**P**romoting **H**ealthy **R**elationships **A**nd **S**exuality (PHRAS) Principles

# Principles for Promoting Healthy Relationships and Sexuality for Disabled People in Ireland

## Introduction

Disabled people have the same rights to healthy consensual relationships and sexuality as everyone else.

In Ireland, disabled people face significant barriers in accessing information and support on relationships and sexuality. More work needs to be done to remove these barriers and better promote people’s rights in this area.

This is further bolstered by the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) which champions these rights under headings such as Freedom of Expression and Opinion, Access to Information, Health, Home and Family, Education, Living Independently and Respect for Privacy.

The principles detailed in this document will serve as a guide for disabled people, healthcare providers, caregivers, educators, and policymakers to ensure that the rights, wishes and needs of disabled people are upheld.

The principles developed are intended to impact or benefit all disabled people in Ireland. The scope is inclusive and intersectional, acknowledging the diverse range of experiences and identities within the disabled community. This includes individuals across all age groups[[1]](#footnote-2), genders, sexual orientations, backgrounds, and types of disabilities/impairments. All points in the document relating to consent must be taken in the context of the legal definition of consent to sexual activity in the [Criminal Law (Sexual Offences) Act 2017](https://www.irishstatutebook.ie/eli/2017/act/2/section/48/enacted/en/html#sec48).

These principles have been created with and by disabled people and are underpinned by the principles and rights outlined in the UNCRPD.

Table of Contents

[Principles for Promoting Healthy Relationships and Sexuality for Disabled People in Ireland 1](#_Toc210212395)

[Introduction 1](#_Toc210212396)

[Glossary 3](#_Toc210212397)

[The Principles: 4](#_Toc210212398)

[1. Autonomy 4](#_Toc210212399)

[2. Choice / Decision Making 5](#_Toc210212400)

[3. Human Rights 6](#_Toc210212401)

[4. Consent 7](#_Toc210212402)

[5. Access 8](#_Toc210212403)

[6. Education for the Person 9](#_Toc210212404)

[7. Education for Supporters 10](#_Toc210212405)

[Supports / Resources 11](#_Toc210212406)

[AGREE Tool (Literature Verification) 12](#_Toc210212407)

[Appendix 1 – HEARTS 22](#_Toc210212408)

[Appendix 2 – Literature Review 23](#_Toc210212409)

## Glossary

**Chosen Family:** a person or people that a disabled person identifies as so important in their life that they are like a family member to them, regardless of biological or legal relationships. This may include close friends, partners, carers, or others who offer love, support, and connection. Chosen family is recognised and respected to be equally as valid and meaningful as traditional family structures.

**Supporter(s):** anyone who helps a disabled person to understand, express and exercise will and preferences in their life. They can do this by promoting equality, upholding the person’s rights and facilitating autonomy. This can include family members, friends, paid staff members, advocates, professionals etc.

**Society:** the community of people, institutions, systems, and cultural norms that shape how people are included, treated, and supported. Society has a role in promoting equality, challenging stigma and stereotypes, and creating environments where disabled people can fully participate, express themselves, and enjoy their life.

**Ableism:** prejudice or discrimination against disabled people based on beliefs and assumptions that non-disabled people are superior or more important. Some examples of ableism:

- Designing buildings without ramps or lifts.

- Speaking to a support person instead of the disabled person.

- Assuming a disabled person’s life is of lower quality.

**Paternalism:** treating disabled people in a way that limits their autonomy or decision-making, based on the belief that professionals, family members, or services know what’s best for them. Some examples of paternalism:

- Making decisions about living arrangements without involving the disabled person.

- Withholding information from a disabled person because it might be too upsetting or too complicated for them to understand.

- Assuming a disabled person can’t understand or express preferences.

## The Principles:

### 1. Autonomy

The person has the right to:

* make decisions about their own body, relationships, and sexual expression.
* express their sexuality freely and without discrimination.
* express themselves through what they wear and how they present themselves.
* have their choices respected, even if others disagree.
* be supported in identifying and overcoming barriers to autonomy.
* make their own informed decisions about reproduction and parenthood.
* identify people important to them as their “chosen family”.
* understand and challenge internalised and external ableism that may impact their autonomy.

The person should expect:

* to be seen as an individual with personal desires, needs, and preferences.
* that their autonomy will not be limited based on assumptions about their ability.
* To be supported in their decisions

Supporters can:

* Promote autonomy
* Be aware of your biases and understand your own and other persons’ standpoint or position
* Affirm the person’s whole identity, including gender identity by using correct pronouns and terminology

### 2. Choice / Decision Making

The person has the right to:

* make their own informed choices about relationships and sexuality.
* explore their own identity and preferences.
* choose their support networks, relationships, and levels of intimacy.
* make mistakes and learn from them, like anyone else.

The person should expect:

* that family, friends, community, services, and society will respect their choices.
* that appropriate supports and resources will be available to them to assist with decision making and expressing their will and preference.

Supporters can:

* encourage and support decision making rather than control or limit choices.
* facilitate and engage in conversations about relationships and sexuality in a supportive way.
* support disabled people have access to the supports and resources they need to facilitate decision making and expressing their will and preference.
* Signpost the person to other relevant organisations that may be able to support the person exploring LGBTQI+ identity.

### 3. Human Rights

The person has the right to:

* equal access to relationships, sexuality, reproductive rights and sexual/gender health supports
* live free from discrimination, abuse, stigma, and harmful stereotypes.
* be recognised as a full person with sexual agency and sexual rights.
* challenge societal and systemic discrimination, including unconscious biases.
* Challenge concepts of ‘vulnerability’ or ‘protection’ and ‘safeguarding’
* be supported by legislation, policies and cultural attitudes that promote sex positivity for disabled people.
* protection under the law, and support to understand their responsibilities in relation to the law.
* proactive supports to enable them to build capacity, learn new skills, and become empowered, so they can feel safe and well in relationships.

The person should expect:

* that services, society, and supporters recognise their rights and act accordingly.
* that their relationships and sexuality are not treated as inappropriate or problematic.

Society should:

* promote sex positivity and recognise that disabled people have the same rights as non-disabled people.

### 4. Consent[[2]](#footnote-3)

The person has the right to:

* make consent decisions about their body and relationships.
* have their preferences, boundaries and consent decisions respected.
* receive support to develop their knowledge, confidence and communication skills around consent.
* understand and exercise consent through clear, accessible education and discussion.

