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Sexual abstinence as a reproductive health-promoting behavior for women: A perspective

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Abstract

This article is intended to provide an appropriate context for adopting sexual abstinence from a health-promoting behavioral perspective that can be applied to women of reproductive age worldwide to improve reproductive health, maintain well-being, and prevent health problems in women. The topics related to women's health status, sexual abstinence definitions, benefits, and application, as well as sexual autonomy and efficacy, including family collaboration, are discussed. This article will provide health care providers, especially nurses and midwives, with new ideas for integrating sexual abstinence into nursing and midwifery practice.

Keywords

sexual abstinence; reproductive health; female; nursing; midwifery; health-promoting behavior; perspective

Introduction

Reproductive health is a circumstance of absolute physical, mental and social well-being. The reproductive system and its processes are functioning well. Reproductive health means that people are satisfied with maintaining sexual life, are able to reproduce, and have the autonomy to make their reproductive health decisions (World Health Organization, 2022). Reproductive health-promoting behaviors such as sexual abstinence have led to targeted prevention of sexually related health problems such as unintended pregnancy, abortion, and sexually transmitted diseases (STDs) among youth for many decades (Centers for Disease Control and Prevention, 2017a). In addition, it has been shown to prevent serious complications in pregnant and postpartum women (Jo et al., 2014; Sunarsih et al., 2020).

In young girls, sexual abstinence is divided into primary and secondary sexual abstinence. Primary sexual abstinence refers to a person never having sex, i.e., penile-oral, penile-anal, and penile-vaginal intercourse with males. Secondary abstinence includes women who have had sexual intercourse but then decided to live abstinently. However, 72% of adolescents were involved in a relationship before high school, and 42% have had sex (Centers for Disease Control and Prevention, 2017b). Early sexual attachment leads to emotional dependence and predisposes an individual to engage in aggressive behaviors toward a partner, primarily perpetrated by males (Arbinaga et al., 2021). Therefore, primary sexual abstinence promotes the well-being of a young group of students (10-24 years) by protecting them from the risks of early sexual initiation, violence, pregnancy, and STDs.

In contrast, remaining sexually abstinent brings fewer difficulties to female adolescents, and they can stick to their plan to study and graduate. About 60% of sexually abstinent girls were less likely to be expelled from school, and 50% were less likely to drop out of high school than sexually active girls. In addition, abstinent girls are twice as likely to graduate from college as sexually active girls (Sabia & Rees, 2009).

In Asia, abortion rates have increased by 23%, even though unintended pregnancies have decreased by 16% over the past 30 years (Guttmacher Institute, 2022). 98% of unsafe abortions occur annually in developing countries, 41% of which occur among 15-to 25-year-old women, and 70% of hospitalizations for unsafe abortions are among adolescents under 20 years of age (Shah & Åhman, 2012). Criminal or legal abortion is a major cause of life stigma or lifelong infertility (Biggs et al., 2020; Chainok et al., 2022). When pregnancy continues in school, adolescent mothers face enormous problems; 37.2% have preterm births and develop stress from motherhood or dropping out of school (Areemit et al., 2012; Kirchengast, 2016; World Health Organization, 2020). Moreover, STDs are rapidly increasing among young people, especially women (Harris et al., 2011; Shannon & Klausner, 2018). In addition, 20 million new STDs are reported annually, half of which are found in young people (ages 15 to 24). The most common sexually transmitted diseases are human papillomavirus, chlamydia, gonorrhea, and syphilis (Act for Youth, 2020).

Sexual abstinence until school graduation is the typical practice for young girls. Although many countries promote the condom strategy and indicate that condom use is gradually increasing in the population, its effectiveness is not present in the adolescent group. Condom use is inconsistent among adolescents. Adolescents have an early sexual debut (< 14

years). The decision to make a sexual debut is influenced by the belief that sex symbolizes true love; therefore, couples may perform the sexual act without a condom (Davids et al., 2021).

Reproductive health knowledge and attitudes are linked to cultures and religious values. For example, in Thai culture, women must avoid the risk of stigma if they lose their virginity before marriage. This is different for men; premarital sex is more accepted than for women (Techasrivichien et al., 2016). Therefore, parents encourage their daughters to maintain sexual abstinence to secure their lives since they are young (Wannarit et al., 2021). As adolescents, they need to protect themselves and focus on academic activities; otherwise, they will feel guilty about having sex (Achen et al., 2021; Je et al., 2020; Wannarit et al., 2019).

