

Sexual wellbeing and supportive care needs after cancer in a multiethnic Asian setting: a qualitative study

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Research Article

Keywords: sexual wellbeing, supportive care, unmet needs, cancer, Asian

Posted Date: April 11th, 2022

DOI: <https://doi.org/10.21203/rs.3.rs-1415565/v1>

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Abstract

Purpose: The physical and emotional impact of cancer and its treatment may be detrimental to the sexual well-being of patients. We aimed to gain an in-depth insight on the impact of cancer on the sexual wellbeing of cancer patients living in a middle-income setting with limited supportive care services.

Methods: Twenty focus group discussions, stratified by gender, were conducted among 102 patients with breast, cervical, colorectal, or prostate cancer. Participants were recruited from five hospitals in Klang Valley, Malaysia. Discussions were audio recorded and transcribed verbatim. Thematic analysis was performed using NVivo.

Results: Three major themes emerged: loss, adjustments, and unmet supportive care needs. Under the main theme of loss, changes in physical appearances and childbearing abilities negatively impacted participants' self-confidence and body image, particularly in the females. Changes in quality of sexual activity were commonly raised, which often brought about conflicts and marital strains. Various methods to cope with the changes were described, including reprioritization of sex, using sexual aids, employing other forms of intimacy, and reframing sex as an obligation. Participants further voiced the unmet need for professional counselling services to enable honest communication between patients and their partners, and also sexual healthcare services, which were all deemed as paramount to address their sexual issues.

Conclusion: In the low- and middle-income countries, provision of sexual healthcare services including counselling and clinical management of sexual dysfunction should not be overlooked as an important component of supportive cancer care.

Introduction

Sexual wellbeing refers to the individual's experience of the physical, cognitive, emotional and social aspects of relations with oneself and with others, including the freedom to achieve sexual wellbeing [1]. Cancer and its treatment have been shown to adversely impact the sexual functioning and intimate relationships of patients [2–3]. The importance of addressing sexual wellbeing in the cancer care continuum is further illustrated by a systematic review that found that while most supportive care needs significantly decreased three months post-diagnosis, sexual needs tend to increase over time [4].

In Malaysia, a multiethnic, middle-income Asian country with limited supportive cancer care services, open discussions regarding sexual wellbeing between clinicians and patients are scarce due to the sensitive nature of the topic [5–6]. While quantitative studies have reported a high prevalence of sexual dysfunction among Malaysian cancer survivors [7–8], only a handful of qualitative research have examined the sexual health experiences of cancer survivors in the country [6], which tended to be limited to a single cancer site or gender. Understanding the impact of cancer on the sexual wellbeing of patients with different cancers and of both genders is crucial to guide the development of supportive care services that is responsive to the sexual needs of cancer patients in the nation.

Generating evidence to close the knowledge gap maybe the first step towards achieving better sexual health and prevention of sexual dysfunction following cancer in the low- and middle-income settings. To this end, we sought to gain an in-depth insight on the impact of cancer on sexual wellbeing of cancer patients living in a multi-ethnic, middle-income country with limited supportive cancer care services.

Methods

Data for the present analysis was obtained from a larger study that assessed the overall supportive care needs, including physical, psychological, sexual, social, and financial needs, of multi-ethnic cancer survivors in Malaysia. Briefly, participants were recruited from five hospitals, comprising a mixture of public, academic and private hospitals in Malaysia. The eligibility criteria were Malaysian women and men diagnosed with either invasive breast, cervical, colorectal, or prostate cancer at least one month prior to the study. Those with recurrent cancers and carcinoma in situ were excluded. Eligible participants were identified by their treating physicians and invited to join a focus group discussion (FGD), which were conducted separately by gender. Written informed consent was obtained from all participants prior to the FGDs. Each FGD comprised four to six participants and was conducted by two trained moderators in either English or Malay language depending on the participants' preference. Audio-recordings of the FGDs were transcribed verbatim, anonymized with pseudonyms by the research team. Forward and backward translation were performed for FGDs that were conducted in the Malay language.

