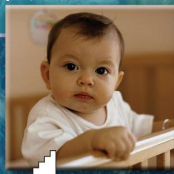


MNCHP Network Bulletin



*best start
meilleur départ*

by/par health **nexus** santé

October 21, 2011

In this week's special issue:

This week's bulletin provides an overview of sexual health before and during pregnancy and during the post-partum period. It includes news articles, recent reports and studies, resources, and links to organizations and programs working in this area. This selection of information is based on a preliminary scan and is not exhaustive.

We invite you to share other relevant information about this topic.

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I. SEXUAL HEALTH BEFORE PREGNANCY: RESOURCES FOR PARENTS

1. YOUR SEXUAL HEALTH: MAKE HEALTHY CHOICES TODAY FOR THE BABY IN YOUR FUTURE

This brochure written by the City of Hamilton Public Health Services (2006) outlines for prospective mothers the relationship between sexual health and pregnancy. Sexual health is important to a couple's ability to conceive and have healthy children. Sexually transmitted infections (STIs) may lead to other illnesses and may negatively impact a woman's ability to conceive or have healthy children. STIs may be present without symptoms, and therefore women should undergo pap smears and blood tests to ascertain whether they are STI free. Couples should discuss their sexual history.

<http://www.hamilton.ca/NR/rdonlyres/C849837A-E390-43C0-9D3A-91E681A88D0C/40463/SexualHealth.pdf>

2. YOUR HEALTH BEFORE PREGNANCY

This resource for prospective parents identifies a wide variety of preconception factors that may impact the health of a baby (such as alcohol, tobacco, stress, and environment). Mentioned in this resource is a variety of sexuality related topics such as STIs, fertility, and safe relationships. STIs may impair a couple's ability to become pregnant. They may also be passed on to the baby during pregnancy or childbirth. Both members of the couple should be tested for STIs as there are often no symptoms. Women may choose to use a variety of birth control methods other than the pill. They should talk to their healthcare providers about coming off of these alternate forms of birth control, as these methods (such as intra-uterine devices or injections) will need to be removed or stopped prior to becoming pregnant (Best Start Resource Centre, 2005).

<http://www.healthbeforepregnancy.ca/>

3. HOW TO TALK ABOUT SEX AND INFERTILITY

This how to guide directed at couples provides information about how to talk about sex and infertility. Suggestions for individuals include entering dialogue with a sense of goodwill, separating feelings from facts, taking time for oneself, breaking down the issues, remaining receptive, respecting their partner's feelings, utilizing professionals for support and ultimately sticking together (About.com, 2011).

http://sexuality.about.com/od/communication/ht/sex_infertility.htm

4. FERTILITY COMPASS

The fertility compass (Merck Serono, 2010) is a tool that upon input of information from both the female and her male partner will provide information on ways to maximize chances of conception.

http://www.fertility.com/en/stage1/tools/fertility_compass/compass_1.html

5. TIPS FOR WHEN YOU'RE TRYING TO CONCEIVE

Within this article, it is suggested that in order to optimize chances of conception, women should have sexual intercourse every other day beginning three to four days before ovulation. There is no evidence to suggest that one sexual position is favourable over others with regards to conception. Certain lubricants should be avoided as they may damage the sperm.

http://www.babyzone.com/preconception/getting_pregnant/article/sex-when-trying-to-conceive

6. CONCEPTION QUIZ

This online quiz tests participants' knowledge around sexuality and conception related issues (About.com, 2011).

<http://infertility.about.com/library/conception-sex-quiz/bl-conception-sex-quiz.htm>

7. ONLINE HEALTH COURSE

This online health course teaches women how to better increase their chances of conception and avoid trying-to-conceive burnout (About.com, 2011).

<http://infertility.about.com/od/better-conception-sex-ecourse/a/Day-1-Timing-Sex-Is-Almost-Everything.htm>

II. SEXUAL HEALTH DURING PREGNANCY: RESOURCES FOR PARENTS

8. SEX DURING PREGNANCY

This article (Nemours, 2011), addresses several of the concerns that are frequently registered by pregnant women and their partners with regards to their sexuality during pregnancy. Sex is considered safe during all stages of a normal pregnancy (one which is low risk for complications such as miscarriage or pre-term labour). Common contraindications to sex during pregnancy include: a history or threat of miscarriage, a history of preterm labour or signs indicating such a risk, presence of unexplained discharge, bleeding, or cramping, leakage of amniotic fluid, placenta previa (a condition in which the placenta, the structure that nourishes the baby is down so low that it covers the cervix (the opening of the uterus)), multiple fetuses, and incompetent cervix, (a condition in which the cervix is weakened and opens prematurely raising the risk for miscarriage or early delivery). Sex cannot harm the baby directly as the baby is surrounded by the amniotic sac (a thin walled bag that holds the fetus and the surrounding fluid), as well as a thick mucus plug that seals the cervix. It is normal for women and their partners to experience increased or decreased sex drive during pregnancy.

