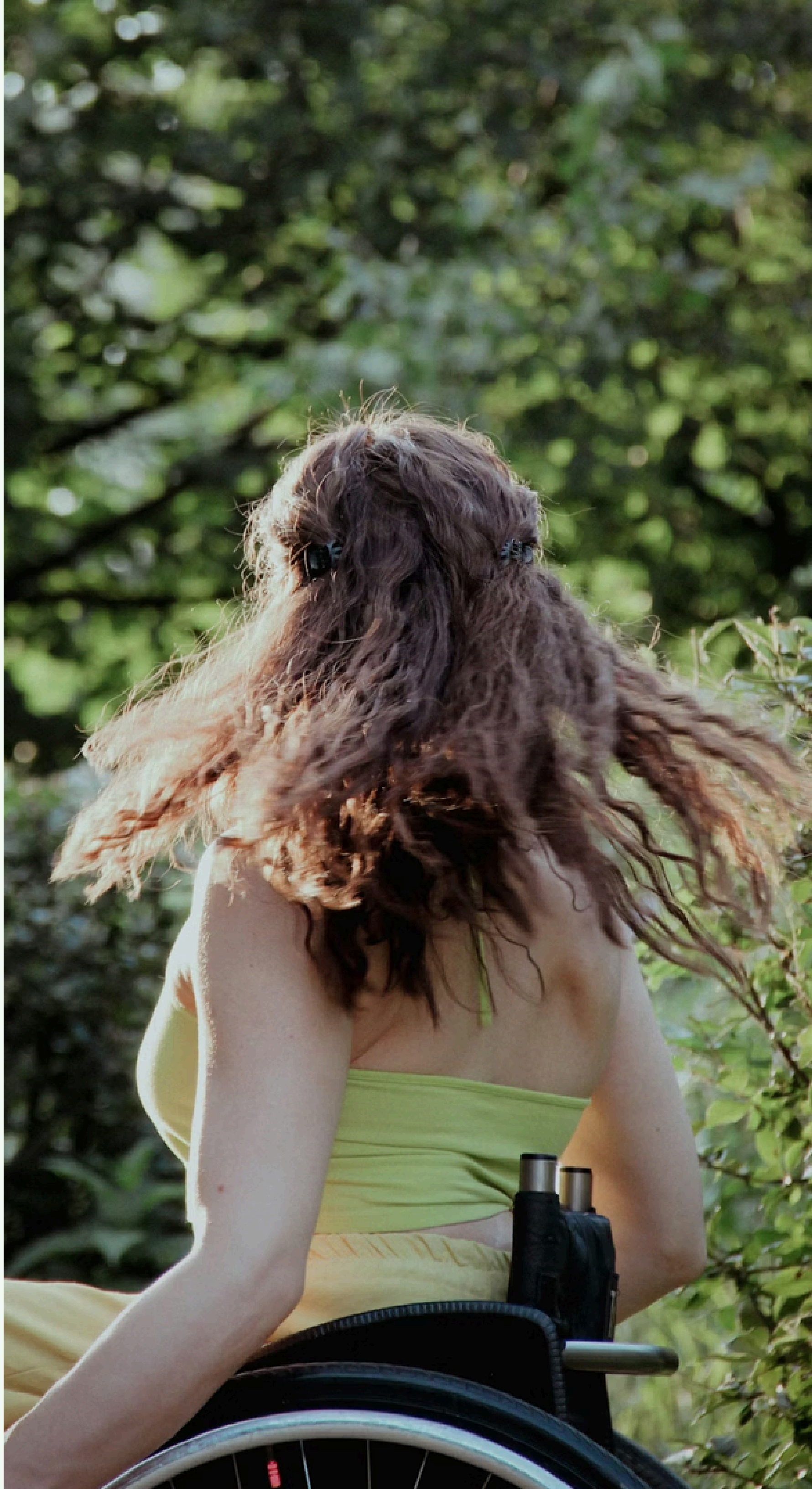
Disability Inclusivity Toolkit

The purpose of this toolkit is to provide support, strategies, and resources for Michigan health teachers who want to make their sex education lessons more inclusive for all students, particularly Disabled youth.

