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Review Article

Initiating Sexual Life: Uncovering the HIV Risks for People with Disabilities in Bujumbura

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ABSTRACT

This article compares the characteristics of sexual initiation among people with and without disabilities in Bujumbura, focusing on age at first sexual encounter, relationships with the first partner, age difference between partners, who initiated the sexual encounter, and male contraceptive use. The data are drawn from the HandiSSR survey conducted between 2017 and 2018 in Bujumbura. This survey uses stratified random sampling, including 600 people with disabilities and 600 people without disabilities (control group). We used matching to ensure comparability between groups and statistical tests to analyze the observed differences. The results show that people with disabilities initiate sexual activity at the same age as their peers without disabilities. These findings reveal that people with and without disabilities begin their sexual lives at similar ages, challenging outdated notions that people with disabilities are asexual or less sexually active. However, people with disabilities are more likely to have older and casual first partners, which increases their risk of adverse outcomes. Although male contraceptive use at the first sexual encounter is similar between the two groups, the reasons for non-use among people with disabilities include forced intercourse, highlighting an increased vulnerability to sexual coercion. These findings underscore the need for tailored public health policies to improve access to sexual education and protective practices among people with disabilities, in order to reduce their risk of HIV infection and enhance their sexual health outcomes.

Keywords: Disability; Sexual initiation; HIV; Vulnerability

INTRODUCTION

The initiation of sexual life is an important stage in individuals' lives, with significant implications for their sexual and reproductive health. The behaviors and circumstances surrounding this first sexual experience play a determining role in the exposure to Sexually Transmitted Infections (STIs), including HIV. For people with disabilities, this phase may involve additional challenges and risks due to stigma, discrimination and limited access to health services tailored to their needs.

People with disabilities often face unique barriers to sexual health. They may have specific needs for sexual education and STI prevention, including HIV, which are not always addressed in public health programs. Studies show that people with disabilities are often less informed about safe sexual practices and have limited access to sexual health resources and services. Groce et al., emphasize that this population is often overlooked in awareness and sexual education campaigns, making them more vulnerable to STIs [1].

Moreover, people with disabilities are more likely to experience sexual and physical violence, increasing their vulnerability to sexually transmitted infections, including HIV. Shapiro et al., demonstrated that this population is frequently exposed to abuse and violence, further complicating their ability to negotiate male contraceptive use and protect themselves against STIs [2].

Including people with disabilities in HIV research and prevention programs is essential to ensure they receive protection and support tailored to their specific needs. It is

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important to understand the characteristics of the sexual initiation process among people with disabilities and the associated risks of HIV infection to develop effective interventions.

The primary objective of this article is to compare the characteristics of the sexual initiation process between people with and without disabilities in Bujumbura. Specifically, it aims to examine the differences between these two groups in terms of age at first sexual intercourse, relationship with the first sexual partner, age difference with the partner, who initiated the first sexual encounter and male contraceptive use. By exploring these aspects, this research seeks to fill an important gap in the current literature and provide essential data for the development of inclusive and effective public health policies. It underscores the importance of considering the specific needs of people with disabilities in HIV prevention strategies to reduce inequalities in sexual and reproductive health.

LITERATURE REVIEW

The initiation of sexual life is a critical stage in individual development, influenced by a complex combination of biological, psychological, social and environmental factors. This literature review explores in depth the characteristics of the sexual initiation process and the associated risks of HIV infection, integrating theoretical perspectives and empirical findings to better understand these complex dynamics.

Several theoretical models can explain the differences in the characteristics of the sexual initiation process between people with and without disabilities.

The theory of dominance and submission provides a powerful analytical framework for understanding how unequal power relations influence sexual behavior. This theory highlights how the vulnerability of people with disabilities can be exploited through coercive behaviors, exacerbating the risks of trauma and sexually transmitted diseases [3,4].

