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EDUCATIONAL OBJECTIVES

- **Describing** the various roadblocks to sexual healthcare, among both the mainstream and sub-population clinicians.
- **Identifying** three communication strategies among clinicians, to facilitate effective cross-cultural sexual healthcare.
- **Applying** two brief therapy interventions, suitable for treating sexuality related stress among diverse clients.

CLINICIANS AS CATALYSTS OF SEXUAL HEALTHCARE

- Do clinicians promote or inhibit patients' sexual healthcare?
- Do clinicians encourage patients to tell their sexual stories?
- **ROADBLOCKS TO DISCUSSING SEXUAL HEALTHCARE**

MY PERSONAL STORY

- Always wondered what kept sex as a taboo topic !?
- My research journey in human sexuality
- The understanding of my own sexual-self
- Becoming a sexologist

MY RESEARCH JOURNEY IN HUMAN SEXUALITY

- Middle Eastern-American Women's Experience With Their Sexuality: A Survey Study
  - California State University Northridge – Educational Psychology, Northridge CA (Rashidian 2002)
- Understanding the Sexual-selves of Iranian-American Women: A Qualitative Narrative Study
  - University of New England, School of Health, Australia (Rashidian et al. 2011)
- **Survey of the Iranian-American Physicians As Providers of Sexual Health Care in the USA**
  - Collaborative Research Network (CRN) -University of New England, School of Health, Australia (Rashidian et al. 2014)
- Publications (ResearchGate)

WHAT KEEPS SEX A TABOO TOPIC?

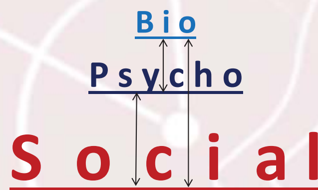
CULTURE

- Interplay of historical heritage (norms)
- Politics
- Economy
- Religion

- **BASICALLY EVERYTHING IN SOCIETY!**

(Rashidian 2002; Rashidian et al. 2013-2014-2015,2017,2018)

HUMAN SEXUALITY (SEXOLOGY PERSPECTIVE)



PERCEPTION → THOUGHTS → FEELINGS → BEHAVIOR

Conceptualization of Human Sexuality (Rashidian et al. 2014)

WORLD HEALTH ORGANIZATION (WHO) DEFINING:

- **Sexual Health: Concept and Scope**
  - ".. .a state of physical, emotional, mental and social well-being in relation to sexuality...."
- **Sexuality**
  - Sexuality refers to "...a core dimension of being human, which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/love, and reproduction..."

(World Health Organization , 2006)

SCOPE OF THE PROBLEM - KEY FACTS

- **Increasing rates:**
  - Sexually Transmitted Infections (STIs)
  - Sexual Difficulties (SDs)
  - Divorce – intimacy, sexually related issues, & lack of effective communication

SCOPE OF THE PROBLEM - KEY FACTS

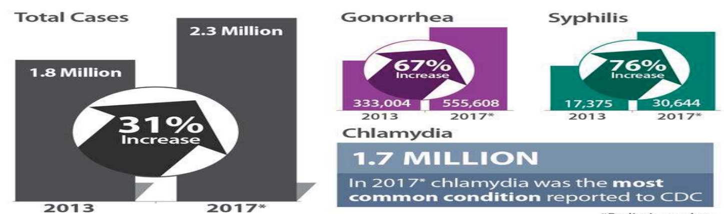
- **Centers for Disease Control and Prevention (CDC)**
  - Nearly 2.4 million Americans living with Hepatitis C (November 6, 2018)
  - Newborn syphilis cases more than double in four years, reaching 20-year high (September 25, 2018)
  - 2018 STD Prevention Conference: New CDC analysis shows steep and sustained increases in STDs (August 28, 2018)
  - **Approximately 60-120 millions - One in every third person in the USA has at least one form of SDs!**

SCOPE OF THE PROBLEM - KEY FACTS

- In the USA, the rates of STIs, and SDs, are higher, compared to many other developed countries!
- It is time to have a one-on-one talk about how clinicians' pervasive roadblocks inhibits the discussion of sexual healthcare with patients!

