nursing students
for sexual & reproductive health

Sexual Health Toolkit

Sexual health is a broad and wide ranging topic. Developing an analysis of sexual health and public health is important and will inform how you support individual patients. However, understanding these issues is just the beginning. While individuals are affected and impacted by overarching dynamics related to sexual health, each person you encounter will have their own experiences, needs, and issues with which you will need to become acquainted. It is important that you develop both an understanding of sexual health as a public health issue and also the skills you will need to meet patients where they are.

This toolkit will give you an overview of comprehensive sexual health education, some topics which received less attention within comprehensive sex ed, an introduction to sexual health counseling, and also examine contraception use in the US. Supplemental handouts will provide comprehensive information about contraception methods and sexually transmitted infections.

SEXUAL HEALTH EDUCATION IN THE US

Comprehensive sex education refers to age-appropriate, medically accurate information on a broad set of topics related to sexuality including human development, relationships, sexual decision-making, abstinence, contraception, and disease prevention. The CDC's recommendations for Exemplary Sexual Health Education emphasizes age-appropriate sequential sexual health education beginning in elementary schools and continuing through high school.

Currently, however, sexual health education is most commonly required only in high schools. According to the Guttmacher Institute, "In 2014, 72% of U.S. public and private high schools taught pregnancy prevention; 76% taught abstinence as the most effective method to avoid pregnancy, HIV and other STDs; 61% taught about contraceptive efficacy; and 35% taught students how to correctly use a condom as part of required instruction." Between 2000-2014, the share of schools providing sexual health education declined, across topics ranging from puberty and abstinence to how to use a condom.

Research supports the efficacy of comprehensive sex education in helping young people to delay sex and also to have healthy, responsible and mutually protective relationships when they do become sexually active. Many of the comprehensive sex ed programs have been demonstrated to increase condom or contraceptive use, and/or reduce sexual risk-taking. Simultaneously, it has been shown that programs which promote abstinence outside of marriage do not reduce or delay sexual activity and put people at an increased risk of pregnancy and STI's.

- The content and quality of formal sexual health education in middle and high schools varies state by state. From the Guttmacher Institute (2016):
- 22 states and the District of Columbia mandate both sex and HIV education; two states mandate sex education alone, and another 12 states mandate only HIV education.
- A total of 37 states require that sex education include abstinence: Twenty-six require that abstinence be stressed, while eleven simply require that it be included as part of the instruction.
- Eighteen states and the District of Columbia require that sex education programs include information on contraception; no state requires that it be stressed.
- Thirteen states require that the information presented in sex and HIV education classes be medically accurate.
- Twenty-six states and the District of Columbia require that sex education be age-appropriate.
- Thirteen states require discussion of sexual orientation in sex education classes. Nine of these states require inclusive discussion of sexual orientation, and the remaining four require that classes provide only negative information about sexual orientation.

What this indicates for you as a healthcare professional is that any individual patient that you're working with may or may not have had access to comprehensive sexual health education that included information on contraception methods, STI's/HIV, and consent and healthy relationships. Furthermore, it is also unlikely that people received comprehensive sex education that reflected their sexual orientation and/or gender identity. As a result, it is important that you not make assumptions about your patient's current knowledge or level of information in regards to their own sexual health.

UNDER-COVERED TOPICS IN COMPREHENSIVE SEXUAL HEALTH EDUCATION

Current guidelines for comprehensive sexual health education curriculum encourage information that can:

- provide young people with the tools to make informed decisions and build healthy relationships;
- stress the value of abstinence while also preparing young people for when they become sexually active;
- provide medically accurate information about the health benefits and side effects of all contraceptives, including condoms, as a means to prevent pregnancy and reduce the risk of contracting STIs, including HIV/AIDS;
- encourage family communication about sexuality between parent and child;
- teach young people the skills to make responsible decisions about sexuality, including how to avoid unwanted verbal, physical, and sexual advances; and
- teach young people how alcohol and drug use can effect responsible decision making (SIECUS)

As we know, what schools are required to teach in terms of sexual health varies state by state. Additionally, even in schools offering comprehensive sex education, some topics in particular may receive less attention.

LGBTQIA+

Only 13 states require discussion of sexual orientation in sex education, 9 of these require inclusive information, while 4 mandate negative information only.

