

PEOPLE WITH DISABILITIES



There are more than one billion people living with a physical, sensory, intellectual or mental health disability in the world—four out of five live in low- and middle-income countries (1).

People with disabilities experience negative attitudes that can result in violence, sexual abuse, stigma and discrimination, which can lead to low self-esteem and social isolation.

Vulnerability, combined with a poor understanding and appreciation of their sexual and reproductive health needs, places people with disabilities at higher risk of HIV infection (2).

{ PEOPLE WITH DISABILITIES

**I am a person living with disabilities.
I face these issues.**



WHY PEOPLE WITH DISABILITIES ARE BEING LEFT BEHIND

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HIV burden

A 2012 survey in South Africa reported an HIV prevalence among people with disabilities of 16.7%, and a study among deaf people in Kenya indicated that nearly 7% were living with HIV (3). However, risk perception remained low: 78% of people with disabilities in South Africa felt that they were at a low risk of acquiring HIV (4).

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Seventy-eight per cent of people with disabilities felt that they were at a low risk of acquiring HIV.

A study among deaf people in Kenya indicated that nearly 7% were living with HIV.

Disability varies widely according to age, sex, stage of life, exposure to environmental risks, socioeconomic status and culture. People with disabilities and households that include people with disabilities experience poorer social and economic outcomes compared with individuals and households without disabilities. Often, additional costs are incurred to achieve a standard of living equivalent to that of people without disabilities.

Whether or not they are living with HIV, people with disabilities have an unmet need for health and HIV services in order to protect themselves. They represent one of the largest and most underserved populations.

THE TOP 4 REASONS

01

Lack of awareness by society

02

Violence and sexual abuse

03

Discrimination in health-care settings

04

Low awareness and risk perception about HIV

Lack of awareness by society

HIV-related data on people with disabilities are sparse, since most countries do not measure HIV prevalence among the group. However, the few existing studies show that HIV prevalence among people with disabilities is nearly the same or higher compared with people without disabilities (5).

Services that people with disabilities need versus what they receive



Source: World report on disability. Geneva, WHO/The World Bank, 2011.

Neglect and discrimination in all their forms place people with disabilities at risk of HIV infection. Often family, caregivers, employers and health-care providers fail to fully understand or appreciate the sexual and reproductive health needs of people with disabilities.

People with disabilities are often neglected in HIV policy planning as well as wider health-care provisioning. Common misperceptions affecting public health planning include the belief that people with disabilities are sexually inactive or unlikely to use drugs or alcohol.

People with disabilities experience all of the risk factors associated with acquiring HIV. They are often at an increased risk because of poverty, severely limited access to education and health care, and a lack of information and resources to facilitate safer sex. Often, they lack legal protection and are vulnerable to substance abuse and stigma. People with disabilities, particularly women and girls, are more vulnerable to sexual violence and abuse (6).

People with disabilities may experience compounded negative consequences, such as low self-esteem and reduced political and civic engagement and participation, and face the double burden of stigma and discrimination if they are also living with HIV.

Violence and sexual abuse

Children and adults with disabilities are at a higher risk of violence than are non-disabled children and adults. People with mental disabilities are particularly vulnerable. There are several factors for this higher risk: exclusion from education and employment; the need for personal assistance with daily living; reduced physical and emotional defences; communication barriers that hamper the reporting of violence; and societal stigma and discrimination (1).

Violence is linked to health outcomes both in the immediate and long term, including injuries, physical and mental health problems, substance abuse and death (7). In the United States of America, reports of violence against people with disabilities were four to 10 times greater than reports of violence against people without disabilities (8).

