The GOALS Approach: Redefining Sexual History to Improve Health

Sarit A. Golub, PHD, MPH
Distinguished Professor | Hunter College, City University of New York
Hunter Alliance for Research & Translation

March 11, 2026|Physician Trainee Program: Sexual Health Integration & Focused Training

HART Hunter Alliance for Research & Translation

HUNTER The City University of New York

THE GRADUATE CENTER CITY UNIVERSITY OF NEW YORK

About GOALS and Acknowledgements

Stephanie Hubbard

Staci Barton

Ariel de Roche

Imani Hall

The GOALS Approach to Sexual History and Health was developed by Sarit A. Golub, PhD, MPH in collaboration with the **New York City Department of Health and Mental Hygiene (DOHMH) Bureau of HIV**.

The GOALS Approach was made possible by the insightful and inspirational contributions of **Stephanie Hubbard**. Staci Barton has made critical contributions to GOALS refinement, dissemination, and training.

Many thanks to **Dr. Julie Myers**, and to the other visionary clinicians who contributed to the GOALS Approach:
Lyn Stevens, Caroline "Kerri" Carnevale, Viraj Patel, Jason Zucker, Karen Hennessey, Peggy Leung, and Carlos Salama.

Learning Objectives

At the conclusion of this session, the participant will be able to:

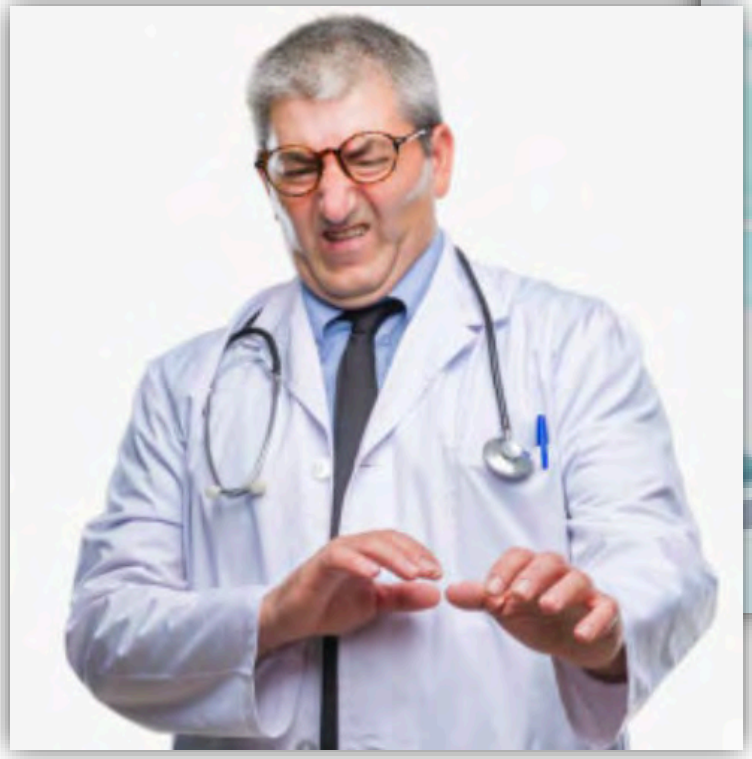
- Understand the rationale behind the GOALS Approach and its evidence-based framework
- Describe the five steps of the GOALS Approach and the ways in which each component is designed to normalize sexual health, reduce bias, and improve patient-provider relationships
- Apply the GOALS Approach to sexual health in a specific practice setting to enhance delivery of status-neutral, client-centered, anti-stigma care.

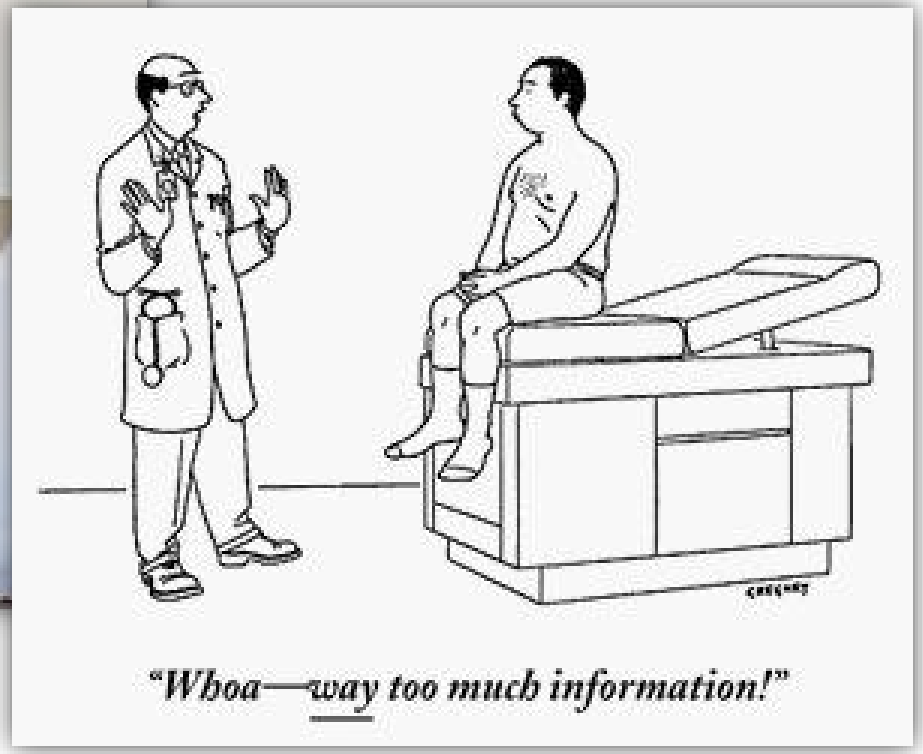
Definition of Sexual History

> A medical history of a patients' sexual practices, concerns, illnesses, partners, preventive activities, and risk factors for sexually transmitted diseases.
>
> A short sexual history is recommended as part of every complete physical examination.

Mosby's Medical Dictionary, 8th edition. (2009).

The sexual history is a critical implementation strategy for increasing access to and uptake of HIV prevention interventions





Let's start with a quick poll…

1. What percent of **clinicians** take a sexual history as part of the **annual exam**?

2. What percent of **patients** report **wanting** to talk about sexual health concerns with their providers?

There are missed opportunities…

6% of primary care providers take a sexual history at every visit.

55% take a sexual history as part of the annual exam.

76% take a sexual history if relevant to the chief complaint

Wimberley et al., 2006, *Journal of the National Medical Association*

Sexual health is a priority for patients

85% of patients report wanting to talk about sexual health concerns with their providers

71% said primary care providers should ask all patients if they have sexual health concerns

68% of patients report fear of embarrassing their provider as a reason for not broaching sexuality

Marwick. *JAMA,* 1999; Ryan et al., *PRiMER*, 2018.

Missed opportunities → inequities

10% of patients who would benefit from PrEP have received a prescription

Blacks and Hispanics account for **71%** of new HIV infections, but only **22%** of PrEP prescriptions

Cisgender women account for **19%** of new HIV infections, but **< 5%** of PrEP prescriptions

Challenges to Sexual History Taking

- Time constraints make it difficult to assess, identify or address problems
- Conversations about sex can be uncomfortable for patients and providers
- Standard sexual history training focuses on questions, but its unclear what to do with the answers
- Risk reduction conversations often feel scripted or ineffective

How can we REIMAGINE
the sexual history
to make it *easier and better*
for clinicians and patients?

What are the Goals of Sexual History Taking?

“I need to figure out whether my patients need HIV testing or what STI tests they need.”

"I need to understand their risk, so that I can provide education and counseling.”

“I need to identify what interventions to offer – like PrEP, contraception, or vaccines.”

Two (provocative) data-driven claims

- The goals for sexual history should be revised and reconsidered
- Revising sexual history goals will streamline the process and improve a focus on sexual health.

