Box 1: Is it safe to have sex?

- If there is a medical reason for a couple not having sex, then explain why and state a time limit.
- If either partner has a sexually transmitted infection (STI), they should use protection. Anal sex is best avoided altogether.
- Most forms of stimulation including intercourse are safe up until late third trimester, when there is a risk they can trigger labour.
- When giving oral sex, don't blow into her vagina.
- Her on top, rear entry and side-to-side are the best intercourse positions.
- Avoid deep or weight-bearing positions and those that cause heartburn or dizziness, such as her lying on her back.
- Sex toys can be used so long as they are clean and used gently.
- If any activity hurts, or if there is bleeding, discharge or cramps, she should see her midwife or consultant.

Box 2: How can health professionals troubleshoot the problems?

- If desire is low, advise creating a sensual atmosphere; romance, time to talk, caressing and kissing.
- If sex is off the agenda, or clients aren't in the mood, suggest sensual massage to maintain physical contact.
- Encourage her to pleasure him to maintain sexual connection.
- If she suffers morning sickness, make love at other times of the day.
- If she's fatigued, make love early in the day.
- If she suffers vaginal discomfort, add lubrication – or stimulate the clitoris instead.
- If some positions don't work, encourage experimentation.
- If she has difficulty orgasming, reassure her that this is normal and will probably right itself after the birth.

Troubleshooting advice

If there is a need to hold back from sexual activity, however, do tell clients the advisable time limit on that. Many a couple have been warned to refrain from sex until the crucial first trimester is over, but interpret that as meaning no sex until after birth. It will also help to be specific about permissible sexual activities. Many hear 'no sex' to mean not 'no intercourse' but 'no sexual contact of any kind'. In fact, even if it's necessary to give up on penetration, it may still be fine to give her hand or mouth clitoral stimulation, and it will be no problem at all for her to give him release, or for the couple to kiss and caress. There's no need to go into detail here; no one expects a health professional to be a sex coach too, so if extra guidance is needed, then the book *Masterclass: Pregnant Sex* by Rachel Foux (Erotic Books, 2008) is easy to read and full of sound yet inspiring ideas.

> "No one expects a health professional to be a sex coach too."

Health professionals may not be expected to be sex coaches, but we may be required to offer occasional troubleshooting advice. Particularly once the first conversation has put the issue on the table, clients may come back to ask for specific guidance on sexual blocks they find. Some of the more common problems, together with suggestions for possible solutions and advice, are given in Boxes 1 and 2. If clients have serious or ongoing sexual problems, of course, refer them on. The British Association of Sexual and Relationship Therapy (www.basrt.org.uk) will have a list of local counsellors.

Concluding remarks

But perhaps the most important role health professionals have is to create client expectation – of an ongoing sex life through and beyond pregnancy. This doesn't mean we should pressure clients; it does mean that we should challenge the all-too-common belief that couples shouldn't continue to make love once they've conceived. If we reassure clients that they can, if we encourage them to keep on being sexually active up to labour – and to resume lovemaking as soon as advisable afterwards – then we will be doing them a great service. A service that arguably could ensure the survival of their entire relationship for decades to come.

Statements on funding and competing interests

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Editor's note

Readers may be interested in a free seminar on "Sex in Pregnancy: Why the Silent Subject?" on 8 May 2010 in Cambridge at which the author will be speaking. See the Meetings & Courses entry on page 112 of this issue for further details.

Reference

1 Quilliam S. Grey sex. *J Fam Plann Reprod Health Care* 2009; **35**: 123–124.

NEWS ROUNDUP

HPV vaccine: continuous protection beyond 6 years

A study[1] by the GlaxoSmithKline Vaccine HPV-007 study group reports that the Cervarix® human papillomavirus (HPV) vaccine offers continued protection beyond 6 years from vaccination. This is against HPV-16 and HPV-18, the types of HPV most commonly associated with cervical cancer. The authors carried out a combined analysis of efficacy data from the initial and follow-up study up to 6.4 years after first vaccination. This provided a good estimation of the general vaccine efficacy, both in the short and long terms.

Vaccine efficacy is defined as the reduction in the incidence of a disease among people who have received a vaccine compared to the incidence in unvaccinated people. Vaccine efficacy against incident infection with HPV-16/18 was 95% and against 12-month persistent infection was 100%. Cervical intraepithelial neoplasias (CIN) are precancerous lesions that can develop into cervical cancer. Vaccine efficacy against CIN 2+ was 100% for lesions associated with HPV-16/18 and 72% for lesions independent of HPV type.

The authors commented: "The target age [for vaccination] is a balance being early enough to catch girls before sexual debut, but late enough to provide an as yet unknown duration of immunity that protects during as many subsequent years of sexual activity as possible. The data in today's study would suggest that this window of protection is at least 6 years, but also leads us to strongly suspect that, as these and other vaccinated women are followed up, the period of protection might be much longer".

Reference

1 The GlaxoSmithKline Vaccine HPV-007 Study Group. Sustained efficacy and immunogenicity of the human papillomavirus (HPV)-16/18 AS04-adjuvanted vaccine: analysis of a randomised placebo-controlled trial up to 6.4 years. *Lancet* 2009; **374**: 1975–1985.

New pro-choice website

Marie Stopes International (MSI) has recently launched a new website, to provide a pro-choice knowledge and information exchange resource for anyone working to eradicate unsafe abortion worldwide. This website was developed in response to feedback from delegates attending the first global conference dedicated to safe abortion in 2007. Tony Kerridge, spokesperson for Marie Stopes International said: "Seventy thousand women die every year as a consequence of unsafe abortion, and it remains a key challenge in women's health. MSI has developed this new online resource for anyone interested in, or working towards, legal or practical reforms to ensure every woman's right to access safe abortion services wherever she lives in the world".

Source: www.globalsafeabortion.org

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