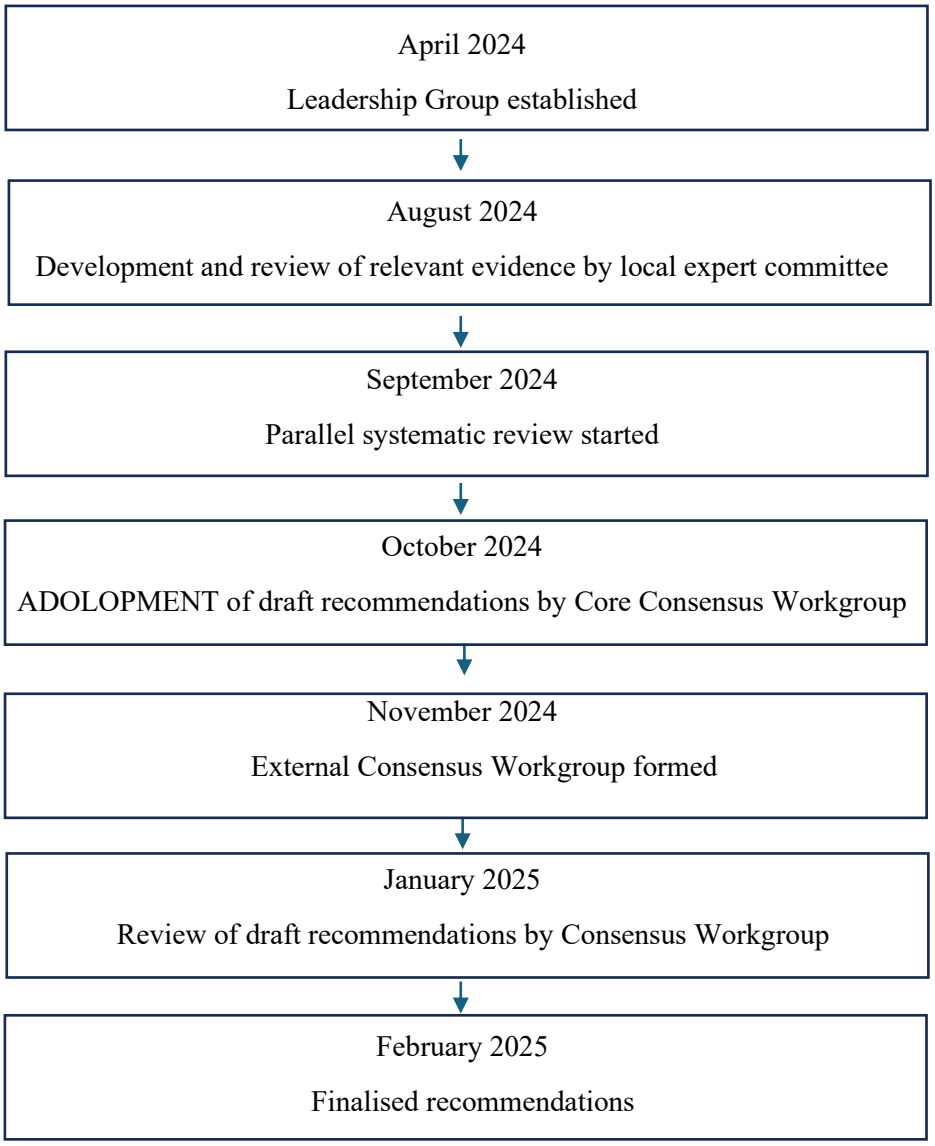
Supplementary materials to: Lee JJML, Tan TY, Chua CSL, et al. Guidelines on sexual health for women of reproductive age in Singapore. Ann Acad Med Singap 2026;55:OnlineFirst. DOI: https://doi.org/10.47102/annals-acadmedsg.2026356

Appendix S1. Timeline for the development of Sexual Health Guidelines for Women of Reproductive Age of 21 to 45 years in Singapore.



Appendix S2. 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 screening for 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 vulvodynia and vulval 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 screen for low 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 screen 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 after 6 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.

Appendix S3. Female Sexual Function Index-6.

Over the past 4 weeks:	
1. How would you rate your level (degree) of sexual desire or interest?	5 = Very high 4 = High 3 = Moderate 2 = Low 1 = Very low or none at all
2. How would you rate your level of sexual arousal ("turn on") during sexual activity or intercourse?	0 = No sexual activity 5 = Very high 4 = High 3 = Moderate 2 = Low 1 = Very low or none at all
3. How often did you become lubricated ("wet") during sexual activity or intercourse?	0 = No sexual activity 5 = Almost always or always 4 = Most times 3 = Sometimes 2 = A few times 1 = Almost never or never
4. When you had sexual stimulation or intercourse, how often did you reach orgasm?	0 = No sexual activity 5 = Almost always or always 4 = Most times 3 = Sometimes 2 = A few times 1 = Almost never or never
5. How satisfied have you been with your overall sexual life?	5 = Very satisfied 4 = Moderately satisfied 3 = About equally satisfied and dissatisfied 2 = Moderately dissatisfied 1 = Very dissatisfied
6. How often did you experience discomfort or pain during vaginal penetration?	0 = Did not attempt intercourse 5 = Almost never or never 4 = A few times 3 = Sometimes 2 = Most times 1 = Almost always or always
Total score: Note: Total score is the sum of the ordinal responses to the 6 items; the score can range from 2 to 30 with lower scores corresponding to worse sexual functioning. A cut off score of ≤19 is indicative of high probability of sexual dysfunction.	

Appendix S4. The PLISSIT model.

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 specialised treatment if necessary

Online Supplementary Material
Appendix S5. GRADE-ADOLOPMENT framework for Singapore Guidelines on Sexual Health for Women of Reproductive Age of 21 to 45 years.

What are the recommendations to provide appropriate screening and sexual education for women of reproductive age in Singapore?

QUESTION 1
Question details
Problem: To improve the screening and assessment for women of reproductive age in Singapore
Option: A set of guidelines that provide recommendations on screening tools and assessment for women of reproductive age in Singapore
Comparison: Separate guidelines targeting screening and assessment for women of reproductive age in Singapore
Main outcomes:
Beneficial and detrimental effects of Screening for Sexual Health
Beneficial and detrimental effects of Assessment for Sexual Health
Setting: Singapore community
Perspective: Healthcare providers

What are the recommendations to provide a holistic approach towards better sexual health for women of reproductive age in Singapore?

