The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

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This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice in collaboration with committee member Virginia C. Leslie, MD.

Sexual Health

ABSTRACT: Sexuality involves a broad range of expressions of intimacy and is fundamental to self-dentification, with strong cultural, biologic, and psychologic components. Obstetrician–gynecologists often are consulted by patients about sexual health and are in a unique position to open a dialogue on sexual health issues. Several obstacles to frank conversations with patients about sexual health exist, including a lack of adequate training and confidence in the topic, a perception that there are few treatment options, a lack of adequate clinical time to obtain a sexual history, patients' reluctance to initiate the conversation, and the underestimation of the prevalence of sexual dysfunction. However, data on reproductive and sexual health morbidity suggest sexual health is an important health care issue. Each year, an estimated 45,000 new cases of human immunodeficiency virus (HIV) and approximately 20 million sexually transmitted infections occur, 3 million women experience unintended pregnancies, and 1 million women are sexually assaulted. Openly discussing sexual health has the potential to prevent these unnecessary sexual health-related outcomes. Clinical conversations should acknowledge the contributions of sexuality, relationships, and sexual behavior to overall health. Obstetrician–gynecologists can address sexual health issues across a lifespan with their patients and encourage a strategic foundation for women's sexual health issues, resulting in improved public health overall. Obstetrician–gynecologists also can support policies that broaden the coalition for effective prevention of sexually transmitted infections and promote healthy sexuality, with the ultimate goal of improving health outcomes and public health.

Recommendations

The American College of Obstetricians and Gynecologists makes the following recommendations:

- Clinical conversations should acknowledge the contributions of sexuality, relationships, and sexual behavior to overall health.
- Obstetrician–gynecologists should focus on the positive aspects of sexuality, not only disease processes, giving examples of positive and respectful relationships.
- Discussions of sexual health and aging within the framework of well-woman care should include the evolution of sexual health issues across a lifespan.
- Obstetrician–gynecologists should support programs that encourage sexual health.

The goal of this Committee Opinion is to increase awareness of the importance of addressing sexual health in routine clinical practice, provide resources for obstetrician–gynecologists to address sexual health issues across a lifespan, and encourage a solid foundation for

women's sexual health issues to be discussed in communities, resulting in improved public health overall. This Committee Opinion also will do the following: define sexual health; acknowledge sexual health as an element of overall health; emphasize the importance of sexual health across a lifespan; provide obstetrician–gynecologists with tools and resources to increase patient, community, and clinician counseling and education regarding sexual health; open dialogues to help abolish the stigma associated with sexual health and well-being; and incorporate sexual health and aging education into the framework of well-woman care.

Definition of Sexual Health

According to the World Health Organization, sexual health is "a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity" (1). Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination, and violence. For sexual health to be attained and maintained, "the sexual rights of all persons must be respected, protected, and fulfilled" (1). Multilayered socioeconomic and educational factors, such as poverty and community violence, may contribute to poor sexual health and should be considered during treatment and counseling (2).

Background

Sexuality involves a broad range of expressions of intimacy and is fundamental to self-identification, with strong cultural, biologic, and psychologic components. The obstetrician–gynecologist has an important role in assessing sexual function because many women view their sexuality as an important quality-of-life issue that frequently is affected by reproductive events. Obstetrician–gynecologists should not make assumptions or judgments about a woman's behavior and, when counseling patients, should keep in mind the possibility of cultural and personal variation in sexual practices (3). Additionally, obstetrician–gynecologists should be aware that some medical conditions and medications can affect sexual function and overall sexual health. Use of antidepressants, particularly selective serotonin reuptake inhibitors, oral contraceptives, and corticosteroids can be associated with hypoactive sexual desire disorder (4).

Several obstacles to frank conversations with patients about sexual health exist, including a lack of adequate training and confidence in the topic, a perception that there are few treatment options, a lack of adequate clinical time to obtain a sexual history, patients' reluctance to initiate the conversation, and the underestimation of the prevalence of sexual dysfunction (4, 5). However, data on reproductive and sexual health morbidity suggest sexual health is an important health care issue. Each year, an estimated 45,000 new cases of human immunodeficiency virus (HIV) (6) and approximately 20 million sexually transmitted infections (STIs) occur (7), 3 million women experience unintended pregnancies, and 1 million women are sexually assaulted (8). The Centers for Disease Control and Prevention reported a trend in the increasing rate of STIs: In the United States, 2015 was the second year in a row in which increases were seen in cases of chlamydial infection, gonorrhea, and syphilis (9). Openly discussing sexual health has the potential to address these unnecessary sexual health-related outcomes (10).

