Including Disability into Sexual Health Education

by

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Abstract

Sexual health education is a vital but often overlooked site of inclusion, justice, and empowerment. Despite being one of the largest minority groups globally, people with disabilities have been historically excluded from comprehensive sexual health discourse. Protectionist policies, cultural stigmas, and systemic ableism have portrayed individuals who are affected by disability as childlike or desexualized, erasing their rights to knowledge, desire, and agency. This exclusion not only perpetuates infantilization but also increases vulnerability to exploitation, misinformation, and abuse. This capstone critically examines the historical and contemporary marginalization of disabled individuals within sexual health education through a feminist and transformative lens. Drawing on interdisciplinary scholarship, it identifies the consequences of exclusion and explores inclusive practices that center pleasure, autonomy, and access. In doing so, it argues that affirming sexual rights and identities is essential to both personal well-being and collective justice. Ultimately, the work calls educators, practitioners, and policymakers to reimagine sexual health education as a space where individuals with disabilities are recognized as full sexual citizens, who are capable of desire, agency, and self-determination.

Keywords: autonomy; disability; infantilization; pleasure; sexual health education

Dedication

This capstone is dedicated to the students I have had the privilege of working with in the past, and to all whom I will meet in the future, whose voices and needs have too often been overlooked when it comes to sexual health education. To every young person who has slipped through the cracks of systems that were meant to support them, please know that you are seen, valued, and worthy of knowledge that affirms your agency and your right to pleasure, safety, and self-determination. I am honoured to use my voice in support of this marginalized community, and to continue learning from your resilience, curiosity, and courage.

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Chapter One: Introduction

Sexual health education is often described as a pertinent aspect of an individual's well-being, yet it has been historically constructed through narrow, ableist, abstinence-based/spiritual, and heteronormative frameworks. Within these frameworks, individuals with disabilities have been marginalized, their rights to sexual expression questioned, and their access to affirming education denied. This chapter introduces the focus of the project, examining the historical and ongoing exclusion of disabled people from sexual health discourse and advocating for more inclusive, pleasure-centered approaches. It begins with an overview of the topic and its significance, followed by a purpose statement, a discussion of the project's contributions to the field of counselling, and a reflexive positioning of myself in relation to this work.

Overview of the Topic

Individuals with disabilities have not had the same access to sexual education as their peers (Atkinson et al., 2022). Research has shown us that often, those with intellectual disabilities have perceptions that are negative regarding sex and sexuality, limited understanding of these topics, and a higher likelihood of negative consequences and abuse than their peers (Dalmijn et al., 2022). While 15% of the population of the world is affected by disability, societies are all moving at differing rates when it comes to recognising the sexual health and reproductive rights of these individuals (Addlakha et al., 2017). People affected by disabilities are constantly having their right to sexual health education contested as the focus in these areas previously has mainly been one that is from a patriarchal, heterosexual family life perspective and thus these individuals have been overlooked (Addlakha et al., 2017). What little education has been provided for those affected in these areas has taken little to no consideration when it comes to pleasures or desires as prevailing assumptions have not allowed a space for education to do so (Loeser et al., 2018). The education system lacks inclusivity in these areas and is failing to create a disability-normalized world, and this is a disservice to those affected with disability, as well as those who are not. Through a transformative lens I believe that there needs to be an analysis of the current sexual health programs in the education system, and that adapting sexual education would be addressing an oppressed community's social inequalities and taking action to mitigate any disparities that are found. Changing the current curriculum to be more inclusive is also pragmatic, as it is finding a solution to unfortunate consequences that this marginalized community face of, such as abuse, contraction of life-long diseases, unplanned pregnancies and neglect.

Purpose Statement

This capstone seeks to address the central question: *How can sexual education be made more inclusive for individuals with disabilities?* At its core, this project arises from the recognition that disabled people have long been excluded from sexual health discourses and educational practices, often under paternalistic logics that frame them as non-sexual, incapable, or in need of protection. Such historical erasures have resulted in profound consequences, including heightened vulnerability to abuse, restricted access to affirming resources, and the denial of sexual autonomy and pleasure.

The purpose of this research is to examine these legacies through a transformative feminist lens and to argue for a shift toward sexual health education that is explicitly inclusive, pleasure-centered, and rights-based. This project brings together scholarship, advocacy, and practice, weaving in own-voices perspectives to foreground the lived realities of disabled individuals. In doing so, it seeks not only to critique the patriarchal, heteronormative, and ableist structures that have shaped sexual education but also to highlight pathways for meaningful change.

By synthesizing the literature on disability and sexuality, this capstone advocates for a reimagined curriculum that normalizes pleasure, recognizes disabled people as sexual beings, and equips educators and care providers with the tools to foster safer, more inclusive environments. In offering tangible recommendations for counselling and education, the project aims to disrupt cycles of neglect and abuse and to advance a vision of sexual health that benefits not only disabled individuals but all learners. Ultimately, the goal is to contribute to a broader cultural and professional shift toward equity, autonomy, and sexual well-being, ensuring that past exclusions are neither replicated nor left unchallenged.

Contribution to the Field

This capstone contributes to the counselling and educational fields by bringing to the forefront the necessity of inclusive, disability-affirming sexual health education for all. Individuals with disabilities, particularly those with intellectual disabilities, are disproportionately excluded from curricula and, as a result, are more vulnerable to abuse, misinformation, and disempowerment (Atkinson et al., 2022). Their lack of access to comprehensive sexual health education is not only a matter of individual harm but a systemic failing rooted in ableism, patriarchy, and heteronormativity.

Through a feminist, anti-oppressive, transformative lens, this project challenges these systemic barriers and positions inclusive sexual health education as a matter of social justice. By normalizing pleasure and affirming disabled people as sexual beings, counselling and education practices can disrupt patterns of infantilization and stigma. In turn, this benefits not only disabled individuals but all learners, as an educational approach that integrates diverse bodies, identities, and experiences fosters safer, more equitable learning environments.

This work also underscores the need for better training and resources for educators and caregivers, who often report limited preparation for supporting the sexual health of disabled people that they are supporting (Atkinson et al., 2022). By equipping those in caregiving and teaching roles with inclusive frameworks and practical tools, the field can move beyond reactive responses to abuse or crisis and instead cultivate proactive, affirming practices. Moreover, by linking theoretical insights to applied strategies, this project advocates for tangible shifts in curricula, policy, and counselling approaches that can advance both autonomy and protection.

In sum, this capstone extends the field's capacity to advocate for marginalized communities by offering a critique of existing practices alongside pragmatic recommendations. Its contribution lies in bridging scholarship and application: dismantling exclusionary histories while also charting actionable pathways for change in counselling, education, and beyond.

Reflectivity & Positionality Statement

This topic is increasingly important to me as someone who is going into the counselling field specializing in sex and sexuality. I feel that the world is a diverse and intersectional space, yet the language of educational materials in these areas is skewed toward a dominant, white, able-bodied, cisgender, heterosexual perspective. Despite how I present to the world as a cis, white, able-bodied woman, I carry the depth of neurodivergence and pansexuality, and I often encounter a lack of inclusive language for even these aspects of my identity. I can only imagine how exclusion is compounded for those who navigate physical disabilities, learning differences, visible difference, or medical diagnoses, where societal structures continue to marginalize their existence.

I also do not identify with any religion, though much of the language within sexual education has historically been rooted in religious discourses of abstinence and shame, which is particularly harmful for disabled communities. While there has been progress in integrating inclusive language around sexuality and gender, disability remains under-addressed. This makes it all the more urgent to name and challenge the assumptions that have cast disabled people as non-sexual, incapable, or unworthy of intimacy. Such framing not only excludes disabled individuals from educational spaces but also perpetuates harmful cultural models of infantilization and discrimination.

In approaching this work, I am conscious of the privilege I hold in how I present outwardly in society, which includes privileges that grant me both access and a platform to be heard. Alongside these privileges, my years of working with differently abled youth in the school system have made the stakes of this project feel deeply personal and ethically necessary. Care providers, educators and counsellors play a critical role in shaping how sexuality is understood and supported, and my experiences in these settings reinforce the urgent need for inclusive, affirming resources.