QUESTION 2
Question details
Problem: To improve the sexual health for women of reproductive age in Singapore
Option: A set of guidelines that provide holistic recommendations towards good sexual health for women of reproductive age in Singapore
Comparison: Separate guidelines targeting different aspects of sexual health for women of reproductive age in Singapore
Main outcomes:
Beneficial and detrimental effects of Education in Sexual Health
Beneficial and detrimental effects of Medical Intervention in Sexual Health
Beneficial and detrimental effects of Psychological Intervention in Sexual Health
Beneficial and detrimental effects of Physiotherapy Intervention in Sexual Health
Beneficial and detrimental effects of Lifestyle Intervention in Sexual Health
Setting: Singapore community
Perspective: Healthcare providers

Background
Sexual health is an integral component of women's overall well-being, yet sexual dysfunction among reproductive-age women remains under-recognised and under-treated. Studies worldwide report varying prevalence rates of sexual dysfunction among women of reproductive age, with figures ranging from 27% to over 50%. Common issues include low sexual desire, arousal difficulties, orgasmic disorders, and sexual pain. The variability in definitions and diagnostic criteria for sexual concerns, difficulties, disorders, and dysfunctions contributes to the challenges in identifying and addressing these issues effectively. Furthermore, many women do not view their sexual health concerns as medical issues and hesitate to discuss them with healthcare professionals. While the healthcare professionals may also avoid sexual health discussions due to various operational, skills and personal factors. Therefore, multidisciplinary collaboration and recognition of sexual health is an essential for comprehensive clinical care.

ASSESSMENT
Problem
Is the problem a priority?
Sexual dysfunction in women is often underrecognised and undertreated. Globally, the prevalence of sexual dysfunction in women of reproductive age is approximately 40.9%. In Singapore, low female sexual function is associated with a longer time to achieve pregnancy, a cohort study of 513 women from the PREconception Study of long-Term maternal and child Outcomes (S-PRESTO) found that 58.9% screened positive for low sexual function on the FSFI-6, which was associated with a reduction in fecundability (adjusted fecundability ratio 0.73, 95% CI 0.54–0.99, equivalent to a 27% reduction, after adjustment for age, ethnicity, education,

parity and body mass index). A 2023 questionnaire study of 514 young women in Singapore examining body mass index, body image, and self-esteem found a 46.5% at risk for sexual dysfunction on the FSFI. Collectively, these data suggest that female sexual dysfunction among young women in Singapore contributes to a significant health burden. Addressing sexual function issues in women is critical for their emotional and mental well-being, relationship satisfaction, and fertility. Ignoring sexual concerns can negatively affect a woman's overall quality of life.

Table 1: Consensus statements, clinical guidelines and expert committee opinions selected for formation of Singapore Guidelines on Sexual Health for Women of Reproductive Age

Type of Outcome	Author/Organisation	Year	Type of Paper	Name of Paper	Agree II Overall Appraisal Rating
Screening, assessment, education and management for female sexual dysfunction- sexual desire disorder	5th International Consultation on Sexual Medicine (ICSM 2024)	2024	Consensus Guideline	Evaluation and management of hypoactive sexual desire disorder in women. Recommendations from the 5th International Consultation on Sexual Medicine (ICSM 2024)	Low to Moderate
Sexual transmitted disease and screening Diverse population consideration	World Health Organisation (WHO)	2022	Normative Guideline	WHO guideline on self-care and interventions for health and wellbeing 2022	High
Education and management for female sexual function for reproduction during preconception period	Practice Committee of the American Society for Reproductive Medicine and the Practice Committee of the Society for Reproductive Endocrinology and Infertility	2022	Recommendation of Practice	Optimising natural fertility: a committee opinion	Moderate
Screening and assessment, education and management for sexual function in perinatal period	Grussu et al.	2021	Recommendation of Practice	Sexuality in the Perinatal Period: A Systematic Review of Reviews and Recommendations for Practice	Low to Moderate
Assessment and management of pelvic floor dysfunction for sexual functioning	National Institute for Health and Care Excellence (NICE)	2021	Clinical Practice Guideline	Pelvic floor dysfunction: prevention and non-surgical management	High
Assessment and management of mental health in preconception, antenatal and postpartum period	National Institute for Health and Care Excellence (NICE)	2020	Clinical Practice Guideline	Antenatal and postnatal mental health: clinical management and service guidance	High
Screening and assessment for female sexual dysfunction	The International Society for the Study of Women's Sexual Health (ISSWSH)	2019	Clinical Practice Guideline	The International Society for the Study of Women's Sexual Health Process of Care for the Identification of Sexual Concerns and Problems in Women	Low to Moderate
Management for female Sexual Dysfunction	American College of Obstetricians and Gynaecologists (ACOG)	2019	Clinical Practice Guideline	Female Sexual Dysfunction: ACOG Practice Bulletin Clinical Management Guidelines for Obstetrician-Gynaecologists, Number 213	Moderate

Table 2 Desirable effects - How substantial are the desirable anticipated effects?
Following Table illustrate the desirable effect for screening in sexual health

Type of outcome	Authors/ Year	No. of studies/ participants	Study Design	Certainty	Effect	Test accuracy CoE	Applicability/ transferability
					Pre-test probability of 0%		Justification
Beneficial Effects of Screening in Sexual Health	Chongcharoen et al. 2024	500	Prospective cross-sectional diagnostic study	⊕⊕⊕○	Cutoff FSFI score of 23.1 for Female Sexual Dysfunction	Sensitivity of 75.6% Specificity of 67.7% An area under the curve of 0.76 (95% confidence interval, 0.70–0.80)	Moderate Median age of Thai women in this study is 39(33,46) As the study was situated within a Southeast Asian sociocultural context, where religious and community practices bear notable similarity to those observed in Singapore, it is possible that certain behavioural or attitudinal patterns may reflect these shared regional influences. Nonetheless, such parallels should be interpreted cautiously and not assumed at the individual/ national level
	Loy et al., 2021	455	Prospective preconception cohort study	⊕⊕○○	Cut-off point based on the median score of FSFI in study	Not done	High Singaporean women from the age of 18 to 45 years old
	Ho et al. 2020	271	Cross-sectional survey	⊕⊕○○	Cut-off FSFI score based on another study	The Cronbach's alpha coefficients were 0.92 for the total scale and 0.72 - 0.89 for the domains	Moderate Mean age of Vietnamese women in this study is 31.25 ± 5.06, age range 20 to 46 years old

						Domain inter-correlations ranged from 0.36 - 0.73 and domain-total correlation coefficients ranged from 0.67 - 0.84 Test-retest correlation coefficients were 0.97 (P < .001) for the total scale and 0.84 - 0.96 for the domains	Although contextual differences remain, the sociocultural and geopolitical similarities between Vietnam and Singapore—particularly in relation to regional cultural norms, gendered social expectations, and Southeast Asian policy landscapes—indicate a high likelihood of transferability. Nonetheless, interpretations should remain attentive to local variations within each national context and at individual level

Legend	
⨁◯◯◯	Very-low certainty
⨁⨁◯◯	Low certainty
⨁⨁⨁◯	Moderate certainty
⨁⨁⨁⨁	High certainty

Table 3 Desirable effects - How substantial are the desirable anticipated effects?
Following Table illustrate the desirable effect for assessment in sexual health

