

**Empowering Through Knowledge: The Critical Role of Sexual Education for Youth with
Disabilities to Promote Autonomy, Safety, and Overall Well-Being**

by

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Abstract

Sexual education is often treated as optional, especially for youth with disabilities. Access to accurate, inclusive information about sex, relationships, consent, and identity isn't an optional extra; it's a right. This capstone explores how comprehensive, affirming sexual health education can promote autonomy, safety, and well-being for youth with disabilities. Through a disability justice lens, it looks at the systemic factors that have shaped how and whether these conversations happen. It reviews the gaps in the current curriculum, the hesitation of caregivers and educators, and the emotional and relational consequences of leaving disabled youth out of the conversation. Just as importantly, it centers what disabled youth are asking for: content that is real, nuanced, and reflective of their lives, moving beyond fear-based messaging and surface-level information. Drawing on recent research and practice insights, the final chapter offers seven recommendations that prioritize accessibility, flexibility, and collaboration. These include individualized programming, support for adults in teaching roles, and a shift toward education that recognizes disabled youth as sexual beings with rights, boundaries, and desires. This work is about reimagining what's possible, not offering a one-size-fits-all solution, but a starting point for those who want to do better. When we leave disabled youth out of sexual education, we leave them more vulnerable. When we offer them the tools, language, and space to understand themselves and others, we help build something that reflects who they are, not who we assume them to be.

Keywords: sexual education, disability justice, developmental disability, youth, autonomy, safety, inclusion, rights-based education, neurodiversity, consent

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Chapter One: Introduction

Sexuality is a natural part of being human, but for many youth with disabilities, access to sexual health education is limited or completely absent (Davies et al., 2023). These youth are often left out of important conversations about relationships, consent, identity, and personal boundaries, even though they face heightened risks of exploitation and misinformation. Despite growing awareness of disability rights and the need for inclusive education, the sexual health needs of disabled youth are either ignored or pathologized, reinforcing the harmful idea that disabled bodies are less deserving of knowledge, autonomy, and connection (Davies et al., 2023).

This capstone examines how comprehensive and accessible sexual education can support youth with disabilities in building safer, more empowered relationships with themselves and others. It explores current gaps, challenges, and possibilities through a disability justice lens, with a focus on how service providers and caregivers can create more inclusive and affirming learning environments. By drawing from existing literature and best practices, this capstone aims to contribute to a broader shift in how sexual health education is understood and delivered, centering the experiences and rights of those who have historically been excluded.

Overview of Topic

Sexual health education plays a critical role in how young people come to understand themselves and navigate their relationships, yet youth with disabilities are often left out of these foundational learning experiences (Treacy et al., 2018). While societal discourse has evolved to recognize the importance of inclusion in many areas of education, sex education continues to reflect outdated beliefs about who is considered sexual and capable of intimacy. As a result, disabled youth are often denied access to the same information and guidance their non-disabled peers receive. When sexual health is addressed at all, it is often fear-based and framed through a

lens of risk and protection, rather than one of empowerment, which prioritizes agency, pleasure, and connection (Treacy et al., 2018).

Research shows that disabled youth are at an increased risk for sexual abuse, unplanned pregnancy, and poor mental health outcomes, yet they remain one of the most underserved populations in sexual health education (Davies et al., 2023). Many programs fail to reflect the diverse cognitive, sensory, and emotional learning needs of students with disabilities, while teachers and caregivers often feel ill-equipped or uncomfortable discussing these topics because it feels inappropriate. Even when resources do exist, they are often retrofitted rather than intentionally designed, and rarely adapted in ways that feel inclusive or grounded in a rights-based approach (Davies et al., 2023).

The ongoing absence of inclusive sexual education reflects a broader history of institutional neglect, where the rights of disabled people to understand and explore sexuality have been systematically denied (Davies et al., 2023). Addressing this gap requires more than an improved curriculum; it calls for a shift in how society views sexuality in the context of disability. This capstone situates itself within the growing movement among researchers and advocates to reimagine disability sexual education not as an afterthought, but as an essential part of promoting one's autonomy, safety, and well-being.

Purpose Statement

Youth with disabilities are regularly excluded from meaningful sexual health education, despite being at higher risk for harm and having the same rights to knowledge, autonomy, and connection as their peers (Treacy et al., 2018). The problem is not a lack of awareness, but a lack of action. Educators and caregivers are still without the guidance, tools, and support needed to create comprehensive and accessible learning experiences. Without foundational change,

disabled youth will continue to face increased risks while being denied access to the resources needed for informed choice and personal autonomy.

This capstone seeks to answer the following: *How can sexual education be reimaged to center the agency of disabled youth while equipping their supporting adults (counsellors, educators, caregivers, community professionals) with the frameworks and skills to show up with greater confidence and understanding?*

Theoretical Framework

This capstone is grounded in a disability justice framework, which centers the lived experiences of those who are most impacted and pushes back against systems that define whose bodies, identities, and relationships are treated as valid (Saia et al., 2024). It offers more than just a set of accommodations, it's a way of rethinking how we relate to disability, to power, and to each other. Rooted in the work of racialized, queer, and trans disabled activists, disability justice emphasizes collective access, interdependence, and the dismantling of ableism, not just in services, but in our thinking (Saia et al., 2024).

In the context of sexual health education, this lens invites us to look closely at who has been left out of the conversation and why, and to start including those voices when designing something better. Too often, sexual education for disabled youth is either avoided entirely or reduced to messaging about risk and protection (Davies et al., 2023). A disability justice approach asks us to stop seeing disabled youth as problems to be managed and start seeing them as people with rights, desires, and the capacity to make informed choices (Saia et al., 2024). This framework is supported by recent research that calls for a shift from protectionist approaches to rights-based, affirming models of sexual education for disabled youth (Carter et al., 2021; Davies et al., 2023).

This framework also urges us to consider intersectionality, recognizing how disability interacts with other identities like race, gender, and sexuality to create layered experiences of oppression and exclusion (Saia et al., 2024). Youth with intersecting marginalized identities are often at increased risk for harm and invisibility, particularly with sexuality education being so rooted in ableist, heteronormative, and cisnormative ideals (Davies et al., 2023).

By using disability justice as a guiding lens, this capstone moves beyond the question of whether disabled youth are ready for sexual education and asks instead whether we, the adults, the systems, the support people, are ready to show up differently.

Contributions to the Field

This capstone contributes to the field of counselling by challenging the ongoing silence and misinformed biases around sexuality in the lives of disabled youth. It brings attention to an area that is often pushed aside or treated as too complex, when it sits at the heart of autonomy, safety, and well-being (Treacy et al., 2018). If we claim to support the whole person in our work, then we can't continue leaving sexuality out of the conversation, especially for youth who already face increased vulnerability and limited access to information that could help them make sense of their bodies and relationships.

For clinicians, educators, and caregivers, this project offers a way in. It brings together current research and advocacy to help us think more critically about the systems we're part of, and what it looks like to show up with affirming care. Many of us know that this type of education matters, but don't always feel equipped to engage in it (Lam et al., 2022; Treacy et al., 2018). This capstone offers guidance that is practical and grounded in justice, shaped by the population we are serving, and designed to help those in support roles become stronger, more informed educator allies. This capstone invites us to stop questioning whether sexual education is

appropriate for disabled youth, and to start reflecting on how we can offer it in ways that are honest, accessible, and affirming.

Reflectivity and Positionality Statement

I approach this work as both a counselling student and someone with lived experience of developmental disability. My personal experiences with sexual health education, and the lack thereof, have shaped my understanding of why this topic is so critical. I attended Catholic schools where sexual education was abstinence-based, fear-driven, and extremely limited in scope. Lessons were brief and focused almost entirely on reproduction and STI prevention, leaving no space to ask questions or engage in dialogue that reflected our identities, experiences, or needs. Conversations around sexuality were absent at home as well. It was treated as something taboo and secretive, surrounded by discomfort. I can remember the hesitancy my mother displayed during the few conversations we had on the topic. When I asked for birth control, I was met not with openness or support, but with a plea to wait longer, and eventually, with visible disappointment when I didn't. Those moments sent a clear message: sexuality was not something to be talked about, and it made the adults around me uncomfortable.

As a result, I entered adolescence and early adulthood without the tools or knowledge to navigate relationships, consent, or my own developing identity. Much of my learning came later, through self-education in adulthood, and I look back with concern at how poorly equipped I was. What stands out to me even more now is how much privilege I had, I was verbal, able-bodied, and my body and identity mostly aligned with the limited curriculum that was offered. Even with these advantages, I felt lost and unsupported. It is deeply concerning to imagine how much more inaccessible and harmful these experiences must be for youth who don't fit into the narrow frameworks that sexual education is typically built around.

In my current work as a counsellor supporting primarily neurodivergent youth, and often their neurodivergent caregivers, I continue to see the consequences of these gaps. Many of the youth I work with do not understand personal boundaries, consent, or their own bodies, and their behaviours are often met with reactive consequences instead of proactive education. I regularly find myself having to reframe for caregivers what sexual health education involves. The goal is not to encourage sexual activity, but to provide skills that support safety, autonomy, connection, and identity development. Without these conversations, disabled youth are not protected, they are left more vulnerable in systems that already place them at greater risk (Davies et al., 2023).

I carry both insight and responsibility in this work. While my lived experience has provided a deep sense of empathy and urgency, I also recognize my position of privilege and the access I've had to education, language, and advocacy. I do not speak on behalf of disabled youth, but I aim to center their experiences and needs with integrity. I wrote this capstone grounded in that intention, to challenge the silence, discomfort, and outdated beliefs that still surround this topic, and to advocate for approaches built on science, accessibility, and connection. Youth are asking for systems to do better, and they deserve nothing less.

Definition of Terms

Ableism: A system of beliefs, practices, and social norms that devalue and discriminate against disabled people, often by positioning non-disabled bodies, minds, and ways of being as the standard or ideal (Sex Information and Education Council of Canada [SIECCAN], 2023).

Accessibility: The intentional design of environments, communication, and services so that they can be used and understood by people with a wide range of abilities, needs, and identities (Andreassen et al., 2024). In this capstone, accessibility includes cognitive, sensory, emotional, and relational access.

Abstinence-based Sexual Education: An approach that promotes refraining from sexual activity, often until marriage or a committed relationship, as the primary or sole strategy for preventing unintended pregnancies, sexually transmitted infections, and other negative sexual health outcomes (SIECCAN, 2019).