Intersectionality theory allows for the examination of how various forms of discrimination and marginalization intersect, creating complex levels of vulnerability. This model is essential for understanding how people with disabilities, facing multiple forms of discrimination based on disability, gender, race, or social class, may be particularly exposed to increased risks of sexual exploitation [5,6].

In parallel, the theory of sexual aggression explores the underlying motives of coercive and violent behaviors towards people with disabilities. This theory helps to understand how some individuals may be driven by a desire for power or control and how they exploit perceived vulnerabilities to commit sexual assaults [7,8].

The theory of social predation also provides a framework for understanding how certain individuals systematically target people perceived as vulnerable for personal gain. This theory analyzes the strategies of psychological manipulation and control used by social predators to maintain their dominance [9,10].

Finally, risk management theory allows for an understanding of how people with disabilities perceive and respond to sexual risks in different contexts. It examines how these individuals assess the risks of contracting sexually transmitted infections and manage these risks based on their social and personal environment [11,12].

Beyond these theories, empirical findings have enabled the comparison of sexual initiation characteristics between groups of individuals.

Age at first sexual intercourse

The age at first sexual intercourse is a key indicator of individuals' sexual behavior and can have significant repercussions on sexual and reproductive health. Research shows that early age at first sexual intercourse is associated with an increased risk of risky sexual behaviors, including not using male contraceptives and having multiple sexual partners [13]. A study by de Graaf et al., revealed that adolescents having their first sexual intercourse at a young age are more likely to contract STIs and have unintended pregnancies [14]. Among people with disabilities, the age at first sexual intercourse may be influenced by additional factors such as limited access to appropriate sexual education and social stigma [15]. Reduced access to sexual education for people with disabilities is often due to erroneous perceptions of their sexuality, considering them as asexual or not requiring comprehensive sexual health information [16].

Nature of the relationship with the first sexual partner

The nature of the relationship with the first sexual partner plays an important role in the experience of sexual initiation. Studies show that relationships with casual partners are often associated with less frequent male contraceptive use and riskier sexual behaviors [17]. In contrast, relationships with regular partners are generally perceived as safer, although this may lead to decreased male contraceptive use due to perceived trust in the partner [18]. For people with disabilities, power dynamics and dependency can complicate their ability to negotiate male contraceptive use and establish healthy and consensual sexual relationships [19]. Studies also show that people with disabilities are more likely to experience sexual abuse from regular partners, negatively affecting their ability to insist on male contraceptive use.

Age difference between sexual partners

The age difference between sexual partners can have significant implications for the power and dynamics of the relationship. Studies have shown that relationships with a large age difference, particularly when the male partner is much older, are associated with increased risks of sexual coercion and violence, as well as less frequent male contraceptive use [20]. This phenomenon is particularly relevant for young women and adolescents, who may feel less capable of negotiating safe sexual practices with older partners [21]. For people with disabilities, this dynamic may be exacerbated by additional vulnerability factors related to their disability. Moreover, relationships with

older partners may expose young people with disabilities to exploitative situations, making it even more challenging to access protected and consensual sexuality [22].

Who initiated the first sexual encounter

The initiation of the first sexual encounter can reveal important aspects of power dynamics within the relationship. Studies show that when the sexual encounter is initiated by the male partner, there is often increased pressure on the female partner, which can lead to non-consensual sexual experiences and reduced male contraceptive use [23]. In contrast, when both partners participate in the decision, sexual encounters are more likely to be consensual and protected [24]. For people with disabilities, non-consensual sexual encounters are more frequent, highlighting the importance of educating and empowering this population to better negotiate and initiate consensual and protected sexual encounters [25]. Non-consensual encounters are often linked to contexts of violence and abuse and it is essential to provide psychological and legal support for these victims.

