

# Insights into Modern Psychiatry & Wellness: An Exploration of Sexual Wellbeing in HIV+ Women

**Narrative review and evidence synthesis from quality improvement project conducted on sexual wellbeing in HIV+ women**

## Abstract

### Background

There are no quality improvement projects focusing on the sexual wellbeing of HIV+ women in the literature and this project aimed to implement interventions in a HIV clinic that would increase conversations around sexual wellbeing.

### Methods

A gap analysis of the unit's baseline practice was conducted via retrospective analysis of patient notes to establish the rationale for this QI project. Interventions were implemented for a month followed by data collection which entailed analysis of the medical records of the last 50 HIV+ female patients to see if sexual wellbeing had been discussed and recorded.

### Results

Baseline practice measurements demonstrated that 2% of patients were able to discuss sexual wellbeing. A verbal presentation promoting the use of the infographic as a tool paired with the digital infographic showed an increase from 2% to 22% of patients discussing sexual wellbeing. Following implementation of the paper-based infographic, results showed that only 4% of patients discussed sexual wellbeing, suggesting that this intervention was not effective.

### Conclusion

This tool holds potential utility across clinical practice and health interventions.

## Introduction

Research into sexual wellbeing as a significant sociological and psychological factor in mental health is in its nascent phase partly due to its nebulous nature and lack of distinction from its more clinical

counterpart, sexual health [1]. Sexual wellbeing is not a simple issue that remains solely within healthcare but extends into the social and political climate, making it very complex to address and although healthcare-based interventions can have a far-reaching consequences, additional efforts need to be made towards shaping a society where barriers towards accessing help regarding sexual wellbeing are not as arduous to overcome as they are currently.

## Objectives and Focus for Review

The objective of this review is to draw out common threads that have shaped scholarship with regards to sexual wellbeing and inform the quality improvement project to be conducted. An approach was taken to collate existing literature which included both grey literature and peer-reviewed journals, requiring articles to address sexual health or wellbeing as a concept, either through an implicit or explicit definition or situating it within a theoretical framework.

## Defining Sexual Health & Wellbeing

The term sexual health is widely used in both healthcare-oriented and public domains with varying definitions, nuances and subconcepts emerging from the term as well. As of 2006, the WHO created a working definition of sexual health, referring to it as a state that incorporates physical, emotional and social factors with regards to sexuality [2]. The WHO elaborated that good sexual health is not merely being physically free from disease - it is also the fulfilment of human rights and is relevant throughout life, not purely during reproductive years [2]. Despite this, public health interventions regarding sexuality remain almost exclusively within clinical contexts and sexual wellbeing is disregarded as a valid outcome of health [1]. A study carried out in the United States aiming to define sexual wellness in mid and later life recorded the responses of 373 adults when asked to provide a definition of sexual wellness [3]. As outlined in Figure 1, These results were analysed to suggest a biopsychosocial-cultural framework which The Lancet conceptualised to show that sexual wellbeing demands recognition and has extensive applications within public health [1].