GOALS Approach
to sexual history and health

Evidence base for the GOALS Approach

- **Meta-analytic review** of articles published from 1999 -2019 about sexual history taking
- **Key-informant interviews** with adult and adolescent providers representing both public and private hospitals, as well as community-based clinics
- Comprehensive review of **35 curricula**/training videos
- **Focused literature review** of research regarding key sexual history components and goals
- **Iterative design and development process** based on Collaborative Institutes with over **45 providers** from **20 practice settings**

The GOALS Approach is designed to…

- Increase rates of routine HIV/STI screening
- Increase rates of universal biomedical HIV prevention and contraceptive education
- Increase patients' motivation for and commitment to sexual health behavior
- Enhance the patient-provider relationship, making it a lever for sexual health and overall wellness
- Streamline sexual history conversations

Agenda for Today's Workshop

1. Overview of the GOALS Approach and its components
2. Information about the data and research that informs and underpins GOALS
3. Provide an opportunity for you to engage with GOALS in a brief (painless) activity
4. Discuss the ways in which GOALS "reduces risk" in sexual history encounters
5. Leave time for questions & discussion

GOALS

- **G**ive a preamble that emphasizes sexual health
- **O**ffer opt-out HIV/STI testing and information
- **A**sk an open-ended question
- **L**isten for relevant information and probe to fill in the blanks
- **S**uggest a course of action

GOALS Approach
to sexual history and health

Give a preamble that emphasizes health

Evidence/Rationale

- "Lack of opportunity" is most common reason patients don't talk to providers about their sexual health
- "Risk"-focused conversations are often stigmatizing and alienating to patients
- Quality of the provider-patient relationship has the greatest single effect on patient engagement (e.g., adherence, health monitoring, and general prevention behavior).

Marwick. *JAMA,* 1999; Ryan et al., *PRiMER*, 2018; Althof et al., *J Sex Med,* 2013; Wimberley et al., *J Nat Med Ass, 2006;* Kingsberg, Obstet Gynecol Clin N Am, 2006; Nusbaum & Hamilton, *Am Family Physician*, 2002; Alexander et al. *Health Service Res,* 2011; Andrews, J Women's Health, 2000; Althof et al., *J Sex Med,* 2013 ; Sheeran et al., Psych Bull, 2013;

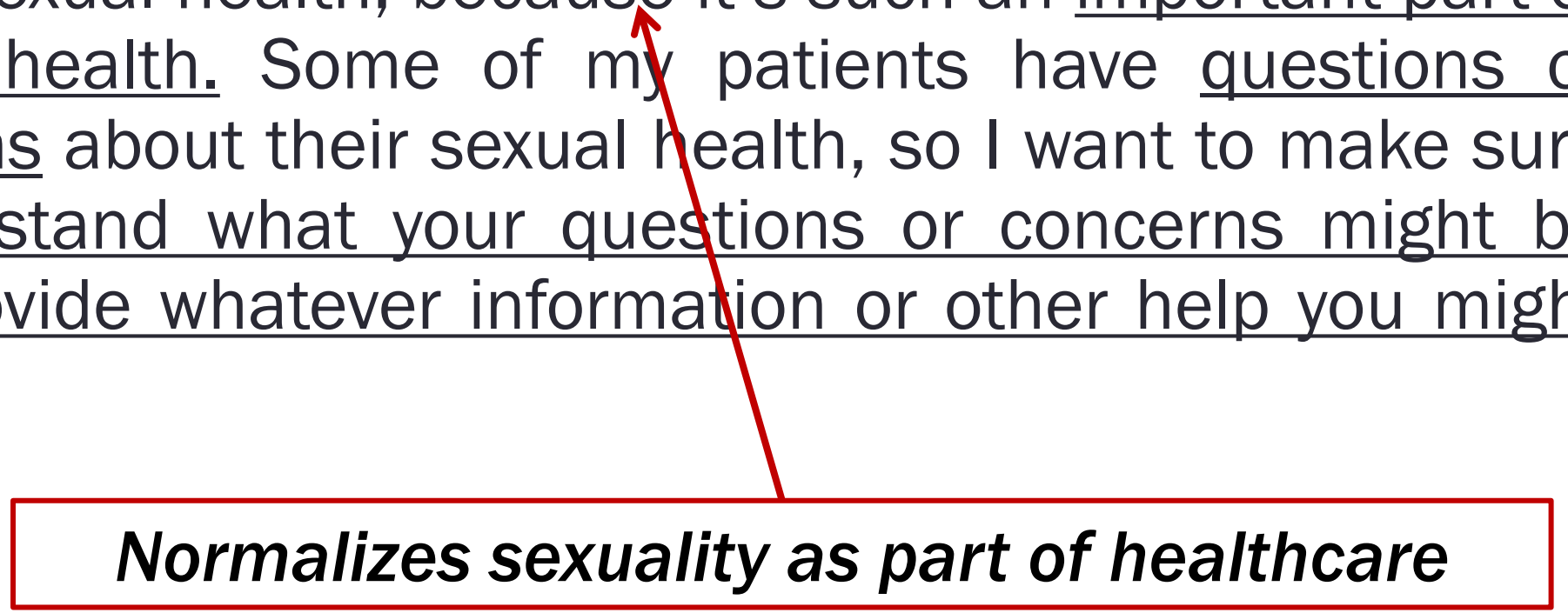
Give a preamble that emphasizes health

> “I’d like to talk with you for a couple of minutes about your sexuality and sexual health. I talk to all of my patients about sexual health, because it’s such an important part of overall health. Some of my patients have questions or concerns about their sexual health, so I want to make sure I understand what your questions or concerns might be and provide whatever information or other help you might need.”

Focuses on health not risk

Give a preamble that emphasizes health

> “ I’d like to talk with you for a couple of minutes about your sexuality and sexual health. I talk to all of my patients about sexual health, because it’s such an important part of overall health. Some of my patients have questions or concerns about their sexual health, so I want to make sure I understand what your questions or concerns might be and provide whatever information or other help you might need.



Give a preamble that emphasizes health

> “ I’d like to talk with you for a couple of minutes about your sexuality and sexual health. I talk to all of my patients about sexual health, because it’s such an important part of overall health. Some of my patients have questions or concerns about their sexual health, so I want to make sure I understand what your questions or concerns might be and provide whatever information or other help you might need.

Opens the door for patients’ questions

Give a preamble that emphasizes health

> “ I’d like to talk with you for a couple of minutes about your sexuality and sexual health. I talk to all of my patients about sexual health, because it’s such an important part of overall health. Some of my patients have questions or concerns about their sexual health, so I want to make sure I understand what your questions or concerns might be and provide whatever information or other help you might need.