Male contraceptive use during the first sexual encounter

Male contraceptive use during the first sexual encounter is an important indicator of responsible sexual behavior and the prevention of STIs, including HIV. Research indicates that male contraceptive use during the first sexual encounter is associated with continued and consistent use thereafter [26]. However, various factors influence this use, including the level of sexual education, cultural norms and power dynamics within the relationship [27]. For people with disabilities, male contraceptive use can be particularly problematic due to a lack of access to appropriate sexual education and increased vulnerability to non-consensual sexual encounters. Limited access to adapted resources and health professionals aware of the specific needs of people with disabilities further complicates their ability to use male contraceptives effectively and regularly [28].

This literature review highlights that the characteristics of the first sexual encounter, such as age at first sexual intercourse, the nature of the relationship with the first sexual partner, the age difference between partners, who initiated the first sexual encounter and male contraceptive use during that first encounter, are significant indicators of HIV infection risks. These factors influence individuals' ability to adopt protected sexual behaviors and are essential for understanding the dynamics of risk related to sexual initiation, especially among people with disabilities.

Despite growing awareness of the unique challenges faced by people with disabilities in sexual health, significant gaps remain in the research. Existing studies primarily focus on general populations, often neglecting the specific experiences and needs of people with disabilities. Although the literature widely addresses sexual initiation and its associated risks in the general population, there is a lack of detailed comparative studies examining how these factors manifest differently for people with disabilities. In particular, the interaction between age at first sexual intercourse, the nature of the initial sexual relationship, age differences with partners, initiation dynamics and male contraceptive use has not been sufficiently explored considering disability-related factors. This study addresses these gaps by providing a comparative analysis of the characteristics of sexual initiation between people with and without disabilities in Bujumbura. By examining how these variables differ between the two groups, this research offers new perspectives on the specific challenges faced by people with disabilities. The findings of this article are essential for informing the development of targeted and inclusive public health interventions and policies aimed at reducing inequalities in sexual health.

Conceptual model and research hypotheses

The literature review reveals that the characteristics of the sexual initiation process vary significantly between people with and without disabilities. These differences are largely influenced by unequal power dynamics and specific vulnerabilities faced by people with disabilities. These factors can exacerbate the risks of HIV infection during their sexual initiation. Considering these observations, we formulate the following hypotheses:

General hypothesis

People with disabilities have distinct characteristics in their sexual initiation process compared to people without disabilities, which could influence their exposure to the risk of HIV infection.

Specific hypotheses

Some of the specific hypotheses includes:

Hypothesis 1: The timing of the first sexual intercourse is earlier among people with disabilities than among people without disabilities. This hypothesis is based on the idea that people with disabilities may initiate sexual life earlier due to their social context and specific pressures they face.

Hypothesis 2: People with disabilities are more likely to have their first sexual intercourse with a casual partner compared to people without disabilities. This may be due to reduced opportunities to form stable relationships and increased vulnerability to less regular sexual encounters.

Hypothesis 3: People with disabilities are more likely to experience significant age differences with their first sexual partner compared to people without disabilities. This hypothesis is based on the idea that people with disabilities may more frequently be exposed to relationships with much older partners, reflecting power imbalances and negotiation power.

Hypothesis 4: People with disabilities are less likely to initiate their first sexual intercourse themselves compared to people without disabilities. This suggests that people with disabilities may often find themselves in situations where they are less able to take the initiative, possibly due to their specific vulnerabilities.

Hypothesis 5: People with disabilities use male contraceptives less frequently during their first sexual intercourse compared to

people without disabilities. This hypothesis is based on the idea that people with disabilities may have less power to negotiate male contraceptive use, potentially exposing them to an increased risk of HIV infection.

