors. *Women with disabilities: found voices*. New York (NY): The Haworth Press, 1993; p. 139–153.
39. Pebdani RN, Johnson KL, Amtmann D. Personal experiences of pregnancy and fertility in individuals with spinal cord injury. *Sexuality and Disability*. 2014;32(1):65–74. <http://doi.org/10.1007/s11195-013-9319-3>
40. Louw JS, Kosciulek J, Chen RK. Investigating educators' views of sexuality, HIV and AIDS education in working with students with disabilities in South African schools. *J Appl Rehabil Counseling*. 2014;45:9–17. Available from: <http://search.proquest.com/openview/95c186d41c276be57f50ba4c949d8d63/1?pq-origsite=gscholar>
41. Chirawu P, Hanass-Hancock J, Aderemi TJ, et al. Protect or enable? Teachers' beliefs and practices regarding provision of sexuality education to learners with disability in KwaZulu-Natal, South Africa. *Sexuality and Disability*. 2014;32:259–277. doi:10.1007/s11195-014-9355-7
42. De Reus L, Hanass-Hancock J, Henken S, et al. Challenges in providing HIV and sexuality education to learners with disabilities in South Africa: the voice of educators. *Sex Educ*. 2015;15:333–347. doi:10.1080/14681811.2015.1023283
43. Chappell P. Secret languages of sex: disabled youth's experiences of sexual and HIV communication with their parents/caregivers in KwaZulu-Natal, South Africa. *Sex Educ*. 2015;16:1–13. doi:10.1080/14681811.2015.1092432
44. Collins C. Reproductive technologies for women with physical disabilities. *Sexuality and Disability*. 1999;17(4):299–307. doi:10.1023/A:1021325612563
45. Lee EO, Oh H. A wise wife and good mother: reproductive health and maternity among women with disability in South Korea. *Sexuality and Disability*. 2005;23:121–144. doi:10.1007/s11195-005-6728-y
46. Smith E, Murray SF, Yousafzai AK, et al. Barriers to accessing safe motherhood and reproductive health services: the situation of women with disabilities in Lusaka, Zambia. *Disability and Rehabil*. 2004;26:121–127. doi:10.1080/09638280310001629651
47. Thomas C. Medicine, gender and disability: disabled women's health care encounters. *Health Care Women Int*. 2001;22:245–262. doi:10.1080/073993301300357188
48. Thomas C. The baby and the bath water: disabled women and motherhood in social context. *Social Health Illness*. 1997;19:622–643. doi:10.1111/j.1467-9566.1997.tb00423.x
49. Thomas C. Narrative identity and the disabled self. In: Corker M, French S, editors. *Disability discourse*. Buckingham: Open University Press; 1999. p. 47–55.
50. Thomas C, Curtis P. Having a baby: some disabled women's reproductive experiences. *Midwifery*. 1997;13:202–209. doi:10.1016/S0266-6138(97)80007-1
51. Weiner SL. Gynecologic care and sexuality issues for women with disabilities. *Sexuality and Disability*. 1997;15:33–40. doi:10.1023/A:1024715514119
52. WHO, UNFPA. Promoting sexual and reproductive health for persons with disabilities: WHO/UNFPA guidance note. Geneva: WHO; 2009.
53. MacLachlan M, Swartz L. Disability and international development: towards inclusive global health. New York (NY): Springer; 2009.
54. Vaughan C, Zayas J, Devine A, et al. W-DARE: a three-year program of participatory action research to improve the sexual and reproductive health of women with disabilities in the Philippines. *BMC Publ Health*. 2015;15(1):984.
55. Rohleder P, Swartz L. Disability, sexuality and sexual health. In: Aggleton P, Boyce P, Moore HL, Parker R, editors. *Understanding global sexualities: new frontiers*. London: Routledge; 2012. p. 138–152.
56. United Kingdom National Government. The equality act 2010; 2010. Available from: <http://www.legislation.gov.uk/ukpga/2010/15/contents>
57. Altman B, editor. *International measurement of disability: purpose, method, and application*. New York (NY): Springer; 2016.
58. Madans JH, Loeb M. Methods to improve international comparability of census and survey measures of disability. *Disability and Rehabil*. 2013;35(13):1070–1073. doi:10.3109/09638288.2012.720353
59. Authors (under review). Dating persons with physical disabilities: the views of some South Africans without disabilities.
60. Chen RK, Brodwin MG, Cardoso E, et al. Attitudes toward people with disabilities in the social context of dating and marriage: a comparison of American, Taiwanese, and Singaporean College Students. *J Rehabil*. 2002;68:5–11. Available from: <http://crawl.prod.proquest.com.s3.amazonaws.com/fpcache/08cdec8794e481a9566041541b65469.pdf?AWSAccessKeyId=AKIAJF7V7KNV2KKY2NUQ&Expires=1455103486&Signature=Oz1b01f58ffMV06Vi43KTjEL%2Bs%3D>
61. Times Media Group, 2016.
62. Magnusson K. Interpreting Cohen's d effect size an interactive visualization [Internet]; n.d. Available from: <http://rpsychologist.com/d3/cohend/>
63. Statistics South Africa. Census 2011: Census in brief (PDF). Pretoria: Statistics South Africa; 2012. p. 23–25.
64. Field A. *Discovering statistics using IBM SPSS statistics*. London: Sage; 2013.
65. Kline R. *Principles and practice of structural equation modeling*. New York: Guildford Press; 2011.

