

## Sexuality & Disability

### Introduction

The discourse in Ireland surrounding sexuality and disability is largely paternalistic and concentrates primarily on issues of protection. This discourse is reinforced formally by legislation and public policy and informally by the social perpetuation of stereotypes and myths. Consequently, people with disabilities are often denied the possibility of exploring and enjoying their sexuality.

The Irish Family Planning Association (IFPA) is committed to promoting the rights of every person to a sexual identity and the rights of every person to access sexual and reproductive health (SRH) services. Realising these rights necessitates addressing the barriers to SRH experienced by people from a variety of life circumstances. In its role as a mainstream sexual and reproductive health provider and as SRH advocate, the IFPA recognises that people with disabilities constitute a large and diverse population who experience a multitude of barriers to achieving sexual and reproductive health. In collaboration with people with disabilities and disability rights organisations, the IFPA has undertaken to examine the issues affecting SRH of people with disabilities in Ireland and develop strategies to remedy their current invisibility in SRH programme design and delivery.

The following report deals with the first strand of the IFPA plan by giving an overview of the conception of disability and sexuality, the current national and international legal situation, myths and stereotypes, sexual and reproductive health service provision and finally recommendations for actions.

### Sexuality

Sexuality is an integral part of being human and can include sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is more than just genital contact and can be experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. Furthermore, sexuality does not exist in a vacuum and is necessarily influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. While sexuality can include all of these dimensions, not all of them are always experienced or expressed (WHO, 2006).

### Sexual and Reproductive Health

Sexual and reproductive health (SRH) is not just the absence of disease but is a state of physical, emotional, mental and social well-being related to sexuality and reproduction. SRH requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. SRH is a fundamental human right of every person (International Conference on Population and Development, 1994).

### Disability

*“The term “persons with disabilities” applies to all persons who have long-term physical, mental, intellectual or sensory impairments that, in the face of various negative attitudes or physical obstacles, may prevent those persons from participating fully in society”*

(United Nations Convention on the Rights of Persons with Disabilities, 2006)

In recent years, the concept of disability has moved away from a traditional medical model of disability towards a social model. The medical model focussed on people's specific impairments as being the main factor inhibiting full participation in society. Any impairment was seen as something that was different from the norm and must therefore be “cured” in order to conform to that norm. In the 1970s, the medical model was increasingly challenged and ultimately rejected by people with disabilities in favour of a social model. From the social model perspective, environmental and attitudinal barriers to inclusion are socially constructed and serve to create the disabling conditions experienced by people with impairments. The focus of this model, therefore, is on changing society to meet the needs of disabled people as equal citizens instead of focussing on individual impairments (Gannon & Nolan, 2006).

### Disability and Gender

The social model of disability is a more progressive approach to addressing the inequalities experienced by people with disabilities. However, it is an insufficient model because it ignores the role that gender plays in creating doubly disabling conditions for women, especially with regards to SRH. The social model is based on the assumption that disabling conditions impact upon men and women in the same way and to the same degree. In reality, men have greater access to power, capital, decision making, education, resources and public space than women. Although disabled men and women constitute the most marginalised of almost every society, the gender imbalance still exists. Disabled women are more likely than disabled men to be poorer, achieve lower educational outcomes, face medical interventions to control their fertility and experience sexual violence (Meekosha, 2005). Furthermore, women have unique sexual health risks such as unplanned pregnancy, higher susceptibility to sexually transmitted infections and cervical and breast cancer.

### The Rights of Disabled People to Sexual and Reproductive health

Advocating for equal access to mainstream sexual and reproductive health services and a positive, healthy understanding of sexuality requires a multi faceted approach that goes beyond the social model of disability. It requires a perspective that acknowledges intersection between disability, gender, race, sexual orientation, age, socio economic status and other factors but does not privilege one over another. A human rights-based approach can accommodate all the above mentioned factors because it is premised on the inherent dignity and equality of all persons. International human rights documents, treaties, conventions and standards provide the platform from which the rights of disabled people to sexual and reproductive health can be realised.

In order to understand the rights of disabled people to SRH, we must start with the acknowledgment that all people have a right to their own sexuality. Although this may seem an obvious point, Irish law does not reflect this principle for people with intellectual disabilities (see below for further details) and public policy is based on this legislation. This kind of selective application of rights is fundamentally incompatible with a human rights framework and must be remedied.