In the present analysis, the focus was on the experiences of changes in sexual wellbeing after a cancer diagnosis. We included all study participants regardless of whether they were sexually active at the time of study or otherwise. We were however unable to extract details on the sexual orientation of the study participants as the information was not available from the parent study. The study participants were probed on *how did cancer impact how you view yourself as a man or woman, how did cancer impact your sexual or intimate relationships, how did you cope with these changes or impact, and what are some supportive care needs that you needed in terms of sexual health*. Follow up questions such as *can you elaborate*, and *can you give a specific example* were also asked when appropriate.

The transcripts of each FGD were analysed thematically. To ensure trustworthiness of coding, all transcripts were analysed independently at least twice by two different researchers.

Ethical approvals for the study were obtained from Medical Research Ethics Committee (NMRR-17-3361-39122), University Malaya Medical Research Ethics Committee (201831-6061) and Ramsay Sime Darby Health Care Independent Ethics Committee (201809.2).

Results

A total of 102 participants, comprising 64 women and 38 men, across 20 FGDs were included (Table 1). Approximately two-thirds of the female participants were of 40–59 years of age, while male participants were generally older, with two-thirds of them aged 60 years and above. The study included a mix of

patients from the major ethnic groups in Malaysia; Malays (43%), Chinese (36%), Indians (17%), other races (4%). A large proportion of the participants was married (78%) while slightly more than half were recruited from public hospitals (56%). Male participants comprised either colorectal (53%) or prostate cancer (47%) survivors while female participants consisted of breast (47%), colorectal (34%) or cervical cancer survivors (19%).

Table 1
Characteristics of study participants.

	Overall (N = 102)	Women (n = 64)	Men (N = 38)
	n (%)	n (%)	n (%)
Age, years			
< 40	19 (18.6%)	15 (23.4%)	4 (10.5%)
40–59	50 (49.0%)	40 (62.5%)	10 (26.3%)
60 and above	33 (32.4%)	9 (14.1%)	24 (63.2%)
Ethnicity			
Malay	44 (43.1%)	36 (56.3%)	8 (21.2%)
Chinese	37 (36.3%)	16 (25.0%)	21 (55.3%)
Indian	17 (16.7%)	11 (17.2%)	6 (15.8%)
Others	4 (3.9%)	1 (1.6%)	3 (7.9%)
Marital status			
Single	10 (9.8%)	6 (9.4%)	4 (10.5%)
Married	79 (77.5%)	49 (76.6%)	30 (78.9%)
Others	13 (12.7%)	9 (14.1%)	4 (10.5%)
Highest education attained			
Primary	5 (4.9%)	5 (7.8%)	0
Secondary	49 (48.0%)	31 (48.4%)	18 (47.4%)
Tertiary	48 (47.1%)	28 (43.8%)	20 (52.6%)
Type of hospital			
Public	47 (55.9%)	37 (57.8%)	20 (52.6%)
Academic	25 (24.5%)	16 (25.0%)	9 (23.7%)
Private	20 (19.6%)	11 (17.2%)	9 (23.7%)
Type of cancer			
Colorectal	42 (41.2%)	22 (34.4%)	20 (52.6%)

[†] Unknown for 3 participants.

[‡] Unknown for 17 participants.

	Overall (N = 102) n (%)	Women (n = 64) n (%)	Men (N = 38) n (%)
Breast	30 (29.4%)	30 (46.9%)	-
Cervical	12 (11.8%)	12 (18.8%)	-
Prostate	18 (17.6%)	-	18 (47.4%)
Time since diagnosis (months) [†]			
Median (25th, 75th percentile)	20 (11, 38)	18 (10, 28)	27 (14, 61)
Cancer stage at initial diagnosis [‡]			
I	10 (11.8%)	7 (11.7%)	3 (12.0%)
II	27 (31.8%)	21 (35.0%)	6 (24.0%)
III	28 (32.9%)	20 (33.3%)	8 (32.0%)
IV	20 (23.5%)	12 (20.0%)	8 (32.0%)
[†] Unknown for 3 participants.			
[‡] Unknown for 17 participants.			

Three main themes emerged from our analysis, namely loss, adjustment, and unmet supportive care needs.

Theme 1: Loss

Three subthemes emerged under the main theme of loss: physical appearances, childbearing, and quality of sexual life (Table 2).

