

**Service Models for Providing Sex Education to Individuals with Intellectual Disabilities in
the United States**

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Abstract

Individuals with intellectual and developmental disabilities face barriers to accessing sex education, including a lack of professional ownership over providing sex education. Limited information exists regarding educator training background, funding structure, and who they serve. We interviewed 58 sex educators of individuals with intellectual and developmental disabilities. We integrated thematic analysis and composite narratives to identify service models and the benefits and challenges associated with them. We identified seven service delivery models: clinic-based board-certified behavior analysis; mental health therapists; small businesses; public health not-for-profits; disability programs; high school-based educators; and university-based educators; and three themes that addressed the strengths and challenges of these service models: Instructional Implications of the Short-term, Drop-in Approach; Getting on the Same Page; and Questioning Who Should Teach Sex Education. Understanding these typologies and their strengths and challenges provide insights into how we can build capacity for sex education services.

Service Models for Providing Sex Education to Individuals with Intellectual Disabilities in the United States

Comprehensive sexuality education (CSE) emphasizes the importance of instruction that addresses the cognitive, emotional, physical, and social aspects of sexuality (United Nations Educational, Scientific, and Cultural Organization [UNESCO], 2018). CSE has been associated with various positive outcomes, such as reductions in child sex abuse and violence in dating and intimate partner relationships, as well as increases in healthy relationship development and improved social and emotional learning (Goldfarb & Lieberman, 2021). Individuals with disabilities, particularly those with intellectual disabilities, are at greater risk of negative sexual health outcomes such as sexually transmitted infections and unwanted pregnancies (Baines et al., 2018; Holdsworth et al., 2018; Michielsen & Brockschmidt, 2021), yet are less likely to receive sexuality education than their typically developing peers (Michielsen & Brockschmidt, 2021; Holmes et al., 2022). Furthermore, parents report that their children with intellectual disabilities do not receive sex education in schools and that this responsibility often falls to them well into adulthood. Yet, they are not confident in their ability to provide the information their children need (Kammes et al., 2020).

One barrier to CSE access for individuals with intellectual and developmental disabilities is educators' lack of ownership, self-efficacy, and preparedness to provide sexuality education (Michielsen & Brockschmidt, 2021; Murphy et al., 2016; Sinclair et al., 2015; Wilkenfeld & Ballan, 2011). Professionals may lack self-efficacy to provide sexuality education due to limited training (Adams Rueda et al., 2014; Murphy et al., 2016; Saxe & Flanagan, 2016; Wilkenfeld & Ballan, 2011) and uncertainty about what topics are appropriate to cover (Bolin et al., 2018; de Reus et al., 2015; Saxe & Flanagan, 2016). Additionally, professionals report difficulty providing

instruction that meets the needs of those with intellectual and developmental disabilities (Louw, 2017). Providing accessible content can be especially difficult given that sexuality education curriculum is typically designed for nondisabled individuals (de Reus et al., 2015). These barriers and a lack of familiarity with or clarity about organizational and institutional policies can lead to a lack of consistency among providers who may be making decisions based on personal values or based on their individual relationships with the people they serve (Sinclair et al., 2015). Furthermore, sexuality education is often delivered reactively in response to problematic behaviors rather than proactively to support prosocial sexual expression (Adams Rueda et al., 2017).

In addition to challenges about what CSE looks like for individuals with intellectual disabilities and how to best deliver instruction, there are also challenges regarding who should teach sex education. There is a lack of ownership over the provision of sexuality education to individuals with intellectual and developmental disabilities (Michielsen & Brockschmidt, 2021; Sinclair et al., 2015). Various studies have examined professionals who provide sexuality education to individuals with intellectual and developmental disabilities in some capacity, including social workers (Adams Rueda et al., 2014, 2017), genetic counselors (Murphy et al., 2016), teachers or other school personnel providing support to people with disabilities such as school psychologists, nurses, or administrators (Bolin et al., 2018; de Reus et al., 2015; Hanass-Hancock et al., 2018; Wilkenfeld & Ballan, 2011), support workers or paid staff caring for adults with disabilities (Saxe & Flanagan, 2016; Schaafsma et al., 2014; Wilkenfeld & Ballan, 2011), and transition staff (Wilson & Frawley, 2016). Yet many professionals who provide sexuality education do not consider this to be within the scope of their professional role (Bolin et al., 2018; Murphy et al., 2016; Wilkenfeld & Ballan, 2011; Wilson & Frawley, 2016).

Despite these challenges, there is a small but growing number of professionals who accept the responsibility of providing sex education and identify as sex educators for individuals with intellectual and developmental disabilities. However, little is known about who teaches sex education to individuals with intellectual and developmental disabilities or about the structural organization that allows these sex educators to implement sex education instruction on a sustainable basis. Additionally, limited research has studied what type of training sex educators of individuals with intellectual and developmental disabilities receive, what populations of individuals they serve, and how they are funded. To increase our understanding of these unknowns, this study seeks to answer the research questions: What are the service delivery models that sex educators of individuals with intellectual and developmental disabilities use to provide instruction? What are the characteristics of the educators from each model in terms of professional background, funding sources, and educational services? What are the strengths and challenges associated with these models?