I situate myself within a transformative feminist paradigm, one that emphasizes the interrogation of power, the dismantling of exclusionary structures, and the amplification of marginalized voices. This lens challenges me to look critically at how ableism, patriarchy, and heteronormativity are embedded within sexual health discourse, and to resist reproducing these hierarchies in my own writing. While I do not personally identify as disabled, I recognize the responsibility that this places on me as a researcher and as a soon to be professional practitioner. To mitigate this tension, I have sought to center own-voices perspectives and scholarship by disabled authors, ensuring that disabled voices remain central, rather than peripheral, to this project. My aim is not to speak for disabled individuals, but to highlight and validate their voices within counselling and educational conversations.

My intersecting identities as a cisgender, white, able-bodied woman who is also neurodivergent and pansexual place me at a point of both privilege and marginalization. These intersections influence how I interpret exclusion, how I engage with the literature, and how I imagine possibilities for more equitable futures. They remind me that inclusivity is not a static destination but a process of continual reflexivity, accountability, and openness to critique.

This commitment also extends to how I see my role as a counsellor in training. I believe in fostering inclusive communities where education is offered with empathy and curiosity, and where people can engage without fear of silencing. In an era where call-out culture often collapses into cancellation, it is essential to leave room for growth, dialogue, and change. Because I have the privilege of education and visibility, I feel a duty to advocate for those with less access to such platforms. My personal identities also help me centre the narrative as addition and adaptation as opposed removal. Centring the addition of disability and pleasure into the sexual education discourse that is currently being utilized.

By naming these positionalities, I aim to recognize my ethical responsibility to conduct scholarship that is both critical and reparative. My intention is for this work to function not only as a critique of historical and systemic exclusion but also as an advocacy piece that points toward tangible strategies for change. Ultimately, this project is grounded in the belief that including disability in sexual education benefits all as it challenges harmful stereotypes, affirms disabled people as sexual beings, and moves us closer to a future where pleasure, intimacy, and autonomy are recognized as universal human rights.

Definition of Terms

Asexual

(Ace for short) World Health Organization (2025) defines as orientation that identifies as having a complete or partial lack of sexual attraction or interest in sexual activities with others.

Body Esteem

The positive or negative feelings overall in regard to one's own physical body. (School of Psychology Deakin University, 2025).

Consent

The voluntary agreement to participate in sexual engagement that is based on an affirmative (i.e., must be a definitive "yes," and not just an absence of, "no") standard. It cannot be given by an individual who is unconscious, intoxicated, or otherwise considered in capable of giving said affirmative "yes." It can also be withdrawn at any time through taking action or verbal statements. In Canada, the age that consent can be given is sixteen years for most individuals. The Criminal Code of Canada states that certain populations cannot give consent for sexual activities because they are not believed to have the mental capability of doing so, even if they are over the legal age to give said consent. (Department of Justice Canada, 2021).

Disability

World Health Organization (2025) defines as impairment to body structure or functioning, limitation to daily activities, and restrictions to participations in normal daily activities.

Disability Inclusion

World Health Organization (2025) defines as a commitment to ensuring that those affected by disability have full ability have participation in society, which includes having access to services for health and receiving the same standard of care as others. This is based on a principle that everyone has every individual has the right to receive the highest standard of care, regardless of if their affected by disability.

Heterosexuality

World Health Organization (2025) defines as an orientation that identifies as having attraction to individuals of a different sex than oneself.

Intellectual Disability

DSM-5-TR (2022) defines intellectual disabilities as neurodevelopmental disorders that begin in childhood and are characterized by intellectual difficulties as well as difficulties in conceptual, social, and practical areas of living

Neurodiversity

American Psychiatric Association (2022) defines as a concept that encompasses differences in brain functioning and behavioural traits as variation from the normal human population and can be seen as strength and/or challenges.

Sexual Esteem

One's confidence and positive regard for their ability and capacity to experience their sexuality in a pleasurable and satisfying manner (School of Psychology Deakin University, 2025)

Sexual Health & Well-Being

World Health Organization (2025) defines has having two aspects, 1) knowledge of risks and any adverse consequences that could arise from unprotecting sexual activities and, 2) access to information about sex and sexuality that is both comprehensive and of quality.

Sexuality

World Health Organization (2025) defines as a central part of being a human and encompasses sex, gender roles/identities, orientation, intimacy, reproduction and pleasure throughout one's life.

Sexual Pleasure

World Association of Sexual Health (2025) defines as physical or psychological satisfaction as well as enjoyment from a solitary or shared sexual experience, including dreams, emotions, fantasies and thoughts.

Sexually Transmitted Infections (STI)

The National Cancer Institute (2025) defines a STIs as a disease caused by infection with certain bacteria, viruses, or other microorganisms that can be passed from one person to another through blood, semen, vaginal fluids, or other body fluids, during oral, anal, or genital sex with an infected person.

Outline of the Capstone Project Chapters

This capstone project is structured into three chapters, each of which builds upon the previous to create a comprehensive and critically engaged exploration of sexuality, disability, and pleasure.

Chapter one situates the project within the broader field of counselling and sexual health education. This chapter introduces the central research question and explains the significance of examining the historical and ongoing exclusion of disabled individuals from discourses of sexuality. It outlines the aims of the project, the theoretical perspectives that guide the analysis, and the relevance of this work for both counsellors and the wider community.

Chapter two examines the existing scholarship on disability and sexuality in depth. This chapter highlights the ways in which people with disabilities have been marginalized, infantilized, and erased from sexual health education and practice. It discusses the consequences of these exclusions, including vulnerability to abuse, lack of access to affirming sexual health resources, and the perpetuation of stigma. In addition to charting these harms, the review also identifies emerging frameworks that center autonomy, desire, and the right to sexual expression. By tracing both the historical underpinnings and contemporary debates, this chapter establishes the need for a shift in approach.

And finally, Chapter 3 synthesizes the findings from the literature review and considers their implications for counselling and education. It argues for a movement away from avoidance- or abstinence-based approaches toward pleasure-centered, inclusive frameworks that affirm disabled individuals as sexual beings. Practical considerations for counsellors, educators, and policy makers are discussed, with attention to how these practices not only benefit disabled people but also enrich sexual health education for all. This chapter concludes by reflecting on the broader importance of integrating equity, autonomy, and pleasure into counselling practice and sexual health discourse.

Chapter 2: Literature Review

The sexual lives and rights of disabled individuals have long been marginalized through a combination of silence, stigma, and systemic exclusion. Rather than being recognized as full sexual citizens with agency, desires, and diverse identities, disabled people have historically been positioned within discourses of protection, control, and pathology. This framing, shaped by segregated histories, paternalistic policies, and entrenched ableist assumptions, has perpetuated infantilization and desexualization, constructing disabled people as either perpetually childlike or inherently vulnerable. The result has been an enduring absence of disabled voices in sexual health education, research, and policy, despite disability being one of the largest minority identities globally. This systemic silencing, where people with disability are repeatedly left out of the cultural sex and sexuality conversations leaves this large percentage of people vulnerable (Soyer, 2018). To understand the present gaps in access and equity, it is crucial to examine the historical exclusions that continue to structure how disabled people's sexualities are imagined, constrained, and denied. Promoting these changes in practice is crucial in acknowledging and celebrating desire and pleasure as fundamental aspects of the human experience. This literature review examines how disabled individuals have been historically excluded and infantilized in sexual health discourse, the resulting vulnerabilities and challenges around informed consent, and the ways education can empower through centering pleasure, autonomy, and access.

Historical Exclusion & Infantilization of Disabled Individuals in Sexual Health Discourse

Societies and institutions have frequently excluded people with disabilities from sexual health discourses under protectionist logics, moralizing impulses, and political contestation. This exclusion is rooted in fears, eugenic legacies, and debates that render disabled people's sexual and reproductive rights politically fraught, despite more than fifteen percent of the world's population being affected by disability (Addlakha et al., 2017). Disabled people are frequently infantilized or desexualized, constructed as childlike, non-desiring, or inherently vulnerable, which erases sexual agency and normalizes paternalistic restrictions. Practical obstacles, lack of privacy, inaccessible activities and infrastructure, scarce opportunities to meet partners, and insufficient accommodations, directly limit sexual experience and participation for disabled people.

