

Perceptions in the medical field towards persons with disabilities' sexual and reproductive health and rights

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Declaração de Integridade

Eu, Jéssica Viviana Nóbrega de Sousa Alcobia, que abaixo assino, estudante com o número de inscrição 39353 do Mestrado Integrado em Medicina da Faculdade de Ciências da Saúde, declaro ter desenvolvido o presente trabalho e elaborado o presente texto em total consonância com o **Código de Integridades da Universidade da Beira Interior**.

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Dedicatória

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Resumo

INTRODUÇÃO: As pessoas com deficiência constituem o maior grupo minoritário do mundo. As condições conferentes de deficiência impactam negativamente vários campos das suas vidas, incluindo as atividades de vida diárias. Como qualquer ser humano, este grupo tem direito a usufruir de direitos humanos iguais e não discriminatórios, o que inclui o direito à saúde sexual e reprodutiva de qualidade. A presente revisão de literatura tem como objetivo analisar as atitudes, percepções e comportamentos tomados pelos estudantes de medicina e médicos em relação à sexualidade das pessoas com deficiência física e/ou intelectual.

METODOLOGIA: Procedeu-se à pesquisa compreensiva de artigos relevantes de 2013 a maio de 2023 na base de dados científica PubMed® entre os meses de abril e maio de 2023. Após a aplicação dos critérios de inclusão e exclusão, recolheram-se os resultados obtidos de 25 artigos.

RESULTADOS: A larga maioria dos estudos realçaram a presença de comportamentos e dinâmicas desfavoráveis em relação à saúde e direitos sexuais e reprodutivos das pessoas com deficiência. São frequentemente mencionadas preconceções discriminatórias por parte dos médicos, bem como a crença de que a sexualidade é um tópico tabu e, por isso, não é abordada em contexto de consulta. Além disso, refere-se a insuficiente formação em cuidados de saúde direcionados a pessoas com deficiência e conseqüente falta de conhecimento sobre como adaptar os cuidados às necessidades específicas destes indivíduos. São igualmente identificadas competências comunicacionais e relacionais deficitárias, o que resulta numa educação sexual insuficiente e negligência das necessidades e preferências de pacientes com deficiência. A inacessibilidade estrutural dos espaços de saúde, o limitado tempo disponível por consulta e o uso de linguagem técnica complexa são outras das barreiras evidenciadas que impactam negativamente o provisionamento adequado de cuidados de saúde sexual e reprodutiva. Por outro lado, há igualmente alusão a experiências e atitudes positivas, ainda que estes casos sejam menos frequentes. É necessária a realização de mais estudos que permitam melhor compreender as atitudes e comportamentos deste grupo de profissionais, de forma a permitir criar mecanismos que contrariem a visão mais prevalente.

CONCLUSÃO: A saúde e direitos sexuais e reprodutivos nas pessoas com deficiência é vista pelos médicos e estudantes de medicina geralmente de forma desfavorável, ainda que haja atitudes e comportamentos contrários aos da maioria e a favor dos melhores interesses destes indivíduos. As perspetivas demonstradas resultam em piores cuidados, bem como na

menor procura dos serviços de saúde por parte das pessoas com deficiência. É imperativo reunir esforços no sentido de melhor formar este grupo de profissionais de saúde e sensibilizá-los para a normalização das pessoas com deficiência, ainda que necessitem de cuidados mais especializados nas suas condições. Os direitos das pessoas com deficiência só estarão totalmente assegurados se se providenciar cuidados de saúde sexual e reprodutiva adequados e adaptados às suas reais necessidades.

Palavras-chave

Deficiência física; deficiência intelectual; saúde sexual e reprodutiva; atitudes; estudantes de medicina; médicos

Abstract

BACKGROUND: People with disabilities, representing the largest minority in the world, are affected by conditions that negatively impact their daily activities. As any human being, they are entitled to have equal and non-discriminatory access to sexual and reproductive health and rights. This narrative review aims to analyse medical professionals and students' behaviours and dynamics towards persons with disabilities regarding their sexual health and rights.

METHODS: PubMed® database search and selection of relevant articles from 2013 to May 2023, resulting in the inclusion of 25 articles.

RESULTS: Most studies allude to unfavourable behaviour and dynamics towards the sexuality of people with disabilities in the medical field. These include mainly discriminatory assumptions, sexuality seen as a taboo topic, lack of knowledge and training on persons with disabilities' healthcare, and communicational and relational handicaps. Physical limitations, time constraints, and complex terms are also identified as barriers. Notwithstanding, positive aspects and experiences on sexual and reproductive healthcare provision are mentioned as well.

CONCLUSIONS: Sexual and reproductive health and rights in persons with disabilities are perceived in the medical field with conflicting views, even though there is a tendency towards the negative side. This results in a poorer care provision to people with disabilities and incapacitate them to have their rights fulfilled. Training in PWD care should be prioritised in medical curricula to improve medical perceptions. Further studies should be conducted to better understand the results.

Keywords

Physical disability; intellectual disability; sexual and reproductive health and rights; attitudes; medical students; physicians

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List of Acronyms

ACOG	American College of Obstetricians and Gynecologists
ATDP	Attitudes toward disabled persons
HIV	Human immunodeficiency virus
IDP	Interactions with disabled persons
PWD	Persons with disabilities
RSI	Rehabilitation situations inventory
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights

Introduction

Disability is a concept in constant evolution that, according to the United Nations Convention on the Rights of Persons with Disabilities, results from the interaction between people with impairments and environmental and behavioural barriers, which in turn will prevent their full and effective participation in society, opposite to the non-disabled persons. (1) In 2023, 164 countries or regional integration organisations have signed this Convention, making it the main reference to define disability. Disabilities, which may be congenital or acquired (2), cause a significant and long-term negative effect on the persons' ability to execute their daily activities (3). Nowadays, approximately 16% of the global population has a significant disability (4).

There are many types of disabilities, which can affect a person's vision, movement, thinking, remembering, learning, communication, hearing, mental health, and social relationships (5). In this dissertation they will be grouped and discussed as physical or intellectual.

Focusing on physical disabilities, they are defined as a limitation that affects a person's physical functioning, mobility, dexterity, or stamina (3). This paper will focus on the physical disabilities that impact mainly people's mobility, associated frequently with neuromuscular and orthopaedic disorders (2).

On the other hand, intellectual disability, as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (6), states that it is a neurodevelopmental disorder that needs to meet the following three criteria for the diagnosis to be made:

1. Deficits in intellectual functioning, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning and learning from experience, confirmed by clinical assessment as well as individualised and standardised IQ testing;
2. Deficits in adaptive functioning which result in failure to thrive developmentally and meet sociocultural standards. Without continuous support, individual independence and the ability to meet their social responsibilities are limited;
3. These onsets occur during childhood.

Sexual and reproductive health and rights is a comprehensive concept that encompasses four major areas: sexual health, reproductive health, sexual rights, and

reproductive rights. Sexual health is defined by “a state of physical, emotional, mental and social well-being in relation to sexuality” and “not merely the absence of disease, dysfunction and infirmity.” For sexual health to be achieved, besides being required to assure positive, pleasurable, and safe sexual experiences, sexual rights must be respected, protected, and fulfilled. These include rights to equality and non-discrimination; to be free from torture or cruel, inhumane or degrading treatment or punishment; privacy; the highest feasible standard of health and social security; to marry and to found a family and enter into marriage with the free and full consent, and to equality in and at the dissolution of marriage; to decide the number and spacing of one's children; to information, as well as education; to freedom of opinion and expression; and to an effective remedy for violations of fundamental rights (7). Therefore, it is possible to conclude that sexual rights meet human rights in various fields, and as stated by the Universal Declaration of Human Rights, everyone is entitled to all rights and freedoms described in it without distinction (8), which includes people with disabilities.

The aim of this narrative review is to analyse how medical staff, including medical professionals and students, perceive and act on the sexual and reproductive health and rights of people with physical and intellectual disabilities, considering their own experiences and those of their disabled patients.