According to qualitative research conducted by Planned Parenthood Federation of America and the Human Rights Campaign, sex education continues to primarily or exclusively focus on heterosexual relationships between cisgender people and pregnancy prevention within those relationships. The 2013 GLSEN National School Climate Survey found that fewer than 5% of LGBTQIA+ students had received sex education that included positive representations of LGBTQIA-related topics. A 2015 survey of Millennial attitudes on sexuality and reproductive health found that only 12% of those surveyed had received sex education that included same-sex relationships. LGBTQIA+ youth are also less likely to have safe, trusted adults with whom they can discuss issues pertaining to sexual health.

This means that LGBTQIA+ youth are more likely to seek information online or from peers, which may or may not lead to accurate health information.

Trans folks specifically are much less likely to have received sex education that includes sexual health information to their experiences. For example, transgender men who have sex with men report a lack of adequate information about their sexual health at rates as high as 93.8%.

LGBTQIA+ folks need accurate sexual health information which is relevant and useful to their lives and experiences. As a healthcare provider, it is vital that you not make assumptions about a patient's gender identity or sexual orientation or their existing sexual health knowledge. It is important that you are equipped to provide respectful, culturally-relevant information, resources, or referrals to any LGBTQIA+ patient with questions about sexual health.

Safer sex and healthy relationship information varies for folks of all sexual orientations depending on identity, behaviors, and practices. You are encouraged to review all supplemental handouts for more information.

Disability

Comprehensive sexual health education programs often do not include the experiences or address the needs of people with physical, cognitive, or developmental disabilities. As a result, people with disabilities are much less likely to receive sexual health information that is useful to their lives and which represents their experiences in a positive light.

Additionally, there is a significant amount of ableist social stigma around disability and sexuality which adds additional barriers for people with disabilities seeking information about sexual health and healthy relationships. People with disabilities, especially cognitive or developmental, are often not viewed as having a sexuality or engaging in sexual activity and so may not receive the same sexual health counseling from healthcare professionals that their peers without disabilities do.

Another problem compounding this issue is that the rate of sexual violence against people with disabilities is very high, with some studies ranging as high as 83% of at least one experience of sexual violence over a lifetime. This, combined with ableist assumptions about disability and sexuality, can create a belief in some healthcare providers that people with disabilities, especially cognitive or developmental, are not capable of consenting to sex and that their partners are perpetrating abuse, even when it is explicitly stated otherwise by the person seeking sexual health services.

People with disabilities need accurate information about sexual health and healthy relationships that is both useful and relevant to their lives. As a healthcare provider, it is your responsibility be be able to be provide information and/or resources and referrals for people with disabilities around issues of sexual health. It is also your responsibility to develop awareness about beliefs and assumptions you

hold about disability and sexuality, identifying ways that these may impact your ability to effectively support your patients.

Consent & Healthy Relationships

The degree to which consent and healthy relationships are covered in comprehensive sexual health education programs varies. Some programs may provide discussion on how to say no to unwanted sexual activity, but may not cover how to negotiate a consent process when sexual activity is desired. Some programs may also supplement with educators from local community organizations that provide sexual violence prevention education.

However, even under the most ideal of educational circumstances, we all still receive information and messages about sexuality and relationships from wide variety of sources including our friends, family, media, religion, and culture. These messages may or may not include healthy ideas that work well for us. Our cultural education (meaning all of the messages we receive) around issues of sexuality and relationships begins from the day we are born and continues until the day the we die. This means that unpacking, understanding, and addressing our beliefs about consent and healthy relationships is a lifelong process.

Culturally, we are in the midst of a shift about how these issues are discussed and there is much more awareness about the dynamics of sexual violence and relationship abuse than ever before. Still it is important not to assume that any patient you're working with shares your understanding of consent or of what constitutes a healthy relationship. Any individual patient may have their own understanding and beliefs about what sexual violence and relationship abuse is. Additionally, the rates of sexual violence, including childhood sexual abuse, and intimate partner violence/domestic violence are very high in the US. This means that it is likely that you will work with patients who are survivors of some form of trauma, even if it is not disclosed to you.

It's important that you, as a healthcare provider, understand how to provide trauma-informed care to patients you may work with and that you are equipped to offer information about consent and healthy relationships, as well as make any useful resources and referrals.

For a more in depth look at issues of sexual and intimate partner violence and trauma-informed care, please see our **Sexual Violence and Intimate Partner Violence 101 Toolkit**.

INTERCULTURAL COMPETENCY THROUGH CULTURAL HUMILITY

A word about terminology:

As a healthcare provider, you will work with people from very different cultural backgrounds than yourself. It is imperative that you work to develop skills around intercultural work, as well as educate yourself about issues of oppression and privilege.

