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Review article

PATIENT SEXUALITY EDUCATION IN HEALTHCARE CURRICULA

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Abstract

Background: Sexual health is an integral dimension of person-centred care, yet healthcare professionals often receive little structured preparation for discussing sexuality with patients.
Aim: This narrative review critically synthesises evidence on education in patient sexuality, identifies barriers that prevent healthcare professionals from opening the topic in clinical encounters, and proposes a feasible educational framework for healthcare curricula.
Methods: A narrative review was updated by a targeted PubMed search on 5 October 2026; 89 records were assessed and 14 additional full-text articles incorporated.
Results: The literature consistently shows that sexual health content is fragmented, unevenly assessed, and often absent from nursing education. Barriers operate at individual, institutional, and system levels. These barriers include embarrassment, lack of confidence, limited time, unclear professional responsibility, and weak managerial support. Educational interventions can improve knowledge, attitudes, self-efficacy, and communication skills, when factual teaching is combined with guided reflection and simulation.
Conclusion: Patient sexuality should be treated as a legitimate component of care rather than an optional topic. A minimum curriculum based on PLISSIT can help non-specialists ask permission, provide limited information, and refer patients appropriately.

Keywords: *Communication; Curriculum; Healthcare professionals; Nursing education; PLISSIT; Sexual health*

INTRODUCTION

Sexual health is not a marginal or purely private matter when a person becomes a patient. Illness, surgery, pharmacotherapy, disability, ageing, pain, fatigue, incontinence, body-image changes, and fear of recurrence can all alter sexual function, intimacy, and partnership. The World Health Organization has described sexual health as a state of physical, emotional, mental, and social well-being in relation to sexuality, not merely the absence of disease or dysfunction (WHO, 2006). In clinical care, this definition implies that sexuality is part of overall well-being and should not be excluded from professional communication solely because it is sensitive.

Despite this, healthcare professionals frequently do not raise sexual concerns with patients. Reviews across oncology, chronic disease, rehabilitation, nursing, and broader healthcare settings describe a recurring pattern: patients often wait for a professional invitation, while professionals wait for patients to initiate the conversation (Alqaisi et al., 2025; Dyer and das Nair, 2013; McGrath

et al., 2021). This mutual silence is clinically important. It can leave preventable problems unrecognised, reduce adherence to treatment, weaken rehabilitation counselling, and undermine dignity in long-term or hospital care.

A major reason for this silence is educational. Sexual health education in healthcare curricula is reported to be inconsistent in content, duration, and assessment, and the evidence base is especially sparse for nursing-specific interventions (Aaberg, 2016; Prize et al., 2023). A recent nursing scoping review from Spain similarly concludes that sexual health remains underrepresented in nursing curricula and is often approached through a narrow biomedical lens rather than as a holistic element of care (Pereira-Afonso et al., 2025). The issue is therefore not simply a lack of goodwill among clinicians. It is a curriculum and institutional problem. Additional curriculum analyses and accounts from nurse educators report similar limitations (Gradellini et al., 2023; Saus-Ortega et al., 2021; Verrastro et al., 2020).

For the Czech healthcare context, the available international evidence is directly relevant but not sufficient. There is a need to translate it into educational objectives, minimum competencies, and feasible clinical teaching formats that respect professional boundaries. The goal is not to turn every nurse, physician, or allied health professional into a sexologist. The goal is to ensure that every professional can recognise sexual health as a legitimate care domain, open the subject respectfully when relevant, provide basic information within competence, and refer when specialist care is needed.

Aim

The aim of this narrative review is to critically synthesise evidence on education of healthcare professionals about patient sexuality, identify barriers that prevent the topic from being addressed in clinical practice, and propose a structured educational framework suitable for nursing and wider healthcare curricula.

MATERIALS AND METHODS

This article is a narrative review. For this revision, a targeted PubMed search was performed on 5 October 2026 for English-language journal publications dated 5 October 2016 to 5 October 2026. Search concepts combined sexual health or sexuality, nursing or healthcare professionals, and professional education or curricula using AND and OR. The exact query and selection counts are provided in Supplementary materials. This update supplements the original narrative source base; the dates and screening counts of the original search were not archived and are not reconstructed here.