Sampling

The data used in this article are derived from the HandiSSR survey conducted in Bujumbura between 2017 and 2018. HandiSSR is a cross-sectional survey of people with disabilities, with a control group of non-disabled individuals with similar sociodemographic characteristics. Households were selected from the general population using a process that minimizes selection bias and people with disabilities were identified using the WG questionnaire within each selected household (screening phase). The assessment of disability in this article was conducted using the Washington Group tool, which is widely recommended for its proven reliability and validity. This tool, developed and validated by the Washington Group on Disability Statistics, is considered the gold standard for measuring disability consistently and strongly in surveys [29]. Empirical studies have demonstrated that the Washington Group Short Set of Questions on disability is not only reliable but also valid for capturing the various dimensions of disability across different cultural and geographical contexts [30,31]. By incorporating these questions into our survey, we benefited from a proven methodology, allowing for a more accurate and comparable assessment of disability levels among participants [32]. This approach ensures that the results obtained are robust and can be compared with those of other studies using the same instrument, thereby enhancing the credibility of our analysis [33].

Eligible people with disabilities were invited to respond to a questionnaire on their disability, socio-economic characteristics and sexual practices, including the characteristics of their sexual initiation process. Individuals in the control group were selected from the nearby vicinity of the selected individuals with disabilities. They were matched to people with disabilities based on gender, age and enumeration area. People with disabilities were selected following a two-stage stratified random sampling method that limits selection biases. In the first stage, Enumeration Areas (EAs) were selected with probability proportional to the number of households based on the sampling frame from the 2016 Demographic and Health Survey (DHS), which itself was derived from the 2008 General Population and Housing Census (RGPH). The total number of enumeration areas was calculated based on the targeted sample size. A sample of 600 people with disabilities aged 15 to 49 years and 600 matched individuals from the control group were selected. For the purposes of our study, we only selected individuals who had already had sexual intercourse and whose disability occurred before the age of 10. This was done to ensure that the first sexual intercourse occurred after the individual had become disabled. After this selection, the sample size used in this article consists of 152 people with disabilities and 152 control individuals.

Analysis variables

In this article, we use two types of variables:

Group variable: This variable is used to define the groups to be compared.

Comparison variables: These are the variables used to evaluate the differences between the study group and the control group in terms of their respective values.

This approach allows us to systematically analyze the characteristics and dynamics of the first sexual encounter between people with disabilities and their non-disabled counterparts.

Group variable

Group variable includes:

Disability: The "Disability" variable indicates whether a participant is disabled or not. This information is collected using the Washington Group tool. This variable has two categories: Disabled and Non-Disabled (control group).

Comparison variables

Some of the comparison variables such as:

Age at first sexual intercourse: This is a quantitative variable that gives the individual's age at first sexual intercourse.

Relationship with the first sexual partner: This is a qualitative variable with two categories: Regular partner (including spouse, boyfriend/girlfriend) and casual partners (including individuals met occasionally and sex workers).

Age difference with the first sexual partner: This is a qualitative variable with two categories: The partner was 10 years older and the partner was less than 10 years older.

Who initiated the first sexual intercourse: This is a qualitative variable with three categories: The respondent initiated the first sexual intercourse, the partner initiated the first sexual intercourse and both initiated the first sexual intercourse together.

Male contraceptive use during the first sexual intercourse: This is a dichotomous variable with two categories: Yes or no.

Analysis methods

To compare the characteristics of the first sexual intercourse between people with disabilities and their non-disabled counterparts in Bujumbura, we used a rigorous methodology, including matching and appropriate statistical tests.

Matching method: Each person with a disability was matched to a non-disabled control with similar characteristics in terms of age, gender and enumeration area. This was achieved during the initial sampling to ensure adequate comparability of the groups. Matching was verified to ensure that the observed differences were not due to variations in these demographic and geographic variables.

Statistical tests: We used the chi-square test to compare proportions between people with disabilities and their non-disabled counterparts regarding the characteristics of the first sexual encounter, such as the type of relationship with the first sexual partner (regular or casual). To compare median ages at first sexual intercourse, which follows a normal distribution, we applied the Student's t-test for independent samples. This test is appropriate for assessing whether the observed differences between the medians of the two groups are statistically significant.

