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Social educator students' readiness to address sexual health in their future profession

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Abstract

Background: Norwegian social educator students' attitudes towards addressing sexual health are unknown, even if their future clients often have needs related to sexual issues.

Purpose: To investigate social educator students' readiness to address sexual health in their future profession.

Methods: In 2019, 213 social educator students (response rate 34%) responded to the *Students' Attitudes towards addressing Sexual Health Extended* online questionnaire.

Results: Most of the social educator students felt comfortable and ready to address sexual health in their future profession, but thought they had insufficient competence and education concerning sexual health. There were gender and age differences when discussing sexual health among persons with intellectual disabilities.

Conclusion: Despite most Norwegian social educator students feeling ready to address sexual health, they needed additional competences and education. Further research is needed concerning the effectiveness of educational interventions targeting competence in sexual health, to ensure sufficient support for clients in this field.

KEYWORDS

intellectual disabilities, sexual health, social educator, students, survey

1 | INTRODUCTION

1.1 | Sexual health and people with intellectual disabilities

There is lack of sexual health promotion and professional work practice surrounding sexual health for people with intellectual disabilities, mental illness, physical disability or physical disease due to the deficient education of health professionals (Black & Kammes, 2019; Blasingame, 2018; Brown & McCann, 2018; Grove et al., 2018; McCann et al., 2016; Pelleboer-Gunnink et al., 2019) and there is scarcity of knowledge of sexual health risks and needs for these groups

(Alexander & Taylor Gomez, 2017; Baines et al., 2018; Byrne, 2018; Fennell & Grant, 2019; McGilloway et al., 2018; Starrs et al., 2018). Many people with intellectual disabilities have distinct needs for protection, coaching and sexual health education throughout life (Blasingame, 2018; Borawska-Charko, 2017; Byrne, 2018; Gil-Llario et al., 2018; Goli et al., 2018; McDaniels & Fleming, 2016). Promotion of sexual health is a universal need, demanding accessible sexual health education for all people (Burke et al., 2019; Chrastina & Večeřová, 2020; Starrs et al., 2018). Sexual health is defined by the World Health Organization (WHO) as a state of physical, emotional, mental and social well-being in relation to sexuality, and the WHO states proclaims that training concerning human sexuality and sexual

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health is necessary in health professionals' education (Chrastina & Večeřová, 2020; World Health Organization, 2006).

Positive attitudes and feelings towards one's own body, combined with knowledge of the body and sexuality contribute to a stronger identity and healthier sexual activities, which are in line with international recommendations (Black & Kammes, 2019; Brown & McCann, 2018; English et al., 2018; Esmail et al., 2010; McCann et al., 2016; Starrs et al., 2018). The Norwegian strategy plan states that information about sexual health must be given also to persons with illness, intellectual disabilities and reduced functionality/disabilities (Ministry of Health and Care Services, 2016).

1.2 | Sexual health education and support for people with intellectual disabilities

People with intellectual disabilities often need education and support to prevent unwanted pregnancies, sexual abuse and sexually transmitted infections, as they may be extra vulnerable to these risks (Borawska-Charko, 2017; Dionne & Dupras, 2014; Skarbek et al., 2009). Many people with intellectual disabilities do not receive the sufficient attention concerning sexual health (Powell et al., 2020; Stoffelen et al., 2019), therefore they are subject to barriers from their environment that oppose interventions aimed at promoting sexual health (Borawska-Charko, 2017; Dionne & Dupras, 2014; Skarbek et al., 2009). There are several different barriers that can hinder sexual education initiatives, from family, school or community (Dionne & Dupras, 2014; Skarbek et al., 2009). Permissive attitudes of parents and professionals, together with positive social representations and actions for social rights, can positively influence sexual health and involvement in sexual activities for people with intellectual disability and their involvement in sexual activities (Dionne & Dupras, 2014; Skarbek et al., 2009).

Better tailored education and support in accessing information regarding sexual health are needed for people with intellectual disabilities (Borawska-Charko, 2017).

1.3 | Sexual health promotion approaches and the role of social educators

People with intellectual disabilities are dependent on staff with specialist competence in communication skills (Bakken, 2020). Social educators work with various groups, who need support with cognitive functioning and communication skills, and people with intellectual disabilities represent a key target group. The professional title 'social educator' can be compared with the English job titles 'learning disability nurse' (Brown et al., 2012; Mitchell, 2000) or 'welfare nurse' (Grung, 2016). The English learning disability liaison nurse's education is similar to the Norwegian Social educator education.

The social educator programme in Norway is a 3-year (180 credits/ECTS) evidence-based and practice-focused health and social care professional education at bachelor level, leading to an authorisation as a health and social professional (Ministry of Education and Research, 2019). The social educator's programme certifies

competence in behavioural, communication, environment therapy work, habilitation and rehabilitation, health promotion and health support, including independent living skills training and rehabilitation service to people with complex disabilities. The social educator programme emphasises alternative training and supplementary ability in communication. The qualification of a professional practice requires the professional knowledge and professional skills, both in study and in the workplace (Brown et al., 2012; Grung, 2016; MacArthur et al., 2015; Mitchell, 2000). Typically, the social educator works in municipal health and social service (Brask et al., 2016). The main aims of the personnel supporting people with intellectual disabilities are to deliver safe and high-quality health and social services to people with complex needs, regardless of their challenges, to give them a good quality of life, independent of age and area and to collaborate with their relatives, other professionals and service providers (Brask et al., 2016; Brown et al., 2012; Grung, 2016, 2019; MacArthur et al., 2015; Pelleboer-Gunnink et al., 2019). Sexual health is a challenge for social educators' professional practice (Lunde, 2013b) and in their daily work, social educators often meet clients who have questions, challenges and problems concerning sexuality and sexual health.