THE U.S. IS EXPERIENCING STEEP, SUSTAINED INCREASES IN SEXUALLY TRANSMITTED DISEASES

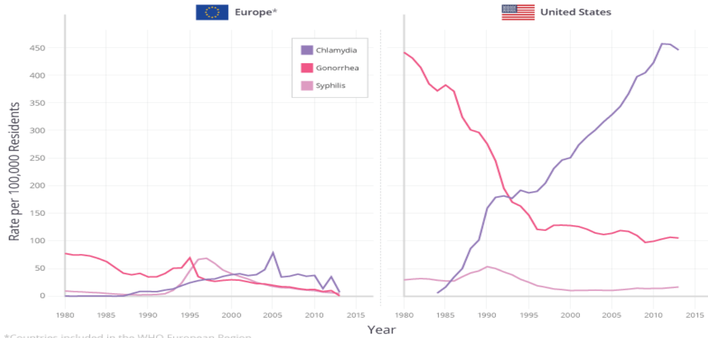
Combined diagnoses of chlamydia, gonorrhea, and syphilis **increased sharply over the past five years**



*Preliminary data

For more information, visit **cdc.gov/nchhstp/newsroom**

Europe vs. US - Comparing the Incidence of STDs Since 1980



*Countries included in the WHO European Region
Sources: World Health Organization and Centers for Disease Control and Prevention

Top 5 European Countries per STD

Average Rate per 100,000 Residents from 2000 - 2013

Chlamydia		Rate
1.	Iceland	618.82
2.	Norway	424.42
3.	Denmark	371.42
4.	Sweden	361.56
5.	United Kingdom	281.07

HPV		Rate
1.	United Kingdom	131.65
2.	Ireland	72.90
3.	Iceland	38.24
4.	Russian Federation	28.86
5.	Belarus	27.02

Hepatitis B		Rate
1.	Iceland	13.08
2.	Latvia	11.71
3.	Russian Federation	10.53
4.	Ukraine	10.46
5.	Bulgaria	10.21

Hepatitis C*		Rate
1.	Iceland	22.75
2.	Sweden	21.97
3.	Finland	20.23
4.	Ireland	14.54
5.	United Kingdom	10.77

Herpes		Rate
1.	Republic of Moldova	67.21
2.	United Kingdom	35.80
3.	Estonia	21.06
4.	Russian Federation	18.52
5.	Belarus	17.96

Gonorrhea		Rate
1.	Russian Federation	68.47
2.	Belarus	56.42
3.	Republic of Moldova	44.85
4.	Ukraine	35.80
5.	United Kingdom	34.60

Syphilis		Rate
1.	Republic of Moldova	78.46
2.	Russian Federation	74.29
3.	Bulgaria	46.79
4.	Ukraine	44.69
5.	Monaco	41.11

HIV		Rate
1.	Estonia	45.25
2.	Russian Federation	33.61
3.	Ukraine	27.05
4.	Portugal	17.35
5.	Latvia	17.34

*Hepatitis C average rate per 100,000 residents, 2000 - 2012

Top 5 American States per STD

Average Rate per 100,000 Residents from 2000 - 2013

Chlamydia		Rate
1.	Delaware	627.95
2.	District of Columbia	570.40
3.	Alabama	567.73
4.	Alaska	513.46
5.	Mississippi	503.48

Gonorrhea		Rate
1.	District of Columbia	421.0
2.	Mississippi	232.45
3.	Louisiana	225.01
4.	Alabama	209.84
5.	South Carolina	195.79

Hepatitis B		Rate
1.	West Virginia	5.52
2.	Kentucky	3.04
3.	Oklahoma	2.92
4.	Tennessee	2.74
5.	Arkansas	2.24

Hepatitis C*		Rate
1.	Kentucky	2.58
2.	West Virginia	1.9
3.	Oklahoma	1.16
4.	Connecticut	1.04
5.	Tennessee	0.98

Syphilis		Rate
1.	District of Columbia	75.54
2.	Louisiana	35.85
3.	Georgia	23.52
4.	New York	22.82
5.	Florida	20.27