michigan organization on
adolescent sexual health

MI Youth Access for Disabled Youth on Inclusive Sex Education
MY ACCESS

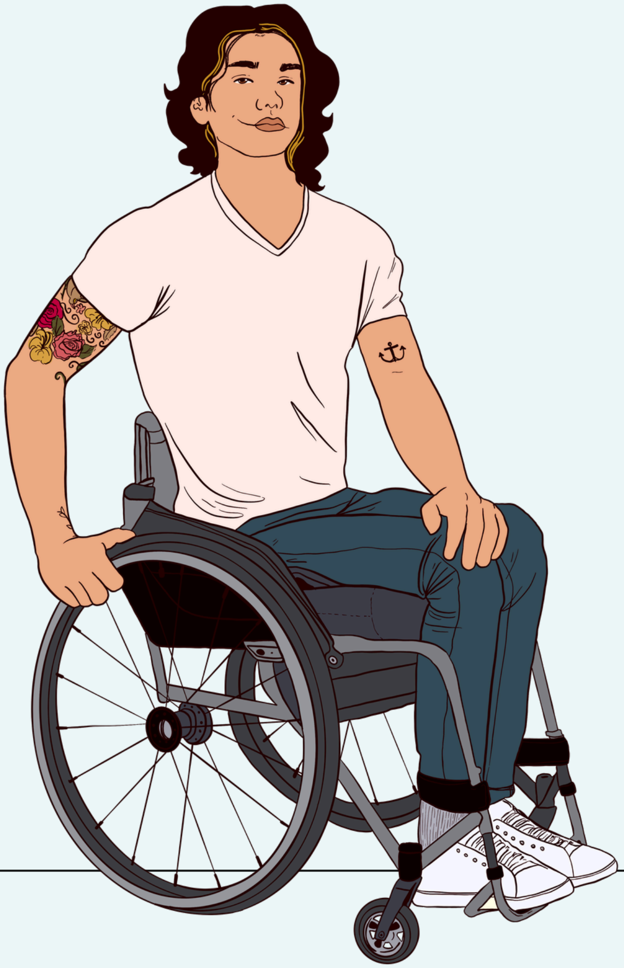
This toolkit was informed by MOASH's
Michigan Youth Access (MY Access) Youth Advisory Council,
a group of Disabled youth ages 13–24, dedicated to advocating for
accessible and accurate sex education and sexual health resources.



Why This Toolkit Exists

There is a significant lack of sex education resources that are inclusive of and affirming for Disabled youth and an equally noticeable gap in the quality and depth of sexual health education they receive.

General education teachers, who are responsible for teaching classrooms with students of widely varying needs, have a responsibility to ensure their teaching and lesson plans account for all students.



Many students with disabilities are not formally identified through IEPs or 504 plans, and you may not be aware of which students in your classroom identify as Disabled. Disability exists on both physical and cognitive spectrums, and it does not always “look” a certain way. According to the Invisible Disabilities Association, invisible disabilities refer to a range of symptoms such as chronic pain, fatigue, dizziness, cognitive dysfunction, brain injuries, learning differences, mental health disorders, and hearing or vision impairments. An invisible disability is any physical, mental, or neurological impairment that is not immediately apparent to others, but may impact a person’s movements, senses, learning, or day-to-day life.

Assumptions and biases are preconceived misconceptions about people based on stereotypes and labeling. Assumptions about an individual can be based on their group status or identity. We know what assumptions and biases are, but you may not be aware of how they pervasively affect different people. For example, you may make assumptions based on someone's appearance, actions, or words that impact your perception. These harmful biases and attitudes towards sexual wellness for Disabled folks are harmful and often lead to subpar care surrounding topics that can and DO affect Disabled youth. Even educators and providers may hold biases and make assumptions about reproductive health, sexual wellness, Disability, and how youth interact with these topics. This toolkit seeks to break down some of those biases and bring some truth and perspective to the conversation alongside actionable steps.

