This guideline was peer-reviewed by the authors in May 2017, and has been reaffirmed for continued use until further notice.

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No. 279-Female Sexual Health Consensus Clinical Guidelines

This clinical practice guideline has been reviewed and approved by the Executive and Council of The Society of Obstetricians and Gynaecologists of Canada.

John Lamont, MD, Hamilton, ON

Krisztina Bajzak, MD, St. John's, NL

Céline Bouchard, MD, Quebec, QC

Margaret Burnett, MD, Winnipeg, MB

Sandra Byers, PhD, Fredericton, NB

Trevor Cohen, MD, Victoria, BC

William Fisher, PhD, London, ON

Stephen Holzapfel, MD, Toronto, ON

Vyta Senikas, MD, Ottawa, ON

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The literature searches and bibliographic support for this guideline were undertaken by Becky Skidmore, Medical Research Analyst, The Society of Obstetricians and Gynaecologists of Canada.

Key Words: Sexuality, sexual health, sexual behaviour, sexual orientation, sexual function, sexual dysfunction, desire, dyspareunia, anorgasmia, pain, sex therapy, counselling, relationships

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Abstract

Objective: To establish national guidelines for the assessment of women's sexual health concerns and the provision of sexual health care for women.

Evidence: Published literature was retrieved through searches of PubMed, CINAHL, and the Cochrane Library from May to October 2010, using appropriate controlled vocabulary (e .g., sexuality, "sexual dysfunction," "physiological," dyspareunia) and key words (e .g ., sexual dysfunction, sex therapy, anorgasmia). Results were restricted, where possible, to systematic reviews, randomized control trials/controlled clinical trials, and observational studies. There were no language restrictions. Searches were updated on a regular basis and incorporated in the guideline to December 2010. Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology assessment-related agencies, clinical practice guideline collections, clinical trial registries, and national and international medical specialty societies. Each article was screened for relevance and the full text acquired if determined to be relevant. The evidence obtained was reviewed and evaluated by the members of the Expert Workgroup established by The Society of Obstetricians and Gynaecologists of Canada.

Values: The quality of evidence was evaluated and recommendations made using the use of criteria described by the Canadian Task Force on Preventive Health Care (Table).

SUMMARY STATEMENTS AND RECOMMENDATIONS

Introduction

Summary Statements

1. Sexual concerns are prevalent in the population (II-1).
2. Many women have to look outside medicine for solutions to their sexual concerns (II-1).
3. Many health care providers have the ability to deal with sexual health issues (II-3).
4. Health care providers need a better understanding of female sexual issues/problems (II-3).

CHAPTER 1

Sexuality Across the Lifespan

Summary Statements

5. Children are sexual from birth. Expression of sexuality is a developmental process (II-2).
6. Most discourse on adolescent sexuality focuses on the potential for adverse consequences such as exploitation, sexual assault, unwanted pregnancy, and sexually transmitted infections, and has generally neglected to communicate to girls that expression of sexuality and sexual experimentation are normal and healthy (II-2).
7. Age-appropriate sexual expression is a positive part of the development of adolescent girls. Negative, coercive, and discriminatory experiences can detrimentally affect sexual well-being (II-2).
8. Variations exist in same-sex and opposite-sex sexual behaviour; same-sex and opposite-sex sexual behaviour is not equivalent to self-definition as heterosexual or lesbian or bisexual. Some women who have sex with women may be reluctant to define themselves as lesbian because women who identify themselves or who are identified by others as lesbian or bisexual may experience social discrimination (II-2).
9. Women express their sexuality in a variety of ways and in a variety of situations, including with a partner and through masturbation (II-2).
10. Masturbation and self-pleasuring can be important for self- knowledge and as a sexual outlet in themselves for women who have and those who do not have a partner (III).
11. Relationship factors have a major influence on a woman's sexual well-being (II-2).
12. Pregnancy and breastfeeding, as well as experience with infertility, can affect sexual functioning (II-2).
13. Decline in frequency of sexual activity at menopause does not alter women's potential for desire, arousal, orgasm, sexual pleasure, or sexual satisfaction (II-2).
14. Psychological, relationship, social, cultural, and biological factors affect women's sexual well-being as they age and experience menopause (II-2).
15. Most women with a partner continue to engage in sexual activity. Women often cease sexual activity not because of lack of interest but because they do not have a partner (II-2).
16. Women's sexuality may be affected by biological events (e.g., puberty, childbirth, menopause, and aging), by their own psychology/psychological health, by their ethnicity and culture, and by their sexual orientation (III).
17. Whether or not women's sexual desire and activity continue through periods of pregnancy, childrearing, menopause, and aging may dependent on the presence of a partner, a partner's sexual function, the quality of the relationship, and both partners' general health (III).
18. There is considerable variation in the patterns of girls' and women's sexual expression and experience (II-2).

Recommendations

1. Health care providers should encourage adolescents to use condoms consistently, and to take other steps to promote sexual health and prevent sexually transmitted infections (e .g ., human papillomavirus vaccination), even while they are in a relationship (II-3A).
2. Health care providers should be well informed about the variability of normal patterns of sexual development before evaluating sexual concerns that pertain to children and adolescents (II-3A).
3. Health care providers should balance concern about adverse sexual consequences for girls with positive messages about adolescent girls' expression of their sexuality (II-3A).
4. Health care providers should consider the effect of the relationship when assessing a woman's sexual well-being (III-A).
5. Health care providers should strive to make their offices open and welcoming environments for women of all sexual preferences and practices (III-A).
6. Health care providers should discuss sexuality at the early prenatal visit, before discharge from the hospital postpartum, and at the postnatal check-up (III-A).