Teaching Sexual and Reproductive Health and Rights at the University:

A Toolkit for Nursing and Social Work Educators

Australian Edition

THE UNIVERSITY OF SYDNEY

SWAN-SR pilot project

Endorsed by

ASHHNA
AUSTRALASIAN SEXUAL HEALTH & HIV NURSES ASSOCIATION INC.

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Endorsement

This resource has been endorsed by the *Australasian Sexual Health and HIV Nurses Association.*

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AUSTRALASIAN SEXUAL HEALTH & HIV NURSES ASSOCIATION INC.

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The views expressed in this work are those of the authors and do not necessarily reflect the positions or policies of the affiliated universities or organisations. This resource has been endorsed by the Australasian Sexual Health and HIV Nurses Association (ASHHNA), though ASHHNA one is one of several professional bodies in the field. Readers should note that the information provided in this resource might not have been reviewed, approved, or endorsed by all relevant authorities. Additionally, the content may be subject to updates to reflect evolving research, practices, or policies. Language editing and image creation support were provided using AI tools to assist with grammar, formatting, and visual design. For any questions or clarifications about this resource, please contact horas.wong@sydney.edu.au.

Acknowledgement of Country

This resource was developed on the land of the Gadigal people of the Eora Nation, whom we acknowledge as the Traditional Custodians. We pay our respects to Elders past, present and emerging, and honour their deep and enduring connection to land, waters and culture. We recognise their significant contributions to knowledge, health, wellbeing and community care.

In the context of sexual and reproductive health and rights, we acknowledge the ongoing impacts of colonisation and systemic inequities experienced by Aboriginal and Torres Strait Islander peoples. We recognise the importance of fostering culturally safe, inclusive and respectful approaches to education and care.

Contributors and Development of the Resource

This resource was developed as part of the SWAN-SR (**S**ocial **W**ork **A**nd **N**ursing – **S**exual and **R**eproductive health and rights) pilot project, led by Dr. Horas TH Wong from the University of Sydney and Dr. Jialiang Cui from The Chinese University of Hong Kong, in collaboration with educators, researchers, and students from Australia and Hong Kong. Key academic contributors included Christiane Klinner, Dr. Margaret Spencer, Dr. Christie van Diggele, Prof. Jacqueline Bloomfield (University of Sydney), Dr. George Turner (Western Sydney University), Prof. Janet Wong Yuen-Ha (Hong Kong Metropolitan University), and A/Prof. Edmond Pui Hang Choi (The University of Hong Kong). Frontline professionals Renee Lovell, Colleen Nugent (NSW Health), and Hannah Chow (The Boys' and Girls' Clubs Association of Hong Kong), along with student co-designers, were integral to the project.

In 2023, the project engaged approximately 300 nursing and social work students in Sydney and Hong Kong through surveys, focus groups, and co-design workshops, generating valuable insights that informed the development of this resource. Educators and students collaborated to define learning outcomes and content. The initial draft, prepared by Kelly Zhang and Rosie Butel, was extensively revised and enhanced by Dr. Horas Wong, with further input and review from the broader group.

Findings of the SWAN-SR pilot project were disseminated through two conference presentations and a journal publication:

Klinner, C., Turner, G., Bloomfield, J., Spencer, M., Lovell, R., van Diggele, C., Choi, E. P. H., Wong, J. Y. H., Cui, J., Nugent, C., Chow, H., Wong, A. S. M., Roberts, S. J., Lin, J. Y. T., Fontaine, C., & Wong, H . (2024). A qualitative exploration of nursing and social work university students' experiences of sexual and reproductive health and rights education in Australia and Hong Kong. *Sex Education, 1*(1), 1–15. https://doi.org/10.1080/14681811.2024.2381192

Turner, G., Wong, H., Klinner, C., Spencer, M., Cui, J., Wong, J. Y. H., Choi, E. P. H., Lovell, R., van Diggele, C., Nugent, C., Chow, H., Zeng, K., Butel, R., Wong, A. S. M., Roberts, S. J., Lin, J. Y. T., Fontaine, C., & Bloomfield, J. (2024, October 24–27). Poster presented at the Council on Social Work Education (CSWE) Annual Program Meeting. Kansas City, MO. USA**.**.

Wong, H., Klinner, C., Spencer, M., Cui, J., Turner, G., Wong, J. Y. H., Choi, E. P. H., Lovell, R., van Diggele, C., Nugent, C., Chow, H., Zeng, K., Butel, R., Wong, A. S. M., Roberts, S. J., Lin, J. Y. T., Fontaine, C., & Bloomfield, J. (2024, July 25–28). Interprofessional collaboration to enhance SRHR education: A cross-national pilot project in nursing and social work [Oral presentation]. *35th International Nursing Research Congress,* Singapore.

Australian collaborators

Hong Kong collaborators

Note for Educators

Some topics covered in this toolkit, such as sexual violence and gender-based discrimination, may be emotionally challenging for students with lived experience. These are not taboo subjects, but essential and routine elements of professional preparation in Nursing and Social Work. Educators are encouraged to normalise these discussions while maintaining trauma-informed awareness. Creating space for student reflection, support, or pausing as needed can foster a respectful, inclusive, and professionally grounded learning environment.

Purpose of this toolkit

This toolkit was designed to assist university educators in teaching **sexual and reproductive health and rights (SRHR)** to nursing and social work students. It promotes open, inclusive, and practical approaches to learning, equipping future professionals with the knowledge and skills required to address sensitive and essential aspects of health care and social support.

SRHR is fundamental to wellbeing and human rights. This toolkit highlights the importance of recognising diversity, promoting fairness, and understanding the unique needs of individuals and communities. It aims to prepare students to provide care that is respectful, person-centred, and supportive of people's choices, autonomy, and dignity. By engaging with this toolkit, educators and students can work towards fostering more inclusive, supportive, and equitable practices, reducing barriers and improving care for all people.

How to use this toolkit

Recognising that SRHR is a broad and evolving field, this toolkit serves as a starting point. It provides ideas for lesson plans, case studies, and activities that encourage meaningful conversations and deeper understanding of SRHR. Educators are encouraged to seek additional resources and information to complement their teaching and adapt the content to meet the diverse needs of their students.

This toolkit can be used flexibly to support curriculum planning, classroom teaching, or reflective learning. Educators can select individual activities, case studies, or themes to suit their course content and student needs. Materials are adaptable and designed to complement both standalone sessions and integrated units.

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Part 1: Integrating Sexual and Reproductive Health and Rights (SRHR) into Nursing and Social Work Education

Should I include Sexual and Reproductive Health and Rights (SRHR) topics in my class?

Every nursing and social work educator should find ways to incorporate SRHR topics into their curriculum or create supportive spaces for students to engage with these crucial issues. SRHR education provides students with the knowledge and empathy required to navigate sensitive, real-life scenarios. For example, students may encounter a cancer patient recovering from a mastectomy and struggling with self-esteem, or an older adult learning to navigate intimacy after the loss of a partner. These situations are common in nursing and social work, emphasising the importance of SRHR education in preparing students for compassionate and effective care.

Given that SRHR is closely linked to overall wellbeing and quality of life, it plays a central role in nursing and social work education. Yet, these topics are often underrepresented in curricula, leaving students unprepared to meet the diverse needs of those they serve, particularly marginalised groups.

Addressing these gaps is in alignment with professional standards, such as the *AHPRA Code of Conduct for Nurses (2022)* and the *AASW Practice Standards for Social Workers* (2023). These guidelines stress the importance of respecting diversity, ensuring fair access to care, and fostering safe, inclusive environments.

Student voices from the SWAN-SR pilot project:

"I can only remember [SRHR] being briefly discussed [in the program]... There's no focus on this topic in the actual course."
(Nursing student)

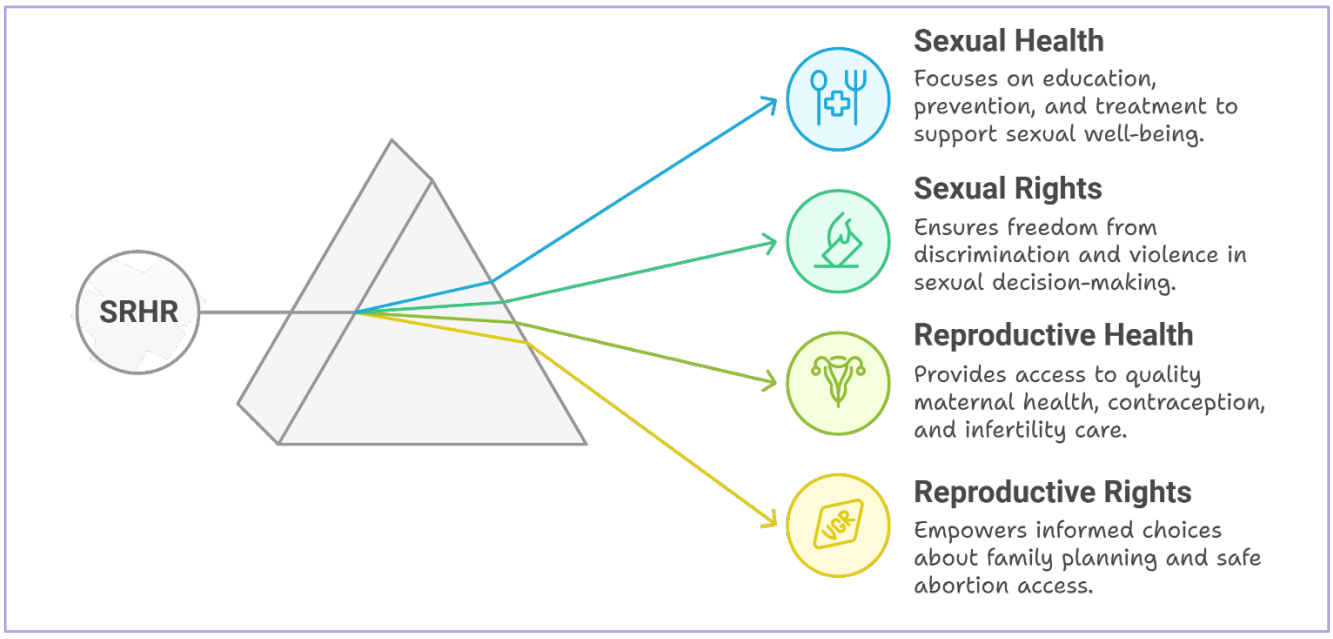
"I can definitely count on one hand how many conversations throughout my academic journey I have had about [SRHR]… I feel like sort of a disadvantage on us when we go into the field… I haven't been upskilled."
(Social work student)

What Does SRHR Include?

While many people may see SRHR as a private matter, the World Health Organization[1] defines it as encompassing physical, mental, and social wellbeing in relation to sexuality. It goes beyond sexual practices and reproduction, promoting a positive and respectful approach to sexuality and relationships. SRHR ensures safe, enjoyable experiences free from coercion, discrimination, and violence, while respecting, protecting, and upholding everyone's sexual and reproductive rights. It is underpinned by the principles of equity and justice.

SRHR is built on four key overlapping concepts:

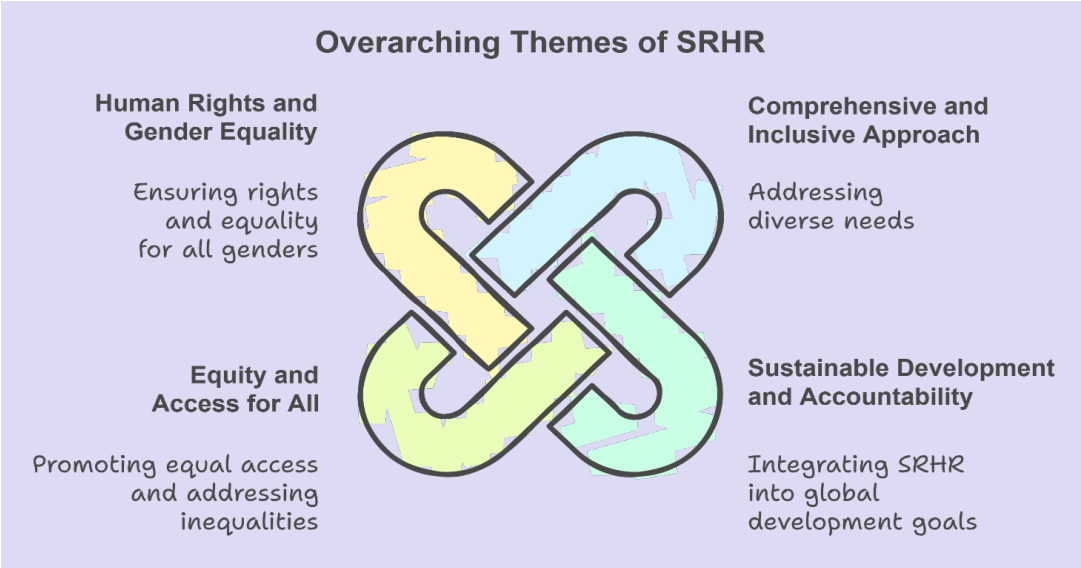
- Sexual Health: Supporting overall sexual wellbeing through education, prevention, and treatment.
- Sexual Rights: Ensuring individuals can make decisions about their sexuality free from discrimination and violence.
- Reproductive Health: Providing access to quality care for maternal health, contraception, and infertility.
- Reproductive Rights: Empowering individuals to make informed choices about family planning and access to safe abortion where permitted.



[1] World Health Organization. (n.d.). Sexual and reproductive health and rights. https://www.who.int/health-topics/sexual-and-reproductive-health-and-rights

Overarching Themes of SRHR

Some overarching themes of SRHR include:[2]



1. Human Rights and Gender Equality

- SRHR is a fundamental human right, essential for achieving gender equality, bodily autonomy, and freedom from discrimination and coercion.

2. Comprehensive and Inclusive Approach

- SRHR encompasses a wide range of issues, including contraception, maternal and newborn care, safe abortion, STI prevention, gender-based violence, infertility, and reproductive cancers, ensuring accessibility for all.

2. Equity and Access for All

- Achieving universal access to SRHR requires addressing inequalities, prioritising marginalised groups, and integrating services into broader development and health systems.

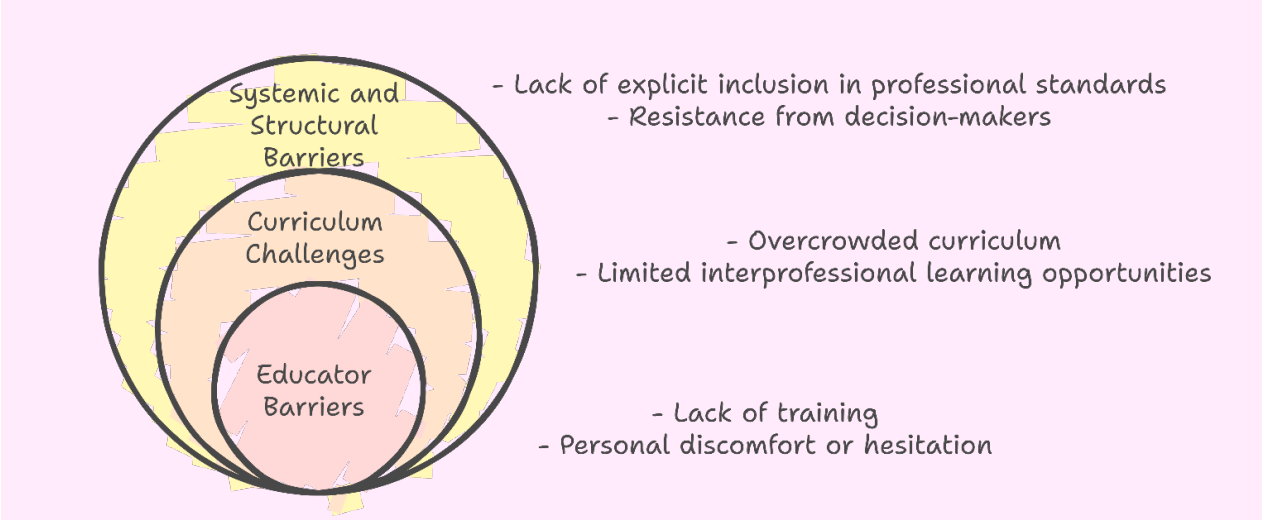
4. Sustainable Development and Accountability

- SRHR is central to achieving Sustainable Development Goals (SDGs) through systemic change, investment, and holding governments accountable for fulfilling commitments.

[2] Starrs, Ann M., et al. "Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission." The Lancet 391.10140 (2018): 2642-2692.

Common Barriers to Incorporating SRHR into the Curriculum

Educators involved in the SWAN-SR pilot project identified several challenges that hinder the integration of SRHR into nursing and social work education:



Systemic and Structural Barriers

- ***Lack of explicit inclusion in accreditation standards.*** SRHR isn't clearly outlined in nursing and social work curriculum accreditation standards (e.g. ANMAC Registered Nurse Accreditation Standards [2019]; Australian Social Work Education and Accreditation Standards [2023]), so it's often overlooked in course planning and curricula development.
- ***Resistance from decision-makers.*** Some educators or program leaders are hesitant to include SRHR, seeing it as too sensitive or unrelated to core practice.

Curriculum Challenges

- ***Overcrowded curriculum.*** With so many topics to cover, there's little room to add SRHR content without cutting other material.
- ***Limited interprofessional learning opportunities.*** Nursing and social work students rarely learn together about SRHR, missing the chance to build shared approaches to care.

Educator Barriers

- ***Lack of training.*** Many educators feel unprepared to teach SRHR because they haven't been given enough resources or training.
- ***Personal discomfort or hesitation.*** Some educators avoid these topics because they feel awkward or uneasy discussing them, often due to cultural or personal beliefs.

What Do Students Want to Learn More About?

The SWAN-SR pilot project engaged nearly 300 nursing and social work students in Sydney and Hong Kong to explore their SRHR learning needs. Students reported uncertainty in addressing SRHR topics and highlighted a lack of curriculum content, especially around communication. Many relied on personal experience, which led to discomfort, particularly when working with diverse populations. The table below summarises key learning areas identified by participants.

Category	Nursing Students	Social Work Students
Specific areas of interest	• Understanding how medications and medical procedures impact SRHR for people from diverse backgrounds. • Recognising and addressing sexual and domestic violence, particularly in emergency or acute care settings. • Providing inclusive care in clinical settings, including respectful language and cultural sensitivity • Exploring non-medical aspects of SRHR, such as ethics, laws and policies, and the impact of social stigma	• Recognising diverse SRHR needs, taking into account factors like age, gender, sexual orientation, (dis)ability, and cultural background. • Discussing and educating about sexual consent effectively, ensuring clarity, understanding, and respect in various situations. • Providing support for intimacy challenges, such as helping individuals cope with the loss of a partner. • Exploring the medical aspects of SRHR, including treatments and care pathways.
Practical Communication Skills	• Using respectful and inclusive language • Communicating effectively with people from diverse cultural, linguistic, and sexual backgrounds	
Professional Boundaries and Intimate Care	• Staying safe and setting boundaries when discussing sensitive SRHR topics. • Responding to inappropriate comments from service users in a professional and respectful manner. • (For nursing students) Managing sensitive procedures involving reproductive organs, while ensuring professionalism and patient comfort.	
Accessing and Referring Resources	• Knowing where to refer service users for additional SRHR support. • Supporting service users' access to SRHR care by addressing barriers like language, stigma or misinformation.	
Advocacy and Education	• Advocating for culturally inclusive and equitable SRHR practices within health and social care settings. • Educating and advocating for SRHR within diverse communities to reduce stigma and promote understanding.	