This resource guide was created to help bridge that gap by making inclusive sex education materials more accessible and rooted in the lived experiences of Disabled youth. We've carefully selected key topics that we believe are most important for educators, providers, and facilitators to understand when working with Disabled students in a health education setting.

The guide also features a resources section, which includes vetted resources, tools, and organizations. This section is meant to support continued learning, build confidence in inclusive practice, and encourage the sharing of information with colleagues and communities.

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This publication was supported by Grant Number 2001MIPREP from the Department of Health and Human Services, Administration for Children and Families. Its contents are solely the responsibility of the Michigan Organization on Adolescent Health and do not necessarily represent the official views of the Department of Health and Human Services, Administration for Children and Families.

This toolkit is part of a series designed to support health teachers. You can learn more on MOASH's resources page.

Images of people created by
Caitlin Blunnie for MOASH

Terminology

Direct vs. Indirect Communication

Direct Communication: using words (spoken, signed, AAC, or written) to clearly express a message

Indirect Communication: using facial expressions, tone, or body language to imply meaning

Classroom Example:

While discussing boundaries, a teacher says directly: “If someone says no or looks uncomfortable, that means stop.” They avoid relying only on facial expressions or tone to model discomfort, and instead narrate clearly: “Right now, I’m showing what discomfort looks like, but I’m also saying it out loud, because not everyone picks up on body language.”

This ensures students who don’t interpret indirect cues still receive the message clearly. This is critical when teaching about consent, body language, and social cues.

Age Appropriate vs. Developmentally Appropriate

Age Appropriate: expected content based on chronological age.

Developmentally Appropriate: adapting instruction to meet how students actually learn and process.

Classroom Example:

A teacher is teaching about the menstrual cycle to a class of 8th graders. In addition to their typical teaching style, they break it down using simplified visuals, a step-by-step sequence with plain language, and pause frequently to check for understanding.

This ensures all students have time to process the information and can learn it through various modalities (i.e. language and visuals).

Accessible

Accessible: Content and environments that allow all students (including those with disabilities) to engage fully.

Classroom Example:

A teacher ensures all lesson materials are shared in advance as both printed and digital documents with large text, plain fonts, and screen-reader compatibility. Videos are captioned, and activities can be done aloud, in writing, or using visuals.

This ensures students are able to access the lesson in the way they learn best, not just what’s “standard.”

Plain Language

Plain Language: Using clear, literal, and straightforward wording and avoiding idioms, slang, or jargon.

Classroom Example:

Instead of saying, “You should always wrap it before you tap it,” the teacher says: “You should use a condom every time you have sex to lower your risk of pregnancy and STIs.” They define new terms out loud and on the board, and provide a plain language glossary in the handout.

This ensures students aren’t left behind by confusing metaphors or slang.

Inclusive Language

Inclusive Language: Using language that acknowledges and respects people's differing intersectional identities without making assumptions.

Classroom Example:

When explaining different kinds of relationships, the teacher says: "Some people date and others don't. Some people are attracted to different genders and some aren't interested in sex or relationships at all."

This ensures all students feel seen and respected in the conversation.

General Guidelines for Disability Inclusion in the Classroom

If you ever feel unsure or overwhelmed, return to these principles to help guide your teaching. They're designed to support inclusive, affirming, and accessible sex education for students with a range of disabilities, including those who may not be visibly Disabled or formally identified.

1 Assume that you have Disabled students in your classroom.

You can't tell who is Disabled just by looking at them. Many students have non-apparent disabilities such as chronic pain, mental health disabilities, learning differences, sensory disabilities, or cognitive fatigue. According to the Invisible Disabilities Association, non-apparent disabilities may impact movement, memory, senses, energy, and learning.

2 Speak directly to the student.

If a student has a paraprofessional or support person, speak to the student like you would anyone else.
Use clear, direct language when teaching. Don't rely on indirect cues like tone or facial expressions alone — say exactly what you mean. This is especially important when teaching about consent, boundaries, or safety. It ensures that students who don't interpret indirect communication cues (such as neurodivergent students) still receive the full message.