Methods

This is a qualitative interview study of practicing sex educators. We used thematic analysis (Braun et al., 2019) to develop service delivery models and composite narratives (Willis, 2019) to explain the models. Thematic analysis (Braun et al., 2019) was also used to identify challenges associated with service delivery models.

Participants and Recruitment

To recruit participants, we first used purposive sampling (Creswell & Poth, 2018; Maxwell, 2012). Using internet searches and professional networks, we identified individuals who taught sex education to individuals with intellectual and developmental disabilities. To further expand our sample pool, we utilized snowball sampling (Biernacki & Waldorf, 1981;

Creswell & Poth, 2018) by asking participants to recommend other professionals who met our eligibility criteria. Eligible participants were at least 18 years of age, employed in the United States, and taught sex education to individuals with intellectual and developmental disabilities as part of their job. In total, 58 sex education professionals consented to participate in the study.

The total participants included 58 sex educators coming from 21 states and the District of Columbia. The majority of participants identified as White females and were highly educated. All participants had earned at least some college credits, and nearly three-fourths of participants had a Master’s degree or higher. They also possessed a wide range of years of sex education teaching experience. Complete demographic information of participants can be found in Table 1.

Table 1

Participant Demographics

	N/Range	Percent
Sex/Gender		
Female	47	81.0%
Male	5	8.6%
Transgender or Non-binary	6	10.3%
Race/Ethnicity		
White	52	89.7%
Hispanic/Latinx	2	3.4%
Black	1	1.7%
Asian	1	1.7%
Middle Eastern	1	1.7%
Did not disclose	1	1.7%
Highest Level of Education		
Some College	2	3.4%

Bachelor's Degree	13	22.4%
Master's Degree	33	56.9%
Doctoral Degree	10	17.2%
Age	21-78 (M=40.1)	
Years teaching sex education	1-37 (M=9.4)	

Note. Due to rounding, percentages may not equal to 100.

Procedure

The study was approved by the Institutional Review Board of the principal investigator. We partnered with a research advisory board consisting of autistic adults¹ in the development of this study. This advisory board provided feedback on the development of research questions and the semi-structured interview protocol. Based on responses, interviewers rewrote, reordered, added, or omitted questions. They also asked different follow-up questions. This allowed us to be responsive and establish rapport. Despite this flexibility, there was a great deal of similarity between interviews. Central to this analysis, interviewers asked how they came to be sex educators (“How did you start teaching sex education to individuals with disabilities?”); the nature of their instruction (“How would you describe the nature of your position?”); their instructional strategies (“Walk us through what an educational session looks like?”); and questions about values (“How do you feel like your personal values show up in your educational practice?”). Interviews were conducted between June 2020 and October 2020. Interested participants were sent a consent form that they could complete via Qualtrics. Consent was verbally reaffirmed at the beginning of the interview. Interviews were conducted via Zoom and lasted approximately one hour. After completion of the interview, audio recordings of the

¹ It should be noted that the members of the advisory board did not have co-occurring intellectual disabilities.

interview were downloaded and professionally transcribed. Any identifying information within the transcripts was deleted.

Data Analysis

This research was part of a project focused on the experiences of those to teach sex education to those with intellectual disabilities. As we began to analyze the data, we noted the important role of service delivery models and developed a plan of analysis to examine this in depth. To that end, we integrated composite narratives (Willis, 2019) and reflexive thematic analysis (Braun et al., 2019) to define and describe the models.

The first step in creating the composite narratives was to identify the service delivery models. We used constant comparative analysis (Corbin & Strauss, 2015) to identify similarities and differences among educators centered around our research questions: professional background, funding sources, and educational services. We then started to group educators into conceptually distinct categories and named them in accordance with their service delivery model. We then explored within each category the properties and dimensions of the service delivery model in terms of types of clients, professional development networks, and instructional assessment. Throughout this process, service delivery categories were expanded and collapsed. We then returned to our data and used constant comparative analysis to identify unique challenges faced by educators based on their service delivery model.

Once we developed our set of service delivery models, we created composite narratives to describe each model (Willis, 2019). A composite narrative uses data from several individual narratives to tell a cohesive story. Composite narratives were selected because they provide anonymity to participants and elucidate complexities among categories (Willis, 2019). Demographic information in each composite narrative represents an average or typical

interviewee. The quotes used in each narrative could come from any of the participants used to form that composite.

For the reflexive thematic analysis, after immersing ourselves in the data, we first coded our data for instances when participants described how the context of instruction or identity as an educator played a role. This coding was directed by the authors and conducted by two undergraduate research assistants. The first author had expertise in qualitative research methods, and the second author was an advanced graduate student with training and experience in qualitative methodology. They met weekly with the undergraduate research assistants during the first round of coding to maintain consistency, discuss challenging data, and come to a consensus. As the first round of coding was being conducted, the authors continuously returned to the data and inductively identified another series of codes. These codes helped us understand the specific features of context and identity that were important to instruction according to the participants: the instructional team, the role of care providers, the role of peers, funding mechanisms, research and training, co-designed instruction, laws and policies, questioning qualifications, and influence of values. In addition to assigning labels to segments of data, we used analytic memos to compare differences within the codes based on the service delivery models. As we moved towards developing the codes into themes, some of the codes allowed us to provide more richness and depth to the composite narratives (e.g., research and training). The remaining codes allowed us to construct themes that highlight the strengths and challenges of the service delivery models.