Historical Exclusion, Protectionism, & Political Framing

Twenty percent of the residents of the U.S.A. have a disabling factor in their lives, which means this is the biggest minority group in that country (Greenwell & Hough, 2008), yet this is a minority that has yet to be included when it comes to sexual health education. People affected by disabilities are constantly having their right to sexual health education contested as the focus in these areas previously has mainly been one that is from a patriarchal, heterosexual family life perspective and thus these individuals have been overlooked (Addlakha et al., 2017). In their own voices, they have stated that it has been hard to overcome beliefs that they themselves have deeply internalized about being desire-free, sexless, and ultimately unworthy of experiencing pleasure, (Soyer, 2018). Those with intellectual disabilities have been historically excluded from mainstream educational programs for sexual health because they were perceived to be asexual, perpetual children with no thoughts or desires regarding sexual activity, as well as a deep fear that inclusion within said programs would cause them to become sexually aggressive perpetrators (Saskatchewan Prevention Institute.2015). What little educational materials that have been provided for those with disability have focused many on hygiene and anatomy for younger individuals, with the addition of avoidance of abuse and exploitation into youth and young adulthood (Black & Kammes, 2021). Some educators are selective in what they present as well, stating that certain things are more important for these individuals than information about sex and sexuality (Gill & Hough, 2007). There has been a false distinction between the freedom from and the freedom to, which is not just unique to disability, but is of heightened concern when it comes to sexual exploitation, abuse and possible eugenic technological factors (Schaaf, 2011).

Disability theory, which is young field of research in itself, historically has not discussed sexuality and has only sought out protection for people with disabilities, often particularly women (Schaaf, 2011). This silencing of society runs deeply in the sexuality of people with disabilities and topics such as genetic screening, impact of eugenics, folks with disability exploring nonheteronormative, non-gendernormative desires and identities, and experiences of raising someone with disabilities, being removed from literature, media, legislation, everyday discussions and more (Addlakha et al., 2017). In Western cultures alone, debates around sexual health education has become political markers for campaigns (Horanieh et al., 2019). Particularly women with disability have been left out of research and education as they have not been seen with femininity, as potential partners, as having desires to be mothers if seen as fit for reproduction at all (Addlakha et al., 2017). Frequently though, people with disability are homogenized rather than treated as individuals with differing genders let alone needs, and supports have not been differentiated for potential gendered social supports (Kim & Zhu, 2023).

Infantilization, Desexualization, & Sexual Ableism

Assumptions that those with disability cannot experience a sexually satisfying life are disrespectful, disempowering and is generally doing a disservice to these folk (Murray et al., 2017). The social construction of the “normal” body has created a binary of “healthy” or “other,” which is the medically diseased or disabled (Loeser et al., 2018). This “otherness” is oppressive and often leads to marginalization, cultural imperialism, discrimination, exploitation and violence (Parchomiuk, 2021). Despite researched evidence that school-aged youth with disability are just as sexual as their peers without, professionals, parents and fellow students still tend to make assumptions about asexuality (Centre for Communicable Diseases and Infection Control, 2013). It is a presumption that people with disability are always asexual, and it further dictates an impression that disability is undesirable and undesiring when it comes to sexual relations (Loeser et al., 2018). Treating this group of people as perpetual or eternal children is desexualizing, infantilizing and leads to even more assumptions that individuals affected by disability do not have the capacity or are simply not interested in relationships that are sexual (Murray et al., 2017). Innocence and vulnerability have become intertwined language with disability, which is further perpetuating sexual ableism, desexualization and discrimination (Davies et al., 2024). Another barrier to those with physical disability in particular, receiving adequate sexual education is the common misperception that all physical disabilities also involve cognitive impairments (Centre for Communicable Diseases and Infection Control, 2013). Furthermore, holding these ableist assumptions while in the role of a carer or educator for individuals with disability forces them to become secretive and start engaging in more risky sexual activities to get their needs met (Murray et al., 2017).

Disabled people are often framed as innocent and therefore vulnerable, especially children, who are seen as dependent, irrational, and incapable of developing into sexual adults (Davies et al., 2024). This framing reinforces sexual ableism by casting them as asexual and without present or future sexualities and results in disabled children being routinely excluded from sexuality education, misrepresented, and denied their rights to full citizenship (Davies et al., 2024). Rather than being given agency and recognized as having diverse sexualities, ableism has framed these individuals as lacking the capacity to and for sexuality at al (Hole et al., 2022).

Studies have gathered data showing that about one-third of the LGBTQ+ community also identify has people with disability (Greenberg, 2022). Affirmative approaches to sexuality and sexual rights were largely absent, as sexuality was treated as a want rather than a fundamental need (Schaaf, 2011). Because of this framing, and with advocacy efforts directed elsewhere, disabled children's sexual health was deprioritized, leaving them excluded from comprehensive sexual education. Disabled children's voices have been frequently disregarded (Davies et al., 2024). When sexual behaviours are deemed a problem such as those from people with disability, there has historically been a removal of them from educational materials in the future (McCarthy, 2022). Many people with disabilities have been advocating for their own voices to be heard in changes being made to sexual health education, and they want reframes of saying yes to pleasure, instead of just a protective no (Hole et al., 2022).

Structural & Social Barriers to Access & Inclusion

Individuals with disabilities have not had the same access to sexual education as their peers (Atkinson et al., 2022). Though there is a difference in needs between those with physical and intellectual disabilities, both populations are constantly facing systemic barriers to sexual health information (Murray et al., 2017). Many students with disabilities leave high school without having received a sexual health education (Black & Kammes, 2021). Many youth with disabilities do not know how to initiate sexual activities because they have not been provided with adequate educational materials, or even been included in mainstream classrooms and social activities where they could meet potential partners (Reznik et al., 2021). Limited inclusion in the schooling activities such as sports, field trips, social events, leisure activities, clubs etc., have contributed to difficulties in finding relational partnerships in youth, (Reznik et al., 2021), and with barriers to accessibility continuing into adulthood, people with physical disabilities are frequently limited to spaces that are share with a majority of other folks with disability. Independence from parents can be an issue for folk with disability that are emerging into adulthood, or in adulthood, as they may rely on them as caregivers, who many have entire control of their socialization (Chrastina & Vecerova, 2018).

Very little research has delved further into the intersectionality of ethnic minorities, or and disability when it comes to these systemic barriers (Greenwell & Hough, 2008), let alone recognition of gender as a spectrum and how that intersects with the sexual health education of those with disability (Addlakha et al., 2017). There has been global discussion from organizations such as the United Nations Educational, Scientific, and Cultural Organizations, around how to diversify educational settings in general, and more specifically in the creation of a comprehensive sexual education for all, however students with disabilities have still been left out (Davies et al., 2023). Although disability is recognized as central to identity and well-being, its intersection with sexuality education is largely overlooked in Canada (Davies et al., 2023). Existing research focuses mainly on students with intellectual disabilities and their social-emotional needs, neglecting the broader challenges faced by students with diverse disabilities and intersecting identities, including race, gender, and sexuality (Davies et al., 2023).

The next section will examine the consequences of the historical exclusion of individuals with disabilities from sexual health discourse. It will explore the ways in which this exclusion has heightened vulnerability to harm, compromised informed consent, and limited access to critical knowledge and resources. Specific areas of focus will include increased risk of abuse and sexually transmitted infections due to lack of education, barriers to forming intimate relationships and reporting abuse, and the internalization of shame and fear. Through this analysis, the section aims to illuminate the tangible impacts of systemic neglect on the sexual autonomy, safety, and well-being of disabled individuals.

Consequences of Exclusion: Vulnerability to Harm & Lack of Informed Consent

The exclusion of individuals with disabilities from comprehensive sexual health education has far-reaching consequences, both in the erosion of personal autonomy and the increased risk of harm. When access to this information has limits or is are actively denied, individuals are left without the tools to understand their bodies, or boundaries, which further perpetuates these cycles of vulnerability (Hole et al., 2022). The historical and ongoing centering of patriarchal, heteronormative perspectives in education systems compounds this harm, creating an environment where desire, pleasure, and informed consent are marginalized topics, if they are even addressed at all (Loeser et al., 2018). This absence of inclusive, affirming sexual health education not only denies a right to knowledge (Addlakha et al., 2017), but also makes this group of individuals more susceptible to abuse, exploitation, and misinformation (Black & Kammes, 2021; Hole et al., 2022).