Table 2
Subthemes and representative quotes related to loss.

Subthemes	Representative quotes
Physical appearances	<p><i>It (breast) is considered an asset. I feel inferior because I feel that no one wants me ... For a long time I was thinking, who is going to marry me? Malay people, their perception is, if you don't have a breast, they (the guys) don't want (you).</i> 42-year-old Malay woman with breast cancer, single</p> <p><i>Socially, if a man experiences hair fall, he will just shave it and it will be acceptable.</i> 63-year-old Chinese man with colorectal cancer, married</p> <p><i>When I was under hormone therapy, one of the side effects is the enlargement of breasts... I dare not go to a swimming pool... I felt embarrassed.</i> 79-year-old Indian man with prostate cancer, married</p> <p><i>After operation, I have removed one side (breast). I really felt like I was lacking, really really lacking... until I got depressed. I was moody and ashamed to meet people.</i> 40-year-old Malay woman with breast cancer, married</p> <p><i>I did radiotherapy, so one side of my breasts is dark. I lost my confidence, thinking what will my husband feel looking at me like this. I felt that it's better if my husband don't see me. I felt embarrassed about my body.</i> 40-year-old Malay woman with breast cancer, married</p>
Childbearing	<p><i>I feel that I am 'cacat' [disabled], as a woman. I feel incomplete. This is very painful as a young woman, we lost our femininity. We don't get our period, we lost our uterus and we cannot conceive a baby.</i> 35-year-old Malay woman with cervical cancer, married</p>
Quality of sexual life	<p><i>I think there was a lot of impact on our sexual activities... It impacts me as well as my wife. Definitely frustrated. I think my wife also feels frustrated.</i> 60-year-old Chinese man with prostate cancer, married</p> <p><i>I am having sexual issues with my husband right now. I feel so numb and my sexual drive is zero. I just want a life without sex... This has caused conflicts between me and my husband.</i> 41-year-old Malay woman with breast cancer, married</p> <p><i>Ever since I was discharged from the hospital, I never had sex with my husband.</i> 42-year-old Malay woman with cervical cancer, married</p> <p><i>To a patient, it really has a lot of impact when our libido and sexual desire goes below a certain level.</i> 60-year-old Indian man with prostate cancer, married</p> <p><i>I feel discomfort because of the itchiness. The treatment caused more white discharge.... I don't have the feelings to engage in sexual relationship.</i> 38-year-old Malay woman with colorectal cancer, married</p> <p><i>I tried to be with my husband but it was so painful and I could not tolerate the pain. It has been two years since we last had sex.</i> 35-year-old Malay woman with cervical cancer, married</p> <p><i>It (colostomy bag) limits the movement (during sex).</i> 63-year-old Chinese man with colorectal cancer, married</p>

Physical appearances

Female participants, particularly women of Malay ethnicity, often described themselves as having “lost their femininity” following mastectomy or hysterectomy. The change in physical appearance particularly affected women with breast cancer who perceived the removal of breast as a “loss of womanly asset”, leading to feelings of being “incomplete” and “lacking something”. They often recounted feeling inferior, depressed and ashamed following their mastectomy, which severely affected their self-esteem. Apart from removal of the breasts, one participant described experiencing loss of self-confidence due to darkening of her breast skin following radiotherapy. A participant with breast cancer, who was single, also shared her worries of being considered ‘unwanted’ and ‘unmarriageable’ due to the loss of her breast.

Compared to their female counterparts, the men appeared to be relatively less affected by the changes in their physical appearances. When probed on the physical changes in terms of masculinity, several male participants with prostate cancer described experiencing enlargement of breasts following endocrine therapy, which they perceived as somewhat embarrassing.

Childbearing

The loss of the ability to conceive a child was most particularly experienced by women with cervical cancer. They described viewing themselves as “incomplete” and “disabled” due to the loss of their uterus. While certain cancer treatments could render patients infertile, it was not brought up by participants with other cancers

Quality of sexual life

While some participants reported no issues with sexual activities following their cancer diagnosis, others described profound changes in the quality of their sex life following cancer diagnosis. The decrease in sexual quality stemmed from reduced sexual desire and sexual dysfunction, leading to abstinence as well as reduction in the frequency of sexual activities. Such patients also reported a lack satisfaction from sexual intercourse following cancer.