Methods

A comprehensive literature search was conducted to identify relevant studies for inclusion in this narrative review. PubMed® database was the source for this review, and articles were searched using the combination of keywords and terms as follows: (“Sexual Health”[Mesh] OR “Sexuality”[Mesh] OR sexuality OR “sexual health” OR “reproductive health” OR “sexual and reproductive health” OR “sexual rights” OR “sexual and reproductive rights” OR “reproductive rights”) AND (“Students, Medical”[Mesh] OR “Physicians”[Mesh] OR “Medical Staff”[Mesh] OR “Education, Medical”[Mesh] OR “medical student*” OR “medical professional*” OR physician* OR “medical education” OR “medical school” OR “undergraduate medical” OR clinician* OR “healthcare provider*” OR “healthcare professional*” OR “healthcare student*” OR “healthcare undergraduate*” OR “primary care” OR doctor*) AND (“Intellectual Disability”[Mesh:NoExp] OR “Disabled Persons”[Mesh:NoExp] OR “intellectual disabilit*”[tw] OR “intellectually disabled”[tw] OR “physical disabilit*”[tw] OR “physically disabled”[tw] OR “people with disabilit*”[tw] OR “disabled people” [tw] OR “disabled person*”[tw] OR “person with disabilit*”[tw] OR “persons with disabilit*”[tw] OR “cognitive disabilit*”[tw] OR “mental retard*”[tw] OR “mentally retarded”[tw] OR “developmental disabilit*”[tw]) AND (“Attitude”[Mesh] OR “Health Behavior”[Mesh:NoExp] OR “Knowledge”[Mesh] OR “Professional-Patient Relations”[Mesh] OR “Delivery of Health Care”[Mesh] OR “Health Knowledge, Attitudes, Practice”[Mesh] OR percept* OR attitud* OR beliefs OR behavio* OR knowledge). Filters were applied to only show results with full-text or free full-text available.

The search method was designed to gather relevant articles published from 2013 up until the cut-off date of May 2023. The database search was carried out between April and May 2023.

Inclusion and Exclusion Criteria

Articles were selected if they met the following inclusion criteria:

1. Studies that focused on the topic of interest;
2. Studies written either in English or Portuguese;
3. Studies that provided sufficient information for data extraction and synthesis.

Articles were ruled out if they met any of the exclusion criteria:

1. Studies that did not focus on the topic of interest;
2. Studies not written neither in English nor Portuguese;
3. Studies that focused on specific conditions that confer disabilities;
4. Studies that did not include medical students or professionals' perceptions;
5. Studies that were review articles, editorials, case reports, essays, clinical reports or in-focus articles;
6. Studies that lacked sufficient information for data extraction and synthesis.

From the made research, 155 results were shown. After applying the inclusion and exclusion criteria, 25 articles were selected to conduct the narrative review.

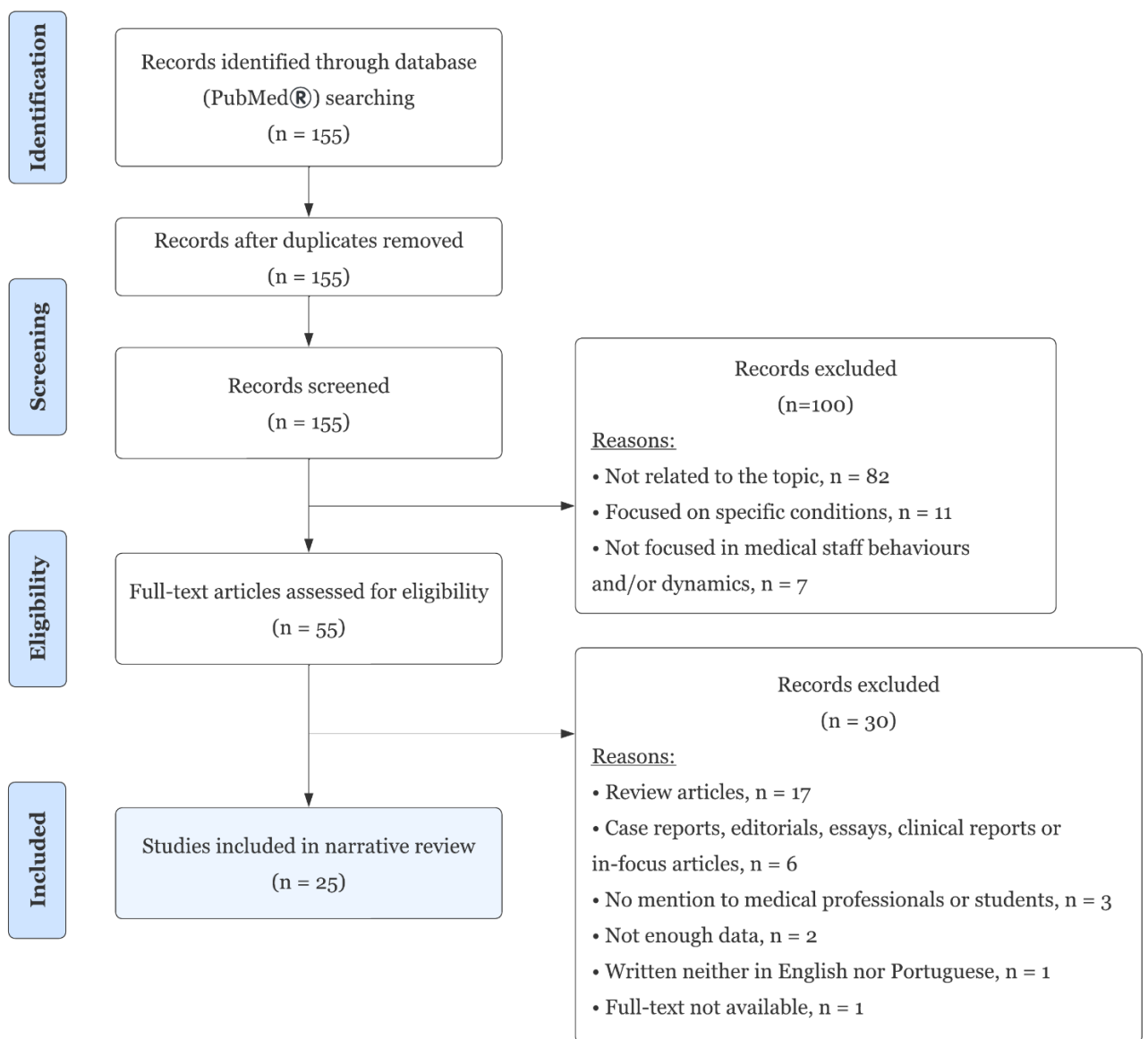


Figure 1 – Flow diagram of narrative review research methods

Results

The selected articles include studies collecting information from participants from the United States (n=11), Canada (n=2), Ghana (n=2), Uganda (n=2), Zambia (n=2), Ethiopia (n=1), Mexico (n=1), Netherlands (n=1), Poland (n=1), Israel (n=1), Nepal (n=1) and Australia (n=1). In addition to articles focused on more general aspects of medical professionals' and medical students' attitudes, some focused on perspectives concerning specific sexual and reproductive health topics, such as sexual and reproductive education (n=1); sexual abuse (n=1); adolescence and puberty (n=3); menstruation (n=1); contraception (n=3); gynaecological examination (n=2); pregnancy and antenatal care (n=4); childbirth and postnatal care (n=1); and HIV (n=2).

The results described below include perspectives of medical students, physicians, people with physical and/or intellectual disabilities and their caregivers.

Table 1 - Included studies evaluating medical students and professionals' behaviours and dynamics towards persons with disabilities' SRHR.