Agency: The ability to make informed decisions about one's own body, identity, and relationships (Carter et al., 2022).

Caregivers: In this capstone, caregivers refer to parents, guardians, and other adults in caregiving roles who support youth in their daily lives.

Comprehensive Sexual Education (CSE): A strengths-based approach designed to promote sexual well-being by fostering respectful relationships, self-acceptance, and access to care, while also preventing negative outcomes such as sexually transmitted infections, unintended pregnancies, sexual harm, and unhealthy relationship dynamics (SIECCAN, 2019).

Developmental Disability: A broad category of disabilities that typically appear early in life and may impact cognitive, emotional, social, or adaptive functioning (Coulter et al., 2022). This capstone includes youth with neurodevelopmental disabilities such as ADHD, autism, down syndrome, and cerebral palsy.

Disability Justice: A political and values-based framework created by racialized, queer and trans disabled activists (Saia et al., 2024). It moves beyond access and inclusion to focus on dismantling ableism, centering the most impacted, and building systems rooted in interdependence, collective care, and liberation (Davies et al., 2023; Saia et al., 2024).

Educator Allies: Supportive adults, including teachers, clinicians, caregivers, and community workers, who commit to showing up in affirming, informed ways for disabled youth.

Intellectual Disability: A disability characterized by significant limitations in both intellectual functioning (such as reasoning, learning, or problem-solving) and adaptive behaviour, which covers a range of everyday social and practical skills (Treacy et al., 2018).

Intersectionality: A framework that considers how various aspects of a person's identity (e.g., race, disability, gender, class) interact to shape their experiences of privilege or marginalization (Saia et al., 2024).

Neurodivergent: A term used to describe people whose cognitive processing differs from the dominant neurotypical norm (SIECCAN, 2023). This includes individuals with ADHD, autism, learning disabilities, and other neurological differences (SIECCAN, 2023).

Outline of Capstone Project Chapters

This capstone began by naming the gap, the ongoing exclusion of disabled youth from meaningful, affirming sexual health education. Grounded in disability justice and informed by both research and lived experience, this chapter outlines the purpose of the project, the problem it seeks to address, and the values guiding the work.

The next chapter turns to the literature to explore how we got here. It examines the historical and current context of sexual education in Canada, highlights the barriers that continue to limit access, and reflects on how these gaps impact disabled youth emotionally, relationally, and systemically. It also identifies what is still missing from current research and practice.

Building on that foundation, Chapter Three shifts the focus toward what could be done differently. It offers recommendations rooted in evidence and experience with tools and ideas that caregivers, educators, and clinicians can use to support youth more effectively. These suggestions are not fixed solutions, but starting points for creating learning environments that feel honest, inclusive, and aligned with the needs of those most often left out.

Looking Ahead

If we want to support the autonomy and well-being of disabled youth, we have to move beyond simply naming the problem and begin reshaping the systems that sustain it. The gap between what disabled youth need and what they receive in sexual health education is not due to a lack of evidence, but to persistent discomfort, under-resourcing, and ableist assumptions about capacity and disability (Andreassen et al., 2024).

What's missing is not just an affirming and comprehensive curriculum, but a shift in how we frame sexual education. This capstone responds to that need by drawing on current literature, advocacy insights, and disability justice frameworks to reimagine how we talk about sex, bodies, and relationships with disabled youth. Rather than concentrating on risk or compliance, this work centers on possibility and agency. The goal is to promote a vision of sexual education that treats disabled youth not as passive recipients of care, but as individuals with rights, desires, and the ability to make informed decisions when given the opportunity to learn in environments that are safe and supportive.

Chapter Two: Literature Review

Having a disability does not lessen an individual's desire for romance, intimacy, or sexual connection, nor does it make them incapable of expressing and fulfilling these needs. Unfortunately, many barriers exist that exclude disabled youth from receiving sexual health education that affirms their identities and experiences. For the study, I will be focusing on sexual education for youth with disabilities, including but not limited to intellectual, developmental, physical, and learning disabilities. This chapter offers a review of the current literature through a thematic lens, exploring areas such as the historical context of sexual education for disabled people, the current state of programming in Canada, the impacts of both abstinence-based and comprehensive education, systemic and social barriers, parental and professional discomfort, and the importance of including the voices of youth. It also highlights methodological and ethical gaps in the research, with the goal of creating more inclusive and empowering sexual education by centering the lived experiences of disabled youth.

Importance of Sexual Education

The Canadian Guidelines for Sexual Health Education states that it is a human right for all people to have access to age-appropriate and comprehensive sexual education (CSE) and resources across their lifespan (SIECCAN, 2023). Sexual education is invaluable for any youth to receive, as we know that knowledge is power and an incredible protective factor. When an individual is equipped with information, they can make informed decisions which promote their autonomy, safety, and overall well-being.

Risk Reduction

Sexual health education contributes to risk reduction as those with disabilities statistically experience the highest rates of mental, emotional, physical, and sexual abuse and are at a high

risk of exploitation, sexually transmitted infections (STIs) and unwanted pregnancies. (Treacy et al., 2018). Studies have repeatedly shown that youth with disabilities are significantly more vulnerable, experience higher rates of child abuse, assault, and family and domestic violence, and are 3.5 times more likely to experience sexual abuse compared to their peers without a disability (Andreassen et al., 2024; Daigneault et al., 2023).

A study by Daigneault et al., (2023) highlights several contributing factors for these rates: higher rates of children in the foster system, the increased need for caregiving support for more years than their peers (e.g. respite, day programs, therapies, group homes), increased support needs for personal care tasks, and challenges expressing their needs or concerns which make them less likely to recognize and seek support for inappropriate situations (Daigneault et al., 2023). The study concludes that one of the biggest factors was the lack of intervention and prevention measures being used that were specific to youth with disabilities, determining that there needs to be a better preventative response in equipping these youth with the education they need to keep themselves safe (Daigneault et al., 2023).

Promoting Autonomy and Informed Choice

Without sexual health education, not only is the vulnerability of disabled youth heightened, but it also limits their opportunity to understand the natural functions of their bodies and develop a healthy sexual identity where they can explore areas like their gender, sexual orientation, romantic connection, pleasure, and preferences (Treacy et al., 2018). Björnsdóttir et al. (2017) argue that access to information, the ability to make choices and the ability to communicate one's needs are essential for someone to develop personal autonomy, which is a fundamental component in exploring and constructing one's gender and sexuality.

Comprehensive sexual health education is not only focused on dating and sexual relationships but also teaches skills for establishing and maintaining healthy platonic and professional friendships through concepts like boundaries, consent, and communication (Andreassen et al., 2024). Information about puberty, personal hygiene, sexual anatomy, contraception, reproductive rights, online dating safety, gender roles, public versus private, safe people, and correct terminology are other components of a comprehensive sexual health education that is paramount for the well-being of all individuals (Andreassen et al., 2024). Without accessible and safe spaces to learn and practice this information, individuals with disabilities are being excluded from receiving support and learning information that not only keeps them safe but also impacts their ability to make independent and informed decisions that contribute to their mental and physical health (Andreassen et al., 2024).

Early Foundations of Sexual Education

The quality and scope of public sexual education have evolved over time, continually improving as the societal stigma around sex has shifted, and we continue to learn more through advancements in science. In the late 19th and early 20th century, formal yet basic sexual education programs were implemented to address public safety concerns of STIs and unwanted pregnancies, but these programs were not tailored to those with disabilities (Treacy et al., 2018). Moving forward, the 1960s-1980s brought about the Sexual Revolution, which sparked a more open discussion of sexual rights and emphasized the importance of CSE. This was also the time of the Disability Rights Movement, which focused on deinstitutionalization, accessibility, and human rights, highlighting the need for inclusive sexual education (Treacy et al., 2018). The 2000s to the present have shown a growing recognition of the importance of comprehensive sexual health education for those with disabilities that is inclusive and accessible, however, these

changes have yet to be fully implemented (Tidey et al., 2022). Currently, options available for sexual health education fall into one of two categories - abstinence-only or comprehensive-based (Stein et al., 2018).

Abstinence-Only Sexual Education: Impacts and Limitations

The concept of abstinence has deep historical roots, often tied to religious beliefs about procreation and morality. In the United States (US), abstinence-only social programming was implemented in the early 1980s with the introduction of the Adolescent Family Life Act (Treacy et al., 2018). This initiative has received significant federal investments over the past few decades, increasing from \$50 million to \$75 million in 2015 when it was rebranded as Sexual Risk Avoidance (SRA) programming (Treacy et al., 2018). The abstinence-only framework promotes the idea that sex should be reserved for marriage and stresses that abstaining from sexual activity is the only way to prevent pregnancy and sexually transmitted infections (STIs), ultimately claiming to result in healthier outcomes for youth (Treacy et al., 2018).

The characteristics of abstinence-only education tend to primarily focus on the biological and reproductive aspects of the human body through a medical perspective, with an emphasis on prevention and negative outcomes (Davies et al., 2023). The content is centralized around heterosexual relationships, does not touch on pleasure but rather encourages sexual avoidance, rarely discusses birth control and safe sex practices, and does not speak to disability, diverse relationships, genders, or sexual identities (Davies et al., 2023; Stein et al., 2017). The results of this type of messaging can create distorted views of sexual shame and stigma, leaving youth unprepared and fearful of these experiences as they are not equipped with the skills to protect and explore their sexual health (Davies et al., 2023; Sex Information and Education Council of Canada [SIECCAN], 2019).

Research has produced mixed results regarding the effectiveness of abstinence-only education in delaying sexual activity or reducing teen pregnancy rates when compared to comprehensive sex education. Stein et al. (2017) found that states solely teaching abstinence-only sexual education had the highest rates of teen pregnancy by approximately 50% and that it did not delay the age at which youth-initiated sex. Despite this, US funding does not consistently align with evidence-based practice, which creates a gap that disadvantages all students, including those with disabilities, by denying them access to accurate, inclusive, and research-informed sexual health education (Treacy et al., 2018).

In Canada, while abstinence-only education has not been formally implemented, its influence remains present within societal norms and certain educational or religious contexts (Davies et al., 2023). The challenge we face in Canada is that sexual education is not federally regulated; rather, it is at the discretion of each province and territory to determine and implement their own curriculum (Davies et al., 2023). This provincial delegation leaves significant room for content interpretation and inconsistencies throughout our Canadian schools.