1.4 | Education and training of future professionals

In Norway it is stated by the Ministry of Health and Care Service that information and sexuality training must be adapted to then cognitive level and need for information of people with intellectual disability (Ministry of Health and Care Services, 2016, 2020). Due to their training in different communication skills and individual support, social educators have the necessary competence to work with people with intellectual disabilities, their families and staff (Brask et al., 2016; Grung, 2016), which should include matters concerning sexuality, but there is a lack of knowledge of to what extent the latter actually happens (Chrastina & Večeřová, 2020; Powell et al., 2020). It is important for social educators to be competent in sexual health is to enable them to promote sexual health for individuals in their work. Professional competence concerning sexual health is essential, including working to change society's view of sexual ableism (Slater et al., 2018).

Health professionals and caregivers are often reluctant to talk about sexuality (Pelleboer-Gunnink et al., 2019; Wilson & Frawley, 2016). Professionals' competences in promoting sexual health are influenced by their attitudes towards addressing sexual health in their professional interventions (Areskoug Josefsson & Gard, 2015; Fennell & Grant, 2019; Gerbild et al., 2018; Haesler et al., 2016). Norwegian health professionals have reported insufficient competences, knowledge, training and education in the field of sexual health (Remme, 2018). There are studies showing insufficient readiness among students in health and welfare professions to address sexual health in their future profession (Areskoug Josefsson et al., 2016; Areskoug Josefsson & Fristedt, 2019; Areskoug Josefsson & Gard, 2015; Areskoug Josefsson, Rolander, et al., 2019; Ballan & Freyer, 2017; Felter, 2020), but none of these studies have included social educators focused on including attitudes towards

persons living with intellectual disabilities, nor have they been performed in a Norwegian context. Other studies of students who are being educated to provide health advice for people with intellectual disabilities have reported a lack of competence in the field of sexual health (Ballan & Freyer, 2017; Dağlı et al., 2020; Felter, 2020; Fennell & Grant, 2019; McDaniels & Fleming, 2018), and have revealed misperceptions and stereotypical understanding of persons with intellectual disabilities (Ditchman et al., 2017; Grove et al., 2018; Kramers-Olen, 2016). The students' attitudes and beliefs are based on their education, knowledge, and experiences (Esmail et al., 2010; Fennell & Grant, 2019; Gerbild et al., 2018).

Even if social educator students have some education in sexuality and sexual health in their educational programme (Lunde, 2013b), there is insufficient research regarding the student's level of comfort and competence in addressing sexual health with future clients. In the social educator programme, to be prepared for their professional role, social educator students need to reflect and be educated about sexual health for people with disabilities. As sexual health and sexual safety are closely linked (Fitzsimons, 2020; Schmidt et al., 2020; Smit et al., 2019) both should be addressed within the social educator programme. Context and society, as well as relationships where sexual abuse happens, all need to be addressed in preventive, risk reductive and health promotive work related to sexuality and sexual health (Fitzsimons, 2020; McGilloway et al., 2018). Lack of sexual health education and professional support for people with intellectual disabilities emphasises the need for education of professionals in order to provide qualified sexual health support (Brown & McCann, 2018; Chrastina & Večeřová, 2020; Fennell & Grant, 2019; McCann et al., 2016; Pelleboer-Gunnink et al., 2019; Schmidt et al., 2020). Sexual training and sexual health education adapted to people with intellectual disabilities is essential to protect their sexual health, autonomy and understanding of their own and others' boundaries (Byrne, 2018; Chrastina & Večeřová, 2020; Hashmi et al., 2018; Lunde, 2013a; Ministry of Health and Care Services, 2016; Schmidt et al., 2020). There is need for progress when it comes to sexuality and how we talk about it with people with intellectual disability (Frawley & O'Shea, 2020).

2 | PURPOSE OF THE STUDY

The purpose of the study was to investigate Norwegian social educator students' perceived readiness to address sexual health in their future profession.

3 | METHODS

3.1 | Design

This was a cross-sectional online survey study. The reporting of the study follows the STrengthening the Reporting of OBservational studies in Epidemiology (STROBE) guidelines (von Elm et al., 2007). Quality was further appraised with relevant parts of the Checklist

Reporting Results of Internet E-Surveys (CHERRIES) checklist (Eysenbach, 2004).

3.2 | Participants

All social educator students in 10 classes at a social educator programme in Norway were invited to participate in this study. The selected programme includes 15 h of education in sexual health over the 3 years of education, since 2013 (Lunde, 2013b). These lectures covered various aspects of sexual health. The first year covers definitions of sexual health, national strategies concerning sexual health and rights, the role and authority as a professional, communication models and organisational cultures. In addition, the lectures address how to create a positive environment with a positive attitude towards sexuality, together with boundaries for professionals.