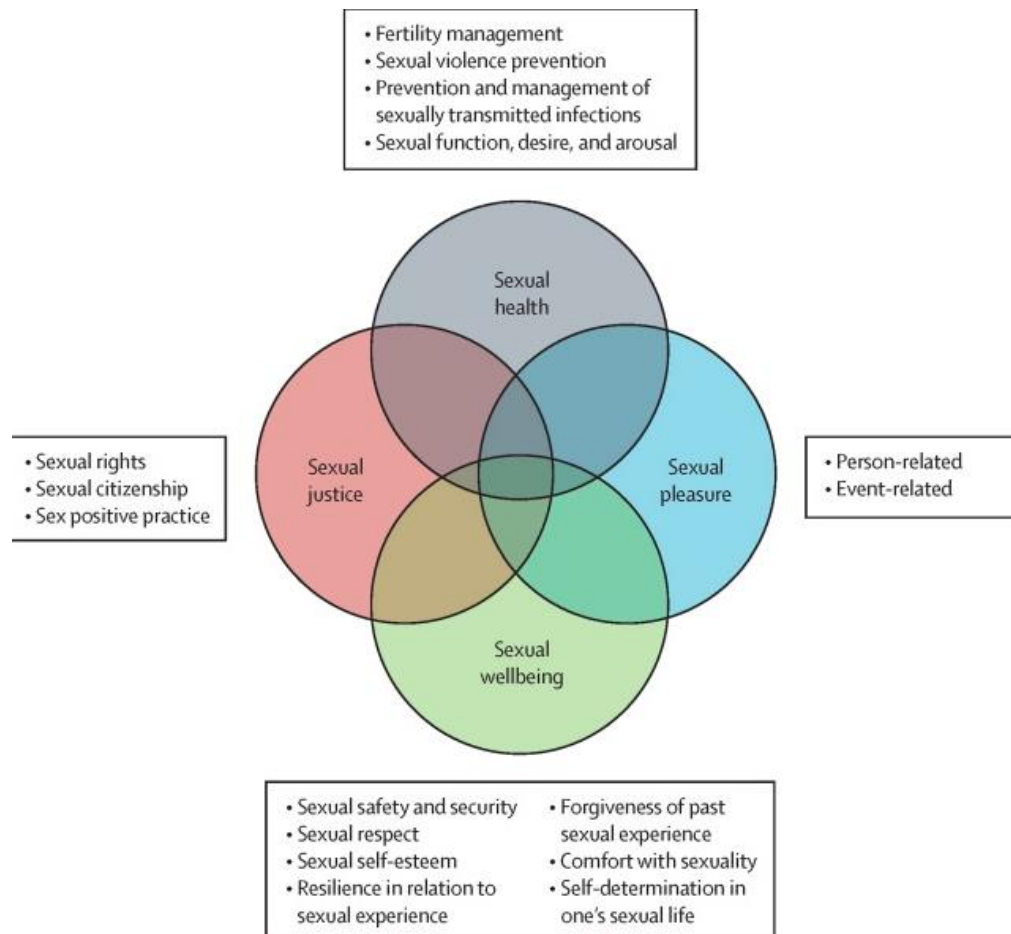


Fig 1: Four pillars of comprehensive public health focused inquiry and intervention in relation to sexuality [2]

## Investigating Measures of Sexual Wellbeing

In order to have a comprehensive understanding of sexual wellbeing and be able to formulate evidence-based management plans, the psychometric measures by which sexual wellbeing is assessed need to be investigated. It has been proposed that a measure of sexual wellbeing can be based on whether their feelings towards their sex lives are predominantly positive or negative and that would correlate with having either a high or low sexual wellbeing [4]. Another approach towards psychological well-being which can also be applied to sexual wellbeing is assessing overall life satisfaction where individuals contrast their ideal situations with the ones they presently have [5] and this assessment can be made regarding their sex lives. In 1995, Lawrance and Byers introduced the term, 'subjective sexual satisfaction' which was based around individuals' subjective evaluation of the positive and negative facets of one's sexual experiences [6]. The theoretical model they conceptualised was called the Interpersonal Exchange Model of Sexual Satisfaction (IEMSS) where sexual satisfaction was determined by four aspects; the difference between sexual rewards (REW) and costs (CST), the difference between expected and actual sexual rewards/costs ( $CL_{REW} - CL_{CST}$ ), perceptions of sexual rewards and costs from members of the couple ( $EQ_{REW}, EQ_{CST}$ ) and satisfaction with the nonsexual aspects of the relationship [6].

Sexual rewards are gratifying exchanges individuals experience while sexual costs are the adverse ones [7]. The IEMSS can be represented algebraically as follows:

$$\begin{aligned} \text{Sexual satisfaction} &= \sum_{\text{time}} (\text{REW} - \text{CST}) \\ &+ (\text{CLREW} - \text{CLCST}) \\ &+ (\text{EQREW}, \text{EQCST}). \end{aligned}$$

Fig 2: Algebraic representation of sexual satisfaction according to IEMSS [8]

The Interpersonal Exchange Model of Sexual Satisfaction Questionnaire (IEMSSQ) [9] includes four psychometric elements, “the Exchange Questionnaire (EXQ), the Global Measure of Sexual Satisfaction (GMSEX), the Global Measure of Relationship Satisfaction (GMREL), and the Rewards/Costs Checklist (RCC) [7]”. The GMSEX is a measure of sexual satisfaction within a relationship and required respondents to rate their sexual relationships on several bipolar scales consisting of 7 points; “good-bad, pleasant-unpleasant, positive-negative, satisfying-unsatisfying, valuable-worthless [8]” and possible scores ranged from 5 to 35. The GMREL is similar to the GMSEX but respondents are evaluating criteria based in their overall relationship not merely the sexual aspect [8].

Another study formulated the Rewards/Costs checklist to help respondents consider aspects of their relationship in order to make a judgement in the IEMSSQ [10]. The checklist included items such as displays of affection, spontaneity, privacy and compromise with regards to sexual activity [10]. In a study validating the IEMSS, analysis of the questionnaire showed differences in responses of men and women. Sexual costs for men and women were fairly similar as both felt having sex when unaroused and spontaneity in their sex lives were negatives [10]. A differing aspect was men felt frequency of sexual engagement was a cost while women identified time spent engaging in sexual activity a cost [10]. The results of this study provided good support for the validity of the IEMSS specifically in long term heterosexual relationships [10] and despite the lack of a gold standard measurement, this particular model amalgamates all the components largely contributing towards sexual satisfaction. In order to determine a more accurate measurement of sexual wellbeing, the assessment can be repeated at chosen time periods as sexual satisfaction is a function of an individual’s broader sexual history [11]. In summary, sexual wellbeing seems to be higher when the individual and their partner’s levels of sexual rewards and costs are closer to a perceived equilibrium. Unlike men, women’s sexual wellbeing seems to depend less on the physical enjoyment and more on the emotional aspect of the sexual relationship [10].

