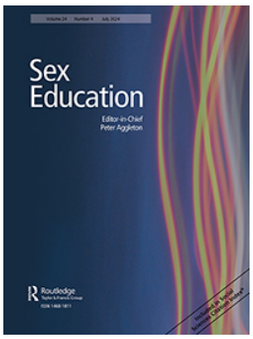

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A qualitative exploration of nursing and social work university students' experiences of sexual and reproductive health and rights education in Australia and Hong Kong

Christiane Klinner[a], George Turner[b], Jacqueline Bloomfield[a], Margaret Spencer[c], Renee Lovell[d], Christie van Diggele[e], Edmond Pui Hang Choi[f], Janet Yuen-Ha Wong[g], Jialiang Cui[h], Colleen Nugent[i], Hannah Chow[j], Adam SM Wong[g], SJ Roberts[b], Jaime Yun Ting Lin[k], Colette Fontaine[a] and Horas TH Wong[a]

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ABSTRACT

Nursing and social work professionals often exhibit avoidance or a lack of competence in delivering sexual and reproductive health and rights (SRHR) care to service users. When such care is provided, it tends to be heteronormative and deficit focus. Thus, understanding how university education prepares professionals in the field is essential. This study is the first to qualitatively explore SRHR attitudes, learning experiences and educational needs of nursing and social work students in Australia and Hong Kong. Using focus groups, insights were gathered from 19 nursing and 21 social work students across two Australian and three Hong Kong universities. Thematic analysis of the data revealed that, despite regional and disciplinary differences, students' SRHR educational needs in both regions and disciplines were not being adequately met. This negatively influenced their practical training and the quality of care provided. The study highlights the need to enhance SRHR knowledge and skills in nursing and social work curricula, thereby improving person-centred care. Recommended curriculum enhancements include promoting diversity and inclusivity, adopting a positive framing of sexuality, enhancing critical self-reflection and communication skills, fostering interprofessional learning, developing educators and mentors as role models, and creating safe and inclusive classroom and placement environments.

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Background

Sexual and reproductive health and rights (SRHR) are recognised as central to human wellbeing. Yet, health and social care professionals often feel ill-equipped to engage with SRHR needs, primarily due to inadequate training and lack of proper role models (Blakey and Aveyard 2017). This is particularly true for vulnerable groups, with SRHR topics sometimes entirely missing from university programmes (Glass 2016; Russell 2018). As a result, graduates are often left feeling un(der)prepared for practice, despite understanding the importance of SRHR in their field and being motivated to 'give it a go' (Areskoug-Josefsson et al. 2016; Areskoug-Josefsson, Rolander, and Bülow 2019; Ramseyer Winter et al. 2016; Russell 2018; Silivri et al. 2021). Lacking a solid educational foundation, healthcare professionals often rely on personal attitudes and experiences when providing SRHR care and confronting challenges posed by negative social norms and organisational barriers (Klaeson et al. 2017).

Effective SRHR care requires healthcare professionals to be well educated and confident in addressing the diverse needs of their clients (Reynolds and Magnan 2005). The World Health Organisation (WHO 2023) emphasises the need for a positive approach to sexual health, promoting pleasurable, safe and non-coercive experiences. Despite progress, challenges persist due to insufficient commitment and hesitancy to address sexuality in services and curricula (Starrs et al. 2018). Current SRHR initiatives often focus narrowly on issues such as contraception, maternal health, and HIV prevention, mainly targeting cisgender and reproductive-age individuals, while overlooking issues such as sexual justice and pleasure, and perpetuating biomedical perspectives focusing on risks and diseases (Gruskin et al. 2019; Starrs et al. 2018). Heterosexism and heteronormativity remain prevalent in health initiatives and professional training (Morison and Lynch 2016; Silivri et al. 2021).