Comprehensive Sexual Education (CSE)

The concept of CSE has been continually evolving since the start of the birth control movement in the early 1900s (Prescott & Thompson, 2020). Initially, the primary focus was on preventing unwanted pregnancies. However, it has since progressed into a more comprehensive and holistic approach to sexual health and well-being, incorporating multiple aspects of human sexuality and integrating principles of human rights (Davies et al., 2023).

A CSE curriculum includes important content focusing on the physical, emotional, relational, and cognitive well-being of all parties (Davies et al., 2023). Learners are taught not only about sexually transmitted infections (STIs) and the biology of puberty and reproduction

but also are educated on topics including but not limited to; birth control methods, masturbation, identity, platonic and romantic relationships, boundaries, consent, sexual orientation, gender diversity, communication, intercourse, self-esteem, dating, online safety, pornography and healthy vs. unhealthy relationships (Davies et al., 2023). Additionally, CSE integrates principles of human rights, bodily autonomy, self-determination, sexual and reproductive rights, self-identification, identity development, and the freedom of thought, belief, and opinion (Davies et al., 2023; SIECCAN, 2019).

Studies show that CSE, when delivered appropriately, has numerous positive and protective outcomes. Andreassen et al. (2024) found that effective CSE enhances learning and is associated with decreased unsafe sexual behaviours, including a reduction in unprotected sexual activity and lower rates of sexually transmitted infections (STIs). When implemented across all grade levels, CSE is linked to reduced rates of family and domestic violence and child sexual abuse (Andreassen et al., 2024). Other benefits of a CSE include an appreciation of sexual diversity, decreased homophobia and homophobic bullying, an expanded understanding of gender norms, gender equity, rights and social justice, healthier relationships, and improved rates of disclosure (Goldfarb & Lieberman, 2021). These positive outcomes extend to behavioural changes, such as increased condom and contraception use, enhanced self-determination, improved communication skills and independence, and better mental and physical health and well-being for all students (Andreassen et al., 2024; SIECCAN, 2019; Treacy et al., 2018).

Current State of Sexual Education in Canada

The Canadian Guidelines for Sexual Health Education states that it is a human right for all people to have access to age-appropriate and CSE and resources across their lifespan (SIECCAN, 2023). This information allows children and youth to protect themselves by making autonomous decisions that enhance their bodily autonomy, sexual health, and overall well-being (SIECCAN, 2023). In Canada, sexual health is part of the school curriculum, with 80% of Canadian youth identifying their school as the primary source of their sexual education (Farmer et al., 2019). Unfortunately, since it falls under provincial jurisdiction, there is no national standard for the structure, funding, time allotments and learning outcomes that each student will receive (Walters & Lavery, 2022).

Provincial Inconsistencies

Some provinces combine health and physical education while others have it as a completely different subject, and the allocated teaching time also ranges, with Ontario requiring only 30 minutes a week while Saskatchewan requires 80 minutes (Walters & Lavery, 2022). Other provinces, such as British Columbia, do not have a mandatory allotment of time specifically for Health, rather, Health is lumped in with several subjects, such as Science and Social Studies which have an expectation of 200-240 minutes total a week which is allocated as per the teacher (Walters & Lavery, 2022). This further contributes to the lack of consistency in time spent learning about Sexual Health, not only between provinces but also within.

Curriculum and Delivery Gaps

There is further inconsistency in how outdated each province's curriculum is, with Newfoundland still teaching material from 1994 and British Columbia having the most recent from 2016 (Walters & Lavery, 2022). Depending on the school, sexual health may be taught by

teachers, external healthcare providers, or community-based sexual health educators, meaning each instructor may have a different level of education and understanding (Lavery et al., 2021). Many teachers have reported that they received no formal training on the topics they were expected to teach, which could create a bias in only teaching what topics they are most comfortable with and unintentionally associate shame with the ones they are not, or possibly defaulting to an abstinence-only curriculum as it can require less preparation and resources (Farmer et al., 2019; Treacy et al., 2018). Davies et al. (2023) note that across Canada, most provincial sexuality education documents make little to no mention of disability, the intersections of disability and sexuality or even how to adjust the curriculum to meet the unique needs of disabled students. The only partial exception is Ontario, as its curriculum emphasizes the need for teachers to find ways to accommodate students with disabilities, though it is vague and places all responsibility on the educator (Davies et al., 2023).

All the limitations, inconsistencies and challenges noted above cover what accessing quality CSE is like for a typical student, noting that there are significant additional barriers if the student is a newcomer, is unhoused, is living in a remote area, or is living with a disability and/or chronic illness (Walters & Lavery, 2022). With how essential CSE is for the autonomy, safety and well-being of all youth, there should be even fewer barriers for those who are more vulnerable, not more. In looking at the inconsistency across all these factors, there is great cause for concern about the efficacy and accessibility of sexual health education in Canada, especially for youth with disabilities.

Systemic Exclusion in Sexual Education

Conversations about sexual health can look very different depending on the individuals involved, their knowledge, experiences, and comfort levels. While much of the existing literature

focuses on the role of parents, many youths with disabilities are also supported by other caregivers, such as group home staff, foster parents, grandparents, siblings, educational assistants, or personal support workers. These individuals often play a significant role in the youth's development, but may also experience discomfort, lack of training, or unclear boundaries when it comes to discussing sexuality. Research indicates that youth receive sexual health information from a variety of sources, including parents, friends, educators, the internet, and their school (Walters & Laverty, 2022).

Equity and Access: A Rights-Based Perspective

Given that over one in four Canadians, approximately 27 percent or 8 million people, live with a disability that affects their daily functioning (Statistics Canada, 2024), it is likely that many were students with disabilities at some point in their lives. Access to sexual health education represents a fundamental human rights issue for students with disabilities. According to the United Nations (2009) Convention on the Rights of Persons with Disabilities, which Canada has officially adopted, countries must “provide persons with disabilities with the same range, quality and standard of free or affordable health care and programs as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes” (Art. 25, para. 2). Despite these international agreements, studies reveal that individuals with disabilities are consistently underserved. They face limited access to CSE and services specifically tailored to their unique needs (SIECCAN, 2023). This is due to many factors, including a general lack of awareness of its importance, as historically, individuals with disabilities have been stigmatized as "less than" or "incompetent" and, therefore, deemed unfit for education of any kind, let alone sexual health education (Treacy et al., 2018).

Curriculum Design and the Exclusion of Social-Sexual Learning

Current school curricula are primarily designed for neurotypical and non-disabled students and often fail to address the unique challenges faced by students with disabilities, such as understanding social cues or navigating flirting (Hannah & Stagg, 2016). While these skills might seem straightforward for neurotypical students, they can be transformative for students with disabilities, who may not acquire them simply by observing their peers. Aside from the content, the format that schools use to teach sexual education is often a group setting, which may pose a challenge for students with disabilities who find it difficult to engage with and learn in peer groups (Hannah & Stagg, 2016).

Students with disabilities typically have a school-based Individualized Education Plan (IEP), which outlines their unique goals and support services for each school year. These plans often prioritize vocational training over social skills development, which typically would include education on sexuality and relationships (Solomon et al., 2019). Given that approximately 80% of a student's sexual education is delivered through schools, the omission of this critical component from their customized education plan raises an important question: Why are students with disabilities being excluded from a proper sexual health education, and how are they going to learn this essential knowledge?

Societal Barriers and Attitudes

Many deeply ingrained societal attitudes and misconceptions create what is the largest barrier for youth with disabilities in receiving proper sexual education. These views are formed from both present and historical influences, such as laws like the Alberta Sexual Sterilization Act, which was in effect from 1928 to 1972, and legalized the involuntary sterilization of those with "negative eugenics" (McCavitt, 2013). Though this law is no longer in effect, its influence

on the social perception of those with disabilities as a medical deficit, inherently asexual, unfit to parent, or incapable of making informed decisions about their bodies, continues to shape public attitudes (McCavitt, 2013).

Another societal view is that those with disabilities are non-sexual beings who are uninterested or incapable of engaging in sexual relationships or that their expressions of sexuality are deviant or taboo (Coulter et al., 2022; Treacy et al., 2018). Sexual behaviours are more likely to be labelled as "inappropriate" and "problematic" and seen as a source of risk for those working with or supporting individuals with disabilities, rather than normalizing their experiences (Davies et al., 2023). This stigma leads to reactive approaches rooted in shame and fear, rather than proactive education that creates understanding and empowerment.

Though the social stigma of sex and discussions involving it has lessened over the last few decades, there remains such varying views and comfortability with the topic across different generations, cultures, religions, and genders ranging anywhere between very liberal and open to very conservative and reserved, creating a complex landscape that influences how sexual education is approached, discussed, and implemented. These polarizing viewpoints are prevalent among students, parents, teachers, school boards, curriculum designers, political parties, and country leaders, which makes it a very heightened topic. This was evident in 2023 when the Sexual Orientation and Gender Identities (SOGI) curriculum in Canadian schools sparked widespread protests among educators, caregivers, and political parties, with sides both for and against the curriculum's content (Link, 2023). This divide only promotes feelings of concern, fear and anxiety for parents and educators, creating an overall cautious attitude which leads to a lack of advocacy for the importance of proper sexual education programming in schools (Treacy et al., 2018).

Educational System Failures

Beyond the influence of political landscapes, there are systemic barriers within the education system that significantly limit access to comprehensive and inclusive sexual education. Given the existing lack of funding and inconsistent support for sexual health education in general, even fewer resources and less awareness are directed toward programs specifically designed for students with disabilities (Treacy et al., 2018).

We have established that a significant barrier is Canada's lack of federal standardization regarding sexual health education, including curriculum content, learning expectations, and evaluation methods. Currently, the programs developed by each province and territory do not include specific requirements for teaching about disability within sexual health education or the intersectional identities of gender, sexual orientation, disability, and trauma history (Lepor-Stevens, 2024). Additionally, they fail to provide adapted materials or guidance on how to modify the curriculum to meet the unique needs and experiences of diverse learners (Davies et al., 2023). This overall lack of standardization leads to significant variability, not only between provinces but also among school districts, regions, and even individual schools and classrooms within the same province (Lavery et al., 2021).