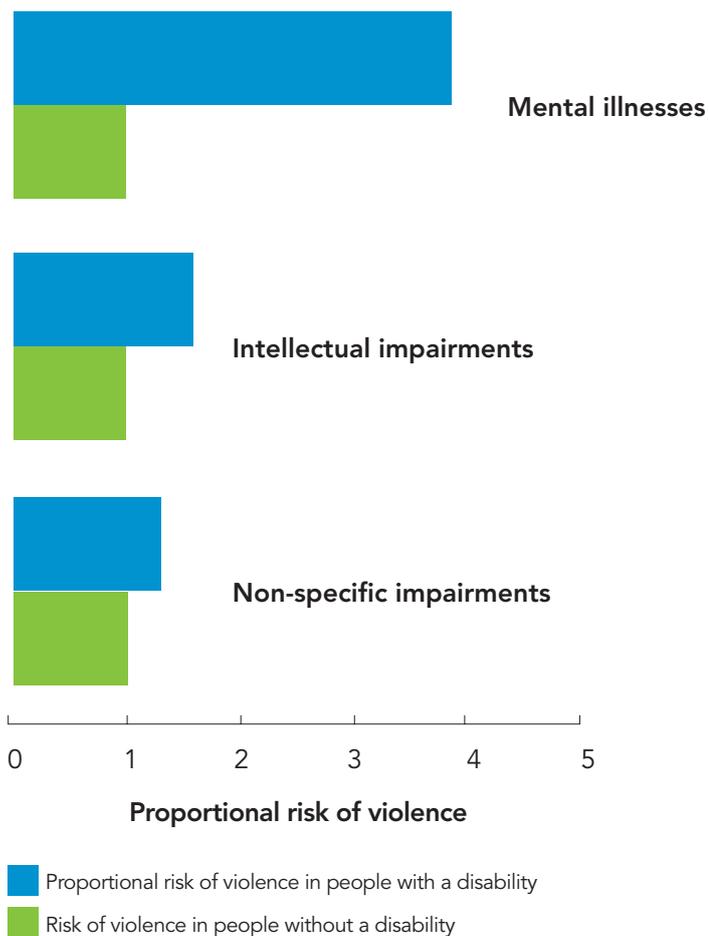
Studies have found that the prevalence of sexual abuse experienced by people with disabilities is higher (9,10), especially for institutionalized men and women with intellectual disabilities (11–13), intimate partners (9,14) and adolescents (6). Research has also found that the incidence of intimate partner violence experienced by people with disabilities is high (6).

Violence against students with disabilities perpetrated by teachers, other staff and fellow students is common in educational settings (15). Students with disabilities often experience physical threats and abuse, verbal abuse and social isolation. Violence and sexual abuse increase an individual's vulnerability and risk of HIV infection. Violence against people with disabilities is a significant public health and human rights issue.

People with disabilities experience all of the risk factors associated with acquiring HIV.

In the United States of America, reports of violence against people with disabilities were 4 to 10 times greater than reports of violence against people without disabilities.

Proportional risk of violence against people with a disability compared with people without a disability



Source: Hughes K, Bellis MA, Jones L, Wood S, Bates G, Eckley L, McCoy E, Mikton C, Shakespeare T, Officer A. Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. *Lancet* 2012; doi:10.1016/S0410-6736(11)61851-5.

Discrimination in health-care settings

All countries need to work towards removing barriers and making existing health-care systems more inclusive and accessible to people with disabilities (1). Globally, more than 10% of women and 23% of men living with a disability reported not returning to seek health care because they were treated badly during a previous visit (1). A national study in the United States showed that women with functional limitations were less likely to be asked about contraceptive use during visits to their doctor (16).

The provision of sexual health information and support for people with disabilities has often been given limited attention or priority. This is, in part, because people with disabilities have not been included in the design and development of these services and hence have not been able to articulate their needs.

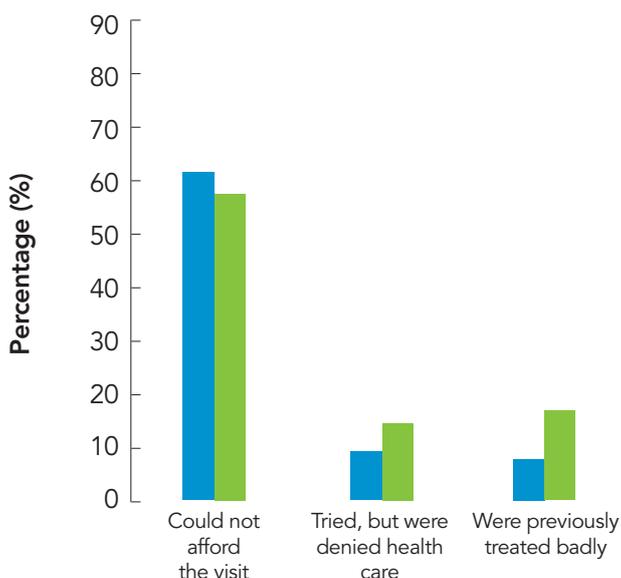
HIV services are needed both for people with disabilities who acquire HIV or who are at risk of HIV infection. Services must also respond to the needs