Type of outcome	Authors/ Year	No. of studies/ participants	Study Design	Certainty	Effect	Test accuracy CoE	Applicability/ transferability
					Pre-test probability of 0%		Justification
Beneficial Effects of Assessment in Sexual Health	Sesari et al. 2022	422	Cross sectional study	⊕○○○	No cut-off score reported	High reliability of 0.831 using Cronbach's Alpha coefficient The r-value on each question in the translated FSFI-6 questionnaire was greater than 0.3	Moderate Indonesian women >18 years old with a mean age of 42.5 years Although contextual differences exist, the sociocultural and geopolitical similarities between Indonesia and Singapore—particularly in relation to community norms, multicultural structures, and regional policy environments—indicate a high likelihood of transferability. Nonetheless, interpretations should remain sensitive to localised variations within each national setting and individual level

Legend	
⊕○○○	Very-low certainty
⊕⊕○○	Low certainty
⊕⊕⊕○	Moderate certainty
⊕⊕⊕⊕	High certainty

Table 4: Desirable effects - How substantial are the desirable anticipated effects?
Following Table illustrate the desirable effect for education in sexual health

Type of outcome	Authors/ Year	Study Design	Summary of findings						Applicability/ transferability
			No. of participants		Effect				
			Education	No Education	Absolute (95% CI)		Relative (95% CI)	Certainty	Justification
Beneficial Effects of Education in Sexual Health	Keshavarz et al. 2025	Non-RCT	40	40	Intervention	Control	Not reported No adverse event reported	⨁○○○	Low
					Women in the intervention group demonstrated significant improvements in all FSFI domains while women in the control group experienced declines in desire, arousal, lubrication, and satisfaction scores, with a slight increase in pain scores between baseline and 8 weeks follow-up				Study population- Iranian women, in the age range of 18 to 45 years, with mean age of 25.63 ± 5.4 in intervention group 27.83 ± 6.26 in control group Potential inference arising from religious practices that align with those commonly observed within Singapore's third-largest religious community (Islam), given regional similarities. though this should not be assumed at the individual level and participants are in the reproductive age group
			Sexual Health Education	Routine Prenatal Care	FSFI: After 4 weeks 25.83 ± 7.79 (no CI reported) After 8 weeks 26.53 ± 7.03 (no CI reported)	FSFI: After 4 weeks 24.07 ± 7.37 (no CI reported) After 8 weeks 20.91 ± 7.02 (no CI reported)			
	Musavi et al. 2024	RCT	56	59	Sexual Self-Concept based Sexual Health Education	Routine Postpartum Care	Not reported No adverse event reported	⨁○○○	Study population- Iranian postpartum women, with mean age of 31.4 ± 6.09 in intervention group 29.06 ± 6.48 in control group Potential inference arising from religious practices that
					Self-efficacy score in the intervention group was higher than the control group after the intervention and one month later				

			Sexual Self-Concept based Sexual Health Education	Routine Postpartum Care	Sexual self-efficacy: After 80.7 ± 7.1 (no CI reported) 1-month after 83.6 ± 5.9 (no CI reported) Sexual Self-Confidence After 60.3 ± 51 (no CI reported) 1-month after 63.8 ± 3.4 (standard deviation) (no CI reported)	Sexual self-efficacy: After 53.9 ± 8.9 (no CI reported) 1-month after 56.3 ± 7.5 (no CI reported) Sexual Self-Confidence After 94 ± 7.06 (no CI reported) 1-month after 40.7 ± 7.4 (standard deviation) (no CI reported)			align with those commonly observed within Singapore's third-largest religious community (Islam), given regional similarities. though this should not be assumed at the individual level and participants are in the reproductive age group
	Juyani et al. 2024	RCT			Mobile-Based Education to prevent STIs	No education	Not reported No adverse event reported	⨁○○○	Study population- Iranian women, in the age range of 20 to 49 years with mean age of 36.24 ± 6.91 in intervention group 34.78 ± 8.20 in control group Potential inference arising from religious practices that align with those commonly observed within Singapore's third-largest religious community (Islam), given
					Role of digital health interventions based on innovative technologies increase knowledge, improve attitudes, and promote preventive behaviours against STIs				
			Mobile-Based Education to prevent STI	No education	STIs Preventive Self-efficacy: 1-month after 16.55 ± 1.46 (no CI reported)	STIs Preventive Self-efficacy: 1-month after 10.65 ± 1.79 (no CI reported)			

					3-month after 16.15 ± 2 (no CI reported) STIs Prevention intentions: 1-month after 17.10 ± 2.05 (no CI reported) 3-month after 16.86 ± 1.98 (no CI reported) STIs Perceived risks: 1-month after 38.65 ± 4.27 (no CI reported) 3-month after 16.86 ± 1.98 (no CI reported)	3-month after 9.75 ± 2.59 (no CI reported) STIs Prevention intentions: 1-month after 11.30 ± 2.37 (no CI reported) 3-month after 10.02 ± 2.40 (no CI reported) STIs Perceived risks: 1-month after 36.84 ± 4.64 (no CI reported) 3-month after 25.94 ± 6.46 (no CI reported)			regional similarities. though this should not be assumed at the individual level and participants mean age are in the reproductive age group

Legend	
⨁◯◯◯	Very-low certainty
⨁⨁◯◯	Low certainty
⨁⨁⨁◯	Moderate certainty
⨁⨁⨁⨁	High certainty

Table 5 Desirable effects - How substantial are the desirable anticipated effects?
Following Table illustrate the desirable effect for psychological intervention in sexual health

Type of outcome	Authors/ Year	Study Design	Summary of findings						Applicability/ transferability
			No. of participants		Effect			Certainty	
			Psychological Intervention	No Psychological Intervention	Absolute (95% CI)		Relative (95% CI)		Justification
Beneficial Effects of Psychological Intervention in Sexual Health	Cengizhan, Ucar 2023	RCT	67	67	Mindfulness -based sexual counselling	Usual care	Not reported No adverse event reported	⨁○○○	Low
			Mindfulness-based sexual counselling	Usual care	Large effect size reported at η2=0.542 for post intervention in experimental group towards attitude during sexuality				Study population- Turkish, pregnant women >18 years old, with mean age of 28.64 ± 4.77, (19-43) in intervention group 29.72 ± 5.85, (19-44) in control group Potential inference arising from religious practices that align with those commonly observed within Singapore's third-largest religious community (Islam), given regional similarities. though this should not be assumed at the individual level and participants are in the reproductive age group
					Sexual distress 7.69 ± 3.14) (no CI reported)	Sexual distress 17.36 ± 4.46 (no CI reported)			
	Refaee & Fereydooni 2022	Non-RCT	15	15	Sexual skills training	Normal	Not reported No adverse event reported	⨁○○○	Low
			Sexual skills training	Normal	Improvement in the Sexual skills training group in all domains				Study population- Iranian women, with an age range of 20 to 45 years Potential inference arising from religious practices that align with those commonly observed within Singapore's third-largest
					Self-control: -3 (1-4) Empathy: -3 (-5- -1)	Details not reported			