The update focused on healthcare professionals or professional students, patient sexuality or sexual health, and curriculum content, evaluated professional education, or reviews of these themes. School or community sexuality education, patient education without a professional learning outcome, reproductive or infection-prevention teaching alone, unrelated training, and protocols without results were outside the focused scope. Additional sources were selected purposively for their direct contribution to the existing themes; the update was not intended to exhaustively map all relevant publications.

The search returned 89 unique records; no duplicate PubMed records were identified. After title and abstract assessment, 15 articles were selected for full-text retrieval: 14 were retrieved and incorporated, while one could not be retrieved through the tested access routes. The other 74 records comprised three already cited articles, 38 outside the focused scope, and 33 potentially relevant publications not taken forward in this purposive extension. The 16 original sources were retained, giving 30 references in the revised manuscript (29 journal articles and one WHO report). Relevant older sources from the original review, including the original PLISSIT model, were retained separately from the ten-year update (Annon, 1976).

Priority was given to systematic reviews, scoping reviews, mixed-methods reviews, validated measurement instruments, educational intervention studies, and qualitative studies that directly addressed barriers to discussing sexuality with patients. The review did not aim to estimate pooled effect sizes. No formal risk-of-bias assessment or meta-analysis was performed, and the conclusions should therefore be interpreted as an evidence-informed synthesis rather than a systematic review. For the additional articles, study design, educational setting, population, main educational

findings, and limitations were charted. Qualitative content analysis grouped this material under the existing themes of curricular fragmentation, communication barriers, educational interventions, assessment, and curriculum adaptation.

The Czech context was interpreted cautiously. Because empirical Czech data on healthcare professionals' knowledge, attitudes and self-efficacy in patient sexuality were not identified during the targeted review, this article does not claim prevalence estimates for the Czech Republic. Instead, it identifies a research and curriculum gap and proposes testable educational steps.

RESULTS

Fragmented education in sexual health

The strongest conclusion across the literature is that healthcare education in sexual health is fragmented. Prize et al. (2023) reviewed educational interventions for healthcare professional students and found substantial variation in content, pedagogical methods, and assessment. Their review also highlights the limited number of studies designed specifically for nursing. Aaberg (2016) reached a comparable conclusion in baccalaureate nursing programmes: sexuality education was present inconsistently and often lacked a clear curricular position.

This matters because sexuality is a cross-cutting clinical issue. It appears in oncology, cardiology, urology, gynaecology, rehabilitation, psychiatry, long-term care, and palliative care. A curriculum that confines sexuality only to reproduction or sexually transmitted infections leaves graduates unprepared for common patient questions about function, intimacy, body image, fear, medication effects, disability, menopause, erectile dysfunction, pain, fertility, and relationship strain. Pereira-Afonso et al. (2025) make the same point from a nursing perspective: sexual health education should be holistic and multidimensional, rather than reduced to a biomedical or risk-prevention topic.

Barriers to professional communication

Barriers occur at three mutually reinforcing levels. Individual barriers include embarrassment, fear of offending the patient, lack of confidence, lack of language for sensitive questions, personal values, cultural discomfort, and uncertainty about professional responsibility. In survey and qualitative studies, nurses describe responsibility for holistic care but also doubts and fears when sexuality is involved (Saunamäki and Engström, 2014; Saunamäki et al., 2010). The common fear of opening a conversation that may become too complex has also been identified in qualitative evidence from the United Kingdom (Dyer and das Nair, 2013). Comparable training needs have been reported in Belgium, Germany, and Finland (Bogaert and Roels, 2025; Manninen et al., 2024; Reinehr et al., 2024).

Institutional barriers include limited consultation time, lack of privacy, absence of protocols, weak managerial support, and unclear referral pathways. In a cardiac-care context, Mangolian Shahrbabaki et al. (2021) reported organisational barriers such as lack of managerial attention, lack of support for counselling, and lack of an appropriate supervision system. Although this study was conducted in Iran and its cultural context differs from Central Europe, the organisational mechanisms it describes are transferable: if staff have no time, space, protocol or supervision, sensitive communication remains dependent on individual courage.