Author	Country	Participants (number and field)	Methodology	Main results
Horner-Johnson et al. (2021) (9)	United States	Women with physical, intellectual, or sensory disabilities (n = 17)	Multiple-category focus group design	<ul style="list-style-type: none"> Physical inaccessibility and time constraints Inability to provide needed accommodations Inaccessible formats of clinic forms and information provided Negative attitudes and disrespectful behaviour Assumptions made about PWD's sexuality Obstructions to access to PWD's desired contraceptive methods Referred occasional situations in which PWD's wishes were assessed and respected and acknowledgement that they have the same desires as non-disabled peers

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<p>Agaronnik et al. (2020) (10)</p>	<p>United States</p>	<p>Physicians (n = 42) Individual interviews (n = 20): Non-rural setting (n = 20) Focus Groups (n = 22): Rural setting (n = 7); non-rural setting (n = 16)</p>	<p>Open-ended individual interviews and video-based focus group interviews</p>	<p>Assumptions that PWD are not sexually active and could not be responsible caregivers Some providers talk directly to PWD, while others disregard them and talk to their caregiver Uncertainty and unpreparedness to discuss SRH and perform screening procedures on PWD Contraception methods defined by disability type and level of patients' presumed adherence, with references to sterilisation</p>
<p>O'Connor-Terry and Harris (2022) (11)</p>	<p>United States</p>	<p>Women aged 18-35 years old who had a mobility, sensory or intellectual disability (n = 16)</p>	<p>Prospective qualitative study (semi-structured interview)</p>	<p>Assumptions that PWD are unable to become pregnant or that their lives would be in danger if they did Lack of support to PWD considering pregnancy Contraceptive methods, including sterilisation, used mainly for menstrual management Some medical providers, however, do not withhold the possibility of PWD becoming pregnant</p>
<p>Lindsay (2021) (12)</p>	<p>Canada</p>	<p>Healthcare professionals (n = 21): Physicians (n = 2); Other (n = 19)</p>	<p>Secondary analysis of interviews</p>	<p>Sex viewed as taboo and lack of attention to sex-related issues Uncertainty if PWD understand what is being explained to them Unpreparedness to approach non-normative gender identities. Some providers make efforts to create a safe, respectful space</p>

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<p>Agmon, Sa'ar and Araten-Bergman (2016) (13)</p>	<p>Israel</p>	<p>Attendees at a rehabilitation day-care centre (n = 35)</p>	<p>Qualitative anthropological methods - participant observation and in-depth open interviews</p>	<p>Infantilising and desexualising attitudes; beliefs of lack of control over PWD's bodies Physicians direct the explanation only to PWD's relatives or caregivers</p>
<p>Wudneh et al. (2022) (14)</p>	<p>Ethiopia</p>	<p>Women with physical and/or sensory disabilities (n = 22)</p>	<p>Qualitative, descriptive, phenomenological study design with in-depth interviews</p>	<p>Positive aspects are evident in some obstetric care settings, including immediate postnatal care Verbal abuse (shouting, yelling, insults, negative comments) Physical abuse (slapped, pinched, forcefully wide opening their legs during childbirth, restraining PWD in a supine position) Communication barriers; neglect and abandonment; violation of privacy Not addressing the PWD's specific needs</p>
<p>Schmidt et al. (2021) (15)</p>	<p>United States</p>	<p>Healthcare providers (n = 12): Physicians (n = 2); other (n = 10)</p>	<p>Semi-structured interviews</p>	<p>Efforts made to talk privately with PWD and to provide patient-centred care Difficulty starting the conversation and assessing if the provided information is understood by PWD Some providers report being more comfortable providing information to male patients Lack of knowledge about or access to appropriate resources and referrals Recognition that SRH should be addressed with PWD</p>

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Ganle et al. (2016) (16)	Ghana	Women with disabilities (n = 72): Physical disability (n = 47) Sensory disability (n = 25)	Multi-methods study; analyses of retrospective survey data and qualitative research using focus group discussions, in-depth interviews, case studies, and structured field observations	<p>Physical inaccessibility and inability to assist efficiently</p> <p>Negative attitudes about disability and reproduction; assumptions on PWD being asexual and on what they can or cannot do</p> <p>Insensibility from providers</p> <p>Lack of knowledge and training on PWD care</p>
Kirkpatrick et al. (2022) (17)	United States	Physicians (n = 16)	Individual semi-structured interviews	<p>A majority assume that PWID are incapable of engaging in sexual relationships and parenting, while others defend the opposite</p> <p>Concerns on PWD being victims of sexual abuse</p> <p>Several providers do not ever provide SRH care, while others describe giving SRH counselling in every visit</p> <p>Discomfort in addressing SRH with PWD</p> <p>Menstruation considered as priority on SRH care, whereas it is the main reason for contraception; expressed ethical and legal concerns on sterilising procedures</p>
Kröger et al. (2022) (18)	The Netherlands	Healthcare regulators (n = 5); Physician (n = 1); Former residential healthcare clients (n = 2); Other (n = 4)	Explorative, qualitative interviews	<p>Sexuality viewed as taboo and discomfort on addressing sexuality, sexual needs and boundaries, even though it is considered important to do so</p> <p>Conflicting perspectives on what is considered sexually appropriate for a PWD</p>

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Mitra et al. (2017) (19)	United States	Women with physical disability (n = 126)	Survey with closed and open-ended questions	<p>Over a third of participants perceived that physicians hold negative attitudes on PWD parenthood</p> <p>Concerns on their ability for parenting and on the effects of disability on pregnancy, with 40,3% of PWD reporting that their provider knew a little or nothing about the effects of PD on pregnancy</p> <p>Efforts made to learn more about pregnancy on PWD</p> <p>Physical limitations</p>
Horner-Johnson et al. (2022) (20)	United States	Women with physical, intellectual, or sensory disability (n = 17)	Multiple-category focus group design	<p>Sexuality seen as taboo</p> <p>Incomplete information and lack of knowledge about contraceptive side effects and alternatives</p> <p>Limited opportunities for shared contraceptive decision-making</p> <p>Complex language, whether written or spoken</p>
Parchomiuk (2013) (21)	Poland	Healthcare students (total n = 181): Emergency medical services (n = 29); other (n = 152)	Likert type scale and semantic differential	<p>SRH care for PWD scarcely included in medical training</p> <p>Positive attitudes on friendship and love</p> <p>Negative attitudes on sexual education, sexual needs, sexual intercourse, and parenthood</p> <p>Contraception highly prioritised for PWD, with contradicting attitudes on sterilisation</p> <p>Some students believe that it is impossible to control PWD's sexual desires, while others consider PWD as deprived of</p>

				sexual needs or normalise their sexuality
Devkota et al. (2017) (22)	Nepal	Healthcare providers: Physicians, health assistants and auxiliary health workers (n = 87); other (n = 309) Women with disabilities (n = 18)	Mixed-method approach: survey on healthcare providers and in-depth interviews on women with disabilities	<p>PWD care is rarely included in medical school; a minority of providers who have given maternal healthcare received some training on PWD care;</p> <p>Contradicting experiences from PWD: kind, caring and respectful physicians or discouraging, rude and abusive</p> <p>Uncertainty on how to communicate with PWD, with mentions to distant and avoidant communication and physicians talking only to their relatives or caregivers</p> <p>Difficulty to understand PWD's needs</p> <p>Incomplete information provided and lack of knowledge</p> <p>Physicians' prejudice and expressed concern on SRH decisions made by PWD</p> <p>Favourable attitudes more frequently shown by males and younger providers</p> <p>No differences found between providers who received or not disability-related training</p>
Márquez-González, Valdez-Martínez and Bedolla (2021) (23)	Mexico	Records from patients with intellectual disability (n = 50)	Cross-sectional, descriptive chart review study	<p>Non-therapeutic hysterectomy is one of the most common procedures performed in females with intellectual disability</p> <p>Justifications to make the procedure comprise fertility control, menstruation management, and protection from the risk of sexual abuse</p>