Increased Risk of Abuse & Disease/Infection Due to Lack of Education

When education is absent or incomplete, disabled individuals are left at greater risk of harm. The gaps in knowledge open space for myths, unsafe practices, and reliance on potentially harmful sources of sexual information. Historically, sexual health education for individuals with disabilities has been shaped by ableist and heteronormative assumptions. These frameworks have systematically excluded disabled individuals from comprehensive, inclusive curricula, often erasing discussions of sexual pleasure and agency and leaving people vulnerable to neglect and abuse. A disabled individual’s right to education around sexual health has continuously been contested (Addlakha et al., 2017). Those with intellectual disabilities alone are seven times more likely to be assaulted than their peers who are without a disability (Atkinson et al., 2022). Women with hearing impairments have a higher level of reported rapes than those without such disabilities (Addlakha et al., 2017). Women with disabilities in general experiences specific vulnerabilities to abuse that their peers of the same gender do not (Nosek et al., 2001). Despite the prevalence of disability in the world, folks with disabilities are still two to three times more likely to be violently victimized, including rape and sexual assault, than those without disability (Greenberg, 2022). The abusers are commonly a known individual of victim, with about twenty-five percent of abusers being from their family, fifteen percent being staff in supportive roles, and then about fifty percent of the abusers being fellow service users, with acknowledgement that the information gathered is most likely skewed by familial and staff abuse is more hidden than that of fellow service users (Black & Kammes, 2021). A need for assistance in daily live creates even more vulnerabilities, and disability is not a protective factor for abuse (Nosek et al., 2001).

If sexual health educational materials are not available for young people with disability, they are more likely to explore in sexually risky behaviours, such as without contraception, (Saskatchewan Prevention Institute, 2015), unsafe locations, and with untrusted individuals. Young people with intellectual disabilities are approximately fifty percent more likely than their peers without, to have unsafe sexual activities like not taking/using precautionary items (Hole et al., 2022). Folks with intellectual disabilities alone may not know how to use contraceptives, have issues procuring said contraceptives or even accessing sexual health facilities, as well as may not even be aware of transmittable diseases or how to prevent them (Saskatchewan Prevention Institute, 2015). Folks with intellectual disabilities may also be unable to fully control or express their preferences or rights sexually, and this puts their guardians and caregivers into the role of consent givers (Saskatchewan Prevention Institute, 2015). Not only may they be unable to seek educational supports for sexual health, but caregivers can also actively reduce their opportunities to acquire this knowledge (Parchomiuk, 2021). Such restrictions can lead to relationships that are secretive and/or exploitative in nature, feelings of powerlessness, compliance, lack of healthy relationship examples to gain knowledge from, lack of knowledge of ways to defend against abuse, and gullibility (Black & Kammes, 2021). Chastisement for physical intimacy, restrictions to overnight relations, and constant electronic of personal surveillance are other suppressions that may lead folk into riskier behaviours to have needs met (Hole et al., 2022). Techniques that have determined abuse prevalence historically do not have the sensitivity for disability related abuse specifically, as they face different forms of abuse, such as isolation, rough care handling, fondling and diminished defences that just are not addressed sufficiently given the context (Nosek et al., 2001). This failure to provide inclusive sexual education for youth with disability lowers their quality (Centre for Communicable Diseases and Infection Control, 2013)

Barriers to Experiencing Intimacy & Reporting Abuse

Although exploitation and abuse are unquestionably major problems that people with disabilities face, they are not the only concerns they may have when it comes to sexual expression (Black & Kammes, 2021). The narrow approach to sexual health education for folks with disabilities has failed to address social stigmatization, or cultural impediments that are often also faced for this group of people (Black & Kammes, 2021). There is evidence that along with a lack of educational materials, less than half of youth who need assistive devices actually have access to them (Centre for Communicable Diseases and Infection Control, 2013). Individuals with disabilities often have far less privacy than those without. Those with disabilities needing of support often have restrictions or prohibiting factors to interacting in their intimate relationships (Reznik et al., 2021). Limited social networks and limited spaces to learn and experience intimacy are restrictions that have forced partnered experiences into secrecy to avoid disapproval, punishment, further prohibition, or upsetting of those who are in the role of carers to these individuals (Reznik et al., 2021). Despite the growing online dating culture, people with people disability are also excluded here due to mobility or cognitive abilities, which is leading to re reduced satisfaction and happiness of this marginalized group (Kim & Zhu, 2023) The sexuality and intimate relationships of folks with intellectual disabilities is still seen as something taboo or too sensitive to talk about, so there is a serious lack of research in this area (Resnik et al., 2021), let alone to updates of sexual health education programs. Those with disability wish to not be fetishized for their disabilities, but rather seen as wanted individuals, communicated with around consent, cared for and respected (Alexander, 2018). There is no test that can determine if an individual is actually capable of giving consent to sexual activity, however The Criminal Code of Canada states that even if some folks are over the age of consent legally, they still may be deemed to not have the mental capacity to give said consent to sexual activity (Saskatchewan Prevention Institute, 2015). Thus, consent can be a barrier to these folk wishing to experience sexual intimacy, as well as evoking debates around abuse.

Socially restricted perspectives that come form insufficient concern and awareness, and denial of maturity adversely affect young people and adults with intellectual disabilities from developing their sexual identities (Chrastina & Vecerova, 2018). The phrase ‘eternal children,” has historically been used to describe folk with intellectual disabilities, and as a result of this stereotyping language they have experienced prejudice, barriers to self-expression, prohibitions from sexual activity, suppression, lack of privacy and exaggerated protections (Chrastina &

Vecerova, 2018). Folks with intellectual disabilities often have barriers to finding friends, learning about their own bodies, exploring relationships, privacy and the right to make mistakes, which has limited their quality of sexual life (Chrastina & Vecerova, 2018). Parental and caregiving figures can dominate the sexual life of those they support with a disability and with restrictive attitudes, limiting beliefs, excessive protectiveness, and overlooking essential needs they can influence, neglect, deprive, and abuse (Parchomiuk, 2021). Caregiver support can also be harmful in that it can put youth with physical disabilities into a place where they have become complacent on touch, which has proven to make them less likely to be able to differentiate between support and inappropriate behaviour (Centre for Communicable Diseases and Infection Control, 2013).

Internalized Shame or Fear Around Sexuality

Barriers to sexual health education are not experienced in isolation, but rather they are layered with other systemic inequities. Intersectionality reveals how multiple identities shape access, vulnerability, and the ways education (or lack thereof) is experienced. Young people with physical disabilities have been found to have a poorer self-image and body self-esteem than their able-bodies peers (Taleporos & McCabe, 2002). Research has shown us that often, those with intellectual disabilities have perceptions that are negative regarding sex and sexuality, limited understanding of these topics, and a higher likelihood of negative consequences and abuse than their peers (Dalmijin et al., 2022). The lack of education in these areas has many negative outcomes, including, high risk of being victimized, STIs, unplanned/unwanted pregnancies, and no understanding of what healthy sexual or intimate relationships can look like (Saskatchewan Prevention Institute, 2015). Discussing the use of the term disability versus the term impairment is also important when it comes to barriers to sexual health for people with disabilities, as often these terms are used interchangeably when they mean different things socially. Impairment denotes a dysfunction, whereas disability is a socially constructed term that was created by an oppressive society and is attached with stigmas that may not even reflect the impairment itself (Schaaf, 2011). When professionals or caregivers to address sexuality for the folk they support with disability, they often unknowingly reinforce misconceptions that sexual experiences for these folk are not fulfilling or adequate, such as suggesting medication or prosthetics to make the activity “functional,” which is very dismissing of their personal and holistic experiences (Dune, 2012).