Clearly states a desire to understand and help

Offer opt-out HIV/STI testing and information

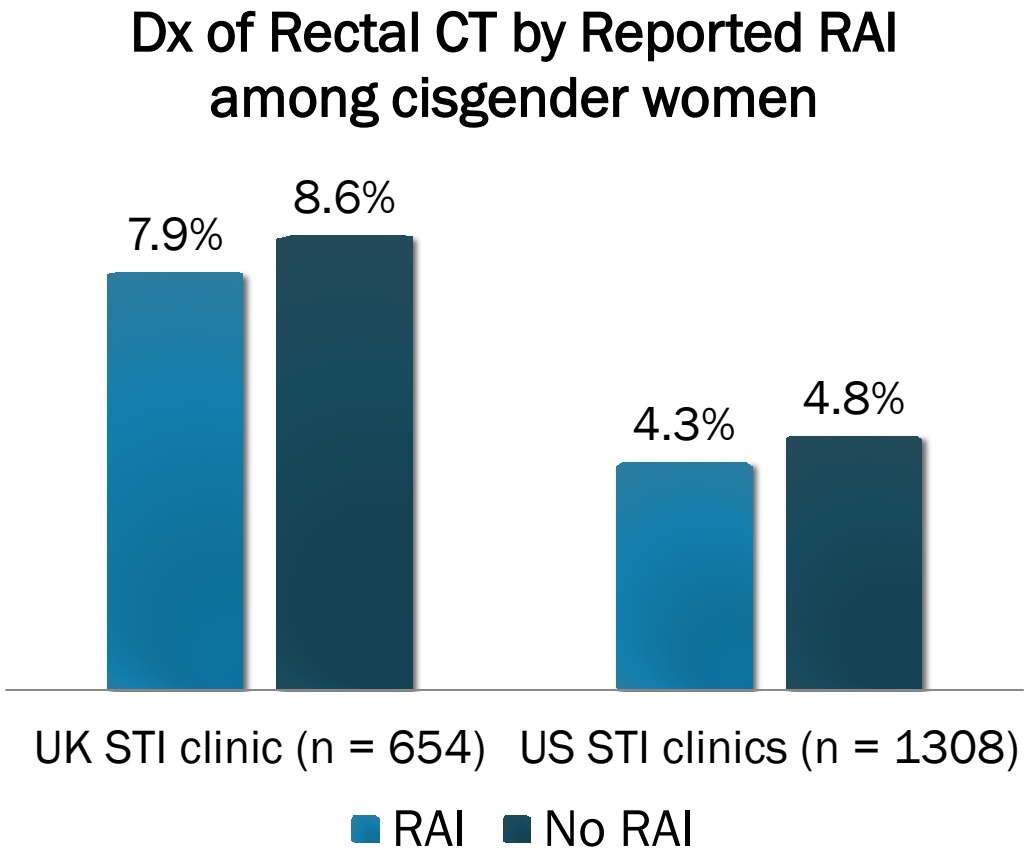
Evidence/Rationale

- Universal HIV/STI screening is more efficient and cost- effective than risk-based screening.
- "Risk-based" screening fails to screen between 45% and 85% of eligible patients each year
- Modeling studies estimate that opt-out screening for high-prevalence populations reduces sequelae from STIs by over 37% and would reduce STI-related costs by over 20% ($18.1 mill) compared to risk-based screening

Wimberley et al., *J Natl Med Assoc*, 2006; Hull et al., *Popul Health Manag*, 2011; Owusu-Edusei et al., *Am J Prev Med* 2016

Evidence base for GOALS Framework

Universal HIV/STI screening is more efficient and cost effective than risk-based screening.



In a 2017 survey of OBGYN patients in NYC

47% reported engaging in anal sex, and

85% reported giving oral sex

Chan et al., *Infect Dis in OBGYN,* 2015; Dukers-Muijrers et al. *BMC Infectious Diseases,* 2015; Hart et al. *Obstetrics & Gynecology,* 2018.

Offer opt-out HIV/STI testing and information

> “So first, I like to test all my patients for HIV and other sexually-transmitted infections. Do you have any concerns about STIs?

- Doesn’t commit to which tests, but normalizes testing
- Sets up the idea that you will recommend testing regardless of what the patient tells you
- Opens the door for patient to talk about STIs as a concern

Ask an open-ended question

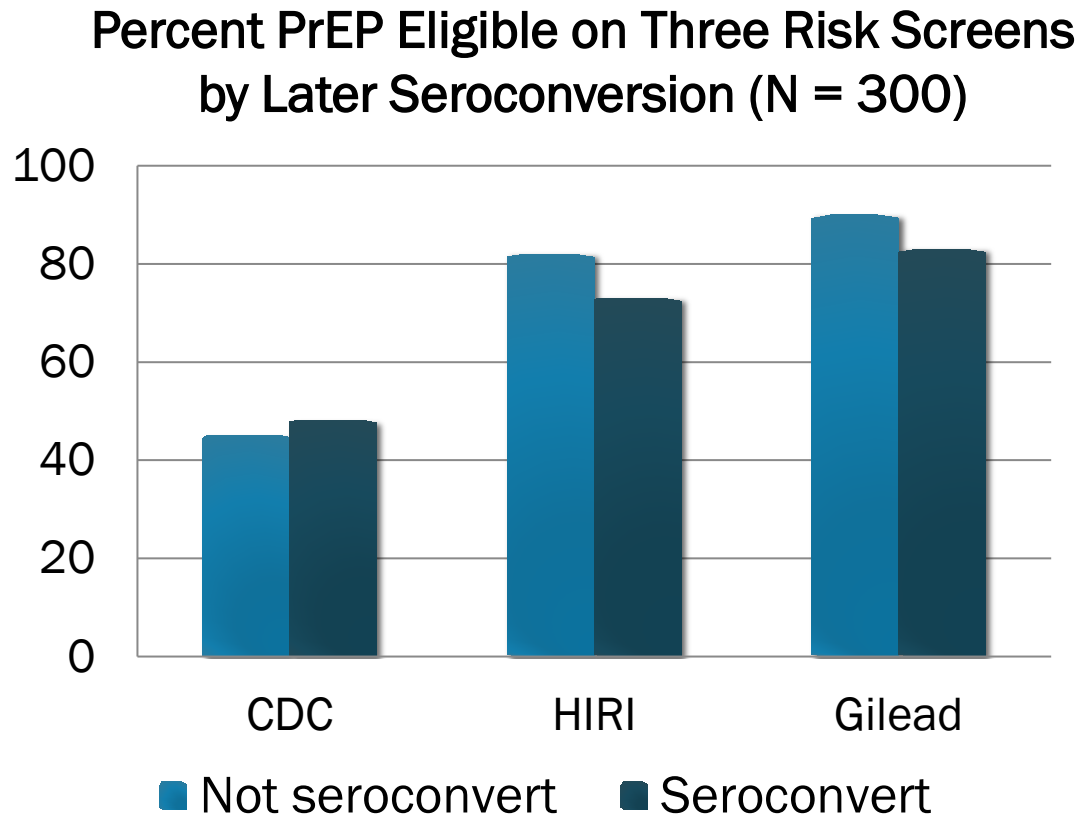
Evidence/Rationale

- Standard **risk assessment** questions are **stigmatizing** and are **not predictive** of exposure or seroconversion
- "Objective" risk scores are **not associated with risk perception** for most patients.
- Attempts to heighten risk appraisals are **ineffective** and often associated with **reactance**
- Closed assessment questions can lead to **failed communication**/misunderstandings

Lancki et al., 2018, *AIDS*; Hoots et al., 2016, *Clin Infect Dis*; Cossarini et al., 2018 *AIDS & Behaviorl* Biello et al., *Arch Sex Behav* 2018; Wilton et al., *Int J AIDS Soc* 2016; Weinstein & Klein, *Health Psych,* 1995; Sheeran et al., Psych Bull, 2013; Schuz et al., *Health Psych*, 2013

Evidence base for GOALS Framework

Data suggest that basing PrEP eligibility screens may "miss" critical populations



Young black MSM are **least likely** to have an indication for PrEP

Seroconversion is most strongly linked to **zip code** and social networks

Lancki et al., 2018, *AIDS*; Hoots et al., 2016, *Clin Infect Dis*; Cossarini et al., 2018 *AIDS & Behavior*

Ask an open-ended question

Choose your favorite…

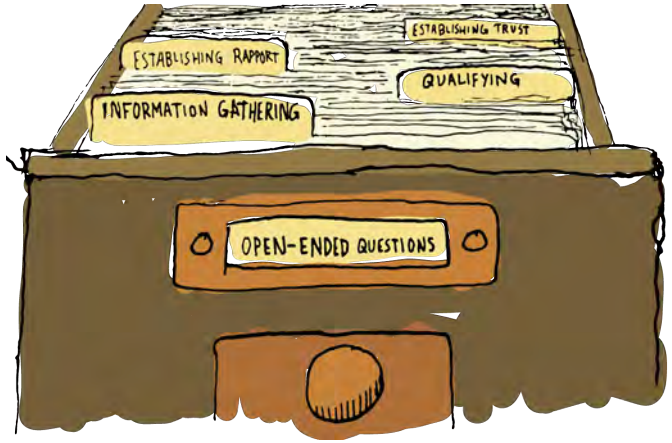
A. Tell me a little bit about your sex life.

B. What would you say are your biggest sexual health concerns?

C. How is your current sex life similar or different from what you think of as your ideal sex life?

Ask an open-ended question

Why start with an open-ended question?



- Puts the focus on the patient
- Let's you hear what the patient thinks is most important first
- Let's you hear the language they use to talk about their body, partners, and sex

Listen and probe to fill-in the blanks

Evidence/Rationale

- **Reduces time** needed for sexual history by focusing only on issues that need to be clarified or addressed
- Provides **flexibility** to tailor conversation for EMR fields or other requirements
- **Reduces bias** by mirroring patients' language and using non-gendered terminology

Fitzgerald & Hurst, *BMC Med Ethics*, 2017; Sabin et al., *AJPH*, 2015; Petroll & Mosack, *Sex Transm Dis*, 2011 .