Sexual Health as an Element of Overall Health

Clinical conversations should acknowledge the contributions of sexuality, relationships, and sexual behavior to overall health (11). Decreasing the stigmatization of sexual health in public opinion is a challenge. However, by using a "broader, sex-positive, health-focused framework" with patients, obstetrician–gynecologists can lead the effort to encourage communication about the different aspects of sexuality and sexual function (11). During the past decade, sexual health promotion has become less stigmatized, and the focus has shifted toward a more holistic view that promotes sexual health as a right for all women and men. This broader perspective recognizes that even factors such as living in a safe community can contribute to a woman being able to make healthy sexual choices for herself (8).

Sexual Health Across a Lifespan

Obstetrician–gynecologists often are consulted by patients about sexual health and are in a unique position to open a dialogue on sexual health issues. Understanding the reproductive lifespan, and the treatment of sexual issues from adolescence through menopause and beyond, may improve the well-being and happiness of the patient. Discussions of sexual health and aging within the framework of well-woman care should include the evolution of sexual health issues across a lifespan. Continued high-quality clinical care through perimenopause and beyond is essential. Hypoactive sexual desire disorder reaches a peak in women aged 40–60 years and in individuals who have undergone surgical menopause (4). Obstetrician–gynecologists should continue to screen (based on risk factors) and counsel patients in this age group for STIs and sexual abuse. In addition, menopause affects sexual health significantly, mostly through vulvovaginal atrophy and, in part, through often detrimental changes in mood and sleep. Obstetrician–gynecologists should be familiar with comprehensive pharmaceutical and nonpharmaceutical options for the management of menopausal symptoms (12). Obstetrician–gynecologists are encouraged to update their questionnaires and in-office interview questions for relevance to the experiences and concerns of patients of all ages.

Incorporating Sexual Health Into Practice

Incorporating comprehensive sexual health into practice involves first taking a comprehensive sexual history (see Box 1). Asking questions will help lay the groundwork for creating an open dialogue with the patient. Obstetrician–gynecologists should focus on the positive aspects of sexuality, not only disease processes, giving examples of positive and respectful relationships (11). Related to a discussion of sexual health and the potential need for contraceptive counseling, the American College of Obstetricians and Gynecologists supports the One Key Question® Initiative to promote direct screening for women's pregnancy intentions as a core component of high-quality, primary preventive care services (13).

The use of broad, open-ended questions in a routine history gathering can disclose issues that may require

Box 1. Sexual History Questions to Ask Patients ⇦

1. Partners
   - Are you currently sexually active? (Are you having sex?)
     - If no, have you ever been sexually active?
   - In recent months, how many sex partners have you had?
   - In the past 12 months, how many sex partners have you had?
   - Are your sex partners men, women, or both?*
     - If a patient answers "both" repeat first two questions for each specific gender.
2. Practices
   - I am going to be more explicit here about the kind of sex you have had over the past 12 months to better understand if you are at risk of sexually transmitted infections (STIs).
   - What kind of sexual contact do you have or have you had?
     - Genital (penis in the vagina)?
     - Anal (penis in the anus)?
     - Oral (mouth on penis, vagina, or anus)?
3. Protection from STIs
   - Do you and your partner(s) use any protection against STIs?
     - If not, could you tell me the reason?
     - Are you comfortable asking your partner to use condoms?†
     - If so, what kind of protection do you use?
     - How often do you use this protection?
     - If "sometimes," in what situations or with whom do you use protection?
   - Do you have any other questions, or are there other forms of protection from STIs that you would like to discuss today?
4. Past History of STIs
   - Have you ever been diagnosed with an STI?
     - When?
     - How were you treated?
     - Have you had any recurring symptoms or diagnoses?
   - Have you ever been tested for human immunodeficiency virus (HIV) or other STIs?
     - Would you like to be tested?‡
   - Has your current partner or have any former partners ever been diagnosed or treated for an STI?
     - Were you tested for the same STI(s)?
     - If yes, when were you tested?
     - What was the diagnosis?
     - How was it treated?