Examples of Incorporating SRHR into the Existing Curriculum

Including SRHR into your teaching can be straightforward. Even if the subject you are teaching does not directly focus on sex and reproduction, you can achieve this by explicitly incorporating sex and reproduction-related topics. The aim is to help students recognise SRHR as an essential aspect of overall wellbeing.

Here are some practical examples that can be used to seamlessly integrate SRHR into your lessons:

In Lectures

- During a lecture on spinal cord injury rehabilitation, include a segment on how the injury may affect sexual health, reproductive rights, and intimacy. Highlight how these issues connect to broader wellbeing and human rights, encouraging students to view SRHR as part of overall care practices.

In Tutorials

- Present a case study where a person recovering from a stroke expresses concerns about intimacy with their partner. Ask students to discuss both medical and psychosocial solutions, touching on communication, sexual pleasure, and emotional support.
- In discussions about accessibility in rehabilitation care, include examples of how marginalised groups—such as LGBTIQ+ individuals or people with disabilities—face barriers to SRHR services. Engage students in brainstorming ways to advocate for gender equality and equitable access.

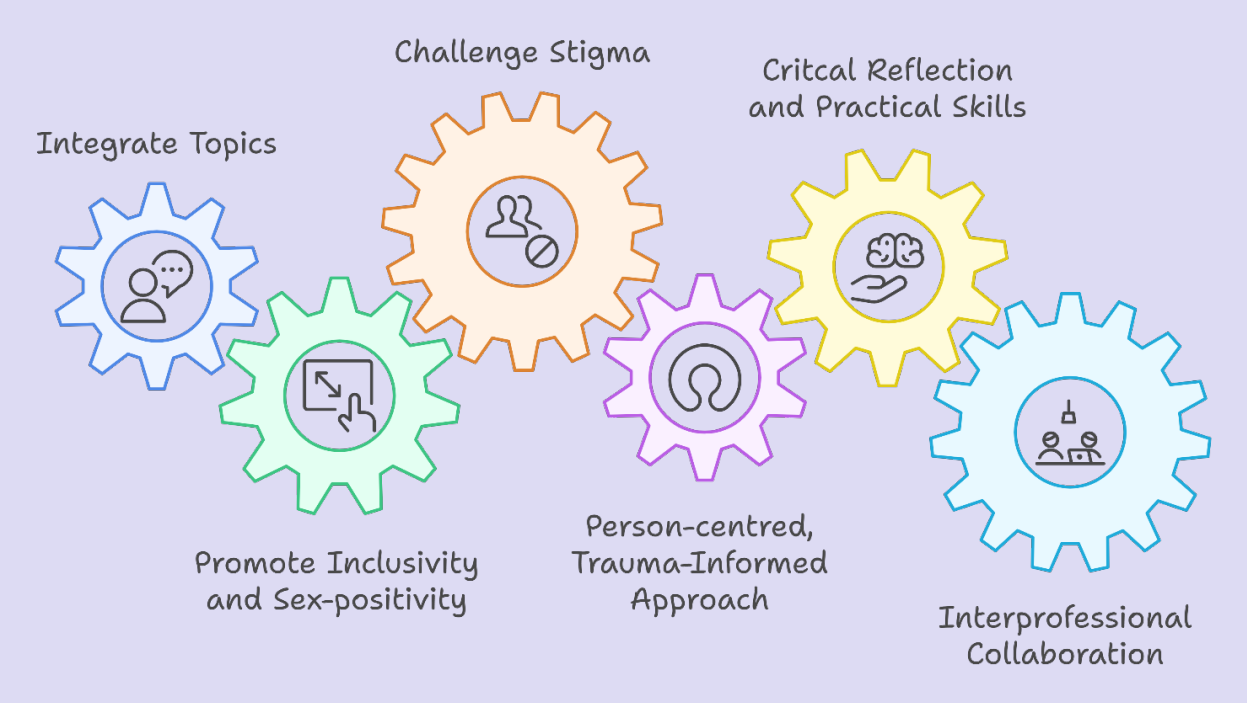
In Interprofessional Workshops

- Organise an activity where nursing and social work students collaborate to develop a comprehensive care plan for a person undergoing rehabilitation after a spinal cord injury. Nursing students may contribute expertise in managing physical changes and medical interventions, while also incorporating emotional and cultural considerations. Social work students may address psychosocial factors such as emotional wellbeing and systemic challenges, while gaining insights into medical aspects like medication side effects and reproductive health issues. Together, the groups present their integrated care plans, demonstrating how teamwork bridges knowledge gaps and supports holistic SRHR care.

Part 2: Promoting Safe, Supportive and Inclusive Learning Environments in SRHR

Key Aspects to Focus When Teaching SRHR in the Classroom

Teaching SRHR in the classroom requires a thoughtful approach to equip students with the skills and understanding needed to address these vital issues effectively in their future professional roles. Drawing from the insights gained from the SWAN-SR pilot project, we recommend focusing on the following key aspects to enhance SRHR education and create impactful learning experiences.



Integrate with other Topics

- Ensuring SRHR topics are integrated into broader discussions of health, wellbeing, justice, and care practices to avoid treating SRHR as an isolated or “add-on” topic.
- Include a broad range of topics, from medical and psychological aspects to human rights and social justice.
- Cover areas such as sexual pleasure, reproductive rights, and gender equality alongside traditional disease or crisis-focused subjects.

Promote Inclusivity and Sex-Positivity

- Create a classroom environment that respects and acknowledges all individuals, including LGBTIQ+ individuals, older adults, people with disabilities, and diverse cultural backgrounds.
- Normalise and encourage open discussions about sexuality in a sex-positive way.
- Incorporate discussions on gender roles, power dynamics, and strategies for promoting gender equality.

Challenge Stigma

- Address societal taboos around sexuality and reproduction.
- Encourage students to challenge stigma and support marginalised groups, advocating for their rights and equitable access to SRHR services.

Person-Centred and Trauma-Informed Approaches

- Foster empathy and respect for bodily autonomy by emphasising person-centred care.
- Use trauma-informed practices to ensure a safe space for learning, especially for students who may have experienced trauma.

Critical Reflection and Practical Skills

- Encourage students to critically reflect on their values, biases, and assumptions about SRSH to enhance self-awareness.
- Teach practical skills, such as how to communicate about sensitive topics, conduct risk assessments, and advocate for individuals' rights. Use activities such as role-playing and case studies to build confidence.

Interprofessional Collaboration and Teamwork

- Highlight the importance of collaboration across disciplines. Encourage students to learn from, with and about peers in studying other fields to provide more holistic and inclusive SRHR services.

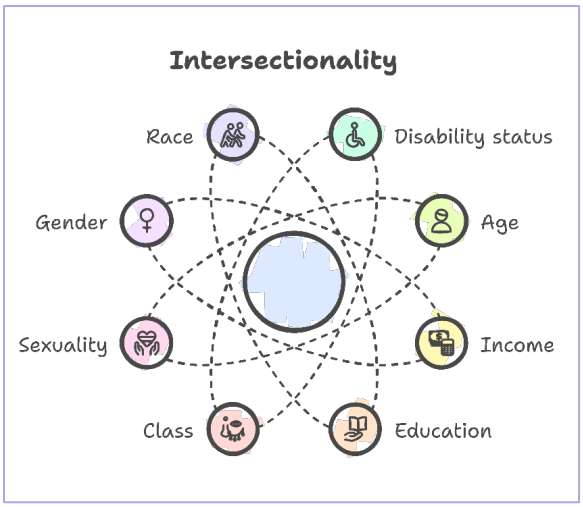
Understanding Intersectionality in SRHR education

To foster an inclusive and comprehensive understanding, it's essential to incorporate ***intersectionality*** into SRHR education[3]. Intersectionality, a concept first introduced by Black feminist scholar Kimberlé Crenshaw, is now widely used across various disciplines to understand how different aspects of a person's identity—such as race, gender, income, education, and cultural background—combine to shape their life experiences.

Why is Intersectionality Important for SRHR?

In the context of SRHR, intersectionality highlights that health and access to rights are influenced by more than just one factor. For instance, being a woman, a migrant, or having a disability will each impact people differently.

However, when these factors overlap, they can create unique challenges that need to be addressed. By recognising these intersecting identities, we can make SRHR care more inclusive, responsive, and better suited to the diverse experiences of individuals.



SRHR and Different Groups

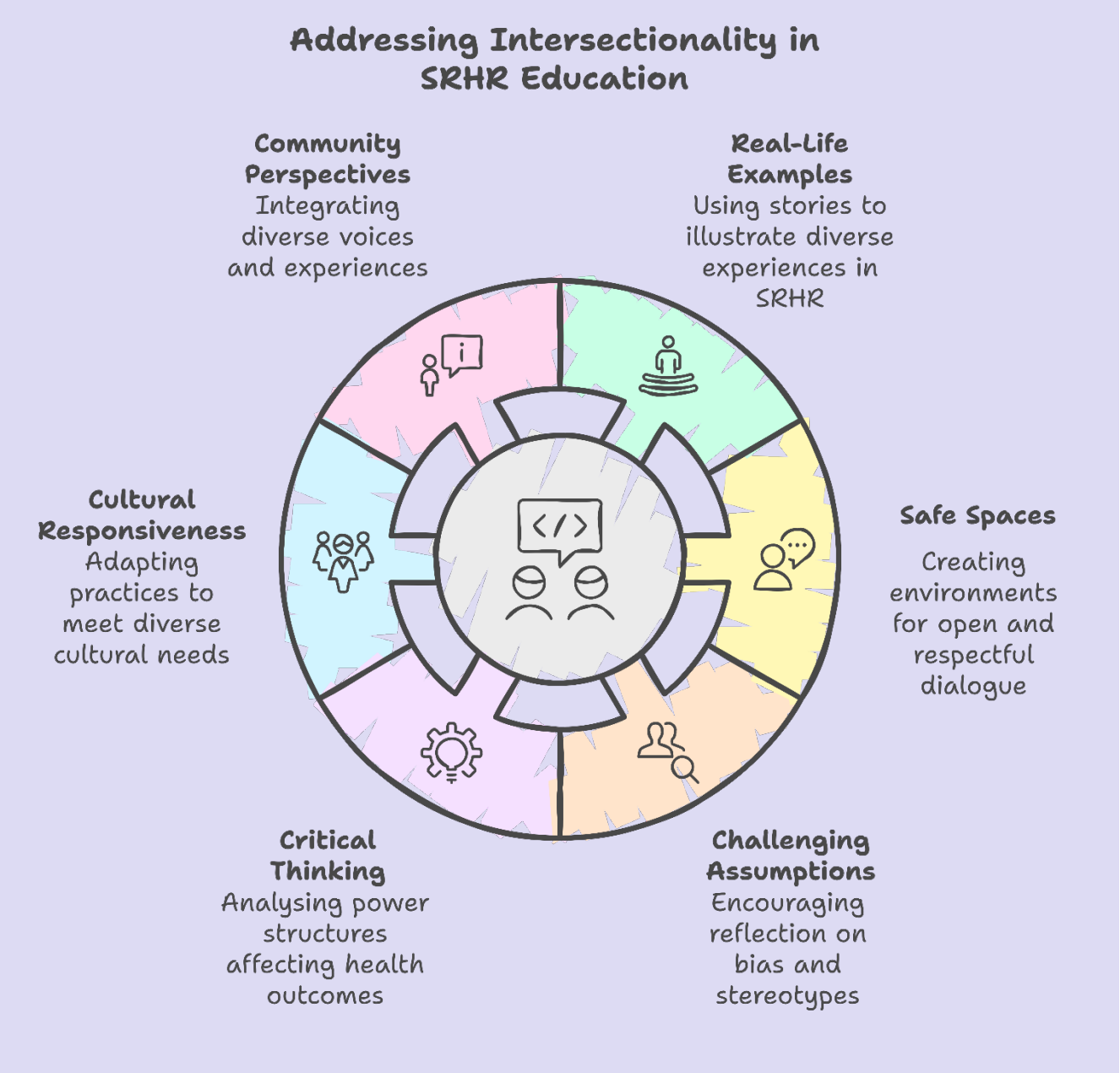
SRHR impacts everyone, but the way it affects individuals varies significantly depending on their identity and life circumstances. To have meaningful and inclusive discussions about SRHR, we need to acknowledge and address these differences.

For example, women, migrants, cultural and linguistic minorities, First Nations people, people from the LGBTIQ+ communities, and those with disabilities face distinct challenges in SRHR. Intersectionality helps us recognise that not everyone in these groups experiences the same issues in the same ways. When we fail to consider these differences, we risk overlooking critical needs, especially when we focus solely on shared vulnerabilities within a group.

To help students understand this complexity, educators are encouraged to use real-world examples, case studies, and stories that demonstrate how different identities influence people's sexual health and rights. The goal is to teach students to see people as individuals with unique needs, rather than making assumptions based on one aspect of their identity.

[3] Kapilashrami, A. (2020). What is intersectionality and what promise does it hold for advancing a rights-based sexual and reproductive health agenda?. *BMJ Sexual & Reproductive Health*, 46(1), 4-7. https://doi.org/10.1136/bmjsrh-2019-200314

Tips to address Intersectionality in SRHR Education



Incorporate Community Perspectives. One of the best ways to teach intersectionality is by bringing diverse voices into the classroom. Invite guest speakers from different communities—such as LGBTIQ+ activists, First Nations elders, or migrant support groups—to share their experiences with SRHR. This will help students gain insights into how intersecting identities affect people's access to care. Engaging with local community organisations also provides students with practical knowledge on how to work with people from diverse backgrounds in real-world SRHR settings.

Use Real-Life Examples and Stories. When teaching SRHR, it's crucial to use real-life examples that show how different identities shape people's experiences with sexual and reproductive health. These stories help students see how someone's gender, age, culture, or background can impact their access to care. For example, consider a migrant woman facing barriers in accessing sexual health services or an LGBTIQ+ person dealing with discrimination in healthcare. By using these examples, students gain a deeper understanding of intersectionality and how to respond to diverse needs in their future practice.

Create a Safe Space for Open Conversations. Teaching about intersectionality in SRHR can bring up tough, challenging and sensitive topics. It's important to create a safe and respectful environment where students feel comfortable discussing these issues. By encouraging open dialogue, you can help students reflect on their own biases and understand how these biases can impact care. This can be done through group discussions, role-playing, or case studies that allow students to explore real-world scenarios involving intersecting identities.

Challenge Assumptions. Intersectionality pushes us to move beyond assumptions and generalisations. It helps students understand that not everyone within a group has the same experience. For example, a woman from a migrant background may face different challenges to accessing care than a woman from a similar cultural background with more support. Encourage students to recognise how different identities intersect to shape an individual's needs and experiences, and remind them that assumptions can limit their ability to offer personalised, effective care.

Promote Critical Thinking about Systems of Power. Intersectionality helps us think critically about the systems that shape people's experiences with SRHR. It's important to teach students how power structures—like gender, race, and socio-economic status—impact health outcomes. For example, students can explore how people from marginalised communities may face barriers to accessing reproductive rights or sexual health services due to these systems of power. By encouraging students to challenge these systems, you can help them become advocates for better policies and services that address the needs of all people.

Focus on Cultural Responsiveness, Not Just Competency. Cultural competency involves understanding different cultures, but cultural responsiveness goes a step further. It's an ongoing process that requires continuous learning, self-reflection on personal biases, and adapting practices to meet the needs of diverse people. In SRHR education, students can be encouraged to view culture as dynamic and unique to each person. By developing cultural responsiveness, students can ensure their approach to SRHR care is not only inclusive but also sensitive to the unique needs of each person. Cultural responsiveness ensures that care providers create a safe environment, actively listen to, and honour individuals' diverse experiences without judgment or discrimination.

Sex-Positive Education

Sex-positivity[4] is about embracing human sexuality as a normal and healthy part of life. It supports all consensual sexual activities as positive and encourages open, accepting attitudes toward different ways people express their sexuality. The goal is to break down negative stereotypes and promote understanding and acceptance[5].

Embracing sex-positivity is essential for nursing and social work educators as it encourages students to approach sexual health with an open, non-judgmental mindset. Research, including the SWAN-SR pilot project, highlights that nursing and social work curricula often focus heavily on risk, disease, and crisis management, and are based on stereotypical assumptions[6]. This approach limits students' understanding of SRHR and leaves them less confident in addressing these topics with individuals.

By creating an environment where students can openly discuss sexuality, educators help them better understand and address the diverse needs of their future clients. Sex-positive education encourages students to focus on healthy relationships, self-esteem, and empowering individuals to make informed choices about their sexual health. This approach not only moves away from outdated, fear-driven methods, but it also fosters confidence and comfort in supporting people from all backgrounds. It challenges societal taboos, promotes inclusivity, and makes it easier for people to access the support they need.