Listen and probe to fill-in the blanks

- **Partners**
  - Tell me about your partners.
  - Tell me about any other partners.
- **Protection**
  - How do you protect yourself against HIV and STIs?
- **Pregnancy**
  - How do you prevent pregnancy (unless you are trying to have a child)?
- **Practices**
  - Do you have any other sexual health concerns?
  - What would help you take (even) better care of your sexual health?

Makes no assumptions about monogamy or partner gender

Can be asked regardless of patient's gender

Emphasizes agency and motivation

Suggest a course of action

Evidence/Rationale

- Belief in the **benefits** and efficacy of an intervention is most strongly associated with adoption of health behavior

Calebrese, et al., 2014, *AIDS & Behavior; Golub, Curr HIV/AIDS Rep, 2018;* Weinstein & Klein, *Health Psych,* 1995; Sheeran et al., Psych Bull, 2013; Schuz et al., *Health Psych*, 2013

Which one sounds like it's "for you"?

"PrEP is for people without HIV who are at **very high risk** of getting it from sex or injection drug use."

"PrEP is for people who want to **take control** of their sexual health and take any anxiety about HIV off their mind."

Suggest a course of action

Evidence/Rationale

- Belief in the benefits and efficacy of an intervention is most strongly associated with adoption of health behavior
- Patients' self-efficacy predicts uptake, adherence, and sustainment of health behavior
- Universal (rather than risk-based) PrEP and contraceptive education increases community-level awareness

Calebrese, et al., 2014, *AIDS & Behavior; Golub, Curr HIV/AIDS Rep, 2018;* Weinstein & Klein, *Health Psych,* 1995; Sheeran et al., Psych Bull, 2013; Schuz et al., *Health Psych*, 2013

Suggest a course of action

“ So, as I said before, I’d like to test you for…

I’d also like to give you information about PrEP/contraception. I think it might be able to help you [focus on benefit].

Here’s some information, and we can talk more or I can refer you to our counselor if you are interested or have questions. ”

- Allows you to tailor to the patient without their feeling targeted
- Allows you to couch education in terms of relevant benefits
- Provides universal education with limited time/effort

GOALS

- **G**ive a preamble that emphasizes sexual health **(20 sec)**
- **O**ffer opt-out HIV/STI testing and information **(5 sec)**
- **A**sk an open-ended question **(2 sec)**
- **L**isten for relevant information and probe to fill in the blanks
- **S**uggest a course of action **(33 sec)**

1 minute

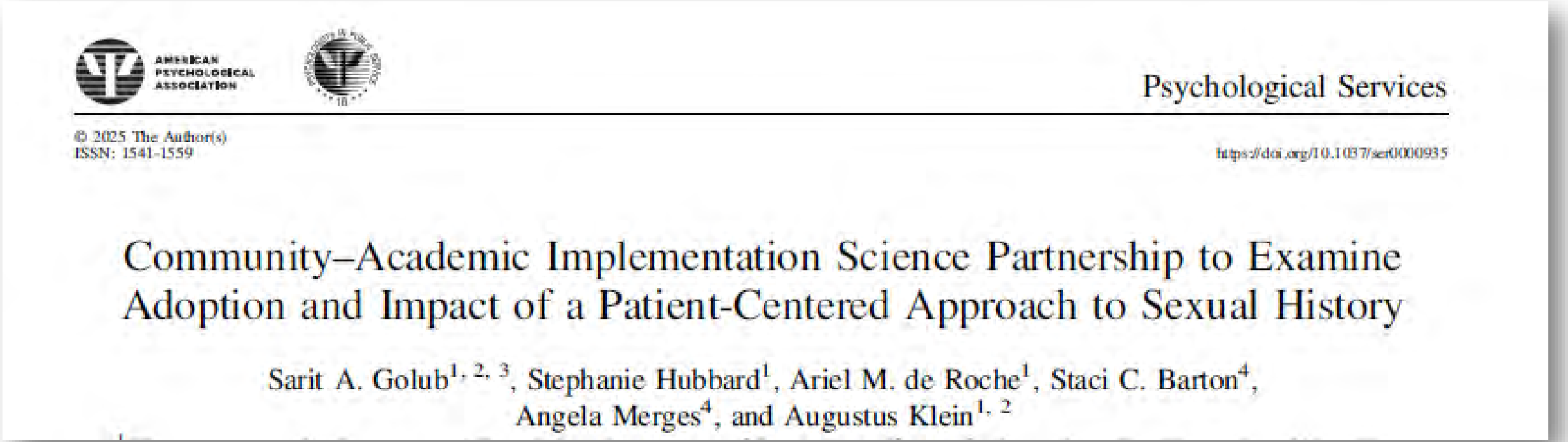
Timing depends on patients' needs

Strengths of the G O A L S Approach

- Data-driven, removes burden of traditional risk-assessment from sexual history taking
- Focuses on building patient-provider relationship, normalizing sexual health
- Designed to identify or elicit specific sexual health concerns, if present
- Reduces bias in HIV/STI screening and education about available prevention options

GOALS Approach
to sexual history and health

But does it work?
Can people really use it?