The person should expect:

* that their consent will not be questioned based on assumptions about their ability.
* that others will respect their "yes" and their "no" equally.

Supporters can:

* understand and respect the principles of consent.
* avoid paternalistic attitudes that take away a disabled person’s ability to give or refuse consent.

### 5. Access

The person has the right to:

* physical, social, and systemic access to relationships, intimacy, and sexuality.
* access spaces that accommodate their needs, provide opportunities to meet people, and respect their right to privacy.
* accessible resources, support and education on relationships and sexuality.
* Accessible and appropriate healthcare
* develop friendships and relationships freely, without unnecessary barriers.
* experience touch, desire, pleasure, and intimacy as important aspects of relationships.
* support to develop digital literacy and their use of assistive technology to facilitate independence in accessing resources and information.

The person should expect:

* that their right to access relationships and sexual experiences will not be ignored or dismissed.
* that access needs (mobility, communication, privacy etc.) will be accommodated.

Society should:

* ensure that disabled people can participate fully in social and romantic life.
* address barriers that prevent disabled people from engaging in relationships and sexual expression.

### 6. Education for the Person

The person has the right to:

* lifelong, comprehensive and accessible education about relationships and sexuality.
* learn about LGBTQI+ communities, gender and identity.
* sexual health literacy, including information on consent, boundaries, contraception, and communication.
* education that is peer-delivered, co-designed, universally designed, and tailored to their needs.
* learn about their rights, autonomy, and decision-making in relationships.
* learn how to socialise, meet people and understand relationships.

The person should expect:

* to be included in formal education on relationships and sexuality from an early age.
* that their learning will not be limited due to assumptions about their ability.
* additional support to be facilitated on these topics if formal education is not accessible

Supporters can:

* ensure that disabled people have access to accessible and quality sex education.
* support education that counters stigma and promotes relationships and sexuality as a natural part of life.

### 7. Education for Supporters

Supporters can:

* undertake disability equality training, to learn about the person’s right to relationships and to challenge misconceptions.
* engage in training and discussions about consent, autonomy, and decision-making.
* undertake training on LGBTQI+ topics
* recognise their own biases and ensure they do not impact negatively on the person’s experience of relationships and sexuality.
* promote a culture that is sensitive to the person’s background, identity, values and beliefs, and respects and upholds the rights of disabled people.
* support disabled people in navigating relationships while respecting and understanding their right to independence.

The person should expect:

* that their supporters will be informed and open-minded about relationships and sexuality.
* that their supporters, and society will encourage their autonomy rather than control or adversely influence their decisions.

## Supports / Resources

* [Callan Institute – Raising Understanding and Awareness](https://www.callaninstitute.org/rua)
* [Choice Support UK – resources for autistic people, staff and families](https://www.choicesupport.org.uk/about-us/what-we-do/supported-loving/helpful-resources)
* [Gender, Orientation, Sexual Health, HIV (GOSHH) – Midwest Ireland](https://goshh.ie/)
* [HSE Sexual Health and Wellbeing](https://www.sexualwellbeing.ie/) HSE’s main source of information on sexual health, including how to access available services.
* [Independent Living Movement Ireland (ILMI)](https://ilmi.ie/) :
  + [Sexuality and disability](https://ilmi.ie/sexuality-and-disability/)
  + [Let’s talk about sex! Webinar](https://www.youtube.com/watch?v=bq9w_PgzS6s)
* Irish Family Planning Association – [Speakeasy Plus training](https://www.ifpa.ie/education/speakeasy-plus/)
* [My Choices – Getting Support to Make Decisions](file:///C:\https:\decisionsupportservice.ie\sites\default\files\2023-04\10919%20MHC%20DSS%20My%20choices%20-%20screen.pdf)
* [National Advocacy Service for People with Disabilities](https://advocacy.ie/)
* [Questions and answers about sexuality and relationships – Mencap UK](https://www.mencap.org.uk/help-and-advice/relationships-friendships-and-sex/sexuality-and-relationships-faqs#:~:text=Find%20the%20answers%20to%20your%20frequently%20asked%20questions,are%20less%20at%20risk%20of%20being%20sexually%20abused.)
* [Sexuality and sexual health education resources – New South Wales](https://education.nsw.gov.au/teaching-and-learning/curriculum/pdhpe/sexuality-and-sexual-health-education)

## AGREE Tool (Literature Verification)

The purpose of the AGREE Tool is to assess the process used to develop these Principles. This is done under a number of domains.

**Domain 1. Scope and Purpose** is concerned with the overall aim of the Principles, specific questions asked, and the target population.

**Domain 2. Stakeholder Involvement** focuses on the extent to which the Principles were developed by the appropriate stakeholders and represents the views of its intended users.

**Domain 3. Rigour of Development** relates to the process used to gather and synthesise the evidence, make recommendations, and seek external review of the Principles.

**Domain 4. Clarity of Presentation** deals with the language, structure, and format of the Principle.

**Domain 1. Scope and Purpose**

* 1. **The purpose of the principles is:**

a. To define principles for promoting healthy relationships and sexuality for disabled people

**1.2 The scope of the principles is:**

**1.2.1 Describe the population to whom the Principles will apply**

These principles are for disabled people, service providers, and anyone supporting disabled people.

**1.2.2 Outside the scope of the principles – not applicable**

**1.3 Objectives**

Report the overall objectives of the principles:

\* to provide principles that can be used to support individuals or organisations with promoting health relationships and sexuality for disabled people

**1.4 Outcomes:**

The outcomes of the implementation of the PHRAS are:

\* Improved quality of relationships and better understanding of key concepts for disabled people and their supports

\* Improve human rights based approach to promoting health relationships and sexuality for disabled people that is in line with the UNCRPD

**1.5 Questions**

Standardised systematic search strategies facilitate and improve rigor in research. PICO (Population, Intervention, Comparison, Outcome) was previously used by our group however we found it limited the types of articles to very quantitative research. A group member informed us of an alternative search strategy for more qualitative and mixed methods research – **SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type**).