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Mac-Seing et al. (2022) (24)	Uganda	<u>In-depth interviews:</u> Other (n = 7) <u>Focus groups:</u> Health service providers (n = 60); other (n = 8) <u>Two-day workshop:</u> Health staff (n = 27); health managers (n = 7)	In-depth semi-structured interviews, focus groups and two-day participatory workshop	Physical limitations Perceptions of PWD being sexually inactive and unable to engage in sexual activities or parenting, therefore not needing SRH care services Arrogant, discriminatory attitudes from providers Lack of knowledge on how to take care of PWD
Parsons, Bond and Vixon (2015) (25)	Zambia	People with disabilities HIV-positive (n = 21); Key informants (n = 11)	In-depth semi-structured interviews	Dehumanisation and marginalisation Assumptions that PWD are asexual and stigma about pregnancy and disability Stereotypes of victimhood Lack of access to information about HIV
Garavatti, Tucker and Pabian (2019) (26)	United States	Medical students (n = 20); other (n = 20)	Survey with likert scales - RSI, ATDP and IDP	Interprofessional education improved attitudes on medical students around PWD's sexuality
Seidu et al. (2023) (27)	Ghana	Physicians/Physician Assistants (n = 32); Other (n = 367)	Mixed-method study design: cross-sectional study in the quantitative phase and phenomenological approach in the qualitative phase	Never being married and working in smaller health centres are related to negative attitudes Male providers, working in district hospitals and receiving training are related to more favourable attitudes Lack of training Lack of skills and discomfort to provide SRH care to PWD Beliefs that PWD are unable to engage in sexual activities Inadequate SRH resources for PWD Compassion and benevolence, educational support and awareness

				creation to overcome the presented barriers Physical inaccessibility and time constraints
Du Mont et al. (2013) (28)	Canada	People with disabilities (n = 194): Intellectual (n = 39); physical (n = 71); other (n = 93)	Client satisfaction survey	PWD were less likely to rate sexual abuse healthcare services as excellent or good Nonetheless, 96% would recommend the service to others
Schenk et al. (2018) (29)	Ghana, Uganda and Zambia	<u>Key informant interviews:</u> Service providers / program managers for HIV services (n = 15); other (n = 6) <u>Focus Group Discussions:</u> People with visual and physical disabilities (n = 71); People with hearing impairments (n = 66); People with intellectual disabilities' caregivers (n = 56); HIV+ people with sensory and physical disabilities (n = 70)	Multi-country exploratory situation analysis: key informant interviews and focus group discussions	Medical providers' perception that PWD are asexual or are not sexually active Negative reactions to PWD's pregnancies Demeaning, abusive, and offensive interactions Limited HIV information available for PWD Complex language on educational materials Perceived signs of positive evolution on providers' attitudes
Secor-Turner, McMorris and Scal (2017) (30)	United States	<u>Key informant interviews:</u> Physicians and others (n = 10) <u>Surveys:</u> People with physical disability (n = 337)	Secondary analysis of data from a prospective, longitudinal study with qualitative key informant interviews and quantitative survey	Lack of SRH information or counselling, with 38% of survey participants indicating that they learned about SRH from healthcare providers Taboos on talking about sexuality with youth, even though it is acknowledged that is important to discuss sexuality with PWD to prevent sexual abuse Recognition that sexual development is an important part of adolescence

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				<p>Occasional efforts to have private conversations with PWD</p> <p>Contraception is a prioritised issue in female youth, to manage menstruation or prevent pregnancies</p>
Peters and Cotton (2014) (31)	Australia	Women with physical disabilities (n = 12)	Qualitative descriptive design: in-depth interviews	<p>Dehumanisation and neglect of PWD's needs</p> <p>Inadequate communication with PWD, including strict commands</p> <p>Inadequate assistance to PWD and inflicted pain, torture and humiliation</p> <p>Insensitive and unfriendly medical providers</p> <p>Time constraints</p>
Kalpakjian et al. (2020) (32)	United States	Women with physical disabilities (n =81)	Semi-structured focus groups and interviews	<p>Physical limitations</p> <p>Lack of knowledge and limited information on sexual healthcare for PWD</p> <p>Assumptions that PWD are not sexually active, therefore SRH is not seen as a priority</p> <p>Negative experiences around pregnancy, with unprepared or insensitive providers</p> <p>Hesitation from provident on when to start a conversation and communication directed to relatives or caretakers</p> <p>Conflicting attitudes between providers and patients on decision-making</p> <p>Contraceptive methods used to prevent pregnancy or suppress menstruation;</p> <p>Willingness to make accommodations improved access to care and</p>

				strengthened patient-provider relationships
Nery-Hurwit et al. (2022) (33)	United States	Women with physical disabilities (n = 59)	Original qualitative study, focus groups and individual interviews	<p>Dehumanisation</p> <p>Sexuality seen as taboo and not a priority</p> <p>Assumptions that PWD are asexual or are unable to engage in sexual activities or in parenthood</p> <p>PWD's concerns dismissed or attributed to their disability</p> <p>Imposing contraceptive methods, including sterilisation, while not discussing them</p> <p>Inability to provide relevant SRH information to PWD</p> <p>Mention to some positive experiences, with understanding and unbiased providers</p>

Attitudes of medical students

One of the studies included for the review focuses on medical students' attitudes towards the sexuality of people with intellectual disabilities, pre- and post-exposure to a formal discussion period in a multidisciplinary team (21).

A duality is noted about the view that persons with disabilities are sexual beings. On the one hand, medical students argue that persons with disabilities are not able to control their sexual desire. On the other hand, people with disabilities are also believed to be asexual and devoid of sexual needs.

Students displayed a positive attitude towards the possibility of these individuals engaging in romantic relationships, although negative attitudes towards marriage are shown.

Regarding contraception, there is a shared view that contraceptive methods are important for people with disabilities, which may be related to the fact that parenthood in

this group is not supported by medical providers. Additionally, there are references that support sterilisation, which is acknowledged as a means to protect individuals from sexual abuse.

Medical students in this study believe that sexuality education for this group could have negative effects in the sense that it could increase the awareness of people with disabilities about their sexual needs. They also express themselves negatively towards engaging in acts of masturbation or sexual intercourse with other people as ways of meeting their sexual needs.

In conclusion, within the group that was interviewed, there are opposing perspectives on how the sexuality of people with intellectual disabilities should be viewed: while some of them are in favour of normalising the sexuality of this group, others display unfavourable attitudes towards the sexuality of people with disabilities. (21)

Attitudes of medical professionals

Health professionals internalize negative and stigmatizing attitudes towards the sexuality of people with disabilities, which results in discriminatory and disrespectful behaviours towards this group when seeking sexual and reproductive health care (9–11,22,24,25,27,32,33). In some cases, these attitudes are caused by professionals themselves being mocked by their colleagues for trying to communicate with people with disabilities (27).

Resulting from these kinds of postures, people with disabilities sometimes prefer to go without healthcare rather than be exposed and victimised by the negative attitudes of healthcare professionals (25).

Assumptions are often made about people with disabilities, without individualising care to each individual seeking it (9,11,17,30).

In some cases, doctors are responsible for preventing people with disabilities from obtaining the desired and expected care (9,22,24).

Discomfort in approaching topics related to sexual and reproductive health was identified in some studies, which in turn makes it difficult to discuss these topics with people with disabilities (18,22). In one of the studies included for this literature review, health professionals mentioned feeling more comfortable providing information on sexual and reproductive health to male clients (15).

Furthermore, physicians have difficulty in establishing effective communication with patients with disabilities - sometimes justified with lack of preparation -, even though most of them recognise its importance (10,15,19,22,27,29,32). However, they often communicate solely with their caregivers and family members, and in some cases, intentionally (10,13,17,22,32), even if the patient has only a physical disability (13,32). It should be borne in mind that this behaviour puts patients' right to confidentiality at risk, as highly sensitive information is shared indiscriminately with third parties without their consent (27).