AMERICAN PSYCHOLOGICAL ASSOCIATION

Psychological Services

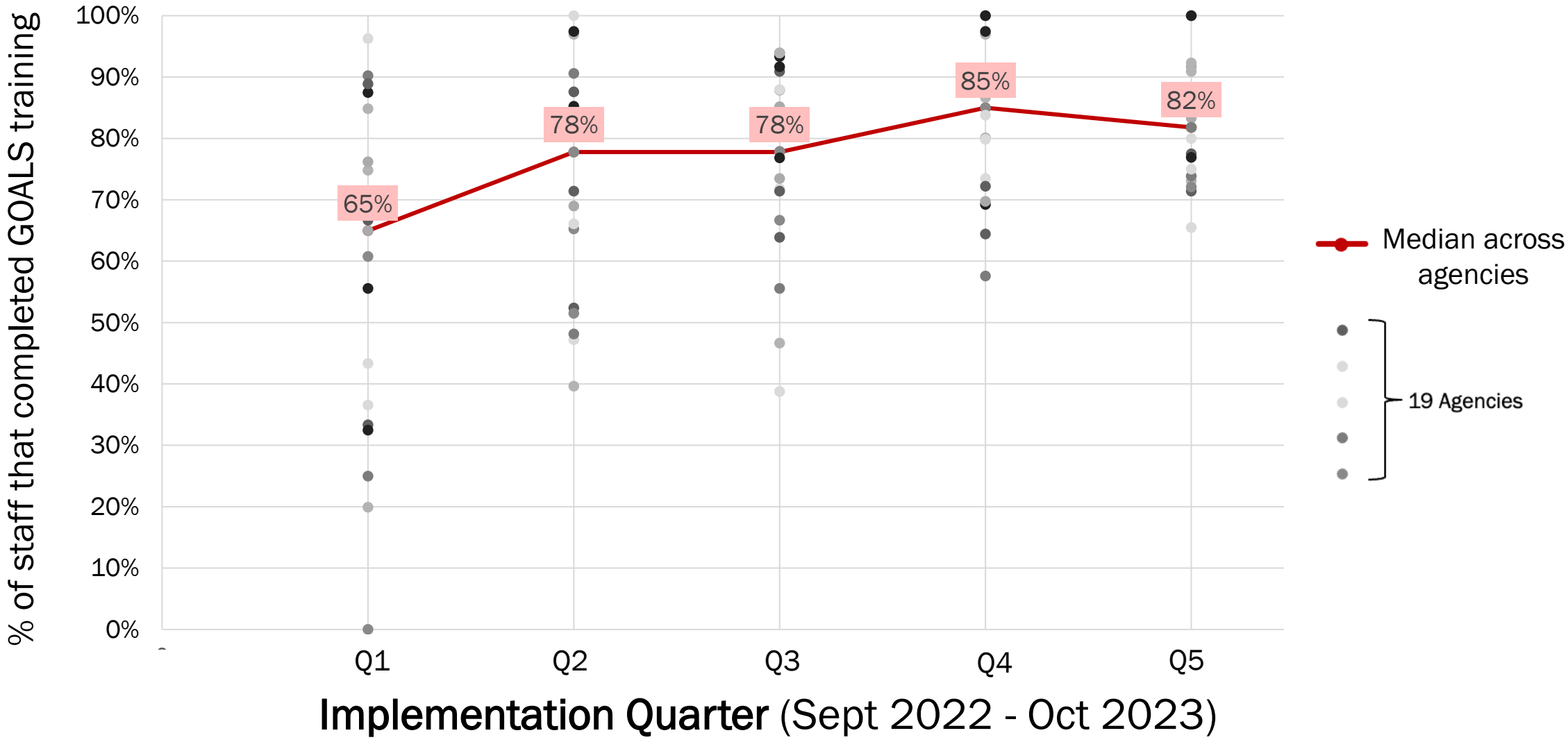
ISSN: 1541-1559

https://doi.org/10.1037/ser0000935

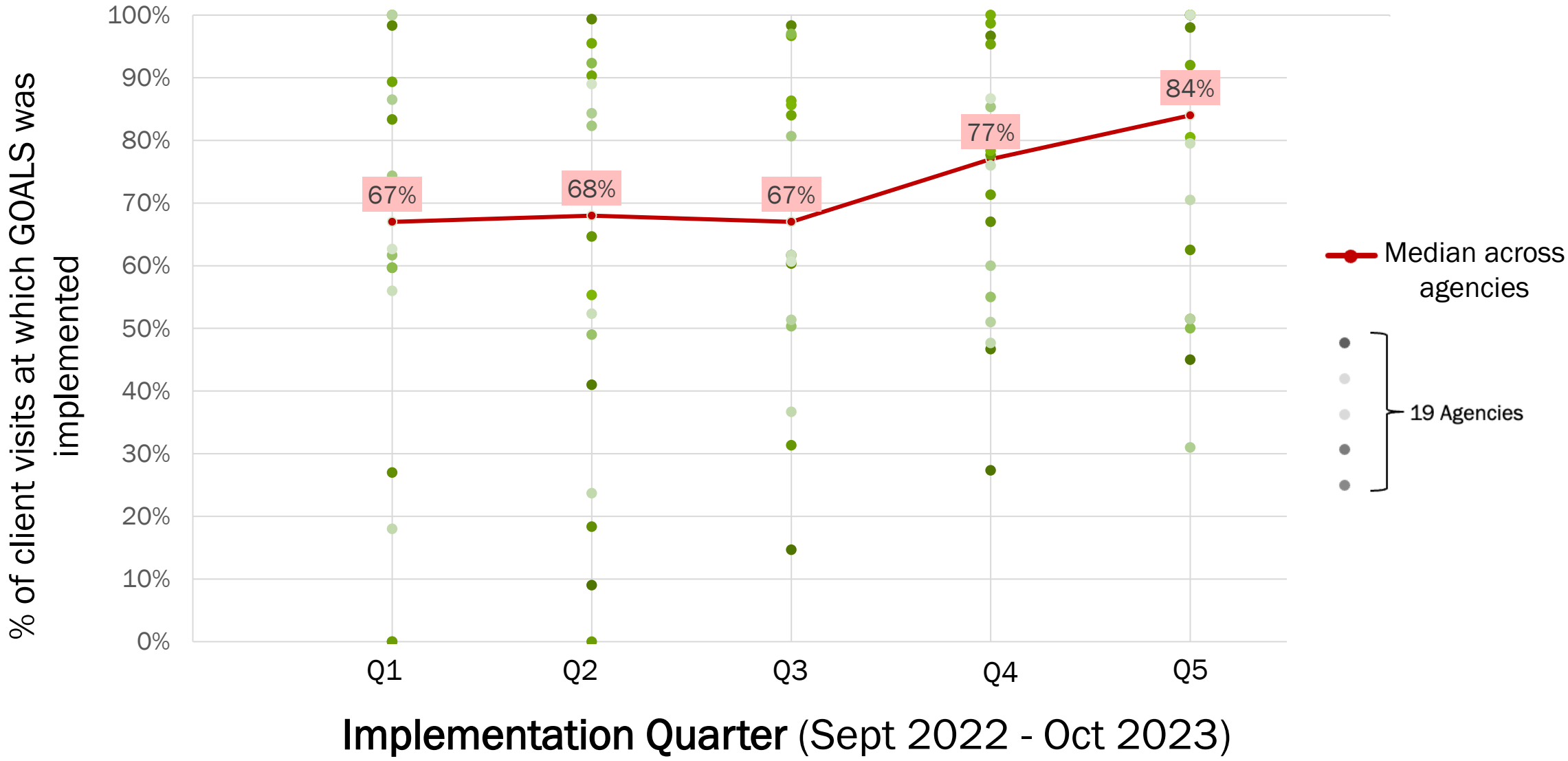
Community–Academic Implementation Science Partnership to Examine Adoption and Impact of a Patient-Centered Approach to Sexual History

Sarit A. Golub[1, 2, 3], Stephanie Hubbard[1], Ariel M. de Roche[1], Staci C. Barton[4], Angela Merges[4], and Augustus Klein[1, 2]

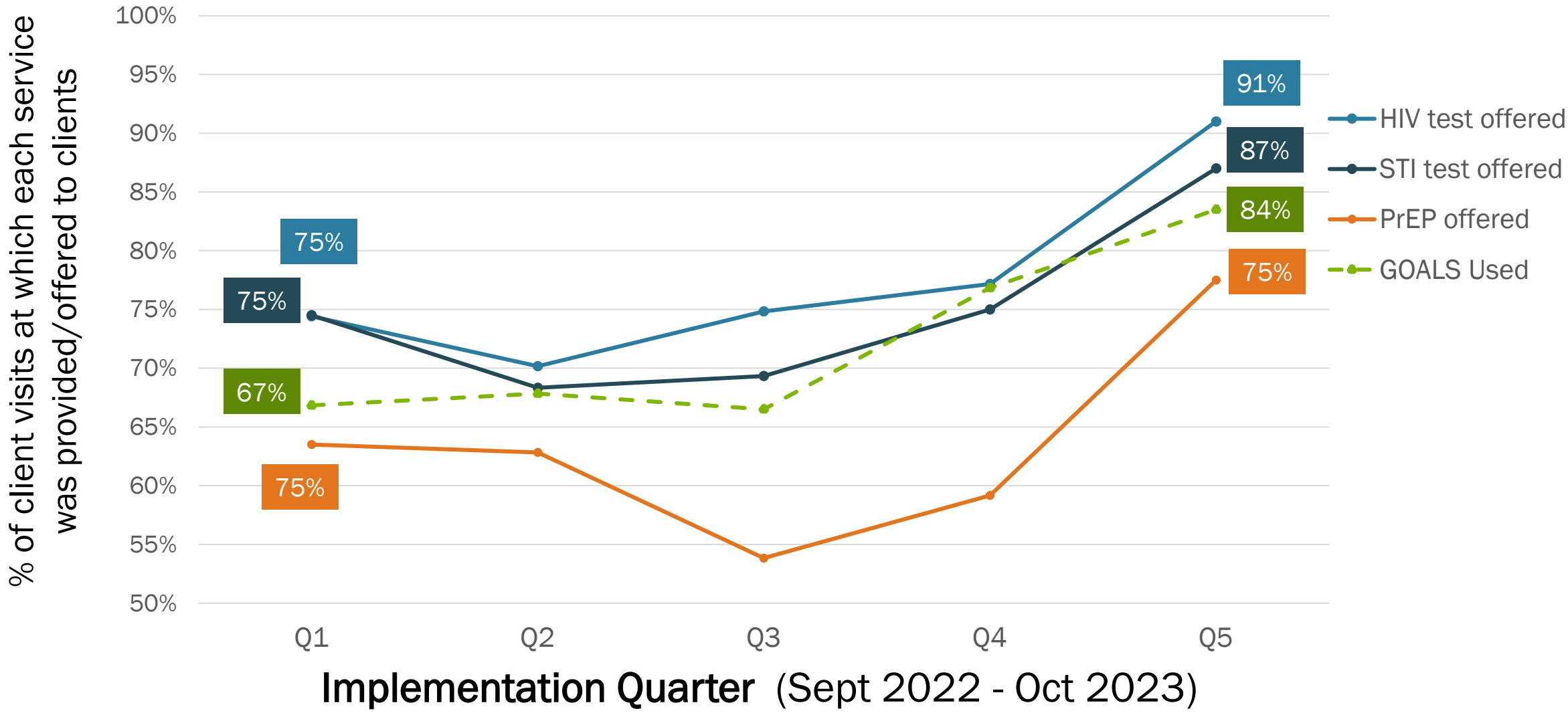
Staff Trained in GOALS Sexual History over Time