HIV		Rate
1.	District of Columbia	179.56
2.	Maryland	39.58
3.	Georgia	38.0
4.	Florida	32.6
5.	Louisiana	32.02

*Hepatitis C average rate per 100,000 residents, 2000 - 2012

SCOPE OF THE PROBLEM - KEY FACTS

❑Prevalence of SDs (USA)

❑Female sexual difficulties

- ❑Painful Intercourse: Deep dyspareunia/vaginismus: one in 10 women
- ❑Lack of libido: four in 10 women
- ❑Anorgasmia: one in three women

❑Male sexual difficulties

- ❑Erectile difficulties: one in five men
- ❑Premature/delayed ejaculation: one in four men
- ❑Lack of libido: one in four men
- ❑Anorgasmia: one in five men
- ❑Concerns about penis: almost one in two men

DSM-5, Diagnostic and Statistical Manual of Mental Disorders, Fifth edition.
FSAD, female sexual interest/arousal disorder; MHSDD, male hypoactive sexual desire disorder
Laumann and Gagnon, National Health and Life Survey (NHLS surve ydate)

SCOPE OF THE PROBLEM - SOLUTIONS

- ❑ **CDC's recommendations**
  - ❑ Awareness
  - ❑ Get tested (at least once/year)
  - ❑ STIs are mostly asymptomatic
- ❑ **Health complications of certain untreated STIs**
- ❑ **Etiologies for STIs/SDs increase in the USA**

Charlotte Gaydos, infectious diseases Johns Hopkins University School of Medicin

SCOPE OF THE PROBLEM - SOLUTIONS

- ❑ **CDC's recommendations**
  - ❑ CLINICIANS' ENGAGEMENT IN SEXUAL HEALTHCARE
    - ❑ Talking about sex
      - ❑ Assessment
      - ❑ Education
      - ❑ Prevention
      - ❑ Encourage testing

FACTORS RELATED TO PATIENTS' RELUCTANCE TO DISCUSS SEXUAL DIFFICULTIES WITH CLINICIANS

- ❑ **Mainstream patients' reports - at least:**
  - ❑ **85%** - Want to discuss sexual difficulties
  - ❑ **71%** - Don't ask, due to physicians' lack of time
  - ❑ **68%** - Don't ask, due to physicians' embarrassment
  - ❑ **76%** - No knowledge of treatment availability
  - ❑ **75%** - Fearing sexual concerns being dismissed
  - ❑ **90%** - Believe it is physician's role to address sexual health concerns

Ende, et al 1984
Marwick C. JAMA 1993; 281:2 173-4 - Maurice WI, Bowman MA, Sexual Medicine in Primary Care 1999
Rashidian 2002; Rashidian et al. 2011, 2013, 2014)

SCOPE OF THE PROBLEM - SOLUTIONS

- ❑ We clinicians **(Physicians and Mental Health Practitioners)** have a key role to play in initiating discussions about sexual healthcare with our patients.
- ❑ **WHY DON'T WE TALK ABOUT SEX WITH OUR PATIENTS!?**

WHY CLINICIANS DON'T ASK PATIENTS ABOUT SEXUAL ISSUES!?

- ❑ No sufficient trainings in human sexuality
- ❑ Lack of comfort with sexual issues
- ❑ Beliefs/ biases/ attitudes
- ❑ Lack of time
- ❑ Worry about offending the patient
- ❑ Stereotyping and marginalizing patients (i.e., patient is too old, sick, or disabled for sex, bias towards LGBTQ, minority/ethnic members)
- ❑ Don't want to 'open a can of worms…'
- ❑ Lack of awareness of clinicians' own cultural conditioning
- ❑ Lack of insight about clinicians' own sexual-self

❑ SURVEY OF THE IRANIAN-AMERICAN PHYSICIANS AS PROVIDERS OF SEXUAL HEALTH CARE IN THE USA Collaborative Research Network (CRN) -University of New England, School of Health, Australia (Rashidian et al. 2014)