RESULTS

The following table compares the characteristics of sexual initiation between people with and without disabilities in Bujumbura (Table 1).

Table 1: Characteristics of sexual initiation between people with and without disabilities in Bujumbur.

Variable	People with disabilities	Control group	Significance
Age at first sexual intercourse			
Median age at first sexual intercourse	17 (152)	19 (152)	ns
Relationship with first sexual partner			
Regular partner	83.6% (127)	92.8% (141)	***
Casual partner	16.4% (25)	7.2% (11)	***
Age difference with first sexual partner			
Partner is older by more than 10 years	26.9% (39)	17.1% (26)	***
The partner was about the same age or younger	73.1% (106)	82.8% (125)	***
Initiation of first sexual intercourse			
Study participant	7.2% (11)	10.6% (16)	**
Partner	27.6% (42)	17.2% (26)	**
Both	65.2% (99)	72.2% (109)	**
Male contraceptive use during first sexual intercourse	22.4% (34)	20.4% (31)	ns

Note: (*) significance level of statistical differences between the two groups (People with disabilities and control group).

Age at first sexual intercourse

The analysis reveals that the median age at first sexual intercourse is 17 years for people with disabilities and 19 years for people without disabilities. Although this difference suggests that people with disabilities tend to begin their sexual life earlier than people without disabilities, this difference is not statistically significant.

Relationship with the first sexual partner

Regarding the relationship with the first sexual partner, the results show that 83.6% of people with disabilities had a regular partner during their first sexual intercourse, compared to 92.8% of people without disabilities. Conversely, 16.4% of people with disabilities had their first sexual intercourse with a casual partner, compared to only 7.2% of people without disabilities. These significant differences suggest that people with disabilities are more likely to have casual partners for their first sexual encounter, which may increase their risk of HIV infection due to the potentially riskier nature of these relationships.

Age difference with the first sexual partner

The age difference with the first sexual partner also shows significant differences between the two groups. Among people with disabilities, 26.9% had a partner who was more than 10 years older, while this percentage is 17.1% among people without disabilities. Having a much older partner may be associated with imbalanced power dynamics, which can make it more difficult to negotiate safe sexual practices, such as male contraceptive use.

Initiation of the first sexual intercourse

The initiation of the first sexual intercourse also varies between the groups. Only 7.2% of people with disabilities initiated their first sexual intercourse, compared to 10.6% of people without disabilities. Additionally, 27.6% of people with disabilities reported that their partner initiated the intercourse, compared to 17.2% of people without disabilities. A significant proportion of 65.2% of people with disabilities and 72.2% of people without disabilities indicated that the initiation was mutual. These differences suggest that people with disabilities may be in positions where they have less control over the situation, which can increase their vulnerability to unwanted or risky sexual experiences.

Use of male contraceptive

The study results show no statistically significant difference in male contraceptive use during the first sexual intercourse between people with and without disabilities. Indeed, 22.4% of people with disabilities and 20.4% of people without disabilities used a male contraceptive during their first sexual intercourse. This difference is not statistically significant (Table 2).

Table 2: Among the reasons for not using a male contraceptive, two significant differences emerge between people with and without disabilities.

Reason for not using a male contraceptive during first sexual intercourse	People with disabilities	Control group	Significance
Trust in partner	27.1% (39)	23.1% (28)	ns
Unplanned intercourse	20.3% (24)	20.7% (25)	ns
Male contraceptive not available	15.25% (18)	26.4% (32)	***
Fear of suggesting male contraceptive use	18.6% (22)	23.1% (28)	ns
Intercourse was forced	10.2% (12)	3.31% (4)	***

Note: (*) significance level of statistical differences between the two groups (People with disabilities and control group).

Availability of male contraceptive: A significantly lower proportion of people with disabilities (15.25%) reported that a male contraceptive was not available, compared to 26.4% of people without disabilities. This difference can be interpreted as an indication that people without disabilities, being generally better informed about the usefulness of male contraceptive in protecting against STIs, are more likely to actively seek out a male contraceptive. In contrast, people with disabilities may face different obstacles, including a lack of adequate information about protection against STIs.