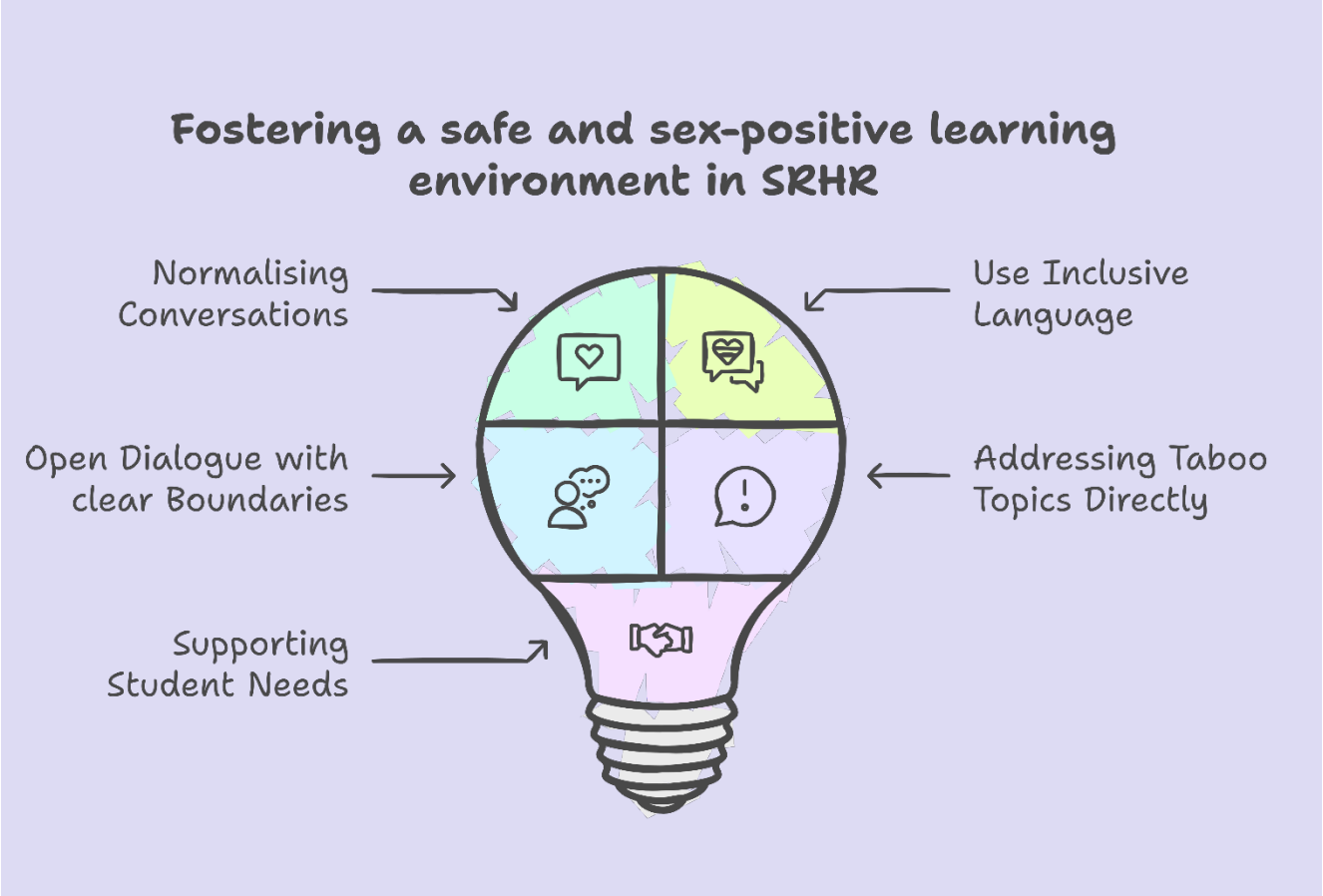
Student voices from the SWAN-SR pilot project:

"If we're not comfortable talking about sex…, we're gonna be missing a huge part of things that might be going on for a client that we're supposed to see."
(Social work student)

"I've noticed that some older teachers tend to avoid discussing this topic….they don't want to spend too much time on this topic because it can be embarrassing."
(Nursing student)

[4] Williams, D. J., Prior, E., & Wegner, J. (2013). Resolving social problems associated with sexuality: Can a "sex-positive" approach help? Social Work, 58, 273–276. doi:10.1093/sw/swt024
[5] Ivanski, Chantelle, and Taylor Kohut. "Exploring definitions of sex positivity through thematic analysis." The Canadian Journal of Human Sexuality 26.3 (2017): 216-225.
[6] Aaberg, Vicki. "The state of sexuality education in baccalaureate nursing programs." Nurse education today 44 (2016): 14-19. | Turner, George, Robyn North, and Gabrielle Drake. "Social work curriculum: Preparation for sexuality and sexual well-being practice." The British Journal of Social Work 53.6 (2023): 3237-3257.

Tips to foster a safe and sex positive learning environment in SRHR



1. Normalise Conversations

Present sexuality as a natural and essential part of overall health and wellbeing. Even if SRHR topics are not directly part of the curriculum, look for opportunities to bring them into discussions. For example, when teaching about aged care, ask students to consider the sexual and reproductive needs of older adults. By normalising these conversations, you help reduce the shame and stigma often tied to sexual and reproductive health. Encourage students to view sexual health as equally important as mental and physical health, promoting open and respectful discussions.

2. Use Inclusive Language

Choose language that respects and includes diverse sexual orientations, gender identities, and experiences. Avoid making assumptions about students' identities and create a space where everyone feels seen and valued.

For instance, use gender-neutral terms like “partner” instead of assuming heterosexuality. Let students know they can share their identities openly if they feel comfortable. Encourage using pronouns to ensure inclusivity and respect for all.

3. Encourage Open Dialogue with Clear Boundaries

Create a safe and respectful environment where students feel comfortable discussing sensitive topics without fear of judgment. Emphasise curiosity, mutual respect, and the importance of consent. Set clear boundaries to protect privacy and confidentiality, ensuring conversations remain supportive and balanced.

Consider methods like anonymous question submissions, small group discussions, or role-playing to help students explore sensitive topics in a way that feels safe and supportive.

4. Address Taboo Topics Directly

Don’t avoid uncomfortable or controversial topics like sexual violence, consent, or LGBTIQ+ health. Tackling these issues directly helps students engage with the realities of sexual health, correct misconceptions, and reduce stigma.

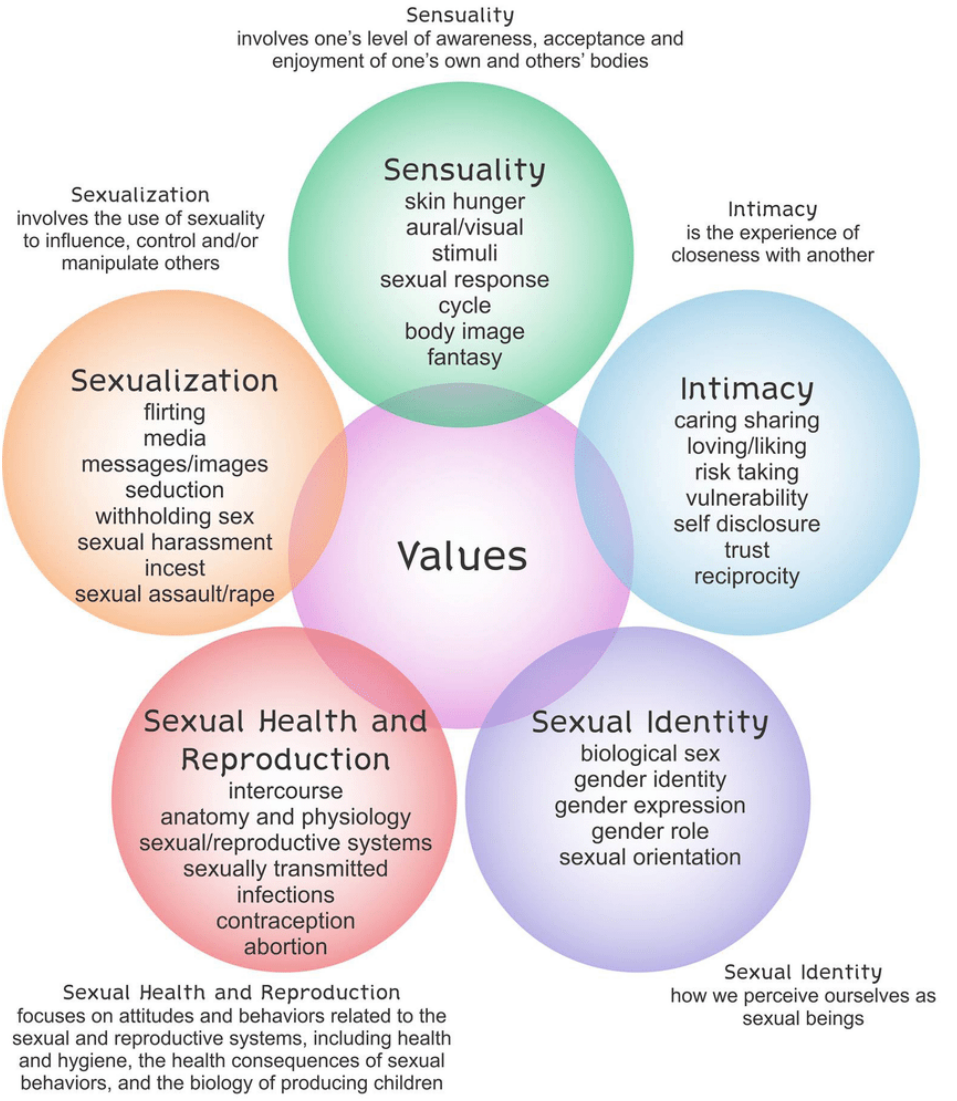
If you don’t know an answer or feel unsure, let students know you will find accurate information and follow up. This builds trust and shows your commitment to providing the best resources.

5. Support Students' Needs

Understand that students may have different levels of comfort when discussing sensitive topics. Use a trauma-informed approach, particularly when addressing potentially distressing issues. Pay attention to students’ needs and offer support through one-on-one discussions, access to counselling services, or additional resources. Make sure students know they have a safe space to seek help if they feel overwhelmed or need further guidance.

The Circles of Sexuality

For nursing and social work educators, the Circles of Sexuality offers a valuable framework to help students approach SRHR in a more holistic and meaningful way. Developed by Dennis Dailey in the 1980s, the Circles of Sexuality breaks down the complex topic of sexuality into five interconnected areas. This model encourages students to see that sex and sexuality are not limited to physical acts or reproductive health—they are deeply connected to emotional, cultural, and social dimensions of a person's identity and experience.



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[7] Image provided by the Unitarian Universalist Association and the United Church of Christ, adapted from Life Planning Education, 1995, Advocates for Youth, based on the original work of Dennis M. Dailey, professor emeritus, University of Kansas. Source: George W. Turner, "The Circles of Sexuality," in *Rooted in Strengths: Celebrating the Strengths Perspective in Social Work*, edited by Amy N. Mendenhall and Michelle Mohr Carney, University of Kansas Libraries, 2020, p. 314.

Circle of Sexuality	Examples of how Educators Can Incorporate It into Teaching
Values Encompasses the messages individuals receive about sexuality and how these shape their beliefs, behaviours, and comfort levels.	• Facilitate r**eflective exercises** on how culture, religion, media, and personal experiences shape students' values • Encourage **critical analysis** of internalised shame, guilt, or bias related to sexuality • Create **safe spaces** for students to reconsider, affirm, or revise personal and professional beliefs
Sensuality Appreciation and enjoyment of one's own body and others', including touch, body image, and the ability to experience pleasure.	• Normalise conversations about **pleasure and personal** satisfaction as part of holistic care • Discuss how **body image and self-esteem** influence overall wellbeing
Intimacy Emotional closeness, trust, and vulnerability, focusing on relationships and how people connect with others emotionally.	• Teach students to use **trauma-informed practices** to address emotional and interpersonal issues sensitively, particularly for people with histories of hardship • Encourage students to **reflect on their own views of intimacy** and how this might shape their interactions in counselling, caregiving, or educational roles.
Sexual Identity How individuals identify themselves in terms of gender, sexual orientation, and their sense of self in relation to others.	• Discuss case **scenarios involving diverse gender identities or sexual orientations** in healthcare, family, or community settings. • Bring in **people with lived experience** to share personal experiences**.**
Sexual Health and Reproduction Focuses on the physical aspects of sexuality, including sexual health, contraception, STI prevention, and reproductive rights.	• Simulate conversations to prepare students for **discussing sensitive topics** such as sexual practices and reproductive concerns. • **Interprofessional learning** to address SRHR concerns of service users • Guide students in identifying and evaluating **local and online SRHR resources** for effective referrals.
Sexualization How sexuality is portrayed and influenced by media, cultural norms, and societal expectations	• **Analyse media portrayals** of identity, relationships, or stigma and their impact on societal norms and on people's lived experiences • Include discussions on **sexual and gender identities, power dynamics, and consent in care and interprofessional interactions**

Example: Promoting an Inclusive and Sex-Positive Discussion in Interprofessional Learning

Interprofessional learning activities such as planning care for someone transitioning from an acute health setting to rehabilitation, provide a valuable opportunity for educators to include discussions about SRHR. These discussions help students see SRHR as an essential part of a person's overall health and identity. They also normalise the discussions of sex, reduce stigma around the topic, and encourage students to think about SRHR in their everyday practice.

Case Study

Present an interprofessional case study of a person recovering from a stroke who is transitioning from a hospital to community rehabilitation. Include a discussion about their needs related to sexual health, intimacy, and relationships, focusing on changes to their sexual identity, physical functioning, and emotional connections. To enrich the learning experience, consider incorporating intersectionality into the person's background, including factors such as age, gender, race, and cultural influences.

Activities

1. ***Use the Circles of Sexuality framework to examine the individual's needs and experiences***
   - Reflect on changes in sensory experiences and physical pleasure post-stroke. (*Sensuality*)
   - Highlight the emotional dimensions of trust, love, and connection in developing meaningful relationships during recovery. (*Intimacy*)
   - Discuss how the individual's self-perception, sexual orientation, or gender expression may shift following the stroke. (*Sexual Identity*)
   - Address concerns such as sexual dysfunction, fertility challenges, safer sex practices, and how these intersect with rehabilitation. (*Sexual Health and Reproduction*)
   - Explore societal stigma, media portrayals of sexuality for people with disabilities, and their impact on self-esteem and relationships. (*Sexualisation*)
2. ***Interprofessional Discussions***
   - Discuss the roles of various professions in addressing the person's SRHR concerns.
   - Identify specific responsibilities and challenges faced by each discipline.
   - Highlight opportunities for collaboration and strategies to overcome barriers such as stigma or lack of training in SRHR.
3. ***Role-Playing***
   - Assess sensitive SRHR topics with people in a way that is inclusive and respectful.
   - Handover with interprofessional team members and community settings to address SRHR concerns and ensure holistic care, with the person's consent.
4. ***Encourage Reflection and Promote a Strengths-Based Approach***
   - Guide students to reflect on their discussions, focusing on whether the approach was risk-based or strengths-based.
   - Emphasise a sex-positive framework that highlights empowerment, consent, emotional well-being, and the importance of pleasure.
   - Encourage students to consider how these perspectives can shape their professional practice and foster inclusive, affirming care.

Trauma-informed Pedagogy When Teaching Sensitive Topics

In nursing and social work, responding to pain, trauma, and loss is an essential part of practice. Professionals must be prepared to face these challenges with competence, compassion, and self-awareness. Preparing students for this reality is a fundamental responsibility of professional education.

At the same time, many nursing and social work students are drawn to helping professions because of their own lived experience[8]. Research highlights high rates of trauma exposure among students, with many facing additional stress during field placements.[9] The pandemic has exacerbated these pressures, contributing to heightened fear, anxiety, and burnout.[10]

Trauma-informed teaching is increasingly recognised as vital in nursing and social work education, especially when addressing sensitive topics like SRHR. These discussions can evoke strong emotions as they often touch on deeply personal issues such as identity, values, beliefs, power, and control. For some, they may trigger past trauma, such as experiences of sexual violence or pregnancy loss, or stir feelings of shame and discomfort due to societal stigma.

Trauma-informed teaching prioritises safety, trust, empowerment, collaboration, and choice to create a supportive learning environment. By adopting these principles, educators can help students navigate difficult topics, minimise the risk of retraumatisation, and build resilience for their professional futures.

[8] Parker, Jonathan, and Sue Merrylees. "Why become a professional? Experiences of care-giving and the decision to enter social work or nursing education." Learning in Health and Social Care 1.2 (2002): 105-114.
[9] Didham, Steve, et al. "Trauma exposure and the social work practicum." Journal of Teaching in Social Work 31.5 (2011): 523-537.
[10] Fowler, Karen, and Melissa Wholeben. "COVID-19: Outcomes for trauma-impacted nurses and nursing students." Nurse education today 93 (2020): 104525.

Core Principles	Examples of how Educators Can Incorporate It into Teaching
Ensure a Safe Learning Environment Ensure students feel comfortable and safe when discussing sensitive topics like sexual health, violence, or trauma.	• Provide content warnings at the start of lessons about sensitive topics • Provide information counselling services and resources for emotional support • Setting ground rules for discussions • Check-in with students periodically
Maintain Trust and Transparency Be open, honest, and clear with students, particularly those with trauma experiences, to create a safe and reliable learning environment.	• Clearly explain the course objectives, how students will be graded, and how the material connects to real-life practice. • Set clear expectations about participation and let students know they can take breaks or step away from certain discussions if needed, and explain how this might impact their grade. • Acknowledge your own limitations and apologise when making a mistake.
Foster Peer Support Encourage a sense of community and reduce isolation by promoting peer interactions in a safe space.	• Set up group discussions or projects where students can share ideas and perspectives. • Set clear guidelines that protect privacy and prevent students from sharing personal information unless they feel safe.
Promote Collaboration and Mutuality Involve students in decision-making, fostering mutual learning and active participation in SRHR discussions.	• Allow students to suggest and choose topics for class discussions related to SRHR • Facilitate open discussions on challenging SRHR issues, ensuring all voices are heard and respected.
Empower Student Autonomy Give students the opportunity to control their learning process, especially those who may feel a lack of agency due to past trauma.	• Provide students with options for assessment topics. • Co-design assessment topics and rubrics with students. • Encourage students to share their experiences or thoughts on SRHR topics, validating their voices and acknowledging their expertise.
Acknowledge Cultural, Historical, and Gender Issues Recognise and respect students' diverse cultural, gender, and historical backgrounds to foster inclusivity and understanding of SRHR issues	• Include case studies and readings that highlight diverse experiences. • Use inclusive language such as "partner" instead of assuming heterosexuality, and make sure students know it's okay to express their own identity. • During discussions, be aware of and address stereotypes or biases related to gender, culture, or identity.

Teaching Reflection: Applying a Trauma-Informed Approach to Teaching Sexual Violence in the Nursing Program

(Reflection: Dr Horas Wong)

I teach a nursing unit on social justice and human rights in healthcare, which includes sexual violence as one of the most sensitive topics we cover. Early in my teaching career, I led a session on the impacts of sexual violence on health and healthcare without using trauma-informed teaching practices. I had not prepared students for the sensitive nature of the material. During the session, I noticed a student sitting still and visibly upset, with tears streaming down her face. Concerned, I gently asked her to step outside the room so I could check in with her. She explained that the content had brought back painful memories of her own experience with sexual violence.

This moment deeply affected me. It showed me that my teaching practices were not enough to protect students' emotional well-being during discussions of sensitive topics. This realisation led me to adopt a trauma-informed approach to create a more supportive and inclusive environment for all students.

