SINGAPORE GUIDELINES ON SEXUAL HEALTH FOR WOMEN OF REPRODUCTIVE AGE

The College of Obstetricians and Gynaecologists Singapore (COGS) Sexual Health Guidelines for Women of Reproductive Age in Singapore Work Group:
Tse Yeun TAN‡, Jean-Jasmin Mi-Li LEE‡, Caroline CHUA, Xinyi CHEONG, Lay Kok TAN, Jason LIM, Suraj KUMAR, Zhi Ying CHIE, Jay LIM, Benny Kai Guo LOO, Weiliang CHONG, Wan Hui YIP, Melissa CHIANG, Delphine KOH, Zhong Wei HUANG, June ENG, Chee Wai KU, Phaik Ling Elaine QUAH, Kok Hian TAN
‡ These authors contributed equally as first authors.

INTRODUCTION

Sexual health is a fundamental aspect of overall health and well-being. According to the World Health Organization (WHO)[1], sexual health is defined as "a state of physical, emotional, mental, and social well-being related to sexuality; it is not merely the absence of disease, dysfunction, or infirmity." Achieving sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of pleasurable and safe sexual experiences, free from coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all individuals must be respected, protected, and fulfilled.

Healthy sexual expression of sexuality offers inherent physical and mental health benefits, contributing to emotional intimacy, relationship satisfaction, and overall quality of life[2]. Female sexual function is also a vital component of this holistic understanding of sexual health. It plays a significant role in fertility and reproductive health, which is especially pertinent when trying to conceive, during pregnancy, and after childbirth[3-5].

Despite its importance, sexual dysfunction in women is often underrecognized and undertreated. Studies worldwide report varying prevalence rates of sexual dysfunction among women of reproductive age, with figures ranging from 27% to over 50%[4,5]. Common issues include low sexual desire, arousal difficulties, orgasmic disorders, and sexual pain[4,5]. The variability in definitions and diagnostic criteria for sexual concerns, difficulties, disorders, and dysfunctions (SCDDD) contributes to the challenges in identifying and addressing these issues effectively[4].

Many women do not perceive their sexual health concerns as medical issues or may feel hesitant to discuss them with healthcare professionals (HCPs)[6]. Barriers include uncertainty about initiating the conversation, confusion about which clinician to consult, and societal stigmas surrounding sexual topics[7,8]. Moreover, HCPs may avoid addressing sexual health due to personal discomfort, lack of training, time constraints, or concerns about professional boundaries[7-9].

Addressing female sexual health is essential for improving overall health, relationships, and reproductive outcomes[10]. HCPs are well-positioned to enhance the quality of care for women by integrating sexual health into routine practice[10,11]. This requires a multidisciplinary approach and should be considered a legitimate and important aspect of clinical care throughout a woman's reproductive life[12,13].

DEFINITIONS AND CLASSIFICATION

Female Sexual Dysfunction (FSD) encompasses various disorders related to desire, arousal, orgasm, and sexual pain. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[14], FSD includes:

- **Female Sexual Interest/Arousal Disorder (FSIAD):** A lack or significant reduction in sexual interest/arousal.
- **Female Orgasmic Disorder:** Difficulty in achieving orgasm or reduced orgasmic intensity.
- **Genito-Pelvic Pain/Penetration Disorder (GPPPD):** Pain during intercourse or penetration attempts, fear or anxiety about pain, or tensing of pelvic floor muscles.

For a diagnosis of FSD, symptoms must cause significant distress, occur at least 75% of sexual events, and persist for a minimum of six months.

These guidelines aim to provide HCPs with an overview of sexual health issues in reproductive-age women and to help them develop the knowledge and comfort necessary to identify and manage women with sexual concerns. The goal is to offer guidance on screening, education, management, and referral for women experiencing sexual problems.

TARGET AUDIENCE

These guidelines are intended for all HCPs who interact with reproductive-age women in their daily practice, including general practitioners, family physicians, obstetricians and gynaecologists, nurses, midwives, pelvic health physiotherapists, and mental health professionals such as psychiatrists, psychologists, counsellors, and social workers.