There is a pressing need for a more inclusive, holistic approach to SRHR education and practice, focusing on equipping health and social care professionals with the skills to work with diverse populations from a person-centred perspective (Fennell and Grant 2019). Extensive research highlights the necessity of comprehensive, patient-focused care, especially for marginalised groups such as those with disabilities, the elderly, people with chronic illnesses, and gender and sexuality diverse individuals and youth (e.g. Addlakha, Price, and Heidari 2017; Adams 2019; Ezhova et al. 2020; Grant, Nash, and Hansen 2020; Sherman et al. 2023; Traister 2020; Morris and Rushwan 2015). Incorporating inclusive practices into healthcare training and policies is vital to ensure equitable and effective SRHR care for all.

Nursing and social work's complementary practices create an ideal environment for interprofessional SRHR education to foster a shared understanding of each discipline's focus and values (Chan et al. 2010; Ewens, Howkins, and Badger 2000). As part of their professional role, nurses and social workers advocate for SRHR by delivering holistic and person-centred care that caters to the needs of diverse groups. However, there is a lack of interprofessional research and training programmes in SRHR, despite evidence suggesting their benefit for health professionals' preparedness (e.g. Huang et al. 2023; Pratt-Chapman and Phillips 2020; Strada, Vegni, and Lamiani 2016). As a pedagogic approach, interprofessional education is designed to prepare healthcare and social care professionals for collaborative practice, aiming to enhance care delivery and patient outcomes

by fostering teamwork and shared understanding among diverse professional groups (Hammick 1998). Guided by the WHO's framework on interprofessional education (WHO 2010), this bi-national study investigated the knowledge, attitudes and experiences of nursing and social work students from Australia and Hong Kong in SRHR education. It helps fill gaps in SRHR education and the development of interprofessional learning programmes and indicates how different sociocultural contexts in Australia and Hong Kong influence SRHR education needs.

Methods

Study design and setting

The paper details qualitative findings from a study conducted at universities in Sydney, Australia, and Hong Kong SAR, China, examining nursing and social work students' attitudes and educational needs with respect to SRHR. The research team comprised educators, frontline professionals, and student researchers from both disciplines and regions. The choice of Sydney and Hong Kong was mainly based on the researchers' work relationships and the distinctive sociocultural environments of the two cities. Both locations offer similar university training in these disciplines, emphasising theoretical and evidence-based practices. In both locations, nursing and social work are regulated by professional bodies, ensuring that education and practice standards conform to international and ethical norms.

Participant inclusion criteria and recruitment

The study population, comprising adult nursing and social work students from two Sydney and three Hong Kong universities, was recruited through flyers, in-class announcements, and mass emails. To join a focus group, interested students were asked to submit an expression of interest (EOI) form detailing demographic information (including programme and duration of study, age, gender, sexuality and ethnic background). Participants were purposively selected using the EOI forms to maximise variation concerning students' educational and practical SRHR experiences, as well as availability for the focus group. Participants received AUD$50 or HKD$100 as compensation, in line with regional norms.

Data collection

In March and April 2023, CK and HW conducted 10 online focus groups, each with three to five participants. CK led the English language groups in Australia; HW conducted the Cantonese-speaking groups in Hong Kong. Four of the groups were interprofessional, in nature, three included only nursing students, and three only social work students. The sessions explored students' perceptions, learning experiences, and learning needs regarding SRHR (supplemental online file 1). The Cantonese interview guide was cross-checked by bilingual team members (JC, EC, JW, HC). Each session lasted 1.5 to 2 h, incorporated *Google Jamboard* for brainstorming (supplemental online file 2) and was audio-recorded and transcribed. CK and HW cleaned and de-identified the transcripts, with two bilingual assistants verifying the accuracy of Cantonese translations into English.

Data analysis

The de-identified transcripts were initially shared among all co-authors and key insights collaboratively elaborated. In parallel, CK conducted a detailed thematic analysis using Clarke, Braun, and Hayfield (2015) method and developed analytical memos with preliminary inductively identified themes and reflective comments on their potential meanings (Birks, Chapman, and Francis 2008). These insights were compared with the larger team's key insights, consolidated, and developed into final themes. CK and HW then structured and abstracted the themes, resulting in three main concepts, using a critical realist approach that extended beyond the mere summarising of findings to identify underlying structures and formulate strategic recommendations (Braun and Clarke 2006). The team collaboratively refined the results, ensuring high levels of reflexivity and accuracy based on diverse perspectives and expertise (Bansal et al. 2019).

