Transcript of *Centering Pleasure, Problems, and Pride in Sexual Health Care*

Tammy Kremer:

How's your sex life going? Adding questions like this one to sexual history taking during medical visits is the current mission of today's guests. Welcome to Coming Together for Sexual Health, where we talk about enhancing sexual healthcare.

Jennifer Rogers:

For most of us, having sex is easier than talking about it. This is not related necessarily to the people who have the infection. It's related to the healthcare system in which they exist.

Bryce Furness:

What can I do? What can I learn that impacts change for the people that are in my sphere of influence?

Jennifer Rogers:

This is so, so preventable.

Tammy Kremer:

These conversations are brought to you by the California Prevention Training Center at the University of California San Francisco. It's time. Let's come together for sexual health. I'm Tammy Kremer, and all views expressed are those of the persons speaking and not of the CAPTC or their employer.

Thank you both so much for joining. I'm really excited to get to speak with you both about pleasure and the great work you've been doing with the National Coalition for Sexual Health. So I just want to warmly welcome you to the podcast. Welcome Jen, and welcome Bryce.

Jennifer Rogers:

Thanks. Thanks so much, Tammy. Thanks for having us.

Bryce Furness:

Thank you. Good to be here.

Tammy Kremer:

So I'll introduce you both. Jennifer Rogers, MPH is the co-director of the National Coalition for Sexual Health, you'll hear us referring to it as NCSH during this episode, a robust coalition of over 200 members working collaboratively to promote high quality sexual health information and health services. She also leads the coalition's Healthcare Action Group to develop evidence-based and practical provider tools and materials. And we also have Bryce Furness with us, MD MPH, who is a medical epidemiologist with the CDCs division of STD prevention. He's been embedded within the Washington D.C. Department of Health since 2002. And a few highlights of his tenure include establishing a transgender health clinic, leading gay men's health and wellness clinics, and improving the PREP clinic. He's recently published several articles on transforming primary care for LGBT people. And to get us started, I'm going to start

with a question for Jen, just wanting to hear more about what is the National Coalition for Sexual Health. And I'd like to hear from both of you, what's the nature of your work there together?

Jennifer Rogers:

Yeah, thanks, Tammy. Your introduction covered a lot of it. I've been working at Altarum which is a non-profit public health consulting and research organization. And Altarum runs the National Coalition for Sexual Health. And so I've been working there for the past 12 years, and I run our sexual and reproductive health program. And then for the past six years, I've been co-directing the Coalition with my close colleague, Susan Gilbert and the project manager who's phenomenal, Molly Carmody. And it's a really collaborative project. So I'm really thrilled to talk about the Coalition. And right now, we're a thriving coalition of about 200 members working to improve the sexual health of Americans nationwide. We really try to make sexual health sort of a common part of our national discourse and to promote, as you said in the opening, high quality sexual health, both [inaudible 00:03:15] information to the public, but also sexual health services.

And so we do this through very different approaches. One is national media outreach, so we really try to get out in the media and tell non-stigmatizing stories, evidence-based stories, get our spokespeople and the people that are members out in the media. We develop practical tools and products. So how can people improve their sexual health? And how can providers help patients improve their sexual health and wellbeing? And then we really try to encourage both providers and the public to take action. So what can they each do to improve the health of themselves and the people in their communities?

And so it started because... I have to give credit to the CDC who funds us, who really had a vision that these sort of traditional approaches to sexual health were not working. And many times, they were very narrow in scope and very disease-specific, so STD prevention or pregnancy prevention. And they really wanted us, and then through this funding mechanism, to embrace a much more positive, comprehensive approach that really emphasizes not just, again, disease prevention, but wellness. So what does wellness mean?

And so together in the first iteration of the Coalition, it was really trying to figure out what would our approach be and what does sexual health mean? We say this all the time. And so we did some testing in the field and we came up with this definition. I'm going to read it because I think it's really important. We believe that being sexually healthy means being able to enjoy a healthier body, a satisfying sexual life, positive relationships, and peace of mind. So I think that really gives you a sense of how we view sexual health and wellbeing.

Tammy Kremer:

I also just want to take a moment with the definition that you've given us of sexual health and just appreciate so much how much broader that standpoint is, as opposed to preventing something, actually cultivating something that can support human flourishing.

Jennifer Rogers:

Yeah. And before I turn it over to Bryce, who's one of our most esteemed members of the Coalition, I just want to give you a sense of who's part of that 200 that I mentioned. So our members do include you all at the Prevention Training Center, public health practitioners, different healthcare providers, a lot of consumer organizations, advocacy organizations, universities, and a lot of people that are also really focused on communications and media, as I talked about a little bit earlier.