SIGNIFICANCE OF THE STUDY

- ❑ **Part of a larger research program: Investigates physicians' barriers & attitudes, impacting their management of sexual healthcare**
  - ❑ Survey of 409 randomly selected GPs in New South Wales (Khan et al. 2008)
  - ❑ Survey of 371 physicians, using cluster random sampling in 3 provinces in Vietnam, in non-STI specialist setting (Do et al. 2014)
  - ❑ Survey of 327 Iranian-American Physicians' barriers, attitudes, & management of sexual healthcare, practicing in California (Rashidian et al. 2014)

SIGNIFICANCE OF THE STUDY

- ❑ **Pilot study - The first ever done on this population on sexual healthcare**
- ❑ **A cross-sectional survey study**
- ❑ **Self-administered questionnaire**
  - ❑ Physicians' and their patients' profiles
  - ❑ Sexual history taking; Practices of physicians
  - ❑ The level of physicians' sexual healthcare training

(Rashidian et al. 2014, 2015, 2016, 2017, 2018)

Table 1. Physician Characteristics

	n(%)
Gender	
Male	203 (57.5%)
Female	132 (37.4%)
Missing	18 (5.1%)
Age	
30 – 39 years	36 (10.2%)
40 – 49 years	110 (31.1%)
50 – 59 years	71 (20.1%)
60 – 69 years	97 (27.4%)
70 – 89 years	15 (4.2%)
Missing	24 (7.1%)
Place of Birth	
Iran	290 (82.2%)
Other	35 (9.9%)
Missing	28 (7.9%)
Country of Medical Education	
Iran	190 (53.8%)
USA	130 (36.8%)
Other	8 (2.3%)
Missing	25 (7.1%)
Location of Medical Practice	
Suburban	175 (49.6%)
Urban	138 (39.1%)
Rural	20 (5.7%)
Missing	20 (5.7%)
Religion	
Muslim	192 (54.4%)
Jewish	77 (21.8%)
Other	64 (18.1%)
[illegible]	[illegible]

I: α*=0.94	Q7: Mentally challenged patients are not sexual	50.5	0.886	0.199	0.200
FACTOR I	Q4: Sick patients are not sexual		0.855	0.159	0.239
	Q6: Overweight patients are not sexual		0.847	0.847	0.220
	Q5: Blind, deaf, cerebral palsied, and paraplegic patients are not sexual		0.846	0.189	0.284
II: α=0.88 FACTOR II	Q10: Women's lack of orgasmic response may be self-interpreted as reducing her value as a person	16.9	0.186	0.853	0.135
	Q11: For women, self-masturbation is more guilt-laden than for men		0.239	0.843	0.061
	Q09: Obtaining sexual history may be seen as questioning the women's sexual value system		0.189	0.833	0.275
	Q12: Traditionally, in most cultures, women have less freedom to express their sexuality		0.004	0.803	0.066
	Q08: American women have adequate sex education		0.419	0.570	0.129
III: α=0.82	Q3: Married patients cannot have Venereal disease	8.8	0.186	0.198	0.879
FACTOR III	Q1: Iranian adolescent patients are not sexual		0.343	0.097	0.835
	Q2: Iranian elderly patients are not sexually active		0.499	0.201	0.585
Notes:	Factor Loading above 0.5 are bold for clarity of reading				
	*Cronbach Alpha				
	%Var: Percent of variations explained by each factor				
ATTITUDE	Factor I: Physicians' attitudes towards various patients				
	Factor II: Physicians' attitudes towards female sexuality				
	Factor III: Physicians' attitudes towards age and married patients				

Table 2. Factor loading values along with Cronbach's Alpha

BARRIERS	Factor1	Factor2	Factor3
Factor 1: Embarrassment (α=0.91)**			
I feel embarrassed with Iranian females	0.76471		
I feel embarrassed with Iranian males	0.77918		
I feel embarrassed with non-Iranian females	0.89086		
I feel embarrassed with non-Iranian males	0.88646		
Factor 2: Cultural and religion (α=0.87)			
My religion does not allow it		0.81285	
A family member presence with the patient		0.50160	
My culture doesn't allow it		0.85946	
I have not had enough training in obtaining sexual history		0.69278	
Fear of patients 'taking it personally'		0.73668	
Factor 3: Time and financial constraint (α=0.87)			
Lack of time			0.89156
Lack of reimbursement			0.88676

Values less than 0.5 are not printed.