Ethics

Ethical approval for this study was obtained from the University of Sydney (2022/846) and the Chinese University of Hong Kong Human Research Ethics Committees (SBRE-22-0163).

Findings

We interviewed 19 nursing and 21 social work students (total $n = 40$). Most participants were female (78%). Two-third of the participants had studied in the programme for over 2 years. Over half of these ($n = 23$) had some clinical or work experience in their respective discipline (see Table 1).

Broadly speaking, the experiences and perceptions of Australian (AU) and Hong Kong (HK) students across disciplines revealed core similarities in describing their SRHR learning experiences and needs. Three interrelated themes were identified: 1) Students' SRHR educational needs are not adequately met; 2) Negative impact of gaps in SRHR education on placement/work experience and person-centred care; 3) Opportunities for enhancing SRHR education in the curricula. Selected participant quotes are provided in-text; additional quotes (Q1a-Q14) can be found in supplemental online file 3.

Students' SRHR educational needs are not adequately met

Theme 1 highlights inadequate SRHR education in both programmes and regions, characterised by limited coverage, sporadic learning opportunities, and a narrow focus on traditional and medical concerns. Consequently, participants often had to rely on personal knowledge and lived experience and had inconsistent interpretations and understandings of SRHR care.

Limited SRHR education

Participants from both disciplines and regions reported not having received enough SRHR education (Q1a). They described how SRHR-related education in class or tutorials happened only briefly and occasionally and lacked depth and interactivity (Q1b and below).

Table 1. Focus group participant demographics.

	Nursing (*N* = 19)		Social Work (*N* = 21)		
	AU (*N* = 10)	HK (*N* = 9)	AU (*N* = 11)	HK (*N* = 10)	Total (*N* = 40)
Gender identity					
Female	9	6	7	9	31
Male	1	2	3	1	7
Transgender	-	1	-	-	1
Non-binary	-	-	1	-	1
Sexual orientation					
Heterosexual	10	6	10	10	36
Bisexual		2			
Gay/lesbian	-	-	1	-	1
Queer	-	-	2	-	2
Pansexual	-	1	-	-	1
Religion					
Christianity	3	3	3	-	9
Buddhism	1	-	1	1	3
Hinduism	1	-	-	-	1
Islam	-	-	2	-	2
Multiple belief systems	1	-	-	1	2
No religious/spiritual belief	4	6	5	8	23
Programme level					
Undergraduate	5	9	10	7	31
Post-graduate	5	-	1	3	9
Programme nature					
Pre-registration	10	9	10	10	39
Post-registration	-	-	1	-	1
Duration of studies					
<12 months	2	1	-	4	7
12–24 months	2	2	-	2	6
>24 months	6	6	11	4	27
Work or placement experience					
Experience	7	4	5	5	21
Minimal* or no experience	3	5	6	5	19

*No more than one placement started and no degree-related work experience.

> I can only remember [SRHR] being briefly discussed and very like small snippets and random units. There's no focus on this topic in the actual course. (3rd year Bachelor of Nursing student, AU)

Self-initiated and elective learning opportunities

Some participants noted exceptions to the perceived silencing of SRHR topics in their programmes: HK students mentioned self-initiated learning events (Q2a), and AU students referred to elective units in which they received more explicit SRHR education (Q2b). The existence of these educational opportunities largely depended on the initiative of individual instructors and students. While the discussions of SRHR reported enhanced preparedness for practice (Q2b), an Australian student observed that some students found open discussion of sex and reproduction 'too in your face', particularly when talking about genitals. In one elective course, this discomfort led several students to drop out of the course (Q2c).

Focus on 'stereotypical' and medical perspectives

Social work participants reported that the SRHR education they had received centred on 'stereotypical men – women kind of values' and was overly 'heterosexual'. On the other hand, nursing students described their education as too medically focused,

highlighting sexual and reproductive health-related anatomy, diseases and pharmacology (Q3a) at the expense of addressing more social concerns. Students from both disciplines noticed an absence of discussion about sexual enjoyment and reproductive rights, especially for minorities. Many joined the study due to feeling undereducated in SRHR, attributing this to societal taboos and negative assumptions about sexual knowledge. An Australian nursing student described a lecturer's euphemistic reference to male genitalia as 'downstairs', impacting effective communication about sexuality (Q3b).