In the second year, the social educator students work with different types of mapping related to sexual health and intellectual disability. In the third year, the lectures cover mental health from a biopsychosocial understanding model, where also gender, sexual and ethical issues are discussed in different cases. Throughout the social educator programme, interprofessional collaboration is emphasised.

The studied social educator bachelor programme was situated in a large city in Norway and included both students studying full-time and part-time. The social educator students received written online information about the study when invited to participate. Prior to answering the questionnaire, the social educator students gave their informed consent to participate in the study, as a question on consent was first in the online questionnaire.

3.3 | Procedure

Data collection was performed using the Norwegian extended version of 'the students' attitudes towards addressing sexual health extended' (SA-SH-Ext) (Lunde et al., 2020).

Data collection procedure:

- The University Colleges' administrative database distributed the invitation to the online version of the SA-SH-Ext to 10 classes of social educator students via their personal student email.
- The email contained written information about the faculty management's support of the research project, the study and the data collection procedure, volunteerism, and anonymity upon participation, contact details for the study and a link to the questionnaire via the web-based application 'Nettskjema', (<https://www.uio.no/tjenester/it/adm-app/nettskjema/>).
- The social educator students had 2 days to respond to the questionnaire, from the 3rd to 5th of December 2019.
- A reminder was sent out to non-respondents, where the social educator students had additional 2 days to respond to the questionnaire, from the 6th to 8th of January 2020.

3.4 | Questionnaire

The SA-SH-Ext questionnaire concerns students' attitudes towards addressing sexual health issues in their future profession, and is based on the original SA-SH (Areskoug Josefsson et al., 2016; Lunde et al., 2020), which has been used for students in health and social professions such as: occupational therapy, prosthetics and orthotics, nursing, physiotherapy and social work (Areskoug Josefsson et al., 2016, 2018; Areskoug Josefsson, Sjökvist, et al., 2019; Felter, 2020; Gerbild et al., 2016, 2021). The SA-SH-Ext has been translated and adapted to suit a Norwegian context of social educator students, including the addition of five new items (Lunde et al., 2020). The SA-SH-Ext consists of 27 items distributed across four domains: feelings of comfortableness (questions 1–13), fear of negative influence on future client relations (questions 14–19), future working environment (questions 20–22), and education needs (questions 23–27) (Lunde et al., 2020). Items in the questionnaire are answered on a Likert scale with five options: disagree, partly disagree, partly agree, agree and strongly agree. The responses 'totally agree and agree' are considered positive for positively loaded items, and for negatively loaded items the responses 'disagree and partly disagree' are considered as showing a positive attitude too. The response option 'partly agree' is not considered to be a positive or a negative attitude, since the response categories of the SA-SH clearly show response discrimination in Rasch analysis (Areskoug Josefsson & Rolander, 2020). Items 13–18, and 20–22 were reversed for analysis as these items were phrased in a negative way compared to all the other items, as in the original SA-SH (Areskoug Josefsson et al., 2016). The responses in the Likert scale in the SA-SH-Ext were coded with points from 1 to 5; where 5 was the most positive value and 1 the most negative value. In addition, descriptive questions related to gender, age and educational level within the programme were included. The online version of SA-SH-Ext was distributed over five pages, had eight items per page and the respondents were able to review and change their answers during their response process.

3.5 | Analysis

Characteristics of the sample are presented by gender, age and semester. Descriptive statistics are presented in numbers and percentage for gender, and age is described with median and range. Each item of the SA-SH-Ext is presented with descriptive statistics. To analyse differences between age and gender, one-sample *t*-test and a one-way ANOVA (one-way analysis of variance) with post hoc Tukey *B* were performed. The limit of statistical significance was set at $\alpha = .05$. The statistical analyses were performed with IBM SPSS version 26 (IBM Corp, Armonk, NY, USA).

3.6 | Ethics

Ethical consideration followed the directions of the Helsinki Declaration and the department board at Department of Behavioural Science, Oslo Metropolitan University approved the study 28 November 2019.

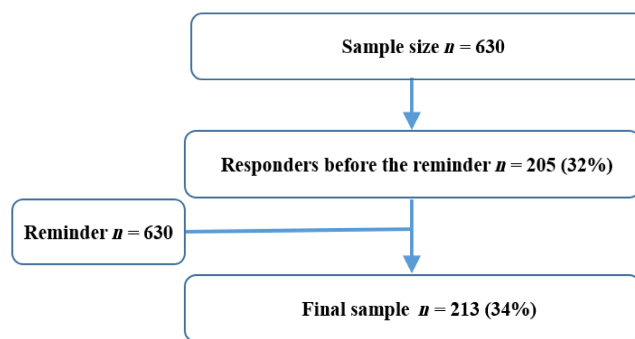


FIGURE 1 Flowchart of survey responses

TABLE 1 Demographic characteristics of the participants

Demographical variable	Total number of respondents (213)
Gender	164 women (76.3%), 48 men (22.3%), 1 other (0.5%)
Age	Median 25 years, range 19–55 years

4 | RESULTS

A total number of 630 enrolled students at a social educational programme in Norway were invited (Figure 1). The response rate was 34% (213 responders).