GUIDELINES OVERVIEW

The guidelines are divided into the following sections:

1. Screening
2. Assessment
3. Education
4. Optimization
5. Preconception Considerations
6. Antenatal Considerations
7. Postnatal Considerations
8. Special Considerations

1. Screening

Recognizing the importance of sexual health is the first step in addressing sexual concerns among reproductive-age women. Sexual health is integral to overall health and is closely intertwined with physical, emotional, and mental well-being[1,2,4]. It encompasses not only medical topics such as contraception and sexually transmitted infections but also includes sexual functioning, which involves desire, arousal, orgasm, and satisfaction[3,4].

Women should be made to feel comfortable as much as possible when discussing sexual health, including sexual functioning, with HCPs[4,15]. Many women expect HCPs to initiate discussions when appropriate about sexual health[9]. Therefore, it is important for HCPs to proactively engage patients in conversations about their sexual well-being[4,9,15]. Incorporating questions about sexual activity, contraceptive use, sexually transmitted infections, pregnancy planning, sexual function, and sexual concerns into routine history-taking can facilitate these discussions when appropriate within the clinical context[4,7].

HCPs who may be consulted by women regarding sexual health include doctors, particularly gynaecologists and primary care providers such as general practitioners and family physicians[4,7,13,16]. Nurses, midwives, physiotherapists specializing in women's and pelvic health, psychiatrists, psychologists, and counsellor also play significant roles in addressing women's sexual health concerns[7,12,13].

It is essential for HCPs to regard the identification and management of a woman's sexual health issues as important and legitimate elements of her clinical care[7,16]. By normalizing discussions about sexual health and demonstrating openness and sensitivity, HCPs can create a safe environment for women to express their concerns[17].

2. Assessment

Assessment of female sexual dysfunction can be undertaken using brief questionnaires such as the Female Sexual Function Index-6 (FSFI-6)[18]. These tools help to identify specific areas of concern and facilitate more targeted interventions.

Involving the woman's partner in addressing sexual concerns can be beneficial when it is appropriate and safe to do so[4,19]. Male sexual issues can also affect the female partner's sexual function and vice versa[4,19]. Communication within the couple has been linked to various aspects of sexual functioning, including sexual desire, arousal, lubrication, orgasm, satisfaction, erectile function, and the experience of pain[20].

The **PLISSIT** (Permission, Limited Information, Specific Suggestions, Intensive Therapy) model[21] can be used for preliminary screening and intervention. This approach starts with giving the patient permission to express sexual symptoms or concerns, offering information about how certain changes can affect sexuality or sexual functioning, providing specific suggestions to address these issues, and referring for intensive therapy if necessary[21].

HCPs should distinguish between sexual concerns or difficulties and sexual dysfunction. Many sexual problems are transient and may resolve with basic education or minor interventions[22].

Early and appropriate intervention may allow resolution of sexual concerns and prevent further progression to sexual dysfunction[22].

It is also important to consider the implications of medical conditions and their treatments on women's sexuality[4]. Chronic illnesses such as hypertension, coronary heart disease, diabetes, and thyroid dysfunction can cause physical and emotional changes that affect sexual functioning[4,23]. Clinicians caring for women with chronic illnesses should integrate information about sexual care into their medical therapy or offer a referral to specialist sexual health services when appropriate[23].

3. Education

HCPs should encourage women to use condoms consistently and to take other steps to promote sexual health and prevent sexually transmitted infections, such as receiving the human papillomavirus (HPV) vaccination if they are sexually active[4,23]. It is important to educate patients about normal fluctuations in sexual function response due to factors such as the menstrual cycle, stress, or relationship dynamics[4,23]. For instance, patients should be informed that it is common to experience changes in sexual function related to the menstrual cycle, periods of stress, or interpersonal conflict[4]. Sexual frequency may also change with age and the duration of the relationship[23].

Changes in sexual functioning should be treated only if the woman expresses distress about these changes and desires treatment[4,23]. HCPs should offer information about the availability and efficacy of treatments and respect the patient's preferences and autonomy in decision-making.