Sexuality and sexual and reproductive health are still seen as taboo topics, either by health professionals or by people with disabilities (12,18,20,30), resulting in discussion of these topics in consultation settings being the exception rather than the rule (32). If this is not initially addressed by professionals, it is less likely to be exposed by people seeking health services (12,33) - except in rare cases where patients who are able to advocate for their needs initiate the discussion (33). Consequently, a snowball effect is faced, stemming into less knowledge of the main problems concerning sexual and reproductive health that people with disabilities face (12).

It is often assumed that people with disabilities, due to their condition, are asexual and devoid of feelings or cognitions regarding their sexuality (12,13,16,17,24,25,27,29,32,33). The view that desexualizes these individuals may be related to the view that the conditions conferring disability have many practical implications in the daily life of the person who has it, making sexuality dispensable (32,33). In addition, they are prone to being infantilised by medical professionals (12,13), as well as being seen as vulnerable (17,25). On the other hand, the lack of control over their body and behaviours is also suggested by health professionals, which contradicts the previously mentioned perspective (13). These behaviours are depicted in one of the studies, where the one person mentions that they have already been humiliated for masturbating (33).

However, some physicians counter the aforementioned considerations by confirming that people with disabilities have the same feelings and desires as their non-disabled peers, as well as being able to have an active sexual life (17,29) and therefore sexual and reproductive health should be accessible to this group (15,18).

Informal contact with people with disabilities, whether in person or through the representation of these individuals in the media, has also been highlighted as a factor that may have a positive impact on attitudes towards people with disabilities (27).

Other factors impacting on physicians' attitudes towards the sexuality of people with disabilities are gender, age, number of years in practice, marital status and work location. More favourable attitudes were found in male health professionals (22,27); the fact that they are or have been married; and practising in urban or district health units (27). Conversely, doctors who are older and have been practicing for more years have more negative attitudes (22), as well as those practicing in rural health units (27).

In one of the studies reviewed, health professionals were more resistant to broaching the subject of marriage with people with disabilities, indicating that they hold more negative attitudes on the subject (27).

There are reported experiences in which health professionals devalued the complaints that people with disabilities brought to the appointment by avoiding the addressed or justifying that it is due to the disability itself and not related to their sexual and reproductive health (33).

One of the included studies reports that only a minority of people with physical disabilities encountered realistic perceptions of their condition and associated limitations (29), even though this is a common concern for these individuals (32).

However, persons with disabilities have identified in some cases positive interactions with health professionals, in environments that are understanding and devoid of stigmatizing attitudes (9,33). This resulted in facilitated access to information about their sexual and reproductive health, as well as expressed support in their sexuality and promotion of the possibility of living their sexuality in a healthy and autonomous way (33).

There are also references to professionals who make efforts to provide quality advice on sexual and reproductive health in every encounter with their disabled patients (17). Some also use visual aids to ensure that the information provided is more effectively assimilated (10).

Training of medical staff

Regarding the training of medical staff, there are mentions of the infrequent occurrence of training moments on health care for people with disabilities, and even rarer is the approach to topics on their sexual and reproductive health (16,21,22,27). A study conducted in Nepal reports that although the majority of professionals surveyed had some contact with persons with disabilities, less than 7% had training in caring for this group of patients (22).

Additionally, physicians are not aware of appropriate sources of information that they can consult to be more aware of specific issues related to the healthcare of these individuals (15).

As an effect, it culminates in increased difficulty in understanding the needs of this group and poor sexual and reproductive health care provision (22,27,32), which may also result in misdiagnosis and dissatisfaction of people seeking these services (27). One of the patients, in the study conducted by Nery-Hurwit et al, reports that she feels the need to teach the attending professionals about what care should be provided to her (33).

A study focusing on the attitudes of medical students before and after they are exposed to multidisciplinary education about caring for people with disabilities shows that this exposition results in a significant improvement in students' attitudes (26). Another of the included studies corroborates that professionals who have received some form of training about people with disabilities also generally have more positive attitudes towards them (27).

Privacy

Some professionals, whenever possible and according to the level of understanding by the persons with disabilities, join efforts to speak privately with the person with disabilities to be accompanied (15).

Nonetheless, clinicians report some insecurities in how to ensure privacy and confidentiality at certain times with people with disabilities when they disclose more sensitive issues. In this sense, professionals are not sure under what circumstances they should or should not be shared and discussed with carers or family members (12).

Gender identity and sexual orientation

Some health professionals point out that they do not feel prepared to explore non-normative gender identities and sexual orientations with their patients. However, there are many who seek to create conditions in which the subject can be approached safely and sensitively (12).

In addition, they ask for easy access to appropriate terminology that allows them to address the issue with their patients in a comprehensive manner (15).

Sex education

A minority of people with disabilities confirm receiving information on sexual and reproductive health through their doctors, even though this group's contact with health services is very frequent (30,33). Consequently, the insufficient information accessible to them directly impacts on their ability to make a conscious and informed decision (32).

Health professionals report that the lower level of understanding of people with disabilities and the lack of knowledge about quality information resources suitable for them, are barriers to sharing quality sexual and reproductive health education. They also share uncertainty about whether people with intellectual disabilities understand the information they are given (15).

The effort made by health professionals in seeking to obtain more information, whether formal or through the experiences of the very people who seek their services, is valued by people with disabilities (32). However, clinicians identify insufficient access to resources and practical guidelines that guide the approach to sexual and reproductive health with individuals with intellectual disabilities, as well as health information that focuses on the specificities of sexual and reproductive health care for people with disabilities (15,16,32).

Sexual abuse

Medical professionals show concern about the increased risk of people with disabilities being victims of sexual abuse (10,17). In this sense, they believe it is important to educate people with disabilities about sexual and reproductive health from an early age in order to decrease the likelihood of these events (17,18,30).

Insufficient training to guide health professionals is a factor that makes addressing this issue more challenging (15). In addition, the reluctance to address the issue is mentioned, given that the person perpetrating the abuse may be the one accompanying the person with disabilities to the appointment who, in turn, will prevent the exploitation of this type of acts (10).

In a Canadian study of sexually abused women with disabilities, patients were less likely to rate the care provided as good or excellent. Nevertheless, the majority of those interviewed recommend the care provided to them (28).

Adolescence and puberty

Doctors recognise that sexual development is an important component of adolescence and that exploring one's sexuality is a normal and necessary behaviour of this phase, regardless of whether or not one has a disability. However, few children and adolescents receive formal information from health professionals about sexual and reproductive health (30).

Health professionals report that it is important to provide information and educate youth on how to fulfil their sexual needs and desires according to their condition, which may only be accessible through physicians (30).

Of the young people who participated in the study conducted by Secor-Turner, McMorris and Scal (30), two-thirds reported having had a private conversation with the doctor, a condition that was more often assured when the adolescent confirmed being sexually active.

Menstruation

Menstruation is also a topic that some doctors report feeling uncomfortable approaching with people with disabilities, as they consider it to be taboo and/or lack skills to adapt the discussion to the level of understanding of people with intellectual disabilities (12).

When menstruation is addressed, it is usually done to control the effects of menstruation, such as causing amenorrhoea (11,17,23,30) or to prevent unwanted or unplanned pregnancies (30), without exploring other factors associated with this process. Some health professionals report having been asked about the possibility of performing hysterectomy in people with disabilities in order to abolish menstruation which appears to be difficult to control for some people with disabilities and their relatives/carers (17), while others confirm having effectively performed this procedure (10,23). A study developed in Mexico reports that this practice is still regularly carried out in people with intellectual disabilities in this country, without any therapeutic intent and, in some cases, at a premenarcheal stage (23).

However, when the intention to control menstruation for therapeutic reasons - such as preventing dysmenorrhoea or regulating menstrual flow - comes directly from people with disabilities, they are eventually faced with resistance from health professionals (32).

Contraception

People with disabilities, regardless of type, face multiple barriers to obtaining quality contraceptive care (9).