(continued)

Box 1. Sexual History Questions to Ask Patients *(continued)*

5. Prevention of Pregnancy

- Are you currently trying to become pregnant?
- Are you concerned about getting pregnant?
- Are you using contraception or practicing any form of birth control?
- Is your partner supportive of your using birth control?†
- Do you need any information on birth control?

Completing the History

- What other things about your sexual health and sexual practices should we discuss to help ensure your good health?
- What other concerns or questions regarding your sexual health or sexual practices would you like to discuss?

*See Health care for lesbians and bisexual women. Committee Opinion No. 525. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;119:1077–80. Available at: http://journals.lww.com/greenjournal/Citation/2012/05000/Committee_Opinion_No__525___Health_Care_for.38.aspx. Retrieved March 21, 2017 *and* Care for transgender adolescents. Committee Opinion No. 685. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;129:e11–6. Available at: http://journals.lww.com/greenjournal/Fulltext/2017/01000/Committee_Opinion_No__685_Summary___Care_for.50.aspx. Retrieved March 21, 2017.

†If no, for more information on reproductive coercion see Chamberlain L, Levenson R. Addressing intimate partner violence, reproductive and sexual coercion: a guide for obstetric, gynecologic and reproductive health care settings. 2nd ed. Washington, DC: American College of Obstetricians and Gynecologists; San Francisco (CA): Futures Without Violence; 2012. Available at: http://www.futureswithoutviolence.org/userfiles/file/HealthCare/reproguidelines_low_res_FINAL.pdf. Retrieved March 21, 2017 *and* Reproductive and sexual coercion. Committee Opinion No. 554. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;121:411–5. Available at: http://journals.lww.com/greenjournal/Fulltext/2013/02000/Committee_Opinion_No__554___Reproductive_and.43.aspx. Retrieved March 21, 2017.

‡Ideally, opt-out HIV screening should be performed, in which the patient is notified that HIV testing will be performed as a routine part of gynecologic care unless the patient declines testing. See Routine human immunodeficiency virus screening. Committee Opinion No. 596. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:1137–9. Available at: http://journals.lww.com/greenjournal/Fulltext/2014/05000/Committee_Opinion_No_596___Routine_Human.42.aspx. Retrieved March 21, 2017.

Data from Centers for Disease Control and Prevention. A guide to taking a sexual history. Atlanta (GA): CDC; 2011. Available at: http://www.cdc.gov/std/treatment/SexualHistory.pdf. Retrieved March 21, 2017.

further exploration. The following are examples of basic questions posed in a gender-neutral fashion:

- "Are you sexually active?"
- "Are you sexually satisfied?"
- "Do you have questions or concerns about sexual functioning?"
- "Do you think your partner is satisfied?"

Inquiry about the partner's sexual function and level of satisfaction may elicit more specific information and give an indication of the couple's level of communication. Deliberate inquiries should be made to assess the quality of the interpersonal relationship between a patient and her partner, including mutual satisfaction with their sexual relationship. After asking general questions, it may be helpful to ask additional questions, such as the following:

- "Do you have orgasms?"
- "Are you satisfied with the frequency of sexual activity?"
- "Does your vagina lubricate enough?"

This information will delineate better the exact nature of a patient's dysfunction. Difficulties with prior sexual experience, insufficient foreplay, and attitudes about sexual pleasure can be elicited with careful history taking. For example, difficulties reaching orgasm or markedly reduced intensity of orgasmic sensations may not be a problem unless the patient or partner perceives it to be (3).

When discussing female sexual response, obstetrician–gynecologists should emphasize the wide range of complex normal experiences. Historically, female sexual response was described as linear, as noted in the Masters and Johnson model in 1966. Over time, other models have been developed that encompass a variety of sequences of the original four stages of female sexual response and the inclusion of others (see Fig. 1) (14). A discussion of sexual responsiveness with a patient can include the importance of not only sexual stimuli, but also factors such as emotional intimacy and relationship satisfaction.