Adapting My Practice

1. **Preparing thoughtfully.** I introduced a pre-unit survey to inform students that the unit would cover sensitive topics and provide an opportunity to share concerns anonymously. For instance, one student disclosed prior trauma through the survey, which allowed me to send regular personalised check-ins to support them throughout the semester. I also incorporated trigger warnings for all sensitive topics, giving students advance notice to prepare for challenging content.
2. **Creating a safe space.** I established ground rules prioritising respect, confidentiality, and empathy at the beginning of the semester and reiterated them before sessions on sensitive topics. I reminded students that they could always take a break or step out if needed, ensuring they felt empowered to manage their engagement with the material.
3. **Giving student choice.** Students were given flexibility in how they engaged, including the option to choose assignment topics they felt comfortable exploring. For instance, in an assignment focused on the health impacts of violence, students were able to select a marginalised population they were most interested in researching.
4. **Reframing the material.** I revised my teaching materials to ensure the framing was inclusive and strength-based. For example, rather than focusing on graphic details, I highlighted survivor recovery stories and healthcare interventions that empower individuals.
5. **Checking in with students.** I followed up with students who appeared withdrawn or flagged vulnerabilities. I sent supportive check-in messages reminding students of available wellbeing resources throughout the semester.
6. **Allow time to process.** After receiving feedback from a student who felt overwhelmed by a previous session, I introduced mid-session pauses during sensitive discussions.

Reflection

These trauma-informed strategies significantly improved student engagement and emotional safety. In the unit evaluation, one student noted, "The way sensitive topics were handled made me feel seen and supported, even when the material was challenging." This affirmed the value of creating a thoughtful, supportive learning environment. While the initial incident was difficult, it became the catalyst for meaningful changes in my teaching practice. I am now committed to ensuring that all students feel safe, respected, and empowered to engage with complex issues in a supportive classroom.

Part 3: Effective Communication in SRHR within the Classroom and Professional Settings

How to Handle Different Opinions in Classroom

Research suggests that educators often avoid discussing controversial or sensitive topics due to fears of unintentionally offending students or losing control of the classroom[11]. However, avoiding these topics can limit students' exposure to important issues and hinder the development of critical thinking and empathy.

In any classroom, especially when addressing sensitive topics like SRHR, students are bound to hold differing opinions. These differences often stem from personal experiences, cultural backgrounds, or deeply held values. As an educator, it is essential to create an environment where diverse perspectives can be expressed respectfully, ensuring that all students feel safe, supported, and included.

The principles of trauma-informed pedagogy, which we discussed earlier, play a crucial role in achieving this. These principles emphasise the importance of fostering a safe and inclusive environment, establishing clear ground rules, and using inclusive language—all of which are particularly important when navigating discussions on sensitive topics.

To effectively manage differing opinions in the classroom, consider the following strategies:

Strategy	What you could do	What you could say
Setting the Right Tone for Respectful Dialogue Begin by fostering an environment where students feel comfortable sharing differing opinions and encourage respectful engagement with one another.	• Set ground rules for discussions. • Provide clear expectations for respectful behaviour and dialogue. • Engage students in contributing to the rules and expectations.	*"It's absolutely fine to have different opinions—we're not here to agree on everything, but we are here to listen and understand. Respecting each other's views is key, so let's keep our discussion thoughtful and kind so we can all learn from each other."*

[11] Wilkerson, William R. "Review of teaching controversial issues, the case for critical thinking and moral commitment in the classroom." Journal of Political Science Education 13.4 (2017): 483-485.

Normalising Discomfort Acknowledges that some topics may be uncomfortable but emphasise the value of learning from these discussions.	• Reassure students that discomfort is a natural part of discussing challenging topics. • Create opportunities for debriefing after difficult discussions.	*"It's completely okay to feel a bit uncomfortable—these are topics we may not be used to discussing. Let's take a moment to sit with those feelings and process them together."*
Modelling Open-Mindedness Shows respect for diverse perspectives and encourages students to think critically and reflect on their own views.	• Encourage students to voice their concerns about the content • Be transparent about your own perspective and the experiences that have shaped it, when appropriate. • Acknowledge when you don't have all the answers and demonstrate a willingness to learn alongside your students.	*"This is a complex topic, and I want to acknowledge that my perspective is shaped by my [e.g., professional experiences or cultural background]. I'd really like to hear your thoughts because your experiences might bring a completely different viewpoint."*
Encouraging Critical Thinking Foster a safe and comfortable space where students can engage in personal and reflective conversations, encouraging them to critically examine their views and the factors that shape them, leading to deeper understanding and growth.	• Ask open-ended, reflective questions to help students explore personal biases and assumptions. • Provide guiding frameworks (e.g., Gibbs Reflective Framework, Circles of Sexuality) to structure thinking • Allow time for thoughtful consideration.	*"Let's take a moment to reflect, what aspects of your background or experiences might have influenced how you see this issue? It's always helpful to consider what's shaped our perspectives."*

Acknowledging and Validating Experiences Acknowledge and validate students' feelings, ensure they feel heard and understood.	• **Actively listen to students' contributions.** • **Use reflective statements to validate feelings and experiences.** • **Encourage empathy in discussions.** • **Use small group discussions for more personal engagement.** • **Monitor group dynamics for inclusivity.**	*"I realise that some topics can feel really personal and bring up strong emotions. That's okay. Let's make sure everyone feels heard and respected as we talk through these issues."*
Addressing Harmful Opinions or Behaviours Ensures the classroom remains a safe and respectful space for all students by addressing inappropriate comments.	• Intervene promptly when harmful comments are made. • Reiterate ground rules to reinforce a respectful environment. • Provide follow-up support for affected students.	*"I understand everyone's right to an opinion, but we also need to ensure this remains a safe space for all. Let's approach each other's views with kindness and focus on constructive dialogue."*
Redirecting Focus to Common Goals Reframes conversations to emphasise shared learning goals and collective growth in professional development.	• Reframe discussions to align with learning objectives. • Highlight shared goals for inclusivity and compassionate care.	*"Even if we don't all agree, our goal is to provide the best care as future professionals. Let's focus on how we can best support others in a respectful and professional manner"*
Promoting Self-Care Encourages students to prioritise their wellbeing and provides opportunities for debriefing when necessary.	• Share self-care and support resources, such as counselling services or peer support groups. • Schedule regular breaks during intense discussions to allow students time to process.	*"Don't forget to take care of yourselves. If today's discussion feels overwhelming, it's okay to step away, take a break, or talk to someone you trust."*

Useful Communication Skills for Discussing SRHR in Professional Settings

There is strong evidence showing that nurses and social workers often avoid discussing SRHR issues with service users. In the SWAN-SR pilot project, students also observed that site mentors sometimes neglected SRHR needs during placements. This highlights the importance of equipping professionals with the skills and confidence to engage in these conversations effectively, ultimately leading to better and more equitable outcomes for all..

Common Challenges in Discussing SRHR in Professional Settings

- Personal discomfort or embarrassment.
- Lack of training or experience.
- Fear of offending individuals or being judged, particularly when caring for people of diverse genders, ages, ethnicities, cultures, and sexual orientations.
- Time constraints.
- Lack of organisational support.

Getting Comfortable

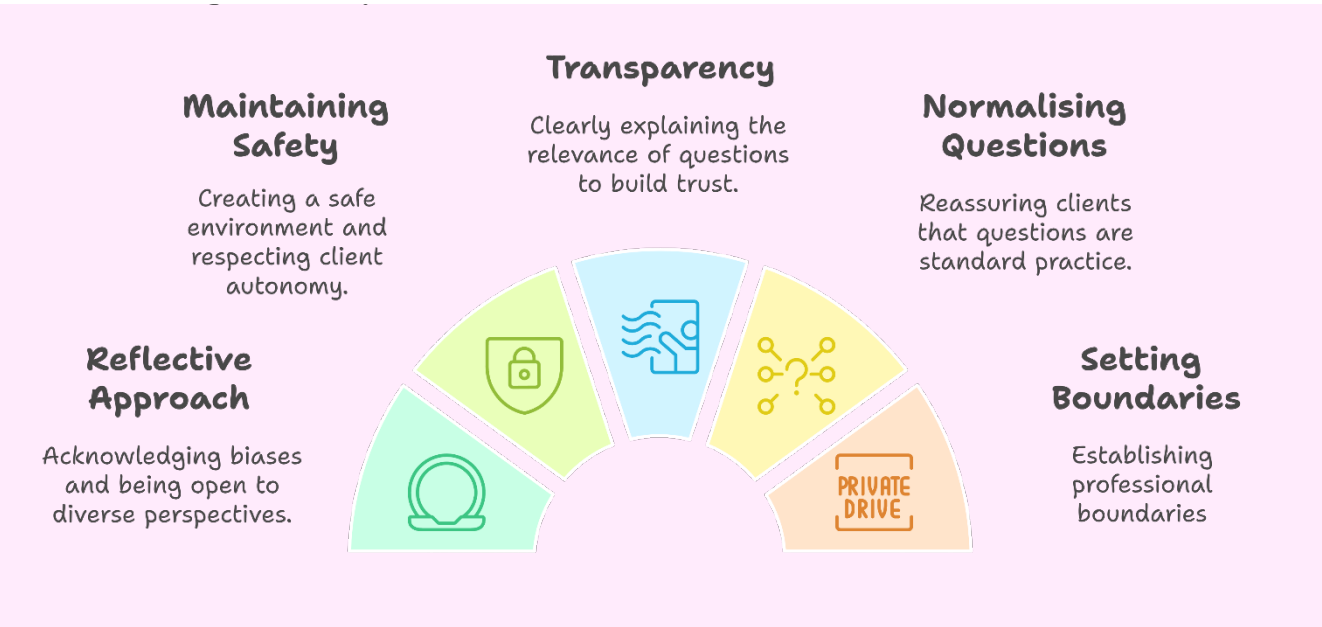
Talking about SRHR may feel awkward at first, but with practice, it can become a natural part of the professional routine. Research highlights two common strategies to facilitate discussions on sensitive topics:

1. Build gradually: Begin with general, non-threatening questions and move toward more specific topics as trust is established. For example, start with, *"How are you feeling overall? Are there any health concerns you'd like to discuss today*?" Once trust is established, transition to more specific concerns related to SRHR.

2. Normalise the conversation: Frame questions as a routine part of care, reassuring individuals that their experiences and concerns are common and valid. For example, say, "*I ask this question to everyone because sexual and reproductive health is an important part of overall wellbeing.*" This helps people feel at ease.

Although there is no universal approach, the key is to prioritise a person-centred focus, tailoring the conversation to the individual's unique needs and allowing them to guide the discussion. We highlight some key principles of effective communication in SRHR on the next page.

Key Principles of Effective Communication in SRHR



Principle	Details
Reflective Approach	• Acknowledge your own biases and emotions to ensure a non-judgemental approach. • Be open to diverse perspectives that may differ from your own beliefs.
Maintaining Safety	• Create a private and safe environment for the discussion. • Allow the person to set the pace; adapt or revisit the topic if needed. • Be sensitive to gender and cultural preferences. • Involve a chaperone if necessary.
Transparency	• Clearly explain why specific questions are being asked and how they relate to care. For example: "May I ask you a few questions about your sexual health? These are important for your overall health."
Normalising Questions	• Reassure the person by framing questions as standard practice. For example: "We ask this question to all our clients because many people have concerns about sex and reproduction. Is there anything you'd like to discuss?"
Setting Boundaries	• Explain confidentiality and legal obligations, such as mandatory reporting. For example: "Our conversation is private, but I am legally required to report any safety concerns about you, others, or a child to the authorities." • Respond professionally to inappropriate comments or behaviors while safeguarding personal boundaries.

Using the EX-PLISSIT Model

The Ex-PLISSIT (Extended-PLISSIT) model[12] is a practical framework for addressing SRHR needs and is widely used in professional settings. It focuses on a person-centred and flexible approach, ensuring permission-giving and reflection are integral at every stage. This model is suitable for nurses and social workers, including those without specialised SRHR training.

Key Features of the Ex-PLISSIT Model

Permission-Giving. Practitioners create a safe, inclusive environment by normalising discussions about sexuality and using non-judgmental language. They encourage individuals to raise or revisit concerns at any time, approaching these topics directly yet sensitively.

Reflection and Review. Practitioners regularly evaluate their interventions, reflect on outcomes, and adjust their approach based on the individual's needs and feedback. This ensures care is client-centred and continually improving.

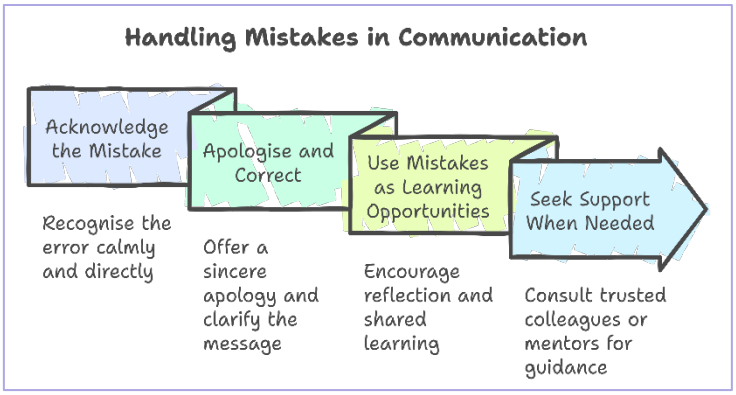
Flexibility. The model adapts to each person's unique needs and circumstances. Practitioners can adjust the stages, address concerns as they arise, or refer to specialists when needed, without following a strict sequence.

Stage (non-linear)	Description
Permission (P)	• Practitioners actively encourage individuals to talk about their sexual wellbeing. • Normalises discussions around sexuality by reassuring individuals that it is okay to share their concerns.
Limited Information (LI)	• Provides individuals with relevant, easy-to-understand information about sexual health tailored to their situation. • May include basic facts about the impact of medical conditions, treatments, or general sexual health topics.
Specific Suggestions (SS)	• Offers personalised advice to address specific concerns raised by the individual. • Often involves gathering more detailed information, such as taking a sexual history, to provide targeted solutions.
Intensive Therapy (IT)	• Refers individuals to specialists for more complex interventions, such as psychosexual therapy, relationship counselling, or medical advice in areas like urology or gynaecology. Ensures individuals receive care from qualified professionals when needed.

[12] Taylor, Bridget, and Sally Davis. "The extended PLISSIT model for addressing the sexual wellbeing of individuals with an acquired disability or chronic illness." Sexuality and Disability 25 (2007): 135-139.

What If I Make a Mistake?

Mistakes are a natural part of navigating complex and sensitive SRHR conversations. Whether it's using incorrect terminology, mispronouncing a name or pronoun, or unintentionally addressing a topic insensitively, what matters most is how you respond.



Avoiding these discussions out of fear of making mistakes can limit meaningful dialogue, but addressing errors constructively can turn them into valuable learning opportunities for everyone.

Acknowledge the mistake

- If you realise you've made an error, address it calmly and directly. This demonstrates accountability and normalises mistakes as part of learning and growth.

Apologise and correct

- Offer a brief, sincere apology and clarify your intended message. Keep it short to stay focused on the conversation. For example, you can say, "*Thank you for pointing that out. I'm sorry for the mistake. What I meant was…*"

- Avoid ***over-apologising*** or reacting emotionally with statements like, "*I'm so sorry! I can't believe I made that mistake. I feel terrible, and I should have known better*." This could shift the focus to your feelings and can make the other person uncomfortable or pressured to downplay the mistake, even if it affected them.

- In a classroom setting, if you're concerned about how the mistake may have affected an individual student, consider speaking with them privately after class.

Use mistakes as learning opportunities

- View mistakes as opportunities for reflection and shared learning and foster a culture of growth.

Seek support when needed

- If you're unsure how to navigate a sensitive topic or address a mistake, don't hesitate to seek guidance from trusted colleagues, mentors, or professional resources. Collaboration and reflection can help you approach similar situations more effectively in the future.

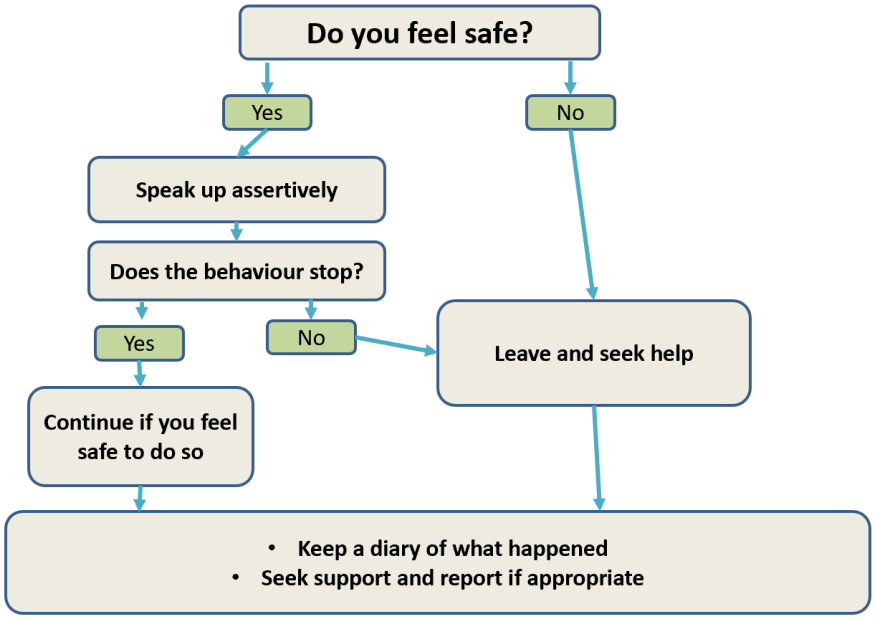
Protecting Yourself from Inappropriate Comments or Behaviours in Professional Settings

Talking about sensitive topics like SRHR in professional settings can sometimes lead to inappropriate comments or requests. Nurses and social workers, in particular, are more at risk of workplace harassment, so it's important to know how to handle these situations while staying safe and professional.

If this happens to you:

1. Stay calm: Take a moment to keep your composure.
2. Restating the boundary: Politely but firmly restate what is appropriate in a professional setting.
3. Take action if needed: If you feel unsafe or the behaviour doesn't stop, leave the situation, get support from your supervisor, and follow your workplace's policies.

The decision-making flowchart below can guide your response in these situations.



[13]

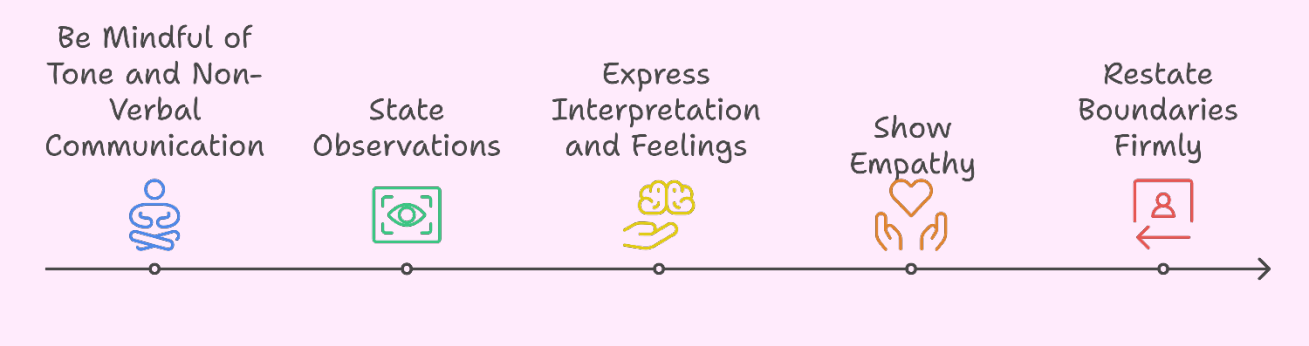
Support is Available

Remember, no matter how you choose to respond—or if you decide not to act in the moment—support is always available to help you navigate these challenges. Don't hesitate to reach out to a trusted supervisor, educator, peer, or support service. Follow your workplace guidelines and policies to ensure your safety and wellbeing.