The last thing I'll mention is that we work within three different work groups. That's how we sort of push the work forward. So we have a communications action group. We have a very newly formed policy

action group that just got off the ground. And then we have our Healthcare Action Group. And we're probably going to be talking most in this podcast about our healthcare action group and what we've done really to move the needle to improve the resources and tools that are available to providers to help their patients in the communities.

Bryce Furness:

So I am part of the Healthcare Action Group, and I bring to the Healthcare Action Group a lot of lived experiences. So within the division of STD prevention at CDC, I am a subject matter expert on LGBTQ+ health. And so I have been working for many years on trying to improve sexual history taking in primary care settings for the general population, but for sexual and gender minorities specifically. And I think another thing that I bring to the table with lived experiences is working with CDC, sometimes the institution seems very focused on identifying, treating, and reporting sexually transmitted infections, and I'm trying to work beyond that, trying to figure out how to implement sexual health, taking into account things like disparities and intersectionality.

Jennifer Rogers:

And the other thing that I would want to add to that, and that was really beautiful, Bryce, especially focusing on the health equity piece, which is such an integral piece of the work that we do, but is really this idea that we need to normalize sexual health conversations and the delivery of these services. This is not just about giving providers a set of questions or a tool, that making the case that this is part of routine care, that this is part of our overall healthcare and wellbeing. And I'm sure we'll go into this in a little bit, but we created a video series that actually features Bryce.

Tammy Kremer:

Let's play an excerpt of those videos.

Bryce Furness:

It's important to talk about sexual health because that's how we all got here. It's a natural part of life. And by talking about it in the context of a regular patient visit, it normalizes talking about sex.

Speaker 6:

I definitely think sexual health in general is very stigmatized, where we don't talk about it openly.

Speaker 9:

Sexual health is an integral part of someone's general health and their wellbeing. So I'm not doing a thorough job if I don't ask those questions.

Bryce Furness:

The five Ps that are traditionally used as part of a comprehensive sexual history are partners, practices, past sexually transmitted infections, prevention of pregnancy, and prevention of sexually transmitted infections.

Jennifer Rogers:

The whole purpose of that was to really help providers understand why this matters. Why does it matter to take a sexual history? Again, it's not just going through the questions, but building that rapport, really

understanding people's situations, their communities, their lives, and being able to have person-centered care that really meets their needs. Sexual health isn't a side issue, it's really part and parcel of our overall health.

Tammy Kremer:

And you both clearly bring a lot of passion to this work. That's already evident in this short conversation we've had so far. And I'd love to hear what has gotten you both involved in promoting sexual health and what has kept you in the field?

Bryce Furness:

I actually know exactly when I first became interested in sexual health, and it was while I was doing internal medicine and pediatrics residency training at UCLA Cedar Sinai Medical Center. And during my third and fourth years, I took some elective time to do what at the time we referred to as high risk adolescents. And it was under Diane Tanaka at Children's Hospital, and I'm giving her a shout out. We were dealing with youth, adolescents that were homeless or had unstable housing, food insecurity, but most importantly were involved in transactional sex. So they were actually exchanging sex for food or shelter or substances. That is where my interest in sexual health came, specifically among adolescents in situations where they didn't really have a choice.

Jennifer Rogers:

I always feel like I was interested in sexual health and wellbeing. I can't remember a time that I wasn't. Professionally, if I can put a pin in it, it probably started in graduate school. My master's thesis was to survey all of the pharmacies in Boston to see whether or not they carried emergency contraception, and if not, why not? This is back in 2002. So EC was still the new thing, and there was a lot of advocacy work that had to happen on the ground. Access is only as good as if people can actually access the drugs and services, as we all know really well.

And so 20 years later, why am I still here? I think it's because I love this topic and I love the people. I get to work with people like Bryce. It's fun. And most of all, I think when I come back to it, I really believe that sexual and reproductive health and rights are human rights, like period, end stop. And so that drives me every day to want to do this work. And I feel really lucky that we get to do this work. Where CDC can't always do this, we get to be innovative and cutting edge and nimble. And because of the Coalition nature, I get to work with some of the best organizations and colleagues and really people that are committed to sexual and reproductive health equity, which has just been really phenomenal.

Bryce Furness:

And I'll add that the reason I'm still doing it is quite simple. I am very lucky to be a CDC employee, but still seeing patients in a publicly funded sexual health clinic. And I still feel like I make a difference almost every day that I go to work. I think the general reason I'm still doing what I'm doing is because I don't necessarily agree with how the STD control programs are set up from the national level to the programmatic level. And I really think instead of concentrating on counting infections, which is historically what we've been doing, we need to pay a little more attention, actually a lot more attention, to some of the really bad outcomes of these infections. Infertility among young women, HIV among MSM, men who have sex with men who get infections in their rectum, the stigma, the shame that we're going to talk about a little bit more, these are the types of things that I think we need to be focusing on while also taking into account and trying to assist with some of these health disparities, intersectionality that preclude these individuals from having the sexual health that they should have. So it's hard in a

publicly funded STI clinic that is stretched very resource poor, both financially and staff-wise, to focus on housing insecurity, to focus on food insecurity, to focus on substance abuse or mental health issues. And we need to change that somehow.