Many participants, regardless of gender, discussed explicitly that their sexual desire was vastly diminished. While some attributed this to cancer treatment particularly hormone therapy, the majority were unsure of the cause for the loss of libido. Nevertheless, a number of male participants reported that the loss of sexual desire was transient and improved over time.

Apart from loss of libido, many participants attributed the lack of sexual activities to other side effect from cancer therapies. Irrespective of cancer type, many participants complained of experiencing pain during sexual intercourse after undergoing cancer therapies. In addition, patients also frequently cited fatigue after cancer treatment as a reason for the decline in the frequency of engaging in sexual activities.

Among women with cervical cancer, other side effects from their cancer treatments, such as vaginal discharge, dryness, itchiness and tightness, were often described as deterrents of sexual intercourse. Moreover, some women with breast cancer recounted experiencing menopausal symptoms such as vaginal dryness and hot flushes following cancer treatment, leading to avoidance of sexual activities. A patient with colon cancer further remarked that the colostomy bag was a hindrance as it restricted his movement and thus reduced his desire for sexual activities.

Theme 2: Readjustments

Participants recounted employing various adjustment methods to cope with the change in their sexual activities and relationships. The subthemes that emerged under this theme were priorities, use of sexual aids and other forms of intimacy, and cultural and religious obligations. (Table 3)

Table 3
Subthemes and representative quotes related to adjustments.

Subthemes	Representative quotes
Priorities	<i>In terms of sexual life. I think once you reach the cancer stage, you set your priorities differently. Sexual urge is not as important as the quality of life with your family.</i> 58-year-old Chinese man with prostate cancer, married
Use of sexual aids and other forms of intimacy	<i>For those who have done the operation, you have to be willing to adapt to sex in a different way ... I have to use a pump to get myself into that state (erection), but the enjoyment was not like it was before.</i> 77-year-old of mixed ethnicity with prostate cancer, married <i>There are other ways to show love apart from sexual intercourse.</i> 50-year-old Chinese woman with colorectal cancer, married <i>Psychologically, I understand the older people's need for hugging and all that. Affection.</i> 78-year-old Indian man with prostate cancer, married
Cultural and religious obligations	<i>I even feel like asking my husband to just remarry because I can't give him what he wants.</i> 41-year-old Malay woman with breast cancer, married <i>Just that when we do it, when we have sex with our husband, it is out of responsibility.</i> 37-year-old Malay woman with breast cancer, married <i>For me, it is okay.... Sometimes we do think that it (sex) is an obligation, a responsibility.</i> 58-year-old Chinese woman with colorectal cancer, married

Priorities

Many participants highlighted the importance of acceptance regarding the change in their sexual life. Some patients for instance recounted that after being diagnosed with cancer, they tended to prioritize quality of life and the time spent with family as more important whereas issues with libido and sexual intercourse were deemed secondary.

Use of sexual aids and other forms of intimacy

A number of participants also pointed out that love and affection may be expressed through other means including physical touch and hugs. A few participants also shared on their experiences of using sexual aids to cope with their sexual issues, such as pumps to facilitate erections or gels to alleviate vaginal dryness. The use of sexual aids, however, were only deemed to be useful up to a certain extent and did not make up to how 'it used to be'.

Cultural and religious obligations

A number of female participants from different cultural and religious background shared that they regarded sexual activities as mere obligations toward their partners. This mindset prompted them to have sexual intercourse with their partners even when they may not be up for it. Some women also recounted asking their husbands to remarry as they felt they were not able to provide a satisfactory sex life.

Theme 3: Unmet supportive care needs

Two subthemes were identified under the main theme of unmet supportive care needs, namely, communication, and clinical care. (Table 4)

Table 4
Subthemes and representative quotes related to unmet supportive care needs.