[13] Adapted from The Royal Australian College of General Practitioners, Responding to Sexual Harassment by Patients: A Brief Guide for General Practices, 2022, p.3.

Speaking Assertively

Assertive communication is crucial for setting boundaries, expressing yourself clearly, and maintaining professionalism, especially when addressing inappropriate comments or requests. Being assertive means communicating respectfully, confidently, and directly while considering both your needs and the individual's wellbeing.



Key Principle	Explanation	What You Could Say
Be Mindful of Tone and Non-Verbal Communication	Use a calm tone, maintain eye contact, and adopt an open but firm posture to reinforce your message.	*"I understand this topic can bring up strong feelings, It's okay to feel uncomfortable. This is part of learning and growing as a professional.*
State Observations	Begin by calmly describing the behaviour or situation. Avoid vague or apologetic statements. Use "I" statements to take ownership of your observations.	*"I noticed that your comment just now was inappropriate and unrelated to our discussion."*
Express Interpretation and Feelings	Clearly explain the issue and its impact on you or the conversation.	*"That comment makes me uncomfortable and is not acceptable in this context."*
Show Empathy	If appropriate, acknowledge the individual's perspective while holding firm to your boundaries.	*"I understand this might be a sensitive topic, and I am here to listen, but we need to ensure our discussion remains respectful."*
Restate Boundaries Firmly	Reiterate what is appropriate and redirect the focus of the conversation.	*"I want to remind you that I'm here to provide professional support. Let's refocus our conversation on your health and care needs*

Case Study: Practicing Assertive Communication

Objectives

This activity aims to help students develop skills in assertive communication, particularly when addressing sensitive or inappropriate comments in professional conversations about relationships and sexual health.

Case study scenario

Jessie is meeting with Chris to discuss concerns about relationships and sexual health following a significant medical treatment. During the conversation, Jessie asks a routine question:

Jessie: "*Are you experiencing any difficulties with intimacy or sexual function*?"

Chris: "*Well, maybe if you spent the night with me, I wouldn't have any problems anymore*."

Activity

Ask students to discuss whether Chris's comment is appropriate.
Have them reflect on how they would respond to the comment in a professional and respectful manner.
Pair students to practice responding to the scenario. Highlight strategies for assertive communication, such as:

- Using clear language to set boundaries (e.g., *"That comment is inappropriate for this discussion."*).
- Steering the conversation back to the professional topic (e.g., *"Let's focus on your concerns about intimacy and health."*).

Explore support options Jessie can use if she needs help after this incident.

Broader discussion

Educators can expand the discussion to consider institutional and social factors that influence professional interactions.

- Discuss organisational changes that can support professionals in handling inappropriate behaviours, such as implementing clear policies, training programs, and support systems.
- Explore how sexualisation and societal norms may shape such interactions, using the Circles of Sexuality framework as a reference.

Part 4: Sample Case Studies on Inclusive and Culturally Responsive SRHR Care for Classroom Discussion

Case Study 1: Addressing SRHR in Aged Care for Residents with Dementia

Learning Outcomes

By the end of this activity, students will:

- Identify the specific SRHR needs of older adults living with dementia in aged care settings.
- Understand the impact of dementia on sexuality, relationships, and intimacy, and how these issues affect residents and their families.
- Explore strategies for providing person-centred, respectful care that upholds dignity, autonomy, and sexual rights in aged care.

Pre-Work

To prepare for this activity, review the following resources:

1. Lucas, A. (2022, Jan 22). *Intimacy, Sexuality, and Caregiving for Those with Dementia | Duke Health* [Video]. YouTube. https://www.youtube.com/watch?v=rJMKRuGau08
2. La Trobe University. (2015). *Sexuality and people in residential aged care.* Australian Research Centre in Sex, Health and Society. https://www.latrobe.edu.au/__data/assets/pdf_file/0009/746712/Sexuality-and-people-in-residential-aged-care.pdf

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Case Study: Alex

Alex, a 68-year-old man with early-stage dementia, has recently moved into your residential aged care facility after living independently for many years. Before his dementia diagnosis, Alex had a long-term, fulfilling relationship with his wife, Sarah. They shared interests, a strong emotional bond, and a healthy sexual relationship. However, since the onset of dementia, Alex's memory and cognitive abilities have declined, leading to significant changes in his behaviour, particularly in his relationship with Sarah.

Recently, Alex has started to show interest in another resident living with dementia, Margaret. He frequently forgets Sarah's name and sometimes becomes confused about who she is. This has caused considerable distress for Sarah, who feels hurt and isolated by these changes in Alex's behaviour. The facility staff have also observed Alex making inappropriate advances towards Margaret, leaving them uncertain about how to respond appropriately.

Sarah is deeply concerned about Alex's well-being and feels that the staff are not adequately addressing his needs related to sexuality and intimacy. She struggles with how to support Alex in maintaining a sense of dignity and self-worth in this new phase of life. Sarah has questions about how to manage Alex's emerging emotional and intimacy needs, while also understanding how dementia is affecting his behaviour.

Discussion Questions

1. What personal and organisational factors make it difficult to address the sexual and reproductive needs of older adults in aged care facilities?
2. How does dementia impact a person's sexuality and relationships?
3. How can staff and family balance respecting Alex's right to form new relationships with the need to assess any potential risks associated with new sexual behaviours?
4. Discuss the challenges of obtaining consent from individuals with dementia regarding intimate relationships and sexual behaviour, such as Margaret and Alex?
5. How can social workers and nurses support Sarah through the emotional turmoil of dealing with Alex's changing behaviour, including feelings of sadness, loss, and frustration?
6. How can staff training be improved to address issues related to sexuality, consent, and dementia care?
7. What steps can the facility take to ensure privacy and dignity for residents while supporting their emotional and physical intimacy needs?

Discussion points for Educators

Question	Discussion Points	Useful Points
1. Personal and organisational factors	• Explore how staff attitudes, biases, and lack of training contribute to challenges in addressing sexuality. • Examine organisational barriers such as policies, resources, and awareness. • Discuss social taboos and their impact on addressing residents' needs.	• **Unconscious Bias**: Identifying and addressing implicit attitudes in healthcare. • **Social Model of Disability**: Recognises how environmental factors limit sexual autonomy. • **Intersectionality**: Overlapping identities (age, gender, disability) complicate care (e.g., older male resident with dementia).
2. Dementia and Sexuality	• Discuss how dementia can cause changes in sexual behaviour and relationships, such as forgetting a partner or seeking new relationships. • Explore how changes in the brain affect sexual feelings and inhibitions.	• **Cognitive and Emotional Changes in Dementia:** Understanding the impacts of dementia on sexual behaviour and relationships. • **Sexual Rights in Dementia Care**: Respecting the rights to intimacy of individuals with dementia.
3. Balancing Relationships and Risks	• Discuss ethical challenges of respecting Alex's right to form relationships (e.g., right to affection with Margaret) vs. ensuring safety (e.g., preventing exploitation). • Assess potential risks (e.g., Alex's confusion leading to inappropriate actions)**.**	• **Ethical Decision-Making in Care:** Supporting relationships while safeguarding vulnerable individuals (e.g., setting clear boundaries, monitoring behaviours).

4. Consent and Dementia	• Explore how cognitive impairments affect the ability to provide consent • Discuss the role of family and staff in supporting consent and decision-making in these sensitive situations. (e.g., Sarah being informed about Alex's behaviour).	• **Capacity to Consent:** Ensuring that consent is informed and respected despite cognitive decline. • **Sexuality and Dementia Care:** Ethical considerations in supporting intimacy and consent**.** (e.g., staff intervening in inappropriate behaviours). • **Continuous Communication and Assessment:** Ongoing, proactive communication to monitor and assess Alex's capacity for consent.
5. Supporting Family (Sarah)	• Discuss the emotional support strategies for family members facing grief and loss. • Discuss coping strategies (e.g., providing counselling or peer support).	• **Grief and Loss in Dementia Care:** Understanding the emotional challenges of family members. (e.g., loss of the "old" relationship dynamic, find ways to make sense with the "new" dynamics). • **Empathy and Emotional Support:** Providing support and referral.
6. Privacy and Dignity in Intimacy	• Explore strategies for creating private spaces and facilitating intimacy while respecting dignity. • Discuss how staff can support residents' emotional needs while ensuring their privacy.	• **Person-Centred Practice**: Creating an environment that respects residents' emotional and physical intimacy needs, upholding dignity and supporting sexual autonomy (e.g., providing private spaces, knocking before entering rooms, and regularly updating family members like Sarah about Alex's behaviour and consent assessments). • **Providing Alternatives**: Offering safe, appropriate outlets for sexual expression, such as self-pleasure, when sexual activity with others is not feasible.

Case Study 2: Inclusive Language and LGBTIQ+ People in Healthcare

Learning Outcomes

By the end of this activity, students will:

- Analyse the significance of inclusive language in interactions with LGBTIQ+ service users to ensure respectful communication.
- Evaluate and identify heteronormative assumptions within professional settings that impact service provision.
- Discuss strategies for providing culturally responsive and client-centred care tailored to the needs of LGBTIQ+ individuals.

Pre-Work

To prepare for this activity, review the following resources:

1. Nursing and NCLEX Mastery. (2022, June 29). *LGBTIQ+ in healthcare: Using inclusive language when taking patient history* [Video]. YouTube. https://youtu.be/zx7Y1dnb2Ao
2. Cooper, K. (2023, March 31). *The importance of using inclusive language in medical practice.* BMJ Sexual & Reproductive Health Blog. https://blogs.bmj.com/bmjsrh/2023/03/31/the-importance-of-using-inclusive-language-in-medical-practice/

Case Study: Taylor

You are a recent graduate employed in a hospital's Emergency Department. You are asked to assist Taylor, a 25-year-old in their third trimester of pregnancy, who was admitted after falling at work. Taylor reports abdominal pain, and the healthcare team is monitoring for possible preterm labour.

Taylor identifies as non-binary and uses they/them pronouns. Taylor is in a relationship with their partner, Jordan, who identifies as a woman. Jordan is Taylor's primary support person. Taylor has expressed pride in their identity but also shared past experiences of marginalisation in healthcare settings, which have made them apprehensive about seeking care.

Taylor is visibly distressed and frustrated, hesitating to engage with staff. During triage, Taylor was asked about their "husband," and a staff member referred to them as "Mrs." without confirming their preferences. Later, when Taylor was called to the examination room, their incorrect pronouns were used, despite no pronouns being indicated on their record.

During your conversation, Taylor shares that they feel unsafe due to the assumptions being made about their pronouns and relationship status. They express frustration over being misgendered and mention that this is not the first time they've felt marginalised in a healthcare setting. Taylor also explains that

their partner, Jordan, is their primary support person, but they cannot be reached because Taylor's phone was damaged in the fall.

The Emergency Department is busy, and staff are rushing to manage multiple patients, leaving Taylor feeling ignored and unsupported. Your task is to engage Taylor, understand their concerns, and advocate for their needs while ensuring they receive appropriate care.

Discussion Questions

1. How does this case challenge or expand your understanding of diverse family structures in professional settings? How might unconscious biases impact the care Taylor receives?
2. How could the initial intake process be improved to create a more inclusive and affirming experience for Taylor?
3. Which theories or frameworks, such as trauma-informed care, person-centred care, or cultural safety, could guide your approach to supporting Taylor?
4. How could institutional policies and training programs be revised to ensure inclusivity and affirming care for diverse service users like Taylor?
5. Role-play with your peers how you would approach Taylor and facilitate contact with their partner, Jordan.

Discussion points for Educators

Question	Discussion Points	Useful Points
1. Impact of unconscious biases	• Identify how biases, such as assumptions about pronouns or relationship roles, influence care delivery. • Discuss strategies for recognising and mitigating implicit biases in healthcare interactions. • Reflect on how biases affect communication, trust, and health outcomes.	• **Unconscious Bias:** Awareness of how implicit attitudes shape behaviour. • **Intersectionality**: Explores how overlapping identities (e.g., gender and sexual identities, parental identity) amplify challenges.
2. Improving the intake process	• Discuss how the use of inclusive language during intake fosters trust and respect. • Reflect on the importance of open-ended questions and neutral terms (e.g., "partner" instead of "husband/wife"). • Explore how inclusive intake forms can capture pronouns, gender identity, and relationship preferences without assumptions.	• **Inclusive Language:** Using neutral, affirming terms to ensure respectful communication.
4. Applying frameworks	• Examine how trauma-informed care can create a safer environment for marginalised people.	• **Trauma-Informed Care:** Recognising the impact of past marginalisation.

	• Discuss how person-centred care emphasises tailoring interventions to Taylor's unique needs. • Explore how cultural safety enhances respectful and inclusive care.	• **Person-Centred Care**: Ensuring care aligns with the individual's preferences and identity. • **Cultural Safety**: Building environments where individuals feel valued and respected. • **Interprofessional Collaboration:** Leveraging diverse expertise to ensure holistic, person-centred care.
5. Revising policies and training	• Discuss the role of training programs in promoting awareness of inclusive language and diverse identities. • Explore how institutional policies can normalise affirming practices and ensure accountability. • Identify gaps in existing policies that might alienate diverse service users.	• **Inclusivity Policies**: Establishing standards for inclusive care practices. • **Staff Training:** Building competency in addressing diverse identities.
6. Role-playing engagement with Taylor	• Practise how to approach Taylor with empathy, validate their concerns, and rebuild trust. • Explore techniques for facilitating contact with Jordan while respecting Taylor's preferences. • Reflect on the role-play exercise and engage in peer evaluation to identify areas for improvement and growth.	• **Therapeutic Communication**: Using empathy, active listening, and validation. • **Inclusive Language:** Using neutral, affirming terms to ensure respectful communication.

Case Study 3: Addressing Domestic Violence in Acute Settings

Learning Outcomes

By the end of this activity, students will:

- Identify signs of domestic violence and understand their impact on the assessment process.
- Apply strategies for confidential screening when the suspected abuser is present and address barriers to disclosure.
- Discuss skills and considerations when working with interpreters in domestic violence screenings.
- Explore key components of a safety plan, tailored to the individual's needs, while considering ethical challenges and mandatory reporting obligations.

Pre-Work

To prepare for this activity, review the following resources:

1. Hegarty, K. (2018, September 21). Domestic Violence: The Hidden Epidemic Implications for Primary Health Care Nurses - [Video]. YouTube. https://youtu.be/1uyeikIR3sg?si=iIgGb7HEv9iZHhUZ
2. Western Australian Clinical Training Network. (2016, August 5). S*imulation Scenario - Family and Domestic Violence a Middle Eastern Woman's Experience* [Video]. YouTube. https://youtu.be/1uyeikIR3sg?si=iIgGb7HEv9iZHhUZ

Case Study: Maria

You are working in the Emergency Department when Maria, a 32-year-old woman, is brought in with multiple injuries, including bruising on her arms and face. Maria speaks only limited English and is accompanied by her partner, James, who speaks English fluently and insists on staying with her during the assessment, offering to act as her interpreter. Maria appears visibly anxious, avoids eye contact, and seems uncomfortable with James's presence. She repeatedly looks to him for reassurance and is reluctant to speak openly in front of him.

Maria is on a partner visa and is financially and socially dependent on James. When asked about her injuries, Maria provides vague explanations, initially attributing them to accidents but later hesitating before offering any further information.

You suspect that Maria may be a victim of domestic violence due to the nature of her injuries and her reluctance to disclose information when James is present. You must navigate this situation sensitively, ensuring Maria's immediate safety while respecting her autonomy and cultural background.

Discussion Questions

1. What are some common signs of domestic violence, and how should they affect how you conduct the assessment?
2. What are some ways you can screen for intimate partner violence privately when the suspected abuser is present, especially if the victim is afraid to speak up?
3. Why might Maria be hesitant to talk about her injuries or the abuse, and how can you help her feel more comfortable?
4. How can you effectively work with an interpreter in this situation, and what are the potential issues with using a family member as the interpreter?
5. What ethical challenges could come up when assessing intimate partner violence, especially if Maria is afraid of retaliation from James and doesn't want to speak openly?
6. What should be included in a safety plan for Maria, and how can you make sure it meets her needs, considering her dependence on James and reluctance to take action right away?

Discussion points for Educators

Question	Discussion Points	Useful Points
1. Signs of DV	• Identify physical and behavioural signs • Discusses ways to create a safe space to discuss the issue	• Bruising or unexplained injuries on the arms, face, or neck; anxiety or nervousness when discussing certain topics. • **Trauma-Informed Care**: Creating a safe space. Recognising that abuse may cause physical and emotional distress.
2. Screening Strategies	• Discuss strategies for private screening when the suspected abuser is present (e.g., make up an excuse to have a private chat, speak assertively to the suspected abuser, offer Maria the opportunity to speak alone). • How to communicate confidentiality and build trust.	• **Communication Skills**: Using open-ended questions such as, "Is there anyone in your life who makes you feel afraid?" Normalising the question such as, "This is a question I ask every woman"

3. Maria's Hesitation	• Explore why Maria may hesitate to disclose (e.g., fear of retaliation, financial dependency). • How to build trust and reassure Maria.	• **Intersectionality**: Understanding how overlapping social factors (e.g., immigration status, financial dependency) affect Maria's experience.
4. Engaging an Interpreter	• Discuss the importance of involving interpreters. • Explain to the client the role of the interpreter, addressing concerns about cost, gender, and confidentiality. • Highlight key skills such as using neutral language, breaking down long sentences, and debriefing after the session. • Address the challenges of using family as interpreters, such as bias, conflicts of interest, and confidentiality risks.	• **Cultural Safety:** Understanding cultural differences in communication and ensuring the interpreter is sensitive to these differences. • **Confidentiality:** The ethical requirement for interpreters to maintain privacy regarding all information shared during the session. • **Interpreter Ethics:** The interpreter's responsibility to remain neutral and accurate, ensuring the communication is faithful to what both parties express.
5. Ethical Challenges	• Discuss ethical challenges when the victim fears retaliation or is reluctant to speak up. • Balancing autonomy and safety.	• **Ethical Dilemmas**: Balancing patient autonomy with safety. • **Mandatory Reporting**: Legal obligations and confidentiality
6. Safety Plan	• Discuss Key elements of a safety plan (e.g., emergency contacts, shelters, legal support). • Tailoring the plan to Maria's specific needs and situation. • Provide information on support resources in a way that ensures Maria's safety (e.g., Instead of giving Maria a flyer or card, discreetly write down the shelter contact information on paper she can hide or send it via a secure, private message.).	• **Safety Planning**: Identifying emergency contacts and safe spaces (e.g., a friend's house or a shelter). • **Person-Centered Care**: Tailoring support to Maria's unique situation. • **Identify Support Resources**: Collaborating with other professionals (e.g., legal, counselling) to ensure comprehensive support

Case Study 4: Supporting Sexual and Reproductive Health and Rights for Young Indigenous People in Rural Australia

Learning Outcomes

By the end of this activity, students will:

- Identify the sexual health needs of young Indigenous people in rural NSW, including common STIs and the cultural, geographic, and socio-economic factors contributing to their prevalence.
- Explore actions to create culturally safe spaces for discussing SRHR with First Nations peoples, ensuring a stigma-free, non-judgemental, and confidential environment.
- Recognise the influence of family and community on sexual health decisions in Indigenous communities, and explore strategies to support these discussions while respecting cultural values and family dynamics.
- Discuss barriers to accessing SRHR services in rural and remote Indigenous communities, and develop solutions such as mobile clinics, telehealth, and community outreach to increase access and reduce stigma.