4.1 | Characteristics of the responding social educator students

The characteristics of the respondents were comparable to current proportions of students in the social educator programmes, concerning age and gender. The median age of the responders was 25 and most of the respondents were female (Table 1).

4.2 | Social educator students' level of comfort in addressing sexual health

The first domain of the SA-SH-Ext concerns the students' feelings of being comfortable in communication about sexual health in their future professional work (Figure 2). The results show that the social educator students were comfortable in addressing sexual health. A majority of the social educator students agreed that they felt comfortable about informing future clients about sexual health, about initiating a conversation, and about discussing sexual health and sexual health issues with future clients with intellectual disabilities, mental illness, physical disability or physical disease, and this was regardless of clients' sex, age, sexual orientation or cultural background. However, a smaller proportion of the social educator students agreed they felt comfortable about discussing specific sexual activities with future clients.

FIGURE 2 Norwegian social educator students reporting feelings of comfortableness addressing sexual health (n = 213)

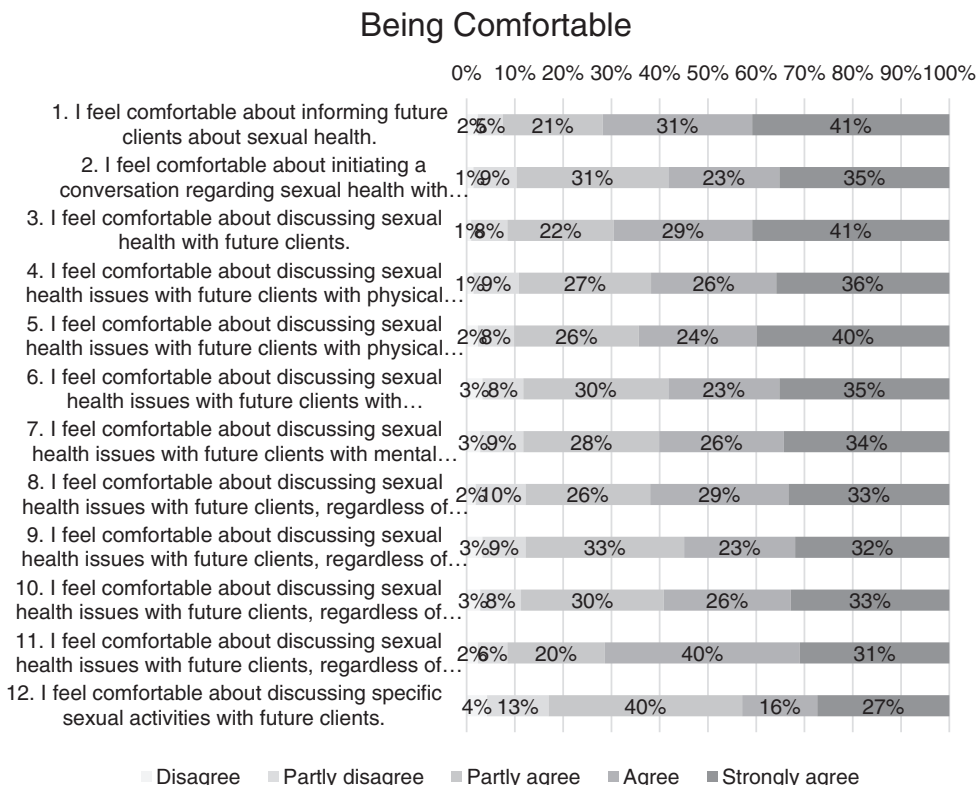
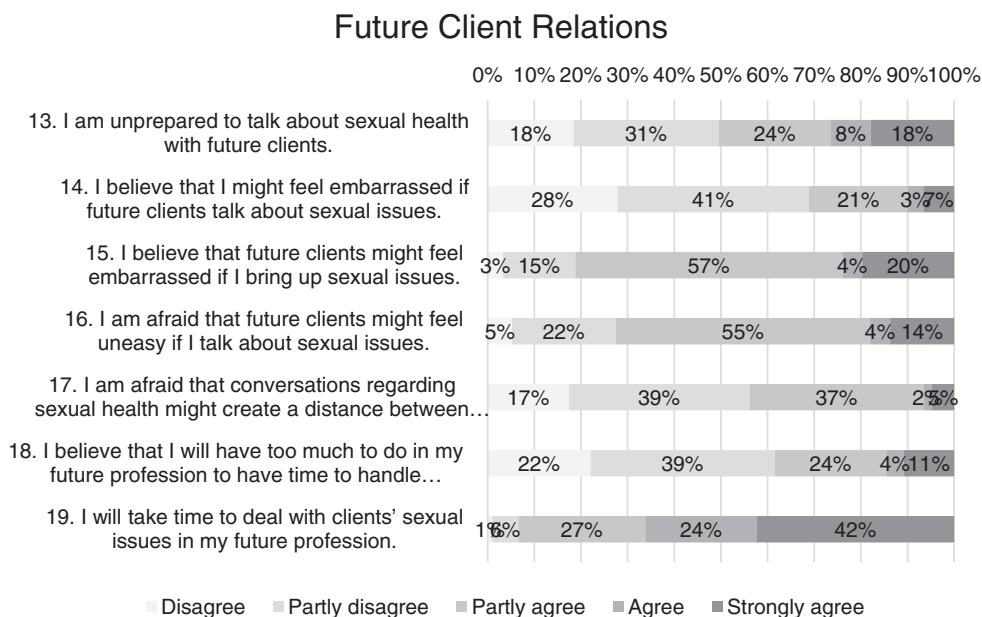


