ORIGINAL ARTICLE

Perceptions about Sex in Pregnancy among Women Attending Antenatal Clinic in a Tertiary Health Institution in South-East Nigeria

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ABSTRACT

Background: There are varied perceptions about sex in pregnancy among women that often lead to poor sexual performance in pregnancy with the attendant marital disharmony. There is need to assess the perceptions about sex in pregnancy among pregnant women in order to devise effective strategies in addressing this issue.

Objective: To study the perceptions about sex during pregnancy among women attending antenatal clinic in a tertiary health institution in Nnewi, South-East Nigeria

Methodology: A cross sectional survey of 430 pregnant women attending antenatal care clinic at Nnamdi Azikiwe University Teaching Hospital (NAUTH) Nnewi, carried out from 1st February 2016 to 31st July 2016.

Results: The mean age of the women was 29.2 ± 4.7 years. A majority (96.0%, n=413) of them had at least secondary education. One hundred and eighty (42.1%) were in the second trimester of pregnancy. Out of the 430 women studied, 320(74.4%) had information about sex in pregnancy. The main source of information was the nurses (50.0%). More than half (51.4%, n= 221) of the women had no discussion on sex in pregnancy with their physicians and the respondents initiated the discussion in 40.7% (n=85) of cases. One hundred and fifty four (35.9%) of the women believed that sex was not safe during pregnancy mainly because sex could lead to miscarriages (86.9%; n=134). One hundred and eight (25.2%) of them reported that their husbands were worried about the safety of sex in pregnancy. Most (89.4%, n=380) of the respondents felt that it was not right to deny their partners sex on account of pregnancy and 87.2%(n=374) of them believed that denying their partners sex during pregnancy could lead to marital disharmony.

Conclusion: A significant number of the studied women had misconceptions about the safety of sex in pregnancy. We recommend that discussions on sex in pregnancy should be incorporated into the routine antenatal classes.

Keywords: *Sexual dysfunction, Marital disharmony, Extra marital affairs, Traditional beliefs, Myths*

INTRODUCTION

Human sexuality is an integral part of human living. In 1966, Masters and Johnson proposed a model which described sexual stimulation as a linear model progressing through sequential phases of desire, arousal, orgasm, and resolution.[1] This model was later modified by Kaplan & co to a pattern of sexual desire, arousal, and orgasm.[2] Female Sexual dysfunction therefore can be a problem of

desire, arousal, orgasm and satisfaction. Many factors interact to impair the female sexual response; these factors may be physical, psychological, environmental and cultural factors. Pregnancy is associated with sexual dysfunction of varying degrees as a result physical, hormonal, psychological, social, and cultural challenges posed to the women by it.[3,4,5,6,7,8,9] These changes, in addition to myths about sex in pregnancy are capable of impairing the normal sexual response as well as the couple's sexual relationship.

The physical factors may include increasing size of the abdomen, tiredness and pelvic pain from subluxation of the pubic symphysis and sacroiliac joints. As pregnancy progresses, deep engagement of the fetal head and the associated stress incontinence and deep dyspareunia become issues. The enlarged abdomen may also interfere with the favourite sex position of the couple and thus may impair sexual function and response. Vaginal discomfort leading to dyspareunia may become more pronounced as a result of changes in vaginal physiology in response to hormonal changes of pregnancy.

Psychological factors such as anxiety about motherhood, stress of pregnancy as well as being afraid that sex may harm the baby can also impair sexual function in pregnancy.

The consequences of impaired sexual response among the pregnant women include loss of intimacy between the couples and in some cases extra marital sexual engagement by the husbands. A high rate of extramarital sexual relationships has been reported among the men whose wives are pregnant.[10,11]

Women's perceptions of the benefits and associated risks of engaging in sexual activity in pregnancy moderates their attitude towards sexual activity in pregnancy. If they perceive sex as a normal event or a beneficial one, they will likely be motivated and encouraged to continue their normal sexual life in pregnancy even in the face of challenges mounted by pregnancy. However, a perception of sex in pregnancy as a risky event capable of affecting the baby or causing miscarriage or preterm birth, will lead to reduced sexual activity and in some cases, an absolute cessation. Globally, women's perceptions of sex in pregnancy differ across the regions in the world.