When it comes to working ethically across cultural differences, there are numerous schools of thought about how to name this work. Commonly used terms include cultural competency, cultural humility, and intercultural practice. There will never be universal agreement about which term best encapsulates the goals and ideals of working across cultural differences. However, it is important to understand what we mean by these different terms and develop a more thorough understanding of the theory and ideas undergirding them.

The term culture refers to communities of origin and communities someone is currently involved in, including racial and ethnic communities, class background, Deaf and disability communities, communities centered around gender and sexual orientation, spirituality and religion, and geographical background, amongst many, many others. Cultures come with their own set of norms, expectations, ideas, oppressive behaviors, and opportunities for resiliency. Cultural norms are often subtle and not explicitly stated, but are typically known to members of that group. Some of these you may pick up on while working with people, but many will be unknown to you.

The term cultural competency implies that one is capable of becoming fluent in another culture by learning about it. However, typically, this is an unrealistic expectation and does not speak to some of the lived realities of working across lines of oppression and privilege. Cultural humility on the other hand is a term which originated in social work and the reproductive justice movement that speaks to the practice of approaching intercultural work from a place of humility and respect. The focus is placed on first understanding one's own cultural background and identifying one's own cultural norms and values. By doing so, we can avoid projecting those onto a patient with whom we are working and, ideally, make space for them to disclose relevant information. Intercultural practice is a term which strives for goals similar to cultural humility but with more emphasis on the element of active practice.

How effectively specific comprehensive sex education programs reflect the cultural experiences and/or address the specific cultural needs of the students they are working with depends on numerous structural and individual factors, including geographic location and individual teacher choice. Some programs, especially those originating on a community level, may be culturally-specific and address the needs of the particular community of which they are a part. However, many comprehensive

sexual health education programs address content from a "culturally neutral" perspective, meaning that there is an assumed white-normative, US/Western cultural perspective.

The impact of this is that specific cultural needs may not be addressed in either content or delivery and may not represent people's lived experiences in a positive light. This means that the information presented may not be relevant, useful, or accessible to many of those receiving it. Some content may also be delivered in oppressive or microaggressive ways. For example, information focused on pregnancy prevention for teens often presents teen pregnancy in a disparaging or negative light, i.e. as an unwanted outcome. This can create increased stigma for teen parents and may also negatively impact people who are members of communities in which teen pregnancy is a somewhat common occurrence.

Thoroughly addressing intercultural competency through cultural humility and skill building for working across cultural differences is beyond the scope of this toolkit. However, it is important that, as a healthcare provider, you work to develop self-awareness of your own cultural values around issues of sex, sexual health, and relationships and examine how these impact your work. For some introductory questions on this issue, see **Introduction to Sexual Health Counseling** below.

Sex Education and Aging Populations

The latter half of the 20th century brought numerous cultural changes around sexuality, pregnancy, STI's (including the existence of HIV), and relationships. School-based sex education, including abstinence-only education, did not become mandated in any state until the late 1980's. This means that many older patients you work with probably did not have access to comprehensive sex education, except for that which they found for themselves. Any formal sex education they may have received likely focused primarily on pregnancy prevention, without including STI prevention, amongst other issues. This is, in part, why STI rates have been rising in populations 65 and older. For example, between 2007 and 2011, chlamydia infections in people 65 and older rose by 31%. From an individual patient perspective and from a public health perspective, it is important that older people have access to accurate and accessible health information.

Any individual patient you're working with brings their own set of internalized ideas around sexual health and relationships. This may be especially true for older people who came of age at a time when conversations about sex and sexuality were even more taboo than they are now. Even those that had had access to accurate sexual health information may need additional information and support as they age and their sexual health needs change.

Social stigma and ageist assumptions around the sexuality and/or the sexual practices of older people continue in our culture. This stigma can make it more difficult for older patients to ask their healthcare provider questions about sexual health and/or disclose their sexual health practices.

Some healthcare providers assume that their patients who are elderly are no longer sexually active or may assume that older patients are already informed about issues pertaining to their sexual health. However, it is vital that you never make assumptions about anyone's sexual practices or level of knowledge. Instead, respectful, intentional, and culturally-informed counseling skills can help you assess what information your patient may need and also create a safe space for your patient to disclose any relevant health information.

Introduction to Sexual Health Counseling Skills

Even if you do not pursue advanced practice work as a primary care provider or work in specialties more directly related to sexual health, patients may still assume that, as a nurse, you have all the answers. As such, it is vital that you are able to provide compassionate and respectful support to patients seeking support and information around sexual health.