66. Sullivan GM, Feinn R. Using effect size – or why the p value is not enough. *J Graduate Med Educ.* 2012;4(3):279–282.
67. Cohen J. Statistical power analysis for the behavioural sciences. New York: Academic Press; 1969.
68. Richardson JT. Eta squared and partial eta squared as measures of effect size in educational research. *Educ Res Rev.* 2011;6(2):135–147.
69. Findler L, Vilchinsky N, Werner S. The multidimensional attitudes scale toward persons with disabilities (MAS): construction and validation. *Rehabil Counselling Bull.* 2007;50:166–176. doi:10.1177/00343552070500030401
70. Kim E. Asexuality in disability narratives. *Sexualities.* 2011;14:479–493. doi:10.1177/1363460711406463
71. Nosek M. Sexual abuse of women with physical disabilities. *Phys Med Rehabil.* 1995;9:487–502. Available from: http://www.vawnet.org/research/print-document.php?doc_id=369&find_type=web_desc_AR
72. Schlesinger L. Chronic pain, intimacy, and sexuality: a qualitative study of women who live with pain. *J Sex Res.* 1996;33:249–256. Available from: <http://www.jstor.org/stable/3813585>
73. Tilley CM. Sexuality in women with physical disabilities: a social justice or health issue? *Sexuality and Disability.* 1996;14:139–151. doi:10.1007/BF02590607

Résumé

Une somme de travail théorique et quelques travaux de recherche empirique donnent à penser que les personnes non handicapées supposent que les personnes avec un handicap physique ne sont pas des partenaires amoureux, n'ont pas de désirs sexuels ou n'ont pas de vie sexuelle. Pour ce second groupe, l'accès aux services de santé sexuelle et génésique est un défi : les personnes avec un handicap physique rencontrent des obstacles à l'accès aux soins de santé sexuelle qui sont structurels (comme l'impossibilité pratique de se rendre dans les bureaux des prestataires de soins) et sociaux (comme des prestataires qui suggèrent que les personnes avec des handicaps physiques ne devraient pas procréer). L'article étudie les croyances des Sud-Africains concernant le degré auquel les personnes avec un handicap physique et les personnes sans handicap ont des droits sexuels et génésiques et bénéficient des soins de santé sexuelle et génésique. Avec une enquête, nous avons demandé à 1989 Sud-Africains d'estimer dans quelle mesure les personnes avec un handicap physique et les personnes sans handicap ont des droits sexuels et bénéficient de services de soins de santé sexuelle et génésique, respectivement. Les répondants avaient davantage tendance à soutenir l'idée que la population sans handicap méritait des droits sexuels, par comparaison avec les personnes ayant un handicap physique. Les répondants avaient aussi plus de probabilités d'estimer que les personnes avec des handicaps physiques bénéficient de soins de santé sexuelle et génésique à un degré inférieur que les personnes sans handicap physique. Ces conclusions fournissent les premières données empiriques montrant que les non-handicapés voient les personnes

Resumen

Existe un conjunto de trabajo teórico y algunas investigaciones empíricas que indican que las personas no discapacitadas suponen que las personas con discapacidad física no son parejas románticas adecuadas, no tienen deseo sexual, o no son sexualmente activas. El acceso de este último grupo a los servicios de salud sexual y reproductiva es un reto: se ha propuesto que las personas con discapacidad física enfrentan barreras para obtener servicios de salud sexual que son estructurales (tales como consultorios inaccesibles) y sociales (tales como cuando profesionales de la salud sugieren que las personas con discapacidad física no deberían procrear). Este artículo examina las creencias de personas sudafricanas no discapacitadas respecto a en qué medida tienen derechos sexuales y reproductivos las personas y en qué medida se benefician de los servicios de salud sexual y reproductiva las personas con discapacidad física y aquellas sin discapacidad. En una encuesta, pedimos a 1989 sudafricanos que estimaran en qué medida las personas con discapacidad física y aquellas sin discapacidad tienen derechos sexuales y se benefician de los servicios de salud sexual y reproductiva, respectivamente. Las personas encuestadas eran más propensas a respaldar la idea de que la población sin discapacidad es merecedora de derechos sexuales comparada con las personas con discapacidad física. Además, eran más propensas a estimar en qué medida las personas con discapacidad física se benefician menos de los servicios de salud sexual y reproductiva, comparadas con aquellas sin discapacidad física. Estos hallazgos figuran entre los primeros en corroborar de manera empírica que las personas sin discapacidad perciben a aquellas con discapacidad física como que tienen menos derechos sexuales y reproductivos, y como

handicapées physiques comme ayant moins de droits sexuels et génésiques, et retirant moins d'avantages des services de santé sexuelle et génésique que la population sans handicap. À notre sens, le fait d'avoir des droits sexuels diminués et de bénéficier moins des soins de santé sexuels et génésiques révèle une négation des besoins et des capacités sexuelles et génésiques des personnes avec un handicap physique.

que se benefician menos de los servicios de salud sexual y reproductiva, comparadas con aquéllas sin discapacidad. Sugerimos que tener menos derechos sexuales y beneficiarse menos de los servicios de salud sexual y reproductiva pone en evidencia la negación de la capacidad y las necesidades sexuales y reproductivas de las personas con discapacidad física.