Incorporating sexual health into well-woman care is the goal. Implementation of these topics into well-woman care is critical to destigmatizing sexual health for patients and communities. Obstetrician–gynecologists should discuss the following: the patient's sexual health, orientation, behavior, and activity; the sex of her partner

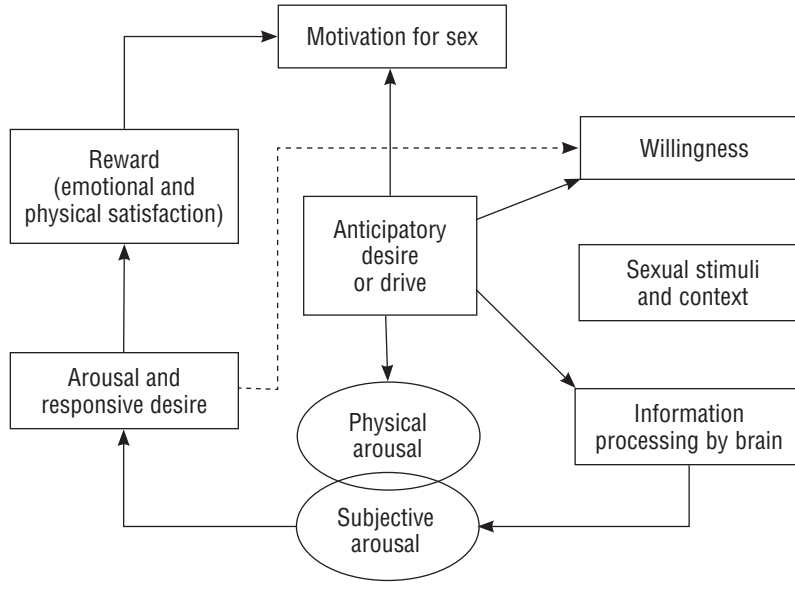

Figure 1. Female sexual response* The circular sexual response cycle shows overlapping phases of variable order. Reasons or motivations for sex are numerous, and sexual desire or drive may or may not be present at the outset but reached after the brain has processed sexual signals as sexual arousal, which conflates with sexual desire. The latter creates an urge for increased arousal, allowing acceptance of increasingly intense sexual stimulation. (Basson R. Sexuality and sexual disorders. Clin Update Womens Health Care 2014;XIII(2):1–108. Available at: http://www.clinicalupdates.org/abstracts/index.cfm?issue=cuwhc-v13n2. Retrieved March 21, 2017.) ⇦

or partners; her number of lifetime partners; her sexual satisfaction; and her sexual function. It is important to discuss initiation of sexual activity with patients who are not yet sexually active. Contraceptive counseling visits are an ideal time to discuss sexual health, and discussion of a patient's contraceptive needs should include emergency contraception (15). Obstetrician–gynecologists also should be prepared to discuss subjects such as intimate partner violence, sexual assault, sexual abuse, and reproductive coercion (16–19).

Obstetrician–gynecologists should be aware that noncoital sexual behavior commonly co-occurs with coital behavior. Because people define sexuality in a variety of ways and may not report noncoital sexual activity, it is important that clinicians ask direct questions regarding sexual activity, including whether the patient has sex with men, women, or both; the number of sexual partners and her partners' sexual behavior; and frequency of oral and anal sex and mutual masturbation (20).

Obstetrician–gynecologists should support programs that encourage sexual health (21, 22). Several models for sexual education can be supported by obstetrician–gynecologists, as practitioners and leaders in the community. One such program is Working to Institutionalize Sexuality Education (23). Activities supported by the Working to Institutionalize Sexuality Education initiative have reached more than 500,000 students. Furthermore, more than 700 teachers have been trained and hundreds of schools have either implemented sex education where previously there was no sex education or significantly improved their programs. As of 2014, 11 states and localities were participating in this initiative. For a comprehensive comparative listing of sex education programs in the United States, see guidance from the American College of Obstetricians and Gynecologists and Advocates for Youth (21, 22).

Conclusions

Obstetrician–gynecologists can address sexual health issues across a lifespan with their patients and encourage a solid foundation for women's sexual health issues to be discussed in communities, resulting in improved public health overall. In practice at a local level, obstetrician–gynecologists can regularly discuss sexual health as integral to overall health and wellness, acknowledging sexual expression across a lifespan and addressing relationships. Obstetrician–gynecologists also can support policies that broaden the coalition for effective prevention of STIs and promote healthy sexuality, with the ultimate goal of improving health outcomes and public health (11). Regardless of whether actions are taken at the local level or more broadly in the community, obstetrician–gynecologists are in a position to initiate conversations about healthy sexuality for patients.

For More Information

The American College of Obstetricians and Gynecologists has identified additional resources on topics related to

this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at www.acog.org/More-Info/SexualHealth.

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization's website, or the content of the resource. The resources may change without notice.

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