## Determinants of Sexual Wellbeing in Women

In a policy paper on Women’s Health Strategy for England [12], the issue of women being largely under-represented in significant clinical trials is highlighted. Disparities in women’s health are evident throughout the UK - an example of this was in the Ockenden review [13] where maternity services failed

to safeguard mothers and their babies leading to devastating consequences. Additionally, despite women in the UK living longer than men on average, women spend a much larger proportion of their lives in poor health coupled with disability [14]. The strategy lays out a 6-point long term plan for transformational change in women's health [12] and is based upon the determinants of women's health, hence can be used as a template for the determinants of sexual wellbeing. In a summarised form, prioritising sexual wellbeing would require access to reliable information on women's health, convenient access to contraception, abortion and fertility services, preventing violence against girls and women and early diagnoses of gynaecological cancers across the life course.

Due to the state of sexual education in the United Kingdom, a continual rise in the rates of sexually transmitted infections exists reflecting the global situation and is particularly seen in the 15-25 age group [15] which is associated with significant maternal mortality and pregnancy complications. Inadequate sex education finally led to the government prioritising public health and education initiatives such as the National Teenage Pregnancy Strategy [16] and the National Strategy for Sexual Health and HIV [17]. In a study assessing sexual health knowledge of pupils in school, it was found that students highly lacked knowledge on emergency contraception and sexually transmitted infections in particular [15] despite the ages they were becoming sexually active decreasing [15].

The rate of teenage pregnancies recorded in Britain in the later decades of the 20th century were significantly higher than other countries in Western Europe [18]. It was found by MSI Reproductive Choices UK that 35% of women who tried to access a contraceptive service thought ease of access to these services had deteriorated [19]. The survey conducted sought to understand how to improve access to contraception for women across the country and found that over a quarter of women want more information on how and where to access contraception [19] while 44% wanted longer supplies of pills or condoms from healthcare [19]. With the significance of contraception contributing towards pregnancy prevention, emergency use and HIV or STI prevention [20], being unable to access services or not being informed on availability would be highly detrimental towards allowing women to have safe sex in which they feel empowered and comfortable.

Infertility affects 1 in 7 heterosexual couples trying to conceive in the UK [21] and 8 to 12% of reproductive aged couples globally [21]. Despite the magnitude of this problem, inequality to fertility treatment exists in all forms. A report by the UK Human Fertilisation and Embryology (HFEA) showed poorer health outcomes for Black women opting for fertility treatment and demonstrated how women from minority ethnicities face considerable barriers when seeking fertility options compared to their White counterparts [22]. In the United States, the Society of Assisted Reproductive Technology national database was analysed to show that black women received 3666 (4.6%) cycles of in vitro fertilisation (IVF) in comparison with white women who received 68 607 (85.4%) cycles of IVF [23]. Even when Black women did attain IVF, they had lower live birth rates and higher miscarriage rates compared to White women [23]. In a study aiming to determine racial differences in self-reported infertility in black and white women, it was found that even after adjusting for socioeconomic circumstances, marital status and other risk factors for infertility, the disparity between infertility in black and white women still persisted [24] yet they were less able to access fertility treatment.

## **Experiences of women living with HIV**

The determinants of sexual wellbeing outlined all have a larger effect in women living with HIV as there are additional stressors on these women including stigmatisation, judgement and conforming to cultural norms. Access to information regarding HIV transmission and safe sex is limited and despite interventions in education such as the publication of the National Strategy for Sexual Health and HIV [17], women still do not have the required knowledge to lead safe and satisfying sex lives with HIV. The large degree of HIV related stigma [25] and psychological distress among pregnant women living with HIV [26] also compromises physiological wellbeing of HIV positive women. 1 in 8 HIV+ patients experience some form of stigma or discrimination towards them [27] and this is largely due to perpetual myths around HIV transmission and diagnosis [28]. The consequences of this stigmatised approach are far-reaching leading to relationship breakdowns, poor reproductive choice and options, loss of income and feelings of withdrawal and hopelessness [29]. Women catastrophising an HIV+ diagnosis was largely due to stigmatisation and this would in turn lead to women taking up avoidant coping strategies that was found to increase their levels of psychological distress [26]. With these additional psychological stressors on women living with HIV, the barriers to achieving optimal sexual wellbeing and satisfaction are much greater and more complex.