In persons with disabilities who are sexually active, it is appropriate to consider the administration of some method of contraception. However, professionals have some reservations regarding therapeutic compliance, depending on the severity of the disability (10). Moreover, people with disabilities are often forcibly subjected to contraceptive methods (10,20,23,33), just as these are chosen without taking into account the preference and autonomy of people with disabilities (20,23,33), being them little involved in the whole process.

In some cases, persons with disabilities are automatically referred for sterilization interventions (11,33). When questioned, doctors refer to doing so in order to eliminate the possibility of a new human being being brought to life that the disabled person would not be able to care for, as well as to prevent sexual abuse (10,17,23). In cases of severe to profound disability, sterilization is a routine practice for some health professionals (10).

People with disabilities identify insufficient access to information on contraceptive methods. They are sometimes unaware of the expected effect of taking a particular contraceptive method, the possibility of side effects and the existence of alternative forms of contraception. Consequently, there may be important adverse effects that are not reported by people with disabilities. (20) Furthermore, it is important that these individuals are adequately informed to ensure that they choose their contraceptive method conscientiously (32).

Further, professionals themselves do not have adequate knowledge about what effects these methods might have on people with physical disabilities, which may stem from information not being available in any form (20). Sometimes, that is the principle behind the displayed resistance on behalf of health professionals to provide contraceptive methods (32).

While there is consistent evidence of doctors' negative attitudes towards contraception for people with disabilities, there are also reports of people considering that they have been properly exposed to the different methods available, as well as being included in the process of deciding which contraceptive method to use (20).

Gynaecological examination

People with disabilities report the importance of professional-patient communication about gynaecological examination, pre- and during procedures (32). However, studies mention the lack of preparation of health professionals to perform them on people with intellectual disabilities (10,32,33).

Health professionals have concerns about examining patients with intellectual disabilities. In one of the included studies, a gynaecologist shows a preference for sedating the people with disabilities they examine, on the grounds that they may not understand the reason for the health professional's constant physical contact. (10)

Other professionals argue that Pap smears should not be performed on all women with disabilities, especially those with severe to profound intellectual disability, and some argue that people with disabilities in general are not sexually active and are therefore at lower risk of cervical cancer (10). Consequently, people with disabilities are less encouraged to seek health services for routine screening, resulting in fewer and later diagnoses of cervical and breast cancers in this population, as well as a higher morbidity and mortality rates (33).

Pelvic examination can be traumatising for people with physical disabilities, as the physical examination may induce pain and due to the exposure throughout the process - the need for support of third parties at the time of examination may bring about feelings of humiliation (32).

Regarding breast cancer screening, people with disabilities reported feeling dehumanized and without the possibility of advocating for their interests and needs. They describe that during the mammogram they were positioned by the professionals without ensuring their comfort, which resulted in pain, fear for their safety and humiliation. In addition, there was no commitment to guarantee that the indications given were properly understood by the individuals. (31)

Maternal health

Pregnancy and antenatal care

Maternity among people with disabilities is a controversial issue among physicians. The maternal health care of people with disabilities who intend to become pregnant, on the part of the health services, is deficient (11,22,27). Firstly, people with disabilities report the

infrequent approach by doctors regarding their desire to become pregnant (11), although there are cases in which professionals do so (17). When they are questioned, some patients report receiving negative reactions from health professionals as they confirm their intention (19,29).

The basis for the presented postures is related to health professionals not looking at patients with disabilities as beings with a desire to become pregnant and be mothers (24,33). Furthermore, they refer that a pregnancy in a person with disability is accompanied by increased challenges and may even put their own life at risk (10,11,19). In other situations, it is considered that people with disabilities are not able to ensure the proper care that a new human being needs, so doctors oppose the maternity of these people (10) - even though, in some, this belief could not be further from reality (19). The potential conflict between the preventive or castrating attitude of the health professional and the willingness of the person to take these risks may compromise the patient's autonomy (32).

People with disabilities generally report that health professionals have not provided them with sufficient and quality information about their pregnancies (22,32). It is also described that health professionals have rude and abusive behaviours during their care of pregnant women with disabilities (22).

On this issue, there are, however, positions that favour the possibility of carrying out a pregnancy and generating a child (11). Some patients with disabilities reported being treated with sensitivity, empathy and respect (22). Finally, a study highlights that although doctors have little knowledge about the specificities of prenatal care that should be delivered to people with disabilities according to their underlying condition (19,32), some attempt to bridge these gaps (19).

Childbirth and postpartum care

Women with disabilities very often report violations of their rights to dignified health care in these circumstances. Nevertheless, there are also reports describing positive experiences of childbirth and postnatal care. (14)

Firstly, a study mentions that few women were advised by health professionals to deliver in a health facility and none of them were explained the importance to perform postpartum check-ups (22). Besides that, a study mentions that the information provided on how physical disability might affect pregnancy and on the specifics of labour according to their condition is insufficient (19). In addition, people with disabilities mention episodes where they sensed insecurity from health professionals regarding the process of labour (22).

Obstetric violence is often a reality experienced by people with disabilities. It comprises physical aggression - such as slapping, pinching, forcing the legs apart - even if it causes intense pain -, among other forms of physical aggression during childbirth. These behaviours are justified as encouragement or a necessary act for the woman with disabilities to be able to deliver successfully. (14)

In addition, many people with physical disabilities are forced to stay in the commonly practised lithotomic position at the time of delivery, even if this entails significant discomfort. This act is of greater violence when women, due to the limitations implied by their physical disability, are unable to cooperate with health professionals, resulting in the latter pushing more harshly. (14)

Regarding verbal violence, assaults include shouting, insults and derogatory comments related to their physical disability, their decision to become pregnant and their alleged inability to be mothers. (14)

Finally, other violent acts mentioned by persons with disabilities are of abandonment, neglect of their needs and violation of their privacy. (14)

Sexually Transmitted Infections

In one of the studies analysed there is reference to the fact that doctors do not discuss sexually transmitted infections with people with disabilities (33). Additionally, in two articles, it was possible to analyse physicians' perceptions regarding Human Immunodeficiency Virus (HIV), whose results are as follows.

People with disabilities living with HIV report being devalued in health facilities, naming interactions that include offensive and humiliating comments (25,29). They even report being met with a surprised reaction from professionals when they seek health services (25), given that the most common route of transmission of this infection is sexual and this suggests that infected people have had sexual intercourse (25,29).

In the study conducted by Parsons, Bond and Nixon (25), there is an account of a disabled patient who was forced to convince the doctor that they needed HIV care and still had to show the positive result.

The insufficient exposure of this group to quality sex education hinders the access to information about HIV, and the knowledge of people with disabilities about the various

aspects of the disease is very limited (25,29). However, there is evidence of interest in obtaining more information about the infection (29).

Consequently, the barriers evidenced induce to less access to health services and subsequent greater morbidity and mortality in this population. (25)

However, there is a positive evolution in the attitude of health professionals (29).

Other barriers

The limited time available for each appointment is also an obstacle to access to the necessary health care, as it does not allow for a effective assessment and discussion about the sexual and reproductive health of the person with disabilities (9,10,27,31). One study mentions that the willingness of health professionals to spend more time with the person with disabilities throughout the consultation process has a positive impact on the professional-patient relationship (32).

Another barrier to be highlighted is the language used with patients. The documents that are given to patients, whether informative or administrative, are full of medical jargon, which is manifestly very difficult to understand for people with intellectual disabilities (9,20,29). Moreover, even the language used by physicians in a conversational context is often too complex for their levels of understanding (20).

Sometimes the access of people with physical disabilities to health services is hampered by the physical conditions of the spaces - due to the existence of stairs (9), lack of space to move around with a wheelchair or non-levelling stretchers (16,19,24,27). In addition, health professionals often find it difficult to assist people with physical disabilities to be transferred or to adjust to the available medical supplies (9,16,24,27).