Seeking alternative learning sources and relying on personal experience

Participants from both disciplines ascribed their preparedness to personal experience and private research rather than their formal education (Q4 and below).

> I put myself on a 3, maybe 3.5 [on a scale of 5 on preparedness], and that is genuinely only because of the training I've done in my workplaces and my own research and experiences as well. But if I was to completely remove all of that and only based it on what I've learned in the course, I would give myself a 0 or a 0.5, as horrible as that sounds. (3rd-year-Bachelor of Social Work student, AU)

Participants sought to bridge their learning gaps by using social media, peers, and personal research, despite concerns about reliability. Some also consulted clinical supervisors, university tutors, and colleagues. Nursing students primarily linked their motivation to learn SRHR to the notion of 'patient safety', a concept infrequently mentioned by social work students. Additionally, participants relied on their personal experiences and felt more comfortable discussing SRHR with service users who were of the same sex, culture or age.

> Especially if it was with males, or it was that they were quite older or quite younger . . . I would kind of go a bit the length, like, what would I actually go on to talk to them like how would I actually address this kind of thing? (1st-Year-Master of Nursing student, AU)

Inconsistent understandings of SRHR

Participants had varied conceptualisations of SRHR. Some aligned their definitions with university teaching, focusing on women's health, 'safe sex . . . for both women and men', 'discourse around abortion and reproductive rights of women', 'midwifery and childbirth', and 'issues around the menstrual cycle'. Others, especially those with relevant lived experience, included in their definitions topics they were *not* taught about including sexual and reproductive justice and inequality, identifying the absence of reference to 'things like dignity of a person', 'bodily autonomy', 'choice over one's sexuality and identity', 'LGBT human rights issues' (Q5a) and 'the right to express oneself sexually'. One participant (Q5b) noted that combining reproductive health and rights might have shifted the focus towards health aspects from a heteronormative perspective. They expressed concern that this focus could potentially neglect broader reproductive rights, especially for marginalised communities.

Negative impact of gaps in SRHR education on placement/work experience and person-centred care

The second theme highlights the effect of SRHR education gaps on participants' interactions with service users and their capacity to deliver person-centred care. Participants, especially from Hong Kong, noted the widespread social taboo surrounding sexuality, leading to avoidance or discomfort in addressing SRHR needs.

Navigating professional boundaries

Navigating professional boundaries was seen as a complex challenge. AU nursing participants mentioned constraints on providing comprehensive sexual healthcare due to professional and organisational rules.

> It's tough, because . . . in nursing we have so many guidelines and policies to keep. What they say is to keep us safe, but it's also like having these policies means there's so many regulations we have to get approval from, in order to actually carry out anything. (1st-year-Bachelor of Nursing student, AU)

One AU nursing participant recounted how her supervisor deemed a paralysed patient's request for sexual function testing as 'non-essential' and 'too time-consuming', even though it was part of the patient's care plan (Q6a). This raised her concern about balancing professional boundaries with patient-centred care because, on the one hand, she recognised the necessity of the care within her professional practice, but on the other hand, the supervisor's attitude made her question the appropriateness of providing such care. HK nursing participants explained that in Hong Kong, discussing social aspects of SRHR with clients was considered the job of social workers. Nurses were expected to refer such cases to them. These participants expressed a desire to shift this norm and provide basic psychosocial SRHR counselling themselves (Q6b). In addition, participants from both nursing and social work in Hong Kong emphasised the value of learning from each other to enhance interprofessional collaboration and ensure continuity in patient care (Q6c).

Discussing sexuality-related issues

Participants from both disciplines and regions felt unprepared, often uncomfortable and lacking confidence in discussing sexuality in practice settings, describing such talk as 'tough conversations' (Q7). They viewed sexuality as a societal taboo, finding it harder to address when faced with age, gender, or cultural differences with clients (Q8a).