GOALS Adoption over Time

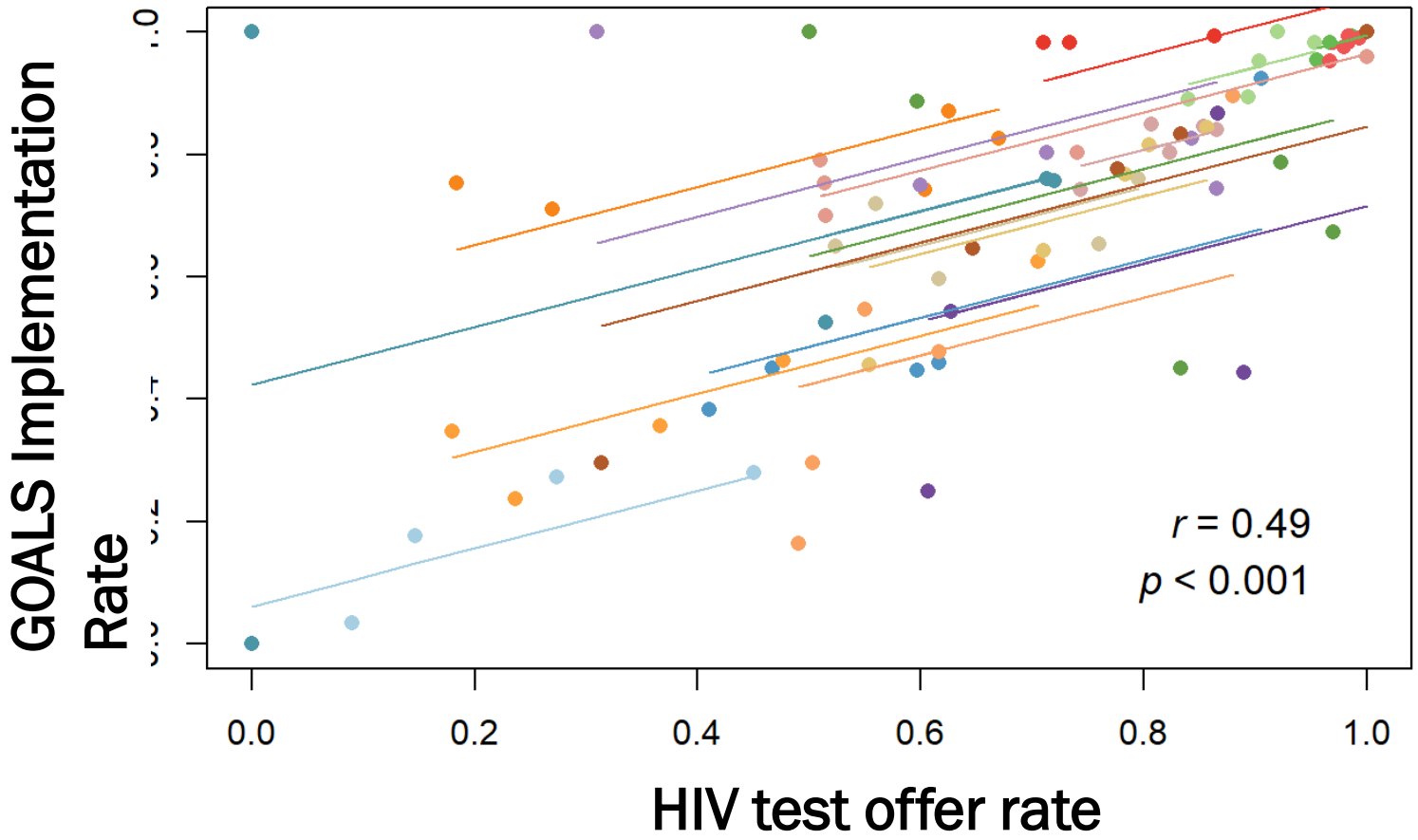


GOALS & HIV Prevention Intervention Offers (median)



Association between GOALS and EBI Adoption

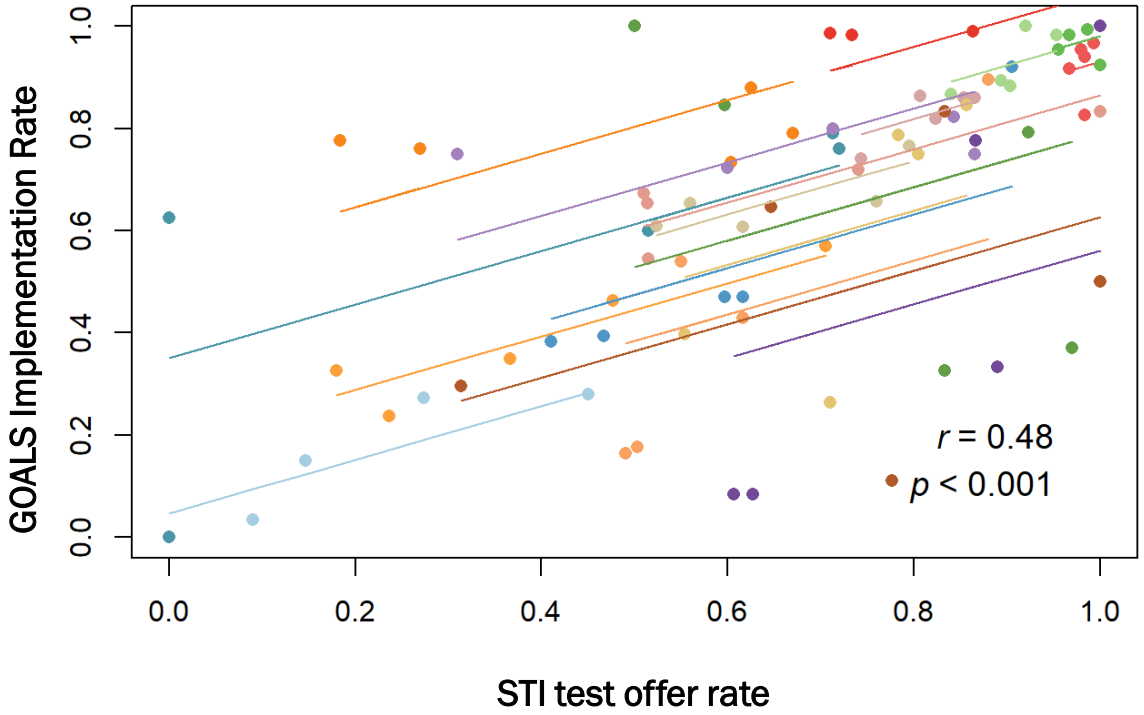
Repeated Measures Correlation Analysis (18 agencies; 5 time-points)