Trustworthiness

The strategies we used to achieve trustworthiness included obtaining a thick, rich data set and triangulation. Obtaining a thick, rich data set requires attention to sample size and selecting

an appropriate sample (Morse, 2015). To achieve this, we interviewed a large sample of educators, collected data with variation, and achieved data saturation. Additionally, we used purposive and snowball sampling to interview professionals with direct knowledge and experience in providing sex education to individuals with intellectual and developmental disabilities. In addition to collecting thick, rich data, we also used several triangulation strategies to achieve trustworthiness. For example, we used investigator triangulation (Stahl & King, 2020): both authors reviewed the data and categorized educators into service delivery models. We also used within methodology triangulation (Campbell et al., 2020) to compare data collected from the sex educators across all service delivery models, as well as within service delivery models, to identify consistencies and differences among professionals.

Positionality

The first author is a cisgender, white, middle-aged woman from the midwest. Prior to her academic career, she was a direct service provider for adults with intellectual disabilities. During this time, she chaired her agency's sexuality resource committee, provided individualized sex education, and trained other educators. She has been teaching or conducting research in the area of sex education and disability for almost twenty years.

The second author is a white, cisgender woman from the Northeastern United States. Prior to pursuing her doctoral degree, she worked as a public school educator of students with disabilities. Although she has served students with disabilities in formal educational settings, she did not teach sex education, nor does she identify as a sex educator.

Findings

We identified seven service models that were used to provide sex education to individuals with intellectual and developmental disabilities. Each model will be discussed in detail. We then

discuss the strengths and challenges presented by the various models of instruction as identified in three themes.

Service Models for Providing Sex Education

The service models we identified were (1) disability programs, (2) small businesses, (3) university-based educators, (4) clinic-based board-certified behavior analysts (BCBAs), (5) public health not-for-profits, (6) mental health therapists, and (7) high school-based educators. A description of each service model can be found in Table 2. We present interpretive descriptions of an average educator from each group that includes the logistics of their instruction, training, funding mechanisms, and student descriptions. The number of participants we had from that group is presented to provide a sense of how many educators on which the composite descriptions are based. Four educators taught in multiple settings, so the sum used for the composites is greater than the sample size. As the composites are written as narratives, rhetorical devices are used to show variations within the model.

Disability programs (n=18). Disability programs offer community programs and services to individuals with disabilities, with sex education provided as one facet of this approach. Jordan is a Black 42-year-old cisgender man with a master's degree in special education and works at a community-based agency for adults with intellectual and developmental disabilities. His agency calls the individuals he works with consumers. The agency has a specific program focused on providing sex education to consumers, which operates fairly independently within the larger infrastructure of the not-for-profit. Still, it did not start out that way. When he first started teaching sex education, he was primarily working as a direct service provider. His agency sent him to trainings to learn more about providing sex education to individuals with intellectual and developmental disabilities so he could teach their sex-ed class.

Table 2*Service Delivery Models and Definitions*

Service Model	Definition	Funding
Disability programs	Community-based agencies offering services to support individuals with disabilities. As one component of these programs, sex education services are provided to consumers, or sometimes the agency is contracted by nearby schools or adult service organizations to provide sex education.	Grants; Donors; agency funds; Medicaid
Small businesses	For-profit enterprises that design and potentially market sex education curricula. Schools and organizations often hire these businesses to provide sex education to individuals with disabilities.	Contracts with schools and organizations; Medicaid; out-of-pocket fee; sale of curriculum; consultations and trainings
University-based educators	University faculty who either provide sex education instruction to students with disabilities in post-secondary programs or offer sex education programs to community partners and conduct research on implementation.	University-based funds and fees; Medicaid; research grants
Clinic-based board-certified behavior analysts (BCBAs)	Clinics that provide behavior services rooted in applied behavior analysis. Some clinic-based BCBAs focus exclusively on sex education, while others offer comprehensive behavior support that may include sex education for individuals who demonstrate this need.	Medicaid or private insurance billing; out-of-pocket fee
Public health not-for-profits	Organizations that provide education and sexual health services for community members with and without disabilities.	Grants (e.g., Office for Violence Against Women and Department of Health and Human Services)
Mental health therapists	Clinicians who provide mental health services to clients and may support victims and perpetrators of sexual violence. Sex education may be offered as part of these services.	Medicaid or private insurance billing; out-of-pocket fee
High school-based educators	Educators based in high school settings who support students with disabilities and provide sex education instruction to these students as part of their job.	School-based funding

We go into the community and do laundry, we go to the gym with them, and we also offer classes. And one of the classes is a sex-ed class, which we also offer in the evenings for the non-day program adults, and that's what we call Boundaries and Relationships, is our sex-ed class.

Over time, sex education became a program within the agency. Jordan was the only person in his program, but it has grown, and now they have three other full-time educators. The other educators had similar career trajectories—they have educational backgrounds in a human services field and started their careers as direct service providers. They then went to additional trainings to learn more about teaching sex education. Their agency has limited opportunities for continued professional development, but when they have the opportunity to do so, they try to attend workshops.