FIGURE 3 Norwegian social educator students' future client relations (n = 213)



4.3 | Social educator students' future client relations

The second domain concerned the students' future client relations in communication about sexual health (Figure 3). The results show that some of the social educator students had ambivalent expectations of future client relations if sexual relations were addressed. Many of the social educator students felt prepared or not

embarrassed to discuss sexual health with future clients; however, many social educator students thought that future clients might feel embarrassed and uneasy if they, as professionals, brought up sexual issues. Nevertheless, most of the social educator students did not believe that conversations regarding sexual health would create a distance in the relation between the client and them as professionals. Additionally, they believed that they would take time to deal with clients' sexual issues in their future profession.

Future Working Relations

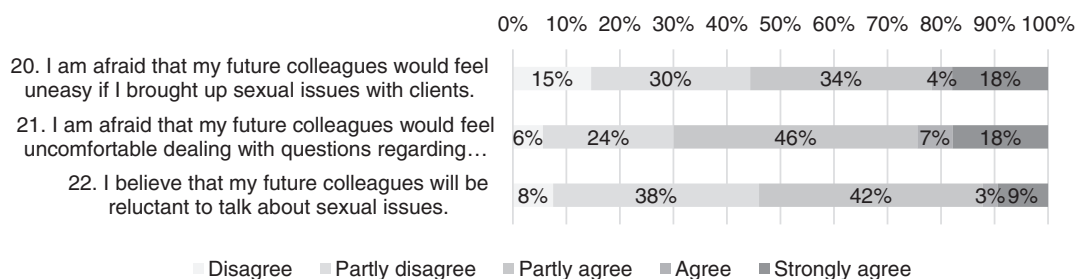


FIGURE 4 Norwegian social educator students' future working relations regarding sexual health (n = 213)

Education and Competence

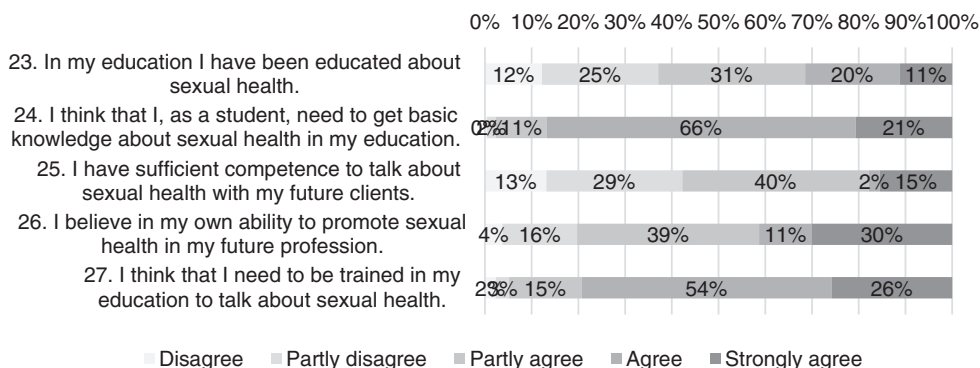


FIGURE 5 Norwegian social educator students' education and competence (n = 213)

4.4 | Expectations of future work colleagues

The third domain concerned the students' future working relations (Figure 4). The results showed that the social educator students did not expect their future colleagues to be comfortable regarding addressing sexual health in practice. Several of the social educator students were afraid that their future colleagues would feel uneasy if they themselves brought up sexual issues with clients, that their future colleagues would be reluctant to talk about sexual issues and would feel uncomfortable dealing with questions regarding clients' sexual health.

4.5 | Social educator students' education and competences

The fourth domain concerned the students' education and competences (Figure 5). The results show confidence and beliefs in the ability to promote sexual health despite a lack of education and competence among many of the social educator students. A majority of the social educator students reported that they, as students, needed to acquire basic knowledge and training to talk about sexual health in their education. At the same time, half of the social educator students were confident in their own ability to promote sexual health in their future profession. One third of the social educator students

confirmed they had been educated in sexual health issues; however, only a few of them thought that they had sufficient competence to talk about sexual health issues with future clients.

4.6 | Differences related to social educator students' gender

The analysis showed (Table 2) that men rated themselves as more comfortable than women in addressing sexual health (item 2), especially concerning clients with physical disability/disease and intellectual disability (items 4, 5 and 6). Men were also more comfortable in addressing specific sexual activities with clients (item 12); whereas women were more concerned about what their future colleagues would think if they addressed sexual issues with clients (items 20 and 21) and they expressed more needs than men about being trained in communicating (item 27).