					Marital satisfaction: 3 (2-4)				religious community (Islam), given regional similarities. though this should not be assumed at the individual level and participants are in the reproductive age group
	Zamani et al. 2022	RCT	35	40	Women's Postpartum Sexual Health Program	Routine healthcare services	Not reported No adverse event reported	⨁○○○	Low
			Women's Postpartum Sexual Health Program	Routine healthcare services	Improvement in all domains of women's sexual function and sexual quality of life				Study population- Iranian postpartum women age 18 to 35 years, with mean age of 29.4 ± 4.2 in intervention group 29.5 ± 4.3 in control group Potential inference arising from religious practices that align with those commonly observed within Singapore's third-largest religious community (Islam), given regional similarities. though this should not be assumed at the individual level and participants are in the reproductive age group
					FSFI: 32.45 ± 2.24 (no CI reported) SQOLF: 64.22 ± 9.20 (no CI reported)	FSFI: 27.65 ± 3.19 (no CI reported) SQOLF: 54.05 ± 13.09 (no CI reported)			

Legend	
⨁○○○	Very-low certainty
⨁⨁○○	Low certainty
⨁⨁⨁○	Moderate certainty
⨁⨁⨁⨁	High certainty

Table 6 Desirable effects - How substantial are the desirable anticipated effects?
Following Table illustrate the desirable effect for physiotherapy intervention in sexual health

Type of outcome	Authors/ Year	Study Design	Summary of findings					Applicability/ transferability
			No. of participants		Effect		Certainty	
			Physiotherapy Intervention	No physiotherapy intervention	Absolute (95% CI)	Relative (95% CI)		Justification
Beneficial Effects of Physiotherapy Intervention in Sexual Health	Kokate, Bulbuli 2025	Non-RCT	23 Pelvic Floor Rehabilitation	N.A.	Pelvic Floor Rehabilitation Improvements in sexual function and pelvic floor muscles tone VPCQ: Median score of 132 to a median of 83 postintervention P-value (<0.001) N.A.	Not reported No adverse event reported	⨁○○○	Study population- Indian women, from 20 to 35 years old, with mean age of 25.7 ± 4.14 Although contextual differences remain, the sociocultural and epidemiological proximities between India and Singapore, combined with Singapore's multicultural composition, in which individuals of Indian heritage constitute the third-largest ethnic group, support a reasonable degree of inferential transferability. Nonetheless, interpretations should remain critically attentive to local variations in healthcare systems, demographic patterns, and policy environments within each national context and individual level.

	Schutze et al. 2022	RCT	74	64	Pelvic Floor Muscles Training	Postnatal gymnastic	Not reported No adverse event reported	⊕○○○	Low
			Pelvic Floor Muscles Training	Postnatal gymnastic	Both groups showed significant improvement over time in pelvic floor and sexual function measures				Study population- German postpartum women, with mean age of 32.3 ± 4.70 in intervention group and 31.57 ± 4.56 in control group Limited ethnicity or sociocultural similarity and participants are in the reproductive age group
					PFQ: 5.08 ± 2.87 (no CI reported) FSFI: 26.45 ± 4.80 (no CI reported)	PFQ: 5.16 ± 3.37 (no CI reported) FSFI: 26.2 ± 5.49 (no CI reported)			
	Morin et al. 2021	RCT	105	107	Physiotherapy	Lidocaine	Not reported No adverse event observed in intervention group with 15% (no CI reported) of the women in control group suffer from minor adverse event	⊕⊕⊕○	Low
			Physiotherapy	Lidocaine	Physical therapy demonstrated significantly better outcomes than lidocaine for pain quality, sexual function (FSFI), sexual distress, satisfaction, and impression of change at post-treatment and 6 months				Study population- Canadian women, age 18 to 45 years, with mean age of 22(21-26) in intervention group and 22(21-25) in control group Limited ethnicity or sociocultural similarity and participants are in the reproductive age group
					Mean differences between groups- NRS: Posttreatment 1.8(1.2-2.3) 6-month follow-up 1.8(1.2-2.5) FSFI: Posttreatment -4.4(6.1-2.7) 6-month follow-up -3.3(5.0-1.6) Satisfaction:				

					Posttreatment 3.3(2.7-4.0) 6-month follow-up 3.2(2.6-4.0)				
					FSFI: 8.9 (7.0-10.9) Effect size 0.96	FSFI: 4.2(2.1-6.4) Effect size 0.81			

Legend	
⊕○○○	Very-low certainty
⊕⊕○○	Low certainty
⊕⊕⊕○	Moderate certainty
⊕⊕⊕⊕	High certainty

Table 7 Desirable effects - How substantial are the desirable anticipated effects?
Following Table illustrate the desirable effect for lifestyle intervention in sexual health

Type of outcome	**Authors/ Year**	**Study Design**	**Summary of findings**					**Applicability/ transferability**
			No. of participants		**Effect**		**Certainty**	
			Lifestyle Intervention	**No Lifestyle intervention**	**Absolute (95% CI)**	**Relative (95% CI)**		**Justification**
Beneficial Effects of Lifestyle Intervention in Sexual Health	Solmaz 2025	RCT	34	36	Yoga: Participants in the yoga group demonstrated significant improvements in sexual activity, arousal, orgasm, lubrication, and overall sexual function No Yoga	Not reported No side effects were observed	⊕○○○	Low Study population- Turkish, women >18 years old, with mean age of 53.15±6.31 in intervention group 55.67±5.89 in control group Potential inference arising from religious practices that align with those commonly observed
			Yoga	No Yoga	Differences between group -3.26 (-4.79 - -1.15)			

								within Singapore's third-largest religious community (Islam), given regional similarities. though this should not be assumed at the individual level and participants are in the older age group
	Tabatabaie et al. 2024	RCT	21	25	Yoga and Pelvic Floor Exercises	Pelvic Floor Exercises	Not reported No adverse event reported	⨁○○○	Study population- Iranian, women from 20 to 54 years old, with mean age of 32.00±5.87 in intervention group 30.48±4.50 in control group Potential inference arising from religious practices that align with those commonly observed within Singapore's third-largest religious community (Islam), given regional similarities. though this should not be assumed at the individual level and participants are in the reproductive age group
					Improvement in sexual function of reproductive-age women with yoga and the pelvic floor exercises			
			Yoga and Pelvic Floor Exercises	Pelvic Floor Exercises	FSFI: Immediate after 31.43 ± 3.76 (standard deviation) (no CI reported) 1-month after 26.43 ± 4.97 (standard deviation) (no CI reported)	FSFI: 29.41 ± 2.38 (standard deviation) (no CI reported) 1-month after 28.41 ± 5.30 (standard deviation) (no CI reported)		

Legend	
⨁○○○	Very-low certainty

⊕⊕○○	Low certainty
⊕⊕⊕○	Moderate certainty
⊕⊕⊕⊕	High certainty

Table 8 Undesirable effects - How substantial are the undesirable anticipated effects?
Following Table illustrate the undesirable effect for psychological intervention in sexual health. Note that there are no undesirable effects observed from the studies for education, physiotherapy intervention and lifestyle intervention in sexual health