Although Jordan occasionally still provides instruction one-on-one to consumers within the agency, the sex education program mostly provides small group instruction to schools and other adult service organizations that contract for his services. When he first started teaching, he started with a curriculum that he found for free online and pulled in other resources. As the agency's sex education services grew, they purchased a curriculum. Over time they have developed their own curriculum and are now partnering with a university to evaluate the curriculum. Although he defines sex education broadly, the program's curriculum emphasizes topics related to safety such as consent, bodily autonomy, relationship boundaries, healthy relationships, and self-advocacy.

Small businesses (n=11). Similar to some disability programs, small businesses were contracted to provide formal sex education and related services; however, small businesses were for-profit enterprises. Courtney is a 46-year-old White cisgender woman who has been teaching

sex education to individuals with intellectual disabilities for approximately 16 years, although she has been teaching sex education to a broader population for longer. Courtney, who has a bachelor's degree in public health, owns a small education-based business dedicated to providing sex education to individuals with intellectual and developmental disabilities and employs three other full-time educators. Her business is hired by schools and adult service providers. Although she occasionally provides one-day workshops, the organization's primary service is small group sessions that run once a week for 8 to 12 weeks. Over time she has developed her own curriculum, and she now sells her curriculum to other educators. She also provides training and consultations as part of her business model.

Although some of her employees started out in special education, Courtney started her career in sexual health and wellness. She was a sex educator for a public health organization. They would get requests to provide sex education for individuals with intellectual disabilities. She would take this on and started to specialize in this area, learning more and more about the unique needs of individuals with intellectual disabilities as she went. Eventually, she left the public health organization and branched out on her own; however, she is still connected to the field of public health, and sex education networks are her primary form of professional development.

As she started her business, she partnered with stakeholders to develop her curriculum and other instructional activities and continues to have an advisory board. "So, we have an advisory board, which has lots of members on it from different professions or self-advocates... We just kind of use them as a sounding board." Courtney has confidence that her students are learning because she continues to get contracts renewed from year to year; however, she does not have formal procedures in place for assessing knowledge gains.

I rely on feedback a lot from families, from professionals. So, for example, as I was modifying and adapting, and simplifying the puberty workshops, parents would say, "Oh my God, I can't believe how well she did with her first period."

The small business uses a comprehensive definition of sex education, but they often have to limit their instruction to topics approved by the agency that is contracting for services. To assess the effectiveness of her instruction, she takes a holistic program evaluation approach, even going so far as to hire external evaluators.

University-Based Educators (n=10). Universities provided formal sex education through individual research labs, University Centers for Excellence in Disability (UCED's), and post-secondary programs for individuals with intellectual disabilities. Lauren is a 43-year-old cisgender White woman who has been teaching sex education for the past nine years. Lauren has a Ph.D. in a health-related field. She teaches sex education, does research on sex education, and trains students to teach sex education. Lauren was primarily trained through a mentorship model, "It has been a lot of guidance from the woman who got me involved in it first and then a lot of reading the literature on what is available, what has been found to be good evidence, and different adapted curriculums." Lauren evaluated a sex education program as part of her doctoral work and has continued that research now that she is a faculty member affiliated with a UCED. Her continued professional development is largely through academic and research networks. Although Lauren has a comprehensive and research-informed conceptualization of sex education, she is often constrained by the grant mechanisms that fund her educational services.

Lauren and her students primarily teach sex education to small groups of youth and adults for several weeks. Although she sometimes teaches classes to students in the university's post-secondary program for students with intellectual disabilities, the majority of her students are

adults in the community. Lauren's educational services are primarily funded through research and community outreach grants. Lauren has utilized a variety of curriculums—sometimes, Lauren uses a specific curriculum as part of a research project. For example, “With the Department of Health, we looked at a couple of different curricula. And we chose this one, it was very controlled by the University of [state], they're proprietary on it. And so, you have to have training through them before delivering the content of the curriculum.” She went on to do research that evaluated the learning of students who went through the program.

Clinic-based BCBAs (n=9). Similar to small businesses, Clinical BCBAs worked in for-profit organizations to provide sex education and support individuals with sexual behavior. Shelly is a 38-year-old White cisgender woman who has been teaching sex education in her BCBA practice for seven years. At first, sex education was just one component of her practice, but now her clinic is focused on sex education and reducing problematic sexual behavior. The progression towards focusing on sex education reflects Shelly's training: she went to school to become a BCBA, and over time, sought out additional training in sex education. Shelly's professional network primarily consists of other BCBAs who are all highly educated like her, having either master's or doctoral degrees. Some of the BCBAs in Shelly's network teach sex education as just one component of their practice. Shelly refers to her students as learners.

At Shelly's clinic, they occasionally provide sex education in small groups; however, the majority of the education is provided one-on-one and on an ongoing basis to meet the learner's needs—sometimes lasting years. Thus, she defined sex education from a needs-based and learned-centric perspective—for one person, it may be focused on consent; for another, about what it means to have a crush; and yet another, how to masturbate to fruition. She primarily serves learners on the autism spectrum, many of whom have co-occurring intellectual

disabilities, although her practice does encompass developmental disabilities generally. She is able to fund sex education through insurance, thus the learners she serves reflect her state's policies regarding applied behavior analysis (ABA). For example, she can see adults, but she knows of other BCBA's who can only see learners until they are 21 due to insurance restrictions. Having said that, she does see a few learners who pay out-of-pocket and others who receive funding specifically through state-funded programs to address offenders of sexual violence. She has colleagues who specialize in this population.