## **Perceived barriers to discussing Sexual Wellbeing of HIV+ Women**

The increasing role of antiretroviral treatment and HIV prevention interventions alongside advances in overcoming discrimination and stigma have collectively contributed towards a better quality of life for women living with HIV [30] however the end goal is far from close. Living with HIV is a complicated matter for a woman as it affects sexuality, pregnancy and childbirth. It can have an effect on relationships by reducing intimacy, restricting opportunities for intimate relationships and having concerns about perinatal HIV transmission [31]. Antiretroviral treatment (ART) has proved extremely effective so when levels of the virus have reached undetectable levels, the risk of transmission is virtually none [32]. Furthermore, when maternal viral suppression is attained, the newborn receives post-exposure prophylaxis so the risk of perinatal transmission has shown to decrease to below 0.5% [32]. With these advances, HIV+ women should be able to engage in safe sex and conceive safely but many women still express the fear of unknowing transmission which can be detrimental to their sex lives and wellbeing [33]. In the UK, a survey showed that comparable to the general population, women are highly satisfied with HIV services and have a good quality of life but feel more needs to be done towards tackling financial hardship, loneliness, stigma and the struggle of disclosing their HIV status and this would go a long way towards their mental health and general wellbeing [34]. They reported a lack of support relating to social and welfare services that would cover employment, claiming benefits, housing support and isolation. They also felt matters such as peer support, psychological services, stress management and childcare services were not being addressed particularly. Using a standardised health-related quality of life instrument, Euroqol (EQ-5D-5L), the quality of life of women living with HIV in the UK was measured [34].

With 0 representing the worst possible health and 1 representing the best, the score for quality of life of women in the UK was 0.87 compared to a worldwide score of 0.83 [34]. With mental health being largely tied to sexual wellbeing, consideration needs to be given to the fact that 35% of women with HIV have been clinically diagnosed with a mental health condition [34]. A considerable factor in the mental health of women with HIV was the stigma around their diagnosis. 1 in 6 women had not disclosed their HIV status to anyone besides those in healthcare settings and even within healthcare, perceived discrimination had led to 1 in 5 women reporting being concerned about disparities in standards of care due to their HIV status [34]. 13% of women with HIV also avoided seeking health services when required due to their HIV status [34].

## **Improving & Promoting Sexual Wellbeing in Healthcare & the Wider Political Agenda**

Until recently, the concept of including variables such as sexual wellbeing, sexual pleasure or desire was unheard of [35] in research on sexual health. However, when Philpott and Knerr reviewed HIV prevention programs worldwide, they discovered that sex positivity encompassing promoting sexual pleasure in conjunction with recommendations about safe sex led to an increase in use of condoms [36]. In a 2003 review analysing the psychosocial factors impacting condom use among adolescents, sexual pleasure and eroticisation of condoms were found to be effective strategies to improve HIV prevention programs as a central finding of the study was that condom use was reported to decrease pleasure [37]. Further research exploring the various factors contributing to sexual engagement and satisfaction can be applied to sexual health interventions and sex education which would include information on ways to enhance sexual wellbeing and positive sexuality [35]. Civil society organisations such as the Sexual Rights Initiative [38], the Egyptian Initiative for Personal Rights [39] and the Sexuality Policy Watch [35] have contributed towards the advancement of sexual rights through promoting sexual rights and raising awareness on the significance of this issue in political spheres.

Maintaining and increasing support for organisations such as these can help allow them to make a larger dent in the wider political agenda concerning sexual rights and sexual wellbeing. Assessing legal frameworks and local policies is a large aspect of promoting and improving sexual wellbeing. For instance, laws that prevent adolescents to access sexual health services without parental consent can be highly detrimental to individuals' sexual wellbeing and is a limitation of their rights [41]. Criminalising identities such as the LGBT population in certain parts of the world limits sexual pleasure and expression and only increases existing stigmas around sexual expression and health. Furthermore, sociocultural taboos are frequently integrated into law and policy making such as penalising same-sex sexual acts, transgender expression, advertisement of contraception or abortion, sex work and many more [42].