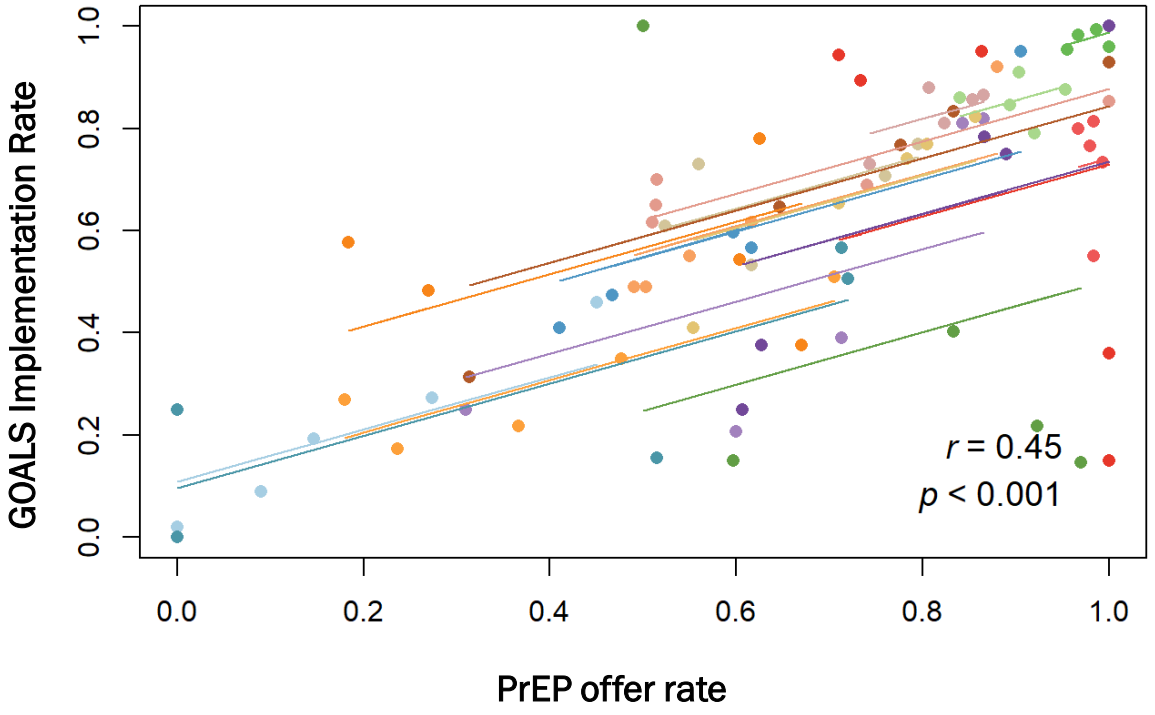


Bakdash JZ and Marusich LR (2017) Repeated Measures Correlation. Frontiers in Psychology, 8:456. doi: 10.3389/fpsyg.2017.00456

Association between GOALS and EBI Adoption

Repeated Measures Correlation Analysis (18 agencies; 5 time-points)





Bakdash JZ and Marusich LR (2017) Repeated Measures Correlation. Frontiers in Psychology, 8:456. doi: 10.3389/fpsyg.2017.00456

Who is Using the GOALS Approach?

The **New York City Health Department** includes the GOALS Approach as part of its **Ending the Epidemic Plan**

The **Southeast AIDS Education & Training Center** hosts ACCME-accredited GOALS training through their **National Coordinating Resource Center**

The **New York State AIDS Institute** recommends GOALS as part of it's **Clinical Guidelines Program**

GOALS Approach trainings have been adapted by the **University of Cincinnati College of Nursing,** among other regional educators

GOALS Approach
to sexual history and health

Online Resources

GOALS Approach Website:

goalsapproach.org

Links to guidelines, self-paced training, videos, palm cards, citations, and other resources

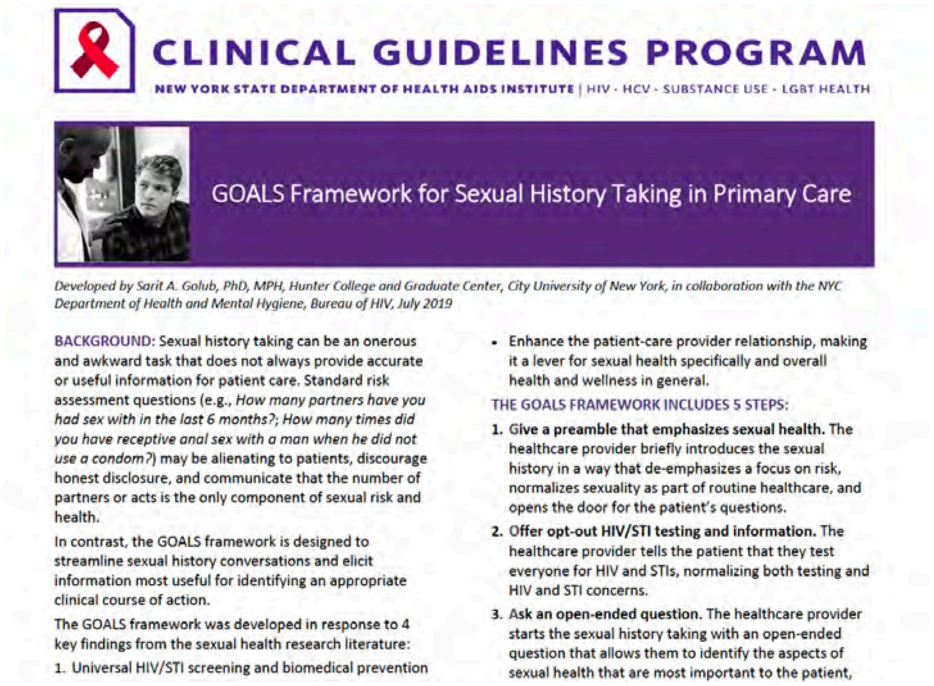
Social Media Toolkit

goalsapproach.org/social-media-toolkit

Please help us spread the word!

GOALS Resources

https://www.hivguidelines.org/guideline/goals-framework



CLINICAL GUIDELINES PROGRAM

NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE | HIV · HCV · SUBSTANCE USE · LGBT HEALTH

GOALS Framework for Sexual History Taking in Primary Care

Developed by Sarit A. Golub, PhD, MPH, Hunter College and Graduate Center, City University of New York, in collaboration with the NYC Department of Health and Mental Hygiene, Bureau of HIV, July 2019

BACKGROUND: Sexual history taking can be an onerous and awkward task that does not always provide accurate or useful information for patient care. Standard risk assessment questions (e.g., *How many partners have you had sex with in the last 6 months?; How many times did you have receptive anal sex with a man when he did not use a condom?*) may be alienating to patients, discourage honest disclosure, and communicate that the number of partners or acts is the only component of sexual risk and health.

In contrast, the GOALS framework is designed to streamline sexual history conversations and elicit information most useful for identifying an appropriate clinical course of action.

The GOALS framework was developed in response to 4 key findings from the sexual health research literature:

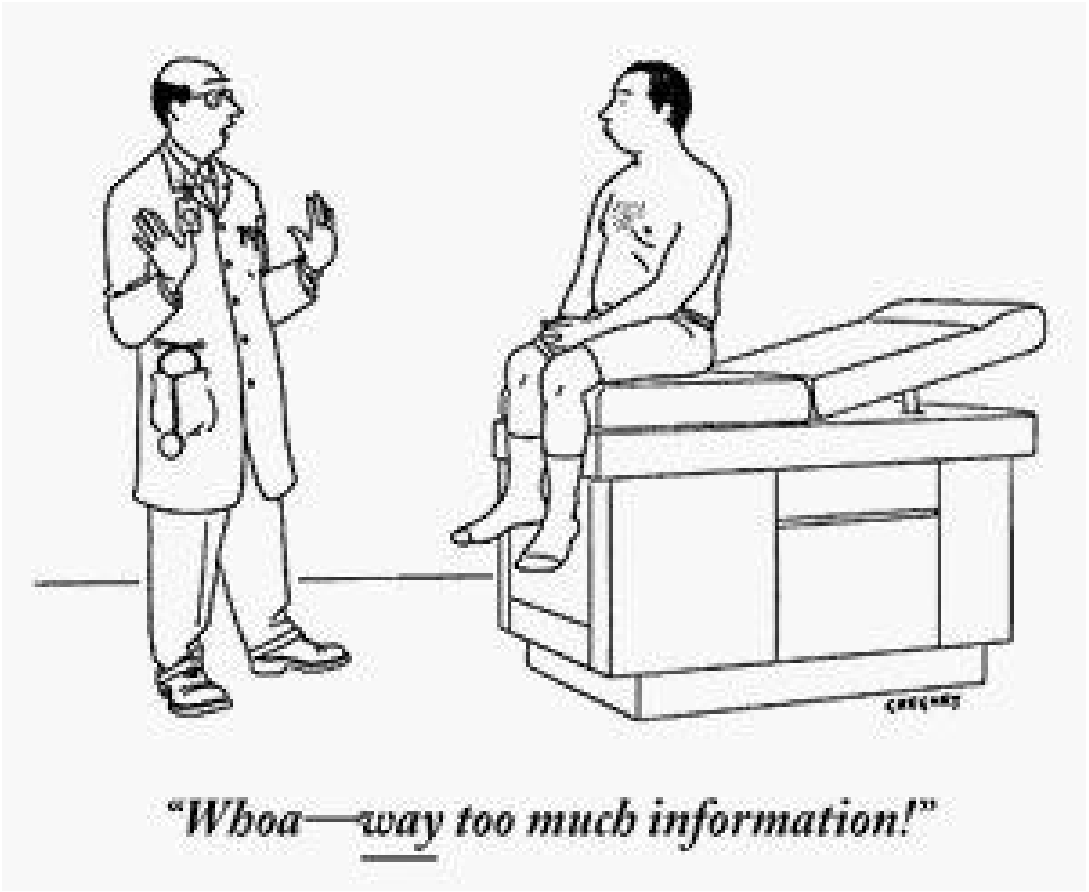
1. Universal HIV/STI screening and biomedical prevention