Effective counseling and support first begins with personal work. To help ensure that you provide nonjudgmental, evidence-based support to any patients you may work with, it is important that you identify your own values and beliefs about sex and sexual health.

Some useful beginning topics for reflection may include:

- At what age is it appropriate to begin having sexual relations? At what age, if any, is it best to stop having sexual relations?
- Is an active sex life, sex drive, or sexual behavior necessary for a 'healthy' adult person? Why/why not?
- What does a healthy sexual relationship look like? What does an ideal romantic relationship look like?
- What does honesty and communication look like in a healthy relationship?
- How many sexual partners should someone have at one time? In one year?
- Beliefs about sex outside of marriage
- Beliefs about disclosure of HIV status
- Beliefs about people who have sex without using a barrier method or method of contraception
- Beliefs about people who have children outside of marriage
- Beliefs about people who stay in unhealthy or abusive relationships

Pay attention to any value-based words (for example, normal, good, bad, safe, risky) that may come up. Try and notice what underlying assumptions are being made. Developing self-awareness is the skill that underlies effective support work, so stay curious about your process and try and avoid initial self-judgments.

As you identify these values and beliefs, think about where they come from. What contributed to them? Can you identify any possible exceptions? Consider doing some research. How does the research corroborate or conflict with what you believe? For example, perhaps one of your values is that a person is healthier when they have fewer sexual partners. Is this evidence-based? What does research say? Our values are useful in determining what we are okay or not okay with doing in our own lives and with our own bodies. However, everyone comes with their own sets of values and beliefs and people look to healthcare providers for evidence-based guidance and information.

When working with patients, **avoid making assumptions** about someone's gender, anatomy, sexual orientation, sexual behaviors, sexual health practices, values/beliefs around sex, relationship models, understanding of consent and abuse, and awareness of health information. Ask questions about these issues respectfully, letting the patient know why you are asking.

Avoid asking questions that begin with 'why.' Why-questions automatically put someone in the position of defending their choices. Assess what you actually need to know. For example, if you need to know why a person hasn't been remembering to take their birth control pills, ask, "what has made it difficult for you to remember to take your birth control pills?" Not only is this approach less judgmental, it is also gives both you and the patient building blocks for possible solutions.

Provide help without judgment. It is okay for you to have an internal reaction to someone's else's health choices. It isn't okay for you to share that reaction with your patient or allow it to overwhelm your professionalism. Instead, let the patient's emotions, questions, and reactions guide the conversation.

Provide information, resources, and referrals when necessary. There are numerous myths and misunderstandings about sexual health, as well as many oppressive ideas about sex and sexuality. Offering accurate, evidence-based information can help correct common misinformation, interrupt negative self-perception and stigma, and normalize someone's experience. If you don't know the answer to someone's questions or how to address what they're going through, say so. Then help connect them with the resources or referral they need.

Practice active listening, paraphrasing, and clarifying. Active listening is a structured form of listening which focuses attention on the speaker. It is a combination of attentive body language, minimal encouragers (for example, 'mhm' 'go on'), summarizing, paraphrasing, and clarifying, amongst others. Active listening overall is a useful communication tool and there are numerous resources that can give your more information about how to do it.

Paraphrasing and clarifying can be particularly useful tools when supporting a patient around issues of sexual health. When we paraphrase, we state back to someone what they just said, perhaps using fewer words to selectively summarize and focus the conversation. For example, you may say something like, "It sounds like you've been having a hard time remembering to take your birth control pills in the morning because your work and school schedules have been changing so much. Is that accurate?" This demonstrates and clarifies your understanding of the patient's statement. It is also gives them a chance to correct you if you misunderstood their meaning.

Asking 'is that accurate' or an equivalent statement opens the door for clarification. Clarification can also be useful if you are unsure of what someone is saying or what they mean. When providing health information, it is important to not make assumptions or infer meaning. For example, you may say something like, "I heard you say a few minutes ago that you are unhappy with your current method of birth control because it has been affecting your mood. Is that accurate?" You may then be able to follow up with an open ended question such as, "in what ways has it been affecting your mood?" This will help both you and the patient identify some of what has been going on for them and give you useful information that may help you guide them to possible solutions.

Identifying Feelings and Reframing

Identifying and reflecting back the feelings someone is expressing is a useful tool when providing active listening. Helping someone sort through the different complicated feelings they may be having will also help identify possible next steps, options, or solutions to sexual health issues. As someone is explaining what's going on for them or responding to your questions, listen for feelings-words and pay attention to how they are framing what they're describing. You may say something like, "it sounds like you're feeling _____, is that accurate?"