Note: Factor Loading below 0.5 are left blanked for clarity of reading. **Cronbach Alpha

HOW OFTEN DO YOU INQUIRE ABOUT SEXUAL ISSUES WITH YOUR PATIENTS?

Patients Profile	Never	Sometimes	Only if patients ask	Very often	Total
Iranian Female	19.6%	22.9%	38.2%	19.3%	327
Iranian Male	24.7%	26.5%	36.7%	12.0%	324
Non-Iranian Female	12.7%	32.0%	35.0%	20.2%	327
Non-Iranian Male	19.5%	28.6%	35.6%	16.4%	324

WHAT ELEMENT OF SEXUAL HISTORY DO YOU FOCUS ON MOST?

	Never	Only if patients ask	Sometimes	Always	Total
Reproductive Care	18.4%	19.3%	26.0%	36.3%	327

Rashidian et al. 2014, 2015, 2016, 2017, 2018)

THE EFFECT OF PHYSICIANS' CHARACTERISTICS ON ALL FACTORS

- **GENDER**
  - Has significant impact on Factor1 (P= 0.03)
  - Partially significant on Factor3 (P= 0.051)
    - Female physicians spend more time with their patients
- **PLACE OF BIRTH**
  - Has significant impact Factor2 (P= 0.02)
  - Partially significant on Factor4 (P= 0.09)
    - Physicians born in Iran are more reluctant to communicate sexual health issues, due to religion and cultural beliefs
- **RELIGION**
  - Has significant impact Factor1 (P= 0.04)
    - Religious clinicians are significantly more reluctant to communicate sexually related issues with patients.
- **COUNTRY OF GRADUATION**
  - Has significant impact Factor2 (P< 0.001) and Factor3 (P= 0.01).
    - Physicians graduated from Iran, are more reluctant to communicate sexually related issues, due to cultural beliefs.
- **CLINICAL SPECIALTY**: Has **no significant impact** on any of the factors (P> 0.10).
- **PLACE OF PRACTICE**: Has **no significant impact** on any of the factors (P> 0.10).

(Rashidian et al. 2014, 2015, 2016, 2017,2018)

IMPACT OF CULTURE/ACCULTURATION ON CLINICIANS OF DIVERSE BACKGROUNDS

- ❑ Home culture vs./and mainstream culture
- ❑ "My culture haunts me no matter where I go…"
- ❑ Challenges of letting go of the cultural attitudes

(Rashidian et al. 2013, 2014, 2015, 2016, 2017, 2018)

WHY CLINICIANS DON'T ASK PATIENTS ABOUT SEXUAL ISSUES!?

PHYSICIANS' NARRATIVES (CURRENT STUDY)

- ❑ **Mainstream cultural prohibitions due to**:
  - ❑ Lack of educational curriculums in medical/counseling schools
  - ❑ Focusing on patients' demands (the belief that patients need to initiate talking about sexual issues)
  - ❑ Pharmaceutical companies don't encourage it
  - ❑ The need to have a medication, first!
  - ❑ The need to have a diagnosis
  - ❑ Gender inequality

(Rashidian et al. 2018)

LET'S TALK OPENLY ABOUT SEX…

- ❑ **What do we need to do to destigmatize sex as a taboo topic ?**
- ❑ **As clinicians, in charge of patients' well-being, it begins with an examination of our own cultural conditioning, & the understanding of our own sexual-self !**

LET'S TALK OPENLY ABOUT SEX…

- ❑ **What do we need to do, to destigmatize sex as a taboo topic?**
  - ❑ The realization that sexuality is a core part of a human being's life

    (**Michel Foucault 1978**)
  - ❑ De-stigmatization begins with us talking openly about sex!
  - ❑ Need to 'open the can of worms…'
  - ❑ Begins with self-modeling

(WHO)World Health Organization (2010)
Rashidian et al. 2018

LET'S TALK OPENLY ABOUT SEX...
What do we need to do, to destigmatize sex as a taboo topic ?