**1. What are disabled people’s experiences with relationships and sexuality?**

S: Disabled people, people with disabilities

P: relationships, sexuality, experiences, barriers, enablers, information, loneliness, attitudes, self-esteem, confidence, platonic relationships, friendships, partnerships, socialisation, communication, self-image, attitudes, identity, pleasure, romantic attraction, sexual attraction, informed consent, benefits, family formation, chosen family

D: questionnaire, survey, interview, focus group, case study, observational, comparative studies

E: experiences

R: quantitative, qualitative or mixed methods

**2. What are disabled people’s experiences with education about relationships and sexuality?**

S: Disabled people, people with disabilities

P: sexual health, education, sex education, SPHE, personal development, consent, boundaries, information, supports, access, sex positivity, body neutrality, information processing, emotional regulation, ableism, pornography, infantilisation, communication, access to education

D: questionnaire, survey, interview, focus group, case study, observational

E: experiences

R: quantitative, qualitative or mixed methods

**3. What are disabled people’s experiences of expressing their sexuality?**

S: Disabled people, people with disabilities

P: sex positivity, pride, queer crip culture, queerness, intersectionality, ableism, deficit, impairment, pleasure, self-expression, value, sexual identity, self-worth, access, communication, significant communication difficulties, reclaiming slurs, community, chosen family

D: questionnaire, survey, interview, focus group, case study, observational

E: experiences

R: quantitative, qualitative or mixed methods

**4 What are outcomes associated with disabled people not having healthy relationships and sexuality?**

S: Disabled people, people with disabilities

P: risks, loneliness, vulnerability, consent, quality information, education, money, public transport, access, social life, friendship, abuse, protection, connectedness, resources, rights, sexual health, unplanned pregnancy, self-worth, depression, mental illness, oppression, unhealthy relationships, violence, reproductive rights, being “out”, parental control

D: questionnaire, survey, interview, focus group, case study, observational

E: experiences

R: quantitative, qualitative or mixed methods

**Domain 2: Stakeholder Involvement**

**2.1 Group Membership**

Report all individuals who were involved in the development process. This may include members of the steering group, the research team involved in selecting and reviewing/rating the evidence and individuals involved in formulating the final recommendations.

The working group is comprised of:

* Ronan Halpenny [chair from 2024-July 2025], Social Care Project Lead, HSE Disabilities QI
* Nicole Lam, [chair from July – Sept 2025] Guidance and Research Lead, HSE Disabilities QI
* Joanne Fitzpatrick, Project Coordinator, HSE Disabilities QI
* Deirdre Carr, Project Officer, HSE CHO 4 Disability Services
* Lisa Condren, RUA Coordinator, Callan Institute, St John of God Community Services
* Rebecca Fitzgerald, Specialist Coordinator and ID Nurse Tutor, Nursing & Midwifery Planning & Development Unit (NMPDU) HSE Dublin and South East
* Tina Gardiner, Principal Social Worker, HSE CHO 1 Primary Care
* Moira Germaine, Education & Training Manager, HSE Sexual Health Programme
* Caoimhe McClafferty, Education and Training Officer, HSE Sexual Health Programme
* Leona Glennon, Social Worker, HSE Mid West Disability Services
* Tanya Hardiman, Registered Nurse in Intellectual Disabilities (RNID), Clinical Nurse Manager 2 (CNM2), HSE CHO 1 Disability Services (Respite)
* Niall Jordan, Founder, Full Spectrum Ireland
* Gillian Kearns / Cír Doyle, Founding Members, Neuro Pride Ireland, **DPO**
* Nem Kearns, Founding Member, Disabled Women Ireland, **DPO**
* Ben Lindsay, Health Promotion & Improvement Officer (HPIO), HSE IHA Dublin North County and Dublin North City & West
* Gerry Maguire, Self-Advocate
* Margaret McGrath, Professor of Occupational Science and Occupational Therapy, University College Cork (UCC), School of Clinical Therapies
* Michelle Murphy, Advocate, National Advocacy Service for People with Disabilities
* Niall Myers, National Safeguarding Lead, Cheshire Ireland
* Amanda Ní Ghabhann, Safeguarding & Ethics, Special Olympics Ireland
* Ciara Palmer, QPS Advisor for Disability Services & Assisted Decision Making, HSE CHO 9 Disability Services
* Brian Paterson, Senior Social Worker, Acquired Brain Injury Ireland (ABII)
* Paula Soraghan, Community Development Worker, Independent Living Movement Ireland (ILMI), **DPO**
* Fiona Weldon, ILMI
* Charlie Thompson, Regional Social Care Manager, HSE CHO 5 Disability Services
* Leanne Wynne, Self-Advocate
* Breda Golden, National Head of Advocacy, Safeguarding, Quality & Training, Brothers of Charity Services Ireland
* Thereze Oliver, Quality of Life Coordinator, AVISTA

**2.2 Target population preferences and views**

Report how the views and preferences of the target population were sought/considered and what the resulting outcomes were

A total of 6 focus groups were conducted. These were the main themes:

1. Education:
   1. Mix of formal, usually primary/secondary school and some in their services. **Focus mainly on contraception, pregnancy, risk based, consent.**
   2. More commonly informally through **peers**, social media and media.
   3. Many felt the content was lacking especially in the areas of sexuality, pleasure and intimacy (more prompting).
   4. **Parenthood** was not seen as a viable option for disabled people, some people were surprised when a wheelchair user had children, another individual thought they couldn’t get pregnant because they are a wheelchair user.
   5. **Sexual ableism persists – girls and women** are still disadvantaged in many ways by the lack of accessible information. Participant recalled working with an older woman with ID who did not know she had a coil in her for 20 years.
2. Relationships
   1. Generally a good understanding of the range of relationships someone can have **beyond a romantic or sexual one,** but when alluding to gender, it was either limited to a cishet relationship or the gender binary.
   2. Participants reported **a range of barriers to relationships and sexual expression** – their disabilities/impairment, lack of education and skills, lack of privacy, social stigma, past trauma, leading to low self-esteem. They also noted a lack of support from family or fear of communicating with family about these topics. Internalised ableism played a huge factor, as adults they feel they do not have sexual agency (de-sexed) because of their disability/impairment.
3. Sexuality and intimacy
   1. Queerness: Of the participants who were queer or understood queerness, many reported **feeling afraid of public displays of affection** such as holding hands with their potential partner.
   2. **Consent** was broadly understood by participants although some had a more in-depth understanding. Many referred to it in the instances of sexual intercourse but others also said it is important in childhood to be able to say no to a hug or touch.
   3. **Intimacy** was a difficult subject for some to pin down, like sexuality, some were able to describe abstract and complex terms to connectedness, trust, touch, etc.

**Domain 3. Rigour of Development**

**3.1 Search Methods**

Report details the strategy used to search for evidence:

A review of Gray Literature was conducted including existing policies on Record Management in Disability services in Ireland.

