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From Health to Behaviour: Multi-Stakeholder Perspectives on Disability-Inclusive CSE in Special Needs Education

Ummu Mas'muah, Budi Susetyo, Endang Rochyadi, Juhanaini Juhanaini & Ana Fatimatuzzahra
Universitas Pendidikan Indonesia, Bandung, Indonesia
ummumasmuah@upi.edu

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ABSTRACT

Children with disabilities face disproportionate vulnerability to sexual abuse, coercion, and misinformation, positioning disability inclusive Comprehensive Sexuality Education (CSE) as a critical educational safeguard. Yet, in socio culturally conservative settings, implementation debates often rely on a single notion of "support," overlooking which parts of CSE are accepted, which are resisted, and where negotiation is most needed across stakeholder groups. This quantitative descriptive study addressed that gap by mapping multi stakeholder readiness for disability inclusive CSE for children with special needs in West Java, Indonesia, using eight UNESCO based CSE dimensions. Purposive sampling recruited teachers, parents, and community leaders (N = 89). Data were collected using a validated Likert scale instrument adapted from UNESCO guidance with strong internal consistency (Cronbach's alpha = 0.87). Results showed high but uneven endorsement across dimensions, with the strongest support for Sexual and Reproductive Health (94.4%) and the lowest support for Sexual Behaviour (77.6%), indicating that behaviour related content remains the central point of hesitation. Exploratory modelling further suggested that enabling capacity factors matter, with education level and teaching experience jointly explaining a substantial share of variance in overall endorsement (R squared = 0.47). By conceptualising readiness as multidimensional and socially negotiated, this study contributes an empirically grounded acceptability map that can guide sequenced curriculum implementation, strengthen teacher professional development, and structure stakeholder dialogue to advance inclusive child protection efforts in Indonesia and comparable contexts.

1. Introduction

For children with disabilities, sexuality education is not a peripheral curriculum issue; it is a matter of safety, dignity, communication, and educational justice. Across many societies, children with disabilities are often positioned as either asexual, dependent, or permanently childlike, and these assumptions can silence their right to understand their bodies, relationships, consent, and protection. Such silence is dangerous. Sexual violence against children remains a profound global public health and educational concern because it produces immediate trauma while also undermining learning, wellbeing, self-trust, and confidence in adult protection systems. For children with disabilities, this vulnerability is intensified by heightened dependence on caregivers, social isolation, communication barriers, limited access to developmentally appropriate information, and reduced opportunities to learn about bodily autonomy, privacy, and safe touch (Sullivan & Knutson, 2000; Barnard-Brak et al., 2014; Schaafsma et al., 2015). In this sense, sexuality education for children with special needs should not be misunderstood as the early introduction of sexual behaviour, but rather as a structured educational safeguard that enables learners to recognise risk, communicate discomfort, assert boundaries, seek help, and participate more safely in social life.

Protection for children with special needs cannot rely on implicit messages, informal warnings, or one-time advice from adults. Many learners require explicit, accessible, repeated, and developmentally calibrated instruction to understand concepts such as body parts, privacy, consent, menstruation, puberty, relationships, personal boundaries, and abuse prevention (Sullivan & Knutson, 2000; Schaafsma et al., 2015). Comprehensive Sexuality Education (CSE) provides a curriculum-based framework for equipping children and adolescents with the knowledge, skills, attitudes, and values needed to support health, wellbeing, dignity, and respectful relationships. When delivered

appropriately, CSE can strengthen bodily awareness, self-efficacy, social competence, help-seeking behaviour, and resistance to exploitation, while reducing stigma and misinformation (Miedema et al., 2020; Ramaswamy, 2021). These outcomes are especially relevant in special and inclusive education settings, where learning is not only concerned with academic achievement but also with independence, communication, self-protection, social participation, and quality of life. Therefore, disability-inclusive CSE must be understood as part of inclusive education itself, because inclusive schooling is incomplete if learners are denied access to knowledge that protects their bodies and supports their participation in society.

Previous studies have consistently shown that children and adolescents with disabilities have limited access to sexuality education, even though their need for such education is clear. Barnard-Brak et al. (2014) demonstrated that students with intellectual disabilities often receive less sexuality education than their non-disabled peers, indicating that access remains shaped by institutional assumptions about disability and sexuality. Schaafsma et al. (2015), in a systematic review of sexuality education methods for individuals with intellectual disabilities, found that effective instruction requires explicit teaching, repetition, modelling, visual support, and skills-based practice rather than abstract or purely informational approaches. Similarly, Goldman and Coleman (2013) argued that teacher preparedness is central because educators' prior learning, professional confidence, and pedagogical training influence whether sexuality and puberty education are actually delivered. Research has also identified teachers' discomfort, inadequate training, limited curriculum resources, fear of parental objection, and uncertainty about cultural or religious acceptability as recurring barriers to implementation (Eisenberg et al., 2013; Nelson et al., 2020; Shibuya et al., 2023). At the family level, Pownall et al. (2012), Kamaludin et al. (2022), and Rashikj-Canevska et al. (2023) showed that parents often recognise the importance of sexuality education for children with disabilities, yet many experience anxiety, embarrassment, lack of language, or uncertainty about when and how to discuss sexuality-related topics. These studies suggest that the problem is not simply whether CSE is needed, but whether schools, families, and communities possess the knowledge, confidence, and shared legitimacy to support it.

A second body of scholarship highlights that CSE implementation is shaped by cultural negotiation, stakeholder interpretation, and the perceived boundaries of acceptable knowledge. Miedema et al. (2020) caution that the term "comprehensive" is often used without sufficient attention to which topics are included, excluded, softened, or resisted. Michielsen and Brockschmidt (2021), in a scoping review on sexuality education for children and young people with disabilities, showed that barriers are multilevel, involving policy, school systems, teacher preparation, parental attitudes, and wider social norms. Andreassen et al. (2024) further argue that people with disabilities continue to be left behind in CSE because programmes are often insufficiently accessible, poorly adapted, or limited in scope. In the Indonesian context, these issues are further complicated by religious values, communal expectations, and moral sensitivities surrounding sexuality, which can make stakeholders more accepting of health- and safety-oriented topics than of topics perceived as behaviourally explicit or morally controversial (Hidayah et al., 2020; Riany et al., 2016). Studies from broader disability and sexuality education contexts also indicate that parents, teachers, support staff, and young people may value different outcomes, such as safety, relationship skills, autonomy, hygiene, emotional vocabulary, or social appropriateness (Brown et al., 2020; de Wit et al., 2022; Colarossi et al., 2023). However, much of the existing literature still focuses on access, curriculum content, teacher readiness, or parental attitudes separately. Less attention has been paid to how different stakeholder groups interpret specific CSE dimensions within a culturally specific educational setting. This creates an important research gap: readiness for disability-inclusive CSE should not be treated as a single general attitude, because stakeholders may strongly support some dimensions while hesitating over others.

Addressing this gap, the study conceptualises stakeholder readiness as multidimensional, content-specific, and socially negotiated. Rather than assessing general support for CSE, it examines how teachers, parents, and community leaders respond to its dimensions and where consensus or tension emerges. Guided by UNESCO's eight dimensions, namely relationships; values, rights, culture, and sexuality; understanding gender; violence and staying safe; skills for health and wellbeing; the human body and development; sexuality and sexual behaviour; and sexual and reproductive health (UNESCO, 2018), the study maps stakeholder support in West Java, Indonesia. Its novelty lies in shifting from broad endorsement to dimensional readiness, identifying accepted areas and those requiring careful pedagogical framing, teacher preparation, and community dialogue. This rarely emphasised multi-stakeholder perspective connects disability-inclusive special education, sexuality education, child protection, and culturally responsive curriculum implementation.