Type of outcome	**Authors/ Year**	**Study Design**	**Summary of findings**						**Applicability/ transferability**
			No. of participants		**Effect**			**Certainty**	
			Psychological Intervention	**No Psychological intervention**	**Absolute (95% CI)**		**Relative (95% CI)**		**Justification**
Detrimental Effects of Psychological Intervention in Sexual Health	Rashedi et al. 2021	RCT	35	35	Mindfulness-based cognitive-behavioural sex therapy	No intervention, on wait-list control	Not reported No adverse event reported	⊕○○○	Low
					Sexual pain score increases over time in the intervention group as compared to the control group. The highest sexual pain score was seen immediately after intervention.				Study population- Iranian women, age 18 to 49 years, with mean age at 38.5 ± 6.9 in intervention group and 37.0 ± 7.0 in control group Potential inference arising from religious practices that align with those commonly observed within Singapore's third-largest religious community (Islam), given regional similarities. though this should not be assumed at the individual level and participants are in the reproductive age group
			Mindfulness-based cognitive-behavioural sex therapy	No intervention, on wait-list control	FSFI: Immediately 26.56 ± 3.94 4th week 26.87 ± 3.94 12th week 27.14 ± 5.18	FSFI: Immediately 21.44 ± 3.56 4th week 22.25 ± 3.88 12th week 22.36 ± 4.79			

Legend	
⨁○○○	Very-low certainty
⨁⨁○○	Low certainty
⨁⨁⨁○	Moderate certainty
⨁⨁⨁⨁	High certainty

Table 9 What is the overall certainty of the evidence of effects?
The following table is the Master Recommendation Table Singapore Guidelines on Sexual Health for Women of Reproductive Age which presents all recommendations from the Singapore Guidelines on Sexual Health for Women of Reproductive Age of 21 to 45 years. Each recommendation is classified according to the nature of its supporting evidence (Evidence-Informed Recommendation, Consensus-Based Recommendation, or Good Practice Statement), accompanied by a brief notation of its primary evidence source, and the agreement level achieved. GRADE certainty ratings and strong/conditional labels are applied, consistent with the evidence base underpinning this guideline.

No.	**Guideline Statements**		**Source/ Origin**	**Adopt/ adapt/ de novo**	**Certainty of evidence**	**Final Agreement level**	**Evidence-to-decision Justification**
	Short points	**Long points**			**Strength of recommendation**	**Type of Recommendation**	
1.	**Screening of Sexual Health**						
1.1	Recognise the importance of sexual health	Sexual health is integral to overall health, encompassing desire, arousal, orgasm, and satisfaction. Women should be made to feel comfortable when discussing sexual health, including sexual functioning, with healthcare professionals (HCPs)	Guidelines • ICSM 2024, • ISSWSH 2019, • ACOG 2019 Other Considerations • WHO 2006	Adapted	⨁⨁⨁○ Strong recommendation	100% Evidence-Informed Recommendation	Guidelines underpinned recommendation and adapted with evidence from local or similar sociocultural region to contextualise for local use with expert consensus.
1.2	Initiate the conversation	Many women expect HCPs to initiate discussions about sexual health when appropriate. HCPs should incorporate questions about sexual activity,	Guidelines: • ICSM 2024, • ISSWSH 2019, • ACOG 2017 Other Considerations	Adapted	⨁⨁⨁○	100%	

		contraception, sexually transmitted infections (STIs), pregnancy planning, and sexual concerns into routine history-taking when appropriate.	• Dukes 2025, • WHO 2006		Strong recommendation	Evidence-Informed Recommendation	
1.3	Identify appropriate healthcare providers	Women may consult various HCPs regarding sexual health, including gynaecologists, primary care providers, nurses, physiotherapists specialising in women's health, and mental health professionals. HCPs should acknowledge and facilitate appropriate referral pathways across these disciplines.	Guidelines: • ICSM 2024, • ISSWSH 2019, • ACOG 2019 Other Considerations • Krakowsky, Grober 2018	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
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.	Guidelines • ICSM 2024, • ISSWSH 2019, • ACOG 2019 Other Considerations • Krakowsky, Grober 2018, • WHO 2006	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
2	**Assessment of Sexual Health**						
2.1	Differentiate between concerns and dysfunction	HCPs should distinguish between temporary sexual concerns or difficulties and persistent dysfunction requiring intervention.	Guidelines • ICSM 2024, • ISSWSH 2019, • ACOG 2019	Adapted	⊕⊕⊕○	100%	Guidelines underpinned recommendation and adapted with evidence from local

			Other Considerations • APA 2022 (DSM-5)		Strong recommendation	Evidence-Informed Recommendation	or similar sociocultural region to contextualise for local use with expert consensus. For recommendations with low strength of evidence, consensus supported by expert judgement through high agreement level
2.2	Use validated tools	Brief validated questionnaires should be utilised to screen for risk of sexual dysfunction, such as the Female Sexual Function Index-6 (FSFI-6).	Guidelines • ISSWSH 2019, Other Considerations • Chongcharoen et al. 2024 • Sesari et al. 2022 • Ho et al. 2020 • Krakowsky, Grober 2018, • Isidori et al. 2010	Adapted	⨁⨁○○ Conditional recommendation	100% Consensus-Based Recommendation	
2.3	Apply the PLISSIT model	The PLISSIT model (Permission, Limited Information, Specific Suggestions, Intensive Therapy) should be used for preliminary screening and intervention, including encouraging patients to express sexual concerns; educating on how changes such as the menstrual cycle can affect sexual function; recommending practical solutions such as lubricants or new intimacy methods; and referring for specialised treatment if necessary.	Guidelines • ICSM 2024 Other Considerations • Anon 1976	Adapted	⨁⨁○○ Conditional recommendation	100% Consensus-Based Recommendation	

2.4	Consider medical and psychological factors	HCPs should be aware of medical conditions, medications, psychological factors, and social issues that may affect sexual function, applying a bio-psycho-social framework to assessment.	Guidelines: • ICSM 2024, • NICE 2021, • ISSWSH 2019 Other Considerations • Krakowsky, Grober 2018	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
2.5	Consider the role of the partner	The woman's partner should be involved when assessing sexual concerns, as sexual function can be influenced by both partners' health and communication.	Guidelines: • ICSM 2024, • ISSWSH 2019 Other Considerations • Refaee & Fereydooni 2022 • Zamani et al. 2022	Adapted	⊕⊕○○ Strong recommendation	100% Evidence-Informed Recommendation	
3	**Education of Sexual Health**						
3.1	Provide information on normal sexual response and function	HCPs should educate patients about normal fluctuations in sexual function due to factors such as the menstrual cycle, stress, or relationship dynamics.	Guidelines • ICSM 2024, • ISSWSH 2019, • ACOG 2019 Other Considerations • Keshavarz et al. 2025	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	Guidelines underpinned recommendation and adapted with evidence from local or similar sociocultural region