STRATEGY I

- ❑ Examining and understanding your own sexual-self
- ❑ Learning to address your own sexual concerns and desires
- ❑ Understanding and confronting your own limiting beliefs and biases about sex and sexuality
- ❑ Desiring your own personal sexual growth

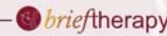
(WHO)World Health Organization (2010)
(Resnick S. 2018)
(Rashidian et al. 2014)

LET'S TALK OPENLY ABOUT SEX...
What do we need to do, to destigmatize sex as a taboo topic ?

STRATEGY II

- ❑ Education and training
- ❑ Seeking personal therapy
- ❑ Sexual Attitude Reassessment and Restructuring (SAR)
- ❑ Knowledge
- ❑ Skills
- ❑ Cultural Competency

(WHO)World Health Organization (2010)
(Resnick S 2018)
(Britton P 2017)
(Rashidian et al. 2018)



LET'S TALK OPENLY ABOUT SEX...
What do we need to do, to destigmatize sex as a taboo topic ?

STRATEGY III

- ❑ Taking a sexual history from your client/patient as soon as possible
  - ❑ What is a sexual history format?
- ❑ Communicating empathy, compassion, sensitivity
- ❑ Having a holistic approach to sexuality

(WHO)World Health Organization (2010)
(Rashidian et al. 2014, 2015, 2016, 2017)

VITAL CONSIDERATIONS AS PART OF SEXUAL HISTORY TAKING

- ❑ Desire to have sex is not limited to young generation
- ❑ Many children know about sex as early as 6-7 years old
- ❑ Many children have sex as early as 8-10 years old
- ❑ The following groups of people are sexual members of society too:
  - ❑ Menopausal women
  - ❑ Marginalized people
    - ❑ Immigrants
    - ❑ Ethnics/minorities
    - ❑ Individuals with disabilities (mental and physical)
    - ❑ LGBTQ
  - ❑ All religious backgrounds
  - ❑ All socio-economical status

VITAL CONSIDERATIONS AS PART OF SEXUAL HISTORY TAKING

- ❑Significant increase in the rate of STIs/STDs among elderly (age 65-up) population (CDC 2018)
- ❑Elderly population can teach us much about quality sexual relationships

VITAL CONSIDERATIONS AS PART OF SEXUAL HISTORY TAKING

A SYSTEMATIC APPROACH

STEP I:

- ❑General psychosocial and sexual history
- ❑Prevalence Of Sexual Disorders
- ❑The problem as the patient sees it

VITAL CONSIDERATIONS AS PART OF SEXUAL HISTORY TAKING
A systematic approach

STEP II:

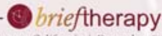
- ❑ Specifics of the presenting problems
- ❑ The emotional dimension
- ❑ The cognitive dimension
- ❑ The physical dimension
- ❑ The behavioral dimension
- ❑ The relational dimension
- ❑ The spiritual dimension
- ❑ The cultural dimension
- ❑ Socio-cultural issues – The anesthetized shame

BRIEF THERAPY INTERVENTIONS (BTI):

- ❑**Patients' education and awareness**
  - ❑We are born as sexual beings
  - ❑Sexual desires are both normal and healthy
  - ❑Challenge cultural norms
    - ❑Hierarchy & power dynamics
    - ❑Assigned roles and places

BRIEF THERAPY INTERVENTIONS

- ❑**Focusing on cultural implications**
  - ❑Sex is NOT dangerous
  - ❑Power tends to corrupt
  - ❑In organized religions
    - ❑The power hierarchy in many cases has attempted to control their followers, in part, by dictating what is permissible, and what is not permissible sexually
  - ❑Next to survival, sex is the most powerful drive
    - ❑It tends to present as a powerful threat to those who seek to control others



BRIEF THERAPY INTERVENTIONS

❑Ask about sexual stories (Narratives)