Tammy Kremer:

I can see how meaningful it could be, Bryce, to have that dual level of engagement in changing the structures that we are functioning within while also providing just the care that is needed. And for you, Jen, to get to make connections across organizations that are all trying to do this work in different ways. On that note, I want to transition to talking about one of your recent projects around the sixth P. So I'll start by asking, what are the five Ps of sexual health? Who created them? How are they used? Why do they matter?

Jennifer Rogers:

Bryce, this is a test. Can you...

Bryce Furness:

Yeah, I wrote them down. The lineage of these five Ps is a little cloudy. But I will say that I think that they became popularized through CDCs guide, they have a guide called A Guide to Taking a Sexual History, and I think that's where they were populated and possibly propagated from. The first one is partners. And I'll give a little description of each as I go through them. Partners. So it's basically asking about the number of partners and the type of partnerships they've had within a given amount of time. In our clinic, we ask in the last three months and in the last year. And this is quite important because physicians, clinicians have a lot of internal biases. And specifically, I have seen where providers have seen pregnant women, not asked about partners, assumed that their only partner was the father of the child when there was actually other partners involved, and perhaps there were bad outcomes for that unborn child, like a stillbirth because of congenital syphilis. So that's an example of why you ask about partners specifically.

The second one is practices. And so practices is very important because the screening guidelines that are out there depend on things like gender and age, but among certain subpopulations, it also depends on behaviors. And so CDC has very clear guidance on screening, sexually transmitted infection screening of men who have sex with men. And they recommend that at least annually, those men who have sex with men are screened for HIV, screened for syphilis, and screened for chlamydia and gonorrhea, depending on exposure. If they've had a penis in their mouth within the preceding year, they need to have a throat swab done for gonorrhea. If they have engaged in insertive intercourse within the preceding year, they need to have a urine test done for chlamydia and gonorrhea. And finally, if they've had a receptive anal intercourse within the proceeding year, they need to have a test for gonorrhea and chlamydia at that site as well. So you are not going to be able to screen a patient appropriately based on CDC guidance if you don't ask about practices. And that goes for heterosexual females that engage in receptive anal intercourse as well. You need to ask about practices to identify sites of exposure so that screening can occur in those anatomical sites.

Also important is a past history of sexually transmitted infections, which is the third P. So we have partners, practices, and a past history of STIs. This is important because individuals who have a lot of bacterial STIs, especially if they're in the rectum, need to be educated about and linked to pre-exposure prophylaxis for HIV or PREP. So that's one of the many reasons why past history of STIs is important, especially among young black MSM, transgender, MSM of color, and transgender females of color. Just realizing whether or not they meet criteria, whether or not you should be offering vaccination for

human papillomavirus, hepatitis A, hepatitis B, some of the other things that can be sexually associated among these populations.

The fourth is protection. Protection means condom. If there is an individual who's HIV positive or has sex with HIV positive individuals but is HIV negative and does what's called sero sorting, that can also be considered protection, where you are engaging in risks based on your HIV status and your partner's HIV status. But I have the flip side of this because there are a lot of gay, bisexual, and other men who have sex with men out there who do not believe in condoms. So trying to counsel them about condom usage would be futile. And you need to establish that upfront. And then the fifth one is pregnancy prevention. And that is family planning. It's not just condoms. It's whether or not they want to start a family, whether or not they've spoken to their partner about starting a family, those types of things.

Jennifer Rogers:

Bryce is great about of going through all those classic five Ps. What he didn't give himself credit for is we as a team took those five Ps and said, "These are really great, and how can we even make them better?" And so for partners, we don't assume that you have a partner. So we ask, "Tell me about your current relationships. Do you have a partner? Do you have one? Do you have multiple?" There's no assumptions, even depending on your marital status or your age or your gender or your race. We ask stuff about partners. "Have you ever been forced or coerced to have sex or sexual activity against your will?" so that if you build that rapport, that we can start talking about intimate partner violence, especially if you have resources to help refer and give folks support.

Under practices, Bryce actually thought it was really important that we ask people when they're having sex, whether or not they are regularly using alcohol and drugs, because that can also be a risk factor for many, many things. And we also felt really strongly when we're talking about past history of STIs, that it was really important not to say, "Have you ever had a STI? If yes, which ones? And where on the body were your infections?" So that really, providers can get the most information so they can, again, better treat their clients.