http://kidshealth.org/parent/pregnancy_center/your_pregnancy/sex_pregnancy.html

9. SEX DURING PREGNANCY: WHAT'S OKAY, WHAT'S NOT

This article written by the Mayo Clinic Staff (2010) outlines what is considered to be safe sexual behaviour during pregnancy. As long as a woman's pregnancy is proceeding normally, she may have sex as often as she desires. Often women experience diminished sexual desire during the first trimester due to nausea, fatigue and hormonal fluctuations. Sexual desire often increases in the second semester due to increased blood flow to the sexual organs. However, sexual desire may decrease in the third trimester due to weight gain, back pain and other symptoms. Sex during pregnancy is not related to miscarriage. Anal sex should be avoided during pregnancy due to risk of spread of bacteria. Oral sex is safe during pregnancy, however receipt of oral sex poses risk of air embolism, (the blockage of a blood vessel by an air bubble), a potentially life threatening illness.

<http://www.mayoclinic.com/health/sex-during-pregnancy/HO00140>

10. SEXUAL HEALTH DURING PREGNANCY AND AFTER DELIVERY

This power point style presentation (Hudson, n.d.), outlines several factors affecting sex during and after pregnancy and the effects of STIs on pregnancy. Contraindications to sex during pregnancy include the advice of a physician, previous history of preterm labor, more than one miscarriage, episodes of bleeding, current placenta previa, infection, or breaking or leaking of the amniotic sac. For at least 3-5 weeks after delivery, while the woman's body adjusts, couples should find alternate ways of intimacy. Women should protect themselves from STIs before, during and after pregnancy, as STIs can affect the baby and in some cases even be transferred to the baby during pregnancy or childbirth.

<http://www.slideworld.org/patient/slideshow.aspx/Sexual-Health-During-Pregnancy-and-After-Delivery-ppt-2843462>

III. SEXUAL HEALTH DURING PREGNANCY: RECENT REPORTS AND RESEARCH

11. SEXUALITY DURING PREGNANCY

A study by Pauleta and colleagues (2010), found that among pregnant women, sexual frequency declines after the first trimester of pregnancy. Fear of intercourse was found to be common among study participants (23%). Sexual satisfaction remained unchanged in approximately one half of respondents (48.4%), while declines were experienced by approximately one quarter (27.7%). Sexual desire was found to remain unchanged or decline in approximately one third of participants, (38.8% and 32.5%, respectively). A high percentage of women were found to remain sexually active during pregnancy, with 98.3% and 38.1% performing vaginal and oral sex respectively.

<http://www.ncbi.nlm.nih.gov/pubmed/19845548>

12. SEXUAL HEALTH DURING PREGNANCY AND THE POSTPARTUM

A literature review conducted by Dr. Christa Johnson (2011) revealed that maintaining a couple's sexual interaction during pregnancy and the post partum period can promote sexual health and well-being

and a greater depth of intimacy. Clinicians should facilitate an open discussion, provide anticipatory guidance for the couple with regards to expected changes in sexual health, as well as promote the design of further studies exploring sexuality during pregnancy and the post partum.

<http://onlinelibrary.wiley.com/doi/10.1111/j.1743-6109.2011.02223.x/abstract>

13. FEMALE SEXUAL FUNCTION, DYFUNCTION, AND PREGNANCY IMPLICATIONS FOR PRACTICE

A recent study by Jessica Murtagh (2011) reviewed the relevant literature regarding sexual function during pregnancy. The study revealed a need for consistent measurement tools of female sexual function during pregnancy, as well as increased dialogue regarding these concerns during health care visits. Practitioners may increase patient satisfaction and overall health by evaluating and communicating with their female patients about their sexual function.

<http://onlinelibrary.wiley.com/doi/10.1016/j.jmwh.2009.12.006/abstract>

14. SEX IN PREGNANCY

Recent research by Jones and colleagues (2011) asserts that sex during pregnancy is normal, and with very few contraindications and risks for women in low-term pregnancies. Although little evidence exists to support abstinence in women whose pregnancies are complicated by placenta previa or increased risk for preterm labour, due to the potentially catastrophic theoretical consequences, abstinence is a reasonable recommendation. There is little evidence that demonstrates that sex during any period of pregnancy may induce labour.

<http://www.ncbi.nlm.nih.gov/pubmed/21282311>

IV. POSTPARTUM SEXUAL HEALTH: RESOURCES FOR PARENTS

15. INFORMATION FOR POST-NATAL WOMEN: SEXUALITY AFTER CHILDBIRTH

This resource (Leichhardt Women's Community Health Centre, 2007) aims to give women and their partners insight into their sexuality after the birth of a baby. During the first year post delivery, women may feel out of touch with their bodies and their sense of sensuality. Women may experience a loss of sexual desire due to a shift in energy towards the nurturing of their baby. There is wide variety in the range of time post delivery that women wait to resume sex. The majority of women resume sex six to eight weeks after delivery. Pelvic floor (Kegel) exercises may help to improve sexual comfort. Hormone fluctuations due to breastfeeding may result in sexual discomfort. Between 10 and 20 percent of breast-feeding women ovulate while breastfeeding and therefore may become pregnant. Therefore it may be appropriate to consider contraception soon after birth.