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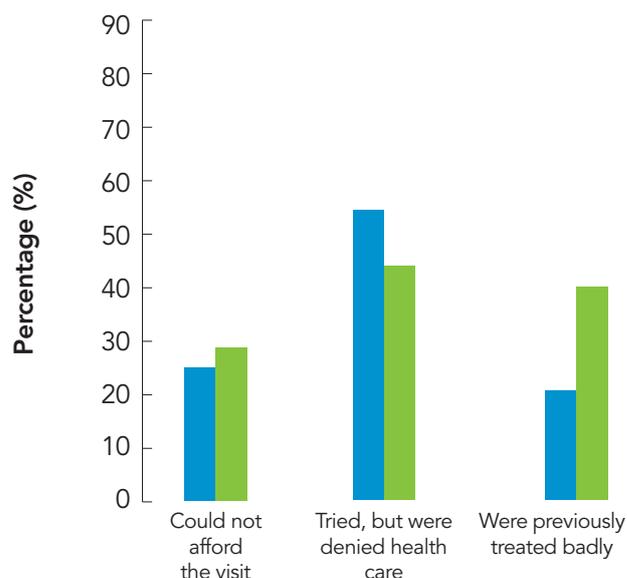
of people living with HIV, who then develop disabilities as a result of the progression of HIV or due to the side-effects of antiretroviral therapy. Many health practitioners lack the necessary knowledge, skills and resources to provide these accessible, appropriate services. Thus, better training is needed and peer support will help to close this gap.

Reasons why people with disabilities cannot access health services

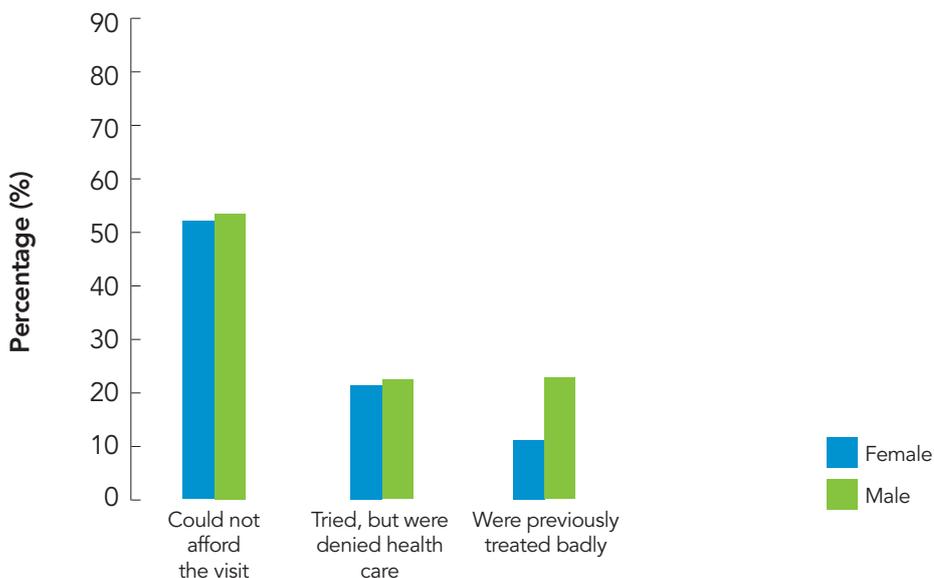
People with a disability in low-income countries



People with a disability in high-income countries



People with a disability globally



Source: World report on disability. Geneva, WHO/The World Bank, 2011.