			• Musavi et al. 2024 • Alidost et al. 2021, • Krakowsky, Grober 2018				to contextualise for local use with expert consensus.
3.2	Address patient concerns	Treatment options should be offered when concerns about sexual function are linked to significant distress and the patient desires intervention.	Guidelines • ISSWSH 2019 Other Considerations • APA 2022 (DSM-5) • Krakowsky, Grober 2018	Adapted	⊕⊕○○ Strong recommendation	100% Evidence-Informed Recommendation	
3.3	Promote safe sexual practices	HCPs should encourage consistent use of barrier methods and preventive measures against STIs.	Guidelines • WHO 2022 Other Considerations • Juyani et al. 2024	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
4	**Optimisation of Sexual Health**						
4.1	Manage health conditions affecting sexual function	Sexual health issues such as vulvodynia and vulval pain should be managed with appropriate treatments. Medical conditions including hypertension, diabetes, and thyroid disorders, and their treatments, that may impact sexual health should be identified and addressed.	Guidelines: • ICSM 2024, • NICE 2021 • ISSWSH 2019, • ACOG 2019 Other Considerations • Das et al. 2022, • Morin et al. 2021, • Krakowsky, Grober 2018	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	Guidelines underpinned recommendation and adapted with evidence from local or similar sociocultural region to contextualise for local use with expert consensus.

4.2	Address gynaecological conditions	Early diagnosis and multidisciplinary management of conditions such as endometriosis and adenomyosis can prevent impairment of sexual quality of life.	Guidelines • ICSM 2024 • NICE 2021 • ISSWSH 2019, • ACOG 2019 Other Considerations • Krakowsky, Grober 2018, • Pluchino et al. 2016	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
4.3	Promote physical health	Regular physical exercise should be recommended to enhance overall well-being and sexual function. Pelvic floor health should be optimised, with referrals to pelvic floor physiotherapy provided as needed.	Guidelines • ICSM 2024, • NICE 2021, • ISSWSH 2019 Other Considerations • Tabatabaie et al. 2024, • Schutze et al. 2022, • Morin et al. 2021, • Krakowsky, Grober 2018	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
4.4	Support psychological well-being	HCPs should screen for stress, mental health conditions, and relationship factors that may impact sexual function, and provide referrals to counselling or	Guidelines • ICSM 2024, • NICE 2021, • ISSWSH 2019, • ACOG 2019 Other Considerations	Adapted	⊕⊕⊕○	100%	

		psychological services when appropriate.	• Refaee & Fereydooni 2022, • Krakowsky, Grober 2018		Strong recommendation	Evidence-Informed Recommendation	
4.5	Consider partner's sexual health	Any sexual dysfunction in male partners should be assessed and addressed, as it can affect the woman's sexual function.	Guidelines • ICSM 2024, • ISSWSH 2019, • ACOG 2019	Adapted	⊕⊕⊕○	100%	
			Other Considerations • Refaee & Fereydooni 2022		Strong recommendation	Evidence-Informed Recommendation	
4.6	Monitor contraceptive impact	HCPs should be aware that oral contraceptives may affect sexual function and should monitor and adjust contraceptive methods as needed.	Guidelines • WHO 2022, • ISSWSH 2019	Adapted	⊕⊕⊕○	100%	
			Other Considerations • WHO 2006		Strong recommendation	Evidence-Informed Recommendation	
4.7	Refer when necessary	A network of clinical sexual health resources should be established for referrals when first-line interventions are insufficient. A multidisciplinary approach should be considered in managing sexual issues.	Guidelines • ICSM 2024, • NICE 2021, • ISSWSH 2019, • ACOG 2019	Adapted	⊕⊕⊕○ Expert consensus	100%	
			Other Considerations • Krakowsky, Grober 2018		Strong recommendation	Evidence-Informed Recommendation	
5.	**Preconception Assessment, Education, & Optimisation**						
5.1			Guidelines	Adapted		100%	

	Use validated questionnaires to assess sexual concerns.	Validated questionnaires should be used to assess sexual concerns in women who are trying to conceive.	• ICSM 2024 Other Considerations • Ku et al. 2024, • Loy et al, 2021, • Ho et al. 2020		⊕⊕○○ Conditional recommendation	 Consensus-Based Recommendation	Guidelines underpinned recommendation and adapted with evidence from local or similar sociocultural region to contextualise for local use with expert consensus. For recommendations with low strength of evidence, consensus supported by expert judgement through high agreement level
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)	HCPs should screen for infertility, defined as failure to conceive after 12 months of regular unprotected intercourse, or six months if the woman is over the age of 35.	Guidelines • WHO 2022, • Practice Committee of the American Society for Reproductive Medicine and the Practice Committee of the Society for Reproductive Endocrinology and Infertility 2022 Other Considerations • Bond et al. 2023	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
5.3	Provide preconception counselling	Preconception counselling should include advice on optimal frequency and timing of intercourse to increase reproductive efficiency. Women should be informed that coital position and post-coital routines such as remaining supine after	Guidelines • Practice Committee of the American Society for Reproductive Medicine and the Practice Committee of the Society for	Adapted	⊕⊕○○	100%	

		intercourse have not been shown to affect conception rates.	Reproductive Endocrinology and Infertility 2022 Other Considerations • Bond et al. 2023		Conditional recommendation	Consensus-Based Recommendation	
5.4	Address lubricant use	Women should be reassured that while some lubricants may affect sperm in vitro, their use does not significantly impact fertility in practice.	Guidelines • WHO 2022, • Practice Committee of the American Society for Reproductive Medicine and the Practice Committee of the Society for Reproductive Endocrinology and Infertility 2022 Other Considerations • Krychman et al. 2025	Adapted	⨁⨁⨁○ Strong recommendation	100% Evidence-Informed Recommendation	
5.5	Discuss sexual function during conception efforts	HCPs should acknowledge that trying to conceive can affect sexual routines and increase stress and should offer support and resources for managing sexual concerns and stress during this time.	Guidelines • Practice Committee of the American Society for Reproductive Medicine and the Practice Committee	Adapted	⨁⨁○○	100%	

			of the Society for Reproductive Endocrinology and Infertility Other Considerations • Ku et al. 2024, • Loy et al. 2021		Conditional recommendation	Consensus-Based Recommendation	
5.6	Apply holistic approaches to optimise medical, psychological, and relational factors affecting sexual health	Holistic approaches should be applied to optimise medical, psychological, and relationship factors affecting sexual health in the preconception period.	Guidelines • NICE 2020 Other Considerations • Ku et al. 2024, • Bond et al. 2023, • Loy et al. 2021	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
6	**Antenatal Screening, Education, Assessment & Optimisation**						
6.1	Incorporate questions about sexual well-being during antenatal visits in all trimesters if appropriate.	Questions about sexual well-being should be incorporated during antenatal visits in all trimesters where appropriate.	Guidelines • ICSM 2024, • Grussu et al. 2021, • ACOG 2019 Other Considerations • Keshavarz et al. 2025	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	Guidelines underpinned recommendation and adapted with evidence from local or similar sociocultural region to contextualise for local use with expert consensus. For recommendations with low strength of
6.2	Use the PLISSIT model for preliminary screening.	The PLISSIT model should be used for preliminary screening of sexual concerns during the antenatal period.	Guidelines • ICSM 2024 Other Considerations	Adapted	⊕⊕○○	100%	