From an Islamic perspective, sexual abstinence is also an optimal goal for adolescent health. Sex before marriage among Muslim adolescents is a serious problem in Muslim societies. The Islamic perspective on sexual health education is underpinned by the Holy Quran, the Hadith, and Sharia (Islamic laws). Islamic values prohibit both premarital and extramarital sexual acts (Wong, 2012). The research found that Muslim adolescent girls view sexual abstinence as a means of self-protection (Piriyasart et al., 2020). Therefore, sexual abstinence is one of the most practical and cultural interventions to promote well-being among Muslim adolescents.

In married women undergoing prenatal care, sexual abstinence affects the production of semen parameters that influence the pregnancy rate in fertility treatment. Many wives use this method to maintain sperm quality and volume until the proper time of ejaculation and then to obtain the appropriate sperm for fertilization with the woman's egg for the next step of each treatment (Degirmenci et al., 2020). In addition, sexual abstinence may prevent health problems during pregnancy and postpartum, while early postpartum intercourse is associated with risk factors in postpartum women (Gadisa et al., 2021).

This article illustrates sexual abstinence from the perspective of a reproductive health-promoting behavior that can be applied to women of reproductive age worldwide. The number of women between the ages of 15 and 49 has been trending upward worldwide. In 2013, there were 1.8 billion women of reproductive age worldwide, projected to increase to nearly two billion by 2025 (Elflein, 2019). This perspective is intended to provide appropriate context to the adoption of sexual abstinence among young and other groups of women who become pregnant, as well as postnatal care. To promote sexual abstinence, nurses must recognize women's health status, the definition of sexual abstinence, and the benefits, and empower women with sexual autonomy and efficacy, including family collaboration.

Different Perceptions of the Meaning of Sexual Abstinence and Its Misconduct

The term abstinence comes from the Latin "Abstinentia," which means "doing nothing." Sexual abstinence includes two aspects: 1) not having sex and 2) waiting until the right time. Centers for Disease Control and Prevention (2017c) defines sexual abstinence among adolescents as voluntarily abstaining from all types of sexual intercourse, penile-vaginal, anal, and oral. The right time is graduation from school, marriage, or independent financial support (Je et al., 2020).

Nevertheless, the practice of sexual abstinence becomes inconsistent. Early adolescents count genital touching, kissing, or genital stimulation as part of this behavior (Hensel et al., 2011). On the other hand, some mid- and late adolescents agreed that penile-anal and oral intercourse was abstinent. In addition, late adolescents or college students believed that sexual intercourse without orgasm meant sexual abstinence (Barnett et al., 2017; Byers et al., 2009; Hans & Kimberly, 2011). These ambiguous misunderstandings of the definition of sexual abstinence lead to confusion about still having sex but knowing they are abstinent and safe from pregnancy or STDs. Therefore, when using the term "abstinence" among adolescents, nurses need to help ensure that they clearly understand it in terms of their health.

Early Sexual Intercourse and Long-Life Difficulty

Biological and cultural aspects influence the timing of menstruation and sexual initiation. Role models of friends and parents influence girls' sexual choices. Sexual reproductive health resources play a significant role in shaping the approach to sexual behavior development. Although genital maturation begins earlier (9-14 years), the optimal age for sexual intercourse is 18-22 years because adolescents are physically and mentally mature during this period. Sex before the age of sixteen leads them to gynecological problems such as cervical cancer, STDs, and ovarian cysts (Ma et al., 2009).

Moreover, many women engage in sexual acts without sexual information and desires, fearing the boyfriend will leave them. They have also had sex at an early age, with feelings of guilt and discomfort because they were not ready for it. Girls tend to have sex because their partner forces them to or because their boyfriend demands it of them (Skinner et al., 2008). Women who have sex too early may be at increased risk of having multiple sexual partners and less likely to use condoms, drink alcohol, smoke, use drugs, be abused, engage in violence, and become single mothers (Van Ouytsel et al., 2019).

Sexual Abstinence and Antenatal Care

Sexual abstinence during pregnancy is encouraged in case of prohibition of penile-vaginal and anal intercourse (while oral intercourse can be practiced) because of complications. These include abnormal vaginal bleeding, low-lying placenta, cervical incompetence, preterm labor (below 37 weeks), and multiple births. In addition, intercourse may increase the risk in women with previous preterm birth, vaginal infection, or multipara. Some pregnant women don't want intercourse because of nausea, vomiting, physical pain, or fear of pregnancy complications. In addition, body fatigue is related to sexual function caused by female hormones. The physical and mental changes during pregnancy also decrease sexual activity (Johnson, 2011; Kulhawik et al., 2022; Sossah, 2014). The increase in estrogen, progesterone and prolactin causes

nausea, breast pain, fatigue, low energy, and stress. During sex, they have difficulty having sex. The hormonal change causes low clitoral sensitivity and climax that persists for up to six months after birth (Caruso et al., 2022). Vaginal dryness, painful intercourse, and pain in the lowest part of the abdomen and pelvis usually occur in pregnant women and persist after delivery (Wuytack et al., 2015). Pregnancy is also associated with changes in the urinary system and pelvis, which leads to difficulty urinating in pregnant women (Rados et al., 2014).