Low awareness and risk perception about HIV

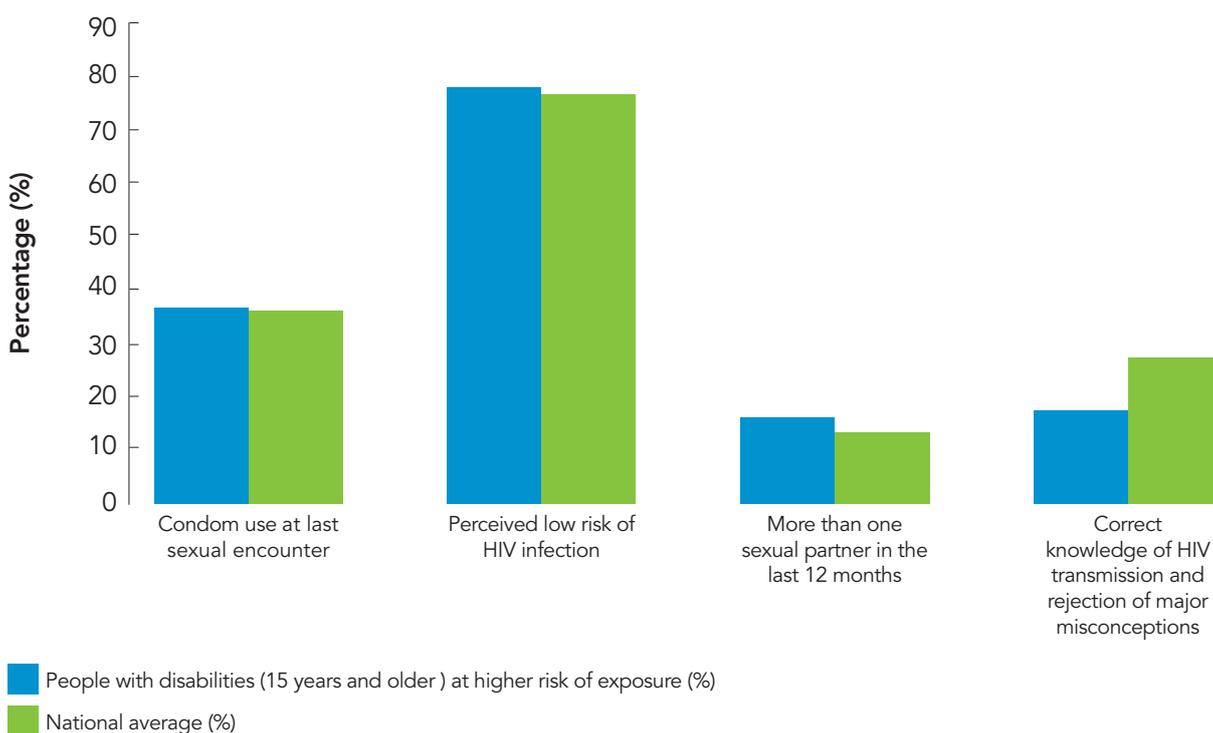
Adolescents and adults with disabilities are more likely to be excluded from sex education programmes than other people (17,18). Knowledge about HIV among people with disabilities is generally low (5), due in part to difficulties in accessing any kind of HIV education or prevention services.

Information materials and approaches to disseminating information are rarely adapted to the diverse communication needs of people with disabilities (19). The lack of appropriate information is thought to limit the ability of people with disabilities to access and understand safer sex messages or to negotiate safer sexual behaviours (20).

A study in South Africa shows that people with disabilities are less likely to have access to information and services, since it is assumed that they are not sexually active. They are, therefore, less likely to have the skills and means to protect themselves against HIV infection (4).

People with disabilities are less likely to have access to information and services, since it is assumed that they are not sexually active.

Low HIV awareness and risk perception among people with disabilities, South Africa



Source: Shisana O, et al. South African National HIV prevalence, incidence, behaviour and communication survey, 2012. Cape Town, HSCR, 2014.

CLOSING THE GAP

HIV programmes must be accessible and meet the needs of people with disabilities. People with disabilities are often denied the opportunity to articulate their specific needs or be heard, owing to their marginalized position in society. Like many individuals, people with disabilities need and want access to HIV education, testing and treatment, as well as to broader sexual and reproductive health services.

People with disabilities should be fully included in national HIV responses. National strategic plans on HIV must include good practice on disability. HIV must also be included as an integral part of disability rights strategies, initiatives and programmes.

Since people with disabilities are vulnerable to physical and sexual abuse in both community and residential settings, protection safeguards are particularly important (21). Mechanisms to detect and prevent physical and sexual abuse in both formal and informal support services are needed.

The United Nations Convention on the Rights of Persons with Disabilities must be implemented. Under the Convention, people with disabilities have the right to enjoy the highest attainable standard of health without discrimination on the basis of disability (22). Countries are tasked with taking all appropriate measures to ensure access to health services for people with disabilities.

For national AIDS responses to genuinely address the unmet needs of people with disabilities, improved disability data collection is needed. This can be achieved by including disability questions in existing surveys, such as national household or national health surveys. Data need to be disaggregated by population features, such as by the type of disability, age, sex, ethnicity and socioeconomic status, to uncover patterns, trends and information about subgroups of people with disabilities. Understanding the specific realities of people with disabilities better will help to remove barriers in country-level efforts and improve the provision of HIV and other health services.