4. Optimization

A holistic approach to optimizing sexual health involves addressing medical, psychological, sociocultural and relational factors that can affect sexual function.

Medical conditions such as hypertension, coronary heart disease, diabetes, obesity, and thyroid dysfunction can affect sexual functioning[4,24]. HCPs should be aware of these implications and integrate information about sexual care into their treatment plans[23,24]. Optimizing the management of these conditions can improve overall well-being and sexual function.

Gynaecological conditions like endometriosis and adenomyosis can also affect sexual functioning[25]. Early diagnosis and multidisciplinary management can prevent impairment of sexual quality of life[11,13]. Symptoms such as menstrual irregularities, pelvic pain, dyspareunia, dysmenorrhea, and subfertility are common[26]. Encouraging patients to communicate sexual problems as part of the assessment and referring them to a gynaecologist for further evaluation and treatment is important.

HCPs should inquire about the presence of any sexual dysfunction in male partners, when possible, as male sexual issues can affect the female partner's sexual function[4,19]. Providing resources for andrology services can help address these concerns.

HCPs should recommend regular physical exercise[27-30] and appropriate pelvic floor muscles training[31-35] to enhance overall well-being and sexual function. Referrals to pelvic health physiotherapy should be provided as needed and may be appropriate for co-managing pelvic floor disorders such as overactive bladder, urinary incontinence, prolapse, and pelvic pain[35-37].

Sexual concerns that do not respond to first-line interventions or cases of sexual dysfunction should be referred to HCPs who specialize in sexual health[38]. Establishing a list of clinical sexual health resources in the community can facilitate timely referrals when necessary.

Oral contraceptives can cause sexual dysfunction in reproductive-age women. HCPs should inquire about sexual function before prescribing oral contraceptives and assess sexual function at initiation and at regular intervals thereafter[39]. This approach allows contraceptive-related sexual dysfunction to be managed early, such as by switching the patient to newer-generation contraceptives or other forms of contraception[40].

Maintaining good mental health is associated with optimal sexual functioning[41]. The experience of psychosocial and interpersonal factors, such as daily life stressors, caregiver duties, family responsibilities, or major life events, can negatively impact sexual functioning[41]. HCPs should explicitly ask about the experience of stressors[42] or use brief screeners such as the Depression Anxiety Stress Scales (DASS-10)[43] to screen for chronic or prolonged stress. Referral to counselling or psychology services should be offered as desired.

Relationship factors like poor communication about sexual issues, conflict, and dissatisfaction can negatively influence sexual functioning[44]. Addressing these issues and offering referrals to couples counselling or psychology services can be beneficial.

Mental disorders (e.g., depressive or bipolar disorder, anxiety disorder, posttraumatic stress disorder, psychotic disorder) along with their treatments, can affect sexual functioning[45]. HCPs should inquire about the presence of any mental health condition and obtain specific information about psychotropic treatments[45]. Informing patients of the link between mental health conditions, their treatment, and sexual dysfunction, and offering referrals to specialist sexual health services for further management, is important.

In cases where poor sexual functioning is linked to past or ongoing sexual or physical trauma, the healthcare provider should consider a referral to agencies that specialize in trauma-focused assessment or support[17].

5. Preconception Considerations

When trying to conceive, sexual concerns can increase due to heightened stress[46]. HCPs should ask about stress related to the process of trying to conceive or use brief screeners like the DASS-10[43] to assess for chronic stress. Infertility, defined as the failure to achieve

pregnancy after 12 months or more of regular unprotected intercourse (or six months for women aged 35 and older), can cause distress and affect sexual functioning[25]. Early evaluation and treatment may be warranted based on medical history and age.

In assessing sexual health concerns, HCPs should involve the woman's partner when appropriate. Administering questionnaires like the FSFI-6[18], can provide more information about sexual concerns.

Preconception counselling on sexual function is important[47]. Couples trying to conceive are encouraged to have regular intercourse, and reproductive efficiency is highest with intercourse every one to two days during the fertile window[47]. However, the optimal frequency of intercourse is best defined by the couple's preference within that context[47].