Bryce Furness:

Yeah, I appreciate that, Jen. Those recommendations were at least annually. And then there are certain criteria that if they occur with these patients, that you need to screen more frequently, every three or every six months, depending. Having sex while high or intoxicated is one of them. Having multiple partners, especially partners that are anonymous or pseudo-anonymous. And when we talk about pseudo-anonymous partners, we're talking about partners where the patient, your patient can reach them through an internet service app like Grinder, Scruff, or Jacked, or one of the other dating apps that are out there that men use to meet other men for dating and/or sex, but they can't call them or they can't text them. And so they can communicate with that particular partner as long as that partner has a profile on one of those apps. But once they delete that profile, they can no longer get in touch with them. So my patients are very clear when I'm asking them about anonymous partners and pseudo-anonymous partners, what that means. But those tend to lead to higher risk partnerships. So it's substance abuse, it's number of partners, and it's the quality of the partners as well.

Tammy Kremer:

That's a great overview. And as you were speaking about the different individuals and communities that are top of mind based on their needs in relation to each of these Ps, something that I was wondering was what about women who have sex with women or women who have sex with non-binary and trans folks, and where do they fit into this?

Bryce Furness:

That's a very good question. I think that historically, we think of women who have sex with women only as being fairly low risk for sexually transmitted infections. The exception to that occurs with women who have sex with women only who share sex toys and don't clean or take care of those sex toys appropriately. I think another category is women who have sex with women and men. And we have some data that show that women who have sex with women and men tend to have higher risk male partners, and therefore sometimes tend to be at higher risk of STIs than women who have sex with men only. So there is some data out there about that. But I will say that the women who have sex with women only tend to have some of the lowest STI rates out there.

Jennifer Rogers:

It's interesting that you say that, Bryce, because the Coalition just conducted 16 focus groups with young adults from ages 18 to 26 on open communication with your partners about sexual health. And people who identified as lesbian women mentioned that one of the topics that they wish they had more information about and heard from their providers about were STIs, that they feel like they're forgotten. Yes, they might be low risk, but for all the reasons that Bryce just mentioned, that they wish they felt more included in that.

Tammy Kremer:

This deep review of the five Ps, what did you find was missing in the five Ps? What did you add as the sixth P?

Jennifer Rogers:

So we thought long and hard about this. We kept on talking about the five Ps. We really felt like it was important to add the sixth P. And to be really quite frank, it's not just six Ps. We actually added three in within that one six, so it's really eight. So we call it the plus category, the six P is plus. But that includes pleasure, problems, and pride. So to go back to your question, what was missing? Those five Ps are really great and they're really thorough. And when you're building rapport, those are great questions to begin with. But we really thought a satisfying, pleasurable sex life is really a key element to sexual health and wellbeing for most people. So our sexual history taking questions really should reflect that. Why aren't we asking about pleasure? Why aren't we asking about problems? And we'll go more into this, but why aren't we asking about support for one's gender identity and sexual orientation?

So we develop these with our healthcare action group, and these questions explore sexual satisfaction, they explore functioning and problems, concerns, and then the support you have with your family, friends, and community. And we really think that asking questions about pleasure and problems and pride, we can really open up that conversation between the provider and patient. So it can include now discussions about consent and intimacy and relationships, which we know are so crucial to improving health and wellbeing. Again, it's not just disease prevention. And then including comprehensive questions in a sexual history can also guide further health counseling and referrals.

So I know Bryce, he's the clinician here, and he can really say more about this, but we know that the lack of pleasure, if you're not experiencing pleasure in your sexual life, it could be due to physical problems, maybe certain medications you may be taking, different relationship problems or other factors or medical conditions. So we have found that if you help uncover some of those sexual concerns such as erectile dysfunction or pain during intercourse, you can also uncover some other psychological or medical issues such as depression or substance use disorders or hormonal imbalances.

Bryce Furness:

That was great, Jen. And I think I can sum it up to all three of these sixth Ps really come from a place of realizing that unfortunately, even in 2022, when talking about sex and sexual health, there is still a lot of shame and stigma associated with those conversations. And I think these three things, they stem from it. The other five are pretty quantifiable, they're pretty straightforward, and this one is much less so, the sixth P. I think of it as the open ended question of the Ps because it does have specifically the pleasure, the problem, and the pride.

The pleasure comes especially from dealing with young female sexually active individuals. I think that you need to be very clear with them that it's not shameful. Having sex is not shameful, and that it should be pleasurable. And I know that that's a different conversation for pediatricians or parents to have, but it's a healthy conversation to have. The pride also came from personal experience and also clinical experience that a lot of gay, bisexual, and other men who have sex with men have internalized homophobia. And that internalized homophobia can lead to higher risk taking behavior if they don't address that or acknowledge it or deal with it. So I think of the sixth P as really stemming from the sad situation of still having stigma and shame underlying most of these conversations around sexual health in the United States of America in 2022.