<http://www.lwchc.org.au/site/uploads/file/PostnatalBrochure.pdf>

16. SEX DURING AND AFTER PREGNANCY

This website (Grey Bruce Public Health, n.d) outlines for pregnant women and their partners the factors that may affect pre and postnatal sexuality. Physical and emotional changes that follow pregnancy may influence sexuality in the post partum period. Episiotomy, vaginal dryness, nipple tenderness, decreased breast sensation, decreased vaginal muscle tone, emotional changes and fatigue may lead to discomfort during intercourse or decreased sexual interest. Women can use a variety of techniques such as lubricants, increased foreplay, Kegel exercises, and simply waiting to heal as methods of overcoming these issues. As fertility can resume at any time after delivery, birth control must be used if a woman wants to avoid pregnancy.

<http://www.publichealthgreybruce.on.ca/family/prenatal/Sex-During-After-Pregnancy.htm>

V. POST PARTUM SEXUAL HEALTH: RECENT REPORTS AND RESEARCH

17. POSTPARTUM SEXUAL DYSFUNCTION: A LITERATURE REVIEW OF RISK FACTORS AND ROLE OF MODE OF DELIVERY

In a review of the literature by Sayasneh and Pandeva (2010), the various forms of post partum female sexual dysfunction are categorized, and their risk factors are assessed, with a focus on the different opinions in the literature regarding the role of mode of delivery (vaginal versus caesarean section) in alleviating or aggravating such dysfunction. Episiotomy was found to be a risk factor for short term post partum female sexual dysfunction. Breastfeeding, the use of the progesterone only pill and the lack of post partum sexual health counselling and treatment have also been found to be significant risk factors for post partum female sexual dysfunction.

<http://www.bjmp.org/content/postpartum-sexual-dysfunction-literature-review-risk-factors-and-role-mode-delivery>

18. HUMAN SEXUALITY DURING PREGNANCY AND THE POSTPARTUM PERIOD

A study by Brtnicka and colleagues (2009) revealed that sexual problems and dysfunctions during pregnancy are often driven by the anxiety of harming the fetus, males' fear of hurting their partners and females' fear of insufficient satisfaction of their male partners. Only a minority of couples deny sexual problems after delivery. The main postpartum risk factor for dyspareunia is the extent of injury sustained during childbirth, in particular incidence of episiotomy. Breastfeeding is linked to low coital activity, low sexual desire and low sexual satisfaction in both females and males. There is a documented lack of interest among post and ante natal care providers regarding issues of sexuality. This lack of interest is largely due to a lack of relevant information.

<http://www.ncbi.nlm.nih.gov/pubmed/19711831>

19. WOMEN'S SEXUALITY AFTER CHILDBIRTH: A PILOT STUDY

A study by Barrett and colleagues (1999) demonstrated that in the post natal period, women experienced significant levels of morbidity. Three months after delivery 58% of women experienced dyspareunia, 39% experienced vaginal dryness, and 44% suffered loss of sexual desire. Women experienced a decrease in the frequency and satisfaction with sexual intercourse. Only a minority of women (19%) who experienced a sexual problem during this period discussed it with a health professional.

<http://www.ncbi.nlm.nih.gov/pubmed/10483509>

20. WOMEN'S PERCEPTION OF SEXUALITY DURING PREGNANCY AND AFTER BIRTH

A qualitative study by Trutnovsky and colleagues (2006) revealed that from early to late pregnancy, women experienced a decrease in the perceived importance of sexuality and sexual intercourse as well as contentment with present sex life. However during the post-partum period, women experienced a slight increase in these variables.

<http://www.ncbi.nlm.nih.gov/pubmed/16866787>

21. DOES THE MODE OF DELIVERY INFLUENCE SEXUAL FUNCTION AFTER CHILDBIRTH

A study by Klein and colleagues (2009) demonstrated that at 12 to 18 months after delivery, there is no significant difference in sexual function in women who delivered vaginally without episiotomy, heavy perineal laceration or secondary operative interventions and women who underwent elective caesarean section. Patients who underwent a vaginal delivery were more likely to experience dyspareunia at 3 months post delivery. Delivery by caesarean section was associated with higher maternal age and body mass index.

<http://www.ncbi.nlm.nih.gov/pubmed/19630552>

22. BREASTFEEDING AND SEXUALITY IMMEDIATELY POST PARTUM

A study by Rowland and colleagues (2005) examined the relationship between breastfeeding and vaginal intercourse. The most significant predictors of resumption of intercourse by 6 weeks post partum was found to be breastfeeding and baby's age in weeks. Mode of delivery (vaginal delivery with no tearing, compared to caesarean section or vaginal delivery with tearing) was also found to be a significant predictor. Older maternal age was found to be a weak predictor of resumption of intercourse. Of the women who had not resumed intercourse at the time of the survey, the most common reason for not resuming intercourse was a lack of interest (18.6%), being too tired (16.8%), fear of pain (16.8%), physician recommendation (15.6%) and the belief that they should wait 6 weeks (14.4%).

<http://www2.cfpc.ca/cfp/2005/Oct/vol51-oct-research-3.asp>

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