Pre-Work

To prepare for this activity, review the following resources:

1. Bell, S., Aggleton, P., Ward, J., & Maher, L. (2017). Sexual agency, risk and vulnerability: A scoping review of young Indigenous Australians' sexual health. *Journal of Youth Studies, 20*(9), 1208–1224. https://doi.org/10.1080/13676261.2017.1317088
2. Young Deadly Free. (2019, July 3). *Working appropriately in Aboriginal sexual health* [Video]. YouTube. https://youtu.be/i3OJyWeib3U?si=3LiIOoQUCKFOl2-g

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Case Study: Jade

You are working in a community health service in rural New South Wales. Today, you meet Jade, a 19-year-old woman from the Wiradjuri community. She lives in a rural area with her extended family. While her community is supportive, healthcare access is limited due to isolation.

Jade has come to the clinic with concerns about her sexual health. She's been sexually active for two years and is in a relationship with Ben, a 21-year-old she's been seeing for six months. Jade has been experiencing discomfort during sex, changes in her period, and unusual vaginal discharge, which she worries could be a sexually transmitted infection.

Though Jade is concerned about her health, she hasn't used contraception consistently. She's discussed family planning with her aunt but feels uncomfortable talking about sexual health. Jade isn't sure how to approach Ben about contraception and safe sex, and finds these conversations difficult.

Jade also worries about the stigma around sexual health in her community. She fears seeking help might lead to judgement, making it harder for her to get support. Additionally, she's anxious that any STI could affect her future reproductive choices.

Jade has been hesitant to visit healthcare services in the past. She feels disconnected from the system, as she believes services may not fully understand her cultural background or unique challenges. Living in a remote area, Jade struggles to access specialised care, especially sexual health services, and finds the healthcare system overwhelming.

Discussion Questions

1. What are some common STIs in Indigenous communities, and what factors contribute to their spread?
2. How can a safe environment be created for First Nations people to discuss their sexual and reproductive health concerns?
3. How do family and community influence sexual health decisions in Indigenous communities, and how can these conversations be supported?
4. What challenges and strengths are faced by First Nations people in rural areas when accessing sexual health services, and how can these be addressed?
5. How can informed decisions about sexual and reproductive health be supported for Indigenous youth while respecting their culture and family values?
6. What can be done to reduce stigma around sexual health in Indigenous communities and support mental health when seeking care?

Discussion points for Educators

Question	Discussion Points	Useful Points
1. Prevalence of STIs in Indigenous Communities	• Discuss common STIs like Chlamydia, gonorrhoea, and syphilis, and their higher prevalence in Indigenous communities. • Explore factors contributing to high STI rates, such as incomplete knowledge about prevention, alcohol consumption, and peer pressures.	• **STI rates**: Young Indigenous Australians aged 15-29 experience higher rates of STIs like Chlamydia, syphilis, and gonorrhoea compared to non-Indigenous peers. • **Intersectionality**: The combination of gender, rural location, and lower socioeconomic status may increase vulnerability to STIs.
2. Creating Safe Spaces for SRHR Discussions	• Discuss strategies to create non-judgemental, culturally safe environments for SRHR discussions.	• **Culturally safe spaces:** Respect cultural values, gender roles, and communication styles. • **Trauma-informed care**: Acknowledge intergenerational trauma and use empathetic approaches.

	• Address fears of stigma and judgement, ensuring confidentiality and trust-building.	• **Community-led initiative**s: Collaborate with Elders and local leaders to foster trust and reduce stigma.
3. Influence of Family and Community on SRHR	• Explore how family dynamics and community values impact sexual health decisions. • Discuss the role of elders and extended family in shaping these decisions.	• **Family influence**: Strong ties support decisions, but gossip and shame may discourage care-seeking. • **Elders' role:** Vital in guiding conversations, though gaps may exist in addressing sensitive topics like contraception and STIs. • **Gender norms**: Adhering to traditional gender roles can hinder open discussions.
4. Barriers to Accessing SRHR Services in Rural Areas	• Identify specific barriers to accessing sexual health services in rural or remote areas, including distance, cost, and cultural mistrust of healthcare systems. • Discuss strategies to overcome these barriers	• **Geographical isolation:** Lack of access to clinics increases testing and treatment barriers. • **Cost and stigma:** Financial challenges and fear of judgement discourage service utilisation. • **Culturally safe services:** Mobile clinics, telehealth, and partnerships with Aboriginal Health Services improve access. • **Decolonising principles:** Ensure services are Indigenous-led and culturally aligned to build trust.
5. Supporting Informed Decisions for Indigenous Youth	• Explore how to help Indigenous youth make informed decisions about SRHR while respecting their culture and family values. • Address the need for culturally relevant sexual health education and community-driven resources.	• **Community-led education:** Indigenous-led models foster trust and engagement. • **Person-centred practice:** Tailor education to the cultural, social, and familial context of youth. • **Empowerment:** Equip youth with tools to navigate sexual health decisions while respecting cultural norms.
6. Reducing Stigma and Addressing Mental Health	• Discuss strategies to reduce stigma related to SRHR and its mental health impacts. • Explore how shame and fear of judgement affect mental health and access to care.	• • **Stigma reduction:** Open dialogue and culturally sensitive care combat stigma. • **Mental health support:** Collaborative approaches and peer networks improve emotional well-being. • **Trauma-informed care:** Address historical and intergenerational trauma in healthcare settings to foster trust.

Part 5: Overview of Common Sexual Transmitted Infections (STIs) and Family Planning Methods

STIs, Family Planning, and the Role of Nursing and Social Work

Nurses and social workers play a key role in supporting sexual and reproductive health, which is a basic human right and important for both individuals and communities. When people have access to clear information, affordable healthcare, and trusted resources to manage sexually transmitted infections (STIs) and family planning, they can make better decisions and live healthier, more independent lives. These issues are deeply intertwined with sociocultural attitudes, trust, respectful relationships, and critical topics such as social justice and gender equity.

That said, research has shown that nurses and social workers often lack important knowledge about STIs and family planning[14]. In the SWAN-SR pilot project, less than half of nursing and social work students were able to answer questions in relation to HIV, proper use of condom, and emergency contraception. Some students noted that topics like abortion have been presented from a risk-focused perspective or even demonised within the curriculum

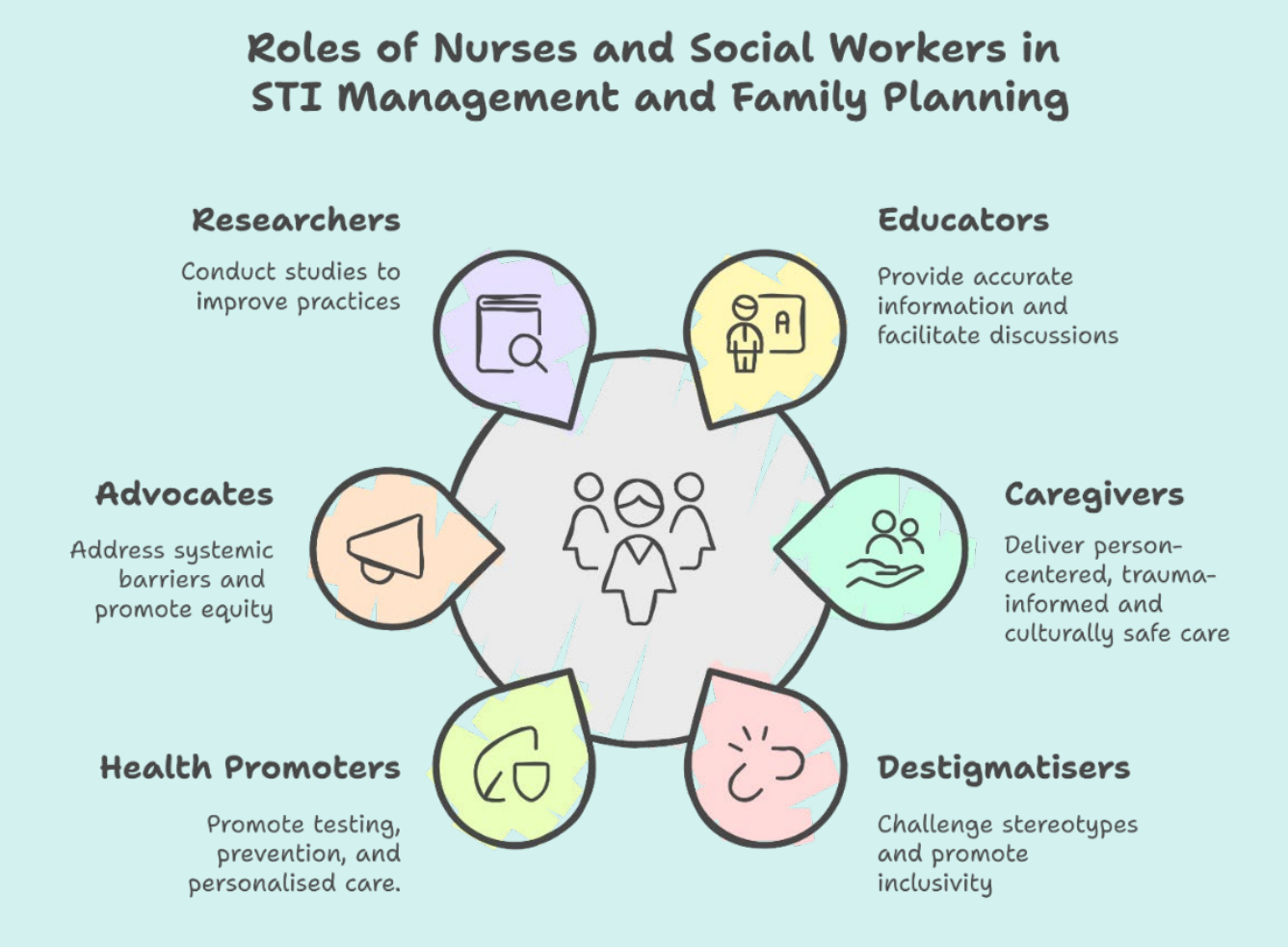
This section offers information about STIs and family planning. It's designed to support educators in preparing students to confidently address these issues in their work. It also encourages professionals to keep learning through specialised training and by using reliable resources online and in their communities.

[14] Blakey, E. P., & Aveyard, H. (2017). Student nurses' competence in sexual health care: A literature review. Journal of clinical nursing, 26(23-24), 3906-3916. | Winter, V. R., O'Neill, E., Begun, S., Kattari, S. K., & McKay, K. (2016). MSW student perceptions of sexual health as relevant to the profession: Do social work educational experiences matter?. Social Work in Health Care, 55(8), 614-634.

The Roles of Nurses and Social Workers in STI Management and Family Planning

Nurses and social workers play a vital role in multidisciplinary teams, empowering individuals and communities by promoting knowledge and access to resources for informed decisions about sexual and reproductive wellbeing.

Through collaboration, they deliver person-centred care, advocate for systemic improvements, and support positive outcomes by addressing barriers and building on strengths. They also drive change by championing human rights, enhancing public health services, and contributing to research, fostering healthier and more equitable communities.



Understanding and Destigmatising STIs

STIs are common conditions primarily spread through sexual contact, though many can also be transmitted via blood, semen, vaginal fluids, and other body fluids. From a biomedical perspective, STIs are often caused by bacteria, viruses, or parasites. Common bacterial STIs include chlamydia, gonorrhoea, and syphilis, while viral STIs include herpes simplex virus (HSV), human papillomavirus (HPV), and HIV. These infections may present with few or no symptoms, making prevention and early detection vital.

Importantly, many STIs are completely treatable with timely medical intervention, such as bacterial infections that respond well to antibiotics. Additionally, certain STIs are vaccine-preventable, such as HPV and hepatitis B. Untreated STIs can lead to severe health outcomes, including neurological and cardiovascular complications, infertility, ectopic pregnancy, stillbirth, and an increased risk of acquiring other infections.

Destigmatising STIs: Key to Advancing Sexual and Reproductive Health and Rights

The stigma surrounding STIs often arises from myths, misinformation, and societal attitudes, fostering fear and anxiety. This stigma can deter individuals from seeking timely care, disclosing their status, or engaging in preventive measures, ultimately undermining public health efforts. Nurses and social workers play a crucial role in addressing these barriers by providing person-centred, trauma-informed care and normalising discussions about sexual health. Encouraging regular testing and open dialogue helps build healthier individuals and relationships.

The shift from “STD” (sexually transmitted disease) to “STI” in the 1980s reflected an effort to reduce stigma.[15] The term “infection” acknowledges that many STIs are treatable and may not progress to severe stages if managed early. Language plays a powerful role in shaping perceptions, and using accurate, non-judgmental terminology supports efforts to destigmatise STIs.

Emotional and Mental Health Challenges of an STI Diagnosis

An STI diagnosis often carries significant emotional and social challenges, primarily due to stigma. Stigma is deeply rooted in societal perceptions, often defined as “socially undesirable attributes associated with isolation, rejection, and discrimination”[16]This stigma can create barriers to accessing testing and treatment, affecting not only those diagnosed but also anyone who is sexually active.

[15] Handsfield, H. H. (2015). Sexually transmitted diseases, infections, and disorders: What’s in a name?. *Sexually transmitted diseases*, *42*(4), 169.

[16] Garcia, P. J., Miranda, A. E., Gupta, S., Garland, S. M., Escobar, M. E., & Fortenberry, J. D. (2021). The role of sexually transmitted infections (STI) prevention and control programs in reducing gender, sexual and STI-related stigma. *EClinicalMedicine*, *33*.

For certain infections that require lifelong management, such as HIV, the burden extends beyond social stigma to encompass emotional and financial challenges associated with ongoing treatment and healthcare access. The need for continuous medication, regular medical appointments, and the fear of disclosure can significantly impact mental health, creating additional layers of stress and vulnerability for those affected.

Public policies and clinical practices may inadvertently perpetuate stigma, particularly when they adopt punitive approaches to STI transmission. These approaches can place disproportionate responsibility on individuals rather than fostering a collective responsibility for sexual health. A more inclusive, supportive approach is necessary to address the broader systemic and social factors contributing to STI transmission. Nurses and social workers are uniquely positioned to advocate for these changes and ensure care that is both equitable and stigma-free.

Promoting Sexual Health through Education, Sensitive Contact Tracing, and Advocacy

Providing accurate and accessible information is a vital responsibility of nurses and social workers, empowering individuals to make informed decisions about their sexual and reproductive health. In addition to education, these professionals play an active role in advocating for systemic changes to reduce stigma and improve overall health outcomes.

At the **individual level,** nurses and social workers help normalise conversations about sexual health by creating safe and supportive spaces. They offer clear, culturally sensitive education on safer practices, such as the use of condoms and vaccinations, while encouraging regular testing. This non-judgmental approach ensures individuals feel supported in addressing their health needs and seeking timely care.

At the **interpersonal level**, nurses and social workers are uniquely positioned to excel in the sensitive process of ***contact tracing***. This involves identifying individuals who may have been exposed to STIs—such as sexual partners of a person diagnosed with an infection—and ensuring they receive appropriate testing and treatment. Effective contact tracing requires exceptional communication skills and a compassionate approach, areas in which nurses and social workers particularly excel.

At the **public level**, advocacy efforts led by nurses and social workers can influence policies, public health campaigns, and community outreach programs. These initiatives often focus on integrating comprehensive sexual and reproductive health and rights (SRHR) education into schools, workplaces, and community settings. By equipping individuals with the knowledge to prevent STIs and reduce stigma, these efforts foster a healthier society. Furthermore, nurses and social workers advocate for equitable access to testing, treatment, and preventive measures, such as HPV vaccination and HIV pre-exposure prophylaxis (PrEP). Their commitment ensures broader populations benefit from improved sexual health services and that public health efforts are inclusive and effective.

Real-World Example: Stigma of Herpes in Western Societies[17]

In many Western societies, herpes is surrounded by a strong negative stigma, despite being both common and manageable. This stigma, deeply tied to cultural attitudes, fosters unnecessary fear and discrimination, leading to psychological distress and creating barriers to disclosure and care-seeking behaviours.

The Impact of Media

The media has played a substantial role in shaping this negative perception, particularly in Western countries. Sensationalised media coverage, especially in the 1980s, portrayed herpes as a devastating disease and even referred to it as "The New Sexual Leprosy," linking it to shame, irresponsibility, and moral failure. This fear-mongering led to widespread feelings of isolation, rejection, and embarrassment among those diagnosed. Even today, media portrayals often depict herpes as a consequence of reckless behaviour or poor character, rather than acknowledging its prevalence and treatability. This perpetuates misinformation and discourages individuals from seeking help or openly discussing their diagnosis.

Nurses and Social Workers' Role in Addressing the Stigma

Nurses and social workers play a pivotal role in addressing the stigma surrounding herpes. These professionals provide accurate information, foster non-judgemental dialogue, and empower individuals to manage their condition with confidence. They also support people in building healthy, fulfilling intimate relationships, helping to reduce the emotional burden of the diagnosis.

As *change agents*, they can actively drive systemic interventions by collaborating with and educating communities to promote accurate and destigmatising narratives, supporting public health campaigns to normalise sexual health, and advocating for accessible and affordable testing and treatment. Through these efforts, they contribute to advancing sexual and reproductive health and rights, fostering equitable access to care, and promoting a culture of respect and inclusivity in all aspects of sexual health.