Discussion

In a generalized way, the attitudes and behaviours of doctors and medical students towards the sexuality of people with disabilities are unfavourable. The belief that persons with disabilities are asexual and therefore there is no need to discuss their sexuality or to provide them with sexual and reproductive health care is blatant. It is critical to demystify these perceptions that do not correspond to the reality experienced by these individuals (9,16,33).

When physicians address the sexual and reproductive health of people with disabilities, it is very often focused on providing contraceptive methods and to talk about sexual abuse.

While it is true that persons with disabilities are a more vulnerable group to sexual abuse (34), focusing health services on this issue is limiting to the wide-ranging of sexual and reproductive health overall. Furthermore, the argument occasionally given by medical providers that contraceptive methods are provided to decrease sexual abuse is a clinically erroneous assertion, since sexual abuse cannot be prevented by the lower or no likelihood of becoming pregnant.

In some studies, sterilisation is supported or quoted as a recurring practice, being more frequently carried out in adolescence or prepubertal stages, even though the ACOG has already stated that it is not recommended (35). This shows that the attitude of some physicians has not yet progressed from the castrating values defended decades ago. (36) Moreover, this is mostly done without the consent of the disabled people who undergo the procedure, which raises some ethical questions, namely the violation of their autonomy.

It was also possible to confirm that people with disabilities are denied access to maternal health care. When provided, the discriminatory attitude of health professionals is frequently handed out, which turns into the poor delivery of maternal health care, including episodes of obstetric violence.

Sexuality is highly influenced by social and cultural values. Fortunately, its approach has undergone a positive evolution, becoming less of a taboo, and the rights of people to live a healthy sexual and reproductive life have been more frequently advocated. However, the approach to sexual and reproductive health of people with disabilities in the medical context does not reflect this evolution, whose attitudes have shown little change from the negative

posture from decades ago (37,38). It is commonly mentioned the professionals' deficient interpersonal and communicational skills (22,27,29), as well as the discomfort in caring for people with disabilities in general. Furthermore, medical providers and students have little training and exposure to the specific needs of people with disabilities and their attitudes may be influenced by surrounding family, friends and cultural values that devalue the person with disabilities (21,22).

Although this is a minority, it should be noted that there are also health professionals who show more favourable attitudes towards the sexuality of people with disabilities and make efforts to meet the specific sexual and reproductive health needs of these individuals. This may be a reflection of a shift in societal perceptions of persons with disabilities' rights. Patients therefore value it when they are seen by doctors who are sensitive to their conditions.

Health, defined as a state of complete physical, psychological and social well-being (39), includes sexual and reproductive health. Thus, for persons with disabilities to live healthier lives, it is equally important that adequate, non-discriminatory sexual and reproductive health is promoted by health professionals. Furthermore, it is imperative that sexuality be de-centred from societal perceptions of what is considered "normal" and from ableism. A healthy and positive sexual life can also be lived without being focused exclusively on reproduction and in alternative ways to the phallocentric and heteronormative (30) and thus more inclusive of the sexual and reproductive health needs of people with disabilities.

Limitations and future directions

One of the main limitations of this study is that valuable information may have been lost, whether from articles whose terms included were alternative to those used in the search conducted, or whose articles were available in other databases than PubMed®. However, efforts were made to conduct a search that would allow for a comprehensive analysis on the studied subject.

The sample of articles included for the present study highlights the insufficiency of studies on the behaviour and dynamics that medical professionals have in relation to the sexuality of people with disabilities - both in an overall perspective, as well as in each specific component that sexual and reproductive health encompasses. Therefore, some of the results presented do not have robust evidence and cautions should be taken when generalising.

It is noteworthy that the studies included in this review, when they indicated the gender of the people to whom health services were delivered, focused mostly on female people, making little reference to the specific health needs and care of male people with disabilities. This may be due to men seeking sexual and reproductive health care less frequently than women (40,41). It was also found that none of the studies address the perceptions regarding sexuality of older people with disabilities, focusing mainly on adolescence and adulthood. In this sense, it is considered relevant to direct the studies to better analyse the attitudes towards sexuality of men and older people with disabilities.

Additionally, given the scarce representativeness of attitudes on a worldwide scale, beyond the United States of America and some countries on the African continent, it may be risky to generalise the conclusions drawn. Further studies are needed to examine whether the findings of this review are evidently representative.

Implications for practice and/or policy

For health services to be more inclusive in the provision of appropriate sexual and reproductive health care, awareness raising among health care workers is needed. The introduction of pre- and postgraduate training moments on the health care of people with disabilities is widely recommended (16,19,22,27,29–31). It is also suggested to empower medical providers to deliver health care individualized to each patient's needs and to communicate empathetically (31). Previous studies have confirmed the effectiveness of training in changing the attitude of health care students and professionals, making them more favourable towards people with disabilities (30,42).

On the other hand, information on the specific health care that should be delivered to people with disabilities is clearly insufficient. It may be prudent to research, write and share guidelines to direct the sexual and reproductive health care provided to these individuals. This will ensure that the information provided by health services is clear and follows the level of understanding of people with disabilities, as well as promote access to sexual and reproductive education for this group (9,20).

Furthermore, it is noticed that further studies are needed to analyse medical students' attitudes to sexuality in people with disabilities. This may help to identify specific gaps in undergraduate training that need to be addressed, both globally and locally.

Conclusion

In conclusion, the present literature review has verified a dichotomy in the behaviours and dynamics of health professionals towards the sexual and reproductive health of people with disabilities, even though it has a strong tendency towards the negative side. The stigmatising attitudes of health professionals widely evidenced may result in a lower search for health care by people with disabilities (9,14,24,27), an inability to make health decisions appropriate to their needs (31,33), in addition to the poor provision of sexual and reproductive health services.

Improved sexual and reproductive health care for persons with disabilities is urgently needed to mitigate inequalities in health care (9,16,25,32,43). This is possible with the implementation of services that are comprehensive and sensitive to patients' disabilities, as well as by training health professionals in order to make them aware of the needs of this group of people and provide them with skills to provide satisfactory and quality health care. Only in this way will it be possible to uphold the right to health as advocated by the Universal Declaration of Human Rights (8).

References

1. United Nations. Convention on the Rights of Persons with Disabilities [Internet]. 2006 [cited 2023 May 19]. Available from: <https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>
2. Scully C. Impairment and disability. In: Scully's Medical Problems in Dentistry. Elsevier; 2014. p. 676–86.
3. Legislation.gov.uk. Equality Act 2010 [Internet]. 2010 [cited 2023 May 19]. Available from: <https://www.legislation.gov.uk/ukpga/2010/15/introduction>
4. World Health Organization. Disability [Internet]. 2023 [cited 2023 May 19]. Available from: <https://www.who.int/news-room/fact-sheets/detail/disability-and-health>
5. Centers for Disease Control and Prevention. Disability and Health Overview [Internet]. 2020 [cited 2023 May 19]. Available from: <https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html>
6. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. 2013.
7. World Health Organization. Sexual and Reproductive Health and Research (SRH) [Internet]. [cited 2023 May 19]. Available from: <https://www.who.int/teams/sexual-and-reproductive-health-and-research/key-areas-of-work/sexual-health/defining-sexual-health>
8. United Nations. Universal Declaration of Human Rights [Internet]. 1948 [cited 2023 May 19]. Available from: <https://www.un.org/sites/un2.un.org/files/2021/03/udhr.pdf>
9. Horner-Johnson W, Klein KA, Campbell J, Guise JM. Experiences of Women With Disabilities in Accessing and Receiving Contraceptive Care. JOGNN - Journal of Obstetric, Gynecologic, and Neonatal Nursing. 2021 Nov 1;50(6):732–41.