These controlling policies and practices also largely undermine the rights and needs of people living with disabilities who are most commonly falsely held to be asexual or hypersexual [43]. People with disabilities are controlled through restricting their access of sexual health information and services, forced sterilisation and dismissing their rights to sexual pleasure, life partnerships and opportunities for motherhood [42]. Human rights standards such as the rights to non-discrimination, human dignity and autonomy are increasingly being applied to sexual health related issues by the UN Human Rights

Committee and the European Court of Human Rights and with more support behind this, it will be better reflected in public health policies and programmes that champion sexual wellbeing. Sexual health education programmes can also be adjusted to cover a wider range of thematic areas addressing reproductive health and rights alongside information on the provision of sexuality counselling, HIV and STI prevention, abortion, unplanned pregnancies, addressing sexual dysfunction and so on [42]. In order to deliver these programmes, there is a lack of training for healthcare providers as they often do not have the expertise or feel comfortable addressing all dimensions of sexuality such as pleasure, desire and satisfaction [42].

## Rationale for Quality Improvement (QI) Project

The study of sexual wellbeing has gained traction in recent years with the benefit of exploring the implications and effects of sexual wellbeing coming to light to researchers. This narrative review shows that research on sexual wellbeing has significant potential for developing understanding on sexual wellbeing and its application into clinical settings. The QI project conducted was a sensitisation project to bring sexual wellbeing as a definitive outcome of health to the forefront. The narrative review outlines the importance of interventions such as these in raising awareness on how exploring sexual wellbeing is integral to holistic sexual health services as it significantly influences the quality of life of patients and their experiences of healthcare.

## Methodology

### Background

There are no quality improvement projects on sexual wellbeing of HIV+ women in the literature and based on the rationale of the project demonstrating the significance of sexual wellbeing in overall health, this gap in research needed to be addressed. Patients should be given the opportunity to discuss their concerns about their sexual health and wellbeing with their healthcare provider during consultations hence this project aimed to implement interventions that would create the space for these conversations to be held and were particularly aimed at reminding clinicians to broach the subject of sexual wellbeing.

### Baseline Measurement

A gap analysis of the unit's baseline practice before the project initiation was conducted via retrospective analysis of patient documentation. The medical records of the last 50 female patients to have been seen in clinic were reviewed to see if questions encompassing sexual wellbeing had been asked and recorded.

These questions included:

1. Understanding of sexual wellbeing
2. Enjoyment of sex



- a. Sexual dysfunction?
- b. Pain?
- c. Issues with female sexual response cycle (libido, arousal, orgasm, resolution)
- 3. History of dyspareunia
  - a. Site
  - b. onset,
  - c. Character - constant? Positional?
  - d. duration,
  - e. Location,
  - f. Alleviating factors
  - g. Exacerbating factors - able to use tampons/speculum?
  - h. Pain score out of 10
- 4. Enjoyment of solo sex and masturbation
- 5. Partner(s)' thoughts
- 6. Previous medical examinations / traumatic birth
- 7. Unwanted / forced sexual experiences
- 8. Mental health & psychological history
  - a. Previous therapy, known to any services, anxiety and stress both within and outside sex, current psychological & emotional state
  - b. Addictions? PTSD? Insomnia? Anxiety? Depression? Suicidal thoughts & self harm?
- 9. Social history regarding sex
  - a. Cultural issues growing up
  - b. Dealing with HIV stigma
  - c. Sexual health education (ways to leads a safe sex life with HIV)
  - d. Chemsex?

Baseline practice results showed:

Questions on sexual wellbeing (Y/N)									Sexual wellbeing discussed? ( <i>min of 2 Qs asked</i> )
Understanding of sexual wellbeing	Enjoyment of sex	History of dyspareunia	Enjoyment of solo sex/masturbation	Partner(s)' thoughts	Previous medical examinations / traumatic birth	Unwanted / forced sexual experiences	Mental health & psychological history	Social history regarding sex	
0/50	0/50	0/50	0/50	0/50	0/50	2/50	3/50	0/50	1/50

Baseline practice results showed that 1/50 patients had been asked about sexual wellbeing with 46 patients not asked a single question pertaining to sexual wellbeing.

As there is a large overlap between sexual health and sexual wellbeing, patient documentation was also reviewed to see if holistic questioning encompassing sexual health was being carried out.

These questions included:

1. Clinical symptoms
  - a. Itching
  - b. Burning
  - c. Provoked/unprovoked pain
  - d. Discharge
  - e. Lumps & bumps
  - f. Bleeding
  - g. Urinary symptoms
2. STI history & screening
3. Past medical history
4. Medications / drug allergies
5. Social history
  - a. Drugs
  - b. Alcohol
  - c. Job
  - d. Living situation
6. Contraception & reproductive history

Baseline practice results showed:

Questions on sexual health (Y)						Sexual health discussed? ( <i>min of 4 Qs asked</i> )
Clinical symptoms	STI history & screening	Past medical history	Medications / allergies	Social history	Contraceptive & reproductive history	
23/50	15/50	49/50	50/50	22/50	10/50	20/50

Baseline practice results showed that 20/50 patients had been asked questions pertaining to their sexual health suggesting that clinicians were perhaps not taking holistic histories on sexual health or may not be recording all information acquired during a consultation. Out of the 6 factors assessing sexual health, all patients were questioned on the medications they were on and 49/50 patients were questioned on their past medical history. However, only 10 were questioned on their contraception use and reproductive history and 15 on their STI history and screening.