Subthemes	Representative quotes
Communication	<p><i>Most important is husband and wife have to communicate. I (am) very open with my husband since we are married for 35 years. 50-year-old Chinese woman with colorectal cancer, married</i></p> <p><i>Whenever I go and see the doctor, I will come back and discuss with my wife on what the doctor advised me to do, what I should tell my wife. It really helps. I think it is really important to discuss with your wife on all these. 60-year-old Indian man with prostate cancer, married</i></p> <p><i>I have never shared with him my feeling on how I don't want sex. How do I tell him? Will he able to accept it? It is really hard. I don't know how to tell him. 38-year-old Malay woman with colorectal cancer, married</i></p> <p><i>After I did my mastectomy, my husband didn't do it (sex) because he was scared... He was scared to look at the operation site. He was scared to injure me. 49-year-old Malay woman with breast cancer, married</i></p> <p><i>Sometimes, we need advice, we need support. Maybe the hospital can come up with some marriage counseling for certain patients who cannot handle it. 55-year-old Malay woman with colorectal cancer, married</i></p> <p><i>My husband thinks that I am purposely avoiding sex. It's not that I don't want, I just don't have the feeling. He thinks that I keep using the advantage of my disease to not have sex with him. I tried so much, but still my husband doesn't understand what I am going through.... The husbands need to be educated more (sexual education) when their spouses have cancer. Maybe they think cancer is infectious. 48-year-old Indian woman with breast cancer, married</i></p>
Clinical care	<p><i>I think they (doctors) did a good job. Before the operation, the doctor will come and interview me on how often I have sex, how is the performance. A long list. It is good that they asked us all this. 72-year-old Chinese man with prostate cancer, married</i></p> <p><i>The doctor encouraged us to have (sexual) intercourse. Because I have cervical cancer, when we do radiotherapy and brachytherapy, it (vaginal lining) will become thicker. So to soften it, we should have sex. 58-year-old Malay woman with cervical cancer, married</i></p> <p><i>The doctor did not mention or explain anything about sexual issues. I felt that the doctor should explain to me... but no one inform me anything. 46-year-old Chinese man with colorectal cancer, married</i></p> <p><i>I know it is not contagious but I want my wife to hear that from the doctor himself that it is not contagious... I just wanted confirmation from the doctor that you can have the intimacy and it (the cancer) doesn't spread to people. 66-year-old Chinese man with prostate cancer, married</i></p>

Communication

Open communication with partners was highly mentioned as instrumental by participants in resolving conflicts regarding sexual relationships with their partners. Through honest conversations, they recounted

convincing their partners to be more supportive, understanding and more willing to compromise when it came to intimacy issues. Nonetheless, a few cancer patients, more commonly females, voiced out that they had difficulties in communicating with their male partners. These patients expressed anger and frustration, describing their partners as being inconsiderate. Patients who had difficulties in communicating their feelings to their partners were found to be more likely to have arguments and were generally more reluctant to engage in future sexual activities. In these patients, unresolved sexual tensions were cited as a leading cause of relationship conflicts with their intimate partners. One patient further recounted of not knowing the right way to initiate the conversation on sexual relationship with her partner. To this end, some study participants felt that access to professional counselling services may provide them an avenue for engaging in honest conversations with their sexual partners, and be somewhat helpful in resolving their conflicts.

Sexual healthcare services

Upon probing, a majority of the study participants meted out their appreciation of the professional sexual advice provided by their treating physicians. The cervical cancer survivors, particularly, mentioned that their doctors tended to encourage sexual activities following completion of radiotherapy/ brachytherapy.

Fear was found to be another major concern for couples in initiating sexual activities. This concern was particularly obvious among female patients who were afraid of experiencing pain during sexual intercourse and this is regardless of cancer type involving genital (e.g. cervical cancer) or non-genital organ (e.g. colorectal cancer). Additionally, some participants pointed that sometimes it was their partners who were reluctant to have sex. In particular, a few participants mentioned that their partners were worried that engaging in sexual activities after cancer was not “safe” and may injure the patients or worsen the illness. Some patients also shared about the perceptions held by their partners that cancer is contagious and may spread through sexual activities. It was also voiced out that some partners were fearful of the patients’ surgical scars. Many participants thus stressed on the need to have professional sexual education and marriage counselling, with their partners being included in such sessions.