The significance of this study lies in its potential to inform realistic, staged, and culturally responsive implementation of disability-inclusive CSE. Readiness patterns matter because they influence what schools feel authorised to teach, what teachers feel confident to deliver, what parents perceive as legitimate, and what community leaders are willing to support. Using a quantitative descriptive design, this study addresses three research questions: (1) What level of support do teachers, parents, and community leaders demonstrate

toward the eight CSE dimensions? (2) How do patterns of support differ across stakeholder groups and CSE dimensions? and (3) Which demographic or professional factors are associated with stronger support for disability-inclusive CSE? By answering these questions, the study aims to generate evidence that can guide curriculum sequencing, teacher training, family engagement, and policy communication. This is particularly important because implementation may be more effective when schools begin with broadly accepted dimensions such as health, safety, rights, and bodily development, while gradually building the trust, vocabulary, and pedagogical confidence needed to address more sensitive dimensions such as sexuality and sexual behavior (Rooks-Ellis et al., 2020).

The study also has significant implications for English Language Teaching (ELT), particularly in inclusive and special education, where language supports safety, identity, and social participation. ELT learners acquire not only vocabulary and grammar but also the ability to describe experiences, express needs, seek help, negotiate boundaries, and engage in relationships. For learners with disabilities, language concerning the body, emotions, safety, consent, privacy, and help-seeking can provide essential protective knowledge. Disability-inclusive CSE can therefore be incorporated into ELT through age-appropriate texts, role plays, functional vocabulary, social stories, dialogic tasks, multimodal resources, and scenario-based communication practice. This approach maintains language-learning objectives while making instruction more meaningful, inclusive, and relevant to learners' lives. The findings can guide ELT educators in selecting appropriate CSE themes, linguistically scaffolding sensitive topics, and using classroom discourse to strengthen communicative competence and safeguarding.

Ultimately, disability-inclusive CSE should be understood not only as health education but also as an educational, linguistic, and social justice concern. By examining how teachers, parents, and community leaders in West Java respond to different CSE dimensions, the study provides evidence for curricula that are protective without being fear-based, culturally responsive without encouraging silence, and comprehensive while recognising stakeholder concerns. Its contribution is threefold: strengthening evidence on disability-inclusive CSE in Indonesia, advancing a dimensional understanding of stakeholder readiness, and highlighting opportunities to integrate safeguarding, communication, and inclusive pedagogy into ELT. Practically, the findings can support teacher education programmes, schools, curriculum developers, and ELT practitioners in designing learning experiences that help children with special needs understand their bodies, communicate boundaries, recognise unsafe situations, and participate with dignity in educational and social life.

2. Literature Review

2.1 Disability-Inclusive Comprehensive Sexuality Education as Protection, Rights, and Inclusive Pedagogy

Comprehensive Sexuality Education (CSE) is a rights-based, evidence-informed, and curriculum-based approach that develops children's and adolescents' knowledge, skills, attitudes, and values concerning health, well-being, dignity, relationships, safety, and bodily autonomy. Rather than focusing only on biological reproduction or risk prevention, contemporary CSE addresses the cognitive, emotional, physical, relational, social, and ethical dimensions of sexuality. This broader orientation is particularly important for children with disabilities, who are often excluded because of assumptions that they are asexual, unable to understand sexuality, or do not require education about relationships, consent, privacy, and safety (Andreassen et al., 2024; Barnard-Brak et al., 2014;). Such exclusion increases vulnerability by limiting their ability to recognise unsafe situations, communicate discomfort, understand bodily changes, and seek help.

Children with disabilities face greater risks of maltreatment, abuse, coercion, and neglect. Sullivan and Knutson (2000) demonstrated their heightened vulnerability to maltreatment, while later research shows that inadequate sexuality education further restricts self-protection and help-seeking capacities (Barnard-Brak et al., 2014; Schaafsma et al., 2015). For learners with intellectual, sensory, developmental, or multiple disabilities, sexuality education should therefore be treated as a safeguarding necessity rather than optional enrichment. Effective instruction requires explicit explanations, repetition, concrete examples, accessible communication, visual and multimodal resources, modelling, and structured practice (Schaafsma et al., 2015). These strategies reflect inclusive education principles that require curriculum adaptation for diverse cognitive, sensory, linguistic, and social needs.

Disability inclusion, however, requires more than placing children with disabilities within mainstream CSE materials. Many programmes remain inaccessible, insufficiently adapted, or limited in scope (Andreassen et al., 2024). Barriers include policy gaps, unavailable adapted curricula, teacher discomfort, family resistance, and stigma surrounding disability and sexuality (Michielsen & Brockschmidt, 2021). Disability-inclusive CSE must therefore combine appropriate curriculum content with inclusive pedagogy, teacher competence, family engagement, institutional support, and cultural sensitivity.

In special education settings, sexuality education also supports independence, self-care, communication, and social participation. Studies on puberty, menstruation, and sexual and reproductive health show

that accessible learning media and adapted instructional models can strengthen understanding and autonomy among learners with disabilities (Fatimatuzzahra et al., 2022, 2024, 2025a, 2025b). These findings show that rights-based principles must be translated into developmentally appropriate, culturally responsive, and disability-sensitive practices. Nevertheless, limited research has examined how multiple stakeholder groups evaluate different CSE dimensions within the same cultural and educational context.

2.2 Stakeholder Readiness, Cultural Negotiation, and Barriers to Implementation

The implementation of comprehensive sexuality education (CSE) is shaped by the knowledge, beliefs, concerns, and authority of teachers, parents, school leaders, policymakers, health professionals, and community leaders. Although teachers are central curriculum agents, many experience tension when delivering CSE in contexts where sexuality is morally sensitive or politically contested (Eisenberg et al., 2013; Shibuya et al., 2023). Educators may support CSE in principle while facing inadequate training and materials, uncertainty about age-appropriate content, and fear of parental or community opposition (Eisenberg et al., 2013). Those teaching students with intellectual disabilities also require confidence, institutional support, and practical strategies for adapting sensitive content (Nelson et al., 2020). Teacher readiness therefore depends not only on personal attitudes but also on professional preparation, school policies, institutional legitimacy, and social expectations.

Parents likewise influence children's access to sexuality education. Parents of children with disabilities often acknowledge its importance but may feel embarrassed, anxious, uncertain, or unprepared to discuss sexuality-related issues (Kamaludin et al., 2022; Pownall et al., 2012; Rashikj-Canevska et al., 2023). Mothers of adolescents with intellectual disabilities have reported needing support to address sexuality and sex education, while Malay mothers have encountered specific challenges when teaching such topics at home (Kamaludin et al., 2022; Pownall et al., 2012). Parental attitudes may also vary by content, with stronger support for health and protection topics than for subjects perceived as encouraging sexual behaviour (Rashikj-Canevska et al., 2023). However, structured training can improve parents' knowledge, communication skills, and self-efficacy, indicating that family readiness can be strengthened through culturally sensitive engagement rather than regarded as fixed resistance (Rooks-Ellis et al., 2020).

Cultural and community factors are equally influential where CSE intersects with religious values, local morality, and understandings of childhood, disability, and propriety. In Indonesia, stakeholders may support education concerning health and protection while questioning explicit discussions of sexuality and sexual behaviour (Hidayah et al., 2020; Riany et al., 2016). Cultural beliefs also shape how disability is understood within families and communities, while religious and cultural expectations affect the acceptability of sexuality education (Hidayah et al., 2020; Riany et al., 2016). These concerns do not necessarily represent complete rejection. Instead, stakeholders may distinguish between protective topics, such as bodily health, safety, and violence prevention, and morally sensitive topics involving sexual behaviour, gender norms, or romantic relationships. Support for CSE may therefore be content-specific rather than uniform.