3 Recognize that all students need sex ed.

Recognize that Disabled students have the right to learn about sex, relationships, and their bodies. All students — regardless of disability or support needs — deserve access to accurate, affirming, and inclusive sexual health education. Withholding this information increases the risk of abuse, coercion, and misinformation. Not every student will be sexually active, but every student deserves the knowledge and tools to make informed choices, understand consent, and advocate for their boundaries.

4 Use multiple teaching methods and styles.

Incorporate various teaching methods that meet youth's learning styles and requirements with an emphasis on accessibility. For example, allow students time to practice putting a condom on through demonstration. Then, hand out a paper breaking down the steps and things to remember.

5 Review accessibility more than once.

Keep learning! Sign up for email newsletters from relevant organizations, freshen up on training, and embrace a learning mindset.

P.S. Share this guide with others! Every time we share resources, we can one by one dismantle a system built on assumptions through education.

“It may look different for me, but I deserve this. I deserve to be heard. I deserve to be taught.”

PAIGE’S STORY

As I got older, my body started feeling different. Not different in the way that “it’s changing” or “I was growing into a woman”, but different in the way that I was tired, my heart racing and shaking upon standing up. Doctors would tell me it was anxiety and ask me if I had been taking my medicine and send me on my way. I begged for tests, I begged to be listened to. Finally, a very annoyed doctor referred me elsewhere. As I sat getting my blood drawn for what felt like the 100th time that month, I started to cry. My quality of life had declined so rapidly in just a few months. On my good days, I could maybe go downstairs and eat something small before heading back up into my room to lay down. Finally a diagnosis came my way, I was diagnosed with Postural Orthostatic Tachycardia Syndrome, or POTS.

I was told to wear compression socks from the moment I got up to when I went to bed, to add more salt into my diet and know that most people grow out of it. At this point, I had already missed birthday parties, classes and other events because just upon standing my heart rate would jump 40+ bpm. At this point in my life, all my sex education classes were over. I had completed the courses on menstruation and childbirth. However, since Michigan is an abstinence based state, I had no idea how I was supposed to navigate this. Would my body not allow pleasure anymore? Was I doomed to having the “I’m sorry, I can’t have sex because if my heart rate jumps I will be sent into a POTS episode” conversation for the rest of my life?

I had this cloud looming over me for months. How was I going to approach intimate relationships now? I wasn’t taught how to navigate this and being able to experience sexual pleasure was not at the top of my care team’s list. Disabled bodies are allowed to have sexual pleasure but how? It never came up in conversations and I was too scared to ask after being gaslit by doctors for years. I wanted a professional to tell me that I could experience sexual pleasure. I wanted a professional to tell me it was possible and that there are ways to experience it, without risking an episode. However, that never came.

I should have been able to pull out tools that were taught to me in middle school and high school but they just weren't there. What I had learned was that I should wear a pad until I got older and then switch to tampons and that while I was learning about periods, boys were watching a movie on dinosaurs. Once again, the labor had to come back to me.

When sexual experiences are not taught, there is more risk in assuming people will find the correct information. Luckily, in the age of social media, I found some sex advocates who empower and teach sexual pleasure to people like me. People who were not taught. The burden of not being taught has always come back to me. I am already dealing with a lot but then having to research everything under the sun about my diagnosis can be exhausting. "Don't get up too fast", "wear compression garments", "don't do tasks that raise your heart rate".
I may not look sick, but I can assure you that I am. I am entitled to sexual pleasure just as much as any other person. It may look different for me, but I deserve this. I deserve to be heard. I deserve to be taught.

-Paige, MOASH Youth Advisory Council Member

"I should have been able to pull out tools that were taught to me in middle school and high school but they just weren't there."

Discussion Questions

Paige's story reveals how medical bias and disbelief can shape a young person's understanding of their own body, autonomy, and sexuality.

- What feelings came up for you as Paige described pleading to be believed by doctors?
- How might experiences of medical dismissal impact a young person's sense of bodily trust, autonomy, or self-worth?
- Many Disabled people encounter disbelief or minimization of their pain. How can educators counter that harm by validating students' experiences in classroom discussions about health and sexuality?
- What can educators do within their teachings to reduce the ripple effects of medical gaslighting and restore trust?