Sexual problems in pregnancy may also have a psychological cause. However, the issue of sexuality is generally not mentioned. Women and couples should meet counselors, receive more information about sexual problems, and find solutions. Nurses should assess their sexual desires, moods, lubrication disorders, erectile dysfunction, and sexual abstinence, especially in the last four months (Kulhawik et al., 2022). During pregnancy, counseling sessions about sexual practices should be conducted based on body dynamics, cultural differences, beliefs, and norms (Zaksek, 2015).

Sexual Abstinence and Postnatal Care

Sexual abstinence means not having penile-vaginal and anal intercourse, while couples can practice oral sex. It is a common practice in many developing countries, such as Africa, to possibly prevent the sexual spread of HIV. Women are expected to abstain from sex after delivery to ensure maternal and child survival (Shabangu & Madiba, 2019; Sule-Odu et al., 2008). Generally, rehabilitation during one-month postpartum concerns sexual dysfunction caused by physical changes, hormonal imbalance, family structure, and support. 80-93% of women usually become sexually functional within three months postpartum, which returns to normal within one year. However, the postpartum mechanism impairs sexual functioning due to episiotomy, exhaustion, stress, depression, and breastfeeding. Therefore, sexual abstinence should be promoted in normal delivery and injury complications.

Women need a few months of sexual abstinence. After a normal birth, there is a vaginal rupture with trauma and edema. Due to lower estrogen levels, vaginal walls are poorly lubricated and often cause vaginal pain during intercourse (Rani & Ayyavoo, 2016). In addition, breastfeeding mothers have lower estrogen levels than nonbreastfeeding mothers. Postpartum mothers experience pain during sex in the first few months, and most lack a desire or sexual interest (Zaksek, 2015). Furthermore, discomfort during intercourse decreases their sexual satisfaction and sexual desire for the next time (Dabiri et al., 2014). Additionally, breastfeeding mothers have high levels of prolactin, which reduces ovarian estrogen production, resulting in vaginal irritation and dyspareunia at 12 weeks (Connolly et al., 2005).

Sexual abstinence for up to six months is beneficial for episiotomy and nerve injury restored. Perineal laceration and genital trauma cause dyspareunia or painful intercourse. Mothers with an episiotomy and perineal suture are dissatisfied with sexual intercourse during the first year after delivery (Gommesen et al., 2019). In addition, prolonged pushing during labor, including the pressure of the fetal head on the pelvis, causes injury to the pudendal nerve, resulting in urethral, perineal, genital, and anal pain that can last up to six months (Hicks et al., 2004; Huy, 2019).

Women may need four to six months to adjust to the psychological changes. Postpartum image and adjustment to motherhood affect sexual activity. Many women reported fatigue affecting their sex life four months postpartum (Zaksek, 2015). Women are usually uncomfortable with the physical changes and feel they are less attractive. The new maternal role adjustment and insomnia also lead mothers to prefer free periods of relaxation to sex (Youseflu et al., 2019). Thus, stress and depression within six months affect sexual activity. Mothers need confidence and accurate information about the above sexual dysfunctions. Nurses could show mothers and couples alternative ways, such as masturbation or oral initiation, during the difficult period until all genitals and mood swings regulate individually.

Discussion

Sexual health education can be part of a comprehensive health education program available to all women. Nurses are valuable resources for women and families in promoting evidence-based sexual health education programs that promote sexual abstinence. Promotion of sexual abstinence should include 1) access to sexual relationships and couples' attitudes toward sexual abstinence, 2) women's satisfaction and freedom of choice regarding their sex lives, 3) the importance and benefits of abstinence, and 4) accurate information about reproductive organ mechanisms during puberty, pregnancy, postpartum, and sexual dysfunction (Kulhawik et al., 2022; Zaksek, 2015).