Culture also plays a role in how one conceptualizes disability (Greenwell & Hough, 2008). What little research has been done in regards to sexual health education when it comes to disability, has failed to include diversities of multiculturalism, poverty, gang violence exposure, discrimination, and more, as previously it has appeared to make the assumptions that one’s disability status eclipses all else (Greenwell & Hough, 2008). Patriarchal culture can also dictate maintaining virginity before marriage, and this has lead to female genital mutilation, a disabling factor itself (Addlakha et al., 2017). Islamic culture shows apprehension to a Western sexual education program in general, calling Westerners obsessive and mad about sex and sexuality (Horanieh et al., 2019). Disabled individuals, along with queer folk have historically been portrayed as threats to societies, perverse, deviant or undesirable and should be either housed in asylums away from everyone, sterilized or exterminated (Loeser et al., 2018), and these extreme heteronormative, ableist perspectives have lingered generationally. To have a sexual desire or want outside of a dominant norm, such as queer or disabled individuals do, still means having to legitimize your sexuality to others as well as internally (Loeser et al., 2018). When it comes to children and youth sexual education in general, more often than not the person/people given the right to choose what information is presented in regards to sex health and sexuality is the caregivers, and this is even more so the case when it comes to students with disabilities (Davies et al., 2024). Those with disabilities are not often given the space to talk about their inner worlds and wants of intimate relationships (McCarthy, 2022) or sexual identification, sexuality or gender (Davies et al., 2024). Although various elements can shape a disabled person's vulnerability or marginalization, ableism sustains attitudes and systems that disadvantage them, as existing structures fail to meet diverse needs. (Greenberg, 2022). The negative scripts that people with disability acquire in their environments effect the quality of their life (Parchomiuk, 2021). As there is a lack of educators with disability or who are willing to speak to the shared backgrounds and lived experiences as students with disabilities their social and romantic needs they are not receiving directly relevant information (Davies et al., 2024).

The next section will explore how the normalization of pleasure withing disability-inclusive sexual health education can resist ableist assumptions, affirm autonomy, and foster healthier, more empowering understandings of sexuality.

Empowering Through Education: Centering Pleasure, Autonomy, & Access

Sexual health education is a vital empowerment tool that supports decision-making, healthy relationships, and reduces vulnerability to abuse among people with intellectual disabilities. It also includes the necessity of tailoring education to meet the needs and pace of learners. Family, caregivers, professionals, and peers are essential supports for delivering effective sexual health education tailored for people with intellectual disabilities, with peer involvement reducing power imbalances and increasing relatability. Educational materials must recognize the sexual desires and the right to form intimate relationships among people with varying disabilities, while also acknowledging ongoing challenges in developing sexual identity, especially for women. There is also a crucial need for cultural sensitivity, inclusive research methodologies, and intersectional awareness in addressing sexual health and rights for people with disabilities. Ultimately, fostering educational practices that affirm sexual identity, desire, and autonomy while advancing access and justice is what is needed for empowering, meaningful, comprehensive sexual education programs.

The Role & Impact of Sexual Health Education

Folk with disability have a right to sexual intimacy, and to love and be loved if they choose so, and sexual health education needs to promote this right to agency and sexual citizenship (Hole et al., 2022). It is unquestionable whether people with disabilities have desire and wants to engage in physical and intimate relationships, but it must be acknowledged that as there is a high rate of abuse and exploitation of people with disability, so it is imperative to evaluate, adapt and create their education regarding such experiences (Black & Krammes, 2021). There is conflict between the desire to protect from abuse and exploitation, and to be able to facilitate sexual expression appropriately (Chrastina & Vecerova, 2018). However, providing sexual health education to people with disabilities has many positive results, like empowerment to explore sexuality in positive ways, be educated around finding and maintaining healthy relationships, learn how to control their agency around sexual health, reduce inappropriate expressions of sexual content or sexualities, and reduce vulnerabilities to exploitation and abuse (Saskatchewan Prevention Institute, 2015). Sexual activity is not limited to penetrative activities, so including disability into sexual education should be as simple as recognizing that pleasure is expansive, customizable, and varies as much as people do themselves (Alexander, 2018).

Comprehensive sexual education can help folks with disabilities build self-esteem, seek out and find rewarding relationships that are non-exploitative and be more informed around their reproductive rights (Saskatchewan Prevention Institute, 2015). People with disability may be able to perceive themselves as being attractive physically, but at the same time still believe that others will not agree, which wrecks havoc on body image, self-esteem and sexuality (Taleporos & McCabe, 2002). An integral part of sexual health education for all is helping young people build and navigate healthy and consensual relationships (Saskatchewan Prevention Institute, 2015). Helping young people with disability build social skills working towards building relationships with themselves and others is integral. These young people need to be able to discuss their feelings, what they want in relationships, navigate maintenance and endings of dating relationships, have contraception discussions, resist peer pressure, refuse sex, communicate with partners about needs and desires (Saskatchewan Prevention Institute, 2015), which most young folk who are not affected by disability would benefit from as well. Mainstream sexual health education should it include students with disability into the discussion limits the influences of power and authority that educators and caregivers have over those with disabilities (Saskatchewan Prevention Institute, 2015). It can make students in general more comfortable, giving everyone more chances to observe and interact with one another, and learn about each other's wants, normalizing sexuality and desires of all (Saskatchewan Prevention Institute, 2015). Along with peer to peer involvement with sexual health education, caregivers and parents also should be included to keep messaging consistent and reinforced (Saskatchewan Prevention Institute, 2015).

Sexual Desire, Identity, & Rights of People with Disabilities

Individuals with disabilities need to be included in the sexual health education planning, so as to properly address their needs and desires (Saskatchewan Prevention Institute, 2015). Women with disabilities particularly must be included in the discourse around sexual health education as they often find it difficult developing sexual identities as they may not always feel pleasure from sexual activities and may consider them to be painful rather than enjoyable (Reznik et al., 2021). Intimate or romantic relationships are a need of most people, with or without disability (Reznik et al., 2021). When included into the conversation about what people with disability wish for from sexual health education, themes of friendship and supports around socializing and networking so as to help form new relationships arise (Reznik et al., 2021). Individuals with disabilities, like their peers without, aspire to futures that include marriage and children (Saskatchewan Prevention Institute, 2015). Regardless of physical and intellectual ability, all adolescents experience psychological, physical and sexual changes during this stage of development, and most have relationship and sexual desires that continue into adulthood (Saskatchewan Prevention Institute, 2015). People with disabilities are aware of their rights and need to be included in discussions around practice and policy of sexual health education for all to further normalize one's right to make their own choices (Reznik et al., 2021).

Empowering individuals with disabilities through education requires that research and practice meaningfully account for cultural contexts, rather than treating them as peripheral concerns. Culture, is deeply intertwined with how sexual desire, autonomy and rights are expressed and experienced. Professional guidelines already emphasize the importance of helping individuals explore and affirm socio-cultural identities, and organizations such as the APA encourage scholars to adopt equitable and inclusive approaches (Greenwell & Hough, 2008). Yet, despite these guiding principles, disability-focused research has too often neglected cultural diversity, overlooking the ways in which race, ethnicity and the broader cultural dynamics inform not only access to education but also the recognition of pleasure and self-determination (Greenwell & Hough, 2008). By ignoring these factors, research risks reinforcing marginalization rather than dismantling it. The voices of those affected by disability need to be centered as they have historically been silenced, so as to address these inequities and expand rights, prioritize cultural data and context-driven methodologies for a richer understanding of the lived realities of people with disabilities (Greenwell & Hough, 2008).

Normalizing Pleasure & Sexuality for People with Disabilities

Challenging the pervasive assumptions that exclude desire and pleasure from the sexual health education discourse can help to normalize pleasure for those affected by disability (Loeser et al., 2018). There is little difference between the rate at which youth with or without disabilities engage in sexual behaviour (Centre for Communicable Diseases and Infection Control, 2013), so it makes little sense that this group of individuals not be integrated into mainstream lessons along with their peers without disability. What little education has been provided for those affected in these areas has taken little to no consideration when it comes to pleasures or desires as prevailing assumptions have not allowed a space for education to do so (Loeser et al., 2018). The normalization and inclusion of disability into mainstream education lessons of sexual health will benefit all students of varying ability with real world applicable knowledge (Loeser et al., 2018). Societies are progressing and different paces when it comes to the sexual health rights of people with disabilities but there is globally a movement towards pushing these discussions forward (Addlakha et al., 2017). The online adaptive courses starting to be offered in some school districts are providing more online social opportunities to foster belonging, autonomy and connections as they become more adapted for those affected by disability, thus building relationships and intimacy in new ways (Kim & Zhu, 2023). Sexual rights and feminist groups have even promoted the collaboration in advocation and research works (Addlakha et al., 2017). Over the last twenty or so years, the silencing around disabilities has been increasingly broken and sexuality is being addressed more and more, reflecting a broader global trend being seen in sexual rights and the struggle for equities (Schaaf, 2011). Debated and campaigns are recognizing folks with disabilities and having aspirations for sexual enjoyment, intimacy, friendship, reproductive rights and love (Addlakha et al., 2017). The broader, normalizing discussion is coming to the forefront of rather than bringing people with disability into the way sexuality is perceived or taught, should we instead be changing the way sexuality is conceived entirely (Schaaf, 2011). More individuals with disabilities are speaking out around sex and sexuality, but also those who are not affected by disability but who are sexually active with those who are have begun to use their voices in advocacy as well sharing about their fulfilling, and active sex lives (Alexander, 2018). Hannah Soyer, a journalist and podcaster who has a disability of her own has been a powerful voice in advocacy for recognizing desire for all, “My body wasn’t make for walking, but it is made for orgasms!” (2018).