Patients should be informed that coital position does not affect fecundability, and remaining supine after intercourse does not facilitate sperm transport[47]. Although some lubricants may affect sperm parameters in vitro, their use does not significantly impact fertility in practice[47]. HCPs should inform patients that sexual functioning may be affected as routines become ritualized and stress increases during efforts to conceive[47]. Support should be offered if desired[47].

Optimizing preconception sexual health involves addressing medical conditions that can affect sexual function, such as chronic illnesses and their treatments[24,27-29]. Inquiring about male partner's sexual dysfunction and providing resources for andrology services can be helpful[4,19].

Maintaining good mental health is crucial[42]. HCPs should ask about psychosocial and interpersonal factors that may impact sexual functioning, such as stress and relationship issues[41,42,44,45]. Addressing mental health conditions and offering referrals to counselling or psychology services is important[4,19].

6. Antenatal Considerations

Pregnancy introduces biological, psychological, and social changes that may alter sexual health[48,49]. Sexual function often declines during pregnancy[49] and may not return to baseline levels during the postpartum period[48]. Factors such as hyperemesis in the first trimester, fear of causing obstetric complications, physical changes, difficulty with coital positioning, changes in body image, fatigue, and urinary complaints contribute to this decline[48].

HCPs should screen for sexual functioning during antenatal visits in any trimester. Questions about sexual well-being should be part of routine medical health questioning. Using the PLISSIT[21] approach can facilitate discussions.

Proactively informing patients and their partners that HCPs are available to address concerns about sex during pregnancy is important[50,51]. Sexual functioning should be discussed early in prenatal care, before hospital discharge postpartum, and at postnatal check-ups[50,51]. Patients should be educated that their baseline for comparison is sexual activity before pregnancy[50,51].

If there are no medical or obstetric complications, couples can be reassured that they can continue sexual activity if they desire[52]. Education about common changes in sexual function and frequency across pregnancy trimesters should be provided[51]. Advice on adapting coital positions and using lubricants to address dyspareunia can support sexual adjustment[51].

Assessment for sexual functioning can be conducted with questionnaires like the FSFI[18]. Including the partner's sexual functioning in the assessment can provide a comprehensive understanding[4,19]. Diagnosing sexual dysfunction is important if difficulties have persisted for six months.

Addressing issues like vulvar pain involves advising women to avoid irritants and providing symptomatic treatment[53]. Referral to pelvic health physiotherapy can prepare women with GPPPD for normal vaginal delivery[53]. Recommending the use of lubricants or vaginal moisturizers for vaginal dryness can alleviate discomfort[4,52].

Treating medical, psychological, and relationship problems, and addressing sociocultural issues can help women and their partners deal with low desire and orgasm difficulties during pregnancy[54]. Encouraging exercise[55] and pelvic floor strengthening exercises[33,56] can improve well-being and maintain sexual function during pregnancy[57].

HCPs should screen for antenatal depression and anxiety using tools like the Edinburgh Postnatal Depression Scale[58]. Referrals to mental health professionals should be made when necessary.

7. Postnatal Considerations

Postpartum women often experience significant changes in sexual function, including dyspareunia, lack of lubrication, difficulty reaching orgasm, vaginal bleeding, and loss of desire[8]. Sexual dysfunction prevalence rates are high in the postpartum period and can significantly impact quality of life[8].

Screening for sexual functioning should occur during postpartum medical reviews. Questions about resumption of sexual activity and sexual difficulties should be incorporated into routine health questioning, using the PLISSIT[21] approach to facilitate discussions.

Assessment can include using the FSFI[18] to ascertain sexual dysfunction. Ensuring that perineal injuries have healed and addressing any bladder or bowel difficulties is essential[58]. Referral to specialists may be necessary for managing complications.

Education about resuming sexual intercourse, typically recommended at least four to six weeks postpartum when healing is complete, is important.[59] Explaining how hormonal changes, breastfeeding, contraception, and fatigue can affect sexual functioning helps women understand and manage these changes[60].