Tammy Kremer:

And for our listeners, I'm just going to put a shout out that there is this great video series we'll continue to discuss on the National Coalition for Sexual Health website. You can find short videos that discuss each of these different sixth Ps in greater depth, and they're quite moving.

Speaker 11:

So when you get a response that a person is so happy that you brought it up because they have needs, that will reinforce you.

Bryce Furness:

The National Coalition of Sexual Health and others have identified that these may not be comprehensive enough for all patient populations. And therefore they have added a sixth P, which is being called plus, and within that are questions about pride, questions about problems with sexual functioning, and questions about pleasure.

Tammy Kremer:

What were some of the conversations like amongst members of NCSH about the sixth P? And what kinds of insights arose through those discussions or negotiations about adding the sixth P?

Jennifer Rogers:

Yeah, I can start with that one, Tammy. So I have to admit that adding a sixth P was not a hard sell for either our HCAG, our Healthcare Action Group, or our members. There's really broad based consent that we should be asking these questions around pleasure, problems, and pride, because I think our members really understand why this matters. I think any disagreement we may have had was around which questions to specifically include and how do we not overwhelm people? So a lot of the back and forth was trying to hone in on what exact questions to ask and how specific to get.

So for instance, one member was really adamant that we differentiate support for one's gender identity as separate from support for one's sexual orientation. As we know, these are not the same. And by

combining them, many do to save space or save time, it conflates the two. So for instance, many folks ask about whether you're transgender and a list of sexual orientations. This is not the same. We know that gender identity is sort of our innermost concept of ourself as male or female or a blend of both or neither. It's how we perceive ourselves and what we call ourselves. Whereas sexual orientation, it's our emotional, our romantic, our sexual attraction to other people. And so by conflating those, we can actually do harm. They felt it was really important that we have, "What support do you have from family and friends around your gender identity? And very separately, what support do you have from your family and friends about your sexual orientation?"

So I think that's a really nice example of how we're trying to really think carefully about how and what and why we ask the questions that we do. I think there's always a sense you'll hear that there's just not enough time, there's just not enough time to ask all these questions, that people already feel like there's so much to do in each visit, especially if you're a primary care provider and there's so many things that they need to cover. We understand that and acknowledge that. And so we created a pocket card. The tool can be found on the NationalCoalitionforsexualhealth.org website. We have a whole section dedicated to healthcare providers. And on that website, there's a tool, it's called Sexual Health Questions to Ask All Patients. And on one side, it lists those essential questions that you really need to ask, those sort of three simple questions to ask all patients at least annually. And then on the back is the six Ps. We call it the six Ps a lot, but it's actually just sexual health questions to ask all patients.

So these are the essential questions we think need to be asked to all patients. So have you been sexually active since the last time we've seen you or in the past year? What types of sex are you having? Are you having oral, vaginal, anal, other kind of sex, sex toys, as I said, and with whom? Who are your partners? What gender identities are they? And being really explicit about behaviors and body parts. Once you get the answers to those, then maybe that leads you to all those five Ps. And I really think, I want to say, especially if people go check out this tool, that there are a lot of questions. It's not meant to be a script. They are written so that providers could take them and ask them, but they're also a way to get people thinking about what kind of questions they can and should be asking, and then to try to integrate them into their routine practice.

I think a lot of people say, like, "Well, they're in for this other reason. How would I start the conversation? That feels a little awkward." And I think just like we talk about anything, if there's something else that you want to cover, you just say, "Hey, it's part of my routine to ask also about sexual health and wellbeing at every visit, including about sexual functioning or pleasure or the five Ps. Can I ask you a few questions?" and ask their permission. And then they might say, "No, I don't want to talk about that. I have a sore throat." And then you honor that. You honor that no. But what I think that sends a signal is that, "Listen, oh, my provider proactively asked me about that and is comfortable and seems really cool to come back to." And I think just opening that door is so important, and it's just those little things that we can do to really signal again to our patients that talking about sexual health and wellbeing matters and that we can do it and you can come back anytime and talk to me.

Tammy Kremer:

I've been having lots of conversations over the course of recording this podcast. And on our recent episode, we had two folks from a medical mistrust summit that focused on transgender experience. And one of the repeated themes was that when folks go in for care, they go in with a certain issue, but then they get asked about their gender identity, they get asked about their sexuality in ways that actually don't feel supportive or appropriate for their needs in that moment. So I just really want to highlight the importance and the value of asking patients if they would like to speak about those topics before going into them.