Forced sexual intercourse: A significantly higher proportion of people with disabilities (10.2%) reported that their first sexual intercourse was forced, compared to only 3.31% of people without disabilities. This difference highlights an increased vulnerability of people with disabilities to non-consensual sexual encounters. This further complicates their ability to negotiate male contraceptive use and protect themselves against sexually transmitted infections, including HIV.

In summary, the availability of male contraceptive constitutes a significant barrier for people without disabilities due to their better information and active search for protection. In contrast, people with disabilities are more often victims of forced sexual intercourse, which represents a major obstacle to their protection against STIs. These results underscore the need for tailored intervention strategies to improve the sexual health of people with disabilities, with a particular emphasis on education and the prevention of sexual violence.

DISCUSSION

The primary objective of this article was to compare the characteristics of the sexual initiation process between people with and without disabilities in Bujumbura, highlighting the differences in terms of age at first sexual intercourse, relationship with the first sexual partner, age difference with the partner, who initiated the sexual intercourse and male contraceptive use during the first sexual intercourse. By exploring these aspects, the study aimed to identify factors that could influence the risk of HIV infection among people with disabilities.

Age at first sexual intercourse

The results show that the median age at first sexual intercourse is 17 years for people with disabilities and 19 years for people without disabilities, with no statistically significant difference. These findings reveal that people with and without disabilities begin their sexual lives at similar ages, contradicting the outdated notions that people with disabilities are asexual or less sexually active [16,19].

Examining these results in light of theoretical frameworks and empirical research, it is clear that the lack of significant difference in the age at first sexual intercourse suggests that people with disabilities are not fundamentally different from their non-disabled peers in terms of the timing of their sexual

initiation. This finding challenges traditional stereotypes that perceive people with disabilities as less interested or less involved sexually. Instead, it highlights that people with disabilities are sexually active and initiate their sexual lives at the same time as their non-disabled peers.

Relationship with the first sexual partner

The results show that people with disabilities are more likely to have a casual partner during their first sexual intercourse compared to people without disabilities. This difference highlights an important aspect of the relational dynamics of people with disabilities, who tend to initiate their sexual lives in less established and more informal contexts.

This phenomenon aligns with previous research indicating that people with disabilities may face greater difficulties in forming stable and long-term relationships [34]. Barriers to establishing stable relationships may include factors such as social prejudice, limitations in access to social opportunities and specific disability-related barriers that may reduce opportunities to meet long-term partners.

Casual partners, often associated with less regular and potentially less safe sexual encounters, present an increased risk of STIs, including HIV. People with disabilities, who are more likely to begin their sexual lives with casual partners, may be exposed to less safe sexual practices, increasing their vulnerability to HIV. Research shows that the informal nature of these relationships can limit opportunities to negotiate safe sexual practices, including male contraceptive use [34].

Age difference with the first sexual partner

The study results reveal that people with disabilities are more likely to experience a significant age difference with their first sexual partner compared to people without disabilities.

Previous studies support this observation, showing that people with disabilities may be more frequently engaged in relationships with much older partners, which may reflect significant power imbalances [20]. These imbalances can have serious implications for the ability of people with disabilities to negotiate safe sexual practices. Older partners may exert disproportionate influence over decisions regarding sexual practices, including male contraceptive use, which could limit the opportunities for people with disabilities to protect their sexual health.

Initiation of the first sexual intercourse

The study results indicate that people with disabilities are less likely to have initiated their first sexual intercourse themselves. This difference is statistically significant and reflects distinct power dynamics between the two groups.

This observation is consistent with previous research highlighting the increased vulnerability of people with disabilities to situations where they have less control and decision-making power in their sexual relationships [25]. People with disabilities may often find themselves in contexts where they are less able to negotiate the terms of their sexual interactions, placing them at a disadvantage or at risk of coercion.