Optimizing sexual health involves referring women to pelvic health physiotherapy for management of post-delivery trauma and pelvic floor rehabilitation[61,62]. Addressing lifestyle

factors, such as stress and fatigue, can improve sexual desire and arousal[59,63]. Advising women to make time for themselves can promote well-being[59,63].

Holistic management includes recommending gradual exercise introduction based on postpartum physical activity guidelines[64] and screening for postpartum depression using tools like the Edinburgh Postnatal Depression Scale[57]. Addressing mental health is crucial, as postpartum depression can present with sexual difficulties[60].

8. Special Considerations

Women who have a history of abuse, including physical, emotional, or sexual abuse are more likely to experience sexual dysfunction [17,65,66]. It's important to consider the impact of adverse events, such as signs of post-traumatic stress disorder (PTSD), as PTSD is associated with poorer sexual functioning[17,65,66]. Referrals to agencies that provide specialized trauma-focused support should be considered[17].

In cases where patients present with high-risk concerns such as ongoing suicidal ideations, referrals to psychiatrists for risk management are necessary.

HCPs should be inclusive and sensitive to the needs of Lesbian, Gay, Bisexual, Trans, Queer or Questioning+ (LGBTQ+) individuals, by acknowledging that they may face unique sexual health concerns[67]. Providing appropriate resources and referrals is important[67].

Women who have undergone cancer treatments may face specific sexual health challenges due to the effects of chemotherapy, radiation, or surgery on hormonal levels, physical function, and emotional well-being.[68] Addressing these challenges and providing referrals for specialized support is essential.[68]

There are women who have other unique sexual health concerns associated with specific physical, cognitive and/or medical challenges. It is important to recognise these concerns and provide referrals for specialized support as needed. [69]

CONCLUSION

Female sexual health is a critical aspect of women's overall well-being and quality of life[1-3]. HCPs have a vital role in identifying, addressing, and managing sexual health concerns[10,11]. By integrating sexual health into routine clinical practice and adopting a patient-centred approach, HCPs can enhance the care provided to reproductive-age women.

These guidelines serve as a comprehensive resource to support HCPs in delivering effective sexual healthcare. Ongoing education, interdisciplinary collaboration, and the establishment of referral networks are essential for providing holistic care.

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Note to HCPs: Stay updated with the latest research and recommendations in sexual health to provide evidence-based care. Regular training and professional development opportunities can enhance your skills and comfort in addressing sexual health concerns. Establishing a supportive network among colleagues can facilitate shared learning and improve patient outcomes.

Disclaimer: These guidelines are intended to support, not replace, clinical judgment. Individual patient circumstances may require tailored approaches. Always consider the patient's preferences, cultural background, and specific health needs when applying these guidelines.

The members of the Sexual Health Guidelines for Women of Reproductive Age in Singapore Work Group are:

Chairpersons: Dr Jean-Jasmin Lee Mi-Li, Family Medicine Service, KKH & Dr Tan Tse Yeun, Department of Reproductive Medicine, KKH
Ms Caroline Chua, Physiotherapy Department, KKH
Ms Cheong Xinyi, Psychology Service, KKH
A/Prof Tan Lay Kok, College of Obstetricians and Gynaecologists Singapore
Dr Jason Lim, Obstetrical and Gynaecological Society of Singapore
Dr Suraj Kumar, College of Family Physicians Singapore
Dr Chie Zhi Ying, Singapore Medical Association
Ms Jay Lim, Psychology Service, KKH
Dr Chong Weiliang, Singapore Urological Association
Ms Yip Wan Hui, Singapore Physiotherapy Association
Dr Melissa Chiang, Health Promotion Board
Ms Delphine Koh, SingHealth Psychology Committee of Practice
Dr Huang Zhong Wei, Society for the Study of Andrology and Sexology, Singapore
Ms June Eng, Physiotherapy Department, KKH
Dr Ku Chee Wai, Department of Reproductive Medicine, KKH
Dr Benny Loo Kai Guo, Sport and Exercise Medicine Service, KKH
Dr Quah Phaik Ling, Senior Research Fellow, Division of Obstetrics and Gynaecology, KKH
Prof Tan Kok Hian, Perinatal Society of Singapore and Lead IPRAMHO MCHRI, KKH