Bryce Furness:

And I just want to add that as part of the National Coalition of Sexual Health, we deal with populations that others may not think of when they think of sexual health. And so I want to pick out three specifically. I've already talked about sexual and gender minorities a bit, but I want to talk about disabled individuals. We have had presentations and we've had outreach, and we have taken into account questions that disabled individuals might appreciate hearing. And that's part of where the problems and the pleasure came from when adding or thinking about the sixth P. Another one is the elderly. We know we don't think about elderly individuals and having robust sexual lives, but some of them do. And that's a lot of where the problem came from was asking about lubrication, asking about pain, asking about problems like that. And then the third subpopulation that we have focused on through the National Coalition of Sexual Health, and part of the lens that we looked at when coming up with the sixth P, were those that are trying to be sexually healthy post trauma, especially trauma that involved coercive sex, something like that. So those are three subpopulations that we have spent a lot of time learning about, educating ourselves about, and also providing resources to. So through that lens of those three subpopulations is also where some of the sixth P came from.

Tammy Kremer:

Thanks so much for highlighting all those groups. It's so important that we keep those folks on the forefront, people that often get left behind in these conversations.

Jennifer Rogers:

We must pay attention to those that are most disproportionately impacted by poor sexual health. They must be at the forefront. They must be our guiding star because we need to move the needle and we're not doing a good enough job doing it. How can we do better every day? The sixth P specifically, I think that ultimately patients have the opportunity to experience pleasurable sex and that common sexual problems don't get in their way. I think everyone deserves if they want to, to have pleasurable, fun, exciting, new sexual activities with as many partners as they choose, or not. And that should be normal and normalized and non-stigmatized. And I think we move in that direction, I think a lot of things around the stigma around STIs could also be reduced.

Bryce Furness:

Jen, the National Coalition of Sexual Health staff and I have done multiple presentations, all of which have a common theme of trying to improve sexual health taking within the context of really busy primary care visits. We've joked about this, but I think that it would be a win for sexual health if every single provider, every time they engage with a patient asked whether or not the patient was sexually active. If that's all we got out of this, we would be leaps and bounds ahead of where we are right now. So to me, that's like the minimum threshold of what we're going for. It's pretty sad, but you look at the data and there are so many barriers to that happening.

Tammy Kremer:

Baseline.

Bryce Furness:

Yeah, the baseline, I think that the six Ps basically provide the opportunity for providers who may be uncomfortable specifically having open-end questions about this, to have a very clear path forward on getting some very important information from their patient that is independent of their comfort level

and their time even, because they don't have to think about it. It's like bam, bam, bam, bam, bam. And then I think what the sixth P does is it puts on the radar for some of these providers something that they probably never thought about within the context of sexual health, which is problems, which is pleasure, which is pride, specifically if they're not asking sexual orientation and gender identity information either in their demographic form or part of their actual visit. So for me, I look at it as like a hierarchy where we'd love every primary care provider, every clinician to ask about sexual health at every visit. And if they do that and they want to go further, here are some tools to help you get there. And don't forget these important things, which is really the addition of the sixth P.

And I'll just say to you asked about measuring that, and that's a little difficult. I think that's one of the issues with sexual health in general is it's hard to define and it's hard to measure. And so we've already mentioned about counting infections and counting whether or not they've been treated appropriately and those types of things. I think this is much broader, much more difficult to define, and therefore much harder to measure. So how our tools and what we're doing provide impact is going to be harder to show, sadly.

Tammy Kremer:

Some people will walk away having just maybe been asked a question that transformed their sense of self. It's just very hard to know. So we've gotten to some of the challenges that providers and institutions faced. The primary one so far that's come up is time and also a little bit of provider discomfort. But what other challenges are front of mind for you for providers, either individually or the institutions within which they work?

Bryce Furness:

I think time is a big one. I think, like we mentioned before, discomfort with talking about sexual health is another one. And then I'm going to throw a third one out there because I've thought about this quite a bit, especially working within the context of federally qualified health centers and other community health centers, is there are no quality indicators for sexual health above and beyond chlamydia screening of women of childbearing age. So, to me, if we really want to improve this across the board, we're going to have to think of some creative ways to measure quality improvement over time of both individual providers and the institutions that they work for.

Jennifer Rogers:

Couldn't agree more, Bryce. I sometimes wonder if time is a excuse maybe sometimes for that discomfort. But I want to normalize that discomfort. Because I think it's so easy to sort of blame providers, and that's not what I want to do at all. Many providers, like all people, are not comfortable about talking about sexual behaviors. And I think there's just also a sense of fear, like, "I don't really know what to say if I do get an answer. I don't know what to do once I do ask these questions," and awkwardness about asking these questions. We've heard, "My patients don't need this kind of care," or, "My patients would be put off if I ask them this."