[17] Posner, T. N. (2000). The 'herpes' phenomenon: Media myths, meanings, and medicines. *Science as Culture*, *9*(4), 445-467.

Common STIs

This table provides an overview of common STIs. For more detailed information, please refer to this webpage (https://www.healthdirect.gov.au/sexually-transmitted-infections-sti) or other trusted resources.

Disease	Type	Transmission Route	Symptoms	Treatment	Prevention
Chlamydia	Bacteria	Sexual contact.	Often asymptomatic; may cause abnormal discharge, pain during urination.	Antibiotics.	Regular testing, safer sex practices (such as using condoms), and open communication with partners
Gonorrhoea	Bacteria	Sexual contact.	Painful urination, unusual discharge; often asymptomatic, especially in women.	Antibiotics (resistance is a concern).	Regular testing, safer sex practices.
Syphilis	Bacteria	Sexual contact; parent-to-child during pregnancy (congenital syphilis).	Painless sore (chancre), rash, fever, swollen lymph nodes; asymptomatic in latent stage.	Antibiotics (penicillin).	Safer sex practices, regular testing, prenatal care for pregnant women.
Mycoplasma genitalium	Bacteria	Sexual contact.	Often asymptomatic; may cause urethritis in men and cervicitis in women, with pain during urination.	Antibiotics, though resistance is a concern.	Regular testing, safer sex practices.
MPOX (Previously known as Monkeypox)	Virus	Close physical contact with lesions, respiratory droplets, or contaminated materials; sexual contact.	Fever, swollen lymph nodes, muscle aches, fatigue, rash, or lesions that may resemble blisters or sores.	Symptomatic treatment; antivirals in severe cases.	Avoid close contact with infected individuals, maintain hygiene, and consider vaccination if at risk

HPV (Human Papillomavirus)	Virus	Sexual contact, skin-to-skin contact.	Often asymptomatic; can cause genital warts or abnormal cells (linked to cancer risk).	No treatment needed if asymptomatic; symptomatic cases treated based on clinical presentation (e.g., warts or abnormal cells).	Vaccination, safer sex practices, regular screening for early detection of abnormal cells (e.g. cervical screening).
Herpes (HSV)	Virus	Sexual contact, kissing, or skin-to-skin contact with infected areas.	Painful blisters or ulcers on mouth or genitals; recurrent outbreaks.	No treatment needed if asymptomatic; Antiviral medications to manage symptoms.	Safe sex practices, avoiding contact during outbreaks.
HIV (Human Immunodeficiency Virus)	Virus	Unprotected sexual contact, sharing needles, infected blood, parent-to-child during pregnancy, childbirth, or breastfeeding.	Asymptomatic or flu-like symptoms within 2-4 weeks.	Ongoing antiretroviral therapy (ART).	Safer sex, regular testing, PrEP, undetectable partners (U=U), and avoiding needle sharing.
Hepatitis B	Virus	Sexual contact, sharing needles, contact with infected blood, parent-to-child during childbirth.	Often asymptomatic, or fever, fatigue, nausea, dark urine, jaundice.	Antiviral medications for chronic cases; vaccine-preventable.	Vaccination, safe sex practices, avoiding sharing needles.
Pubic Lice ("Crabs")	Parasite	Sexual contact, close personal contact, or sharing infested bedding/clothing.	Intense itching in the genital area; visible lice or eggs on pubic hair.	Topical insecticides or prescribed treatments.	Avoid sharing personal items; ensure bedding and clothing are clean.
Trichomoniasis	Parasite	Sexual contact.	Often asymptomatic; may cause itching, irritation, abnormal discharge, or discomfort during urination.	Antiprotozoal medications (e.g., metronidazole).	Safer sex practices, regular testing.

Promoting Equity in Family Planning

Research highlights the essential contributions of nurses and social workers in ensuring accessible and inclusive family planning services. Nurses play a critical role in reducing unintended pregnancies through evidence-based contraceptive management[18]. Social workers, meanwhile, often address social and systemic factors affecting access to family planning services, especially for marginalised populations[19]. Together, they address barriers such as limited contraceptive access, cultural stigma, and religious considerations. Through psychosocial support and expert contraceptive counselling, they empower individuals to make informed reproductive health decisions.

Promoting Gender Equality through Family Planning

Nurses and social workers contribute significantly to advancing gender equality by fostering inclusive approaches to family planning. A key strategy involves engaging men and boys in family planning initiatives. Programs that involve men and couples have demonstrated success in improving communication, increasing knowledge about contraception, and fostering shared responsibility[20]. By leading these efforts, nurses and social workers help men view family planning as a collaborative effort, benefiting both partners.

Another critical aspect of promoting gender equality is empowering individuals to have full control over their reproductive choices. Nurses and social workers address issues like coercion from partners, families, or societal pressures by providing clear, unbiased information and supporting autonomous decision-making. They also play a crucial role in addressing domestic violence, which can undermine reproductive autonomy through forced pregnancies or restricted access to contraception. By offering routine screenings, creating safe spaces, and connecting survivors with resources, they help individuals regain control over their reproductive health.

Nurses and social workers also work to dismantle deeply ingrained gender norms that limit women's reproductive autonomy. Through educational campaigns and community advocacy, they foster social attitudes that promote equality and encourage joint decision-making in family planning. By addressing these dynamics, they not only improve outcomes for family planning programs but also contribute to reshaping societal attitudes toward reproductive health and equality.

[18] Levi, A. J., Simmonds, K. E., & Taylor, D. (2009). The role of nursing in the management of unintended pregnancy. *Nursing Clinics*, *44*(3), 301-314.
[19] Bell, M. M., & Rubin, D. (2013). Social workers and family planning knowledge: Are we still gatekeepers?. Journal of Baccalaureate Social Work, 18.
[20] Hartmann, M., Gilles, K., Shattuck, D., Kerner, B., & Guest, G. (2012). Changes in couples' communication as a result of a male-involvement family planning intervention. *Journal of health communication*, *17*(7), 802-819.

Advancing Equitable Abortion Care

Millions of women seek abortions annually, with nurses and social workers playing crucial roles in supporting individuals throughout the process. While abortion care remains a contentious topic, it is a vital component of family planning and reproductive health, essential for ensuring equitable access and addressing systemic barriers. Restrictive abortion policies disproportionately affect marginalised groups, including adolescents, women of colour, rural residents, and economically disadvantaged individuals[21]. These policies exacerbate inequities, limiting access to safe and equitable care.

In Australia, nurse practitioners are authorised to provide medical termination of pregnancy in many states and territories, significantly increasing the accessibility of abortion services. Nurses and social workers work collaboratively to provide both technical and psychosocial support in abortion care, fostering non-judgmental and culturally safe environments where individuals feel respected and empowered. They offer evidence-based information, normalise conversations about abortion, and address barriers such as financial constraints and geographical inaccessibility.

In addition to their practical roles, nurses and social workers navigate complex ethical challenges, balancing personal beliefs with professional responsibilities to ensure their care remains patient-centred and unbiased. They often manage conflicts arising from legal constraints, institutional policies, and their ethical obligation to advocate for patients' rights and well-being. Through advocacy, they push for policies that expand equitable access, dismantle restrictive laws, and address structural barriers like mandatory waiting periods and state-mandated counselling. By engaging in public health campaigns, community outreach, and comprehensive education, they combat stigma and promote understanding. Together, nurses and social workers ensure abortion care is accessible, inclusive, and aligned with reproductive justice principles, addressing both individual needs and systemic inequities to advance safer, more equitable reproductive healthcare for all.

Student voices from the SWAN-SR pilot project:

> "Our program seems to demonise abortion…, and it tends to exaggerate the harmful aspects... [But I believe] abortion is not a one-sided issue; it involves multiple perspectives."
> (Nursing student)

[21] Owda, R., & Loder, C. (2024). Achieving Reproductive Justice Within Family Planning. *Obstetrics and Gynecology Clinics of North America*, *51*(1), 211-221.

Common Contraception Choices

Contraception is the prevention of pregnancy. Options range from natural methods and barrier methods to oral pills and permanent solutions like sterilisation. Emergency contraception is also available to help prevent unintended pregnancies.
This table provides an overview of common contraceptive methods. For more detailed information, please visit https://www.fpnsw.org.au/health-information/individuals/contraception/contraception-choices or consult other trusted resources.

	Contraception Method	Effectiveness	Description	Advantages	Considerations
Natural Methods	**Withdrawal**	78–97%	Penis withdrawn before ejaculation.	No cost or tools needed.	High failure rate; no STI protection.
	Fertility Awareness Methods (FABMs)	75–99.6%	Monitoring the menstrual cycle to avoid fertile periods.	Natural; no hormones.	Requires education, careful monitoring; no STI protection.
	Lactational Amenorrhoea Method (LAM)	98%	Breastfeeding reduces ovulation; effective if fully breastfeeding within 6 months postpartum.	Hormone-free; natural.	Only effective under specific conditions; temporary.
Barrier Methods	**Male Condom**	82–98%	Latex/polyurethane sheath covering the penis during sex.	Protects against STIs; easy to use.	Requires correct use every time.
	Female Condom	79–95%	Polyurethane sheath inserted into the vagina.	Protects against STIs; gives women control.	Less widely available; requires proper use.
	Diaphragm	88–94%	Silicone dome placed over the cervix before sex.	Non-hormonal; reusable.	Must be fitted by a healthcare professional; does not protect against STIs.
Oral Methods	**Combined Oral Contraceptives**	91–99.7%	Daily pill containing oestrogen and progestogen.	Can help with acne, lighter periods.	Requires daily use; not suitable for some health conditions; no STI protection.
	Progestogen-Only Pill (Mini Pill)	91–99.7%	Daily pill containing only progestogen.	Suitable for women who cannot take oestrogen.	Must be taken at the same time daily; no STI protection.

Vaginal Ring	**Contraceptive Vaginal Ring**	91–99.7%	Self-inserted ring releasing oestrogen and progestogen for 3 weeks.	Convenient monthly use; can help with acne, lighter periods.	Requires monthly management; no STI protection.
Intrauterine Devices (IUD)	**Hormonal IUD**	99.80%	T-shaped device releasing low-dose progestogen; inserted into uterus.	Long-term; lighter or no periods; reversible.	Requires insertion by a healthcare professional; no STI protection.
	Copper IUD	99.20%	Non-hormonal device stopping sperm and fertilised egg from attaching.	Long-term; hormone-free; reversible.	May cause heavier periods; no STI protection.
Injection	**Contraceptive Injection**	94–99.8%	Injection of progestogen every 12 weeks.	Effective; infrequent dosing.	Delayed return to fertility after stopping; no STI protection.
Implant	**Contraceptive Implant**	99.90%	Small rod placed under the skin releasing progestogen for 3 years.	Highly effective; convenient; reversible.	May cause irregular bleeding; no STI protection.
Emergency Contraception	**Emergency Contraceptive Pill**	85% (within 72 hrs)	Pill taken up to 5 days after unprotected sex; most effective within 24 hours.	Reduces risk of pregnancy after intercourse.	Not for regular use; no STI protection.
	Emergency Copper IUD	99% (within 5 days)	Copper IUD inserted within 5 days of unprotected sex for emergency contraception.	Extremely effective; offers ongoing contraception.	Requires professional insertion; no STI protection.
Permanent Solution	**Sterilisation (Male or Female)**	99.50%	Permanent surgical procedure.	Highly effective; permanent.	Irreversible; no STI protection.

Bibliography and Further Resources

SRHR Principles and Definitions

- Dupont, J., Chollier, M., Meštrović, T., Quayle, E., Skrenes, A., & Dewaele, A. (2022). Towards a transnational sexual health research and policy agenda: The European Sexual Medicine Network Delphi study. *Sexuality Research and Social Policy, 19*(4), 1888–1903. https://doi.org/10.1007/s13178-022-00686-y
- Garcia, P. J., Miranda, A. E., Gupta, S., Garland, S. M., Escobar, M. E., & Fortenberry, J. D. (2021). The role of sexually transmitted infections (STI) prevention and control programs in reducing gender, sexual and STI-related stigma. *EClinicalMedicine, 33*. https://doi.org/10.1016/j.eclinm.2021.100767
- Gruskin, S., Yadav, V., Castellanos-Usigli, A., Khizanishvili, G., & Kismödi, E. (2019). Sexual health, sexual rights and sexual pleasure: Meaningfully engaging the perfect triangle. *Sexual and Reproductive Health Matters, 27*(1), 29–40. https://doi.org/10.1080/26410397.2019.1593787
- Handsfield, H. H. (2015). Sexually transmitted diseases, infections, and disorders: What's in a name? *Sexually Transmitted Diseases, 42*(4), 169. https://doi.org/10.1097/OLQ.0000000000000255
- Ivanski, C., & Kohut, T. (2017). Exploring definitions of sex positivity through thematic analysis. *The Canadian Journal of Human Sexuality, 26*(3), 216–225. https://doi.org/10.3138/cjhs.2017-0017
- Kapilashrami, A., & Hankivsky, O. (2018). Intersectionality and why it matters to global health. *The Lancet*, *391*(10140), 2589-2591.
- Kapilashrami, A. (2020). What is intersectionality and what promise does it hold for advancing a rights-based sexual and reproductive health agenda?. *BMJ Sexual & Reproductive Health*, *46*(1), 4-7. https://doi.org/10.1136/bmjsrh-2019-200314
- Parker, R. G. (2007). Sexuality, health, and human rights. *American Journal of Public Health, 97*(6), 972–973. https://doi.org/10.2105/AJPH.2007.113365
- Starrs, A. M., Ezeh, A. C., Barker, G., Basu, A., Bertrand, J. T., Blum, R., ... & Ashford, L. S. (2018). Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission. *The Lancet, 391*(10140), 2642–2692. https://doi.org/10.1016/S0140-6736(18)30293-9
- United Nations Population Fund. (2022, April 4). Sexual & reproductive health. *UNFPA.* Retrieved from https://www.unfpa.org/sexual-reproductive-health#readmore-expand
- World Health Organization. (2006). *Defining sexual health: Report of a technical consultation on sexual health, 28–31 January 2002, Geneva.* World Health Organization.
- World Health Organization. (n.d.). Sexual and reproductive health and rights. https://www.who.int/health-topics/sexual-and-reproductive-health-and-rights

Nursing and Social Work Education on SRHR

- Aaberg, V. (2016). The state of sexuality education in baccalaureate nursing programs. *Nurse Education Today, 44*, 14–19. https://doi.org/10.1016/j.nedt.2016.05.004
- Blakey, E. P., & Aveyard, H. (2017). Student nurses' competence in sexual health care: A literature review. *Journal of Clinical Nursing, 26*(23–24), 3906–3916. https://doi.org/10.1111/jocn.13836
- Klinner, C., Turner, G., Bloomfield, J., Spencer, M., Lovell, R., van Diggele, C., ... & Wong, H. T. (2024). A qualitative exploration of nursing and social work university students' experiences of sexual and reproductive health and rights education in Australia and Hong Kong. *Sex Education*, 1-15.
- Lee, S., Fenge, L.-A., & Collins, B. (2018). Promoting sexual well-being in social work education and practice. *Social Work Education, 37*(3), 315–327. https://doi.org/10.1080/02615479.2017.1401602
- Penwell-Waines, L., Wilson, C. K., Macapagal, K. R., Valvano, A. K., Waller, J. L., West, L. M., & Stepleman, L. M. (2014). Student perspectives on sexual health: Implications for interprofessional education. *Journal of Interprofessional Care, 28*(4), 317–322. https://doi.org/10.3109/13561820.2014.884553
- Sharon, D., Gonen, A., & Linetsky, I. (2020). Factors influencing nursing students' intention to practice sexuality education in their professional work. *American Journal of Sexuality Education, 15*(2), 262–278. https://doi.org/10.1080/15546128.2020.1724223
- Sherman, A. D. F., Smith, S. K., Moore, S. E., Coleman, C. L., Hughes, T. L., Dorsen, C., ... & Mukerjee, R. (2023). Nursing pre-licensure and graduate education for LGBTQ health: A systematic review. *Nursing Outlook.* https://doi.org/10.1016/j.soncn.2017.12.005
- Turner, G., North, R., & Drake, G. (2023). Social work curriculum: Preparation for sexuality and sexual well-being practice. *The British Journal of Social Work, 53*(6), 3237–3257. https://doi.org/10.1093/bjsw/bcad109
- Turner, G. W., Al Vernacchio, & Satterly, B. (2018). Sexual justice is social justice: An activity to expand social work students' understanding of sexual rights and injustices. *Journal of Teaching in Social Work, 38*(5), 504–521.
- Turner, G. W. (2024). Positioning Sexual Justice Within Teaching Human Rights: Calling on Social Work to Counter the Contemporary Attack on Sexuality. *Social Work Education: The International Journal.* DOI: 10.1080/02615479.2024.2358821
- Turner, G.W. & Joseph, B. (2023). Lets Talk About Sexuality Podcasting in Social Work Education: A Deeply Personal Pedagogical Approach to Explore the Deeply Personal, *Social Work Education*. http://dx.doi.org/10.1080/02615479.2023.2280632
- Turner, G. W., Pelts, M, Frabotta, R. Paceley, M. (2023). They were the best of times; they were the worst of times: Student narratives of their sexual experiences emphasize a critical need for sexuality courses, *Journal of Sexuality Research and Social Policy*, https://doi.org/10.1007/s13178-023-00865-5

- Turner, G. W.; Pelts, M. (2022). Sexual well-being informed social work practice: Harnessing the power of reflection and a hallmark experiential sexuality education activity, *The British Journal of Social Work,* 52, 2, 872–889, https://doi.org/10.1093/bjsw/bcab071
- Winter, V. R., O'Neill, E., Begun, S., Kattari, S. K., & McKay, K. (2016). MSW student perceptions of sexual health as relevant to the profession: Do social work educational experiences matter? *Social Work in Health Care, 55*(8), 614–634. https://doi.org/10.1080/00981389.2016.1191577
- Wilkerson, W. R. (2017). Review of teaching controversial issues, the case for critical thinking and moral commitment in the classroom. *Journal of Political Science Education, 13*(4), 483–485. https://doi.org/10.1080/15512169.2017.1336064

Interprofessional Practices

- Chan, E. A., Pang, M. C., Ching, S., & Lam, S. K. (2010). Interprofessional education: The interface of nursing and social work. *Journal of Clinical Nursing, 19*(1–2), 168–176.
- Gilbert, J. H., Yan, J., & Hoffman, S. J. (2010). A WHO report: Framework for action on interprofessional education and collaborative practice. *Journal of Allied Health, 39*(Suppl 1), 196–197.
- Huang, C.-Y., Tsai, L.-Y., Chung, C.-H., Shih, F.-F., & Wang, Y.-M. (2023). The effect of design thinking approach in interprofessional education programme of human sexuality course: A quasi-experimental design. *Nursing Open, 10*(2), 967–976. https://doi.org/10.1002/nop2.1363
- Olson, R., Bidewell, J., Dune, T., & Lessey, N. (2016). Developing cultural competence through self-reflection in interprofessional education: Findings from an Australian university. *Journal of Interprofessional Care, 30*(3), 347–354.
- Parker, J., & Merrylees, S. (2002). Why become a professional? Experiences of caregiving and the decision to enter social work or nursing education. *Learning in Health and Social Care, 1*(2), 105–114. https://doi.org/10.1046/j.1473-6861.2002.00013.x
- Pratt-Chapman, M. L., & Phillips, S. (2020). Health professional student preparedness to care for sexual and gender minorities: Efficacy of an elective interprofessional educational intervention. *Journal of Interprofessional Care, 34*(3), 418–421. https://doi.org/10.1080/13561820.2019.1665502
- Strada, I., Vegni, E., & Lamiani, G. (2016). Talking with patients about sex: Results of an interprofessional simulation-based training for clinicians. *Internal and Emergency Medicine, 11*(6), 859–866. https://doi.org/10.1007/s11739-016-1468-9
- World Health Organization. (2010). *Framework for action on interprofessional education and collaborative practice* (Report No. 00907421). World Health Organization.