Recent scholarship consequently questions the measurement of CSE support as a single general attitude. The term "comprehensive" can conceal differences in what is included, excluded, weakened, or contested during implementation (Miedema et al., 2020). Relationship and sexuality education programmes for people with intellectual disabilities also vary substantially in content, design, delivery, evaluation, and long-term effectiveness (Brown et al., 2020; McCann et al., 2019). Furthermore, support staff, relatives, parents, and young people hold heterogeneous and sometimes ambivalent views about sexuality education and support for individuals with intellectual disabilities (Colarossi et al., 2023; de Wit et al., 2022). These findings highlight the need to examine not only whether stakeholders support disability-inclusive CSE, but also which curriculum dimensions they accept or resist and the cultural, educational, and institutional reasons underlying those positions.

2.3 Bridging Research Gaps in Disability-Inclusive CSE

Although previous research confirms the importance of sexuality education for learners with disabilities, several gaps remain. Most studies examine teachers, parents, or learners separately, even though CSE implementation depends on the interaction of school authority, family legitimacy, and community acceptance. Research also often measures support as a general attitude without distinguishing among relationships, gender, violence and safety, human development, health skills, sexual behaviour, and sexual and reproductive health. Evidence from Indonesian special education settings remains limited, particularly in culturally and religiously sensitive regions such as West Java, where CSE may be viewed as necessary for protection yet contested on moral grounds. Existing Indonesian studies have addressed parental understanding, puberty and menstrual health education, and adapted instructional models, but systematic mapping of stakeholder support across multiple CSE dimensions is still needed (Fatimatuzzahra et al., 2022, 2024, 2025a, 2025b). The novelty of this study therefore lies in comparing the

readiness of teachers, parents, and community leaders across eight CSE dimensions. This multidimensional approach examines actual curriculum content rather than general declarations of support (Miedema et al., 2020) and extends research on accessibility and implementation barriers within a culturally specific disability-inclusive context (Andreassen et al., 2024; Michielsen & Brockschmidt, 2021; Shibuya et al., 2023).

The study also offers implications for inclusive education and English Language Teaching (ELT), where language supports not only academic learning but also safety, identity, self-expression, and social participation. Learners with disabilities need accessible language to name body parts, express emotions and discomfort, seek help, refuse unsafe touch, understand privacy, and develop respectful relationships. Disability-inclusive CSE can provide meaningful communicative contexts through vocabulary instruction, social stories, role play, dialogue practice, picture-supported texts, multimodal materials, and scenario-based learning, thereby strengthening functional communication, autonomy, and safeguarding. Its implementation should be staged, collaborative, and culturally responsive, beginning with widely accepted topics such as health, bodily development, rights, safety, and violence prevention before addressing more sensitive issues involving relationships, gender, and sexual behaviour. Teacher education should include disability-sensitive pedagogy, accessible communication, ethical classroom language, and family collaboration, while parents and community leaders should be engaged as partners rather than treated solely as barriers. By framing readiness as negotiated, multidimensional, and educable, this study provides evidence for curriculum sequencing, teacher preparation, parental engagement, community dialogue, and the design of CSE that is comprehensive, accessible, protective, and culturally legitimate.

3. Method

This study used a quantitative descriptive design to document and compare readiness for disability inclusive Comprehensive Sexuality Education (CSE) among key stakeholder groups in West Java, Indonesia. The design was selected because it enables systematic profiling of support patterns across groups and supports exploratory examination of demographic correlates of readiness in survey based educational research (Michielsen & Brockschmidt, 2021; Shibuya et al., 2023). The study framework followed the eight dimensions from the UNESCO International Technical Guidance on Sexuality Education (UNESCO, 2018): Understanding Gender; Sexual and Reproductive Health; Values, Rights, Culture, and Sexuality; Relationships; Violence and Staying Safe; Skills for Health and Well-being; The Human Body and Development; and Sexuality and Sexual Behaviour. Data were collected from September to November 2024, and analyses were completed in December 2024.

3.1 Participants and sampling

The target population comprised teachers, parents or guardians, and community leaders who were directly involved in the education, care, or social support of children with special needs in West Java. Purposive sampling was applied to ensure respondents had relevant experience. Inclusion criteria were: (1) teachers with documented experience in special or inclusive schools; (2) parents or guardians of children formally identified with special needs; and (3) community leaders with sustained involvement in programmes serving families of children with special needs. The final sample included N = 89 participants: teachers (n = 65, 73.0 percent), parents (n = 20, 22.5 percent), and community leaders (n = 4, 4.5 percent). The small community leader subsample is noted as a limitation for subgroup inference. Demographic characteristics are summarised in Table 3.1.

Table 3.1. Demographic Characteristics of Research Sample (N = 89)

Variable	n	%	Teachers (n=65)	Parents (n=20)	Community Leaders (n=4)	χ^2/p
Teaching experience					—	
< 3 years	5	7.7	5 (7.7%)	—	—	
3–10 years	9	13.8	9 (13.8%)	—	—	
> 10 years	50	76.9	50 (76.9%)	—	—	
Age group						
< 30 years	13	14.6	10 (15.4%)	1 (5.0%)	2 (50.0%)	
30–40 years	27	30.3	18 (27.7%)	7 (35.0%)	2 (50.0%)	
> 40 years	49	55.1	37 (56.9%)	12 (60.0%)	1 (25.0%)	

Variable	n	%	Teachers (n=65)	Parents (n=20)	Community Leaders (n=4)	χ^2/p
Education level						χ^2=9.24*
Primary/middle school	6	6.7	—	6 (30.0%)	0	
High school	6	6.7	—	5 (25.0%)	1 (25.0%)	
University	77	86.5	65 (100.0%)	9 (45.0%)	3 (75.0%)	p<.05
Household income (parents/leaders)			—			χ^2=8.76*
Low income	9	37.5	—	7 (35.0%)	2 (50.0%)	
Middle income	6	25.0	—	5 (25.0%)	1 (25.0%)	
High income	9	37.5	—	8 (40.0%)	1 (25.0%)	

Note. *p < .05. Percentages represent proportion within each stakeholder group. Chi-square tests compare education and income distributions across stakeholder groups. Dashes (—) indicate variable not applicable to that group. All teachers held university qualifications as required by Indonesian special education certification standards.

3.2 Instrument and measures

The survey instrument was adapted from the UNESCO guidance (UNESCO, 2018) and validated through expert panel review involving three special education specialists and two sexuality education researchers. Items were rated on a five-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). It also allows ordinal responses to be summarised descriptively and compared across groups, provided that interpretation remains cautious and appropriate to the measurement level (Norman, 2010). Reliability testing indicated strong internal consistency, with a Cronbach's alpha coefficient of 0.87. This value suggests that the items were sufficiently coherent in measuring stakeholder support for disability-inclusive CSE. Cronbach's alpha was used because it remains a common indicator of internal consistency in survey-based educational research, although it should be interpreted alongside theoretical coherence and item relevance rather than as a purely mechanical indicator of quality (Taber, 2018). Confirmatory factor analysis also supported the intended eight-dimension structure, with factor loadings ranging from 0.68 to 0.85 and all loadings statistically significant at $p < .001$. These results indicated that the instrument was suitable for describing support across the eight CSE dimensions.

3.3 Data collection and ethical considerations

Data collection was conducted from September to November 2024 using an electronic questionnaire administered via Google Forms. Written informed consent was obtained from all participants. Ethical approval was obtained from the relevant institutional review body at Universitas Pendidikan Indonesia, with the committee name, approval number, and date to be inserted prior to final submission. Data were stored in password protected files accessible only to the research team.

3.4 Data analysis

Analysis followed three steps. First, descriptive statistics were used to summarise respondent characteristics and overall patterns of CSE support, including frequencies, percentages, means, and standard deviations. Second, Spearman rank order correlation (r_s) was applied to examine bivariate associations between ordinal demographic variables and CSE support, which is appropriate for ordinal measurement and non-normal distributions. Third, exploratory multiple regression was conducted to estimate the relative contribution of demographic and professional variables to overall support, with coefficients interpreted cautiously due to the cross sectional design. Bonferroni correction was applied in inter group analyses to control familywise error at alpha = .05.