In addition to the already limited and varying content educators are expected to deliver, many report receiving little to no training in how to effectively teach sexual health, even to neurotypical and non-disabled students (McKenney et al., 2024; Treacy et al., 2018; Walters & Lavery, 2022). This lack of training becomes even more apparent when addressing the needs of students who fall outside of the traditional framework of what is considered "normal" sexual development and knowledge, leading to increased discomfort among educators and further marginalization of disabled students (SIECCAN, 2023). When teachers do not feel comfortable

or prepared to teach about topics like sexual health, there is a likelihood that they will resort to teaching only the topics they feel knowledgeable and comfortable with (Lavery et al., 2021; McKenney et al., 2024). While this already contributes to inadequate education, the lack of teacher training creates opportunities for personal biases, whether conscious or unconscious, societal stigmas and the projection of shame and embarrassment to come through when educating about sexual health (Lavery et al., 2021). Other barriers noted by teachers include a limited amount of preparation and teaching time, not enough funding, insufficient curricula, school and district policy limitations, legal ramifications, and concerns about the responses of students, parents, and administration (Treacy et al., 2018).

Exclusion and Segregation

Most sexual health curricula in Canada are not stand-alone courses but rather are blended into other courses like physical education or science (Walters & Lavery, 2022). Some students with disabilities may not participate in mainstream academic courses due to a variety of factors, such as mobility limitations, health conditions, or sensory sensitivities (Davies et al., 2023). Others may be enrolled in specialized education programs, miss school frequently for medical or therapy appointments, face behavioural challenges that impact attendance, or attend alternative learning programs in place of traditional schooling. (Davies et al., 2023). As a result, these students are more likely to miss out on sexual health education, further widening the gap in knowledge, safety, and autonomy between them and their non-disabled peers.

In addition to academic exclusion, students with disabilities often experience social exclusion within their broader school environments, resulting in fewer opportunities to engage with their non-disabled peers. Many students with disabilities are supported by an educational assistant throughout their school day, which is often essential for their academic and social

success (Davies et al., 2023). However, the constant presence of an adult can unintentionally create barriers to natural peer interactions (Davies et al., 2023). Outside of the classroom, informal learning and social development take place in everyday settings such as the cafeteria, hallways, school buses, and during extracurricular or after-school activities (Davies et al., 2023). Gougeon (2009) refers to this as the "ignored curriculum," the unstructured moments where youth can organically learn and practice social skills, interpret social norms and cues, and navigate the dynamics of peer relationships.

Parental and Professional Discomfort

There is often a disconnect regarding who is responsible for delivering sexual health education to youth; a conversation that becomes even more complex when disability is involved. While both parents and educators generally agree on the importance of this education, research shows that both sides often experience discomfort, anxiety, and hesitation about being the ones to provide it (Treacy et al., 2018). Educators have shared concerns about the potential backlash from parents and the legal ramifications of providing CSE to students, particularly those with disabilities (Treacy et al., 2018). For parents, the desire to "protect" their child often leads to shielding them from certain topics, including sexuality (Coulter et al., 2023). Though well-intentioned, it can inadvertently increase the youths' vulnerability by withholding the very information that could keep them safe (Coulter et al., 2023).

Parents of youth with disabilities often feel an increased sense of responsibility to protect their children from harm, exploitation, or misunderstanding. This is an understandable reaction as disabled youth are statistically more vulnerable (Davies et al., 2023). To protect them, parents may try to shield their youth from any topics they perceive as risky, and sexuality tends to be one of those topics (Davies et al., 2023). Many individuals with disabilities are also infantilized,

where they are viewed and treated as "eternal children" who are thought of as lacking sexual needs or desires (Lepor-Stevens, 2024). Studies have shown that parents of children with disabilities are less likely to initiate conversations about sexuality, or they tend to provide less detail due to concerns about their child's comprehension, maturity, or developmental age (Stein et al., 2017). These conversations are often delayed or deprioritized in favour of other academic goals, are triggered only in response to perceived "inappropriate" behaviour or are limited to safety-focused topics rather than addressing the broader spectrum of sexuality (Colarossi et al., 2023a; Stein et al., 2017).

A common fear among parents, caregivers, and educators is that sexual education will encourage inappropriate sexual behaviour, leading to even greater challenges than just a lack of awareness (Coulter, 2022). Some parents deny that their child has any interest in sex or believe that learning about it will lead to negative outcomes such as pregnancy or becoming a victim of sexual assault, despite evidence showing that limited access to sexual education increases the risk of these outcomes (Colarossi et al., 2023b; Coulter et al., 2023). These fears may be the result of the parents' own discomfort with discussing sexuality, conflicting cultural or religious values, or a lack of training in how to address these topics (Colarossi et al., 2023b).

Cultural Influences on Parental Attitudes

Cultural background can significantly shape parental attitudes toward sexual education. In some communities, discussions about sexuality are considered taboo or inappropriate at certain ages, especially when it comes to youth with disabilities. For instance, a study involving Malay mothers revealed that even though they recognized the importance of sex education, discussions about sexuality remained taboo due to conflicting family values and cultural norms (Kamaludin et al., 2022). Similarly, a study involving professionals in China found that

collectivist cultural views on sex and parental opposition created substantial barriers in advocating for personal autonomy and effective sex education for individuals with intellectual disabilities (Lam et al., 2022). As a result, families may default to abstinence-based approaches or avoid sexual health education altogether (Coulter, 2022). These findings highlight the importance of cultural sensitivity when developing and implementing sex education programs so that they accurately address the unique needs of diverse communities. This cultural discomfort often overlaps with broader fears and misconceptions about youth sexuality, especially for those with disabilities.

Discomfort and avoidance are often based on the belief that youth with disabilities are not already thinking about their bodies, relationships, or desires for connection, intimacy, and attraction, and that these thoughts would suddenly be activated if these topics were introduced. These thoughts and experiences are already occurring within the youth and denying them access to appropriate and accessible sexual health education deprives them of the opportunity to become informed, empowered, and self-determined individuals (Treacy et al., 2018). When caregivers and educators avoid discussing sexuality, it sends a harmful message to youth that these topics are taboo or irrelevant because of their disability, reinforcing feelings of exclusion and contributing to internalized shame.

Centering the Voices of Youth with Disabilities

Much of the existing research focuses on the perspectives of parents, caregivers, educators, and professionals, while often overlooking the voices of disabled youth, whose experiences are the most important (Coulter et al., 2022). While these differing perspectives offer valuable insight, excluding the voices of the very population these programs are meant to support leads to curricula that fail to reflect their lived experiences and actual needs. Unfortunately, a

common ableist assumption is that individuals with disabilities are incapable of understanding or making informed decisions about their own lives, especially their sexual health (Coulter et al., 2022). This limits them to being a passive recipient of care instead of an active participant in their own life. To address this gap, it is essential to center the voices of youth with disabilities in the development and delivery of sexual health education, as doing so fosters self-determination, dignity, and agency, while also contributing to more authentic and impactful programming.

When the voices of disabled youth are included, they speak clearly about their needs and desires regarding sexuality education. Many express frustrations with being excluded from conversations or treated as if they are uninterested or incapable of understanding topics related to sexuality (Coulter et al., 2022). They view sexuality as a meaningful part of their identity and have the same expectations for relationships and sexual expression as their peers; they want the freedom to explore and experience this natural part of life. Like their peers, many youths express a desire to date, form meaningful connections, fall in love, and eventually build long-term relationships that may lead to marriage and/or having children. (Coulter et al., 2022). Unlike their peers, youth with disabilities experience significantly more barriers and challenges in obtaining the education they need and the supports they require to pursue these goals (Coulter et al., 2022).

Youth Perspectives on Gaps and Challenges

When given the opportunity to share their perspectives, youth with disabilities consistently highlight a range of barriers that limit their access to comprehensive, inclusive, and affirming sexual education. These barriers span social stigma, exclusion from school-based programs, lack of representation and differences in developmental experiences.

Systemic Exclusion and Social Gatekeeping

In multiple studies, youth identified societal stigma and ableism as the largest barrier, often acting as gatekeepers that restrict their access to essential information (Carter et al., 2022; Davies et al., 2023; Toman et al., 2024). Youth feel they must convince authority figures that they are autonomous sexual beings as they advocate for access to sexual health information, with varying levels of success (Toman et al., 2024). Many report experiences of their sexuality being dismissed by teachers, medical professionals, parents, and peers, driving disabled youth to seek out their own answers through other avenues such as online communities, social media, and educational resources (Toman et al., 2024). Though this is a viable option for some youth, navigating the internet and filtering through the endless amounts of misinformation can be a significant barrier for others, eliminating self-guided sexual education as an option for some (Davies et al., 2023). With the right design, online curricula have the potential to be a highly accessible tool for diverse learners if the content is inclusive, adaptable, and developmentally appropriate.

Curriculum Gaps and Lack of Representation

When asked about their experiences with sexual health education in school, many youths identified that it was unhelpful and fear-based (Andreasen et al., 2025; McKenney et al., 2024). The curriculum covered was not inclusive or comprehensive, with a heavy focus on reproduction, sexually transmitted infections, and contraception (McKenney et al., 2024; Toman et al., 2024). Youth note that there was a complete lack of disability or queer representation in the material they were learning, with some students quickly losing interest and disengaging due to its heterosexual able-bodied focus (Coulter et al. 2022). Youth who hold multiple marginalized identities, such as those who are 2SLGBTQA+, BIPOC, or from different cultural

backgrounds or religions, face layered barriers when their experiences are not reflected in sexual health content or classroom discussions (Andreassen et al., 2024). This lack of intersectional representation further isolates youth and creates additional barriers to receiving relatable sexual education and reinforces feelings of invisibility.

Exclusion of Youth with High Support Needs

Youth with high support needs, particularly those who are non-verbal or rely on augmentative and alternative communication (AAC), are among the most excluded from sexual health education (SIECCAN, 2023). These individuals sometimes require intensive daily support, may have impairments in language comprehension and/or expression, and may rely on non-traditional forms of communication (Vivet et al., 2025). As a result, they are frequently left out of both research and classroom settings, reinforcing the harmful assumption that they are incapable of understanding, experiencing, or participating in sexuality and relationships (Vivet et al., 2025).

This exclusion is not because they lack the capacity to learn about sexuality, but because systems are not built to include them. Traditional sexual education programs are almost entirely verbal, abstract, and delivered in group-based formats (Treacy et al., 2018). These curricula are typically designed for able-bodied, neurotypical learners and only adapted afterward, if at all, for disabled students (Hole et al., 2022). Youth report that these delivery formats rarely align with their learning styles or communication needs, especially for non-verbal youth or those requiring individualized support (Tidey et al., 2022).