Paige's line, "I may not look sick, but I can assure you that I am", highlights disabilities that are often overlooked.

- How do cultural expectations of what disability "looks like" influence whose needs are recognized or ignored?
- In what ways might students with non-apparent or fluctuating disabilities be excluded from lessons about consent, bodies, or sexual activity?
- What classroom practices could make sex education more accessible for students who manage fatigue, pain, or variable energy levels?
- How can educators affirm students' self-knowledge of their bodies without demanding proof or disclosure?

Paige’s experience of being dismissed, misdiagnosed, and forced to advocate for herself highlights the inequities Disabled and chronically ill young people face in healthcare.

- How do repeated experiences of not being believed by doctors affect a young person’s confidence in seeking help or asking questions about their body?
- What messages might young people internalize when professionals dismiss their pain or concerns?
- How can sex education incorporate lessons on self-advocacy in medical settings (i.e. teaching youth how to ask questions, request accommodations, or seek a second opinion)?
- What could educators do to help rebuild students’ trust in systems that have historically failed them?

Paige’s story reflects broader cultural narratives that link health to worth and productivity.

- How do cultural messages about “healthy” or “normal” bodies influence the way youth understand disability and illness?
- What examples from media, curriculum, or everyday language reinforce those ideas?
- How can educators actively disrupt the idea that a person’s value or desirability is tied to physical ability?

Safety and belonging are prerequisites for learning. Paige’s experience shows what happens when systems fail to provide either.

- What does safety mean in the context of health or sex education for chronically ill or Disabled youth?
- How can programs measure whether Disabled youth truly feel seen and supported, not just accommodated?

Changing Your Language

Instead Of...	Try Using	Rationale
Always using person-first language (i.e. Person with a disability, Person with autism)	Both identity first language ("Disabled person") and person-first language ("person with a disability") when writing broadly to honor varying preferences. Person-first language should be used when requested by a person or group and not used as a default.	More and more Disabled people are choosing identity first language because they see disability as an important part of who they are, not something to distance from. This framing resists shame-based narratives and aligns with movements like Disability Justice, which affirm disability as a culture, identity, and source of wisdom. Meanwhile, person-first language may be preferred by individuals who see their disability as separate from their identity or who come from medical or clinical contexts.
Using "Normal" or "typically developing" language	Terms such as Nondisabled, neurotypical, non-autistic, or not chronically ill (depending on context).	Saying "normal" or "typically developing" reinforces ableist norms and implies being Disabled is abnormal or lesser.
Using differently-abled, challenged, crippled	Physical disability, developmental disability, disabled	Outdated words, euphemisms, and other terms that avoid referencing disability can imply fear, disgust, or pity. Speak directly and use neutral, accurate terms.

ACCESSIBILITY IN THE VIRTUAL CLASSROOM

- Ensure students know they can unmute or chat about access issues at any time.
- Ask students to keep their camera on when reasonable. This helps those that rely on lipreading.
- Direct students to the closed captioning (CC) or transcript settings.
- Ensure students wait until someone is done talking to speak and state their name each time. This is an American Sign Language (ASL) courtesy.
- Use the chat minimally. This is a screen reader courtesy. If chat is regularly in use, pause instruction to read chat threads out loud regularly.
- Ensure students stay on mute when not speaking.

Consent & Disability

Disabled youth can and do have sex. But they often receive little to no education about boundaries, relationships, or consent. This lack of information, combined with ableism, compliance culture, exclusion from sex education, and stigma, contributes to significantly higher rates of sexual assault and abuse among Disabled youth.

Disabled students may:

- be taught to be compliant or agreeable to adults
- have experienced being touched, moved, or assisted without being asked
- need support with dressing, toileting, or medical care
- have communication styles that others don't respect or wait for

These experiences are often a result of ableism, not informed choice. Being touched without consent should never be normalized. And needing physical assistance does not mean someone has consented to being touched in other ways. That's why sex education must directly address bodily autonomy, consent, and personal boundaries with all students.