PLISSIT Model.[19]

The First Level of Treatment
Permission
Encourage patients to express sexual concerns
The Second Level of Treatment
Limited Information
Educate on how changes (e.g., menstrual cycle) can affect sexuality
The Third Level of Treatment
Specific Suggestions
Recommend practical solutions (e.g., lubricants, new intimacy methods)
The Fourth Level of Treatment
Intensive Therapy
Refer for specialized treatment if necessary

Annex A – Summary Statements of Singapore Guidelines on Sexual Health for Women of Reproductive Age

1. Screening of Sexual Health
1.1 Recognise the importance of sexual health
1.2 Initiate the conversation
1.3 Identify appropriate healthcare providers
1.4 Legitimise sexual health in clinical care

2. Assessment of Sexual Health
2.1 Differentiate between concerns and dysfunction
2.2 Use validated tools
2.3 Apply the PLISSIT model.
2.4 Consider medical and psychological factors
2.5 Consider the role of the partner

3. Education of Sexual Health
3.1 Provide information on normal sexual response and function
3.2 Address patient concerns
3.3 Promote safe sexual practices

4. Optimisation of Sexual Health
4.1 Manage health conditions affecting sexual function
4.2 Address gynaecological conditions
4.3 Promote physical health
4.4 Support psychological well-being
4.5 Consider partner's sexual health
4.6 Monitor contraceptive impact
4.7 Refer when necessary

5. Preconception Assessment, Education & Optimisation
5.1 Use validated questionnaires to assess sexual concerns.
5.2 Screen for infertility, defined as failure to conceive after 12 months of regular unprotected intercourse (or six months if over the age of 35).
5.3 Provide preconception counselling
5.4 Address lubricant use
5.5 Discuss sexual function during conception efforts
5.6 Apply holistic approaches to optimise medical, psychological, and relational factors affecting sexual health

6. Antenatal Screening, Education, Assessment & Optimisation
6.1 Incorporate questions about sexual well-being during antenatal visits in all trimesters if appropriate.
6.2 Use the PLISSIT model for preliminary screening.
6.3 Initiate discussions early
6.4 Inform about common changes
6.5 Provide reassurance
6.6 Offer practical advice
6.7 Utilise tools like the FSFI-6 to assess sexual function.

6.8 Evaluate for sexual dysfunctions, including Genito-Pelvic Pain/Penetration Disorder (GPPPD), which may affect delivery and persist postpartum.
6.9 Refer to sexual health practitioners (section 4.7) for conditions like GPPPD.
Screen for and address antenatal depression and anxiety, which can adversely affect sexual function.

7. Postnatal Screening, Education, Assessment & Optimisation
7.1 Address sexual function during postpartum medical reviews.
7.2 Use the PLISSIT model to facilitate discussions.
7.3 Use tools such as FSFI-6 to assess for sexual dysfunction.
7.4 Evaluate healing of perineal injuries and address any bladder or bowel difficulties.
7.5 Advise on resumption of sexual activity
7.5 Discuss postpartum changes
7.6 Consider a multi-disciplinary approach in managing sexual issues.
7.7 Refer to pelvic health physiotherapy for management of perineal trauma and pelvic floor rehabilitation.
7.8 Address lifestyle factors to alleviate stress and fatigue.
7.9 Screen for postnatal depression and anxiety, providing referrals as needed.

8. Special Considerations: Abuse and trauma; LGBTQ+ individuals; Cancer survivors & Special populations
8.1 Recognise that a history of physical, emotional, or sexual abuse can negatively impact sexual function. Consider referrals to specialised services that can provide trauma-informed support, when appropriate.
8.2 Be inclusive and sensitive to the needs of LGBTQ+ individuals, acknowledging that they may face unique sexual health concerns.
8.3 Address the specific sexual health challenges faced by women who have undergone cancer treatments and provide specialised support and referrals as needed.
8.4 Recognise that there are women who have unique sexual health concerns associated with specific physical, cognitive and/or medical challenges and provide specialised support and referrals as needed.