4. Result

This section reports the study's core objective, namely to map and compare readiness for disability inclusive Comprehensive Sexuality Education across three stakeholder groups in West Java and to identify demographic and professional factors associated with support. Results are presented in four parts: (1) respondent characteristics, (2) overall support patterns across the eight CSE dimensions, (3) comparative profiles by stakeholder group, and (4) associations between support and demographic variables, including an exploratory model of predictors.

Overall, the results show high readiness for disability inclusive CSE with clear, systematic variation by dimension, stakeholder role, and enabling background factors. The central empirical message is a content hierarchy: health protective dimensions attract near consensus, while behaviour focused dimensions attract the most hesitation. The central interpretive

message is that readiness is conditional and negotiated, and that implementation should be designed as a staged educational process that builds shared meaning across teachers, families, and community leadership rather than assuming a single, uniform form of support. The details explained in the following:

4.1 Demographic Characteristics of Respondents

The teacher subsample ($n = 65$) was characterised by professional maturity: 76.9% reported more than 10 years of experience, and 56.9% were aged above 40. All held university qualifications consistent with Indonesian certification requirements. The parent subsample ($n = 20$) exhibited greater heterogeneity in educational background, with 45% holding university degrees and significant variation in household income (chi-square analysis: $\chi^2 = 8.76$, $p < .05$). Community leaders ($n = 4$), though small in number, were predominantly university-educated (75%). Across the full sample, education level was significantly positively correlated with overall CSE support ($r_s = 0.42$, $p < .01$), as was teaching experience among teachers ($r_s = 0.38$, $p < .01$).

4.2 Distribution of Support Across CSE Dimensions

Table 4.1 presents the distribution of agreement across all eight CSE dimensions, and Figure 1 displays this distribution visually. Overall support was high across all dimensions, ranging from 77.6% to 94.4%. Sexual and Reproductive Health received the strongest endorsement (SA = 42.7%; A = 51.7%; total = 94.4%; SD = 0.23), indicating convergent and relatively uniform agreement. Understanding Gender ranked second (90.8%; SD = 0.29), followed by Values, Rights, and Culture (89.2%; SD = 0.31). Support declined progressively for Relationships (87.6%), Violence and Safety (86.5%), Health Skills (85.4%), and Human Body and Development (83.2%). Sexual Behaviour received the lowest support (77.6%) with the highest within-sample variability (SD = 0.42), indicating that while a clear majority endorsed this dimension, responses were more dispersed. The inverse relationship between support rank and standard deviation suggests that greater disagreement accompanies behaviourally explicit content.

Table 4.1 Distribution of Stakeholder Support Across Eight CSE Dimensions (N = 89)

CSE Dimension	SA (%)	A (%)	Total (%)	SD	Level	Rank
Sexual & Reproductive Health	42.7	51.7	94.4	0.23	Very high	1
Understanding Gender	29.2	61.6	90.8	0.29	Very high	2
Values, Rights & Culture	25.8	63.4	89.2	0.31	High	3
Relationships	23.6	64.0	87.6	0.33	High	4
Violence & Safety	24.7	61.8	86.5	0.34	High	5
Health Skills	22.5	62.9	85.4	0.35	High	6
Human Body & Development	20.2	63.0	83.2	0.37	High	7
Sexual Behaviour	16.9	60.7	77.6	0.42	Moderate–high	8
Overall mean	25.7	61.1	86.8	0.33	—	—

Note. SA = strongly agree; A = agree; SD = standard deviation. Support level classification: Very high ≥ 90%; High = 80–89.9%; Moderate–high = 70–79.9%. Dimension abbreviations: SRH = Sexual & Reproductive Health; UG = Understanding Gender; VRC = Values, Rights & Culture; REL = Relationships; VS = Violence & Safety; HS = Health Skills; HB = Human Body & Development; SB = Sexual Behaviour.

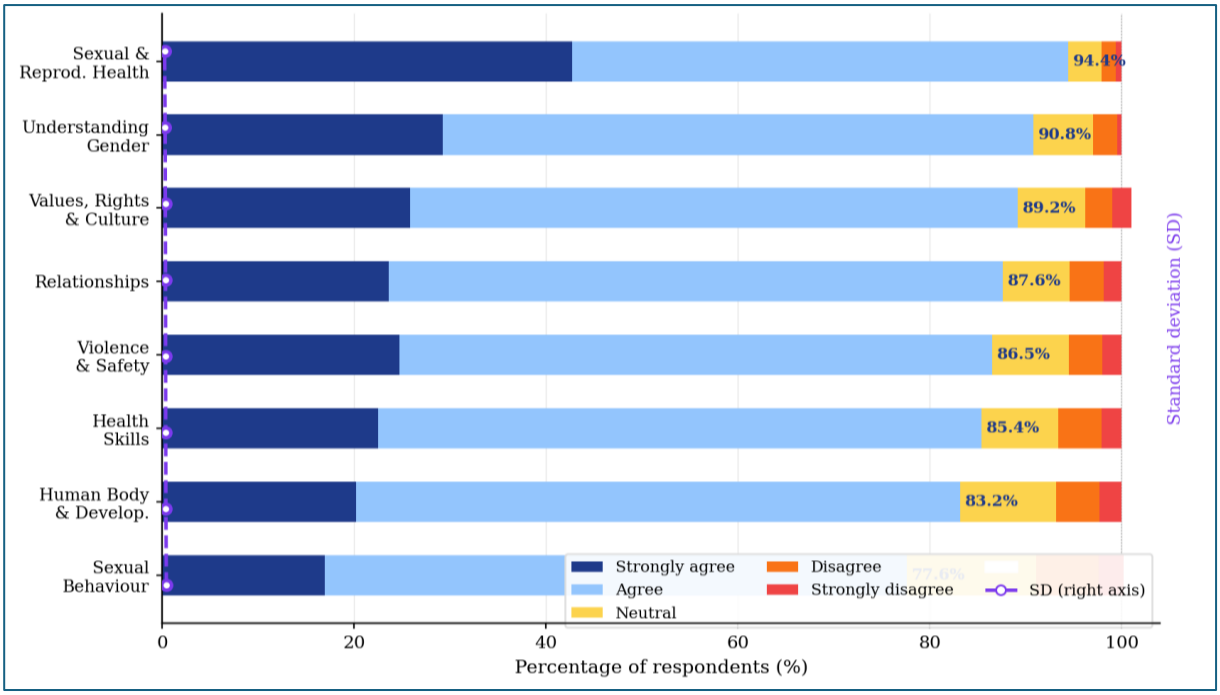

Figure 1. Distribution of stakeholder support across eight UNESCO-based CSE dimensions (N = 89)

Note. SA = strongly agree; A = agree. The secondary axis (right) depicts standard deviation (SD) values per dimension. Total support = SA + A. Dimensions ordered by descending total support. SRH = Sexual & Reproductive Health; UG = Understanding Gender; VRC = Values, Rights & Culture; REL = Relationships; VS = Violence & Safety; HS = Health Skills; HB = Human Body & Development; SB = Sexual Behaviour.

Taken together, Table 4.1 and Figure 1 show that stakeholder readiness for disability-inclusive CSE in West Java is high, structured, and selective. The overall mean support of 86.8% confirms that most respondents viewed CSE positively. However, the ranking of dimensions reveals that acceptance follows a clear hierarchy. Health and reproductive knowledge received the strongest endorsement, followed by gender understanding and values-based content. Support then gradually declined for relational, safety, health-skill, and body-development dimensions before reaching its lowest point in Sexual Behaviour.

This hierarchy indicates that stakeholders are most comfortable with CSE when it is associated with protection, wellbeing, dignity, and educational responsibility. They are less comfortable when the topic appears closer to sexuality as behaviour. This is a critical finding because it identifies the precise location of implementation tension. The challenge is not to convince stakeholders that children with special needs need protection and education; that point is already broadly accepted. The challenge is to help stakeholders understand that sensitive dimensions, including sexual behaviour, can also be taught in age-appropriate, disability-sensitive, protective, and values-based ways.