A literature search was conducted by the HSE librarian including a full SPIDER search of CINAHL, MEDLINE, EBSCO DISCOVERY.

**3.2 Evidence selection criteria**

Report the criteria used to select (i.e. include and exclude) the evidence. Provide rationale, where appropriate:

The HSE librarian Gethin White found 81 relevant articles.

Nicole Lam excluded articles based on the criteria:

Exclusion criteria (31)

* Too clinical, legal, abstract (philosophy)
* Staff perspective
* Could not source (22)

Research questions:

1. what are disabled people’s experiences with relationships & sexuality?

2. what are disabled people’s experiences with education about relationships & sexuality?

3. what are disabled people’s experiences of expressing their sexuality?

4. what are outcomes associated with disabled people not having healthy relationships & sexuality?

Based on the exclusion criteria, 51 articles were included in the literature review

**3.3 Strengths and limitations of the evidence**

Describe the strengths and limitations of the evidence. Consider from the perspective of the individual studies and the body of evidence aggregated across all the studies. Tools exist that can facilitate the reporting of this concept. GRADE is a commonly used tool with further information available through this link: <http://ktdrr.org/products/update/v1n5/dijkers_grade_ktupdatev1n5.pdf>

**Key questions to answer:**

**3.3.1 Are the results valid?**

The literature search on disabilities and sexualities yielded mainly articles published after 2010, written in English and thus evidenced a western perspective on disability sexualities. Compared to many other areas of disability studies, sexuality and relationships is well researched and is supported by a body of rich qualitative and experiential evidence from disabled people including disabled researchers themselves. However, there are limitations to the evidence, as people with intellectual disabilities are still underrepresented in the collaborative research front.

**3.3.2 Are the results applicable to the population group?**

Yes, the results are applicable to all disabled people and includes a wide range of disabilities, ages, gender, sexuality and races. The main themes arising from the literature are as follows:

1. **Child/adolescent experiences**
   1. **Lacking and risk based**: pregnancy, consequences, body parts, STIs
   2. **Early construction of disabled person**: asexual or perpetual child/victim, or hypersexual, deviant; unequipped and unable to make decisions.
   3. **Sexual scripts** upholds racist, gendered, cisheteronormative and ableist notions of “appropriate” behaviour and functionality, disabled people’s desires historically ignored, prevented or punished: is then internalised – identity formation.
   4. **Disabled girls encounter extra barriers** and institutionalisation (eugenic history of forced sterilisation to lack of accessible contraception or forced – reproductive coercion), made vulnerable to abuse, STIs, pregnancy.
   5. **Post-institutionalisation**: shared housing, confinement in rigid ethos, isolated, staff views of sex & sexuality as sensitive and serious, uncomfortable.
   6. **Abuse & violence:** PWID SA’d at a rate 7 times higher than general population, perpetrator is generally known by person.
   7. Majority of young people want **more information on sex**, sexuality and intimacy, delivered by healthcare professional and peer.
   8. **Family and caregivers are the first barrier encountered** (alongside formal institutions such as schools or residential centres).
2. **Adult experiences**
   1. Education is knowledge based, not skills based, learned mostly through peers. **Experential knowledge** is more relevant but also risky.
   2. Desire to learn more about **abstract concepts** such as consent in relationships, unspoken rules and cues, how to behave in non romantic relations vs strangers
   3. **Co-learning and co-constructing sex education** on IG; participatory research (reflexive) engage in curiosity and “abnormal” sex topics
   4. Crip Queer Alliance – **encouraging alliances on the margins**, both groups pathologized by medicine, demonized by religions, stereotyped, isolated socially. Opportunity for disabled activists to imagine possibilities and reconnecting with their body
   5. **Sex work/sexual assistance**: oppose therapy, charity, or care approach, centering pleasure.
   6. **Parenthood – often dissuaded by support network**, internalise belief of not good enough, prove they have skills that they don’t have, access to new social status.
   7. **Online dating/apps** – hierarchy of disabilities/impairments, shame of visible disabilities/impairments
   8. Essential to **centre self advocates** in re-imagining what sex ed looks like

**3.4 Formulation of recommendations**

3.4.1 What are the recommendations?

The principles, which are attached in this document

3.4.2 Describe the methods used to formulate the recommendations and how final decisions were reached. Specify any areas of disagreement and methods used to resolve them:

Recommendations in the form of principles were drafted by the members of the working group taking into account the themes from the focus group and the themes arising from the literature review.

Once the working group agreed on the principles, the document was sent back to the focus groups to ensure their comments were reflected in the principles.

**3.5 Considerations of benefits and harms**

Report the benefits, side effects and risks that were considered when formulating the recommendations (may not be required)

**3.6 External review**

Report the methodology used to conduct external review:

The principles will be reviewed by the participants of the focus groups and the Human Rights & Ethics Review Group

**3.7 Competing interests**

Confirmation that the full group has completed a Declaration of Interest Form: Yes

Any other information to bring to the attention of the working group? None at this time

Signed: Nicole Lam (lead of working group)

Date: 25th September 2025

## Appendix 1 – HEARTS

Co-designed with one of our focus groups at the Callan Institute:

HEARTS
Principles for Promoting Healthy Relationships and Sexuality for Disabled People in Ireland
- Human rights
- Education
- Autonomy
- Respect for consent
- Thoughtful choice/decision making
- Support through Access

## Appendix 2 – Literature Review

**Literature review of disabled people’s experiences with sexualities, relationships and education.**

**PHRAS – Promoting Healthy Relationships and Sexuality**

**Introduction**

The intersection of disability, relationships, and sexuality has been an area of increasing academic and social interest in recent years. Historically, people with disabilities have been viewed through a lens of asexuality, dependency and/or hypersexualised with their sexual rights often marginalized or ignored. However, as disability studies and social justice movements progress, there is a growing recognition of the need for inclusive sexual education and the promotion of healthy sexual lives for disabled individuals. The ratification of the UNCRPD (United Nations Convention on the Rights for Persons with Disabilities) has resulted in a renewed conversation on the rights of disabled people, including the right to health relationships, sexuality and being educated and empowered to explore those ideas.

This literature review seeks to address four key research questions concerning the experiences of disabled individuals with relationships, sexuality, and education:

1. What are disabled people's experiences with relationships and sexuality?
2. What are disabled people's experiences with education about relationships and sexuality?
3. What are disabled people's experiences of expressing their sexuality?
4. What are the outcomes associated with disabled people not having healthy relationships and sexuality?