10. Agaronnik N, Pendo E, Lagu T, DeJong C, Perez-Caraballo A, Iezzoni LI. Ensuring the reproductive rights of women with intellectual disability. *J Intellect Dev Disabil*. 2020;45(4):365–76.
11. O'Connor-Terry C, Harris J. Pregnancy decision-making in women with physical disabilities. *Disabil Health J*. 2022 Jan 1;15(1).
12. Lindsay S. Healthcare providers' perspectives with addressing sex-related issues and sexual identity within pediatric rehabilitation: A qualitative study. *Disabil Health J*. 2021 Jul 1;14(3).
13. Agmon M, Sa'Ar A, Araten-Bergman T. The person in the disabled body: A perspective on culture and personhood from the margins. *Int J Equity Health*. 2016 Sep 15;15(1).
14. Wudneh A, Cherinet A, Abebe M, Bayisa Y, Mengistu N, Molla W. Obstetric violence and disability overlaps: obstetric violence during child birth among womens with disabilities: a qualitative study. *BMC Womens Health*. 2022 Dec 1;22(1).
15. Schmidt EK, Beining A, Hand BN, Haverkamp S, Darragh A. Healthcare providers' role in providing sexual and reproductive health information to people with intellectual and developmental disabilities: A qualitative study. In: *Journal of Applied Research in Intellectual Disabilities*. John Wiley and Sons Inc; 2022. p. 1019–27.
16. Ganle JK, Otupiri E, Obeng B, Edusie AK, Ankomah A, Adanu R. Challenges women with disability face in accessing and using maternal healthcare services in Ghana: A qualitative study. *PLoS One*. 2016 Jun 1;11(6).
17. Kirkpatrick L, Collins A, Harrison E, Miller E, Patterson C, Sogawa Y, et al. Pediatric Neurologists' Perspectives on Sexual and Reproductive Health Care for Adolescent and Young Adult Women With Epilepsy and Intellectual Disability. *J Child Neurol*. 2022 Jan 1;37(1):56–63.
18. Kröger C, van Baarle E, Widdershoven G, Bal R, Weenink JW. Combining rules and dialogue: exploring stakeholder perspectives on preventing sexual boundary violations in mental health and disability care organizations. *BMC Med Ethics*. 2022 Dec 1;23(1).

19. Mitra M, Akobirshoev I, Moring NS, Long-Bellil L, Smeltzer SC, Smith LD, et al. Access to and Satisfaction with Prenatal Care among Pregnant Women with Physical Disabilities: Findings from a National Survey. *J Womens Health*. 2017 Dec 1;26(12):1356–63.
20. Horner-Johnson W, Klein KA, Campbell J, Guise JM. “It Would Have Been Nice to Have a Choice”: Barriers to Contraceptive Decision-making among Women with Disabilities. *Women’s Health Issues*. 2022 May 1;32(3):261–7.
21. Parchomiuk M. Model of intellectual disability and the relationship of attitudes towards the sexuality of persons with an intellectual disability. *Sex Disabil*. 2013 Jun;31(2):125–39.
22. Devkota HR, Murray E, Kett M, Groce N. Healthcare provider’s attitude towards disability and experience of women with disabilities in the use of maternal healthcare service in rural Nepal. *Reprod Health*. 2017 Jun 29;14(1).
23. Márquez-González H, Valdez-Martínez E, Bedolla M. Clinical, Epidemiologic and Ethical Aspects of Hysterectomy in Young Females With Intellectual Disability: A Multi-Centre Study of Public Hospitals in Mexico City. *Front Public Health*. 2021 Nov 18;9.
24. Mac-Seing M, Ochola E, Ogwang M, Zinszer K, Zarowsky C. Policy Implementation Challenges and Barriers to Access Sexual and Reproductive Health Services Faced By People With Disabilities: An Intersectional Analysis of Policy Actors’ Perspectives in Post-Conflict Northern Uganda. *Int J Health Policy Manag*. 2022 Jul 1;11(7):1187–96.
25. Parsons JA, Bond VA, Nixon SA. ‘Are we not human?’ Stories of stigma, disability and HIV from Lusaka, Zambia and their implications for access to health services. *PLoS One*. 2015 Jun 3;10(6).
26. Garavatti E, Tucker J, Pabian P. Utilization of an interprofessional integrated clinical education experience to improve medical and physical therapy student comfort in treating patients with disabilities. *Education for Health: Change in Learning and Practice*. 2018 Sep 1;31(3):155–62.
27. Seidu AA, Malau-Aduli BS, McBain-Rigg K, Malau-Aduli AEO, Emeto TI. “Sex Should Not Be Part of the Lives of Persons with Disabilities, but They Are Human

- Beings Too”: Perceptions of Healthcare Providers and Factors Affecting Service Delivery in Ghana. *Healthcare (Switzerland)*. 2023 Apr 1;11(7).
28. Du Mont J, Macdonald S, White M, Turner L. She was truly an angel: Women with disabilities' satisfaction with hospital-based sexual assault and domestic violence services. *J Forensic Nurs*. 2013;9(3):129–39.
 29. Schenk KD, Tun W, Sheehy M, Okal J, Kuffour E, Moono G, et al. “Even the fowl has feelings”: access to HIV information and services among persons with disabilities in Ghana, Uganda, and Zambia. *Disabil Rehabil*. 2020 Jan 30;42(3):335–48.
 30. Secor-Turner M, McMorris BJ, Scal P. Improving the Sexual Health of Young People With Mobility Impairments: Challenges and Recommendations. *Journal of Pediatric Health Care*. 2017 Sep 1;31(5):578–87.
 31. Peters K, Cotton A. Barriers to breast cancer screening in Australia: Experiences of women with physical disabilities. *J Clin Nurs*. 2015 Feb 1;24(3–4):563–72.
 32. Kalpakjian CZ, Kreschmer JM, Slavin MD, Kisala PA, Quint EH, Chiaravalloti ND, et al. Reproductive Health in Women with Physical Disability: A Conceptual Framework for the Development of New Patient-Reported Outcome Measures. *J Womens Health*. 2020 Nov 1;29(11):1427–36.
 33. Nery-Hurwit MB, Kalpakjian CZ, Kreschmer JM, Quint EH, Ernst S. Development of a Conceptual Framework of Sexual Well-being for Women with Physical Disability. *Women's Health Issues*. 2022 Jul 1;32(4):376–87.
 34. Mahoney A, Poling A. Sexual Abuse Prevention for People with Severe Developmental Disabilities. *J Dev Phys Disabil*. 2011 Aug 3;23(4):369–76.
 35. ACOG Committee Opinion No. 448: Menstrual Manipulation for Adolescents With Disabilities. *Obstetrics & Gynecology*. 2009 Dec;114(6):1428–31.
 36. Reilly PR. Involuntary Sterilization in the United States: A Surgical Solution. *Q Rev Biol*. 1987 Jun;62(2):153–70.
 37. Satchidanand N, Gunukula SK, Lam WY, McGuigan D, New I, Symons AB, et al. Attitudes of healthcare students and professionals toward patients with physical disability: A systematic review. Vol. 91, *American Journal of Physical Medicine and Rehabilitation*. 2012. p. 533–45.

38. Leavesley G, Porter J. Sexuality, fertility and contraception in disability. *Contraception*. 1982 Oct;26(4):417–41.
39. World Health Organization. Constitution of the World Health Organization. In: *Basic Documents*. 49th Edition. 2020.
40. Burrell CN, Sharon MJ, Bassler J, Davidov DM. Gender Differences in Sexual Health Knowledge Among Emerging Adults in Acute-Care Settings. *Journal of Osteopathic Medicine*. 2019 May 1;119(5):289–98.
41. Metz ME, Seifert MH. Men's expectations of physicians in sexual health concerns. *J Sex Marital Ther*. 1990 Jun;16(2):79–88.
42. Symons AB, McGuigan D, Akl EA. A curriculum to teach medical students to care for people with disabilities: development and initial implementation. *BMC Med Educ*. 2009 Dec 30;9(1):78.
43. Dyer K, das Nair R. Why don't healthcare professionals talk about sex? A systematic review of recent qualitative studies conducted in the United Kingdom. Vol. 10, *Journal of Sexual Medicine*. Blackwell Publishing Ltd; 2013. p. 2658–70.