			• Annon 1976		Conditional recommendation	Consensus-Based Recommendation	evidence, consensus supported by expert judgement through high agreement level
6.3	Initiate discussions early	HCPs should proactively inform patients that they are available to address concerns about sex during pregnancy.	Guidelines • Grussu et al. 2021, • ACOG 2019	Adapted	⨁⨁◯◯	100%	
			Other Considerations • Keshavarz et al. 2025		Conditional recommendation	Consensus-Based Recommendation	
6.4	Inform about common changes	HCPs should educate patients on typical changes in sexual function and frequency throughout pregnancy due to physical and body image changes, fatigue, and hormonal shifts.	Guidelines • Grussu et al. 2021, • ACOG 2019	Adapted	⨁⨁◯◯	100%	
			Other Considerations • Keshavarz et al. 2025		Conditional recommendation	Consensus-Based Recommendation	
6.5	Provide reassurance	If no medical or obstetric complications are present, couples should be reassured that sexual activity can continue safely during pregnancy if desired.	Guidelines • Grussu et al. 2021	Adapted	⨁⨁◯◯	100%	
			Other Considerations • Keshavarz et al. 2025		Conditional recommendation	Consensus-Based Recommendation	
6.6	Offer practical advice	HCPs should suggest adaptations for coital positions to accommodate physical changes during pregnancy and address sexual concerns such as dyspareunia with lubricants.	Guidelines • Grussu et al. 2021,	Adapted	⨁⨁◯◯	100%	
			Other Considerations • Keshavarz et al. 2025, • Krychman et al.		Conditional recommendation	Consensus-Based Recommendation	

			2025				
6.7	Utilise tools like the FSFI-6 to screen for low sexual function	Tools such as the FSFI-6 should be utilised to screen for risk of sexual dysfunction during the antenatal period.	Guidelines • ICSM 2024, • Grussu et al. 2021, • ACOG 2019 Other Considerations • Isidori et al. 2010	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
6.8	Evaluate for sexual dysfunctions, including Genito-Pelvic Pain/Penetration Disorder (GPPPD), which may affect delivery	HCPs should evaluate for sexual dysfunctions including Genito-Pelvic Pain/Penetration Disorder (GPPPD), which may affect delivery and persist postpartum.	Guidelines • NICE 2021, • Grussu et al. 2021, • ACOG 2019 Other Considerations • Kokate, Bulbuli 2025	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
6.9	Refer to sexual health practitioners (section 4.7) for conditions like GPPPD.	Women with conditions such as GPPPD should be referred to sexual health practitioners. Antenatal depression and anxiety should be screened for and addressed, as these can adversely affect sexual function.	Guidelines • Grussu et al. 2021, • NICE 2020, • ACOG 2019 Other Considerations • Cengizhan, Ucar 2023	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
7	**Postnatal Screening, Education, Assessment & Optimisation**						
7.1	Address sexual function during	Sexual function should be addressed during postpartum medical reviews.	Guidelines • ICSM 2024, • Grussu et al. 2021,	Adapted	⊕⊕⊕○	100%	Guidelines underpinned recommendation and

	postpartum medical reviews		• ACOG 2019 Other Considerations • Ng et al. 2024, • Musavi et al. 2024		Strong recommendation	Evidence-Informed Recommendation	adapted with evidence from local or similar sociocultural region to contextualise for local use with expert consensus. For recommendations with low strength of evidence, consensus supported by expert judgement through high agreement level
7.2	Use the PLISSIT model to facilitate discussions	The PLISSIT model should be used to facilitate discussions about sexual health in the postpartum period.	Guidelines • ICSM 2024 Other Considerations • Annon 1976	Adapted	⊕⊕○○ Conditional recommendation	100% Consensus-Based Recommendation	
7.3	Use tools such as FSFI-6 to screen for low sexual function	Tools such as the FSFI-6 should be used to screen for risk of sexual dysfunction in the postpartum period.	Guidelines • ACOG 2019 Other Considerations • Isidori et al. 2010	Adapted	⊕⊕⊕○ Conditional recommendation	100% Consensus-Based Recommendation	
7.4	Evaluate healing of perineal injuries and address any bladder or bowel difficulties	Healing of perineal injuries should be evaluated, and any bladder or bowel difficulties should be addressed during postpartum reviews.	Guidelines • NICE 2021, • Grussu et al. 2021, • ACOG 2019 Other Considerations • Ng et al. 2024	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
7.5	Advise on resumption of sexual activity	Women should be advised to wait after six weeks postpartum for	Guidelines • Grussu et al. 2021 Other Considerations	Adapted	⊕⊕○○	100%	

		healing and readiness before resuming sexual activity.	• Artieta-Pinedo et al. 2025		Conditional recommendation	Consensus-Based Recommendation	
7.6	Discuss postpartum changes	HCPs should educate women on how hormonal changes, breastfeeding, contraception, and fatigue can affect sexual desire and function in the postpartum period.	Guidelines • ICSM 2024, • Grussu et al. 2021, • ACOG 2019 Other Considerations • Ng et al. 2024, • Musavi et al. 2024	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
7.7	Consider a multi-disciplinary approach in managing sexual issues	A multidisciplinary approach should be considered in managing sexual issues in the postpartum period.	Guidelines • NICE 2021, • NICE 2020, • Grussu et al. 2021, • ACOG 2019 Other Considerations • Ng et al. 2024	Adapted	⊕⊕⊕⊕ Strong recommendation	100% Evidence-Informed Recommendation	
7.8	Refer to pelvic health physiotherapy for management of perineal trauma and pelvic floor rehabilitation	Women should be referred to pelvic health physiotherapy for management of perineal trauma and pelvic floor rehabilitation.	Guidelines • NICE 2021, • Grussu et al. 2021, • ACOG 2019 Other Considerations • Ng et al. 2024, • Schutze et al. 2022	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	

7.9	Address lifestyle factors to alleviate stress and fatigue	Lifestyle factors should be addressed to alleviate stress and fatigue in the postpartum period.	Guidelines • ICSM 2024, • Grussu et al. 2021 Other Considerations • Ng et al. 2024	Adapted	⊕⊕○○ Conditional recommendation	100% Consensus-Based Recommendation	
7.10	Screen for postnatal depression and anxiety, providing referrals as needed	HCPs should screen for postnatal depression and anxiety, providing referrals as needed.	Guidelines • NICE 2020 Other Considerations • Zeng et al. 2025, • Ng et al. 2024, • Zamani et al. 2022	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
8	**Special Considerations**						
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.	HCPs should recognise that a history of physical, emotional, or sexual abuse can negatively impact sexual function, and should consider referrals to specialised services that can provide trauma-informed support when appropriate.	Guidelines • ICSM 2024, • Grussu et al. 2021, • ISSWSH 2019, • ACOG 2019 Other Considerations • Krakowsky, Grober 2018	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	Guidelines underpinned recommendation and adapted with evidence from local or similar sociocultural region to contextualise for local use with expert consensus.