Of the 82 titles found by the HSE librarian, 51 articles were included in this review. Exclusion criteria was based on the following: unable to source article; clinical, legal or philosophical perspectives; staff perspectives. Articles in this review were predominantly published after 2010, are all written in English and largely from a Western perspective. This review provides an in-depth exploration of these areas, highlighting both the barriers that disabled individuals face and the potential strategies to overcome them.

The main theories used by authors were critical disability studies, feminist critical disability studies, and social justice studies. The authors frequently referenced the UNCRPD, with the following articles being most relevant: Article 6: Women with disabilities; Article 16: Freedom from exploitation, violence and abuse; Article 19; Living Independently and being included in the community; Article 21: Right to freedom of expression, opinion and access to information; Article 23: Respect for home and the family; Article 24: Education; Article 25: Health. The WHO definition of sexual health and sexuality was cited widely, and are working and dynamic definitions:

*“sexual health is:“…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (WHO, 2006a)*

Sexual health cannot be defined, understood or made operational without a broad consideration of sexuality, which underlies important behaviours and outcomes related to sexual health.

*The working definition of sexuality is:*

*“…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.” (WHO, 2006a).*

Other concepts that were widely mentioned included the medical model versus social model, intersectionality of oppression, and discursive violence.

**1. Disabled People’s Experiences with Relationships and Sexuality**

People with disabilities experience unique challenges in forming and maintaining romantic and sexual relationships. These challenges are often rooted in societal stigma, ableism, and a lack of support systems that acknowledge their sexual rights and needs.

**Social Stigma and Ableism**

One of the most significant barriers to forming relationships for disabled individuals is the pervasive ableism that underlies societal attitudes towards disability and sexuality. Research by Correa et al. (2022) and Bahner et al. (2024) reveals that individuals with intellectual and developmental disabilities are often perceived as incapable of engaging in romantic or sexual relationships. These attitudes are reinforced by caregivers, healthcare providers, and society/institutions at large, contributing to a social climate in which disabled individuals are excluded from the sexual realm.

The stigma surrounding disabled sexuality can also lead to the infantilization of disabled individuals, whereby they are seen as asexual or incapable of experiencing sexual desire. This view of disabled people’s sexualities as taboo, as noted by Schmidt et al. (2021), restricts their ability to form meaningful romantic connections. It is essential to acknowledge that people with disabilities, like their non-disabled counterparts, have diverse experiences and desires when it comes to intimacy and relationships. Denying them the right to explore these aspects of their lives is a violation of their sexual autonomy.

The sexual rights of disabled individuals are overlooked, and they are often seen as unworthy of romantic attention. This cultural narrative not only diminishes the humanity of disabled people but also deprives them of opportunities for emotional and physical intimacy. According to Bonder et al. (2021), healthcare professionals and educators frequently fail to address the sexual health needs of disabled youth, often assuming that they are not interested in or capable of sexual expression. This lack of acknowledgment exacerbates social isolation and deprives disabled individuals of the tools they need to navigate relationships.

Disabled people live in a dichotomy whereby they are either infantilised as asexual beings incapable of forming or developing relationships and sexualities, or they are hypersexualised (and historically incarcerated or criminalised) for displaying what society deems problematic sexualities. Both characterisations of disabled people strips them of agency and dehumanises them, preventing them from social scripts and opportunities to form fulfilling human modalities.

**Barriers to Relationship Formation**

Beckwith and Drake (2022) provide insights into how disabled women experience barriers to both relationships and sexual expression. They argue that the lack of accessible dating opportunities, combined with societal expectations that women with disabilities should be passive or asexual, makes it difficult for these women to form romantic relationships. For disabled women, these challenges are compounded by gendered ableism, which stereotypes them as unattractive or undeserving of sexual desire.

Moreover, people with disabilities often face logistical and practical barriers that complicate relationship formation. These include physical accessibility issues, such as the lack of accessible dating spaces, and the absence of social support systems that facilitate opportunities for disabled people to meet others. As Turner and Crane (2016) point out, social isolation is a pervasive issue for many disabled individuals, particularly when it comes to forming romantic relationships.

However, it is important to note that some disabled individuals have found ways to navigate these challenges. MacKeigan (2021) highlights the role of disability advocacy groups and social media platforms (including dating apps) in creating spaces where disabled people can express their sexual desires and connect with others. These platforms provide an opportunity for disabled individuals to build relationships based on mutual respect and shared experiences, challenging societal expectations and norms surrounding disability and sexuality.

**2. Disabled People’s Experiences with Education about Relationships and Sexuality**

Education about relationships and sexuality is a fundamental aspect of human development, yet many disabled individuals face significant barriers to accessing appropriate and quality sexual education. These barriers stem from a combination of institutional neglect, lack of awareness, and entrenched prejudices about the sexuality of disabled people.

**Lack of Accessible and Inclusive Sexual Education**

Numerous studies document the inadequacies of sexuality education for disabled individuals. Hole et al. (2021) and Michielsen and Brockschmidt (2021) point out that sex education programs for disabled students are often either nonexistent or insufficiently tailored to the unique needs of this group. This lack of comprehensive sex education leaves many disabled people uninformed about key aspects of sexual health, relationships, and consent. In particular, students with intellectual and developmental disabilities are often excluded from discussions about contraception, safe sex, and healthy relationships.

Furthermore, Schnellert et al. (2021) argue that many sex education programs for disabled individuals focus solely on the prevention of sexual activity rather than promoting positive sexual health and relationship skills. This fear-based approach to sexuality education can be harmful, as it reinforces the notion that disabled individuals are incapable of experiencing healthy, consensual sexual relationships. Instead, sexuality education should be centred around teaching individuals about consent, emotional intimacy, and the importance of mutual respect in relationships.

The absence of disability-specific sexual education is also exacerbated by the tendency to adopt a one-size-fits-all approach in schools and healthcare settings. As Beckwith and Drake (2022) point out, most sexual education materials are designed with non-disabled students in mind, which often leaves disabled students without the necessary information to navigate their sexual identities safely. Furthermore, Rodriguez et al. (2020) highlight that sex education programs for disabled individuals are often delivered in a manner that assumes a level of understanding that may not be appropriate for all learners.