Shelly provides sex education using ABA, including how she approaches the assessment of student learning which she sees as a strength of her approach. "I like to do a lot of fluency-based instruction. So, we typically do per-minute assessments and gauge that utilizing the standard acceleration chart to check data paths over time, and that's at the forefront of a lot of it." Shelly has experienced ethical challenges related to using ABA to teach sex education, specifically, the role that compliance played in her instructional approach. "The problem is that there's no discrimination between the typical compliance training of touch your nose, touch your head...and then touch my genitals...So there's a danger in that traditional compliance training that runs counter to consent and also increases vulnerability."

Public health not-for-profits (n=7). Public health not-for-profits provided education and sexual health services for community members, including those with disabilities. Phoebe is a White non-binary femme who works at a local affiliate of a national public health agency for the past five years. She primarily sees herself as a sexual health and wellness educator and she will provide education to whoever asks for it—including individuals with intellectual and developmental disabilities. She defines sex education from her understanding of the public health research on comprehensive sex education. She has even partnered with a local disability service

organization to co-teach a sex education course specifically geared towards individuals with disabilities with one of their providers. Having said that, for the most part, when she thinks about her instruction, she thinks about her instruction in a general sense—not necessarily disability-specific. Phoebe provides sex education in a variety of settings such as schools, juvenile detention, adult correctional facilities, chemical treatment centers, mental health treatment centers, alternative learning schools, and domestic violence centers. When Phoebe is teaching specifically to individuals with disabilities, she uses a curriculum that her agency has purchased.

Kacie is a White cisgender woman who works at a public health agency, but her organization is a bit different from Phoebe's. At Kacie's organization, it is her role to specifically provide educational services to individuals with intellectual and developmental disabilities and has been doing so for three years, although she has been teaching sex education for longer. Kacie provides sex education one-on-one, in special education classes, and in programs that serve adults with disabilities. Kacie has been part of the team at her organization that has been developing the curriculum that she uses.

Although Phoebe and Kacie have different roles based on the services their organization has, they have similar backgrounds. They both have master's degrees in public health with a specialization in sexual health. They receive the majority of their continued professional development from the field of public health; however, Kacie has also attended several trainings and workshops specifically about sex education for individuals with disabilities. Their organizations are primarily funded through state and federal public health grants. Kacie's organization is unique in that it also has specialized grants to provide educational services to individuals with intellectual disabilities through the state's developmental disability board and

the Office for Violence Against Women. Both Phoebe and Kacie primarily assess student learning through check-ins during instruction.

Mental health therapists (n=4). Mental health therapists had a similar business model to BCBA's; however, their educational background and instructional approach were quite different. Jill is a 51-year-old White cisgender woman who has been teaching sex education to individuals with intellectual and developmental disabilities for 16 years as part of her clinical practice. She has a master's degree in human sexuality and a Ph.D. in social work. Over the years, Jill has worn several hats and worked at different organizations that provide mental health services focused on sexuality to individuals with disabilities, but now she is in private practice. Clients pay for their services on a sliding scale if it is not covered by insurance. She has also been hired by disability organizations through grants they have acquired from the Community Protection Program.

Her practice focuses on both victims and perpetrators of sexual violence and she provides sex education to her clients on a one-on-one basis. She works across the age span with individuals with a variety of different disabilities. She defined sex education from a needs-based and learned-centric perspective, yet unlike BCBA's she was less bounded by external behavioral indicators and often focused on inner states of being or metacognitive skills. For example, she might focus on learning about levels of intimacy (e.g., friend, acquaintance, romantic partner) and the different feelings associated with each level. For the most part, she does not use a set curriculum; however, she recently heard of a curriculum that was specifically developed for one-on-one instruction.

High School-based educators (n=3). High school special education teachers and social workers provided both formal and informal sex education instruction. Maria is a 44-year-old

White cisgender woman who is a high school special education teacher. Maria has a master's degree in special education. At first, she had not had formal training, but when her school started implementing sex education for students with disabilities about eight years ago, she volunteered to do it. She had already been providing additional support to students who were going through a mainstream sex education class and supporting students who had behavioral difficulties in the area of sexuality. When she learned of an opportunity to get a little more formal training in sex education, her school was willing to send her to a workshop. She uses some of the lessons she learned at the workshop, but it was more of a starting point for her to expand on based on what her students need.

In terms of how she defines sex education, she thinks about it in two ways. First, the limited, school-board-approved definition of sex education that she helps to support students with and covers things like preventing sexually transmitted infections and unwanted pregnancy. Second, she considers the social aspect of sex education, which many of her students had to navigate. The social aspects she addressed less formally through incidental teaching. For example, she had a small group of students who had a study hall with her, and she worked with them on both academic and social skills. Some of that social skills instruction was informal support in the area of sexuality. For example, gender expression “We started just talking about gender expression. How do you express your gender, and what is gendered about the way people look? So, we talked about hair and clothes and colors and things like that.” Compared to other academic topics, she finds it much more difficult to assess student learning in the area of sexuality.