In some situations, especially if someone is expressing negative emotions such as guilt, shame, or self-blame, it may be helpful to reframe what they're saying to something that can be more productive for their process. For example, if someone says, "I feel like a terrible person for having an abortion," you could say something like, "it sounds like you are taking this decision very seriously and it has been very difficult for you. That sounds responsible to me."

Sometimes people may feel multiple, conflicting emotions in regards to their choices around sexual health. For example, someone could feel relief and guilt or grief and anger simultaneously. This can be confusing for someone to sort through, especially while trying to make choices about what is best for one's sexual health and overall well being. Identifying this and reframing it as a normal part of their process can be helpful.

Validating and Normalizing

As you help someone sort through their feelings, reactions, and needs, it is useful to provide validation and normalization. People often feel like their reactions or emotions are wrong or not appropriate in some way, especially around issues of sex and sexuality. Normalization and validation can help interrupt these negative internalized ideas and provide useful evidence-based information. It may be useful to speak in the third person when doing this. For example you could say, "A lot of patients feel that way" or "That's a really common reaction" or "You have every right to feel that way."

Patient-led Decision Making

Although you may have the information necessary to help guide your patient, ultimately they are the best authority on their own needs and experiences. When given space, safety, and accurate information, most people will choose what is actually useful and accessible to them—at that particular moment in their life. It may be that what they are choosing is not what you perceive as the most healthy option or what you yourself would do in their situation. It is okay for you to address those concerns directly and provide accurate information without sugarcoating it. Ultimately, though, each of us gets to decide what happens to our life and body. By providing a consistent, non-judgmental space in which someone can access healthcare and information, hopefully, over time, a person will be able to make choices that enrich their life and well being.

When it comes to helping someone around issues of sexual health, let someone talk through their feelings and reactions, provide useful information, and create a safe space for them to choose what is best for them.

Contraception Use in the US

Access to contraception has increased in the last several years due to increased availability of health care services through the Affordable Care Act and specific coverage of contraception, particularly long acting reversible contraceptive methods (LARCs), which include IUDs, injections, and subdermal contraceptive implants. Now 9 out of 10 insured people in the US can have an IUD for free. However, concerns have been raised about the disproportionate promotion of LARCs in marginalized communities. From Sister Song and the National Women's Health Network:

> "Many of the same communities now aggressively targeted by public health officials for LARCs have also been subjected to a long history of coercive reproductive practices or outright denial of the ability to make their own decisions about pregnancy, parenting and reproductive health care. This is a history of the oppression of people of color, low-income women, Indigenous women, women with disabilities and people whose sexual expression was not respected. From forced sterilization to restrictions on abortion access to coercive

limits on the ability to have children, marginalized people and particularly women of color have encountered disrespect, discrimination and abuse at the hands of the medical system.

We believe that we should all should have the right and the ability to control their own fertility whether planning, preventing or terminating a pregnancy. In order to ensure that this critical principle is upheld, we must examine some of the broader social forces that can constrain a woman's ability to exercise her reproductive rights, as well as the structural forms of discrimination that inhibit the ability of many people to exercise their human right to health care." (2016)

For more information about contraception use and different methods of contraception, see supplemental handouts.

Sexually Transmitted Infections and HIV

Data around sexually transmitted infections, as well as information about signs, symptoms, prevention, and treatment of STIs and HIV is readily available through the Center for Disease Control. As this data changes regularly, you are encouraged to do your own research and stay informed!

RESOURCES

https://www.guttmacher.org/fact-sheet/facts-american-teens-sources-information-about-sex

http://answer.rutgers.edu/file/A%20Call%20to%20Action%20LGBTQ%20Youth%20Need%20Inclusive%20Sex%20Education%20FINAL.pdf

http://www.hrc.org/resources/a-call-to-action-lgbtq-youth-need-inclusive-sex-education

http://www.glsen.org/sites/default/files/2013%20National%20School%20Climate%20Survey%20Full%20Report_0.pdf

http://www.siecus.org/index.cfm?fuseaction=Page.ViewPage&PageID=1193

https://transgenderequality.wordpress.com/2012/03/29/9-facts-about-trans-sexual-and-reproductive-health-2/

http://seniorplanet.org/safe-sex-for-seniors-the-facts-no-ones-giving-you/

http://ageing.oxfordjournals.org/content/early/2011/07/19/ageing.afr049.full

http://www.sexhealthmatters.org/for-healthcare-providers/discussing-sex-with-the-elderly