Summary

The historical exclusion and infantilization of individuals with disabilities from sexual health discourse represents a persistent and multifaceted form of marginalization. Protectionist policies, ableist assumptions, and systemic barriers have not only denied access to critical sexual health education but have actively silenced the voices, experiences, and desires of disabled individuals. These omissions perpetuate harmful stereotypes and infantilization, leaving disabled people at heightened risk of social isolation, misinformation, and disempowerment. By failing to provide inclusive and affirming sexual health education, society directly compromises the ability of disabled individuals to make informed decisions about their bodies, relationships, and sexual rights. This persistent lack of recognition lays the groundwork for increased vulnerability to exploitation, coercion, and abuse, emphasizing the urgent need to examine the tangible consequences of exclusion, particularly in terms of personal autonomy, safety, and informed consent.

The consequences of exclusion extend far beyond the absence of information. Disabled individuals face disproportionate exposure to abuse and neglect, limited opportunities for healthy relational and sexual expression, and the internalization of shame regarding their sexuality. These harms are systemic rather than personal, stemming from ableist societal structures, restrictive caregiving practices, and educational systems shaped by heteronormative and patriarchal frameworks. Denying inclusive sexual health education perpetuates cycles of vulnerability while reinforcing narratives of dependency and infantilization. Yet, focusing solely on risk obscures the critical reality that disabled people are sexual beings with desires, agency, and the capacity for pleasure. Equitable sexual health education must therefore move beyond deficit and risk-based frameworks to affirm these rights and capabilities.

Education that centers inclusion, empowerment, and pleasure is not a luxury; it is a matter of justice, equity, and human rights. Thoughtfully designed programs provide individuals with the knowledge, tools, and support to resist exploitation, build healthy and consensual relationships, and exercise autonomy over their bodies and desires. Such programs must be holistic, informed by the lived experiences of disabled people, culturally responsive, and intersectionally aware. Engaging peers, caregivers, and community networks further strengthens the normalization of disability and ensures that educational initiatives are consistent, meaningful, and sustainable. Importantly, inclusive sexual health education affirms an inherent right to intimacy, pleasure, and sexual citizenship, challenging narratives grounded in protectionism or deficit and replacing them with frameworks that prioritize empowerment, fulfillment, and self-determination. In doing so, sexual health education transforms not only how disabled individuals experience sexuality but how society as a whole understands and values sexual diversity.

Ultimately, synthesizing this body of literature highlights the need for a paradigm shift in sexual health education and counselling. Recognizing disabled individuals as sexual agents demands frameworks that affirm pleasure, autonomy, and access, moving beyond avoidance or abstinence-focused approaches toward inclusive, equity-centered practice. These insights not only inform counselling strategies and educational programming but also guide policy development, emphasizing the broader importance of integrating equity, autonomy, and pleasure into all aspects of sexual health discourse. In this way, the foundations laid in this literature review pave the way for Chapter 3, which considers practical implications for educators, caregivers and policymakers and focuses on highlighting strategies to create sexual health environments that are affirming, inclusive, and empowering for all.

Chapter 3: Discussion & Applied Practices

This capstone set out to ask: How can sexual education be made more inclusive for individuals with disabilities? Guided by a transformative feminist lens, the purpose of this project has been to critically examine how disabled people have been excluded from sexual health education and to consider how reframing curricula around pleasure, autonomy, and rights might redress those inequities.

The findings of the literature review underscore both the urgency and the complexity of this question. They reveal how historical patterns of infantilization, desexualization, and protectionist policies continue to shape disabled people's access to sexual health information and to limit their agency (Addlakha et al., 2017; Davies et al., 2024; Schaaf, 2011). They also highlight the profound consequences of exclusion, from heightened vulnerability to abuse to the internalization of shame and fear (Atkinson et al., 2022; Black & Kammes, 2021; Nosek et al., 2001). At the same time, the literature points to emerging frameworks that resist ableism and begin to normalize pleasure as a vital part of sexual citizenship (Loeser et al., 2018; Wong, 2022). While these findings provide critical insights into the marginalization of disabled individuals in sexual health discourse, they also reveal notable silences and gaps within the existing body of research. Identifying these limitations is essential for understanding both the strengths and the constraints of the current knowledge base.

This final chapter will reflect on the findings from chapter two, highlighting what can be learned from the existing research while also acknowledging its limitations and silences. It will consider how structural power and systemic inequities continue to shape the discourse, and it will address the tensions and challenges that accompany efforts to create more inclusive sexual education. By revisiting the aims of the project alongside the current state of knowledge, this chapter lays the groundwork for the applied practices and recommendations that follow.

Discussions

Limitations of the Literature

While the existing literature provides valuable insight into the exclusion and marginalization of disabled individuals in sexual health discourse, it also reveals significant limitations that constrain the field's capacity to address these inequities fully. Much of the research remains centered on Western, white, and heteronormative contexts, which limits the applicability of findings to culturally diverse communities. For example, Addlakha et al. (2017) note that although disability affects over 15% of the global population, progress toward sexual and reproductive rights has occurred unevenly across societies, with non-Western cultural perspectives often overlooked or underrepresented. This lack of cultural diversity in the scholarship narrows the conversation and risks reinforcing a one-size-fits-all approach to sexual health education. There are voices such as Yu Xiuhua, a woman of colour with a disability famous for her poetry, who also express a need for better sexual education for all, as she would have been able to embrace and explore her own sexuality much earlier on in life had she not been forced into a place of being an obedient, incapable wife (Etmanski, 2020).

Another limitation is the overemphasis on intellectual disabilities at the expense of exploring the experiences of individuals with physical, sensory, or invisible disabilities. Much of the research, such as Black & Kammes (2021), focuses on intellectual disabilities in youth, often framing education around hygiene, anatomy, and abuse prevention. While this work is essential, it sidelines the experiences of those whose disabilities are not cognitive, as well as the ways disability intersects with gender identity, sexual orientation, race, and class (Davies et al., 2023).

This lack of intersectionality means that the nuanced and layered realities of disabled people's sexualities are not fully captured. Alice Wong, who is herself a person of colour with a disability focuses her work (2020, 2024) on gathering own-voices to capture people's intersecting identities. One such voice depicts the individual being generalized as asexual before she even knew what the term meant, only to later, after going out of her way to prove society wrong, discover that this is in fact her preferred sexual expression, and is now owning it and thriving in her LGBTQ+ identity (Wong, 2020).

There is also a notable absence of own-voices research, where disabled individuals author, co-author, or otherwise lead scholarly work about sexuality and education. While many studies cite the voices of disabled people as participants (Soyer, 2018; Hole et al., 2022), and I have purposely included own-voiced information, (Soyer, 2018; Wong, 2020, 2024) fewer position them as knowledge producers or experts shaping the discourse. These dynamics risk perpetuating the very paternalism the literature critiques, where disabled people are studied rather than empowered as co-creators of knowledge. The integration of own-voices perspectives is critical for ensuring that research agendas are not only about disabled people but also meaningfully informed by them. We cannot ask the folk with disability to sacrifice themselves (Etmanski, 2020), for other's learning though, as this is putting this group of people into a place of vulnerability again, so intentional collaboration must always be done with explicit consent.