The findings therefore support a staged implementation model. Schools may begin with dimensions that already have high legitimacy, such as Sexual and Reproductive Health, Understanding Gender, Values, Rights, and Culture, Violence and Safety, and Health Skills. These areas can build trust and demonstrate the protective purpose of CSE. Once stakeholder confidence increases, more sensitive dimensions such as Human Body and Development and Sexual Behaviour can be introduced through carefully designed materials, teacher training, parent orientation, and culturally appropriate language.

In conclusion, this subsection reveals that disability-inclusive CSE readiness in the sample is not weak; it is *conditional and dimension-specific*. Respondents largely support the idea of CSE, but their level of confidence varies according to the perceived sensitivity of each dimension. This finding is central to the study's contribution because it moves the analysis beyond a simple support-versus-rejection model. Instead, it shows that implementation should be guided by a more nuanced understanding of stakeholder readiness, where curriculum sequencing, communication strategy, and pedagogical preparation are aligned with the specific sensitivity level of each CSE dimension.

4.3 Response Patterns by Stakeholder Group

Table 4.2 and Figure 2 present comparative support levels across the three stakeholder groups. Teachers demonstrated the most consistent pattern (M = 87.2%, SD = 0.24) with the lowest within-group variability. Their highest endorsements were for Sexual and Reproductive Health (92.3%) and

Understanding Gender (90.8%), reflecting professional alignment with health-centred and gender-responsive educational frameworks. Parents showed greater variability (M = 83.1%, SD = 0.31), with full endorsement of Relationships (100.0%) alongside notably lower support for Sexual Behaviour (65.0%)—a protective orientation prioritising relational and reproductive content while exhibiting hesitancy toward behaviourally explicit dimensions. Community leaders demonstrated the highest variability (SD = 0.37) and provided unanimous support for Sexual and Reproductive Health, Values, Rights and Culture, and Health Skills (100.0% each), while endorsing remaining dimensions at 75.0%, reflecting a values-health framework grounded in cultural and religious normativity.

Table 4.2 Comparison of CSE Support Levels by Stakeholder Group (N = 89)

CSE Dimension	Teachers (%)	Parents (%)	Community Leaders (%)	Range (pp)
Sexual & Reproductive Health	92.3	95.0	100.0	7.7
Understanding Gender	90.8	75.0	75.0	15.8**
Values, Rights & Culture	89.2	85.0	100.0	15.0**
Relationships	88.5	100.0	75.0	25.0**
Violence & Safety	87.7	85.0	75.0	12.7*
Health Skills	86.2	80.0	100.0	20.0**
Human Body & Development	84.6	80.0	75.0	9.6*
Sexual Behaviour	78.5	65.0	75.0	13.5**
Mean	87.2	83.1	84.4	—
SD	0.24	0.31	0.37	—

Note. Values represent percentage of respondents within each group expressing agreement (strongly agree + agree). pp = percentage points. Range = maximum minus minimum across the three groups. *p < .05; **p < .01 (Bonferroni-corrected). Community leader comparisons (n = 4) should be interpreted with caution.

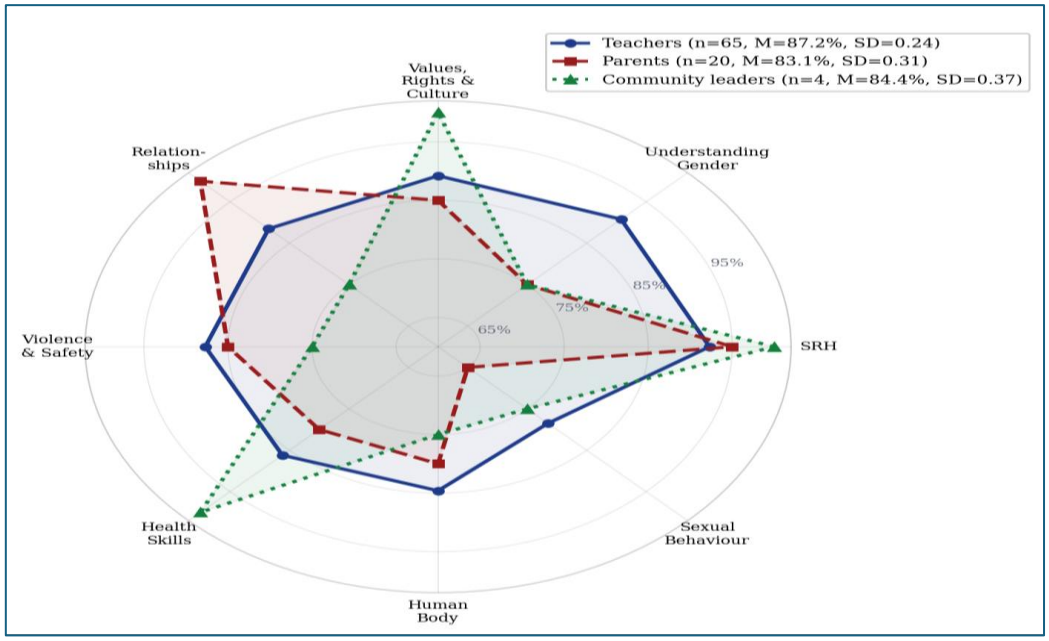

Figure 2. Comparative CSE support profiles across stakeholder groups plotted across eight UNESCO-based dimensions

Taken together, Table 4.2 and Figure 2 show that support for disability-inclusive CSE was broadly positive across all stakeholder groups, but the meaning of support differed by role. Teachers appeared to interpret CSE primarily as an educational and safeguarding responsibility. Parents interpreted it through a protection-first lens, strongly supporting relationship and reproductive health content while hesitating over sexual behaviour. Community leaders interpreted it through a values-health framework, supporting dimensions that could be aligned with health, culture, rights, and practical wellbeing.

This pattern provides a more advanced understanding of readiness. It shows that stakeholder support is not simply high or low; it is *role-shaped*. Each group brings a different logic of acceptance:

1) **Teachers:** pedagogical legitimacy
   Teachers support CSE because they see its relevance to learning, development, and classroom safeguarding.
2) **Parents:** protective legitimacy
   Parents support CSE when it clearly protects children and helps them manage relationships safely.
3) **Community leaders:** cultural legitimacy
   Community leaders support CSE when it aligns with health, values, rights, and social responsibility.

The practical implication is that disability-inclusive CSE should not be communicated in the same way to all stakeholders. Teacher training should focus on curriculum delivery, classroom language, disability-sensitive pedagogy, and managing sensitive questions. Parent engagement should focus on safety, relationship skills, bodily protection, and reassurance that CSE can be age-appropriate. Community dialogue should frame CSE as a values-based safeguarding initiative that supports dignity, health, and inclusive education.

The most important conclusion from this subsection is that readiness exists, but it must be mobilised differently across stakeholder groups. Teachers provide the most stable implementation base, parents provide strong relational and protective motivation, and community leaders provide potential cultural legitimacy. However, the dimension of *Sexual Behaviour* remains the most sensitive area and requires the greatest care in framing, sequencing, and pedagogical preparation. Therefore, successful implementation should adopt a staged and stakeholder-responsive strategy rather than a one-size-fits-all approach.

4.4 Correlations Between Demographic Characteristics and CSE Support

Table 4.3 and Figure 3 report Spearman correlation coefficients between demographic variables and dimension-specific CSE support. Education level demonstrated significant positive associations with all eight dimensions (r_s range: 0.25*–0.45**), with the strongest coefficients for Understanding Gender ($r_s = 0.45$, $p < .01$) and Sexual and Reproductive Health ($r_s = 0.42$, $p < .01$). Teaching experience showed consistently stronger correlations across all dimensions (r_s range: 0.32**–0.52**), with the apex at Sexual and Reproductive Health ($r_s = 0.52$, $p < .01$). Age demonstrated positive but more modest associations (r_s range: 0.18*–0.35**), while household income showed the weakest pattern with non-significant associations for Human Body and Development ($r_s = 0.12$) and Sexual Behaviour ($r_s = 0.10$).