The lack of initiative in initiating sexual intercourse may be indicative of greater vulnerability to non-consensual or risky sexual experiences. People with disabilities may find themselves in situations where they must respond to the expectations or desires of their partners rather than expressing their own preferences and needs. This dynamic is concerning as it may limit their ability to exert control over sexual practices, including male contraceptive use, thereby increasing the risk of exposure to sexually transmitted infections such as HIV [25].

Additionally, the results show that people with disabilities are more likely to be in situations where the first sexual intercourse is initiated by their partner. This may suggest that these individuals have fewer opportunities to develop sexual communication and negotiation skills, which are important for protected and consensual sexual behaviors. Consequently, they may be less prepared to discuss and insist on the use of protection such as male contraceptive, which could increase their vulnerability to HIV and other STIs.

Male contraceptive use

Although there is no statistically significant difference in male contraceptive use during the first sexual intercourse between people with disabilities (22.4%) and people without disabilities (20.4%), the analysis of reasons for non-use reveals significant disparities that deserve particular attention.

First, regarding the availability of male contraceptive, a significantly lower proportion of people with disabilities (15.25%) reported that a male contraceptive was not available, compared to 26.4% of people without disabilities. This result suggests that physical access to male contraceptives is not a major barrier for people with disabilities. In contrast, people without disabilities seem more aware of the importance of protection against Sexually Transmitted Infections (STIs), which drives them to actively seek male contraceptive. For people with disabilities, more complex obstacles may exist, such as information gaps, social prejudice, or difficulties in accessing adequate health services. These obstacles may limit their ability to obtain and use male contraceptive effectively, despite their physical availability.

Second, the data show that a higher proportion of people with disabilities (10.2%) reported that their first sexual intercourse was forced, compared to only 3.31% of people without disabilities. This result highlights the increased vulnerability of people with disabilities to situations of sexual coercion. Non-consensual sexual encounters, in addition to exposing individuals to a high risk of HIV transmission, severely complicate the ability to negotiate male contraceptive use. People with disabilities may find themselves in situations where they have less power to impose conditions on their sexual partners or to demand adequate protection. This dynamic may exacerbate their vulnerability to sexually transmitted infections, underscoring the need for targeted intervention to promote safe sexual practices and ensure informed and respected consent in their relationships.

In conclusion, although male contraceptive use during the first sexual intercourse is similar between people with and without disabilities, the underlying reasons for non-use reveal distinct challenges faced by people with disabilities. The emphasis on information barriers and situations of sexual coercion indicates that additional efforts are needed to address these specific obstacles and improve access to protected sexual practices for this population.

CONCLUSION

This study aimed to compare the characteristics of the sexual initiation process between people with and without disabilities in Bujumbura, with a focus on age at first sexual intercourse, relationship with the first sexual partner, age difference with the partner, initiation of sexual intercourse and male contraceptive use. The results obtained provided a better understanding of the differences and similarities between these two groups, offering valuable insights for the formulation of adapted and inclusive public health policies.

The results show that people with disabilities begin their sexual lives at the same age as their non-disabled peers, challenging the stereotypes of asexuality. They are more likely to have a casual partner and a significant age difference, often with less negotiation power. Despite similar male contraceptive use, the reasons for non-use include forced intercourse, highlighting their vulnerability to sexual coercion.

These findings have significant scientific implications, emphasizing the need for more nuanced and inclusive approaches in HIV prevention strategies. Politically, it is important to develop awareness and sexual education programs tailored to the specific needs of people with disabilities to reduce infection risks and improve their sexual and reproductive quality of life.

In conclusion, this study provides essential data for understanding the unique challenges faced by people with disabilities regarding sexuality. The findings highlight the need for public health policies that recognize and address the particular needs of this vulnerable population while promoting equal access to sexual resources and education.

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