Overall, the gap analysis demonstrated that discussions on sexual wellbeing were not taking place with HIV+ women and hence those who had concerns could not be referred to psychosexual services or have their concerns addressed. Furthermore, despite history taking with regards to sexual health being a lot more in depth than that of sexual wellbeing, thorough and complete questioning was still not taking place making it difficult to treat patients holistically.

## **Design**

The aim of this QI project was that all HIV+ women at Grahame Hayton Unit, Royal London Hospital would be given the opportunity to discuss their concerns on their sexual wellbeing with one of their healthcare providers.

Based on the barriers identified through interviewing consultants in the sexual health team, standardisation of notes and reminders to clinicians were selected as initial options for the project. It was discussed that discussions around sexual wellbeing could occur at the end of consultations. Potential solutions suggested included distribution of paper-based checklists and attending staff meetings to verbally present the intervention to promote the idea and the importance of talking about sexual wellbeing in women's health.

The consultants felt that the proposed interventions were realistic, sustainable and could be replicated on different sites. There were no supply costs to the program and the time commitment for these discussions to occur was not expected to be burdensome. Each intervention was to be implemented for a month followed by analysis of patient notes to compare the effect of interventions.

## **Strategy**

Plan, Do, Study, Act (PDSA) cycles were used in this quality improvement project as a framework for developing, testing and implementing changes on a small scale.

The four stages of the cycle are:

P - plan the intervention

D - implement the intervention

S - collect data on measurable outcomes decided beforehand

A - plan the full implementation of project or next change cycle

### ***PDSA Cycle 1***

Upon interviewing consultants in the sexual health team, the biggest barrier towards discussing sexual wellbeing was the lack of initiation by consultants and less to do with time allocated in clinics.

Implementing a conversation tool to remind clinicians to broach topics on sexual wellbeing and cover aspects of it holistically would allow clinicians to create space for patients to discuss their concerns on sexual wellbeing.

### ***PDSA Cycle 2***

A digital infographic (see Appendix A) illustrating the questions and concepts surrounding sexual wellbeing and sexual health that should be broached by clinicians was created and distributed via email to

all staff at Grahame Hayton Unit (GHU). A verbal 10 minute presentation at a GHU staff meeting was carried out promoting the use of the infographic and how it could be referred to during consultations to allow conversations around sexual wellbeing to occur. Clinicians were also reminded to record information acquired in the patient notes as these conversations could be occurring without being recorded. This would be to the detriment of the patient as different clinicians overseeing patients would not have any point of reference of the state of sexual wellbeing of these patients and this aspect of sexual health would then not be explored. The percentage of patients who received the opportunity to discuss their concerns on sexual wellbeing increased with the implementation of this intervention.

### ***PDSA Cycle 3***

Following feedback and discussion on the initial tool to increase conversations around sexual wellbeing, the team of consultants came to the consensus that implementing a paper-based visual supported tool mirroring the digital infographic may be of greater effect. The infographic was printed and placed in all clinician rooms in the GHU so it could be a more convenient point of reference for staff at GHU to initiate conversations on sexual wellbeing. This paper-based intervention was much less effective than the verbal tool paired with the digital conversation tool as results demonstrated that the intervention did not increase conversations on sexual wellbeing even marginally compared to the baseline practice measurements.

## **Results**

Results from the first intervention:

Questions on sexual wellbeing (Y/N)									Sexual wellbeing discussed? ( <i>min of 2 Qs asked</i> )
Understanding of sexual wellbeing	Enjoyment of sex	Enjoyment of painful sex	Enjoyment of solo sex/masturbation	Partner(s) thoughts	Previous medical examinations / traumatic birth	Unwanted / forced sexual experiences	Mental health & psychological history	Social history regarding sex	
2/50	6/50	5/50	1/50	3/50	7/50	4/50	19/50	9/50	11/50

Questions on sexual health (Y)						Sexual health discussed? ( <i>min of 4 Qs asked</i> )
Clinical symptoms	STI history & screening	Past medical history	Medications / allergies	Social history	Contraceptive & reproductive history	
48/50	13/50	48/50	48/50	16/50	17/50	23/50

Results from the first intervention showed that 11 out of 50 patients were questioned on sexual wellbeing constituting 22% of patients compared to the 2% of patients who were able to discuss sexual wellbeing in the baseline practice measurements. Furthermore, 3 patients were asked about 5 of the 9 aspects of sexual wellbeing compared to a maximum of 2 aspects of sexual wellbeing being asked about in baseline measurements.