Exploratory multiple regression identified education level as the strongest predictor ($\beta = 0.39$, $p < .001$), followed by teaching experience ($\beta = 0.35$, $p < .001$), age ($\beta = 0.28$, $p < .01$), and household income ($\beta = 0.21$, $p < .05$). Together, these variables explained approximately 47% of the variance in overall CSE support ($R^2 = .47$, $F(4, 84) = 18.7$, $p < .001$). These estimates are interpreted as indicative given the cross-sectional exploratory design.

Table 4.3 Spearman Rank-Order Correlations Between Demographic Variables and CSE Dimension Support

Variable	SRH	UG	VRC	REL	VS	HS	HB	SB
Education level	0.42**	0.45**	0.38**	0.35**	0.32**	0.30**	0.28*	0.25*
Teaching experience	0.52**	0.48**	0.45**	0.42**	0.40**	0.38**	0.35**	0.32**
Age	0.35**	0.32**	0.30**	0.28*	0.25*	0.22*	0.20*	0.18*
Household income	0.28*	0.25*	0.22*	0.20*	0.18*	0.15*	0.12	0.10

Note. *p < .05; **p < .01 (two-tailed, Bonferroni-corrected). Teaching experience computed within teacher subsample (n = 65); income computed within parent + community leader subsample (n = 24). Dimension abbreviations as per Table 2.

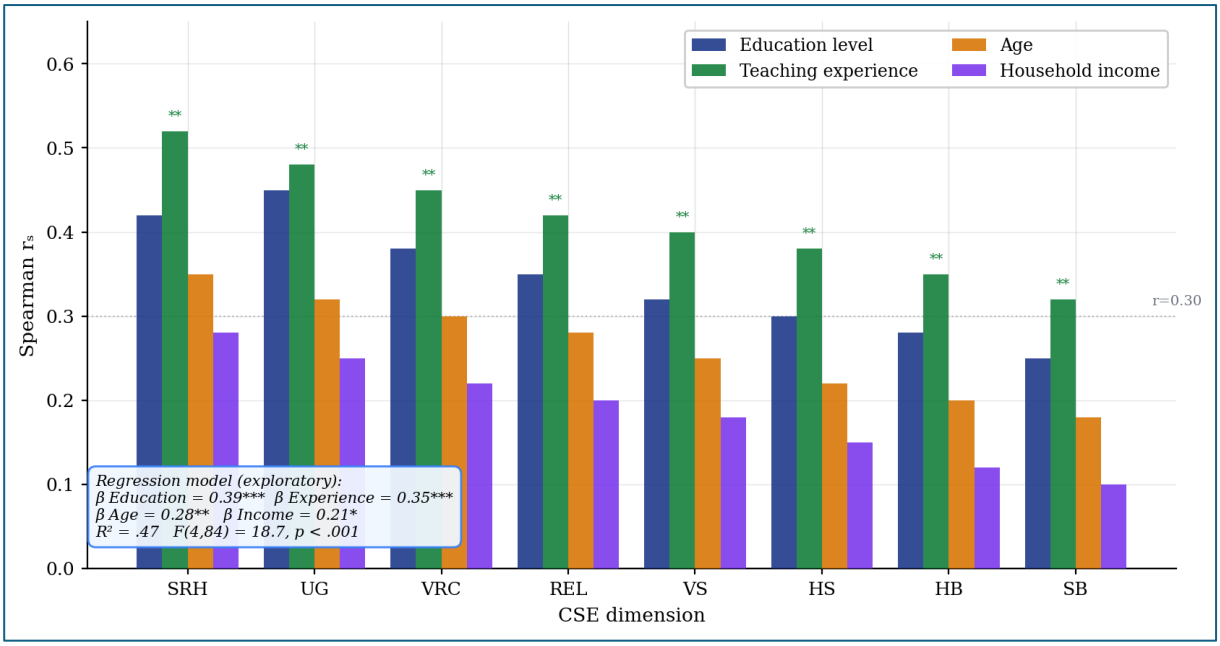

Figure 3. Spearman correlation coefficients (r_s) between demographic variables and CSE dimension support, with exploratory regression model summary

Note. Dots represent Spearman r_s values. *p < .05; **p < .01 (two-tailed, Bonferroni-corrected). Teaching experience correlations computed within teacher subsample (n = 65). Household income correlations computed within parent + community leader subsample (n = 24). Regression summary (inset): β = standardised coefficient; R^2 = coefficient of determination.

The combined findings from Table 4.3 and Figure 3 show that readiness for disability-inclusive CSE is not simply a matter of personal opinion. It is strongly linked to forms of capacity: educational capacity, professional capacity, maturity, and, to a lesser degree, economic capacity. The strongest evidence for this interpretation comes from the consistently high correlations for teaching experience and education level. Respondents who had more formal education and more teaching experience were more likely to support CSE across nearly all dimensions.

This has an important implication for implementation. If support increases with education and professional exposure, then readiness can be developed. Stakeholder hesitation should not be treated as permanent resistance. Instead, it may reflect limited access to information, limited pedagogical confidence, limited exposure to disability-inclusive CSE models, or uncertainty about how to discuss sensitive topics appropriately. Training, orientation, parent workshops, teacher mentoring, and community dialogue may therefore increase support over time.

The pattern also shows that the most sensitive dimensions especially Sexual Behaviour and, to a lesser extent, Human Body and Development were less strongly associated with demographic advantages. This means that even educated, experienced, or older respondents may still require careful support when dealing with content perceived as morally or culturally sensitive. Implementation should therefore combine information-based training with values-sensitive communication and practical classroom guidance.

The central conclusion of this subsection is that stakeholder support for disability-inclusive CSE is capacity-linked, professionally shaped, and dimension-specific. Education and teaching experience are the strongest foundations for readiness, while income plays a smaller role. These findings justify a staged implementation strategy that invests first in teacher training and stakeholder education, then expands into parent engagement and community dialogue. By doing so, schools can transform existing support into informed, confident, and sustainable readiness for disability-inclusive CSE.

4.5 Inter-Group Differences in CSE Support

Table 4.4 and Figure 4 report mean differences in support between stakeholder group pairs. The most pronounced inter-group divergence was observed for Understanding Gender, where teachers exceeded both parents and community leaders by 15.8 percentage points ($p < .01$ and $p < .05$, respectively), suggesting professional training confers distinct conceptual resources for gender-inclusive framing. Significant parent–community leader differences emerged for Relationships ($\Delta = 25.0$ pp; $p < .01$), Values, Rights and Culture ($\Delta = -15.0$ pp; $p < .01$), and Health Skills ($\Delta = -20.0$ pp; $p < .01$), reflecting divergent prioritisation frameworks rooted in familial versus cultural leadership orientations.

Table 4.4 Exploratory Inter-Group Comparison: Mean Differences in CSE Dimension Support

CSE Dimension	Teacher vs. Parent (Δpp)	Teacher vs. Community Leader (Δpp)	Parent vs. Community Leader (Δpp)
Sexual & Reproductive Health	−2.7	−7.7*	−5.0
Understanding Gender	15.8**	15.8*	0.0
Values, Rights & Culture	4.2	−10.8*	−15.0**
Relationships	−11.5**	13.5*	25.0**
Violence & Safety	2.7	12.7*	10.0*
Health Skills	6.2	−13.8*	−20.0**
Human Body & Development	4.6	9.6*	5.0
Sexual Behaviour	13.5**	3.5	−10.0*

Note. Values represent absolute percentage-point (pp) differences in agreement rates. Positive values indicate the first-named group expressed higher support. *p < .05; **p < .01 (Bonferroni-corrected). Comparisons involving community leaders (n = 4) are preliminary. Dimension abbreviations as per Table 2.