For many, words from the doctors were deemed to be powerful and increased the patients’ confidence levels in engaging in sexual activities. Therefore, most cancer patients strongly advocated the need to for their clinicians to pre-empt them regarding the potential impact on their sexual lives and what they can do to overcome these issues.

Discussion

Through this qualitative study, we found that cancer and its treatment brought about profound challenges to the sexual wellbeing of cancer survivors living in settings with limited supportive care services. Changes in physical appearances and loss of childbearing ability following administration of cancer surgery and therapies negatively impacted participants’ self-confidence and incited psychological distress. The side effects of cancer, including loss of libido, and pain, often led to a decrease in quality of sexual relationships, which subsequently spurred further psychological stress and led to strained

relationships with partners. Various adjustments were made to improve their sexual relationships including reprioritization of sex, use of sexual aids, employing other forms of intimacy, or reframing sex as an obligation. While the role of healthcare professionals was stressed as paramount in helping to address sexual wellbeing issues following cancer, this need was deemed as largely unmet.

Similar to findings from other settings, the female participants in this study narrated that they felt “incomplete” following the loss of their breasts or uterus [9–10]. This perceived loss of femininity was more common among women of Malay ethnicity and may be linked to the societal expectations of womanhood, in which the breasts and ability to conceive are often deemed as symbols of being a “complete woman” [11]. Conversely, men appeared to be relatively less affected by changes in their physical appearances. From the clinical perspective, while mastectomy and hysterectomy may be life-saving treatments, the socio-psychosexual effects experienced by women on losing the breast and ability to conceive should not be overlooked by healthcare professionals [10, 12]. As illustrated from this study, the lowered body image due to the removal of the breasts or uterus affected not only the patients’ self-esteem but also their relationship with their intimate partners.

Cancer survivors often report a decline in the quality of their sexual relationships, which are mainly attributed to the side effects of cancer and its treatment. Consistent with many studies, concerns on changes in sexual activities were raised by almost all participants in this study irrespective of cancer type, age, and gender [13–14]. Although it is conceivable that reproductive cancers such as prostate and gynaecological cancers are more likely to be associated with sexual dysfunction due to hormonal imbalances [15–16], our study findings suggest that psychosexual care should not only be limited to a selected subgroup of patients but also extended to all patients with cancers. Although a prior study focussing on women with breast cancer in Malaysia had shown that when compared to other survivorship care needs, sexual functioning tended to be rated as a lower priority [17], the findings does not in any way preclude the importance of sexual wellbeing. The current study in fact highlights that sexual wellbeing remains an important concern for cancer patients including in those living in multiethnic, multicultural settings.

Several adjustment strategies were adopted by cancer patients to improve their sexual relationships. At the individual level, approaches to ensure sexual well-being included acceptance and adjustment to the new normal such as switching from penetrative sexual intercourse to other avenues such as physical touch and hugs, as well as adoption of medical aids. The need for open and honest communication between partners was also frequently brought up. Interestingly, this study found that psychological distress was not only experienced by the cancer patients but also their partners, who were described as “being afraid of hurting them” or “scared” to look at the surgical scars. Alarming, there were misconceptions held by the participants’ intimate partners including notions that sexual activities are not safe for cancer patients, may worsen cancer and that cancer is contagious and may spread through sexual activities. Professional counsellors thus play a crucial role to not only facilitate renegotiation of sexual practices between cancer patients and their partners but also importantly to dispel myths regarding cancer and sex [18]. The adoption of couple-focused sex therapy interventions, adapted to the

local socio-cultural beliefs, should also be implemented as they have been shown to be beneficial in fostering communication between couples, managing mismatched expectations, and improve the quality and satisfaction with sexual relationships in both the cancer patients and their partners [19].

In this multi-ethnic, middle-income country where sexual health is largely left undiscussed, we found a major unmet need for clinicians to counsel patients and their partners on the potential impact of cancer and its treatment on patients' sexual wellbeing. Healthcare professionals play an important role in the provision of reassurance that there is no medical contra-indication to sexual activities during and after cancer therapy, and that sex after cancer is safe as long as both parties are ready for it [18, 20–21]. Besides prescribing medications and medical aids, referring patients to support groups may also be an effective intervention to provide emotional support to patients with sexual difficulties.