And I think it can also be traced back to training in both nursing and medical schools. So we know, again, from the data that people don't get this kind of training, or if they do, it's a day, or if people are really interested, they can get an elective. And so of course it's going to be hard for so many people if you don't sort of specialize in this. And so I think we need to provide our internists, our PCPs with that kind of information because they haven't received the training. And then as a Coalition, we're trying to work more and more with medical students, nursing students. We have a big initiative that we're trying to do

it this year with minority serving institutions and HBCUs to get in those spaces as well to make sure that this gets part of the training and education.

Bryce Furness:

I think the normalization of sexual history taking needs to start very early in the medical training. But there's one other thing that I think is a barrier that I've mentioned briefly previously, and that's internal biases that any provider can have. The internal bias of assuming that a 14 year old girl who you've been seeing since she was born is not sexually active. The internal bias of the person sitting in the wheelchair doesn't have sex. So I think that that's another barrier above and beyond the lack of knowledge, the lack of comfort, the lack of resources. I think that that's a big one.

Jennifer Rogers:

Yeah. In other words, the providers disproportionately discussed sexual history or not based on preconceptions or biases driven by patients' demographic characteristics. And if we don't normalize it, then we're going to continue to have health disparities. And an example that you said, Tammy, about asking some people and not asking others.

Tammy Kremer:

Yeah, there's so much that we need from our providers, and I just appreciate the come from of real compassion that all of our providers, just like all of us as patients, are an aspect of the society in which we swim. And so of course, our providers are going to reflect the ways that patients also might come in with concerns that they're not comfortable speaking with around sexual health or with their own biases as well. So looking at those kinds of bigger picture needs in the realm of training seems like a really important insertion point. So I'm going to play back part of the video talking about pleasure, and I'd love to hear your response to it.

Bryce Furness:

We felt very strongly about adding a sixth P for multiple different reasons. I think for me, one of the biggest driving factors was that sex should be pleasurable.

Speaker 7:

If you take a random sample of folks walking around the street and ask them, "Why do you have sex?" most of them would say, because it feels good, or it brings me pleasure.

Speaker 11:

If you don't ask about sexual pleasure, I think you can miss quite a bit. You can miss emotional problems and you can miss physical problems that you might be able to correct.

Bryce Furness:

I think as a society, unfortunately, we still have so much stigma and shame associated around sex that we're not comfortable as a society, and unfortunately as some providers, asking about pleasure.

Tammy Kremer:

So yeah, I'd love to hear some kind of initial takes on that in the context of our conversation, listening back to your own work.

Jennifer Rogers:

Might recognize one of those voices.

Bryce Furness:

I'll echo what I said in that recording and that video basically was that I think that the basis for most of us for having sex is pleasure. It goes above and beyond procreating, it goes above and beyond a bunch of different things. We have sex because it's fun to have sex. Unfortunately, when you look at the five Ps, none of the five Ps address anything like that. Why are you having sex? Are you being coerced to have sex? Are you enjoying sex?

Jennifer Rogers:

I think it can be potentially overwhelming to say, "Oh my gosh, I now have to ask my patients about their sexual pleasure? I'm not sure if I signed up for that." Bryce would say, "Yes, you did sign up for that." But I think it can be as simple as, "How is your sex life going? What concerns do you have? Do you have any concerns today that you want to raise with me?" And then have them talk or not. But use their language that they brought up. Make no assumptions. Practice. I think it takes practice, practice on one another, practice on each other. It can be tricky at first. In our tool about pleasure, we also added a question that I really love around partners. Are you and your partners on the same page about what's pleasurable? It's so important. Do you guys agree? Do you even know what makes you feel pleasurable? Does your partner? Are you able to talk about that? And then do you talk openly with your partners or do you feel comfortable? Do you feel comfortable talking about your sexual desires and your sexual boundaries? So those things that you're like, "Yes, I'm into that, and you know, that's not for me," and that's sort of a firm no, versus like, "I might be curious." Can you have those kinds of conversations? And are you able to advocate for yourself to have sexual pleasure and have good relationships?

Tammy Kremer:

So we're coming towards a close here, but I want to just ask you both if there's any other work going on at NCSH in particular right now that you want to bring forward and highlight?

Jennifer Rogers:

So as I mentioned, we have three working groups right now, so there's a lot of ways to get involved. And I encourage anybody listening to this podcast to become a member. You're definitely within our wheelhouse. Membership is free and you can be as engaged or not as you want. For instance, Bryce is a very engaged member and helps us sort of develop, review new tools, comes to meetings, helps us sort of form what we're doing next. But I think it's also, "Oh, I just want to see what's going on and get your newsletter." And we have a thing called Sexual Health in the News. It's a news roundup that we put out each week for our members so everyone can stay on top of the headlines around sexual health in the country.