4.7 | Differences related to social educator students' age

The participants were divided into three age groups: <25 years, 26–35 years and >36 years, prior to the analyses. There were significant differences between age groups (Table 3). Younger social educator

TABLE 2 Significant gender differences

	Items	Mean value: women	Mean value: men	p-Value
2	I feel comfortable about initiating a conversation regarding sexual health with future clients.	3.61	4.00	.014
4	I feel comfortable about discussing sexual health issues with future clients with physical disability.	3.67	4.06	.016
5	I feel comfortable about discussing sexual health issues with future clients with physical disease.	3.68	4.06	.018
6	I feel comfortable about discussing sexual health issues with future clients with intellectual/psychological disability.	3.58	3.96	.024
12	I feel comfortable about discussing specific sexual activities with future clients.	3.29	3.67	.025
20	I am afraid that my future colleagues would feel uneasy if I brought up sexual issues with clients.	2.74	2.40	.045
21	I am afraid that my future colleagues would feel uncomfortable dealing with questions regarding clients' sexual health.	3.04	2.67	.042
27	I think that I need to be trained to talk about sexual health.	4.34	3.98	.045

TABLE 3 Significant differences between age groups

	Items	<25 years	26–35 years	>36 years	p-Value
5	I feel comfortable about discussing sexual health issues with future clients with physical disease.	3.90	3.73	3.48	.043
6	I feel comfortable about discussing sexual health issues with future clients with intellectual/psychological disability.	3.81	3.65	3.31	.019
7	I feel comfortable about discussing sexual health issues with future clients with mental illness.	3.89	3.60	3.40	.014
8	I feel comfortable about discussing sexual health issues with future clients, regardless of their sex.	3.95	3.62	3.48	.014
10	I feel comfortable about discussing sexual health issues with future clients, regardless of their cultural background.	3.94	3.50	3.42	.003
11	I feel comfortable about discussing sexual health issues with future clients, regardless of their sexual orientation.	4.23	3.88	3.63	.002
13	I am unprepared to talk about sexual health with future clients.	3.50	3.43	2.92	.022
19	I will take time to deal with clients' sexual issues in my future profession.	4.09	3.58	3.52	.000

students (<25 years) were more comfortable in addressing sexual health than older students (>36 years) (items 5, 6, 7, 8 and 11), which included discussing sexual health with persons with intellectual disabilities in their future profession. When it came to cultural background, social educator students <25 years were significantly more comfortable than both the group of students aged 26–35 years and the group aged >36 years (item 10). Social educator students aged 26–35 years were less prepared than both the older and the younger students to address sexual health (item 13). The youngest age group was significantly more prone to take time to address sexual issues with their clients (item 19).

4.8 | Differences related to age for each gender

There were significant differences related to age for women on eight items (items 6, 8, 10–13, 19 and 27) and for men on nine items (items

1, 5–7, 10, 17, 19–21). The results were consistent for men when testing with Tukey *B*, but for women only items 10, 11 and 19 were significant with Tukey *B*. The significant differences, when looking at age and gender, showed that the youngest age group of men tended to rate themselves as more comfortable and prepared to address sexual health compared to the other age groups and compared to women.

5 | DISCUSSION

This study is the first investigation of social educator students' attitudes towards addressing sexual health in their future professional work in Norway.

These Norwegian social educator students rated themselves as more prepared and comfortable in regard to addressing sexual issues with clients than other health professional students in Scandinavia

(Areskoug Josefsson et al., 2016, 2018; Areskoug Josefsson, Sjökvist, et al., 2019). A previous Norwegian study found that social educator students perceived sexual health as a taboo topic (Lunde, 2013a). Thus, the result of this study may indicate a positive development since 2013 by showing an increased readiness among future social educators to meet the sexual health needs of clients. This may in turn decrease negative restrictions, abuse, risk of violence, discrimination as well as social, environmental and structural barriers often experienced and imposed by staff on people with intellectual disabilities, as described in previous studies (Black & Kammes, 2019; Byrne, 2018; English et al., 2020; Fitzsimons, 2020; Grove et al., 2018; McDaniels & Fleming, 2016; Starrs et al., 2018; Stoffelen et al., 2019). The positive attitudes, perceived readiness and education among social educator students may improve the currently missing professional support in relation to sexual issues for people with intellectual disabilities. However, previous studies have reported insufficient competences and education in the field of sexual health among professionals (Dağlı et al., 2020; English et al., 2020; McDaniels & Fleming, 2016, 2018; Powell et al., 2020; Remme, 2018; Wilson & Frawley, 2016). Research exploring the extent to which future social educators are able to include sexual health in their professional practice among people with intellectual disabilities is recommended. The social educators' positive attitudes in our study may be a result of the inclusion of sexual health in the investigated social educator programme since 2013 (Lunde, 2013b). Educational interventions targeting sexual health at bachelor level have shown positive outcomes on student's attitudes towards addressing sexual health (Gerbild et al., 2018). The inclusion of sexual health education in the educational curriculum has probably influenced social educator students' attitudes towards addressing sexual health in a positive way.