Finally, much of the existing research is reactive rather than proactive, emphasizing protection from abuse or avoidance of harm rather than envisioning affirming, pleasure-centered education. As Schaaf (2011) and Murray et al. (2017) point out, the tendency to frame disabled people as "eternal children" continues to limit how curricula are designed and evaluated. By privileging protectionist approaches, the literature underrepresents frameworks that normalize desire and affirm disabled individuals as sexual beings. There needs to be a place of to move away from a "freaky" image of sex and disability (Etmanski, 2020) and into a place of exploration and freedom. These omissions have not been accidental but reflect broader structural power dynamics that continue to shape which voices and perspectives are prioritized in research and education. A closer examination of these systems highlights how societal inequities are reproduced through policies, practices, and cultural narratives.

Structural Power & Systemic Inequities

The inequities revealed in the literature are not simply oversights but are actively maintained by systems of structural power. Ableism, patriarchy, and heteronormativity intersect to define disabled individuals in relation to an imagined norm, casting them as problems to be managed rather than as people with full sexual citizenship (Addlakha et al., 2017). These frameworks do not just marginalize disabled people, but they also produce conditions where agency, intimacy, and pleasure are systematically denied.

Alice Wong's anthology *Disability Intimacy* adds critical depth to this analysis by foregrounding disabled people's own experiences of sexuality, intimacy, and desire. For example, one contributor reflects on the cultural pressures that shaped her understanding of desirability, showing how ableism and sexism combined to limit how she could see herself as a sexual being (Wong, 2024). Similarly, another writer highlights the barriers that augmentative and alternative communication users face in navigating consent and sexual agency, underscoring how structural inequities extend beyond physical accessibility to communication itself (Wong, 2024). These narratives reveal how abstract systems of exclusion translate into daily embodied realities, filling the gap left by research that too often silences or sidelines disabled perspectives.

Institutional practices further reproduce these inequities. Gill and Hough (2007) document how educators filter sexual health information, deciding what is “appropriate” for disabled students, while Parchomiuk (2021) describes caregivers acting as gatekeepers to relationships and knowledge. These practices reflect systemic paternalism rather than individual failures which are structures that continue to privilege protection and control over autonomy and pleasure. Wong’s contributors echo this critique, with writer/activist naming the ways caregivers’ assumptions can become “walls” that dictate who disabled people are allowed to love or desire (Wong, 2024).

Intersectionality also sharpens the picture. Research often homogenizes “disability” as a single category, neglecting the realities of disabled women, queer and trans disabled people, and disabled people of colour (Davies et al., 2023; Greenwell & Hough, 2008). In contrast, *Disability Intimacy* offers accounts that embody this complexity with queer disabled contributors who are narrating experiences of layered marginalization in both LGBTQ+ and disability communities, revealing how exclusion operates differently across social contexts (Wong, 2024). These perspectives highlight the urgent need for scholarship and education to move beyond one-dimensional models of disability.

Ultimately, structural power ensures that disabled people are positioned as objects of care and protection rather than subjects of rights and desire. Until systemic forces are disrupted in education, caregiving, and cultural discourse, sexual health education will remain exclusionary and partial. At the same time, the insights of disabled writers and activists point toward more liberatory possibilities, reminding us that inclusion is not simply about adding disability into existing frameworks but about reshaping those frameworks entirely.

Recognizing these structural inequities also makes clear that change is both necessary and fraught. Moving toward inclusive, pleasure-centered sexual health education demands more than curriculum reform, it requires cultural shifts, resource redistribution, and the willingness to challenge entrenched norms. These realities invite us to consider the tensions and challenges moving forward, particularly around balancing protection with autonomy, avoiding tokenism, and navigating resistance in educational and caregiving systems.

Tensions & Challenges Moving Forward

While the movement toward inclusive, pleasure-centered sexual health education is necessary, the literature and own-voices accounts make clear that such change is not without tensions. Efforts to affirm disabled people's rights to sexual education must navigate persistent societal fears, paternalistic tendencies, and the practical complexities of reshaping long-standing systems.

One key challenge is the tension between protection and autonomy. As noted in the literature, disabled individuals are frequently framed as "eternal children," which has justified restricting their access to information under the pretense of protection (Chrastina & Vecerova, 2018; Davies et al., 2024). Yet, as Kaufman et al., (2003) emphasize, safety cannot come at the expense of agency. Their work demonstrates that disabled people benefit most when given tools to make informed decisions, not when others withhold knowledge (Kaufman et al., 2003). Balancing the need for protection against exploitation with the drive to foster autonomy remains a central challenge for educators, caregivers, and counsellors.

A second challenge involves resistance from institutions and caregivers who remain invested in avoidance or abstinence-based models. Gill and Hough (2007) found that educators often filter content they deem "appropriate," reinforcing paternalism. These dynamics can create shame and secrecy, as disabled individuals often learn that their sexual needs are inconvenient or even threatening to current established support systems (Kaufman et al., 2003). Changing these entrenched patterns requires not only curricular reform but also deep cultural work to shift the assumptions of those in positions of authority.

There is also the risk of tokenism and superficial inclusion. As Davies et al. (2023) note, disabled people are often homogenized, with intellectual disability overrepresented in research and practice, while the experiences of those with physical, sensory, or invisible disabilities, especially queer and racialized disabled people, remain marginalized. Wong (2024) makes clear that real inclusion requires centering diverse disabled voices and treating them as knowledge-holders, not as symbolic representatives. Without this depth, efforts at inclusion risk reproducing exclusion in subtler ways.

Finally, the pursuit of inclusive frameworks must contend with structural inequities in resources and policy. Even where educators and counsellors are motivated, limited training, funding, and systemic support constrain what can be implemented (Atkinson et al., 2022). Kaufman et al. (2003) highlight that access to affirming sexual health information often depends on geography, class, and healthcare systems, which are inequities that disproportionately affect disabled people. These barriers make clear that inclusion is not only a matter of curriculum design but also of resource distribution and systemic advocacy.

Taken together, these tensions do not diminish the need for inclusive, pleasure-centered sexual health education, they underscore its urgency. By acknowledging the difficulties inherent in disrupting deeply seeded norms, we can avoid naive or overly simplistic solutions. Instead, these challenges invite more nuanced, collaborative, and resilient approaches to creating change.

Applied Practices & Recommendations

The insights from the literature and discussion make it clear that change must happen on multiple levels at once. Exclusion from sexual health education is not only a matter of missing educational materials/tools, but it is rather the product of systemic forces, institutional practices, and cultural assumptions that work together to silence people with disability's sexual citizenship. To create meaningful transformation, recommendations must therefore address a few different areas of influence, such as schools, where sexual health education is first formalized, as well as caregivers and support workers, who shape knowledge and attitudes in daily life, and finally within policy and advocacy, which determine whether inclusive practices are sustained at a structural level. The following applied strategies highlight how educators, caregivers, and policymakers can work in interconnected ways to normalize pleasure, affirm autonomy, and expand access for disabled individuals.

Educators in Schools: Inclusive Language & Curriculum

Educators play a huge role in reshaping sexual health education into a space that affirms rather than erases disabled students. As the literature highlights, disabled individuals are often excluded from comprehensive educational sessions or presented with material limited to hygiene and anatomy, with little acknowledgement of desire, intimacy, or pleasure (Black & Kammes, 2021; Loeser et al., 2018). Such omissions are not neutral as they reflect ableist assumptions that cast disabled youth as asexual, childlike, or incapable of sexual agency. In order to resist this framing, educators must instead present inclusive practices that normalize disability as part of human diversity and recognize pleasure as a legitimate and necessary aspect of sexual health. Part of the normalization process could be the simple act of providing sexual health education to students who are affected by disability at the same time and in the same space as those students who are not.

One avenue for this change lies in the language educators use. Teaching about anatomy, hygiene, and bodies without pathologizing difference creates a foundation where all students see themselves reflected. Inclusive language avoids heteronormative assumptions, such as, the presumption that all relationships are heterosexual in nature, while it also challenges ableist tropes by acknowledging that people with disability, like their peers, have desires, needs, and the right to intimacy. As Kaufman et al,, (2003) emphasize, when information is presented in affirming ways, it provides students not only with knowledge but also with validation of their identities. Adolescence and youth are pivotal ages when one is establishing an identity, so to be provided with disability-normalizing language and tools for all will not only support those affected by disability, but will also set a standard of communication, compassion and care for all. Programs such as the *Healthy Relationships Curriculum* (Wollen, 2020), sets a perfect example of taking an educational program for students with disability beyond just anatomy and hygiene and into a place that includes pornography usage, and sexuality and the law.