**Inclusive and Co-Created Educational Models**

Despite these challenges, there have been notable advancements in the development of inclusive sexual education programs. Curtiss et al. (2023) describe co-created educational initiatives, such as those on social media platforms like Instagram, that allow disabled individuals to learn about sexuality in an accessible and empowering way. These initiatives provide a space for disabled people to engage in open conversations about their sexuality, explore their desires, and gain knowledge about sexual health and relationships. Through these co-created platforms, disabled individuals are not only receiving the information they need but are also becoming active participants in the creation of educational content.

Moreover, inclusive sexuality education should not only address physical and emotional aspects but also acknowledge the social and relational dimensions of sexuality. For example, Beckwith and Drake (2022) advocate for a more holistic approach to sexual education that recognizes the diverse sexual identities and desires of disabled individuals, particularly disabled women, who often face unique challenges in expressing their sexuality. In such inclusive models, education should address topics such as self-advocacy, relationships, boundaries, and sexual consent, in order to equip disabled individuals with the knowledge and skills to navigate the complexities of intimate relationships.

**3. Disabled People’s Experiences of Expressing Their Sexuality**

The ability to express one’s sexuality is a fundamental human right, yet for many disabled individuals, societal expectations and ableism severely restrict their ability to do so. Studies show that disabled individuals face numerous barriers when it comes to sexual expression, ranging from social stigma to physical challenges.

**Societal Expectations and Ableism**

As Correa et al. (2022) and Stanojević et al. (2023) highlight, ableism plays a critical role in shaping the sexual lives of people with disabilities. The prevalent view in many societies is that people with disabilities are inherently asexual, which not only limits their opportunities for sexual expression but also silences their desires and experiences. This is particularly true for individuals with intellectual disabilities, who are often denied the opportunity to discuss or explore their sexuality openly.

The marginalization of disabled sexuality is compounded by the sexual objectification or infantilization of disabled people. Bahner et al. (2024) explore the impact of ableist rhetoric in Swedish society, which positions people with intellectual disabilities as non-sexual subjects. This rhetoric, which denies disabled individuals the right to sexual autonomy, perpetuates harmful stereotypes and fosters a culture of silence around disabled sexuality.

The denial of access to a sexual script for disabled people reinforces the power structures imposed on them by ableist notions of “appropriate” behaviour for disabled people. Disabled people’s expressions of sexuality are viewed under a lens of “inappropriate” behaviour and functionality, their desires ignored, prevented, or punished. This script is internalised and often foundational to the identity formation for disabled people. Instead of focusing on “appropriate” or functional behaviours – which change over time, social and cultural contexts, disabled people’s sexualities should be supported even when it differs to non-disabled normative understandings or expectations.

**Barriers to Sexual Expression**

The physical and practical barriers to sexual expression are equally significant. For individuals with physical disabilities, accessing accessible spaces and resources can be a major obstacle. Sakairi (2020) discusses how the medicalization of disability often leads to the silencing of disabled people’s sexual desires, as their sexuality is seen through a medical lens rather than a personal or emotional one. These individuals may struggle to find appropriate care, accessible sexual aids, or even intimate spaces that accommodate their needs. This is especially difficult for queer disabled people. In the context of post-institutionalisation, shared housing and confinement to a rigid ethos scaffolds the institutional and cultural framework that staff and organizations still use. Lack of privacy was cited as a major concern, whether the person is living with parents or with others.

Nevertheless, some disabled individuals have found ways to express their sexuality despite these obstacles. Turner and Crane (2016) note that adults with intellectual disabilities, particularly those with the support of advocacy organizations and sexual assistance organisation, can engage in meaningful sexual expression. These efforts, while significant, remain largely marginalized within broader society.

**4. Outcomes Associated with Disabled People Not Having Healthy Relationships and Sexuality**

The failure to support disabled individuals in developing healthy relationships and expressing their sexuality can have significant long-term consequences, both emotionally and physically.

**Emotional and Psychological Impact**

For many disabled people, the lack of opportunities to explore romantic and sexual relationships leads to feelings of isolation, frustration, and low self-esteem. Studies such as Friedman (2022) and Verbeek et al. (2023) highlight how these individuals may experience mental health challenges, including anxiety and depression, due to the societal devaluation of their sexual identities. The inability to form intimate relationships or engage in healthy sexual expression can contribute to a sense of being incomplete or unworthy. The lack of access for disabled people to a sexual script where they can safely explore and develop a sense of (a)sexual self is detrimental to ones development of a healthy sense of self as a whole.

Furthermore, Esmail and Concannon (2022) explore how the lack of sexual education and support for individuals with cognitive disabilities can lead to confusion about consent and healthy relationships. This confusion can put disabled individuals at a greater risk of exploitation, abuse, or coercion, as they may lack the tools to identify unhealthy or unsafe relationships.

**Health Risks and Consequences**

The lack of sexual education and access to sexual health resources for disabled individuals also leads to significant physical health risks. Rydstedt and Lachowsky (2020) discuss the consequences of unprotected sexual activity, including unplanned pregnancies and sexually transmitted infections (STIs), which are more prevalent among disabled individuals who have limited access to appropriate sexual education. Additionally, Verbeek et al. (2023) highlight that disabled individuals are often denied access to contraception and sexual health services, which increases their vulnerability to health-related issues.

For disabled women and girls, they encounter extra barriers and institutionalisation. This can be traced in the eugenic history of forced sterilisation, lack of accessible contraception and reproductive coercion. This marginalisation is compounded if the disabled person is racialised and or queer, as medical racism and ableism intersects to further marginalise the individual.

Accessibility is a major facilitator in combatting some of the aforementioned outcomes. Timely access to quality and unrestricted reproductive health services, incorporation of recording or braille in clinics, adapted communications (e.g. showing face to lip reading persons, learning sign language, advocacy skills), all can ameliorate some of the negative outcomes.

**Conclusion**

The experiences of disabled individuals with relationships, sexuality, and sexual education are shaped by a complex matrix of societal, cultural, and institutional barriers. From social stigma and ableism to the lack of inclusive educational opportunities, disabled people face significant challenges in exploring and expressing their sexuality. However, the literature also highlights the potential for positive change, as advocacy, inclusive education, and social media platforms provide spaces for disabled individuals to assert their sexual rights and engage in meaningful relationships. To promote the well-being of disabled individuals, it is crucial to address the gaps in sexual education, ensure that they have access to sexual health resources, and challenge the societal norms that limit their sexual autonomy. By doing so, we can foster a more inclusive society where disabled individuals are empowered to live full and fulfilling sexual lives.