SA-SH-Ext uses the term 'comfortable' in different contexts to mean a personal feeling of safety, security and comfortableness in specific situations (Lunde et al., 2020). More than half of the social educator students reported that they were comfortable with informing future clients about sexual health and initiating conversations on the subject, regardless of the clients' age, gender, cultural background, disability or sexual orientation. An appreciative and respectful approach is essential in professional meetings, habilitation and rehabilitation, where professionals must work towards addressing unmet needs for persons with disabilities (Burke et al., 2019). However taboo subjects, like sexual health, need more knowledge and practice than others do to ensure clients meet competent and comfortable health professionals, not professionals showing prejudices or believing myths related to sexuality (Burke et al., 2019; Remme, 2018). A suggestion for future educational interventions for social educators is to employ people with intellectual disability as peer educators, as recommended in previous studies to improve sexual health for clients (Frawley & Bigby, 2014; Frawley & O'Shea, 2020). Our results show that the social educator students were more comfortable with informing about and discussing general sexual issues than with discussing specific sexual activities. Those results may indicate that the social educator students are able to distinguish between a general competence level and deeper specific levels and that they have a need for additional specific

knowledge, training and practice in communicating and dealing with clients about specific sexual activities. The social educator students acknowledged the possibility that clients might feel embarrassed if professionals addressed sexual health, even if the professionals were comfortable in doing so. This may be a barrier for future conversations concerning sexual health, since it can be seen as unprofessional to put clients in embarrassing situations.

Older social educator students rated themselves as less ready to address sexual issues than younger students. Maybe extra life experience adds to their understanding of the complexity of sexuality and sexual health. The middle age group may understand the complexity but may still not have attained sufficient life experience to feel comfortable in addressing sexual health in all situations. However, the differences are quite small, and the clinical relevance has not been explored. According to analysis of response patterns of the original SA-SH (Areskoug Josefsson, Sjökvist, et al., 2019), the change in response patterns is of greater clinical value than changes in rating on individual ratings. Response pattern analysis has not yet been performed on SA-SH-Ext. To gain further understanding of the relation between age and the responses in this study, additional studies are needed. They are also required to understand the implications of this relation in practice and education. In this study, there are gender differences, as men reported a higher level of competence than women did. This finding corresponds with previous studies (Ng & Boey, 2020; Papaharitou et al., 2008) however; it is unknown whether these differences have an impact on the support given to clients. In our findings, younger men tended to rate themselves as being more competent and ready to address sexual health than other age and gender groups, which is of interest and should be explored further to ensure educational interventions suitable for all social educator students. The finding of younger men rating themselves as being more competent may be due to the group being more risk tolerant (Prims & Moore, 2017), which is another perspective which is relevant to consider in the sexual health education of professionals. Prims and Moore (2017) found that a 'lifetime of experience may increase our confidence that we know what we're talking about', which can be a reason for the differences between age groups in our study. Here, the influence of life experience could have influenced the older social educator students' responses, if they recognised their lack of knowledge of how it is to work as a social educator and handle sexual health issues. Cultural background may have also influence the responses, and reasons for variance in responses relating to gender and age should be explored in further research, especially since the findings of this study show that item 6 ('I feel comfortable about discussing sexual health issues with future clients with intellectual/psychological disability') is significantly affected by age and gender, which can affect how sexual health needs are being met for persons with intellectual disability. Social educators work with clients facing challenges related to sexuality and sexual health (Ministry of Education and Research, 2019). In this study, the social educator students reported being quite prepared to include sexual health in their future professional work. This positive result implies that the social educator students may be able to implement the National Sexual Health Strategy 'Talk about it!' (Ministry of Health

and Care Services, 2016). The strategy highlights that professionals must safeguard people's privacy, assist persons who face challenges with sexuality and sexual health, as well as prevent sexual harassment, assault and the risk of violence which is in line with research in this field (Åker & Johnson, 2020; Blasingame, 2018; Bowen & Swift, 2019; Byrne, 2018; Grove et al., 2018; Starrs et al., 2018). In this work it is essential that social educators use recognised and well-established methods (National Institute for Health and Care Excellence (<https://www.nice.org.uk/>), 2015); when mapping challenging sexual behaviours (Bowen & Swift, 2019; Chrastina & Večeřová, 2020; Frawley & O'Shea, 2020; Walsh et al., 2019). The mapping should lead to presenting possible reasons for the behaviours, to ensure high quality and well-planned interventions (Chrastina & Večeřová, 2020; Frawley & O'Shea, 2020; Gil-Llario et al., 2018; Walsh et al., 2019).