Additional data are also needed on the prevalence of unsafe sex as well as linkages between disability and poverty, sexual violence, stigma, risk behaviours and gender inequality. The absence of data reflects an overall failure to recognize the needs of people with disabilities and a failure to develop services that will respond to these needs.

HOW TO CLOSE THE GAP

01

Ending violence and sexual abuse

02

Including people with disabilities fully in national HIV responses

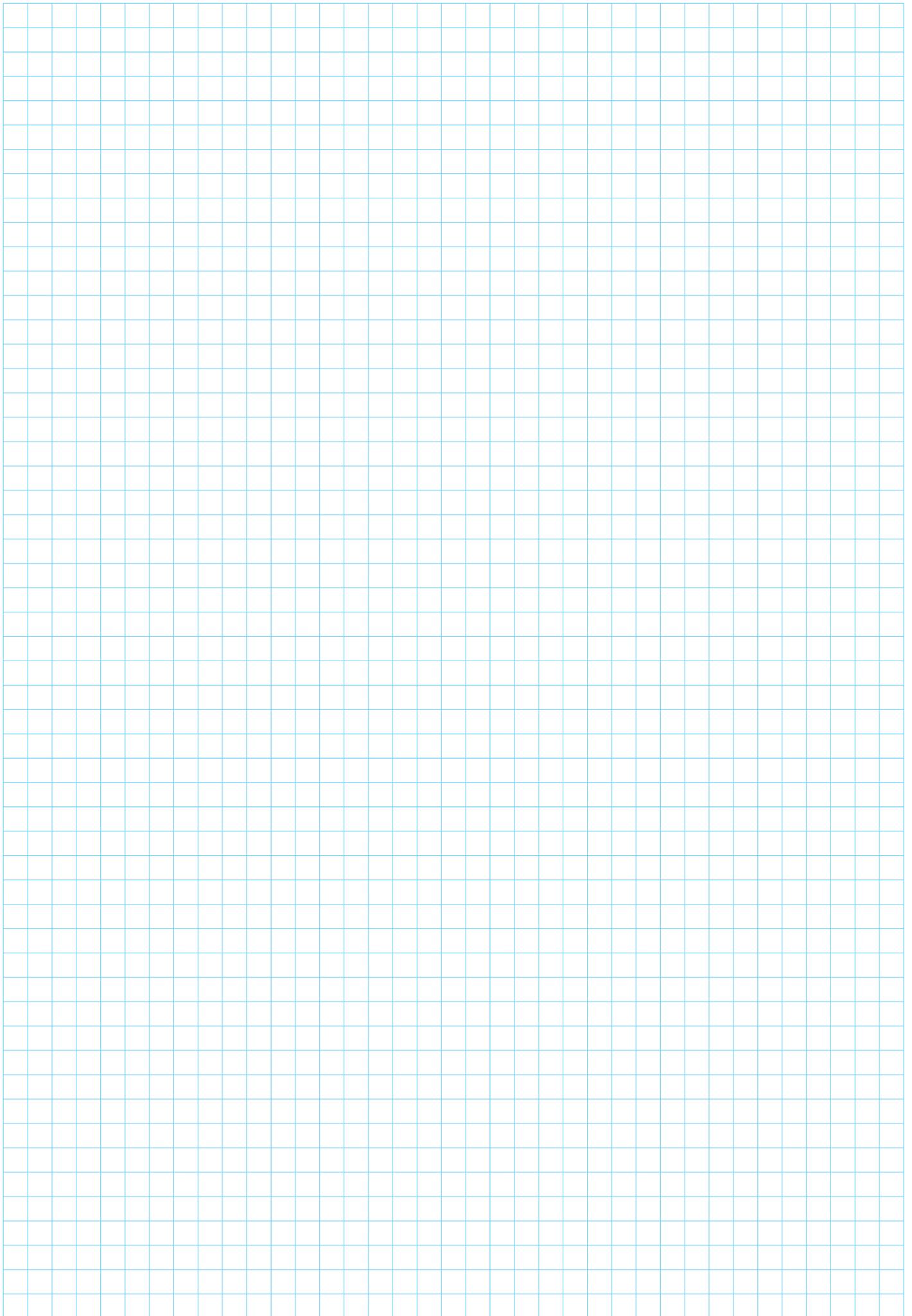
03

Data collection on disability and HIV

04

Access to sexual and reproductive health services and information

Improved disability data collection is needed, which can be achieved by including disability questions in existing surveys.



UNAIDS / JC2656 (English original, July 2014, updated September 2014)

ISBN 978-92-9253-062-4

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