Beyond language, educators can implement accessible tools that ensure full participation. This may include the use of pic symbols to support students with intellectual disabilities, with examples in *Healthy Relationships Curriculum* (Wollen, 2020), braille resources for students with visual impairments, or adaptive technologies that make lessons inclusive across sensory, cognitive, and physical differences. These tools communicate an essential message, that sexual health knowledge belongs to everyone. As Loeser et al. (2018) argue, centering pleasure and inclusivity in the curriculum benefits not only disabled students but also their peers, fostering a more disability-normalized world where diversity is integrated rather than marginalized.

Incorporating these changes requires more than technical adjustments, it represents a cultural shift in schools. Educators are positioned at the intersection of knowledge and care, with the potential to disrupt cycles of exclusion by modeling affirming, curiosity-driven approaches to sexuality. When they normalize the presence of disabled students in discussions of desire, intimacy, and pleasure, they not only challenge ableist narratives but also expand the possibilities of sexual health education for all students.

Caregivers & Support Workers: Affirming Agency Outside of School

Caregivers, parents, and support workers often play the most immediate role in how disabled individuals learn about their bodies, relationships, and intimacy. Yet, as the literature shows, these individuals may inadvertently act as gatekeepers, filtering or restricting access to sexual health knowledge in the name of protection (Parchomiuk, 2021). While the intent may be care, the impact can be silencing. When information is withheld, folk with disability are more likely to explore their sexuality in secret, increasing the likelihood of unsafe practices and reinforcing shame (Murray et al., 2017). Shifting this dynamic requires caregivers to move from control to more of a place of partnership, that is supporting exploration in ways that are safe, affirming, and inclusive.

One practical strategy is to normalize self-pleasure practice discussions. Kaufman et al., (2003) emphasize that masturbation is a safe and accessible way for people with disability to explore their bodies, build confidence, and learn about consent in a low-risk environment. Caregivers who approach these conversations with openness reduce secrecy, dismantle stigma, and affirm that pleasure is a valid and healthy part of life. There are many supports out there for parents and caregivers around these discussions as well, such as the Sex Ed Rescue website (2025), that delves deep into how to approach the discussion of masturbation with a child/youth that has a disability. Framing self-pleasure as one option among many for sexual expression also expands the understanding that intimacy is not limited to penetrative sex, which is a shift that benefits all people, affected by disabled or not. The inclusion of discussion around pornography and the usage of it are also pertinent when taking a pleasure-forward stance around sexual health education and the *Healthy Relationships Curriculum* (Wollen, 2020), again can support parents with tools and stills on this.

Caregivers and support workers can also make use of accessible resources to meet people where they are. This might include visual supports such as those in *Healthy Relationships Curriculum* (Wollen, 2020), simplified guides, or adaptive technologies that allow disabled individuals to engage with material in formats that align with their needs. Importantly, these tools should not only cover topics like hygiene and anatomy but also include pleasure, desire, and intimacy as key aspects of humanity. Alice Wong's *Disability Intimacy* echoes this call, with contributors describing how affirming conversations about their desires with caregivers or partners opened up space for agency and self-advocacy (Wong, 2024).

Supporting agency outside of school is not only about tools and information, but also about attitude. Caregivers who approach sexuality with curiosity and respect, rather than fear or avoidance, foster safe spaces where folks affected by disability can ask questions, set boundaries, and express desires. This approach breaks down the paternalism that has historically limited autonomy and instead affirms disabled individuals as full participants in their own sexual lives.

Policy & Advocacy: Structural Change for Long-Term Equity

While educators and caregivers play critical roles in day-to-day inclusion, meaningful and lasting change requires systemic support at the policy and advocacy level. Without broader structural reform, inclusive practices risk remaining isolated, unevenly distributed, or potentially dependent upon individuals who are championing them rather than being embedded into education practice and care.

Current literature highlights how people affected by disability have been systematically excluded from national and provincial sexual health frameworks (Addlakha et al., 2017; Davies et al., 2023). This exclusion is not simply an oversight but a reflection of generational ableist and heteronormative assumptions within policy making bodies. When sexual health education is designed around a narrow vision of the “typical” student, disabled people are rendered invisible. As Schaaf (2011) argues, this results in a “freedom from” model of protection rather than a “freedom to” model of agency and pleasure.

Policy and advocacy efforts must therefore focus on embedding disability-inclusive sexual health education into curriculum standards, teacher training programs, and professional development. This includes mandating that sexual health materials be produced in accessible formats, such as braille, large print, audio recordings, and pictorial symbols, and that more than the basics are addressed, but also desire, intimacy, and pleasure. As Kaufman et al., (2003) note, access to affirming sexual health information should not depend on geography, socioeconomic status, or the discretion of individual educators, it must be a guaranteed right.

Beyond education, advocacy organizations can help to bring about cultural and systemic change. Disability justice organizations, feminist groups, and queer advocacy networks increasingly recognized the intersections of ableism, sexism, and heteronormativity in shaping access to sexual health (Addlakha et al., 2017; Wong, 2024). Organizations such as the Autism Community Training (ACT) providing Real Talk (n.d.), for free and accessible health education, DisAbles Women’s Network of Canada (DAWN) helping the intersecting voices be heard, and Self Advocate Net being a place to stand up for one’s self, are just a few of the places that are working towards changes, and where more information can be gathered. Building alliances across these movements strengthens the collective call for change and resists the one-size-fits-all approaches. Policy advocacy at this level also helps shift public discourse, positioning disabled individuals as sexual citizens with rights, not as exceptions or afterthoughts.

Finally, structural reform must address resource inequities. Even where policy mandates exist, the implementation of them often has issue due to underfunding, limited training of educators, or lack of caregiver support. Advocacy must therefore push for funding streams dedicated to disability-inclusive sexual health education, ensuring that inclusive practices are sustainable rather than symbolic. Without this redistribution of resources, disabled individuals will continue to face gaps in access and knowledge, regardless of policy intentions. Policy and advocacy represent the long-term backbone of inclusive sexual health education. By mandating inclusive educational materials/tools, supporting educators and caregivers by providing training and resources, and amplifying the voices of disabled activists, policy reform can move us closer to a world where disabled people are recognized as full sexual citizens.

Taken together, these applied practices demonstrate that inclusive sexual health education cannot be reduced to a single site of change. Educators have the power to normalize pleasure and accessibility within the classroom, caregivers and support workers can foster agency and affirm desires in everyday life, and policy reform ensures these practices are embedded and resourced rather than left to chance. Each level reinforces the others. By weaving these approaches together, the barriers of exclusion, infantilization, and silence identified in earlier chapters can begin to be taken down. What emerges is a vision of sexual health education that is not only disability-inclusive but transformative for all students, a model that celebrates autonomy, embraces diversity, and recognizes pleasure as a fundamental aspect of human flourishing.

Final Reflection

This capstone set out to explore how sexual health education can become more inclusive of disabled individuals by centering pleasure, autonomy, and access for all. Across the literature, the historical exclusion and infantilization of folks with disability have been shown to carry ongoing consequences, leaving people vulnerable to harm while denying them the recognition of their full sexual citizenship. By tracing these systemic silences and exclusions, and by incorporating own-voices narratives, this project has highlighted not only the harm of the status quo but also the possibilities for transformation.

The applied practices outlined here demonstrate that meaningful change requires work on multiple fronts. Inclusive language and tools within schools, affirming practices among caregivers and support workers, and policy reforms that embed accessibility and pleasure into systemic frameworks are outlined here as necessary adaptions to current practice. Together, these illustrate that disability-inclusive sexual health education is not a specialized addition but a reimagining of what sexual health education can and should be for everyone.

Future work in this area must address the persistent gaps in representation, particularly the lack of intersectional perspectives from queer, culturally, spiritually, and racially diverse disabled individuals. More research led by scholars with disability and activists themselves is high important, as is advocacy that ensures these perspectives are not tokenized but instead meaningfully integrated.

Ultimately, disability-inclusive sexual health education is not only about correcting historical exclusions but about reshaping the future. It is a call to recognize pleasure as a fundamental right, to affirm autonomy as essential to dignity, and to create spaces where all people can claim their sexual citizenship. By centering disabled voices, we move toward an education system, and a society, that is richer, more just, and more humane for everyone.

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