Disabled youth are often left out of conversations about healthy relationships. Some are assumed to be asexual or childlike; others are seen as incapable of understanding. These assumptions are harmful and dangerous.

Consent is not just a one-time "yes." It can change. It can be taken back. It must be freely given. And it applies to all kinds of touch, not just sex.

Tips for Teaching Consent in an Inclusive Way

Teach and Model: "This topic includes some sensitive stuff. You can step out, take a break, or let me know if you want to check in privately — totally your call." This models respect for boundaries and different comfort levels.

Emphasize that needing help does not mean you lose your right to boundaries.

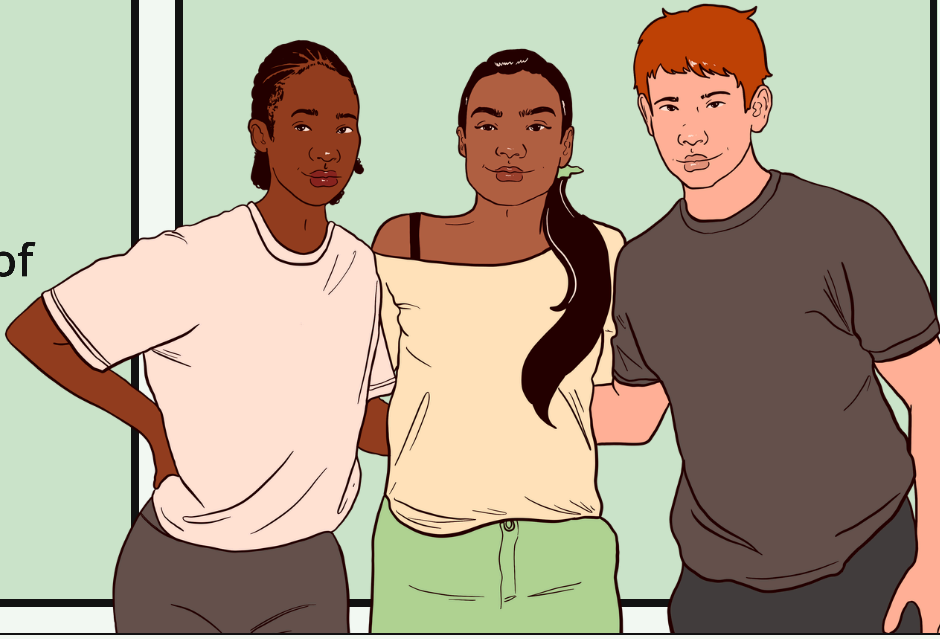
Reinforce that consent applies to a broad range of areas that aren't related to sex such as medical touch, helping with clothes, hugging, and more!

Disabled Youth Deserve to Know...

You can say yes. You can say no.

You can change your mind.

You get to decide what happens to your body and when.



“We shouldn’t have to find sex ed on TikTok. Our schools owe us real, honest, inclusive education.”

ZI’S STORY

When reflecting on my own experience with sex education, I often think about the gaps: what was covered, what wasn’t, and how much of it felt entirely irrelevant to me as a Disabled person. I had the privilege of receiving sex education that was queer-friendly, something many don’t have access to. Attending private schools and being in more progressive spaces afforded me this benefit, but even there, Disabled people were left out of the conversation. It felt as though no one thought Disabled people even had sex, let alone needed guidance on how to do so safely and in ways that respected their bodies.

I’ve lived with chronic pain for a long time and I now know I have been physically Disabled for the majority of my life, but I’m new to considering myself physically Disabled. When it came to sex and intimacy, I had to figure things out on my own. This meant learning how to adjust my approach to sex and, perhaps more importantly, how I approached my own body. There were no readily available narratives or resources tailored to Disabled people. I didn’t have a teacher, a trusted adult, or a guide to turn to. Instead, I had to seek answers online and on social media platforms like TikTok.

But relying on the internet as my main source of information came with challenges. Finding the right resources - ones that were accurate, safe, and supportive of my needs - was difficult. I didn’t just want information. I needed good, safe information. For me, the stakes were high. Getting it wrong could mean unintentionally triggering a flare or causing harm to my body. That reality added layers of anxiety and frustration to an already isolating experience.