Annex B – Expanded Summary Statements of Singapore Guidelines on Sexual Health for Women of Reproductive Age

1. Screening of Sexual Health

1.1 Recognise the importance of sexual health

• Sexual health is integral to overall health. A crucial aspect is sexual function- encompassing desire, arousal, orgasm, and satisfaction.

• Women should be made to feel comfortable as much as possible when discussing sexual health, including sexual functioning, with healthcare professionals (HCPs).

1.2 Initiate the conversation

• Many women expect HCPs to initiate discussions when appropriate about sexual health.

• Incorporate questions about sexual activity, contraception, sexually transmitted infections (STIs), pregnancy planning, and sexual concerns into routine history-taking when appropriate.

1.3 Identify appropriate healthcare providers

• Acknowledge that women may consult various HCPs regarding sexual health, including doctors (especially gynaecologists), primary care providers, nurses, physiotherapists specialising in women's health and mental health professionals.

1.4 Legitimise sexual health in clinical care

• HCPs should view the identification and management of sexual health issues as essential components of patient care.

2. Assessment of Sexual Health

2.1 Differentiate between concerns and dysfunction

• Distinguish between temporary sexual concerns/difficulties and persistent dysfunction requiring intervention.

2.2 Use validated tools

• Utilise brief questionnaires for assessing female sexual dysfunction (FSD), such as: Female Sexual Function Index-6 (FSFI-6)

2.3 Apply the PLISSIT model

• Use the PLISSIT (Permission, Limited Information, Specific Suggestions, Intensive Therapy) model for preliminary screening and intervention:

• Permission: Encourage patients to express sexual concerns.

• Limited information: Educate on how changes (e.g., menstrual cycle) can affect sexual function.

• Specific suggestions: Recommend practical solutions (e.g., lubricants, new intimacy methods).

• Intensive therapy: Refer for specialised treatment if necessary.

2.4 Consider medical and psychological factors

• Be aware of medical conditions, medications, psychological and social issues that may affect sexual function (bio-psycho-social).

2.5 Consider the role of the partner

• Involve the woman's partner when assessing sexual concerns, as sexual function can be influenced by both partners' health and communication.

3. Education of Sexual Health
3.1 Provide information on normal sexual response and function
• Educate patients about normal fluctuations in sexual function response due to factors like the menstrual cycle, stress, or relationship dynamics.

3.2 Address patient concerns
• Offer treatment options if concerns in sexual function are linked to significant distress and the patient desires intervention.

3.3 Promote safe sexual practices
• Encourage consistent barrier methods use and preventive measures against STIs.

4. Optimisation of Sexual Health
4.1 Manage health conditions affecting sexual function
• Manage sexual health issues such as vulva pain with appropriate treatments.
• Address medical conditions (e.g., high blood pressure, diabetes, thyroid disorders) and their treatments that may impact sexual health.

4.2 Address gynaecological conditions
• Early diagnosis and multidisciplinary management of conditions like endometriosis and adenomyosis can prevent impairment of sexual quality of life.

4.3 Promote physical health
• Recommend regular physical exercise to enhance overall well-being and sexual function. Optimise pelvic floor health and provide referrals to pelvic floor physiotherapy as needed.

4.4 Support psychological well-being
• Screen for stress, mental health conditions, and relationship factors that may impact sexual function.
• Provide referrals to counselling or psychological services when appropriate.

4.5 Consider partner's sexual health
• Assess and address any sexual dysfunction in male partners, as it can affect the woman's sexual function.

4.6 Monitor contraceptive impact
• Be aware that oral contraceptives may affect sexual function; monitor and adjust contraceptive methods as needed.

4.7 Refer when necessary
• Establish a network of clinical sexual health resources for referrals when first-line interventions are insufficient.
• Consider a multi-disciplinary approach in managing sexual issues.

5. Preconception Assessment. Education, & Optimisation

Women trying to conceive may experience increased stress, which can negatively impact sexual function. Infertility itself is associated with distress and can negatively impact sexual function.