HK participants appeared to report greater public taboo than AU participants, especially regarding gender diversity and extramarital reproduction, and highlighted inadequacies in public SRHR services (Q8b). Regardless of discipline, HK participants frequently described their society's attitudes towards sex and reproduction as 'inadequate', 'old-fashioned', and 'conservative' and emphasised the need for more public forms of sex education (Q8c).

Participants who felt (somewhat) comfortable talking about SRHR in practice settings noted a lack of preparedness to provide SRHR advice, conduct interventions, and advocate for service users (Q9 and below).

> I would have appreciated having the education and models for intervention around this area as a part of the course. We can't rely on every practitioner going through uni to have

> extensive lived experience in this area and I think it's setting a lot of service users who do genuinely want to explore this, or need to, as a part of their recovery, up for failure. (3rd year Bachelor of Social Work student, AU)

Impact on care

Lack of preparedness in SRHR had a direct impact on person-centred care. Some participants talked about how they covered up their lack of SRHR knowledge and skills by 'doing nothing' or avoiding talking about the topic during placement (Q10). Female nursing students who had experienced sexual harassment at work reported avoiding talking about sexuality-related issues with male patients for fear of triggering sexual harassment.

> As an occupation, we're quite traumatised with being sexualised and being verbally and sexually harassed in clinical settings, even though the patient has no intention to being inappropriate towards us, as soon as something related to the sexual health mentioned, we kind of take a step back. (3rd year Bachelor of Nursing student, AU)

Some participants were concerned that their limited SRHR knowledge and skills could make them miss service users' needs, lose their trust, or trigger unidentified past sexual trauma.

> If we're not comfortable talking about sex, which many people I would guess are not[. . .], we're gonna be missing a huge part of things that might be going on for a client that we're supposed to see but we're not seeing when we're not comfortable. (3rd year Bachelor of Social Work student, AU)

When feeling stuck regarding how to support a service user with SRHR needs, participants from both disciplines considered referring them to specialised service providers and hoped to gain more SRHR knowledge and skills over time through practising in their profession.

Opportunities for enhancing SRHR education in the curricula

The third theme centred on participants' desire for a more comprehensive and inclusive approach to SRHR. It reflected their desire to improve their ability to engage with diverse SRHR topics effectively and sensitively. This theme also highlighted the needs for educational activities to enrich students' learning experiences and address the challenges of integrating SRHR into academic programmes.

Desire for inclusive and reflective learning

Participants in both regions and disciplines expressed the desire to enhance their understanding of various SRHR topics. HK students prioritised basic sex education, followed by gender-diverse care, care for sexuality minorities, and men's sexual health. They also wanted to learn how to adopt a person-centred approach (Q10).

AU students wanted a more holistic and inclusive SRHR education that taught them how to identify and respond to the physical and psychosocial needs and rights of diverse service users, including sexuality and gender diverse people, older people, young people, people with disabilities, and people from different cultural backgrounds.

> I think generally … we lack a lot of education towards providing different healthcare services … removing judgements, discrimination … We don't get taught enough about the social kind of stuff surrounding that … So, I wouldn't say I would be equipped enough to carry out a service for specific population groups. (1st year Bachelor of Nursing student, AU)

Participants in both regions wanted more opportunities to reflect on their own beliefs and assumptions when working with people from diverse backgrounds (Q11a, b and below).

> It's so funny that they keep teaching us [. . .] you might have biases that will affect how you provide care, but they never tell us explicitly what you do with those biases. (3rd year Master of Nursing student, AU)

Improving communication skills

Many participants sought to enhance their skills for discussing sensitive topics (Q12a). They wanted to learn how to initiate conversations, deal with assumptions and prejudices about SRHR, and advocate for service users (Q12b-d). Some participants emphasised the need to learn how to approach service users with diverse sexual needs with openness, empathy and respect (Q12f).