In this conservative settings, it may also be necessary for healthcare professionals to proactively initiate conversations on sexual health with cancer patients and their partners during routine clinical encounters. The mismatch in communication expectations between patients and their clinicians can occur when patients assume that their clinicians would inform them about the sexual side effects associated with cancer and its management, while the clinicians assume that patients would initiate discussions about sexual health if they experienced such issues [2, 22]. While oncologists generally agree that sexual counselling is important, many are not able to translate this into routine practice, citing barriers such as insufficient knowledge, lack of training, lack of time and fear of over involvement in patients' personal lives [23]. Training programs for healthcare providers to have open and honest discussions regarding sexual concerns of their patients should be integrated and implemented into routine clinical care [24]. Designing a standardized and validated sexual needs assessment tools may have the potential to aid clinicians in identifying patients with dire sexual health needs, and thus manage their concerns and provide appropriate referrals in a timely and appropriate manner [25].

Study Strengths And Limitations

A major strength of this study is the inclusion of both male and female cancer survivors, as well as participants with diverse types of cancer, compared to previous studies that only included either women or men, or focused solely on a single cancer site. This study also includes participants with or without sexual partners to understand different perspectives. It is acknowledged that the presence of others may have hindered some participants from disclosing their personal experiences given the sensitive nature of this topic. However, we found that participants were generally engaged during the FGDs, where many appeared to be relieved to hear from other participants who faced similar issues and were eager to share and learn from each other. It is in fact believed that separation of the FGDs by gender had facilitated more open and honest discussions as the participants were more at ease in terms of sharing their experiences and sensitive information with other counterparts of the same gender.

The male participants in our study were generally of older age; about a quarter were between the age of 40–59 while only four male participants were below the age of 40 years. This could be attributed to the

inclusion of male participants with only prostate or colorectal cancer, both of which usually afflict older men in this setting [26]. Future research should be conducted among younger male cancer patients to validate our study findings. Additionally, studies to understand the perspectives of the partners of people living with cancer may also yield useful information towards the provision sexual health counselling services.

Conclusion

The present study illustrates that sexual wellbeing remains as an important patient-centred outcome and should not be overlooked in planning of supportive cancer care services in the low- and middle-income settings. While the role of healthcare professionals in addressing issues with sexual wellbeing were deemed important by many study participants, there currently appears to be a gap in provision of supportive care that is responsive to their sexual needs. To this end, screening and management of sexual dysfunction, as well as implementation of sexual health counselling services may be able to address the unmet needs. Access to patient support groups and promotion of sexual health awareness are also crucial to help patients cope with the emotional distress arising from sexual health issues.

Declarations

Funding: This study was supported through an unrestricted educational grant from PhAMA (Pharmaceutical Association of Malaysia). The funders had no role in the design of the study, data collection and analysis, preparation of the manuscript, or decision to publish.

Conflicts of Interest: The authors declare no competing conflicts.

Availability of Data and Material: The data that support the findings of this study are available from the corresponding author upon reasonable request.

Code Availability: Not applicable

Authors' Contribution: Wai-Chee Kuan: Formal analysis, data interpretation, and writing – review and editing. Yek-Ching Kong: Conceptualization, data curation, formal analysis, data interpretation, and writing – review and editing. Ros Suzanna Bustamam: Data curation, and writing – review and editing. Li-Ping Wong: Data interpretation, and writing – review and editing. Yin-Ling Woo: Data curation, and writing – review and editing. Nur Aishah Taib: Data curation, and writing – review and editing. Gwo-Fuang Ho: Data curation, and writing – review and editing. Cheng-Har Yip: Data curation, and writing – review and editing. Nirmala Bhoo-Pathy: Conceptualization, funding acquisition, formal analysis, data interpretation, and writing – review and editing.

Ethics Approval: Ethical approval for the study was obtained from the Medical Research Ethics Committee (NMRR-17-3361-39122), University Malaya Medical Research Ethics Committee (201831-6061) and Ramsay Sime Darby Health Care Independent Ethics Committee (201809.2).

Consent to Participate: Written informed consent was obtained from all participants prior to the focus group discussion.

Consent for Publication: Written informed consent was obtained from all participants prior to the focus group discussion.

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