- Enhance the patient-care provider relationship, making it a lever for sexual health specifically and overall health and wellness in general.

THE GOALS FRAMEWORK INCLUDES 5 STEPS:

1. **Give a preamble that emphasizes sexual health.** The healthcare provider briefly introduces the sexual history in a way that de-emphasizes a focus on risk, normalizes sexuality as part of routine healthcare, and opens the door for the patient's questions.
2. **Offer opt-out HIV/STI testing and information.** The healthcare provider tells the patient that they test everyone for HIV and STIs, normalizing both testing and HIV and STI concerns.
3. **Ask an open-ended question.** The healthcare provider starts the sexual history taking with an open-ended question that allows them to identify the aspects of sexual health that are most important to the patient,

The **GOALS** approach is designed to reduce "risk" in the sexual history…



The GOALS Approach reduces the risk of…

- **Failing to screen** a patient for HIV/STIs who really needs screening
- **Failing to provide** HIV prevention or other sexual health **education** to patients who would benefit from it
- Unintentionally **offending or alienating** patients with risk-focused language

Traditional risk assessment

- How many partners have you had in the past 6 months?
- How many times did you have receptive sex?
- How many of those acts were condomless?
- How many of your partners were HIV+?

Disconnects in risk assessment

- Communicates that number (of partners, of acts) is the biggest factor in risk
- Fails to assess risk in primary partnerships
- Reinforces the idea that it is easy to know a partner's HIV status
- Eliminates potential to assess patient's concerns, knowledge, or agency
- Ignores baseline prevalence in patients' networks and communities

A focus on context…

High-risk contexts in which HIV/STI exposure may occur include:

- Experiences of sexual violence or assault
- Sexual encounters with an unequal balance of power
- Engagement in sex work as a form of survival
- Dating and sexual expression in high prevalence communities
- Incarceration and CJ involvement

Motivating behavior change

Data support a focus on benefits instead of risks.

Behavior change is associated with beliefs in:

① Effectiveness of a proposed intervention

② Self-efficacy to engage in behavior

Weinstein & Klein, *Health Psych,* 1995; Sheeran et al., Psych Bull, 2013; Schuz et al., *Health Psych*, 2013

The GOALS Approach reduces the risk of…

- **Failing to screen** a patient for HIV/STIs who really needs screening
- **Failing to provide** HIV prevention or other sexual health **education** to patients who would benefit from it
- Unintentionally **offending or alienating** patients with risk-focused language
- Falling prey to **unconscious biases** that limit care

FitzGerald and Hurst *BMC Medical Ethics* (2017) 18:19
DOI 10.1186/s12910-017-0179-8

BMC Medical Ethics

RESEARCH ARTICLE Open Acces

Implicit bias in healthcare professionals: a systematic review

Chloë FitzGerald* and Samia Hurst

20/25 clinical vignette "assumption" studies found bias in diagnosis, treatment recommendations, number of questions asked of the patient, or number of tests ordered for the patient.

Patient characteristics subject to bias…

- Age
- Gender
- Race/ethnicity
- Socioeconomic status
- Weight
- Mental Illness
- HIV/AIDS
- Substance use
- Disability or ability

Overcoming biases in sexual history taking

- "Old" people have sex
- Married people aren't always monogamous
- Sexual identity doesn't always determine partners or behavior
- Telling patients about PrEP or U=U leads to risk compensation

Strategies for managing bias

1. Never supply an answer in a question

"Tell me about your partners…"

"Tell me about your sex life…"

"What are your biggest sexual health concerns?"

Strategies for managing bias

1. Never supply an answer in a question

2. Try and use gender neutral language as much as possible.

- If a person answers your “tell me about your sex life” question with – “Well, I’m married,” you can say “Tell me about your spouse”
- If a person says “I only have sex with one person,” you can say, “Tell me about them and how the two of you take care of your sexual health”

Strategies for managing bias

1. Never supply an answer in a question
2. Try and use gender neutral language as much as possible.
3. Be explicit about your lack of assumptions

"I try never to make any assumptions about my patients, so can you tell me…"

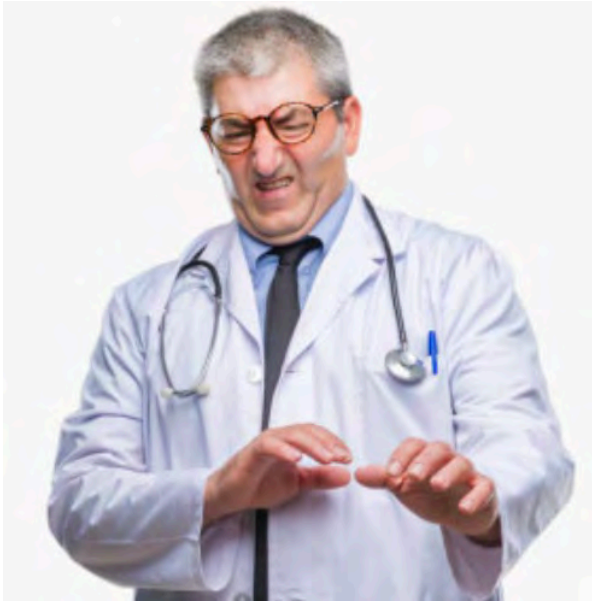
Strategies for managing bias

1. Never supply an answer in a question
2. Try and use gender neutral language as much as possible.
3. Be explicit about your lack of assumptions
4. When in doubt – ask!

"I want to make sure I understand you. Can you explain what you mean by…"

Strategies for managing bias

1. Never supply an answer in a question
2. Try and use gender neutral language as much as possible.
3. Be explicit about your lack of assumptions
4. When in doubt – ask!
5. Practice not reacting



Beyond the questions…

- Be aware of non-verbal behavior
  - Leaning forward
  - “Open” arms and legs
  - Nodding
  - Smiling
- Minimize note-taking
- Maximize eye contact
- Practice listening
- Language really matters

Strategies for managing bias

1. Never supply an answer in a question
2. Try and use gender neutral language as much as possible.
3. Be explicit about your lack of assumptions
4. When in doubt – ask!
5. Practice not reacting
6. Use the GOALS approach

GOALS is superior to traditional sexual history because…

- It is **more efficient**
- It **reduces bias**
- It is **de-stigmatizing**
- It **reduces "risk"** in patient-provider encounters
- It helps **build better** patient-provider **relationships**.

The GOALS Approach does not require clinicians to ask any *specific* question as part of the sexual history. It relies on **open-ended**, **patient-driven** conversations about sexual health, and it provides **universal, unbiased access** to sexual health screening and interventions.

> Language is power, in ways more literal than most people think. When we speak, we exercise the power of language to transform reality. **Why don't more of us realize the connection between language and power?**

Julia Penelope