So social-emotional, I think if I had to put a measure on it, I'd go from most kids starting their freshman year, they eat lunch in my room. But by senior year, most of them are

eating lunch with their peers. I don't know how in a high school setting one would measure sexual knowledge. I don't know.

Each of the seven service models we identified varied in terms of the funding, structure, and or training of the educators. Each model had its own strengths and challenges.

Service Model Strengths and Challenges

We identified three themes that address the strengths and challenges of the different service models: Instructional Implications of the Short-term, Drop-in Approach; Getting on the Same Page; and Questioning Who Should Teach Sex Education. Each will be described in detail.

Difficulties with the Short-term, Drop-in Approach. Although small businesses, not-for-profits, and disability programs differed in terms of how they could be funded and administered, many used a short-term, drop-in approach which had instructional implications that were quite different from clinical providers or disability programs engaged in long-term education. A common challenge faced by both not-for-profits and small businesses was they often did not have much background on the educational and communication support needs of the individuals they would be teaching. For example, this educator who worked at a sexual health-oriented not-for-profit described her experience coming into a school where she did not feel she was particularly successful,

I think that it was a pretty ableist system of having me come in as an outside educator... Students who had certain disabilities or whose disabilities manifested in certain ways did not have the same opportunities as other students, simply because I was not able to serve them as well. In terms of how successful it was overall, I don't know if I can give an overall assessment. There were some classrooms where I felt like, by the end of it, I almost just made students really uncomfortable.

This same educator also described a different experience where she was working with a transition center where she felt like she was much more effective, “With the transition center, I think it was really successful because I think they were really ready. That was a little bit different because I think they were really ready for these conversations. There was a level of comfort that already existed before I even got there.” These contrasting examples highlight the difficulty that educators who provided drop-in services faced—they were less likely to know the individual learning needs of their students and had less time to build rapport. Thus, the effectiveness of their instruction was somewhat dependent on factors outside of their control.

They also had constraints on what they felt they could teach based on both logistical and content-related parameters of the contracting organization. For example, an educator who worked at a not-for-profit discussed getting birth control covered in her class,

So, I've had some teachers where there are a few cases where I really felt like I had to push to cover birth control and STIs with some of these classes. I never had an experience like that where a teacher was not being student-centered. The teachers always knew the students really well and were really focused on what was best for them and trying to work towards that, but there were these moments where I felt like I had to push for that.

Other educators discussed the constraints of what they could and could not teach at the policy level. For example, an educator who worked at a not-for-profit said,

“It's frustrating that we don't have supportive policies in schools, which we're actually right now looking to overhaul the sex-ed program in [our school district], but not for special education because that's so taboo. So supportive policies in schools, supportive policies in institutions and group homes, and even talking to parents, a lot of medical

professionals just don't know how to talk about this and don't know who to reach out to, to have this conversation.”

Drop-in educators also discussed how it could be difficult to meet their learning objectives due to the limited time they spent with students. One educator from a not-for-profit discussed the challenges of having so few sessions with a student who they felt needed more support,

We've had learners who we were not equipped to be able to meet their educational needs. We had a learner who was very low verbal, just like a few words and phrases and probably pretty low comprehension too. And he was having inappropriate touching behaviors at his day program. And so, it was just really difficult. We were not able to see any improvement in knowledge or any change in learning.

Although educators acknowledged the challenge that short-term relationships posed, they had creative strategies to attempt to supplement instruction after their time was complete. For example, an educator who worked at a disability program that contracts with schools explained, “We also have videos of the role plays, and videos of the lesson... We give those on a Google drive to teachers so they could replay the videos with their students.”

Getting on the Same Page. In addition to the challenge of developing relationships with individuals in the short-term drop-in approach, many educators reported that they felt they were not always on the same page as families or adult service providers. Even providers who worked with individuals on a long-term, ongoing basis could have difficulty getting on the same page with families and support professionals. The lack of continuity led to several obstacles, such as (1) getting buy-in to provide sex education; (2) individuals receiving sex education but being

denied access to avenues for prosocial sexual expression; and (3) navigating broader bias against sex education.

Like drop-in educators who might have difficulty being allowed to teach specific topics, educators who worked with youth on other skills could have difficulties getting families to buy-in to the need for sex education. For example, a clinical BCBA discussed this challenge, “I would say my biggest challenge is getting caregivers to buy-in for any number of reasons. You have people that just spiritually, religiously, they just vehemently do not believe that they should be doing this. You will get families that are like, ‘He can't do it. He's delayed.’” Educators discussed how they used safety to get buy-in for sex education as evidenced in this comment from a disability program educator,

“Because teachers and parents see sex ed and they have whatever kind of internalized reaction that they have, that they didn't want to come to a meeting or a training...When it was safety, they were like, ‘your kid is going to have this safety class.’ they were like, ‘Great. Fine. Whatever. Just do it.’ Now that it's like, ‘We're going to teach them sex ed.’ They're like, ‘Holy crap! Let's talk about that.’”

In this situation, the educator was able to build on the relationships and connections she made when providing safety-specific education to teach sex education more broadly.