It also felt a bit ridiculous at times. For example, I learned how to safely navigate sex with hypermobile joints from TikTok videos. While a few creators were incredibly helpful, it was jarring to realize that I was learning something so personal and crucial from a social media app. It shouldn’t be this way. Disabled people shouldn’t have to rely on internet research to figure out their sexual health, but often, that's the reality. Whether it's learning to adapt activities for hypermobility or discovering how to accommodate conditions like heart issues, the responsibility falls on us to "make it up as we go."

There's another layer to this: sex education, when it does address disability, often centers interabled relationships, where one partner is Disabled and the other is not. This creates a narrative that forgets Disabled people can and do have sex with each other. That dynamic brings its own set of challenges and nuances. With an able-bodied partner, there's room to focus on your own needs, but when two Disabled people are together, there's an additional consideration: ensuring you're not unintentionally harming the other person's body while still tending to your own needs. It's a balancing act that rarely gets talked about.

I think about other people like me who are newly Disabled and how critical it is that providers remind them to relearn their bodies. This was my experience, too. I started having sex before I identified as Disabled, and when my body changed, I had to completely relearn everything. You can't just trust your instincts, because those instincts come from a body you no longer have. It's a disorienting process that requires patience, education, and support.

Sex education must be inclusive of Disabled young people, not as an afterthought but as a central component. Our bodies deserve care, understanding, and intentional guidance. When we leave Disabled people out of the conversation, we force them to navigate these deeply personal experiences alone, often risking harm in the process. It's time for sex education to reflect the reality that Disabled people exist, Disabled people have sex, and Disabled people deserve to do so safely.

-Zi, MOASH Youth Advisory Council Member

"Sex education must be inclusive of Disabled young people, not as an afterthought but as a central component."

Discussion Questions

First, some reminders:

Disability is diverse. There's no single experience or body.

Zi's story reflects one Disabled person's experience, not a universal truth.

Use identity-first language (i.e. "Disabled people") unless someone expresses another preference.

Zi's story highlights how even progressive, queer-affirming environments can still exclude Disabled people. This section invites reflection on who is centered—and who isn't—in sex ed content and classrooms.

- What assumptions about different kinds of disability might be built into traditional sex education?
- Why do you think disability inclusion often lags behind other forms of inclusion, even in otherwise affirming spaces?
- How might curriculum materials, visuals, or examples unintentionally exclude Disabled students?
- What would it look like for disability to be central to sex education rather than treated as an add-on?

Zi describes a process of “relearning their body” after recognizing their physical disability. For others, this might look different—or not feel necessary at all. The focus here is on self-knowledge, adaptability, and self-trust.

- Zi talks about needing to “relearn” their body. What might that process look like for people whose bodies change or who experience pain, fatigue, or new physical realities?
- How can educators normalize the idea that sexuality can evolve as our bodies change over time?
- What kinds of classroom messages or activities could encourage young people to build curiosity and compassion toward their own bodies, rather than shame or frustration?

Many Disabled youth turn to social media because formal education fails to meet their needs. This section focuses on access, accuracy, and systemic gaps.

- Zi describes learning about hypermobility and sex from TikTok. What does this reveal about how inaccessible traditional sex education can be?
- How can educators help students evaluate whether online sexual health information is accurate, inclusive, and safe for their unique needs?
- What institutional or systemic barriers might prevent Disabled youth from getting the same quality of sexual health education as their peers?
- What partnerships (for example, with Disabled advocates or organizations) could strengthen access to reliable, affirming resources?

Zi points out that sex education, when it mentions disability at all, often focuses on one Disabled and one non-Disabled partner. This section invites discussion on broadening those narratives and addressing diverse dynamics.

- Why do most depictions of disability and intimacy focus on interabled relationships? What messages does that send?
- How can sex education acknowledge and support relationships between two Disabled people while affirming consent, safety, and mutual care?
- What might realistic and affirming examples of Disabled intimacy look like in curriculum materials or classroom discussions?

The following questions invite self-reflection but should be tied to concrete action.