8.2	Be inclusive and sensitive to the needs of LGBTQ+ individuals, acknowledging that they may face unique sexual health concerns	HCPs should be inclusive and sensitive to the needs of LGBTQ+ individuals, acknowledging that they may face unique sexual health concerns.	Guidelines • WHO 2022 Other Considerations • Dukes 2025, • WHO 2006	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
8.3	Address the specific sexual health challenges faced by women who have undergone cancer treatments and provide specialised support and referrals as needed	The specific sexual health challenges faced by women who have undergone cancer treatments should be addressed, with specialised support and referrals provided as needed.	Guidelines • ICSM 2024, • ISSWSH 2019, • ACOG 2019 Other Considerations • Krakowsky, Grober 2018	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	
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	HCPs should recognise that women with specific physical, cognitive, and/or medical challenges may have unique sexual health concerns and should provide specialised support and referrals as needed.	Guidelines • WHO 2022 Other Considerations • WHO 2006	Adapted	⊕⊕⊕○ Strong recommendation	100% Evidence-Informed Recommendation	

Legend	
⨁◯◯◯	Very-low certainty
⨁⨁◯◯	Low certainty
⨁⨁⨁◯	Moderate certainty
⨁⨁⨁⨁	High certainty

Values

Is there important uncertainty about, or variability in, how much people value the main outcomes?

Research evidence

There are existing sexual health guidelines for women, in general, globally. In Singapore, Healthcare professionals agreed that standardised sexual health guidelines for reproductive-age women would be useful.

Balance of effects

Does the balance between desirable and undesirable effects favour the option or the comparison?

Research evidence

Female sexual dysfunction among young women in Singapore contributes to a significant health burden. Addressing sexual function issues in women is critical for their emotional and mental well-being, relationship satisfaction, and fertility. Ignoring sexual concerns can negatively affect a woman's overall quality of life.

Resources required

How large are the resource requirements (costs)?

Research evidence

The public will benefit from educational or infographic aids for easy understanding and reference. Healthcare providers will benefit from scientific reports and educational lectures or workshops to improve skills in delivering the recommendations. Improvement in sexual health for women of reproductive age will contribute to considerable savings in healthcare expenditure over time.

Certainty of evidence of required resources

What is the certainty of the evidence of resource requirements (costs)?

Improvement in sexual health for women of reproductive age in Singapore will contribute to considerable savings in healthcare expenditure over time.

Cost-effectiveness

Does the cost-effectiveness of the option favour the option or the comparison?

The investment in the public education of these recommendations will contribute to considerable savings in healthcare expenditure over time.

Equity

What would be the impact on health equity?

These recommendations are available to all women of reproductive age in Singapore.

These recommendations can be delivered from primary care, tertiary care and related organisations.

Acceptability

Is the option acceptable to key stakeholders?

The option is likely acceptable to key stakeholders.

Feasibility

Is the option feasible to implement?

The option is likely feasible to implement as this approach.

CONCLUSIONS

Table 4 - Summary of judgements

Problem	- Don't know	- Varies		- No	- Probably No	- Probably Yes	**Yes**
Desirable effects	- Don't know	- Varies		- Trivial	- **Small**	Moderate	- Large
Undesirable effects	- Don't know	- Varies		- Large	- Moderate	**Small**	- Trivial
Certainty of the evidence	- No included studies			- Very Low	**Low**	- **Moderate**	- High
Values				- Important uncertainty or variability	- Possibly important uncertainty or variability	**Probably no important uncertainty or variability**	- Probably no important uncertainty or variability
Balance of effects	- Don't know	- Varies	- Favours the comparison	- Probably favours the comparison	- Does not favour either the option or the comparison	**Probably favours the option**	- Favours the option
Resources required	- Don't know	- Varies	- Large Costs	- Moderate Costs	- Negligible costs or savings	**Moderate savings**	- Large savings
Certainty of evidence of required resources	- No included studies			- Very low	- Low	**Moderate**	- High

Cost-effectiveness	- Don't know	- Varies	- Favours the comparison	- Probably favours the comparison	- Does not favour either the option or the comparison	**Probably favours the option**	- Favours the option
Equity	- Don't know	- Varies	- Reduced	- Probably Reduced	- Probably no impact	**Probably increased**	- Increased
Acceptability	- Don't know	- Varies		- No	- Probably No	**Probably Yes**	- Yes
Feasibility	- Don't know	- Varies		- No	- Probably No	**Probably Yes**	- Yes

Type of recommendation

Recommendation

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 screen for low 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

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 screen for low sexual function
7.4 Evaluate healing of perineal injuries and address any bladder or bowel difficulties
7.5 Advise on resumption of sexual activity
7.6 Discuss postpartum changes
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 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

Justification

We recommend these guidelines to provide HCPs with an overview of sexual health issues in reproductive-age women and to help women to develop the knowledge and comfort necessary to identify and provide management to their sexual concerns. By integrating sexual health care into routine clinical practice and adopting a biopsychosocial, patient-centred, multidisciplinary, and interprofessional approach we hope to optimize sexual health for women.

Detailed justification

☒ **Problem**	**Problem** In Singapore, there remains a clear research gap in high-quality evidence for interventions addressing female sexual dysfunction, with no randomised controlled trials providing robust, generalisable findings up until 2025. Additionally, no studies in Singapore have established validated screening or assessment tools for female sexual dysfunction, limiting early identification and consistent clinical evaluation.
☒ **Desirable effects**	**Desirable effects** The evidence is at very low to low certainty to recommend a guidance on screening, education, management, and referral for women experiencing sexual problems
☒ **Undesirable effects**	**Undesirable effects** Possibility of reduced efficacy in sexual pain management through education and psychological intervention.
☒ **Certainty of the evidence**	**Certainty of the evidence** The review of the evidence consisted of international randomised controlled trials with moderate to large number of studies or participants and the overall evidence is at least low to moderately certain to support the recommendations.
☒ **Values**	**Values** Improvements in female sexual function will contribute to better population health outcomes in Singapore.
☐ **Balance of effects**	
☐ **Resources required**	
☐ **Equity**	
☐ **Certainty of evidence of required resources**	
☐ **Cost-effectiveness**	
☐ **Acceptability**	
☐ **Feasibility**	

Note: Please see the reference list in the main manuscript for the references cited in this appendix.