The right to sexuality and sexual and reproductive health for every person can be found in the following human rights principles which are recognised in international treaties and conventions such as the European Convention on Human Rights, Universal Declaration on Human Rights, International Covenant on Civil and Political Rights, Convention on the Elimination of All Forms of Discrimination Against Women, International Covenant on Economic, Social and Cultural Rights, Beijing Platform for Action, International Conference on Population and Development :

- The right to equality and non discrimination
- The right to marry and found a family
- The right to reproductive health, including family planning and maternal health services, information and education
- The right to physical integrity
- The right to respect for private and family life
- The right to benefit from scientific progress
- The right to freedom of expression

### The United Nations Convention on the Rights of Persons with Disabilities

The decision to add a universal human rights instrument specific to persons with disabilities was borne of the fact that, despite being theoretically entitled to all human rights, persons with disabilities are still, in practice, denied those basic rights and fundamental freedoms that most people take for granted (United Nations, 2007).

The United Nations General Assembly adopted the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2006. Ireland signed the CRPD in 2007 but has not yet incorporated it into domestic law. This means that until ratification, Ireland must refrain from acts that would defeat the purpose of CRPD but is not legally bound its terms.

CRPD is a particularly useful advocacy tool because Articles 23 & 25 provide explicit rights to sexuality and sexual health services for people with disabilities:

#### **Article 23 – Respect for home and the family**

1. *States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others so as to ensure that:*

*(a) The right of all persons with disabilities who are of marriageable age to*

*marry and to found a family on the basis of free and full consent of the intending spouses is recognised.*

- (b) The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided.*
- (c) Persons with disabilities, including children, retain their fertility on an equal basis with others.*

### **Article 25 – Health**

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities for health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

- (a) Provide persons with disabilities with the same range, quality and standard of free affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based health programmes.

### **Criminalisation of Consensual Sexual Relationships in Irish Law**

Section 5 of the Criminal Law (Sexual Offences) Act 1993 (hereafter 1993 Act) makes it a crime for a person who has or attempts to have sex with a person who is “mentally impaired” unless they are married to each other. If convicted under this legislation, a person may face a maximum penalty of 10 years in prison.

Because Section 5 of the 1993 Act does not allow for a defence of consent, the effect of this legislation is to criminalise mutually consensual sexual relationships between adults with intellectual disabilities.

In 1990, the Law Reform Commission (LRC) reported that the role of the law with regards to people with intellectual disabilities and sexuality should be to respect the right to sexual fulfilment and also to protect against sexual exploitation.

Section 5 of the 1993 Act defines “mental impairment” as:

*“Suffering from a disorder of the mind, whether through mental handicap or mental illness, which is of such a nature or degree as to render a person incapable of living an independent life or guarding against serious exploitation.”*

In a 2005 consultation paper and a 2006 report, the LRC considers both the concept and the definition of “mentally impaired” under the 1993 Act unsatisfactory. The LRC regards the language of the 1993 Act as being out of date with current understanding of disability and notes the “regrettable effect” of criminalising consensual sexual relationships between people with intellectual disabilities. The LRC further states that the “test of ability to guard against exploitation constitutes a better yardstick of capacity to consent than ability to lead an independent life because some degree of dependency would not necessarily preclude an ability to consent.”

### Capacity to Consent

The LRC recommends that the capacity of intellectual disabled people to consent to sexual relationships should be legally interpreted in terms of functional capacity to understand the nature and consequences of the act. The UK Sexual Offences Act 2003 reflects this understanding of consent and can be used as a model for potential Irish legislation.

Another avenue to developing a more appropriate concept of capacity can be found in the Mental Capacity and Guardianship Bill 2007 (2007 Bill) currently under review in the Oireachtas. The 2007 Bill defines capacity as “the ability to understand the nature and consequences of a decision in the context of available choices at the time the decision is to be made”. Although the 2007 Bill is a civil Bill and will not amend existing criminal law, it could provide the statutory basis to advocate for change in the criminal law.