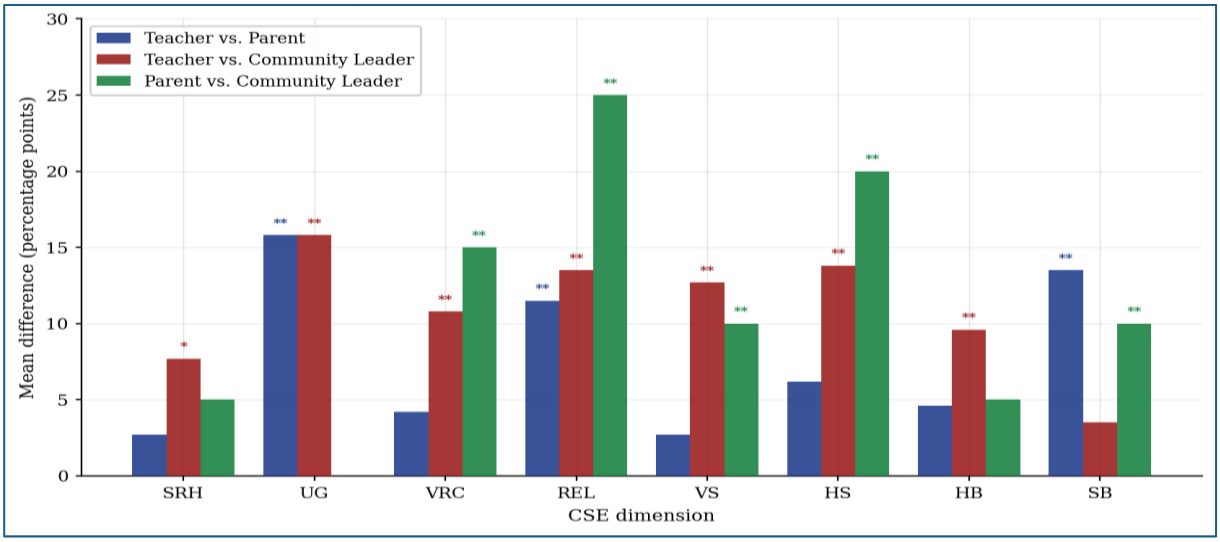

Figure 4. Mean percentage-point differences in CSE support across stakeholder group pairs by dimension

Note. Values represent absolute percentage-point (pp) differences in agreement rates between stakeholder pairs. Positive values indicate the first-named group expressed higher support. *p < .05; **p < .01 (Bonferroni-corrected). Comparisons involving community leaders (n = 4) are preliminary.

The inter-group comparison in table 4.4 and figure 4 provide one of the clearest findings of the study: stakeholder readiness for disability-inclusive CSE is *shared but role-specific.* All groups showed broad support, yet they prioritised different dimensions according to their social position and perceived responsibilities.

Teachers showed higher support for dimensions requiring pedagogical and conceptual framing, particularly Understanding Gender and Sexual Behaviour. This suggests that teachers may be more willing to engage with sensitive content when it is positioned as part of structured learning and child protection. Parents showed the strongest support for Relationships, indicating that family-level readiness is rooted in daily concern for children's social safety, boundaries, and interpersonal vulnerability. Community leaders showed stronger support for Values, Rights, and Culture and Health Skills, suggesting that community-level legitimacy depends on whether CSE is framed as morally responsible, culturally appropriate, and beneficial for collective wellbeing. These differences have direct implications

for implementation. A single communication strategy will not be sufficient. Teachers need professional development that strengthens content knowledge, classroom language, and disability-sensitive pedagogy. Parents need reassurance that CSE protects children and supports safe relationships rather than promoting inappropriate behaviour. Community leaders need to see CSE as consistent with values, rights, culture, health, and social responsibility.

The most important conclusion from this subsection is that inter-group differences should not be interpreted as obstacles only. They can also be treated as implementation resources. Teachers provide pedagogical legitimacy, parents provide protective urgency, and community leaders provide cultural legitimacy. A successful disability-inclusive CSE programme should integrate these three forms of legitimacy into a staged implementation model. Health and values-based dimensions can serve as initial entry points, while relationships, gender, body development, and sexual behaviour should be introduced through carefully sequenced, age-appropriate, and culturally responsive strategies.

5. Discussion

This study produced three interconnected findings. Overall support for disability-inclusive Comprehensive Sexuality Education (CSE) was high but varied across the eight curriculum dimensions; Sexual Behaviour received the lowest endorsement and greatest response variation; and support differed by stakeholder role and enabling capacity, particularly education and teaching experience. In West Java, the main challenge is therefore selective legitimation of behaviourally explicit content, not broad rejection of CSE. Comprehensiveness should be assessed through what schools are prepared to teach, not general declarations of support (UNESCO, 2018; Miedema et al., 2020; Andreassen et al., 2024).

Strong endorsement of Sexual and Reproductive Health, Understanding Gender, and Values, Rights, and Culture indicates that stakeholders accept CSE most readily when linked to health, dignity, rights, safety, and educational responsibility. Lower support for Sexual Behaviour reflects concern about how this dimension is defined and enacted, especially when sexuality education is misinterpreted as encouraging sexual activity rather than developing judgement, boundaries, and protective skills (Shibuya et al., 2023; Davies et al., 2023). Restricting instruction to biological health and general safety provides only partial protection because learners must also distinguish public and private behaviour, understand consent and refusal, recognise coercion, regulate boundaries, and seek help (Schaafsma et al., 2015; Brown et al., 2020). The lower endorsement of Sexual Behaviour is therefore a curriculum-design signal, not a reason for exclusion.

This dimension requires the most careful scaffolding. Age-appropriate, disability-responsive outcomes should begin with privacy, safe and unsafe touch, personal space, consent, appropriate conduct, and help-seeking, then progress, where relevant, to attraction, relationships, decision-making, sexual risk, and digital conduct. Instruction should use explicit language, visual supports, repetition, modelling, social stories, role-play, and scenarios adapted to learners' cognitive, sensory, linguistic, and communication profiles. Educator discomfort can produce avoidance, whereas appropriate guidance strengthens teachers' ability to address sexual health and safety (Jeyachandran et al., 2024; Greene et al., 2025). Staged implementation must therefore mean sequencing and scaffolding, not indefinite postponement or dilution.

Teachers showed the most consistent support, suggesting that professional responsibility and classroom experience strengthen recognition of CSE as part of safeguarding and inclusive education. This aligns with evidence that delivery depends on training, confidence, resources, policy, and support from families and administrators (Eisenberg et al., 2013; Goldman & Coleman, 2013; Nelson et al., 2020; Shibuya et al., 2023). Nevertheless, their lower endorsement of Sexual Behaviour confirms that general experience does not automatically provide the specialised vocabulary and pedagogy needed for sensitive content. Teacher preparedness, stigma, limited support, and inaccessible curricula remain interconnected barriers (Greene et al., 2025). Professional readiness is therefore a foundation requiring targeted development.

Parents displayed a protection-first pattern, strongly supporting Relationships and Sexual and Reproductive Health while hesitating over Sexual Behaviour. Parents of children with disabilities often value sexuality education while remaining uncertain about terminology, timing, moral boundaries, or misunderstanding (Pownall et al., 2012; Kamaludin et al., 2022; Rashikj-Canevska et al., 2023). They are also more comfortable with puberty and affection than with shared sexual behaviour, masturbation, consent, or diverse identities (Smith Hill et al., 2025). Structured education and workshops can improve parental knowledge, confidence, self-efficacy, and understanding of curriculum and disability adaptations (Rooks-Ellis et al., 2020; Donnelly et al., 2023). Their hesitation should therefore be addressed through partnership rather than treated as fixed opposition.