**Bibliography**

A meta-analytic review of attitudes towards the sexuality of adults with intellectual disabilities as measured by the ASQ-ID and related variables: Is context the key? (2022). *A. B. Correa; J. D. Moreno; A. Castro*, 727-742.

Alvaro Besoain‑Saldaña, Javiera Bustamante‑Bravo, Jame Rebolledo Sanhueza, & Eloisa Montt‑Maray. (2023). Experiences, Barriers, and Facilitators to Sexual and Reproductive Health Care Access of People with Sensory Impairments: A Scoping Review. *Sexuality and Disability*, 411-449.

Bahner, J., Johansson, R. G., & Svanelov, E. (2024). Who counts as a sexual subject? The impact of ableist rhetoric for people with intellectual disability in Sweden. *Sexuality Research and Social Policy*, 161-176.

Beckwith, D., & Drake, G. (2022). Exploring women’s experiences of sexuality education, sexual expression and violence: inclusive research with disabled women. *Disability & Society, 39*(2), 422-434.

Black, R., & Kammes, R. (2021). Sexuality interventions for individuals with intellectual disability. *Education and Training in Autism and Developmental Disabilitie*, 371-393.

Bonder, R., Wincentak, J., Gan, C., Kingsnorth, S., Provvidenza, C. F., & McPherson, A. C. (2021). “They Assume That You’re Not Having Sex”: A Qualitative Exploration of How Paediatric Healthcare Providers Can Have Positive Sexuality-Related Conversations with Youth with Disabilities. *Sexuality and Disability*, 579-594.

Bornman, J., & Rathbone, L. (2016). A sexuality and relationship training program for women with intellectual disabilities: A social story approach. *Sexuality and Disability*, 269-288.

Čedomir Stanojević, Tyler Neimeyer, & Jennifer Piatt. (2021). The Complexities of Sexual Health Among Adolescents Living with Autism Spectrum Disorder. *Sexuality and Disability*, 345-356.

Charitou, M., Quayle, E., & Sutherland, A. (2021). Supporting Adults with Intellectual Disabilities with Relationships and Sex: A Systematic Review and Thematic Synthesis of Qualitative Research with Staff. *Sexuality and Disability*, 113-146.

Curtiss, S., Myers, K., D'Avella, M., Garner, S., Kelly, C., Stoffers, M., & Durante, S. (2023). Sex.Ed.Agram: Co-created inclusive sex education on Instagram. *Sexuality and Disability*, 483-503.

Elie Mimoun, & Daniella Margalit. (2023). Disclosing an Invisible Disability During a Romantic Relationship: Schizophrenia and Epilepsy. *Sexuality and Disability*, 63-80.

Esmail, S., & Concannon, B. (2022). Approaches to Determine and Manage Sexual Consent Abilities for People With Cognitive Disabilities: Systematic Review. *Interactive Journal of Medical Research*.

Estruch-García, V., Gil-Llario, M. D., & Fernández-García, O. (2024). Sexual experiences and knowledge of people with moderate intellectual disability. *Journal of Intellectual Disability Research*, 512-523.

Fernández, A. G.-S., Bosch, N. V., & Samaranch, E. A. (2017). 'From alliance to trust’: Constructing Crip-Queer intimacies. *Journal of Gender Studies*, 269-281.

Friedman, C. (2022). Sexual Health and Parenting Supports for People with Intellectual and Developmental Disabilities. *Sexuality Research and Social Policy*, 257-272.

Geymonat, G. G. (2019). Disability Rights Meet Sex Workers’ Rights: the Making of Sexual Assistance in Europe. *Sexuality Research and Social Policy*, 214-226.

Giurleo, C., McIntyre, A., Harnett, A., Cao, P., Teasell, R., & Schmidt, J. (2023). Sexual Health Among Individuals with Spinal Cord Injury: A Meta‑Synthesis of Qualitative Evidence. *Sexuality and Disability*, 713-737.

Grigorovich, A., & Kontos, P. (2018). Advancing an Ethic of Embodied Relational Sexuality to Guide Decision-Making in Dementia Care . *The Gerontologist*, 219-225.

Guénoun, T., Essadek, A., Clesse, C., Mauran-Mignorat, M., Veyron-Lacroix, E., Ciccone, A., & Smaniotto, B. (2022). The desire for parenthood among individuals with intellectual disabilities : systematic review. *Journal of Intellectual Disabilities*.

Hole, R., Schnellert, L., & Cantle, G. (2021). Sex: What Is the Big Deal? Exploring Individuals’ with Intellectual Disabilities Experiences with Sex Education. *Qualitative Health Research*, 453-463.

Laura Retznik, Sabine Wienholz, Annelen Höltermann, Ines Conrad, & Steffi G. Riedel‑Heller. (2021). “It tingled as if we had gone through an anthill.” Young People with Intellectual Disability and Their Experiences with Relationship, Sexuality and Contraception. *Sexuality and Disability*, 421-438.

Liddiard, K., & Slater, J. (2017). ‘Like, pissing yourself is not a particularly attractive quality, let’s be honest’: Learning to contain through youth, adulthood, disability and sexuality. *Sexualities*.

MacKeigan, T. (2021). Sexual citizenship through resistance: a movement that centers disabled women’s voices. *Disability & Society*, 656-677.

Manoj, M. P., & Suja, M. K. (2018). Sexuality and Reproductive Health in Young People with Disability: A Systematic Review of Issues and Challenges. *Sexuality and Disability*, 207-216.

Mazur, E. (2022). Online Dating Experiences of LGBTQ+ Emerging Adults With Disabilities. *Sexuality and Disability*, 2013-231.

Michielsen, K., & Brockschmidt, L. (2021). Barriers to sexuality education for children and young people with disabilities in the WHO European region: a scoping review. *Sex Education*, 674-692.

Mintz, K. (2017). Ableism, ambiguity, and the Anna Stubblefield case. *Disability and Society*, 1666-1670.

Onstot, A. (2019). Capacity to Consent: Policies and Practices that Limit Sexual Consent for People with Intellectual/Developmental Disabilities. *Sexuality and Disability*, 633-644.

O'Reilly, K., Wilson, N. J., Kwok, C., & Peters, K. (2022). An exploration of women's sexual and reproductive health following traumatic brain injury. *Journal of Clinical Nursing*, 901-911.

Özlem Haskan Avcı. (2023). It’s a Taboo: Women with Disabilities Applying for Psychological Counseling Due to Romantic Relationship and Sexual Problems. *Sexuality and Disability*, 335-355.