Developmental Differences and Missed Social Learning

Some students noted challenges with sexual development timelines as there is a bidirectional link between sexuality development and disability symptoms, sometimes resulting

in early or delayed onset of puberty (Toman et al., 2024). Some youth with disabilities reported feeling separate from their peers and the sexual health information they were learning, as it did not apply to their developmental experiences (Toman et al., 2024). Many youths shared that they learned about sexual health, dating, and intimacy vicariously through their peers, while others missed out on these opportunities due to challenges with social engagement, a skill that could be supported through comprehensive sexual health education (Carter et al., 2022). Others reported having little to no interest in learning about sexual health and relationships, which further limited their understanding, as they were not actively seeking information or engaging in the educational opportunities available to them (Toman et al., 2024). Beyond these barriers, many youths also described the emotional impacts of being excluded from or misunderstood in sexual education.

Emotional and Psychological Impacts

The absence of inclusive, affirming sexual health education can have lasting emotional consequences. Youth report feeling ashamed, confused, or invisible when their identities and experiences are not acknowledged, leading to internalized stigma, and missed opportunities for self-understanding and confidence-building (Coulter et al., 2022). Disabled youth have voiced fears of rejection from their peers for being perceived as different, anxiety when encountering information that did not align with their bodies or experiences, and disappointment in how unprepared they felt to navigate their sexual health (Coulter et al., 2022). For some, this exclusion also creates frustration, isolation, and the sense that their needs and identities are unimportant and intentionally ignored. These emotional impacts can shape how youth view themselves, their bodies, and their relationships well into adulthood.

Intersectionality

Youth with intersecting identities, such as those with disabilities who also identify as 2SLGBTQA+, report experiencing higher levels of discrimination and stigma compared to their non-disabled peers (Amos et al., 2024). These youth are significantly more likely to experience psychological distress, mental health challenges, suicidal ideation, and suicide attempts (Amos et al., 2024). When we look at the intersections of race, gender, and disability, BIPOC men with disabilities are often seen through a lens of stigma and suspicion. Lepor-Stevens (2024) found that their sexuality is more likely to be perceived as deviant, leading to harmful assumptions that they are aggressive or dangerous. Colarossi et al. (2023b) also noted that parents of Black youth with intellectual disabilities fear their children will be unfairly accused of sexual offences, which highlights how these overlapping identities increase the risk of both victimization and wrongful blame. These overlapping identities amplify barriers and intensify the potential consequences of not receiving inclusive sexual education, placing these youth at a higher risk of harm and marginalization. This makes it even more critical that these voices are centered in the development of comprehensive and diverse programming.

Youth Perspectives on Caregiver Support

While many youths acknowledge the role of parents and caregivers in sexual education, they often do not see them as their preferred or primary source of information (Lavery et al., 2021). Youth commonly report turning to schools or trained professionals instead due to concerns about discomfort, judgment, or outdated information when trying to discuss these topics at home (Colarossi et al., 2023b). Some youth are open to involving their caregivers, but only if they create a safe, open, and non-judgmental space for conversation (Colarossi et al., 2023b). Both caregivers and youth reported that these conversations were avoided when adults

seemed embarrassed or if the content conflicted with cultural or religious values (Hole et al., 2022). Youth also feared their interests and curiosities would be met with negativity, shame, or stigma, especially for 2SLGBTQA+ youth who worried their identities would not be accepted (Hole et al., 2022).

In a study by Hole et al. (2022), youth with intellectual disabilities described caregivers, family members and support staff as gatekeepers who often restricted their relationships and sexual expression. Participants shared experiences of being reprimanded for showing physical affection, getting teased or told they were being inappropriate when they brought up sexual topics, and denied privacy with their partners (Hole et al., 2022). Any sexual education they received was often focused on safety and risk without mention of pleasure and connection (Hole et al., 2022). Youth also felt that their sexual orientation was often assumed to be heterosexual, with any interest outside of that framed as a phase or experimentation rather than a valid part of their identity (Hole et al., 2022).

Despite these challenges, many youths expressed a desire for independence in accessing accurate, up-to-date information, while still wanting the option to turn to caregivers when they need additional support. When caregivers were seen as safe and supportive, youth identified them as helpful sources for navigating values, boundaries, relationships, complex situations, and emotional safety (Colarossi et al., 2023b; Hole et al., 2022). Ultimately, parents and caregivers can be a powerful source of guidance and support when they are equipped with accurate information and the tools to create open and affirming spaces for youth to learn and gain self-understanding.

What Youth Want from Sexual Education

In addition to highlighting the many gaps in current sexual education, youth with disabilities have also clearly expressed what they want to see done differently. Across multiple studies, youth consistently call for sexual health education that is honest, accurate, and relevant to their lives (Lavery et al., 2021; Walters & Lavery, 2022). They want more than just anatomy and risk prevention; they want content that includes topics like pleasure, communication, consent, relationships, and identity (Colarossi et al., 2023b). Many are frustrated by outdated materials, overly clinical lessons, and fear-based messaging that fails to reflect their lived experiences (Lavery et al., 2021).

Youth emphasize the importance of inclusive content that reflects diverse sexual orientations, gender identities, cultural backgrounds, and disabilities (Walters & Lavery, 2022). They want to see themselves represented in what they are learning, and they want the information delivered in ways that are practical, relatable, and reflect modern realities (Lavery et al., 2021). There is a strong desire for learning environments that are non-judgmental and safe, where questions are welcomed, and educators are trained and supportive (Walters & Lavery, 2022). These requests are not unreasonable; they are foundational to building a CSE curriculum that is accessible and empowering. Chapter Three will explore these education topics more fully and offer recommendations for how sexual education programs can better reflect the realities, needs, and desires of youth with disabilities.

Methodological and Ethical Considerations

Several methodological and ethical gaps emerged from the literature reviewed. While many studies used a variety of approaches, such as interviews, focus groups, surveys, and mixed-methods designs, there were several common limitations. These included small sample sizes,

convenience sampling, limited participant diversity, little attention to intersectional identities, and a lack of randomized control trials. In some cases, this made it difficult to assess how effective an intervention was or whether the findings could be generalized to other populations. Increasing collaboration between youth with disabilities, researchers, practitioners, and educators could help address these limitations and bridge the gap between research and realistic implementation.

One of the most significant concerns was the exclusion of youth with disabilities, especially those with high support needs who are non-verbal or communicate in non-traditional ways. These youth were often not included in research at all, or their experiences were conveyed by parents or professionals speaking on their behalf. While these perspectives can add valuable insight, relying on them exclusively risks misrepresenting the true needs and desires of youth and can reinforce deficit-based narratives. Even in the few studies that did include the perspectives of disabled youth, many used research methods that were not accessible or flexible enough to accommodate a full range of communication styles and developmental experiences.

Ethically, most studies followed basic protocols, such as securing informed consent, protecting confidentiality, and offering emotional support when discussing sensitive topics. However, research involving people with disabilities requires more than just basic ethical practices, given the history of their exploitation within research (Saia et al., 2023). Truly inclusive and respectful research involves adapting consent and data-gathering methods, prioritizing emotional safety, and actively removing barriers for full participation to amplify the voices of those who are most often excluded. Ethical research should also aim to benefit participants and their communities, not just minimize harm, by ensuring that findings are accessible, meaningful, and shared in ways that create real-world change.

Moving forward, more inclusive, transparent, and participatory research practices are needed. There must be a stronger effort to center the voices of disabled youth who have been consistently excluded from both research and education. Real change will only happen when disabled youth are seen as experts in their own lives and are at the center of every decision that impacts them, because there should be "nothing about us without us" (SIECCAN, 2023).

Conclusion

Youth with disabilities have long been left out of sexual education that affirms their identities, reflects their realities, and respects their rights. This exclusion is not incidental; it stems from deep-rooted ableism, outdated systems, and the discomfort of adults who underestimate or fear the sexuality of disabled youth. These education gaps don't just withhold important learning; they deny youth the opportunity to build autonomy, increase safety, and develop well-being in their bodies and relationships.

Disabled youth have been clear about what they want: relationship-based, affirming, and honest education that centers their experiences and needs. The following chapter responds to that call by outlining practical recommendations for caregivers, schools, and service providers. These strategies are not quick fixes, but a starting point for building sexual health education that moves beyond inclusion as an ideal and into a practice that truly empowers.

Chapter Three: Practice Recommendations and Training Considerations

Chapter Two explored the current state of sexual education for youth with disabilities and the many barriers that prevent them from receiving the support they need. The literature revealed how inconsistent programming, a lack of professional training, and the discomfort of adults often result in disabled youth being excluded from conversations about sex and relationships. While disability-specific sexual education programs do exist, they are not widely implemented in school settings. This is due to a combination of factors, with one of the most significant barriers being the social perception that disabled people are not sexual beings or that their sexuality is somehow taboo. Combined with the reality that no single curriculum can meet the needs of all disabilities, schools and caregivers often default to avoidance rather than adaptation, leaving many students without the education they deserve.

This chapter shifts from understanding the problem to imagining what could be done differently. It offers seven practice-based recommendations grounded in disability justice, each aimed at creating more inclusive, accessible, and affirming experiences for disabled youth. These are not meant to be one-size-fits-all solutions, instead, they are intended as a flexible framework that educators and caregivers can adapt in collaboration with each youth.

At the core of this work is the belief that sexuality is a natural and meaningful part of who we are—beautiful, complex, playful, intimate. Yet we’ve built systems that teach youth to fear it, suppress it, or view it as something shameful. This is especially true for disabled youth, who are often infantilized or excluded from conversations altogether. Rather than avoiding it or trying to control it, we need to create opportunities for youth to explore this part of themselves in safe, supported, and informed ways. Sexual education should not be rooted in fear; it should be built around autonomy, safety, and belonging. That is what every young person deserves.

Key Recommendations: A Vision for Inclusive Practice

Throughout the literature, all youth, regardless of disability, background, or support needs, benefit from access to comprehensive and affirming sexual health education. This information should not be treated as optional, as it is a core part of development that supports autonomy, consent, identity, and safety (Goldfarb & Lieberman, 2021; Schmidt et al., 2021). For disabled youth, who statistically are the most vulnerable and who are often left out of these conversations, it is even more essential (Treacy et al., 2018).