Once individuals had access to sex education, there could still be difficulty with accessing space for sexual expression as direct support professionals and families were rarely part of the education process. A small business educator expressed this concern, “I would say an unmet need...is the support of their sexuality and sexual expression. We find that a lot of parents and staff just don't know how to support them.” Only some disability program educators, who were also involved with providing direct service, did not experience the challenge of getting on

the same page. However, other providers also discussed ways in which they were able to partner with families and professional caregivers. For example, a clinical BCBA shared about transferring instruction over to the parent after the mom had observed several sessions, “We made kind of a little home book for them to use at home. Then, we kind of faded out the instruction in therapy, and mom was doing it more at home since it's kind of more natural for that instruction to be happening at home.”

In addition to getting on the same page with families and service providers, educators also had to navigate the political climate toward sex education in their localities. For example, a university-based educator discussed navigating a difficult political climate, “I live in the south, and we're not allowed to say sex education, so what we call it is we call it healthy relationships.” Although the cultural norms of the area could be a barrier, it could also be a facilitator as in some areas, disability advocacy organizations, funders, and policymakers could get on the same page to improve access to sex education. For example, a disability program educator mentioned legislation that she helped to get passed, “I would say that, at least in [state], we're becoming more aware of how important these topics are. And mostly that's through legislation. So, we have our [state] House Bill, which passed.” This bill provided avenues for adults who received disability services to get sex education.

Questioning Who Should Teach Sex Education. Educators came from a variety of backgrounds and training, with many having roots in special education or public health. Some educators felt that their level of education and training was sufficient to achieve expertise, pointing specifically to college coursework in human sexuality, as well as health and sexuality educator certifications they had obtained. However, other educators reported not having enough training to feel confident in providing sex education. For example, one educator who taught both

in a high school and a disability program discussed her sex education training, “A lot of it has been self-research and just being asked to do it and realizing oh my gosh, I'm doing this thing, I need to learn more.”

Considering their experiences and training, many educators offered opinions about what the appropriate level of training for a sex educator of individuals with intellectual and developmental disabilities should be, yet there was little agreement both within and between service models. Educators debated whether a background in special education or public health positioned the educator to best serve the needs of their students. Some educators argued that it was more important to have a deep understanding of disability and knowledge of how to support the unique needs of individuals with disabilities. One small business educator emphasized this idea, “If you know how to teach people with intellectual disabilities and you simply apply the same teaching strategies to this different subject matter ... you don't really need that much more.” Yet, other educators suggested that a comprehensive understanding of sex education content was critical. For example, one BCBA stated,

“There are... a lot of behavior analysts who think that they can provide sex education because they know how to teach things. And I've seen situations where they're not teaching accurate information because they haven't learned it themselves. Just because you have sex doesn't mean you know everything about sex.”

Many educators described the American Association of Sexuality Educators, Counselors, and Therapists (AASECT) Certification as the epitome of expertise. Educators who held this certification emphasized its value in ensuring that qualified educators were providing sex education. One university-based and small business educator viewed the AASECT certification as a strategy to demonstrate mastery to others, “I found AASECT, so I was taking classes and I

was like, I'm going to get AASECT certified. Because I needed, if I'm going to talk about sexuality for a living, I needed some clout.” Other educators felt that the certification requirements were confusing, intensive, and precluded educators from access due to constraints with time and finances. For example, one BCBA highlighted various obstacles to access,

“I looked into it, but it's quite expensive and there's very specific locations that you can get it done. I'm a single parent of an eight-year-old. So, I can't like take off for the week and spend \$7,000 doing training.”

Rather than pursue AASECT certification, some educators sought training with a professional development certificate program, which required less time and financial resources from educators. But this choice was also questioned by some educators, such as this small business educator, who felt that sex education expertise cannot be achieved in a single professional development workshop, “I think people going in think, “Certificate, okay, now I'm trained so I can delve into this area of sexuality.” And then they find out some of the complicated stuff that pops up that they're not really trained for.”

Across the models, the three themes we identified reflect the challenges and opportunities educators faced. The majority of the models used the Short-term, Drop-in Approach and faced challenges. For all educators who were not also providing direct support, there was trouble Getting on the Same Page. Educators Questioned Who Should Teach Sex Education from both within and between the models.

Discussion

Service Models and Educator Characteristics

Although previous research has reflected the perceptions of educators from a variety of professional backgrounds (e.g., Adams Rueda et al., 2017; Bolin et al., 2018; Saxe & Flanagan,

2016; Wilson & Frawley, 2016), this is the first study to explore various service delivery models across educators. By identifying how sex education is provided in terms of who provides it, their qualifications, how they organize their services, who funds it, and how they implement sex education, this research provides insights into how we can build capacity for greater sex education services as there are many individuals for whom this is an unmet need (Michielsen & Brockschmidt, 2021; McDaniels & Fleming, 2016; Frawley & Wilson, 2016). The service models we identified, clinical BCBAAs, mental health therapists, small businesses, public health not-for-profits, disability programs, high school-based educators, and university-based educators, provide clarity to the eclectic landscape of sex education for people with intellectual disabilities.