Parsons, A., Reichl, A. J., & Pedersen, C. (2017). Gendered Ableism: Media Representations and Gender Role Beliefs’ Effect on Perceptions of Disability and Sexuality. *Sexuality and Disability*, 207-225.

Paulauskaite, L., Rivas, C., Paris, A., & Totsika, V. (2022). A systematic review of relationships and sex education outcomes for students with intellectual disability reported in the international literature. *Journal of Intellectual Disability Research*, 577-616.

Pérez-Curiel, P., Vicente, E., Morán, M. L., & Gómez, L. E. (2023). The Right to Sexuality, Reproductive Health, and Found a Family for People with Intellectual Disability: A Systematic Review. *International Journal of Environmental Research and Public*.

Piatt, J. A., Stanojevic, I. S., Stanojevic, C., Zahl, M. L., Richmond, M. A., & Herbenick, D. (2022). Sexual Health and Women Living With Spinal Cord Injury: The Unheard Voice. *Frontiers in Rehabilitation Sciences*.

Ransohoff, J. I., Kumar, P. S., Flynn, D., & Rubenstein, E. (2022). Reproductive and pregnancy health care for women with intellectual and developmental disabilities: A scoping review. *Journal of Applied Research in Intellectual Disabilities*, 655-674.

Roden, R. C., Schmidt, E. K., & Holland-Hall, C. (2020). Sexual health education for adolescents and young adults with intellectual and developmental disabilities: recommendations for accessible sexual and reproductive health information. *The Lancet Child & Adolescent Health*, 699-708.

Rydstedt, D., & Lachowsky, N. (2020). Sex research conferences as heterotopias: A queer crip theory perspective on universal design. *The Canadian Journal of Human Sexuality*, 197-204.

Sakairi, E. (2020). Medicalized Pleasure and Silenced Desire: Sexuality of People with Physical Disabilities. *Sexuality and Disability*, 41-56.

Sandberg, L. J., Rosqvist, H. B., & Grigorovich, A. (2020). Regulating, fostering and preserving: the production of sexual normates through cognitive ableism and cognitive othering. *Culture, Health & Sexuality*, 1421-1434.

Schmidt, E. K., Dougherty, M., Robek, N., Weaver, L., & Darragh, A. R. (2021). Sexual Experiences and Perspectives of Adolescents and Young Adults With Intellectual and Developmental Disabilities. *Journal of Adolescent Research*, 280-305.

Schnellert, L., Tidey, L., Co-Creators, R., & Hole, R. (2021). “You have the right to love and be loved”: participatory theatre for disability justice with self-advocates. *Qualitative Research*, 1-19.

Sellwood, D., Raghavendra, P., & Walker, R. (2022). Facilitators and barriers to developing romantic and sexual relationships: lived experiences of people with complex communication needs. *Augmentative and Alternative Communication*, 1-14.

Sinclair, J., Unruh, D., Lindstrom, L., & Scanlon, D. (2015). Barriers to Sexuality for Individuals with Intellectual and Developmental Disabilities: A Literature Review. *Education and Training in Autism and Developmental Disabilities*, 3-16.

Slater, J., Ágústsdóttir, E., & Haraldsdóttir, F. (2018). Becoming intelligible woman: Gender, disability and resistance at the border zone of youth. *Feminism & Psychology*, 409-426.

Smith, E., Zirnsak, T.-M., Power, J., Lyons, A., & Bigby, C. (2021). Social inclusion of LGBTQ and gender diverse adults with intellectual disability in disability services: A systematic review of the literature. *Journal of Applied Research in Intellectual Disabilities*, 46-59.

Smusz, M., Allely, C. S., & Bidgood, A. (2024). Broad Perspectives of the Experience of Romantic Relationships and Sexual Education in Neurodivergent Adolescents and Young Adults. *Sexuality and Disability*, 459-499.

Stanojević, I. S., Baugh, M., Greer, K. M., Piatt, J., & Yarber, W. (2023). Increasing Opportunities for Healthy Sexual Socialization in LGBTQ+ People with IDD: The Role of LGBTQ+ Organizations and Community. *Sexuality and Disability* , 531-541.

Stein, S., & Dillenburger, K. (2017). Ethics in sexual behavior assessment and support for people with intellectual disability. *International Journal of Disability and Human Development*, 11-17.

Truss, A. (2020). 71. Effects of sexual education on the sexual attitudes of adults with intellectual and developmental disabilities. *Spalding University ProQuest Dissertations & Theses*.

Turner, G. W., & Crane, B. (2016). Pleasure is paramount: Adults with intellectual disabilities discuss sensuality and intimacy. *Sexualities*, 677-697.

Ubisi, L. (2020). Addressing LGBT+ issues in Comprehensive Sexuality Education for Learners with Visual Impairment: Guidance from Disability Professionals . *Sex Education*, 347-361.

Verbeek, M. C., Luijk, M., Weeland, J., & Bongardt, D. v. (2023). Male Adolescents with Mild Intellectual Disabilities: Normative Sexual Development and Factors Associated with Sexual Risks. *Sexuality and Disability*, 769-784.

Verlenden, J. V., Bertolli, J., & Warner, L. (2020). Contraceptive Practices and Reproductive Health Considerations for Adolescent and Adult Women with Intellectual and Developmental Disabilities: A Review of the Literature. *Sexuality and Disability*, 541-557.

Verschuren, J. E., Geertzen, J. H., Enzlin, P., Dijkstra, P. U., & Dekker, R. (2015). People with lower limb amputation and their sexual functioning and sexual well-being. *Disability and Rehabilitation*, 187-193.

Wit, W. d., Oorsouw, W. M., & Embregts, P. J. (2021). Attitudes towards sexuality and related caregiver support of people with intellectual disabilities: A systematic review on the perspectives of people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 75-87.

Yau, C. (2023). Making Sense of Sexual Rights of the Disabled in Today’s Social–Cultural–Digital World. *Archives of Sexual Behavior* , 3279-3283.

1. All points relating to children/ young people must be taken in the context of [Criminal Law (Sexual Offences) Act 2017](https://www.irishstatutebook.ie/eli/2017/act/2/enacted) [↑](#footnote-ref-2)
2. All points relating to consent must be taken in the context of the legal definition of consent to sexual activity in the [Criminal Law (Sexual Offences) Act 2017](https://www.irishstatutebook.ie/eli/2017/act/2/section/48/enacted/en/html#sec48). [↑](#footnote-ref-3)