Sexual Education Should Be Its Own Subject

Sexual education is already being taught in most schools, but the way it is delivered is deeply inconsistent and often inadequate. In many provinces, it is embedded within physical education or health courses, which means it receives inconsistent instructional time, lacks clear learning outcomes, and the content is often left to the discretion of individual teachers. Students in special education programs may not be enrolled in these classes or miss them due to therapies, health appointments, or behavioural support needs (Davies et al., 2023; Lepore-Stevens, 2024). Even when students are present, the content may be skipped, diluted, or taught only through a risk-based lens that reinforces fear rather than empowerment (Davies et al., 2023; Lepore-Stevens, 2024; Treacy et al., 2018).

The location of this education should not change. Schools are still the most direct and consistent way to ensure all youth receive sexual health education; however, this does not mean that classroom teachers should be responsible for delivering it. Many educators report feeling underprepared or uncomfortable teaching topics related to sex and relationships, particularly when working with disabled students (Farmer et al., 2019; Lavery et al., 2021). When this

responsibility is left to individual teachers or solely caregivers, discomfort, personal values, and systemic bias can shape or limit what is taught (Schmidt et al., 2021; Treacy et al., 2018).

To change this, sexual education should be treated as its own subject, with dedicated instructional time, clear curriculum guidelines, and taught by professionals who are trained in sexual health. This could include sexual health nurses, community-based educators, or counsellors who have the awareness of how to teach in inclusive and developmentally appropriate ways (Goldfarb & Lieberman, 2021; Wellington et al., 2024). These educators should collaborate with disability specialists to ensure that the content reflects the diverse needs and lived experiences of disabled youth and can be adapted as needed through further collaboration with the youth and their caregivers.

For students who are not attending school due to behavioural challenges, trauma, or other complex factors, education must still be made accessible. This might mean offering sessions in community health clinics, youth programs, or other trusted spaces. Schools already adapt how academic and mental health support is delivered to meet students where they are, and sexual health education should be no different.

Seven Guiding Principles for Inclusive Sexual Education

Sexuality Is a Right

Sexual health is recognized internationally as a human right, grounded in the values of dignity, autonomy, equality, and self-determination (SIECCAN, 2023). Youth have the right to learn about their bodies, relationships, boundaries, and identities in ways that are both accessible and relevant to their lived experiences. The United Nations Convention on the Rights of Persons with Disabilities supports this by stating that disabled individuals are entitled to the same standard of education, health care, and information, including access to sexual and reproductive

health, as their non-disabled peers (United Nations, 2006, as cited in SIECCAN, 2023). These rights include legal capacity, privacy, the right to marry and have children, and the ability to access reproductive health care (SIECCAN, 2023). This reinforces that sexual agency and expression are not privileges; they are rights that apply to everyone (SIECCAN, 2023).

Sexual rights are deeply connected to other fundamental human rights, including the right to health, equality, privacy, access to information, and protection from discrimination and violence (Carter et al., 2022; SIECCAN, 2023). The World Health Organization (WHO) defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (SIECCAN, 2023, p. 11). This biopsychosocial lens is a more holistic approach that gives a broader understanding of the importance and impact of sexual health. It also highlights how barriers to expressing or exploring one’s sexuality can affect much more than development, often leading to lasting impacts on mental health, safety, and one’s sense of self. (SIECCAN, 2023).

These human rights are reflected in the Sex Information and Education Council of Canada's Canadian Guidelines for Sexual Health Education, which assert that comprehensive, inclusive sex education is essential to bodily autonomy and overall well-being (SIECCAN, 2023). When disabled students are excluded from this education, it sends a message that their bodies, experiences, and desires are not valid. It increases their vulnerability to harm and challenges their sense of self (Goldfarb & Lieberman, 2021; Lepore-Stevens, 2024). A human rights-based approach is about more than just information; it affirms identity, builds confidence, and supports the ability to make informed, empowered choices. Disabled youth deserve education that reflects this, not as a privilege, but as a human right they are already owed (Wellington et al., 2024).

Flexible and Accessible

Sexual health education must be both flexible and accessible to meet the diverse and evolving needs of all students, especially those with disabilities. Traditional, one-size-fits-all models, or curricula that are retrofitted for disability, often overlook learners who require different supports, communication tools, or pacing (Tidey et al., 2022). For many disabled students, especially those with high support needs or non-traditional communication methods, pre-set curricula and group-based formats make participation difficult or impossible (Tidey et al., 2022). The result is a system that unintentionally excludes the very students who could benefit the most from this education (SIECCAN, 2023; Vivet et al., 2025).

Flexibility means adjusting the content and the way it is taught to fit the needs of the group, without omitting important information. Educators should have the tools and support to pause, revisit, or deepen certain topics based on student questions and developing needs (Andreassen et al., 2024; Coulter et al., 2022). It also means creating space for students themselves to shape the learning process, especially when they are looking for specific information or have clear preferences around how they learn best (Goldfarb & Lieberman, 2021). Methods like incorporating movement, storytelling, visual media, role play, and tactile and sensory supports help make abstract ideas more concrete and can make learning feel more relevant and applicable to real life (Davies et al., 2023; SIECCAN, 2023).

Accessibility is not just about the physical environment, it's also about the language, format, and pacing of the content. Written materials should be offered in plain language, visual formats, braille, or other assistive devices as needed (Hole et al., 2022; Tidey et al., 2022). Lessons should allow for sensory breaks, alternative participation or learning options, smaller groups or individualized lessons, and communication supports like sign language, AAC devices,

or picture-based systems (Lepore-Stevens, 2024; Vivet et al., 2025). Students must feel safe to leave or rejoin as they need, ask anonymous questions, and participate in ways that reflect their comfort and ability (Tidey et al., 2022).

Accessibility also means recognizing that not all learning happens at school. Youth who are home-schooled, health-compromised, or attending community-based programs must still be able to access inclusive, affirming, and developmentally appropriate sexual health education. This includes training for caregivers, access to online resources, and partnerships with healthcare providers and local agencies (Andreassen et al., 2024; SIECCAN, 2023).

Ultimately, flexible and accessible sexual education tells students that they are worth including. It says, "You deserve to understand your body, your choices, and your relationships, and we will meet you where you are to help make that happen."

Centered Lived Experience

For sexual health education to be relevant and affirming, it must be shaped by the people it's meant to serve. Disabled youth have made it clear that they don't want content made for them without them. They want to see themselves reflected in the material, learn from people who understand and live their realities, and have a say in what is taught and how (Coulter et al., 2022; SIECCAN, 2023).

This approach is rooted in co-creation and representation. It values the lived expertise of disabled youth, not just as participants, but as leaders and decision-makers. When youth are involved in creating and co-delivering content, the material becomes more grounded and relational and builds autonomy (Tidey et al., 2022). It challenges the top-down, expert-driven, retrofitted models that have historically excluded or misrepresented them, and prioritizes the

perspectives of lived experience (Tidey et al., 2022). These voices can easily be heard through interviews, focus groups, storytelling, and surveys (Laverty et al., 2021).

Centering lived experience also means making space for real stories, peer-led teaching, co-facilitation, and conversations that grow in real time from the questions students are carrying (Toman et al., 2024). When education includes the realities of disabled bodies, identities, and communication styles, it stops treating difference as something to manage and starts treating it as something to learn from (Walters & Laverty, 2022). Students are far more likely to engage when they see themselves reflected and when they feel that their voices are important and welcome (Davies et al., 2023).

Educators have a role in this too, not as a source of knowledge, but as facilitators who can hold space for curiosity and connection. Set the stage for open discussions, role plays, art-based learning, personal shares, and real-life case studies so that students can connect to the material and feel safe to share their perspectives (Tidey et al., 2022). When we let lived experience guide education, we create something that is genuinely inclusive (Andreassen et al., 2024).

Teach the Whole Person

Sexual health education for disabled youth is often limited to safety, hygiene, or anatomy, and framed almost entirely around what could go wrong. While risk education is important, it's only one small part of what youth want and need. Teaching the whole person means offering education that speaks to the full human experience, including emotion, identity, curiosity, relationships, and pleasure.

In several studies, disabled youth have spoken about what information they want to learn (Andreassen et al., 2025; Colarossi et al., 2023b; Laverty et al., 2021; Walters & Laverty, 2022).

They're asking for content that reflects their real lives, like understanding how to form and maintain friendships, dating relationships, and deeper romantic or sexual connections (Andreasen et al., 2025; Colarossi et al., 2023b). They are looking for tools to identify and navigate conflict, build respect and trust, communicate clearly, and know what care looks and feels like in practice (Hole et al., 2022).

There is also a strong desire for honest conversations about consent, boundaries, and coercion explained through scenarios that mirror their real life (Colarossi et al., 2023b). Many students have shared that they've been taught ways to recognize and protect themselves from physical danger, but not enough practice in giving, obtaining, and understanding consent and boundaries (Colarossi et al., 2023b; Tidey et al., 2022). Students shared that their education often avoids talking about the positive aspects of sexuality, such as pleasure, masturbation, partnered sex and sexual expression, which leaves many youth feeling lost and confused (Colarossi et al., 2023b). Teaching the whole person means naming these topics and approaching them in ways that honour different bodies, sensory needs, and ways of connecting (Lepore-Stevens, 2024; SIECCAN, 2023).

Youth also want to explore gender, orientation, and identity without stigma (Toman et al., 2024). Many youth are navigating intersectional identities as queer, trans, or racialized disabled people, and they want education that helps them make sense of those layers, not one that pretends the identities exist in isolation of one another or not at all. This wrap-around education includes learning about intersectionality, self-advocacy, navigating heteronormative, ableist and cisnormative cultural expectations, and how to access affirming care (Amos et al., 2024).

Teaching the whole person means teaching in a way that sees disabled youth as capable and sexual beings while making space for questions that may not have easy answers. Disabled

youth don't just want to know how to stay safe, they want to understand what feels good, what feels right, and how to create relationships that are both safe and satisfying.

Challenge Ableism

Challenging ableism in sexual health education requires more than adding a few disability-specific resources. It asks us to reconsider how society views disability, how we define access, and how we decide whose experiences are seen as valid. Ableism isn't just found in the gaps of sexual education, it is built into the structure and assumptions of sexual education programs (Davies et al., 2023). For disabled youth, this often means being overprotected from or overlooked entirely in the content.