In Nigeria, in line with global trends, there is a high rate of sexual dysfunction in pregnancy at varying degrees mainly due to reduced libido; fear that sex may harm the baby, physical discomfort from anatomical and hormonal changes in pregnancy.[12,13,14,15] However, women's perception of sex in pregnancy differ across regions of the world. While Bello *et al*. reported that 86.6% of women attending antenatal clinic in Ibadan, South-West Nigeria felt that sex in pregnancy should be encouraged; Adinma showed that only 44.3% of women in the South-East Nigeria felt that sex in pregnancy was necessary.[12] The main reasons they adduced for supporting sex in pregnancy were that it facilitates normal delivery, helps in maintaining marital harmony during pregnancy and that it helps to keep the man around.[12,13]

In view of the high rate of sexual dysfunction reported in Nigeria and lack of current reports on this subject, we undertook to investigate the perception of pregnant women attending an antenatal clinic in Nnewi South-East region of the country about sex in pregnancy. The findings will give an insight on how best to help solving this problem that is capable of separating families.

METHODOLOGY

Study Design and Population

This is a cross sectional survey of 430 pregnant women attending antenatal care clinic at Nnamdi Azikiwe University Teaching Hospital, Nnewi carried out from 1st February 2016 to 31st July, 2016. The study population comprised consecutive married pregnant women who presented for antenatal clinic at the hospital and who gave consent for the study after adequate counseling. Those with complicated pregnancies such as hypertensive disorders, diabetes mellitus, cardiac diseases in pregnancy as well as multiple gestations were excluded from the study.

The prevalence of poor perception of sex in pregnancy among pregnant women in Nnewi,

Nigeria of 30.2% reported by Adinma JI was used as a reference value for the calculation of sample size.[13] The minimum sample size for a statistically meaningful deduction was determined by using the statistical formula of Fisher for calculating sample size (WHO):

$$N=Z^2p(1-p)/d^2$$

Where N is the minimum sample size for a statistically significant survey,
Z is normal deviant at the portion of 95% Confidence interval = 1.96,
P is prevalence value of poor perception of sex in pregnancy among pregnant women in Nnewi (30.2%) [12,16]
and d is margin of error acceptable or measure of precision =0.05.

Using this formula, Minimum sample size (N) =323. Therefore, the study of 323 women will give meaningful statistical deductions. However, the sample size was increased to 430 to improve the power of the study

Data Collection
Consecutive pregnant women attending the antenatal clinic in Nnamdi Azikiwe University Teaching Hospital Nnewi were educated on the purpose, value and the nature of the study and those that gave consent for the study were recruited. Data was collected by trained house officers and nurses with a semi-structured, validated questionnaire that has two sections-section on sociodemographic characteristics and section on perceptions of sex in pregnancy.

Data Analysis
The data collected were analyzed with STATA software, version 12.0 SE (STATA Corporation, TX, USA). Continuous variables were expressed as means and standard deviations and categorical variables as percentages. Results were presented in tables.

Ethical Considerations
Ethical approval for the study was obtained from the Ethics Committee of the hospital and the study protocol was made to conform to the ethical guidelines of the declaration of Helsinki (1975). As much as possible, the rights of the patients were fully protected in this research work. Only women who gave consent were recruited for the study. The patients were required to fill the informed consent form. As much as possible, confidentiality was maintained at all stages of the research work. Every participating patient had the right to privacy and could withdraw from the study at any time after counseling. Patients also had the right to anonymity.

RESULTS
Sociodemographic Characteristics Of The Respondents
The age of the women ranged from 18-44 years with a mean age of 29.2 ± 4.7 years. A majority (96.0%,n=413) of the women attained at least secondary level of education; many were in the second trimester (42.1%; n= 180). The parity ranged from 0 to 10. The other characteristics were presented in Table 1.

Perceptions Of Sex In Pregnancy Among The Women
Out of the 430 women studied, 320(74.4%) had information about sex in pregnancy. The main source of information was the nurses during antenatal teaching sessions (50.0%). A majority of the women(51.4%'n= 221) had no discussion on sex in pregnancy with their husbands. One hundred and fifty four (35.9%) of them believed that sex was not safe during pregnancy mainly because sex could lead to miscarriages (86.9%; n=134). One hundred and eight (25.2%) of the women reported that their husbands were worried about the safety of sex in pregnancy.
Most (89.4%, n= 380) of the respondents felt that it was not right to deny their partners sex on account of pregnancy and 87.2%(n=374) of them believed that denying their partners sex during pregnancy could lead to marital disharmony(Table 2).