We have an annual meeting where we really try to have cutting edge priority sexual health topics. So we talked this year about stigma and shame and our new research on young adults and open communications with their partners. In the past, we've talked about porn use. We've talked about this issue pleasure. About people with intellectual and developmental disabilities and sexual health. The three working groups, just to mention them one more time, is the communications action group, focused on media and really getting out messages to the public about how they can improve their sexual health.

The healthcare providers, which we've talked most about, we just got new funding from the CDC, new five year funding, so we're about to embark on new priority setting so it's a perfect time to get involved. But we're currently working on what does it mean to have inclusive clinic or a clinician? What are the guidelines? What does that mean? And having that be released by the Coalition. So that's something that we're currently working on as well as a trauma informed care tool, giving providers scripts and tips on how to have a trauma informed care visit. What do you say? How do you handle this situation? How do you follow up? How do you provide referrals? How do you hold that space? I'll just mention lastly, we have, as I said, a new policy action group. So really trying to educate decision makers about positive and proactive policies to improve sexual health, especially given this moment.

Tammy Kremer:

Such great work. So I would encourage our listeners to go to NationalCoalitionforsexualhealth.org to learn more.

Bryce Furness:

The one thing I would add to what Jen says is we have tools, and I see patients in the D.C. Health and Wellness Center here in Washington, D.C. And have a lot of folks who are training, so a lot of students, medical students, residents, fellows, those types of things. And I give them the tools and I see how much the tools are appreciated and see that they're very impactful. One of the things I hope that the National Coalition for Sexual Health is creating apps for some of the tools so that the impact can be spread beyond who we can hand those things out to, to anybody who can access the app. So that's one thing I hope we do is turn some of the very good tools we have, very much used tools, but trying to spread the use a little bit further.

Jennifer Rogers:

There's other larger issues at play too. We need to have accountability. But we also have to make sure that insurers pay for the time to have these in-depth conversations. We have to make sure that these kinds of questions are integrated into electronic medical records, because we know that that really helps to institutionalize change. Curricula really needs to include this in medical and nursing education.

Tammy Kremer:

The last question I like to ask our guests, which we've kind of been touching on throughout our entire conversation, is what do you hope we can create by coming together for sexual health?

Bryce Furness:

What I see as the Shangri-la of sexual health would be that anybody, regardless of their skin color, their gender, who they love, who they have sex with, how they like to enjoy having sex, how they get pleasure out of sex, can be free to talk about that above and beyond a specialty clinic or a place where they know that they're accepted. So I'm talking about having those conversations or being able to talk about those things in a primary care provider, in an emergency department if it warrants those types of things. I think one of the most impactful things about what I do is having a couple African patients of mine, some of whom are from countries where homosexuality is illegal, and just watching them blossom in a setting where they could truly be themselves, oftentimes initially with tears in their eyes because they've never been able to talk to anybody honestly about their sex lives. And I want those individuals to be able to do that in multiple different settings throughout the clinical sphere.

Jennifer Rogers:

I think number one, it's that sexual health is a core element, really core element of our overall health and wellbeing. It's not a side subject. Number two, exactly what Bryce says, that everyone of all ages, gender, sexual orientations, race, ethnicity, education, income, ability really have access to accurate and complete information about sexual health, which is really based upon the best available data. And I think last but not least, that we really normalize these conversations, that this conversation that we're having right here becomes sort of the normal so that we ensure patients get all the services ultimately so they can enjoy good sexual health, pleasurable sex, and wonderful, fulfilling, committed or not relationships.

Tammy Kremer:

Beautiful. And I'm so grateful to you for the work that you do every day and for taking the time to come on and speak with me about that. Good work.

Jennifer Rogers:

Thanks so much for having us, Tammy. This was really lovely.

Bryce Furness:

Yeah, thank you, Tammy.

Tammy Kremer:

Pleasure. You're welcome. Thanks for listening, and check out the show notes for the resources mentioned in this episode. You'll also find the link to the transcript of the show. Please follow and rate us wherever you get your podcasts. This will help more people find us. Connect with us on Instagram at Coming Together Pod and learn more about us and get in touch at comingtogetherpod.com.

This podcast is brought to you by the California Prevention Training Center, where we build the capacity of healthcare professionals working in sexual health and emerging infectious diseases. Check us out at californiaptc.com and follow us on Twitter @CaliforniaPTC. This podcast is produced by me, Tammy Kremer, with Laura Marie Lazar and Catalina MacDonalds. It is edited by Leila Mohimani and Isaiah Ashburn, with original music by Leila Mohimani. We're based at the University of California San Francisco and would like to acknowledge the [inaudible 00:48:02] people, the traditional custodians of the land that UCSF sits upon. Thank you for coming together for sexual health.