A truly inclusive approach begins by acknowledging that most sex education is designed around ableist norms (Davies et al., 2023). It assumes learners have certain types of bodies, physical abilities, can use verbal communication, and are in able-bodied relationships. To shift this, sexual health education needs to be grounded in disability justice; programs must be co-created with disabled youth, reflect a range of identities and needs, and prioritize access and agency from the beginning (Davies et al., 2023).

This also requires what disability scholars and activists call "cripping the curriculum" (Davies et al., 2023). To "crip" something is to examine how existing systems and practices reinforce ableist ideas, and then reimagine them in ways that create true access, agency, and inclusion (Davies et al., 2023). In sex education, this means dismantling the unspoken belief that only certain types of people are sexual or worthy of being taught about their own bodies and desires. Crippling the curriculum asks educators to build content that reflects the full spectrum of bodies, minds, and ways of being, and to do so from the start, not as an afterthought (Davies et al., 2023).

Ableism also shows up in the hidden curriculum, the unspoken rules and values that shape how students relate to themselves and each other (Davies et al., 2023). When disabled youth are excluded from peer interactions, left out of discussions about dating or gender, or offered only the most basic content, it sends the message that their needs are too complicated and/or inappropriate (Davies et al., 2023). Challenging that means creating learning environments where they can engage fully, see themselves reflected, and feel safe asking questions without fear of judgment (Amos et al., 2024; Tidey et al., 2022).

Educators, caregivers, and support staff all play a role in shaping how both disabled youth and their non-disabled peers come to understand things like sexuality, identity, and what inclusion looks like. This means being willing to reflect on their personal biases, becoming comfortable with the content, and committing to practices that respect and affirm the sexual rights of disabled youth (Colarossi et al., 2023a). It also means noticing where ableism is showing up and doing the work to create environments that support agency and understanding.

Challenging ableism also means pushing for cultural and policy change. We need to challenge the belief that disabled people are inherently less capable of love, pleasure, and autonomy and instead recognize them as whole, multi-dimensional individuals with equal rights. Until we shift the cultural narrative that sees disability as a limitation rather than a difference, education will likely continue to reflect and reinforce that narrative.

Make It Ongoing and Relational

Sexual health education shouldn't be a one-time lesson or a rigid checklist of topics, as human development is lifelong and constantly shifting. What a ten-year-old needs to know is very different from what a sixteen-year-old needs, or someone living independently with a partner for the first time (SIECCAN, 2019). For many disabled youth, learning needs to happen

over time, through real relationships, and in ways that can adapt as their questions and understanding evolve (Lavery et al., 2021). When education is rushed or only offered once, it leaves no room for processing time and nuances. New questions come up all the time about bodies, identities, relationships, and safety, and students need more than a single unit in health class to navigate it all.

Youth are more likely to engage honestly when they trust the adults they are learning from, and trust takes time to build when such personal topics are being discussed (Lavery et al., 2021). When a student feels safe in the relationship, they are more likely to disclose a worry, name a boundary, or speak up when something does not feel right (Lavery et al., 2021). For many disabled youth, especially those who have been dismissed or misunderstood, that sense of safety makes all the difference. The relational connection helps ease the silence and shame that often surround conversations about sexuality and disability.

This kind of learning also supports the development of real-life key skills; boundaries, consent, advocacy, and communication are not one-time lessons (Lavery et al., 2021). They take repetition and clarity, and the time and space to practice, as they can be more abstract concepts to grasp. Youth need the chance to revisit these ideas and try again as their relationships and identities evolve. What didn't feel relevant one year might feel essential the next. Having access to adults who are approachable and open to continuing the conversation matters just as much as the information itself (Lavery et al., 2021).

Engage Families, But Ensure Access

Caregivers play a significant role in shaping how youth think and feel about sex, relationships, and identity (Colarossi et al., 2023b). Youth benefit most when their caregivers are informed, supportive and able to create space for open conversations (Colarossi et al., 2023b).

Unfortunately, this is not the experience of all youth, which is why access to sexual health education should never depend on caregiver involvement or permission.

Some families may feel uncomfortable or unsure about how to approach these topics, while others may hold values that make them hesitant to engage (Lepor-Stevens, 2024). Offering education and resources to caregivers is important, but it must be framed as an optional and supportive, not a requirement to their youth receiving a CSE. Caregivers can be invited to learn alongside their youth through tools such as program overviews, workshops, support groups, conversation guides, online modules, and approved resource lists (Colarossi et al., 2023a; SIECCAN, 2019). For families who are unsure or navigating cultural differences, there should be space to share concerns, ask questions anonymously, or connect with professionals who understand and respect their values (Colarossi et al., 2023a). The more information caregivers have, the more likely they are to continue these important conversations at home.

Education systems need to make it clear that sexual health education is a right. In fact, it is mandated by every provincial and territorial Ministry of Education in Canada (SIECCAN, 2019). While caregiver input can inform curriculum design, it should never override a youth's right to access CSE. The content is too important. Youth must be able to turn to trusted adults outside their home, whether that is teachers, counsellors, or healthcare professionals, especially when their family environment is unsupportive or unsafe (Lepor-Stevens, 2024). They also need private ways to access resources and ask questions without fear of being punished or denied support (Lepor-Stevens, 2024). These youth still deserve access to a comprehensive, inclusive sexual education that is grounded in care and respect. They have a right to understand their own sexual health and make informed choices. Supporting families matters, but access must come first.

Challenges and Limitations

While this chapter has outlined several practice-based recommendations for improving sexual health education for disabled youth, there are still significant gaps in the existing research and the way it is applied in practice. These limitations exist at every level, from research design and content delivery to societal attitudes and systemic structures, and they directly shape the effectiveness of this work.

One of the biggest concerns is the lack of representation of disabled youth in the actual research. Many studies seek out the perspectives of caregivers, educators, or service providers, which can shift the focus and narrative toward perceived challenges and difficulties rather than the true needs and wants of youth with disabilities (Vivet et al., 2025). Participatory research approaches are underused, even though involving disabled youth in the research and design of programs would likely lead to more relevant curricula and more empowering outcomes (Vivet et al., 2025). By reinforcing the top-down model of research, we contradict the values that these programs are meant to promote: autonomy and agency.

According to a systematic review by Vivet et al. (2025), many studies have small sample sizes of less than 30 participants, are concentrated in high-income countries, and lack representation from racialized, LGBTQ+, unhoused or remote, or culturally diverse youth with disabilities (Lavery et al., 2021). They are also often missing long-term follow-up, making it difficult to generalize findings to larger populations, to understand long-term impacts, or to know how to effectively design programming for marginalized youth (Vivet et al., 2025).

On a content level, the majority of sexual health education is focused on risk prevention, biology, or basic anatomy (Lavery et al., 2021). Very few programs address pleasure, desire, emotional safety, identity, or self-advocacy (Lavery et al., 2021). There is an absence of adapted

learning materials, inclusive representation in content and delivery, and alternative communication modes, which limits accessibility for students with diverse support needs (Treacy et al., 2018; Vivet et al., 2025). The lack of customization forces many students to either “fit in” with a program or be left out.

At the system level, educator discomfort and limited training remain major barriers to effective sexual education (Treacy et al., 2018). Many professionals and caregivers report feeling unsure of how to deliver content in a way that is developmentally appropriate, inclusive, and safe, and feel uncertain about whose role it is to ensure that youth are receiving this education (Treacy et al., 2018). This discomfort often leads to avoidance of the subject altogether or defaulting to abstinence-based programming, as it can feel more straightforward to teach (Treacy et al., 2018). Additionally, societal stigma, cultural taboos, and medicalized views of disability continue to reinforce the narrative that disabled youth are asexual and incapable of autonomy or giving true consent (Vivet et al., 2025).

There is a lack of clear, evidence-based policy and formal assessment to support CSE (Lavery et al., 2021). While “some form” of sexual health education is mandated by every Ministry of Education in Canada, most provinces and territories do not have standardized tools to measure student comprehension, and there are no systems in place to ensure schools are meeting expectations (Lavery et al., 2021; SIECCAN, 2019). This gap already exists for non-disabled students, but it becomes even more concerning for disabled youth, who are already more likely to miss out on this education. Without clear expectations and methods for accountability, Canadian sexual education will remain inconsistent.

Ethical uncertainty around consent and privacy, combined with limited collaboration between researchers, educators, and those with lived experience, continues to impact progress

(Treacy et al., 2018). Programs are often designed without input from the people they're meant to serve, and when the voices that matter most are missing, the result is education that does not align with true need.

Future Directions and Research Needs

Improving sexual health education for disabled youth requires more than identifying what's missing, it means actively building systems, programs, and research that reflect the real needs and lives of the people they support. One of the most important shifts going forward is moving toward more participatory, youth-led research (Wellington et al., 2024). Disabled students should be directly involved in shaping the questions being explored, the materials created, and how accessible that information is. These youth are not just subjects, they are active contributors, advisors, and co-facilitators.

Future research should also focus on capturing the experiences of disabled youth who are often overlooked, including those with high support needs, comorbid disabilities, those who are unhoused or living in rural or remote areas, and youth with intersecting identities across race, gender, and sexuality (Lavery et al., 2021). Studies must move toward larger, more demographically diverse participant groups that will allow for more meaningful representation and generalizability across broader populations (Schmidt et al., 2021). We also need to better understand how impactful this learning is over time through longitudinal and mixed-mode studies, which will provide more generalizable information (Carter et al., 2022). Currently, most research provides little information about how knowledge and behaviour changes are sustained over time, how youths' views on sexual education evolve as they age, and the long-term health impacts of receiving CSE (Carter et al., 2022).

In terms of curriculum and content, more research is needed to test different teaching methods and delivery models, as what works for one group of students may not work for another. Materials must be designed to support diverse learning needs from the start, using accessible language, incorporating visual and sensory supports, and offering content in flexible, multimodal formats (Andreassen et al., 2024; Schmidt et al., 2021). This will help ensure that all students, including those who communicate or process information differently, can fully participate and engage with the content. Programs must also reflect cultural, religious, and physical diversity so that youth see themselves represented and can access learning in ways that feel safe and relevant (Colarossi et al., 2023b). This could include blended formats that combine school-based, digital, and community learning spaces, using a mix of multimedia content, role-playing, direct instruction, peer-led activities, social stories, and online modules to support all disabilities and learning styles (Andreassen et al., 2024).