In terms of sexual health, 23/50 had quite holistic questioning on their sexual health compared to the 20/50 in the baseline measurements so a 6% increase was seen with the introduction of this tool. 17/50 patients were asked about contraception which was a large increase compared to the 10/50 previously. However, other inconsistencies surfaced such as the percentage of patients asked about medications, social history and STI history decreased during this analysis.

Results from the 2nd intervention:

Questions on sexual wellbeing (Y/N)									Sexual wellbeing discussed? ( <i>min of 2 Qs asked</i> )
Understanding of sexual wellbeing	Enjoyment of sex	History of painful sex	Enjoyment of solo sex/masturbation	Partner(s)' thoughts	Previous medical examinations / traumatic birth	Unwanted / forced sexual experiences	Mental health & psychological history	Social history regarding sex	
0/50	0/50	1/50	0/50	0/50	0/50	0/50	6/50	3/50	2/50

Questions on sexual health (Y)						Sexual health discussed? ( <i>min of 4 Qs asked</i> )
Clinical symptoms	STI history & screening	Past medical history	Medications / allergies	Social history	Contraceptive & reproductive history	
47/50	10/50	49/50	42/50	11/50	11/50	21/50

Results from the 2nd intervention showed that only 2/50 patients had been questioned on sexual wellbeing, a large reduction from the effects the previous tool had and a maximum of 2 factors around sexual wellbeing was asked compared to 5 with the last intervention. 42 patients were not questioned at all on sexual wellbeing.

In terms of sexual health, it was discussed holistically with 21 out of 50 patients, 42% of patients. The results on sexual health questioning were similar throughout the course of the QI, suggesting that interventions that were conversation tools were better focused on sexual wellbeing as conclusive evidence to support certain interventions seemed to be able to be attained.

# Discussion

## Main Findings

Overall, the baseline practice measurements demonstrated that the need for quality improvement projects focusing on sexual wellbeing in HIV+ women existed as 2% of patients were given the opportunity to discuss sexual wellbeing while 92% of patients were not asked a single question pertaining to sexual wellbeing. A verbal presentation promoting the use of the infographic as a tool to remind clinicians to initiate conversations around sexual wellbeing paired with clinicians possessing a digital copy of the infographic showed an increase in the percentage of patients who were able to discuss their sexual wellbeing. There was an increase from 2% to 22% after a month of the project being implemented.

The results also demonstrated clinicians were asking more questions on sexual wellbeing after the intervention rather than just asking about a few factors. In the following month, there was no verbal presentation at the weekly staff meeting but the infographic detailing questions on sexual wellbeing and sexual health were printed and distributed throughout clinician rooms as a reference point to assist clinicians with initiating these conversations. Results showed that only 4% of patients discussed sexual wellbeing, suggesting that this intervention was not effective. Upon evaluation and interviewing the team of consultants, it was found that many clinicians held phone clinics so many of the rooms the infographic was present in weren't even being interventions that allow integration of sexual wellbeing into healthcare, the findings from further research can be used to inform further strategies and frame the questions that need to be outlined in longitudinal studies and interventional research.

## Conclusion

Sexual wellbeing remains a crucial component in overall health, wellness and quality of life of patients. With a multitude of reasons affecting sexual wellbeing and psychological state, particularly in women. The recognition of sexual wellbeing as a valid outcome of health needs to be integrated into healthcare, particularly psychiatric practice as sexual wellbeing in itself holds such a large psychological component with concrete links to mental health and psychological state. It is important that clinicians broach the subject of sexual wellbeing to elicit relevant information and always enquire about this with a degree of sensitivity. Clinicians should also be able to direct their patients towards evidence-based interventions such as psychosexual referrals and make individualised recommendations based on the patient's desires and needs. Despite the sociopolitical circumstances and attitudes around sexual health, the need for healthcare-based interventions within healthcare is still apparent and can be incredibly advantageous in departments such as psychiatry which place emphasis on wellness. Additional interventions need to be implemented in healthcare to allow for a more seamless transition of sexual wellbeing into patient care and can include mandatory training for health professionals, implementing standardised checklist methods to ensure it is well-integrated into patient interactions, creating valid criteria using insights from patients and propelling this recognition of sexual wellbeing being clinically significant into interventional research that can deepen understanding and improve application to clinical practice.

Furthermore, the consultants preferred being reminded about initiating conversations on sexual wellbeing via weekly verbal presentations at the staff meeting and utilised the digital infographic easily compared to having a paper-based tool that was not necessarily present where they were.