- What biases or assumptions might educators unconsciously hold about Disabled people and sexuality?
- How can educators recognize and interrupt those biases in real time?
- What training, resources, or partnerships would help you feel prepared to teach inclusive sex education that meaningfully serves Disabled youth?

Zi ends with a call to joy, not just safety. These questions encourage imagining how your teaching may foster this.

- If you could redesign one part of your sex ed curriculum based on Zi's story, what would it be and why?
- How might centering disability improve sex education for all students, not just those who identify as Disabled?

Disabled people are significantly more likely to experience sexual violence and less likely to receive the education and tools that could prevent it.

90% of people with intellectual or developmental disabilities will experience sexual abuse at some point in their lives.

→ That's nearly every person with an intellectual or developmental disability.

(Disability Rights Texas)

50% of people with intellectual or developmental disabilities will experience 10 or more incidents of sexual abuse.

(Disability Rights Texas)

Women with disabilities are more likely to have experienced physical and sexual interpersonal violence in their lifetime, the past five years, and the past year.

(National Library of Medicine)

These numbers show a disturbing reality: Disabled people face much higher rates of sexual violence and are far less likely to receive meaningful support or justice. That's why inclusive and accessible sex education is not just beneficial, but necessary.

What Makes an Accessible Classroom?

A Checklist for Accessible Health Education

Creating an accessible classroom means designing your environment and materials so all students can learn, engage, and feel respected.

Accessible Content & Materials

- ☐ Offer multiple formats: text, audio, visual, tactile
- ☐ Use plain language — avoid metaphors, jargon, or slang
- ☐ Provide transcripts for audio and captions for all videos
- ☐ Use screen-reader friendly documents and avoid image-only text
- ☐ Break text into smaller chunks (fewer items per line/page)
- ☐ Use sans serif fonts
- ☐ Use minimum 14pt font size
- ☐ Use high color contrast
- ☐ Write out all verbal instructions, and pair them with visuals
- ☐ Avoid busy layouts — keep slides and handouts clean and simple

Accessible Classroom Environment

- ☐ Ensure classroom is wheelchair/mobility-aid accessible
- ☐ Avoid last-minute room changes (communicate early!)
- ☐ Think about lighting, sound, and scent sensitivity
- ☐ Check for clear walkways and space for service animals
- ☐ Provide flexible seating or movement breaks if needed

Accessible Communication

☐ Always speak directly to students, not their aides
☐ Use direct communication (avoid implied meaning)
☐ Ask students how they learn best — and believe them
☐ Reinforce: all students can learn, process, and grow
☐ Mirror students’ preferred disability language (identity-first or person-first)

Built-in Accessibility for Everyone

☐ Use accessibility checkers in Google Docs, Canva, or Word
☐ Avoid color-only meaning (e.g., don’t say “choose the red one”)
☐ Provide all instructions in written form
☐ Create handouts and slides that can be printed in grayscale
☐ Add alternative text (alt text) for all images

Resources

Elevatus Training: a national leader in the field of sexuality and intellectual and developmental disabilities offering evidence-informed, trauma-informed products (curriculum, online training, workshops, keynotes, etc.) to help professionals, educators, self-advocates and parents skillfully and confidently navigate the topic of sexuality

SexEd Mart: toolboxes, activity kits, sequencing cards, manuals, and lectures for all ages and abilities, including adapted materials for students with special needs to teach about puberty, hygiene, safety, boundaries, consent, identity, sexuality, dating, and healthy relationships

Sexpressions: offers the largest selection of tools for working with individuals with special needs, all of which are tested in classrooms first, designed with specific learners in mind, and explore essential subjects for everyone

Autistic Self Advocacy Network's Real Talk: free resources for individuals with disabilities and providers focused on improving quality of sexual health education

Disability After Dark Podcast: a podcast hosted by Andrew Gurza featuring real conversations about disability, sexuality, and everything else we don't discuss about the disability experience

Project Shine: a toolkit and online game created with and for youth with intellectual and developmental disabilities featuring content about sexuality topics to help young people make informed decisions around sexual and reproductive health