Many of the social educator students were worried about what future colleagues would think if they addressed sexual health in their professional role. These concerns are in line with professionals reporting having difficulties in initiating conversations concerning sexual health with persons living with intellectual disabilities (Brask et al., 2016; Goli et al., 2018; Karellou, 2017; Pelleboer-Gunnink et al., 2019; Remme, 2018; Wilson & Frawley, 2016). Therefore, staff can be reluctant counsellors when it comes to sexual health (Gil-Llario et al., 2018; Wilson & Frawley, 2016), as they may feel uncomfortable when discussing the topic (Lunde, 2013a). Thus, workplace development activities, training and further education in the field of sexual health are recommended for the social educator professionals and their colleagues. Social educator students may have experienced lack of openness concerning sexual health during their practice placements, which may be a reason why they consider future colleagues as reluctant to address sexual health with clients, even if the social educator students themselves are prepared to do so. The Norwegian National Framework Plan for Social Educators includes health promotion but not sexuality and sexual health (Ministry of Education and Research, 2004, 2019). Therefore, the framework plan may need to be revised considering the social educators' professional responsibilities and their clients' rights and needs. The results from this study show that more education related to sexuality and sexual health is needed and wanted by the social educator students to enable them to support their future clients. Previous research stresses the importance of education of professionals in order to provide qualified sexual health support to people with intellectual disabilities (Burke et al., 2019; Chrastina & Večeřová, 2020). Social educators must actively work to increase legal security, equality and improved living conditions for the individual as sexuality is an issue of equality, rights and ethics for people with intellectual disabilities (Chrastina & Večeřová, 2020; Fitzsimons & Anklan, 2021; Frawley & Bigby, 2014; Frawley & O'Shea, 2020; Pelleboer-Gunnink et al., 2019; Stein & Dillenburger, 2017). All people have the right to self-determination and to live a dignified life based on their own wishes and conditions (Fitzsimons & Anklan, 2021; Frawley & O'Shea, 2020; Norwegian Union of Social Educators and Social Workers (FO), 2017; Pelleboer-Gunnink et al., 2019). Therefore, initiating sexuality education provides normative premises for professional practice. Professionals

working with people with intellectual disabilities need to be aware of these people's need for advice and support regarding sexual health but also their capacity to lead and part-take in sexual health education with their peers (Frawley & Bigby, 2014; Frawley & O'Shea, 2020). Frawley and O'Shea (2020) recommend peer educators for people with intellectual disability. Therefore, education models with persons with intellectual disability as educators would be a potential way to improve competence among future social educators and to enhance understanding of support needs concerning sexual health for persons with intellectual disability.

5.1 | Methodological discussion

Versions of the SA-SH have been used in several different countries and contexts to measure various professionals' attitudes towards addressing sexual health, and it is valuable to use a questionnaire that allows comparison between professions. The comparisons provide opportunities to assess how students in various professional roles think of their role in practice and to gain a broader insight into competences concerning sexual health. The SA-SH-Ext includes an item concerning discussing sexual health with persons with intellectual disability, and along together with the other items in the questionnaire, the response can provide a view of the students' experienced ability to address sexual health for persons with intellectual disability. To provide more in-depth focus concerning discussing sexual health with persons with intellectual disability additional qualitative research is needed. The SA-SH-Ext does not encompass items combining potential problematic themes in sexual health, and it is possible that the students would reveal other attitudes and/or readiness if the themes is the items were combined for example communication with young, non-heterosexual persons with intellectual disability.

The response rate was 34%, which is a proportion to be expected with email-based questionnaires (Nulty, 2008). In comparison in a survey using the Danish version of the questionnaire (SA-SH-D) the response rates were higher (occupational therapy 70%, nursing 44% and physiotherapy 43%) (Gerbild et al., 2021), but the response rate was lower in a survey using the original Swedish questionnaire (SA-SH) (occupational therapy 32%, nursing 23% and physiotherapy 23%) (Areskoug Josefsson et al., 2016). The response rate in our study might have been higher if the social educator students had several days available to answer the questionnaire online or if the data collection had been performed at another time of the year. However, our experience is that if student do not respond immediately to an email, and they rarely respond to the same email after a reminder. Responders may differ from non-responders in their interest in the topic, which is not explored in this study but may affect the results. If the responders are social educator students with more interest in the topic of sexual health, it can be assumed that non-responders may be less prepared or ready to address sexual health in their future profession than responders.

The chosen social educator programme may differ from other professional programmes concerning sexual health education, which

may affect the transferability of the results to other contexts, but the results indicate that there is need for increased sexual health education than the 15 h provided in the investigated social educator programme. This study clarifies the importance of ensuring relevant and comprehensive education for professionals, such as social educators, to ensure that clients' needs are being met.

6 | CONCLUSION

In this survey, most Norwegian social educator students were ready to address sexual health—which may be due to including sexual health being included in the curriculum of their educational programme. However, the social educator students also expressed need for additional knowledge, training, competences and education in the field of sexual health. Considering previous research in this field, it is probable that similar needs for knowledge, training, competences and education in sexual health exist among students in other international or professional settings. Therefore, it is suggested that it is necessary to evaluate students' feelings of comfortableness, fear of negative influence on future client relations, expectations of future colleagues and education needs related to sexual health to optimise sexual health education in professional higher education.

Further research is needed concerning the effectiveness of educational interventions targeting competence in sexual health not only for social educator students, to ensure sufficient support for clients in this field, but also for all professional students who will work with persons living with intellectual disabilities in various settings. There is also a need for further research on how professionals, such as social educators, in practice address sexual health and what form of sexual health support the clients experience from professionals, to ensure clients' needs are being met. There is a gap in the provision of services to promote sexual health for persons living with intellectual disabilities and educating professionals to better address this topic in practice is a step towards better sexual health for clients.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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