Community leaders legitimised CSE primarily through health, values, rights, culture, and collective responsibility. In West Java, this religiously and communally shaped orientation may constrain implementation or provide public legitimacy. Indonesian research shows that cultural and religious frameworks shape acceptable language and purposes in discussions of sexuality and disability (Hidayah et al., 2020; Riany et al., 2016). International evidence

similarly shows that such attitudes vary by stakeholder group, familiarity, culture, age, and stereotypes (Correa et al., 2022; de Wit et al., 2022). Community leaders should therefore be engaged early to frame CSE as protection, dignity, responsibility, and informed behaviour. Because only four participated, this pattern is exploratory rather than representative.

Positive associations between support, education, and teaching experience show that endorsement is partly capacity-based. Greater educational and professional exposure may increase encounters with puberty, inappropriate touch, hygiene, relationship difficulties, behavioural misunderstandings, and communication barriers, revealing the limits of silence and the need for accessible, repeated education. This supports disability-responsive preparation combining sexuality knowledge, practical methods, institutional guidance, and safeguarding procedures (UNESCO, 2022; Nelson et al., 2020; Shibuya et al., 2023; Davies et al., 2022). Readiness can therefore be strengthened rather than merely measured.

Professional learning should connect the eight UNESCO dimensions to outcomes, adapted lessons, assessment indicators, classroom scripts, referral pathways, and disclosure procedures. Because delivery is often fragmented among teachers, health professionals, counsellors, families, and external providers, schools need clear ownership (Curtiss & Stoffers, 2024). A whole-school plan should specify who teaches each dimension, when and how it is taught, how parents are informed, and how concerns are documented and referred. Yet weaker associations between demographic factors and support for Sexual Behaviour and Human Body and Development show that education and experience alone are insufficient. Sensitive dimensions require values-aware learning that addresses misconceptions, respectful terminology, the distinction between education and encouragement, and developmentally appropriate examples (Shibuya et al., 2023; Hidayah et al., 2020).

The study addresses a literature that commonly examines access, teacher preparedness, or parental attitudes separately. Previous studies show unequal learner access, professional and institutional barriers, and parental need for support (Barnard-Brak et al., 2014; Eisenberg et al., 2013; Pownall et al., 2012; Nelson et al., 2020; Kamaludin et al., 2022). General approval measures can conceal strong support for health, safety, and relationships alongside caution about behaviour-related content. Analysing all eight dimensions identifies the curriculum boundary at which support becomes less stable.

A second gap is limited evidence from culturally specific, non-Western special education settings. Much research comes from high-income contexts, while reviews report variation in access, content, delivery, and stakeholder attitudes (McCann et al., 2019; Brown et al., 2020; Michielsen & Brockschmidt, 2021; de Wit et al., 2022). Indonesian scholarship has advanced understanding of cultural barriers, parental knowledge, puberty education, menstrual health, and adapted reproductive-health models (Hidayah et al., 2020; Riany et al., 2016; Fatimatuzzahra et al., 2022; Fatimatuzzahra, et al, 2024; Fatimatuzzahra, et al, 2025; Santoso et al., 2025). This study extends that work by comparing three stakeholder groups within one UNESCO-based framework.

Its novelty lies in conceptualising readiness as multidimensional, role-shaped, and curriculum-specific. The acceptability map distinguishes high-consensus entry points from content needing preparation and reveals different grounds for legitimising CSE. Teachers emphasise education and safeguarding, parents prioritise relational protection, and community leaders link acceptability to health, culture, rights, and moral responsibility. This reframes the support-versus-resistance model and offers a more actionable basis for curriculum design, professional learning, family engagement, and public communication.

Schools should retain all eight dimensions while adapting language, intensity, methods, and sequencing to learners' age, development, communication, and stakeholder preparedness. Sexual Behaviour should form part of a planned progression rather than appear only in informal discussion or crisis response. Teachers need sustained development involving adapted lessons, precise vocabulary, multimodal resources, social stories, role-play, assessment tools, case analysis, rehearsal, mentoring, and institutional guidance because uncertainty often concerns content boundaries, parental expectations, and administrative support (Jeyachandran et al., 2024; Greene et al., 2025; Davies et al., 2023). Parents should receive orientations, demonstrations, and take-home prompts for discussing body parts, privacy, consent, refusal, relationships, and help-seeking (Rooks-Ellis et al., 2020; Donnelly et al., 2023; Smith Hill et al., 2025). Community leaders should be engaged through dialogue framing CSE as child protection and inclusive education grounded in dignity, responsibility, respect, and non-violence.

The findings also inform English Language Teaching in special and inclusive education. Functional language for naming body parts, expressing discomfort, refusing contact, requesting help, negotiating personal space, and reporting unsafe situations can be integrated into picture-supported vocabulary, simplified texts, social stories, dialogues, and scenarios. Although ELT cannot replace formal CSE, it can strengthen protective communication, autonomy, safety, self-advocacy, social participation, and language learning.

Several limitations warrant caution. The small community-leader subsample restricts inter-group comparison; purposive sampling in one province limits transferability; self-reports may reflect social

desirability; and the cross-sectional design cannot establish whether education or experience causes stronger support. These issues are especially relevant in Indonesia, where disability and sexuality are interpreted through diverse social frameworks (Hidayah et al., 2020; Riany et al., 2016). Future research should use larger, multi-province, longitudinal, intervention-based, and mixed-methods designs to explain hesitation toward Sexual Behaviour, Understanding Gender, and Human Body and Development. It should include school leaders, health professionals, religious figures, disability organisations, curriculum developers, families, and learners with disabilities because barriers operate across policy, institutional, familial, professional, and sociocultural levels (Michielsen & Brockschmidt, 2021; Shibuya et al., 2023; Andreassen et al., 2024). Further studies should test whether sequenced curricula, teacher coaching, parent workshops, community dialogue, and adapted ELT materials improve teaching quality, comprehension, consent knowledge, boundary-setting, help-seeking, and safeguarding outcomes across disability types, communication needs, ages, genders, school settings, and regional cultures.

6. Conclusions

This study concludes that readiness for disability-inclusive Comprehensive Sexuality Education (CSE) for children with special needs in West Java is broadly supportive, yet clearly dimension-specific and socially negotiated. Across stakeholder groups, support was strongest for health-protective and socially legitimate dimensions, particularly Sexual and Reproductive Health (94.4%), while Sexual Behaviour received the lowest support (77.6%) and the highest variability, indicating that hesitation concentrated around behaviourally explicit content rather than CSE as a whole. Teachers demonstrated the most consistent support, parents showed a protective but selective orientation by strongly endorsing relational and reproductive health content while expressing caution toward sexual behaviour, and community leaders supported CSE most strongly when it was connected to values, rights, culture, and health skills.

The study's novelty lies in reframing CSE readiness not as a single attitude of acceptance or resistance, but as a multidimensional, role-shaped, and culturally mediated pattern of support across the eight UNESCO-based CSE dimensions. This finding has important implications for special education, inclusive education, and English Language Teaching (ELT), because disability-inclusive CSE can strengthen learners' safety, dignity, communication, bodily awareness, relationship skills, and help-seeking language when delivered through accessible, age-appropriate, and culturally responsive pedagogy. Practically, the results suggest that implementation should follow a staged model: schools may begin with high-consensus dimensions such as health, safety, rights, values, and relationships, while gradually introducing more sensitive topics through teacher training, parent engagement, and community dialogue. Future research should extend this work through larger multi-province and mixed-methods studies involving school leaders, health professionals, religious figures, disability advocates, and learners with disabilities themselves, as well as intervention studies testing whether teacher professional development, parent workshops, community consultation, and ELT-integrated CSE materials can increase readiness and improve safeguarding outcomes in diverse Indonesian educational contexts.

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