The effect of these interventions on assisting and reminding clinicians to have more thorough conversations on sexual health so no part of a patient's care would be missed was minimal. Throughout the course of the QI project, minimal progress was seen with the percentage of patients receiving more detailed questioning on their sexual health so a different course of action would have to be implemented to tackle this.

## **Limitations**

Large discrepancies between patients in the cohort analysed existed as the study did not control for factors such as use of medication, existence of a partner, presence of co-morbidities and other restrictions which would have large implications on the state of perceived state of sexual wellbeing. Age of participants also varied considerably, ranging from ages 28 to 69 years. As this large age range encompasses different stages of life affecting stability with regards to finances, emotions or physical health, this should have been a controlled variable to increase accuracy of data interpretation.

There was also significant heterogeneity with patient notes as they had been done by a range of healthcare staff including consultants and nurses. Some patient documentation was very extremely extensive while many were quite brief hence sexual wellbeing and elements of sexual health may have been discussed but not recorded in the notes. Additionally, the promotion of the interventions for this project included a verbal presentation at a staff meeting and a mass-distributed email to all on-site healthcare staff and many staff who were conducting clinics with patients may not have read this particular email or attended the staff meeting and hence were unaware that they should aim to broach the topic of sexual wellbeing.

A range of sites for the intervention to be implemented at instead of a singular site would also have increased the sample size and minimised anomalous data however the project was carried out at one site for logistical purposes.

Had time restraints not existed, ideally PPIE (patient and public involvement and engagement) research would've been conducted and patients would be involved in the design of the study to craft interventions that were based more on the first-hand experiences of patients instead of the assumptions of the healthcare body.

The study was also cross-sectional instead of longitudinal, hence the pattern of sexual wellbeing and sexual health of patients was not followed through and instead was analysed at fixed points in time.

## **Recommendations for further research**

The narrative review highlights the paucity of data in this field. Further studies are required to better understand determinants and domains of sexual wellbeing and to critically evaluate the impact that sexual

wellbeing, pleasure and satisfaction have on quality of life and wellness in women. Findings from these studies can then be used to better integrate sexual wellbeing into specific care models for patients in psychiatry and other relevant departments.

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[report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions](#)



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# Appendix A

## Infographic used in Service Evaluation

Ask about?  **SEXUAL WELLBEING** 

<p><b>UNDERSTANDING OF SEXUAL WELLBEING</b></p>	<p><b>HISTORY OF PAINFUL SEX</b></p> <ul style="list-style-type: none"> <li>• site</li> <li>• onset</li> <li>• character - constant? positional?</li> <li>• duration</li> <li>• alleviating factors</li> <li>• exacerbating factors - able to use tampons / withstand a speculum?</li> <li>• pain score</li> </ul>	
<p><b>ENJOYMENT OF SEX</b></p> <ul style="list-style-type: none"> <li>• sexual dysfunction</li> <li>• pain during sex</li> <li>• issues with female sexual response cycle (libido, arousal, orgasm, resolution)</li> </ul>	<p><b>SOLO SEX / MASTURBATION</b></p>	<p><b>PARTNER(S) THOUGHTS</b></p>
<p><b>MENTAL HEALTH &amp; PSYCHOLOGICAL HISTORY</b></p> <ul style="list-style-type: none"> <li>• previous therapy, any services they're currently using, anxiety both within and outside sex</li> <li>• current psychological &amp; emotional state</li> <li>• addictions? PTSD? insomnia? depression? suicidal thoughts &amp; self harm?</li> </ul>	<p><b>SOCIAL HISTORY REGARDING SEX</b></p> <ul style="list-style-type: none"> <li>• cultural issues growing up, dealing with any stigma</li> <li>• extent of sexual health education (informed on ways to lead a safe sex life with HIV?)</li> <li>• chemsex?</li> </ul>	
<p><b>SEXUAL HEALTH</b></p>		
<p><b>CLINICAL SYMPTOMS</b></p> <ul style="list-style-type: none"> <li>• itching</li> <li>• burning</li> <li>• provoked / unprovoked pain</li> <li>• discharge</li> <li>• lumps &amp; bumps</li> <li>• bleeding</li> <li>• urinary symptoms</li> </ul>	<p><b>STI HISTORY &amp; SCREENING</b></p>	
<p><b>CONTRACEPTIVE &amp; REPRODUCTIVE HISTORY</b></p>	<p><b>PAST MEDICAL HISTORY</b></p> <p>atopy? (eczema, hayfever, asthma?) other conditions that could be interfering with sexual health?</p>	
<p>Discuss  Record </p>	<p><b>SOCIAL HISTORY</b></p> <ul style="list-style-type: none"> <li>• drugs, alcohol, job?</li> </ul> <p><b>MEDICATIONS / ALLERGIES</b></p>	