Of particular interest to building capacity was the variety of funding mechanisms educators utilized, including fees for services, insurance billing, contracts with adult service providers, contracts with schools, providing training, selling curriculum, and grants. The grants came from disability councils, departments of public health, local grants, and federal offices such as the Office for Violence Against Women. Attention to local-level funding decisions is an important contribution, as previous research has focused on federal-level decisions that affect the climate toward providing sex education (Treacy et al., 2018) and stakeholder attitudes (Lafferty et al., 2012).

Clinical BCBAAs and mental health therapists often provided sex education in response to sexually problematic behavior or experience with sexual trauma—often, the lack of prior sex education played a role. However, many of the educators in our study, especially small business, high-school-based, university-based, public health not-for-profits, and disability programs, provided sex education on a regular basis in schools or to adults receiving developmental disability services. This is in line with calls to provide sex education proactively (Black &

Kammes, 2021; Travers et al., 2014; Gomez, 2012). Black & Kammes (2021) identified that there has been greater attention to proactive sex education in research over the past decade. Our research suggests this shift may also be true in practice.

Service Model Strengths and Challenges

Educators from small businesses, high-school-based, university-based, public health not-for-profits, and disability programs expressed *difficulties with the short-term, drop-in approach*. They indicated that the number and length of educational sessions could also impact what students learn and retain. Yet, during interviews, educators reported that a finite or predetermined number of sessions did not always yield the desired results for each student. This aligns with prior research, which suggests that individuals with intellectual disabilities benefit from continuous sex education to ensure the retention of knowledge and skills (Schaafsma et al., 2017). Some educators who utilized the short-term, drop-in approach discussed the challenge of not knowing the needs of their students ahead of time to ensure instruction was designed to benefit each individual. However, research indicates that sex education instruction for those with intellectual disabilities should be designed around the individual needs of the student (McDaniels & Fleming, 2016).

Educators who provided both long-term and short-term instruction reported facing biases surrounding sex education that could make it difficult for families and caregivers to *get on the same page* with the provision of sex education and ensure that students had avenues for prosocial sexual expression. However, educators from some service models, such as those that take a more holistic approach to supporting the individual's daily life, reported greater opportunities to connect and build rapport with students' caregivers. This allowed educators to facilitate conversations with caregivers to enhance their comfort with sex education instruction. It is

unsurprising that educators reported that parents and caregivers experience discomfort with addressing sex education as prior research has indicated that parents are uncertain with how to provide appropriate sex education to their child with an intellectual disability (Kammes et al., 2020) and support staff often receive little preparation in delivery of sex education (Wilson & Frawley, 2016). Additionally, individuals with intellectual disabilities report ecological limitations to their sexual expression, such as a lack of privacy or restrictive regulations in-service programs (Healy et al., 2009). Educators with access to caregivers were better able to support their students in facilitating greater autonomy.

Participants in the study *questioned who should teach sex education*. Previous research has identified a lack of training as a barrier to individuals receiving sex education (Curtiss & Ebata, 2016). Our study highlights multiple pathways educators received education and training: studying public health and then applying that knowledge to working with individuals with disabilities and studying special education or a disability-related field, and then learning more about teaching sex education. At the intersection of disability and sexuality, educators received training in the form of informal mentorship, formal training programs and workshops, college coursework, and professional certification. Despite these pathways, training remained a barrier. Although everyone in our study was a practicing sex educator, they did not feel equally confident in their own training and sometimes had concerns that others were ill-qualified. Future research could systematically examine the training pathways and how it affects instructional practices and student learning outcomes.

Strengths and Limitations

Our study represents one of the broadest samples of sex educators who focus on individuals with intellectual and developmental disabilities. Thus we were able to identify

patterns in their services that have previously been unidentified, yet, we cannot be confident that this is an exhaustive list of service delivery models. Additionally, these service models may only be applicable in the United States due to variations in funding mechanisms and training opportunities. Furthermore, through our interpretive approach, we made distinctions that we thought were meaningful between educators. For other research purposes, different distinctions may be more relevant. For example, we had BCBAAs who were not in clinical practice but worked in disability programs, and for us, that distinction was more relevant to the elucidation of business models.

Of the models we articulated, we had the least representation of school-based educators. Extant research focuses on school-based personnel as the most likely people to provide sex education. Our research was able to highlight the formal and informal sex education that school-based educators provide, yet due to our limited representation of this group, there may be more within-group variability that we were not able to capture. Many of the educators we interviewed provided education in schools but on a contractual drop-in basis. Our research highlights this often-overlooked service delivery model.

Conclusion

Extant research has focused on what sex education for individuals with intellectual and developmental disabilities looks like, but this study is focused on how sex education is provided. This study builds an understanding of the professionals who provide sex education services to individuals with intellectual and developmental disabilities, as well as identifies the implementation strategies and funding mechanisms that professionals utilize to offer sex education. Through interviews with 58 sex educators, we identified seven service delivery models that demonstrate the varied ways in which professionals approach sex education and

manage their professional practice. By thematically analyzing interview transcripts, we identified three themes that highlight the strengths and challenges of these service delivery models, including Instructional Implications of the Short-term, Drop-in Approach; Getting on the Same Page; and Questioning Who Should Teach Sex Education. This research highlights how sex educators acquire funding and the training pathways they follow, which provides insight into sex education service capacity building.

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