System-level barriers arise when curricula, accreditation standards, and continuing professional education do not define sexual health as a core competence. Åling et al. (2021) identified institutional legitimation as an important enabling factor for nurse-patient discussions about sexuality and sexual health. In practical terms, this means that professionals need a visible signal from education providers and healthcare organisations that sexual health is a legitimate part of care and that they will be supported when addressing it appropriately.

Educational interventions and what they can change

Educational interventions can improve knowledge, attitudes, self-efficacy, and communication skills, but factual teaching alone is unlikely to be enough. The evidence supports a combination of knowledge, reflection, and skill practice. Students and professionals need basic facts about disease- and treat-

ment-related sexual problems; they also need guided reflection on their own discomfort and assumptions, and they need a safe setting in which to practise wording, permission-giving, and referral. Reviews of professional training and an interprofessional educational study provide further support for these approaches (Huang et al., 2023; Karimian et al., 2018; Sekoni et al., 2017).

Vendramini et al. (2024) showed that a structured intervention can improve nursing students' knowledge and attitudes regarding the sexuality of older adults. Mrad et al. (2024) reported that an online simulation focused on nursing communication about sexual health in gynaecologic oncology was feasible and was perceived to improve knowledge, beliefs, attitudes, communication, and practice-related outcomes. These findings are important because they show that education does not need to be limited to lecture-based teaching. Simulation, role-play, structured debriefing, and online formats can make sensitive communication trainable. A randomised trial involving 412 healthcare students found improved knowledge and standardised-patient communication after a four-day curriculum, with assessment at three months (Rosser et al., 2025). A nursing workshop evaluation reported improved self-rated confidence, but had no control group or long-term follow-up (McKeaveney et al., 2026).

Validated instruments can help education move from intention to evaluation. The Sexuality Attitudes and Beliefs Survey has been used internationally, and Marcinowicz et al. (2024) validated a version for Polish nursing and midwifery students. This is relevant for the Czech Republic because it suggests a realistic pathway for cultural adaptation and psychometric testing of a tool suitable for Central European nursing education. The Sexual Health Education Professionals Scale (SHEPS) also illustrates the assessment of knowledge, communication confidence, and attitudes as distinct educational outcomes (Ross et al., 2018).

PLISSIT as a minimum competence framework

The PLISSIT model offers a useful educational scaffold because it separates levels of intervention. The original model includes Permission, Limited Information, Specific Suggestions, and Intensive Therapy (Annon, 1976). This structure helps students understand that basic professional responsibility does not require specialist therapy. At the minimum level, a nurse, physician, or allied health professional should be able to give permission for the topic to be mentioned and provide limited, accurate information about common effects of illness, treatment, or medication.

For curriculum design, Permission and Limited Information are the realistic universal competencies. Specific Suggestions should be taught according to professional role and clinical setting, while Intensive Therapy belongs to specialist referral pathways. This distinction reduces a frequent barrier: the belief that opening the topic obliges the professional to solve every sexual problem personally. Evidence on PLISSIT and EX-PLISSIT interventions, including the meta-analysis by Cicek Ozdemir et al. (2024), supports the clinical relevance of structured sexual counselling, although many studies focus on patient outcomes rather than curriculum outcomes.

Proposed educational module

A minimum educational module should be short enough to be implemented, but structured enough to change practice. It should not be presented as an optional add-on or solely as sexology content. The topic should be integrated into nursing and healthcare education as a component of dignity, holistic assessment, chronic disease management, rehabilitation, oncology, urology, gynaecology, mental health, long-term care, and palliative care. The proposed minimum educational module is summarised in Table 1. Local needs assessment can inform content adaptation (Rosser et al., 2022), while students' existing cultural and personal attitudes merit explicit reflection (Martínez-Vázquez et al., 2023).