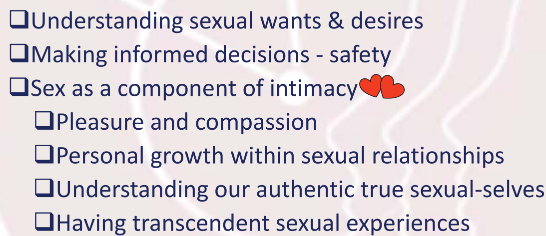
- ❑Internal struggles
- ❑Fear, guilt, shame, sinfulness
- ❑Secrets
- ❑The do's and don'ts
- ❑The attitudes

- ❑**Assertiveness** (unlearning and relearning)
- ❑**Communication** (begins by learning and knowing how to find their sexual words)
- ❑**Resourcefulness**

BRIEF THERAPY INTERVENTIONS

❑Focusing on "Sex Positive Culture"

- ❑Understanding sexual wants & desires
- ❑Making informed decisions - safety
- ❑Sex as a component of intimacy
  - ❑Pleasure and compassion
  - ❑Personal growth within sexual relationships
  - ❑Understanding our authentic true sexual-selves
  - ❑Having transcendent sexual experiences



Focusing on "Sex Positive Culture"

- ❑ **Steps for making positive cultural changes**
  - ❑ **Improving sexual healthcare requires:**
    - ❑ A collaborative response throughout society
    - ❑ Supported by the public health community, and healthcare systems, government and policy makers
    - ❑ Physicians & mental health professionals need to be effectively supported to; **Refuse /challenge** the '**appropriate laws and policies**', if they are not addressing patients' best interests.

Focusing on "Sex Positive Culture"

❑The elimination of "VIRGINITY-TESTING"

(WHO, UN Human Rights and UN Women, October 17, 2018)

- ❑**Has no scientific or clinical basis**.
- ❑Such procedures must never be carried out.
- ❑Impacts girls' physical, psychological, and social well-being.
- ❑Reinforces stereotyped notions of female sexuality, and gender inequality.

❑ **Steps to making cultural positive change**

❑ **"VIRGINITY TESTING"**

- ❑The examination can be painful, humiliating, traumatic, and ultimately dehumanizing.
- ❑It is unethical for doctors or other health providers to undertake them! (WHO, UN Human Rights and UN Women, October 17, 2018)

❑My support/theory of promoting sexual healthcare in accordance to WHO's policies:

- ❑ A human rights-based approach
- ❑ A gender-responsive approach
- ❑ A people-centered healthcare systems approach
- ❑ A whole-of-government, and whole-of-society approach.
- ❑ A public health approach

❑WE, AS CLINICIANS, ARE COLLECTIVELY, RESPONSIBLE TO:

- ❑ DESTIGMATIZE SEX AS A TABOO TOPIC, AND BREAK THE UNHEALTHY AND DEADLY HISTORICAL CONTROL OF PEOPLE'S SEXUALITIES!
- ❑ ENCOURAGE AND PROMOTE TALKING ABOUT SEX ACROSS SOCIETIES!

❑CULTURE IS A TANGIBLE PHENOMENA ...WE MUST CHALLENGE IT!

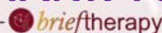
- ❑ GOVERNMENT MAKING DECISIONS FOR SEXUAL HEALTH CARE
- ❑ ECONOMICAL LIMITATIONS IMPACTING SEXUAL HEALTH RESEARCH AND EDUCATION
- ❑ EDUCATIONAL SYSTEMS FOR NOT PROVIDING EFFECTIVE CURRICULUMS FOR MEDICAL AND MENTAL HEALTH STUDENTS
- ❑ RELIGIOUS DOGMA

WE (CLINICIANS)ARE THE CHAMPIONS & THE LEADERS…

WE MUST IMPLEMENT HUMANE & EFFECTIVE SEXUAL HEALTHCARE FOR OUR PATIENTS!

LET'S TALK ABOUT SEX…

THANK YOU!



RESOURCES

- Centers for Disease Control and Prevention (CDC)
- World Health Organization (WHO)
- American Association of Sexuality Educators, Counselors and Therapists (AASECT): www.aasect.org
- Center for sexual health/ UMHS: 1 – 734 – 763 – 963 ; www.med.umich.edu/sexualhealth
- Sexual Health Sheffield – UK

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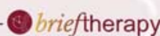

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