At the systems level, research needs to explore how policy and education frameworks can be updated to mandate and evaluate sexual health education (Lavery et al., 2021). This way, all students, regardless of ability, receive quality, comprehensive learning. There is also a need to better train educators, parents, and caregivers so they feel confident and competent in supporting their youth(s) in this area (Andreassen et al., 2024). As a society, if we can shift disability narratives, reduce stigma, and better support both families and professionals, we can move from fear-based thinking to a rights-based framework that centers dignity, autonomy, and well-being for all of those with a disability.

Finally, future work should also focus on expanding what is considered important to teach. Youth with disabilities have made it clear that they want more than just biology and safety facts out of their sexual education. They want to learn about pleasure, connection, identity, and

relationships. They want help navigating dating apps and figuring out how to talk about their needs. They want content that empowers them, not just protects them. Research and education must keep up with those evolving realities. If we want programs to feel useful and supportive, they need to be grounded in real life.

Conclusion

This work is about more than just updating the curriculum; it's about rethinking how we value disabled youth and the space we make for them to grow into their full selves. Sexual health education should not be treated as an optional add-on, a risk management strategy, or a difficult topic to avoid. It should be part of how we show youth they matter and that their bodies, questions, and experiences are valid.

This chapter has outlined a framework for what that could look like. The seven principles introduced here offer a foundation for educators, caregivers, and systems to build from, each grounded in the belief that all youth have a right to this knowledge and deserve the opportunity to engage with it in ways that make sense for them. To move forward, this work must be collaborative, grounded in justice and accessibility, and guided by disabled voices at every level, from policy to practice.

The changes outlined are not small, but they are possible. They begin with listening, with reimagining what is possible, and with being willing to evaluate and challenge our own biases. By shifting the way we approach sexual health education, we don't just fill a gap; we actively build a culture where disabled youth are seen, heard, and supported in becoming who they are. That is the work. That is the invitation.

References

- Amos, N., Hill, A. O., Lyons, A., Bigby, C., Carman, M., Parsons, M., & Bourne, A. (2024). Factors associated with experiences of harassment or abuse among lesbian, gay, bisexual, trans, queer, and asexual young people with disability in Australia. *Journal of Interpersonal Violence, 39*(9–10), 2189–2213.
- Andreasen, S., Allison, T., Kamelchuk, B., Formusa, V., Reissner, B., Howe, S., McCabe, J., Martino, A. S., & McMorris, C. A. (2025). Fostering healthy relationships in Special Olympic athletes: Supporting the intersection of intellectual disability and sexual health. *Journal of Applied Research in Intellectual Disabilities, 38*(2), e70032.
- Andreassen, K., Quain, J., & Castell, E. (2024). Stop leaving people with disability behind: Reviewing comprehensive sexuality education for people with disability. *Health Education Journal, 83*(8), 830–840. <https://doi.org/10.1177/00178969241269656>
- Björnsdóttir, K., Stefánsdóttir, Á., & Stefánsdóttir, G. V. (2017). People with intellectual disabilities negotiate autonomy, gender and sexuality. *Sexuality and Disability, 35*(3), 295–311.
- Carter, A., Strnadová, I., Watfern, C., Pebdani, R., Bateson, D., Loblinzk, J., Guy, R., & Newman, C. (2022). The sexual and reproductive health and rights of young people with intellectual disability: A scoping review. *Sexuality Research & Social Policy, 19*(1), 372–390.
- Colarossi, L., Collier, K. L., Dean, R., Pérez, S., & Riquelme, M. O. (2023a). Sexual and reproductive health education for youth with intellectual disabilities: A mixed methods study of professionals' practices and needs. *Prevention Science, 24*(Suppl 2), 150–162.

- Colarossi, L., Riquelme, M. O., Collier, K. L., Pérez, S., & Dean, R. (2023b). Youth and parent perspectives on sexual health education for people with intellectual disabilities. *Sexuality and Disability, 41*(3), 619–641.
- Coulter, D., Lynch, C., & Joosten, A. V. (2023). Exploring the perspectives of young adults with developmental disabilities about sexuality and sexual health education. *Australian Occupational Therapy Journal, 70*(3), 380–391. <https://doi.org/10.1111/1440-1630.12862>
- Daigneault, I., Paquette, G., De La Sablonnière-Griffin, M., & Dion, J. (2023). Childhood sexual abuse, intellectual disability, and subsequent physical and mental health disorders: A matched cohort study. *American Journal on Intellectual and Developmental Disabilities, 128*(2), 134–144.
- Davies, A. W. J., Balter, A., Street, K., Parsons, A. R., & Clampitt, J. (2023). Disabled students and the erasure of disability in Canadian sexuality education curriculum: A call to crip the curriculum. *The Canadian Journal of Human Sexuality, 32*(2), 153–165.
- Farmer, E., Fleming, N., Black, A., & Dumont, T. (2019). Where are we in terms of sexual health education? An Ontario perspective. *Journal of Obstetrics and Gynecology Canada, 41*(6), 835–837.
- Goldfarb, E. S., & Lieberman, L. D. (2021). Three decades of research: The case for comprehensive sex education. *Journal of Adolescent Health, 68*(1), 13–27.
- Gougeon, N. A. (2009). Sexuality education for students with intellectual disabilities, a critical pedagogical approach: Outing the ignored curriculum. *Sex Education, 9*(3), 277–291.

- Hannah, L. A., & Stagg, S. D. (2016). Experiences of sex education and sexual awareness in young adults with autism spectrum disorder. *Journal of Autism and Developmental Disorders, 46*(12), 3678–3687.
- Hole, R., Schnellert, L., & Cattle, G. (2021). Sex: What is the big deal? Exploring individuals with intellectual disabilities' experiences with sex education. *Qualitative Health Research, 32*(3), 453–464.
- Kamaludin, N. N., Muhamad, R., Mat Yudin, Z., & Zakaria, R. (2022). Barriers and concerns in providing sex education among children with intellectual disabilities: Experiences from Malay mothers. *International Journal of Environmental Research and Public Health, 19*(3), 1070.
- Lam, A., Yau, M. K., Franklin, R. C., & Leggat, P. A. (2022). Challenges in the delivery of sex education for people with intellectual disabilities: A Chinese cultural-contextual analysis. *Journal of Applied Research in Intellectual Disabilities, 35*(6), 1370–1379.
- Laverty, E. K., Noble, S. M., Pucci, A., & MacLean, R. E. D. (2021). Let's talk about sexual health education: Youth perspectives on their learning experiences in Canada. *The Canadian Journal of Human Sexuality, 30*(1), 26–38.
- Lepore-Stevens, M. (2024). Adapting a human sexuality curriculum for students with disabilities. *Health Education Journal, 83*(8), 841–854.
- Link, R. (2023). Terrace City Hall becomes flashpoint for SOGI curriculum protests. *Terrace Standard*.
- McCavitt, C. M. (2013). Eugenics and human rights in Canada: The Alberta Sexual Sterilization Act of 1928. *Peace and Conflict, 19*(4), 362–366.

- McKenney, E. E., Cucchiara, C., Zapotitla, S. B., & Gotham, K. (2024). You don't 'just know': Difficulties in determining desire, recognizing trauma, and accessing high-quality sexual education in neurodiverse young adults. *American Journal of Sexuality Education*, 1–36.
- Prescott, H. M., & Thompson, L. M. (2020). A right to ourselves: Women's suffrage and the birth control movement. *The Journal of the Gilded Age and Progressive Era*, 19(4), 542–558.
- Saia, T., Yaghmaian, R., Cuesta, R., Mueller, C., & Pebdani, R. N. (2024). A call to action for disability and rehabilitation research using a discriit and disability justice framework. *Disability and Rehabilitation*, 46(14), 3189–3195.
<https://doi.org/10.1080/09638288.2023.2242780>
- Schmidt, E. K., Robek, N., Dougherty, M., Hand, B. N., Havercamp, S., Sommerich, C., & Darragh, A. (2020). Recommendations to improve accessibility of sexuality education for individuals with intellectual or developmental disabilities: A qualitative study. *American Journal of Sexuality Education*, 16(1), 38–56.
<https://doi.org/10.1080/15546128.2020.1860177>
- Sex Information and Education Council of Canada. (2019). *Canadian guidelines for sexual health education*.
- Sex Information and Education Council of Canada. (2023). *Canadian guidelines for sexual health promotion with autistic youth*.
- Solomon, D., Pantalone, D. W., & Faja, S. (2019). Autism and adult sex education: A literature review using the information-motivation-behavioral skills framework. *Sexuality and Disability*, 37(3), 339–351. <https://doi.org/10.1007/s11195-019-09591-6>

- Statistics Canada. (2024, October 8). *Canadians with learning, developmental and memory disabilities, 2022*.
- Stein, S., Kohut, T., & Dillenburg, K. (2018). The importance of sexuality education for children with and without intellectual disabilities: What parents think. *Sexuality and Disability, 36*(2), 141–148.
- Tidey, L., Schnellert, L., & Hole, R. (2022). Everyone should get the chance to love: Sexual health education and disability research-based theatre with self-advocates. *The Canadian Journal of Human Sexuality, 30*(1), 35–45. <https://doi.org/10.3138/cjhs.2022-0018>
- Toman, M., Wesche, R., & Shivers, C. M. (2024). Narratives of personal health and sexual education experiences of emerging adults with disabilities. *Sexuality and Disability, 42*(4), 851–880.
- Treacy, A. C., Taylor, S. S., & Abernathy, T. V. (2018). Sexual health education for individuals with disabilities: A call to action. *American Journal of Sexuality Education, 13*(1), 65–93. <https://doi.org/10.1080/15546128.2017.1399492>
- United Nations. (2009). *Convention on the rights of persons with disabilities*.
- Vivet, N., de La Rochebrochard, E., & Martin, P. (2025). Young people with disabilities and their sexual health: A descriptive review of needs, recommendations and interventions. *BMC Public Health, 25*, 930.
- Walters, L., & Laverty, E. (2022). Sexual health education and different learning experiences reported by youth across Canada. *Canadian Journal of Human Sexuality, 31*(1), 18–31.
- Wellington, M., Dew, A., Frawley, P., David, J., & O’Shea, A. (2025). Engaging people with intellectual disability in participatory action research: Co-developing sex educational resources. *Sexuality and Disability, 43*(1).