LGBTQ Health

- Alice's Garage. (n.d.). *A social enterprise aimed at empowering LGBTIQ+ older persons.* Retrieved from https://www.alicesgarage.net/
- Briskman, L., Sullivan, C. T., Spurway, K., Leha, J., Trewlynn, W., & Soldatic, K. (2022). (Re)Claiming health: The human rights of young LGBTIQ+ Indigenous people in Australia. *Health and Human Rights Journal, 24*(1), 35–47.
- Grant, R., Nash, M., & Hansen, E. (2020). What does inclusive sexual and reproductive healthcare look like for bisexual, pansexual, and queer women? Findings from an exploratory study from Tasmania, Australia. *Culture, Health & Sexuality, 22*(3), 247–260.
- Priddle, T., Crawford, T., & Power, T. (2023). The inclusion and representation of LGBTIQ+ content in undergraduate nurse education: A scoping review. *Nurse Education Today*, *124*, 105771.
- Radix, A., & Maingi, S. (2018). LGBT cultural competence and interventions to help oncology nurses and other health care providers. *Seminars in Oncology Nursing, 34*(1), 80–89. https://doi.org/10.1016/j.soncn.2017.12.005
- Sherman, A. D. F., Smith, S. K., Moore, S. E., Coleman, C. L., Hughes, T. L., Dorsen, C., ... & Mukerjee, R. (2023). Nursing pre-licensure and graduate education for LGBTQ health: A systematic review. *Nursing Outlook.* https://doi.org/10.1016/j.soncn.2017.12.005
- Smith, R., & Wright, T. (2021). Older lesbian, gay, bisexual, transgender, queer, and intersex peoples' experiences and perceptions of receiving home care services in the community: A systematic review. *International Journal of Nursing Studies, 118,* 103907.
- Spurway, K., Sullivan, C., Leha, J., Trewlynn, W., Briskman, L., & Soldatic, K. (2023). "I felt invisible": First nations LGBTIQSB+ young people's experiences with health service provision in Australia. *Journal of Gay & Lesbian Social Services, 35*(1), 68–91.

Sexual Violence

- Agllias, K. (2012). Keeping safe: Teaching undergraduate social work students about interpersonal violence. *Journal of Social Work Practice*, *26*(2), 259-274.
- Department of Communities and Justice. (2019). *Domestic violence safety assessment tool.* NSW Government. Retrieved from https://www.facs.nsw.gov.au/download?file=592948
- Didham, S., Dromgool, L., Csiernik, R., Karley, M., & Hurley, D. (2011). Trauma exposure and the social work practicum. *Journal of Teaching in Social Work, 31*(5), 523–537. https://doi.org/10.1080/08841233.2011.615253
- Hibbs, L. E. (2019). Regulation and reporting: A study of policy-based inhibition of sex-positive cultures and sexual assault reporting on college campuses.
- Insight Exchange. (2023). *My safety kit.* Insight Exchange. Retrieved from https://www.insightexchange.net/my-safety-kit/

- Legal Aid NSW. (2023). *Sexual assault communications privilege services.* NSW Government. Retrieved from https://www.legalaid.nsw.gov.au/my-problem-is-about/victims-rights/victims-support-scheme/sexualassault-communications-privilege-service
- LoGiudice, J. A., & Douglas, S. (2016). Incorporation of sexual violence in nursing curricula using trauma-informed care: A case study. *Journal of nursing education*, *55*(4), 215-219.
- Oak, E. B., Jülich, S., & Morton, S. (2020). 'Never mind the mechanics, what about the (sexual) ethics?'Sex, sexuality and social work education in sexual violence prevention. *Social Work Education*, *39*(5), 617-635.
- Park, J. E., Kim, D. H., & Park, J. H. (2017). Violence against nursing students during clinical practice: experiences, perception, responses and coping with violence. *Journal of the Korea Academia-Industrial Cooperation Society*, *18*(10), 652-662.
- Settlement Service International Limited. (2023). *In my voice: Insights into domestic and family violence from my community.* SSI. Retrieved from https://www.ssi.org.au/our-services/domestic-family-violence/in-my-voice/
- Strunk, J. L. (2017). Knowledge, attitudes, and beliefs of prenursing and nursing students about sexual assault. *Journal of forensic nursing*, *13*(2), 69-76.
- The Royal Australian College of General Practitioners. (2022). *Responding to sexual harassment by patients: A brief guide for general practices* (p. 3). https://www.racgp.org.au

Sex and Disabilities

- Amaze Org. (2019). *Disability and sexuality* [Video]. YouTube. Retrieved from https://www.youtube.com/watch?v=MfYSpuKq_-8&ab_channel=AMAZEOrg
- Disabled People's Organisations Australia. (2019). *Joint position statement: A call for a rights-based framework for sexuality in the NDIS.* Retrieved from https://dpoa.org.au/joint-position-statement-a-call-for-a-rightsbased-framework-for-sexuality-in-the-ndis/
- Family Planning NSW. (2013). *All about sex - fact sheets for people with intellectual disability.* Retrieved from https://www.fpnsw.org.au/factsheets/individuals/disability/all-about-sex
- Ireland, B., Pebdani, R. N., Heck, M., Mudholkar, A., & Verdonck, M. (2024). Sex-positive sexuality post-spinal cord injury: A systematic review and qualitative metasynthesis. *Rehabilitation Psychology.* https://doi.org/10.1037/rep0000477
- Kokay, W., Power, E., & McGrath, M. (2023). Mixed study systematic review and meta-analysis of sexuality and sexual rehabilitation in LGBTQI+ adults living with chronic disease. *Archives of Physical Medicine and Rehabilitation, 104*(1), 108–118. https://doi.org/10.1016/j.apmr.2022.07.014
- McCabe, J., & Holmes, D. (2014). Nursing, sexual health and youth with disabilities: A critical ethnography. *Journal of Advanced Nursing, 70*(1), 77–86. https://doi.org/10.1111/jan.12172
- NSW Health Central Coast Local Health District. (2021, February 16). *People with intellectual disabilities: Relationships, sex, and sexual abuse* [Video]. YouTube. Retrieved from https://www.youtube.com/watch?v=Em_ApNeSJgM&ab_channel=HNECCPHN

- Rueda, H. A., Bolin, S. J., Linton, K. F., Williams, L. R., & Pesta, E. (2017). Social workers' roles in supporting the sexual and relational health of children with disabilities. *Child and Adolescent Social Work Journal, 34*, 493–505. https://doi.org/10.1007/s10560-017-0505-4
- Spencer, M., Tarleton, B., Collings, S., McIntyre, G., & Turney, D. (2024). If we know what works, why aren't we doing it? *The British Journal of Social Work.* https://doi.org/10.1093/bjsw/bcae080
- TEDx Talks. (2017). *Sexuality and disability: Forging identity in a world that leaves you out – Gaelynn Lea* [Video]. YouTube. Retrieved from https://www.youtube.com/watch?v=akGYugciSVw&ab_channel=TEDxTalks
- TEDx Talks. (2018). *Forgotten: Reproductive health in women with disabilities – Hilary Brown* [Video]. YouTube. Retrieved from https://www.youtube.com/watch?v=zVBqoXBr4Jo&ab_channel=TEDxTalks
- Tugut, N., Golbasi, Z., Erenel, A. S., Koc, G., & Ucar, T. (2016). A multicenter study of nursing students' perspectives on the sexuality of people with disabilities. *Sexuality and Disability, 34*, 433–442. https://doi.org/10.1007/s11195-016-9460-z
- Turner, G. W., & Crane, B. (2016). Sexually silenced no more, adults with learning disabilities speak up: A call to action for social work to frame sexual voice as a social justice issue. *The British Journal of Social Work.* https://doi.org/10.1093/bjsw/bcw133
- Women With Disabilities Australia. (2017). *WWDA position statement: Sexual and reproductive health* [Video]. YouTube. Retrieved from https://oursite.wwda.org.au/sex-and-your-body/information-for-supporters-and-services
- World Health Organization. (2009). *Promoting sexual and reproductive health for persons with disabilities: WHO/UNFPA guidance note*. Retrieved from https://www.unfpa.org/sites/default/files/pub-pdf/srh_for_disabilities.pdf

Working Across Cultures

- Aibangbee, M., Micheal, S., Liamputtong, P., Pithavadian, R., Hossain, S. Z., Mpofu, E., & Dune, T. M. (2024). Barriers to sexual and reproductive health and rights of migrant and refugee youth: An exploratory socioecological qualitative analysis. *Youth, 4*(4), 1538–1566. https://doi.org/10.3390/youth4040105
- Briskman, L., Sullivan, C. T., Spurway, K., Leha, J., Trewlynn, W., & Soldatić, K. (2022). (Re)Claiming health: The human rights of young LGBTIQ+ Indigenous people in Australia. *Health and Human Rights Journal, 24*(1), 35–47. Retrieved from https://www.hhrjournal.org/2022/06/reclaiming-health-the-human-rights-of-young-lgbtiqindigenous-people-in-australia/
- Department of Health. (2023). *Aboriginal and Torres Strait Islander cultural safety*. Victorian Government. Retrieved from https://www.health.vic.gov.au/health-strategies/aboriginal-and-torres-strait-islander-cultural-safety
- Hadziabdic, E., & Hjelm, K. (2013). Working with interpreters: Practical advice for use of an interpreter in healthcare. *JBI Evidence Implementation, 11*(1), 69–76. https://doi.org/10.1097/01.XEB.0000427460.22441.39

- Hickey, S., Roe, Y., Harvey, C., Kruske, S., Clifford-Motopi, A., Fisher, I., Bernardino, B., & Kildea, S. (2021). Community-based sexual and reproductive health promotion and services for First Nations people in urban Australia. *International Journal of Women's Health, 13*(1), 467–478. https://doi.org/10.2147/IJWH.S304538
- Mengesha, Z. B., Perz, J., Dune, T., & Ussher, J. (2018). Talking about sexual and reproductive health through interpreters: The experiences of healthcare professionals consulting refugee and migrant women. *Sexual & Reproductive Healthcare, 16*, 199–205. https://doi.org/10.1016/j.srhc.2018.03.006
- Napier-Raman, S., Hossain, S. Z., Lee, M. J., Mpofu, E., Liamputtong, P., & Dune, T. (2022). Migrant and refugee youth perspectives on sexual and reproductive health and rights in Australia: A systematic review. *Sexual Health, 20*(1), 35–48. https://doi.org/10.1071/SH22212
- Queensland Health. (2013). *Aboriginal and Torres Strait Islander adolescent sexual health guideline*. State of Queensland. Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0018/161541/adolescent_sexual_health_guideline.pdf
- Ronica Mukerjee, D. N. P., Wesp, L., Singer, R., & Menkin, D. (Eds.). (2021). *Clinician's guide to LGBTQIA+ care: Cultural safety and social justice in primary, sexual, and reproductive healthcare*. Springer Publishing Company. https://doi.org/10.1891/9780826189142
- YoungDeadlyFree. (2019, December 5). *The bigger picture in First Nations sexual health: Exploring the broader issues* [Video]. YouTube. Retrieved from https://www.youtube.com/watch?v=mjWV5cIuZD0&ab_channel=YoungDeadlyFree
- YoungDeadlyFree. (2019, July 3). *Working appropriately in Aboriginal sexual health* [Video]. YouTube. Retrieved from https://www.youtube.com/watch?v=i3OJyWeib3U&ab_channel=YoungDeadlyFree

STIs and HIV

- Allan-Blitz, L. T., Gandhi, M., Adamson, P., Park, I., Bolan, G., & Klausner, J. D. (2023). A position statement on mpox as a sexually transmitted disease. *Clinical Infectious Diseases*, *76*(8), 1508-1512.
- Bungay, V., Masaro, C. L., & Gilbert, M. (2014). Examining the scope of public health nursing practice in sexually transmitted infection prevention and management: What do nurses do? *Journal of Clinical Nursing, 23*(21–22), 3274–3285. https://doi.org/10.1111/jocn.12596
- Centers for Disease Control and Prevention. (2023). *About HIV*. CDC. Retrieved from https://www.cdc.gov/hiv/basics/whatishiv.html
- Hood, J. E., & Friedman, A. L. (2011). Unveiling the hidden epidemic: A review of stigma associated with sexually transmissible infections. *Sexual Health, 8*(2), 159–170. https://doi.org/10.1071/SH10070
- Lee, A. S., & Cody, S. L. (2020). The stigma of sexually transmitted infections. *Nursing Clinics, 55*(3), 295–305. https://doi.org/10.1016/j.cnur.2020.04.002

- NSW Health. (2024). *How much does STI treatment cost?* NSW Health. Retrieved from https://playsafe.health.nsw.gov.au/sti-treatment/much-sti-treatment-cost/
- NSW Ministry of Health. (2022). *NSW sexually transmissible infections strategy 2022–2026*. NSW Government. Retrieved from https://www.health.nsw.gov.au/sexualhealth/Publications/nsw-sti-strategy.pdf
- Petry, S., Padilha, M. I., Kuhnen, A. E., & Meirelles, B. H. S. (2019). Knowledge of nursing students on the prevention of sexually transmitted infections. *Revista Brasileira de Enfermagem, 72*, 1145–1152. https://doi.org/10.1590/0034-7167-2018-0658
- Ross, A. M., Zerden, L. D. S., Ruth, B. J., Zelnick, J., & Cederbaum, J. (2020). Contact tracing: An opportunity for social work to lead. *Social Work in Public Health, 35*(7), 533–545. https://doi.org/10.1080/19371918.2020.1793085
- Victorian Government. (2023). *Victorian sexually transmissible infection (STI) plan 2022–2030*. Department of Health. Retrieved from https://www.health.vic.gov.au/publications/victorian-sexually-transmissible-infections-sti-plan-2022-30
- World Health Organization. (2023). *New good practice statement on counselling behavioural interventions for key populations to prevent HIV, viral hepatitis and STIs: Policy brief*. World Health Organization. Retrieved from https://www.who.int/publications
- World Health Organization. (2024). *Sexually transmitted infections (STIs)*. Retrieved from https://www.who.int/health-topics/sexually-transmitted-infections
- Wright, M., & Rodway, M. (2014). Sexually transmitted diseases: Psychosocial parameters and implications for social work practice. In *Decade of the Plague* (pp. 21–35). Routledge. https://doi.org/10.4324/9780429030186

Reproductive Rights, Contraception, and Family Planning

- Adams, B. (2019). Sexual and reproductive health care for adolescents. *Professional Nursing Today, 23*(2), 30–33.
- Australian Human Rights Commission. (2017). *Change the course: National report on sexual assault and sexual harassment at Australian universities.* Retrieved from https://humanrights.gov.au
- Beddoe, L. (2022). Reproductive justice, abortion rights, and social work. *Critical and Radical Social Work, 10*(1), 7–22. https://doi.org/10.1332/204986022X16450344132470
- Carvajal, B., White, H., Brooks, J., Thomson, A. M., & Cooke, A. (2022). Experiences of midwives and nurses when implementing abortion policies: A systematic integrative review. *Midwifery, 111*, 103363. https://doi.org/10.1016/j.midw.2022.103363
- Dupont, J., Chollier, M., Meštrović, T., Quayle, E., Skrenes, A., & Dewaele, A. (2022). Towards a transnational sexual health research and policy agenda: The European Sexual Medicine Network Delphi study. *Sexuality Research and Social Policy, 19*(4), 1888–1903. https://doi.org/10.1007/s13178-022-00686-y

- Mainey, L., O'Mullan, C., & Reid-Searl, K. (2023). Working with or against the system: Nurses' and midwives' process of providing abortion care in the context of gender-based violence in Australia. *Journal of Advanced Nursing, 79*(4), 1329–1341. https://doi.org/10.1111/jan.15536
- Morris, J. L., & Rushwan, H. (2015). Adolescent sexual and reproductive health: The global challenges. *International Journal of Gynecology & Obstetrics, 131*(Suppl), S40–S42. https://doi.org/10.1016/j.ijgo.2015.02.006
- National Academies of Sciences, Engineering, and Medicine. (2021). *Supporting and expanding the future STI workforce.* In *Sexually transmitted infections: Adopting a sexual health paradigm*. National Academies Press. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK573165/
- Sheeran, N., Jones, L., Corbin, B., & Melville, C. (2024). Attitudes towards models of abortion care in sexual and reproductive health: Perspectives of Australian health professionals. *Australian Journal of Primary Health, 30*(6). https://doi.org/10.1071/PY22143
- Starrs, A. M., Ezeh, A. C., Barker, G., Basu, A., Bertrand, J. T., Blum, R., ... & Ashford, L. S. (2018). Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission. *The Lancet, 391*(10140), 2642–2692. https://doi.org/10.1016/S0140-6736(18)30293-9
- United Nations Population Fund. (2022, April 4). *Sexual & reproductive health.* UNFPA. Retrieved from https://www.unfpa.org/sexual-reproductive-health#readmore-expand
- Witt, H., Younes, M. K., Goldblatt Hyatt, E., & Franklin, C. (2022). Examining social work students' knowledge of and attitudes about abortion and curriculum coverage in social work education. *Affilia, 37*(2), 215–231. https://doi.org/10.1177/08861099211057235
- World Health Organization. (2006). *Defining sexual health: Report of a technical consultation on sexual health, 28–31 January 2002, Geneva.* World Health Organization.
- World Health Organization. (2010). *Developing sexual health programmes: A framework for action.* World Health Organization.

About This Toolkit

The SWAN-SR Teaching Toolkit is a co-designed resource supporting inclusive, trauma-informed SRHR education for Nursing and Social Work students. Developed by educators, students, and practitioners in Australia and Hong Kong, this toolkit offers practical strategies, case studies, and classroom tools for transformative learning.

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