Assessment
5.1 Use validated questionnaires to assess sexual concerns.
5.2 Screen for infertility, defined as failure to conceive after 12 months of regular unprotected intercourse (or six months if over the age of 35).

Education
5.3 Provide preconception counselling
• Advise on optimal frequency and timing of intercourse to increase reproductive efficiency.
• Inform that coital position and post coital routines such as remaining supine after intercourse have not been shown to affect conception rates.

5.4 Address lubricant use
• Reassure that while some lubricants may affect sperm in vitro, their use does not significantly impact fertility in practice.

5.5 Discuss sexual function during conception efforts
• Acknowledge that trying to conceive can affect sexual routines and increase stress.
• Offer support and resources for managing sexual concerns and stress during this time.

Optimisation
5.6 Apply holistic approaches to optimise medical, psychological, and relationship factors affecting sexual health.

6. Antenatal Screening, Education, Assessment & Optimisation
Pregnancy introduces biological, psychological, and social changes that may alter sexual function.

Screening
6.1 Incorporate questions about sexual well-being during antenatal visits in all trimesters if appropriate.
6.2 Use the PLISSIT model for preliminary screening.

Education
6.3 Initiate discussions early
• Proactively inform patients that HCPs are available to address concerns about sex during pregnancy.
6.4 Inform about common changes
• Educate on typical changes in sexual function and frequency throughout pregnancy due to factors like physical and body image changes, fatigue, and hormonal shifts.
6.5 Provide reassurance
• If no medical or obstetric complications are present, reassure couples that sexual activity can continue safely if desired.
6.6 Offer practical advice
• Suggest adaptations for coital positions to accommodate physical changes.

• Address sexual concerns such as dyspareunia with lubricants.
Assessment
6.7 Utilise tools like the FSFI-6 to assess sexual function.
6.8 Evaluate for sexual dysfunctions, including Genito-Pelvic Pain/Penetration Disorder (GPPPD), which may affect delivery and persist postpartum.

Optimisation
6.9 Refer to sexual health practitioners (section 4.7) for conditions like GPPPD. Screen for and address antenatal depression and anxiety, which can adversely affect sexual function.

7. Postnatal Screening, Education, Assessment & Optimisation
Postpartum women often experience significant changes in sexual function.

Screening
7.1 Address sexual function during postpartum medical reviews.
7.2 Use the PLISSIT model to facilitate discussions.

Assessment
7.3 Use tools such as FSFI-6 to assess for sexual dysfunction.
7.4 Evaluate healing of perineal injuries and address any bladder or bowel difficulties.

Education
7.5 Advise on resumption of sexual activity
• Recommend waiting at least four to six weeks postpartum for healing and readiness before resuming sexual activity.
7.6 Discuss postpartum changes
• Educate on how hormonal changes, breastfeeding, contraception, and fatigue can affect sexual desire and function.

Optimisation
7.7 Consider a multi-disciplinary approach in managing sexual issues.
7.8 Refer to pelvic health physiotherapy for management of perineal trauma and pelvic floor rehabilitation.
7.9 Address lifestyle factors to alleviate stress and fatigue.
7.10 Screen for postnatal depression and anxiety, providing referrals as needed.

8. Special Considerations : Abuse and trauma; LGBTQ+ individuals; Cancer survivors & Special Populations

8.1 Abuse and trauma
• Recognise that a history of physical, emotional, or sexual abuse can negatively impact sexual function.
• Consider referrals to specialised services that can provide trauma-informed support, when appropriate.

8.2 Lesbian, Gay, Bisexual, Trans, Queer or Questioning+ (LGBTQ+) individuals
• Be inclusive and sensitive to the needs of LGBTQ+ individuals, acknowledging that they may face unique sexual health concerns.

8.3 Cancer survivors
• Address the specific sexual health challenges faced by women who have undergone cancer treatments.
• Provide specialised support and referrals as needed.

8.4 Special Populations
• Recognise that there are women who have unique sexual health concerns associated with specific physical, cognitive and/or medical challenges.
• Provide specialised support and referrals as needed.