Table 1 – Proposed minimum educational module for patient sexuality

Competency	Core content	Teaching method	Assessment
Recognise sexuality as part of care	Sexual health definition; disease, treatment and medication effects; dignity and privacy.	Short lecture with clinical vignettes	Case-based questions
Open the topic respectfully	Permission-giving phrases; timing; privacy; inclusive language; patient autonomy.	Role-play or simulation with debriefing	Observed structured communication task
Provide limited information	Common sexual concerns in oncology, cardiology, urology, gynaecology, rehabilitation and long-term care.	Problem-based seminar	Written care-plan component
Know when and where to refer	Boundaries of competence; referral to sexology, urology, gynaecology, psychology, physiotherapy or counselling.	Referral pathway mapping	Scenario-based referral decision
Evaluate attitudes and confidence	Reflection on personal discomfort, cultural assumptions, and professional responsibility.	Guided reflection and validated questionnaire	Pre/post self-efficacy and attitude measure

Note: The module is intended as a minimum framework; specialty-specific teaching can add detailed sexual medicine content and local referral pathways

DISCUSSION

The evidence reviewed here supports a clear conclusion: the problem is not that sexuality is clinically irrelevant, but that healthcare education has not consistently equipped professionals to address it. This gap is especially problematic in nursing, where holistic assessment and continuity of care are central professional responsibilities. International reviews repeatedly show that staff discomfort is not an isolated personal weakness. It is produced and maintained by curricular silence, lack of practice, weak institutional signals, and uncertainty about boundaries.

The practical implication is that education must be competence-based. A one-off lecture can raise awareness, but it is unlikely to change clinical behaviour unless students also practise communication, receive feedback, and learn referral pathways. The most defensible minimum is a PLISSIT-based module that teaches every graduate to create permission and provide limited information, while making clear when specialist care is required. This approach is clinically realistic and protects professional boundaries.

For the Czech Republic, the immediate research need is not to claim that local barriers are identical to those found abroad. The need is to measure them. A Czech study should assess students' and healthcare professionals' knowledge, attitudes, beliefs, self-efficacy, and perceived institutional support. It should also test whether a culturally adapted educational module changes these outcomes. The literature from Poland and other European settings suggests that validated instruments can be adapted and used for such work (Marcinowicz et al., 2024).

Implementation should involve both undergraduate and postgraduate education. In undergraduate education, the module can be placed in communication, ethics, clinical nursing, rehabilitation, or specialised care subjects. In postgraduate education, short online simulations and ward-based seminars may be more feasible for practising staff. However, education alone is not enough if clinical settings do not provide privacy, time, managerial support, and referral options. Curriculum reform and institutional policy therefore need to develop together.

Strengths and limitations

The strength of this review is its focus on a clinically important but underdeveloped educational issue and its direct translation of the literature into a feasible curriculum framework. The review also corrects a common

overreach: it does not infer Czech prevalence estimates from foreign studies. Its main limitation is its narrative design. The search was targeted rather than fully systematic, no formal risk-of-bias assessment was performed, and the proposed module has not yet been tested empirically in the Czech Republic. These limitations should be addressed by future primary research. The documented update used one database and purposive selection of accessible full texts; relevant sources may therefore have been missed. Educational improvements should not be assumed to establish sustained clinical behaviour change or patient benefit.

CONCLUSION

Patient sexuality should be taught as a legitimate part of healthcare, not left to individual courage or chance. A minimum PLISSIT-based curriculum can help healthcare professionals open the topic respectfully, provide basic information within their competence, and refer patients for specialist support when needed. The next step for the Czech setting is empirical mapping of knowledge, attitudes, and confidence, followed by pilot testing of a structured educational module in nursing and clinical practice.

Author contributions

V. Fišera contributed to the conceptualisation, literature screening, first working draft, and the healthcare quality and implementation perspective. *M. Broul* contributed sexual medicine expertise, clinical interpretation, reference verification, and critical revision. *M. Vostrý* contributed the nursing education and academic context, methodological review, and critical revision. All authors have confirmed their contributions and approved the final manuscript for submission.

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Ethics approval and consent to participate

Not applicable; this is a narrative review and reports no primary human-subject data.

Use of generative artificial intelligence

Generative AI tools were used to support language editing, structural revision, and preliminary reference checking. All substantive content, interpretations, and references have been reviewed and approved by the authors, who remain responsible for the manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

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