Participants from both disciplines and regions also prioritised learning how to give service users practical advice and conduct interventions:

> it's obvious telling someone, 'Oh, you've got swelling in your legs. You should put a stool down so that you don't get oedema … ', but I wouldn't really know, wouldn't feel comfortable giving anyone a direct advice about [sex]. (3rd year Bachelor of Nursing student, AU)

Many said it was important to learn how to conduct risk and safety assessments, particularly in relation to sexual misconduct, and how to approach and act on suspected or identified SRHR violations. In this context, some AU nursing and HK social work participants expressed a particular desire to learn more about the legal frameworks and professional boundaries in situations such as sexual violence and to be informed of referral pathways and how to access support in the community.

Challenges incorporating SRHR into curricula

Participants were divided in their opinions on the merits of dedicated SRHR teaching versus integrating SRHR education into existing programme areas. However, they shared an interest in scaffolding SRHR education, with practice opportunities in safe spaces including role-play and simulated learning (Q13). Case study videos and external practitioner guest lectures were suggested to gain practical insights. Additionally, participants wanted to practise talking about SRHR, so as to reduce the stigma around sexual health.

> There could be a lab where you just specifically talk about that. Because just being able to practice saying it out loud, … it becomes more routine, it becomes more like, Oh, yeah, okay, I know what I'm talking about. … I feel more comfortable actually saying the words. (1st year Master of Nursing student, AU)

A few nursing participants from both regions noted the challenge of teaching personalised SRHR care in the classroom. A nursing participant questioned the need for better SRHR education for those not pursuing a career in this field (Q14). Nonetheless, participants across both disciplines and regions regarded sex and reproduction as vital aspects

of human life, seeing them as important to include in the education of all healthcare practitioners.

> I think it is definitely a very important part as a person to be aware of cause it's a part of your overall health as well. So, your mental health and everything also is linked somehow. So, there's definitely knowledge required. (3rd year Bachelor of Social Work student, AU)

Discussion

To our knowledge, this is the first study to use an interprofessional, bi-national sample of university students to explore SRHR preparedness, learning experiences, and educational needs of nursing and social work students in Australia and Hong Kong. Our findings indicate a common sentiment of unpreparedness across students from both regions and disciplines, which is linked to the narrow, deficit-based, and predominantly stereotypical, risk-focused, and biomedical educational approaches to SRHR. During placements, students faced constraints from supervisors and organisations that hindered their ability to practice comprehensive SRHR care. Despite these challenges, students clearly recognised the urgent need for a more inclusive and comprehensive SRHR education to provide person-centred care to diverse populations. The continuing exclusion of a broader SRHR perspective in nursing and social work curricula is evidently unacceptable and inadequate to meet students' learning needs. Educational reform is necessary to better prepare future professionals to meet the diverse SRHR needs of service users.

SRHR education in nursing and social work should address the ongoing stigmatisation of sex and sexuality by adopting a positive framing that challenges existing societal stigma. In this study, Hong Kong students emphasised how 'conservative' social environments lead to the avoidance of discussions about sex and reproduction in their learning, while Australian students also noted how social taboos and negative assumptions on sex and sexuality can hinder their education. In recent years, some educators have advocated for curricula that prepare students to adopt a more sex-positive approach, encouraging open discussions about sexual pleasure, sexual wellbeing, and justice (Turner, North, and Drake 2023). Moreover, as building self-awareness is the first step for developing person-centred practice (McCormack and McCance 2016), it is crucial to support students to identify how personal experiences, values and beliefs may affect the care they provide (Klaeson et al. 2017; Shindel et al. 2016). Research has also shown that curricula encouraging open discussions about sex and sexuality can enhance students' understanding of vital topics such as sexual agency and consent (Hubach et al. 2019; Lafrance, Loe, and Brown 2012). These topics are particularly relevant for nurses and social workers when supporting those in needs, such as sexual violence victims/survivors.

To foster open discussion, it is important to provide safe and inclusive environments where students can discuss and articulate their concerns and explore their assumptions and biases on SRHR issues. Effective strategies may include experiential learning through self-reflection exercises, role-play, and simulations (Huang et al. 2023; Kong, Ha Wu, and Yuen Loke 2009; Rowntree 2014; Russell 2018; Shindel et al. 2016). Additionally, many nursing and social work students are 'wounded healers' (Clark and El-Makarim Aboueissa 2021; Lyter 2021) who may have experienced trauma and harassment during placement or other points in

their lives. A trauma-informed pedagogical approach, which acknowledges the prevalence of trauma among students and integrates this awareness into all aspects of education, should be adopted to prevent re-traumatisation when discussing SRHR issues. This consideration is particularly important for students from socially marginalised backgrounds, such as those from ethnic, gender, or sexual minorities, as well as those with disabilities (Paceley et al. 2022).