### Irish Public Policy

In 2000, the Irish government adopted a policy of mainstreaming public services for people with disabilities. The policy was realized through legislation such as the Equal Status Act 2000 & 2004 and the Disability Act 2005 and also through several strategic plans such as the National Health Strategy, the National Women’s Strategy 2007-2016 and the National Disability Strategy. The legislation and strategies placed an obligation on public services to facilitate access to buildings, information and services and also required key government departments to design Sectoral Plans that ensure access for people with disabilities will become an integral part of service planning and provision. The strategic plans recognise that people with disabilities are currently underserved in the health system and places special emphasis on addressing the barriers that prevent people with disabilities from getting the services they need. Furthermore, the Equality Authority, as a statutory agency, encourages all public services to define access as not only physical adjustments such as installing a ramp but also meaningful commitment to improving services to meet individual needs by adopting a planned and systematic approach to equality.

Although not specifically stated, these public policies apply to sexual and reproductive health services as well. However, due to the legal situation, cultural representation of

disability, social and physical barriers and prejudicial assumptions on behalf of doctors, nurses, administrators, carers and parents, these policies are not meaningfully implemented to ensure ease of access for people with disabilities to SRH services.

### Harmful Myths and Stereotypes

Various, conflicting myths with respect to sexuality and disability prevail in society which perpetuate and reinforce the marginalisation and discrimination of people with disabilities. Examples of some myths include:

- All disabled people have the same needs
- All disabled people are heterosexual
- All disabled people are asexual or hyper sexual
- Information and education about sex will encourage “inappropriate” sexual behaviour
- Intellectually disabled people are incapable of understanding sexuality
- Physically disabled people are unable to have sex
- Disabled people cannot/should not be parents
- Disabled people should be grateful for any type of sexual relationship

### Service Provision

Over protective laws, non implementation of public policy and harmful stereotypes and myths converge at the level of service provision. The impact of this negative convergence is exclusion from services designed to meet individual needs of achieving sexual health.

Exclusion from SRH services occurs when people with disabilities experience a combination of social, emotional and physical barriers that serve to prevent access. Some common barriers to access include:

- Doctors or nurses that subscribe to the harmful stereotypes noted above;
- Doctors or nurses who are not informed of the ways in which certain medications can impact upon a person’s sexuality;
- Clinical environments that are difficult to navigate. For example, examination tables that are not height adjustable, reception counters that are very high, no parking close to the entrance, narrow hallways and small bathrooms;
- Doctors and nurses who do not routinely inquire about the client’s sexual health or discuss preventative health such as cervical and breast screening;
- Lack of information in appropriate formats such as large print, easy to understand language or Braille;
- Lack of awareness that people with disabilities and women in particular are much more likely to experience sexual violence and for longer periods of time;
- Lack of sex education creates conditions under which people with disabilities may not know if there is a problem with their sexual and reproductive health or have the language to express their concerns;

- Services that provide residential care for people with intellectual disabilities who actively discourage relationships or ignore the sexual health needs of clients for fear of facilitating the commission of a crime.

### Moving Forward

This report outlines some of the key concepts related to sexuality and disability but is by no means exhaustive. Further investigation is required into other issues such as reproduction, genetic testing, assisted sexuality, participatory research, sex education, sexual orientation and socialising opportunities. However, with regards to the issues and concepts presented in this report the following recommendations can be made:

- Advocate for changes in the criminal law to recognise the right of intellectually disabled people to pursue consensual relationships
- Encourage the Irish government to ratify the UN Convention on the Rights of Persons with Disabilities
- Apply a human rights framework to all policies regarding sexuality and disability
- Recognise the intersection of gender, sexual orientation, race, age and other factors with disability
- Challenge harmful myths and stereotypes by raising awareness among health service providers, policy makers, legal professionals, politicians, the general public and the media.
- Include positive representations of people with disabilities in mainstream sexual health education
- Inform people with disabilities about their rights
- Train people with disabilities to advocate on their own behalf
- Be proactive about making service environments more accessible and inclusive
- Introduce policies and procedures so that health care staff will know how to best serve their clients;
- Investigate and research further issues including reproduction, genetic testing, assisted sexuality, participatory research, sex education, sexual orientation and socialising opportunities;
- Ensure meaningful commitment to improving services by adopting a planned and systematic approach to equality.

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