Nurses play an essential role in promoting sexual abstinence in schools, clinics, and the community, especially among young women. Nurses can promote primary sexual abstinence to preserve virginity and empower girls who have sex but eventually choose to abstain from sex. Knowledge about sexual abstinence should be emphasized, including the ability to refuse, sexual autonomy, self-awareness, and how to handle risky situations to maintain abstinence. These messages should encourage youth to understand and use sexual abstinence to maintain their well-being. In addition, they should be taught about rights to their bodies, sexual desire, and effective sex at the right time.

Comprehensive sexuality education can effectively promote responsible sexual decision-making in young people. It is necessary to encourage both primary and secondary sexual abstinence. Collaboration with parents and teachers in schools can help educate women early in adolescence (Breuner et al., 2016). Using theoretical nursing models could also help nurses understand the health-related factors involved in adolescents' bio-psycho-social complexity, rapid physical growth, and changes over time and support nursing practice. School nurses can support sexual health education in accessible, inclusive, developmentally, and culturally appropriate ways for all students (Kemppainen et al., 2013). Nurses need to understand parents', teachers', and caregivers' attitudes toward sexual abstinence through persuasion, information, and understanding throughout adolescence.

Nurses should consider religious beliefs and cultural perspectives when promoting women's sexual health and incorporate the principles into educational modalities. For example, Muslim female adolescents view sexual abstinence

as self-protection. Therefore, nurses can emphasize this important point to use this behavior to prevent health problems. Gender-specific intervention is essential to be accepted in the religious context. As girls develop, they naturally become interested in sex, and questions about sex and sexuality become relevant at younger ages. Comprehensive information about sexual abstinence, the promotion of reproductive health, and the well-being of the reproductive organs and their functions must be provided earlier. If girls have religious beliefs and expectations in a conservative society, nurses should find appropriate ways to promote sexual abstinence and develop cultural approaches for each population (Piriyasart et al., 2020).

During pregnancy, nurses should accurately inform women and couples about the physiological and psychological changes that lead to sexual dysfunction in women. Women must be informed about the absolute prohibition of sexual intercourse and the relative risks during their first prenatal care visits if they are at high risk. Sexual abstinence or complications-related decisions should be discussed among health care providers, obstetricians, midwives, physicians, pregnant women, and couples (Zamani et al., 2019). Pregnancy complications that cause women to avoid sexual intercourse, such as nausea, breast pain, fatigue, or dyspareunia, need to be considered, including an assessment of women's health during early prenatal care. Nurses can assess women's sexual activity using counseling techniques while maintaining confidentiality. Nurses should use a variety of questions to clarify sexual problems, sexual dysfunction, and satisfaction (Zaksek, 2015). Nurses may encourage women to temporarily maintain abstinence to meet the pregnant woman's individual needs and the well-being of the fetus until the end of the third trimester. In this case, couples should also be advised to use alternative methods for happy living, such as touching, masturbation, or helping the other person achieve orgasm without intercourse.

Counseling related to postpartum sexual dysfunction is critical to postpartum sexual health. Postpartum nurses should highlight the regenerative mechanisms of uterine involution, genital organs such as the vagina, uterus, lochia, hormones, sexual arousal, desire, climax, and sexual satisfaction after childbirth. Nurses should also alert postpartum women and couples that premature vaginal/anal intercourse leads to dyspareunia or more perineal tears. In some cases, they should receive specific postpartum sexual abstinence counseling before discharge from the hospital. In a normal delivery, it takes at least a few months for the woman's body to follow up, four to six months for perineal lacerations, and the same for psychological adjustment. Women's physical and psychological rehabilitation and sexual health need to be assessed at a follow-up visit or referred to the nearest community medical facility (Zamani et al., 2019).

Conclusion

Sexual abstinence, or "postponing sexual intercourse until the proper time," serves to preserve women's well-being within the right to their bodies and minds. Sexual abstinence in women is related to reproductive organ rehabilitation, pregnancy, postpartum care, and family planning, including cultural values and religions. To promote sexual abstinence, nurses should emphasize the definition and benefits to women and families in schools, clinics, and the community. Promoting sexual abstinence is appropriate for health-promoting behaviors and disease prevention, such as maintaining wellness during adolescence, prenatal, antenatal, and postnatal care. As knowledge about abstinence should be brought to bear, health care providers should consider abstinence as an option for promoting women's sexual autonomy and health status while taking into account the understanding and maintenance of family relationships.

Declaration of Conflicting Interest

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Author's Contribution

The author meets four authorship criteria based on ICMJE Recommendations.

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Data Availability

Not applicable.

Ethical Consideration

Not applicable.

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