Our findings also support the need for educational content that addresses the diverse SRHR needs of diverse populations, including LGBTIQ+ individuals, young people, older adults, and people with disabilities. These groups are often overlooked in current curricula due to prevailing assumptions about sex and reproduction rooted in heteronormativity, ableism, and ageism (e.g. Goulden 2021; Radix and Maingi 2018; Sherman et al. 2023; Turner and Crane 2016b). Professionals who lack training may shy away from discussing SRHR needs with those who do not fit traditional expectations of sex and reproduction (Dyer and Das Nair 2013; Lee, Fenge, and Collins 2018; Wilschut et al. 2021). They may also dismiss their SRHR needs if not directly raised by patients (Blakey and Aveyard 2017), or consider them less critical than other medical concerns (Klaeson et al. 2017). Such deficiencies can result in care that is dehumanising and even traumatising for service users, conflicting with the principles of trauma-informed, person-centred care, and ultimately affecting well-being outcomes (Lovell et al. 2022).

In placement settings, supporting the development of role models and facilitating cultural changes is crucial. Our study revealed that students encountered resistance from frontline professionals when attempting to provide sexual wellbeing care to service users. This finding aligns with existing literature, which shows that individual professionals' efforts to address the SRHR needs of service users often meet with disparaging comments from colleagues (Kong, Ha Wu, and Yuen Loke 2009). To foster a cultural shift in placement settings, it is essential to provide training to placement facilitators and frontline staff. Additionally, employing strategies such as engaging 'early adopters' who are more receptive to new practices as role models, starting with small initiatives, and celebrating quick success in improving SRHR outcomes can promote organisational changes (Melnyk 2014).

Last but not least, SRHR issues are 'inherently interprofessional in nature' (Penwell-Waines et al. 2014, 35). Given the similarities and differences between the nursing and social work professions, interprofessional education is essential to foster comprehensive learning of SRHR issues (Olson et al. 2016). Nurses, who have often been educated to prioritise biomedical approaches to wellbeing, may benefit from a greater consideration of relevant legal and human rights aspects of SRHR. Conversely, social workers, who often place a stronger emphasis on social justice and psychosocial issues (Turner 2021), can gain a deeper understanding of the medical aspects of SRHR, as well as the healthcare cascade when supporting service users in navigating different health services. Ultimately, a more comprehensive and collaborative approach to SRHR across disciplines is needed so that students can 'learn about, from, and with each other' (WHO 2010, 7).

Strengths and limitations

This study allowed us to identify similarities and differences between social work education and nurse education with respect to SRHR, as seen through the eyes of students in Australia and Hong Kong. A limitation of our study was limited practical experience among many participating students who were early in their programme of professional education. Perspectives on SRHR and practices may change later in the programme, particularly after gaining more practical experience. It is also important to note that this study focused exclusively on student perspectives. Future research should involve university educators, mentors and placement supervisors to better understand and enhance current provision for SRHR education, especially considering the need for role models who exemplify inclusive, person-centred SRHR care.

Conclusion

In conclusion, our study underscores the need for curriculum revision in SRHR education for nursing and social work students in Australia and Hong Kong. While acknowledging that professional practice and education in both fields and regions are heavily regulated by regulatory bodies, it is crucial for educators and curriculum designers to adapt to the evolving nature of social care and healthcare needs in the context of SRHR. Addressing gaps in professional SRHR education requires an integrated approach that combines biomedical, psychosocial, and human rights elements, promotes interprofessional collaboration, and considers local sociocultural and legal factors. By developing curricula that focus on sexual justice, inclusivity, and the diverse needs of different populations, and by creating safe, trauma-informed learning environments, we can better prepare future nurses and social workers to deliver compassionate and comprehensive SRHR care.

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