DISCUSSION
Our study showed that 1 in 3 of the women had misconception about sex in pregnancy and believed that sex is not safe in pregnancy and should be discouraged. Almost 2 out of every 3 of them had information about sex in pregnancy predominantly from a nurse during

Table 1. Distribution by sociodemographic characteristics

Sociodemographic characteristics	Frequency	%
Age category		
<20	3	0.70
20-24	77	17.91
25-29	168	39.07
30-34	128	29.77
35 and above	54	12.56
Educational status		
Primary	17	3.95
Secondary	170	39.53
Tertiary	243	56.51
Occupation		
Student	94	21.86
Public servant	104	24.19
Business	138	32.09
Housewife	94	21.86
Marital status		
Married	425	98.84
Single	1	0.23
Divorced	4	0.93
Occupation of the husband		
Professional	66	15.35
Skilled	80	18.60
Unskilled	284	66.05
Religion		
Catholic	280	65.12
Anglican	65	15.12

Table 2. Distribution by perceptions of sex among Nigerian pregnant women

Perceptions about sex in pregnancy	Frequency	%
Do you have Information about sex in pregnancy		
No	110	25.58
Yes	320	74.42
Have you discussed sex in pregnancy with your physician?		
No	221	51.40
Yes	209	48.60
Who initiated the discussion?		
The respondent	85	40.67
The physician	124	59.33
Is sex safe in pregnancy?		
Do not know	112	26.11
No	154	35.90
Yes	163	38.00
Why do you think sex is not safe in pregnancy?		
It could cause miscarriage	134	87.01
Not advisable	14	9.09
It can injure the baby	6	3.90
How is your sex life now?		
It has reduced	276	64.19
It is same as before	88	20.47
It has increased	66	15.35
Are you worried that sex in pregnancy can cause problems in pregnancy?		
No	310	72.09
Yes	120	27.91
Is your partner worried that sex in pregnancy can cause problems in pregnancy?		
No	321	74.83
Yes	108	25.17
Do you think it's justified to deny your husband sex based on pregnancy?		
No	380	89.41
Yes	45	10.59
Do you believe that denying your husband sex can lead to marital disharmony?		
No	55	12.82
Yes	374	87.18

antenatal classes. A significant number of the women had held no discussion on sex in pregnancy with their physicians and when they did, the women initiated the discussion in almost half of the cases. Reduction in sexual activity was reported by 2 out every 3 of the women. A majority of the women felt that it is not right to deny their husbands sex on the basis of pregnancy and that doing so could lead to marital disharmony.

The study demonstrated good knowledge about issues pertaining to sex in pregnancy but the main source of information was the nurses. A significant number of the women had not discussed sex in pregnancy even as most of them were in second and third trimesters. This clearly shows a very limited role played by the physicians in counseling pregnant women on good sexual practices, a trend that has been previously reported. It has been noted severally

that most pregnant women do not receive counseling on the issues of sex in pregnancy from their physicians.[3,4,17] In China, Fox *et al*. noted that only 9.4% of the pregnant women had discussed sex in pregnancy with their doctors; and half of the times, the issue was raised by the women themselves.[3]

A similar finding was reported among Canadian pregnant women, where only 29 % of pregnant women had discussed sex in pregnancy with their physicians; again, the discussions were initiated by the women in 49% of the cases. [17] It was reported that 76% of the women who had not discussed issues on sex with their physicians felt that it should be discussed. In our study, 51.4%'n of the women had not discussed sex in pregnancy with their doctors at the time of the study; and in 40.7% of times when the discussions were held, the women brought up the cases themselves.[17]

Lack of proper information about sex in pregnancy creates room for misconceptions concerning its safety and may subsequently lead to dysfunction. It is not surprising therefore that globally, there is a high rate of sexual dysfunction among pregnant women mainly on the basis of fear that sex may injure the baby or cause miscarriage. [3,6,7,12,13]

The reasons why doctors do not routinely discuss issues on sexuality with the antenatal mothers may border on cultural norms that do not encourage open and free discussions on sexuality within so many societies. It may also be a result of deficient training in the medical school as sexuality in pregnancy does not feature in the curriculum for medical training and as such, the doctors are unlikely to be knowledgeable about the safety or otherwise of sex in pregnancy.

There is need therefore to sensitize the doctors on the need to discuss safety of sex in pregnancy with the antenatal women and to include sexuality in pregnancy in the obstetric curriculum for medical undergraduates. Highlighting the safety and utility of sex in pregnancy while demonstrating the clinical situations where sex may not be safe in pregnancy. Routine antenatal classes should feature discussions on sex in pregnancy, preferably with the male partners in attendance.

Studies show that women are often times shy to initiate discussions concerning sex in pregnancy even when they felt there is need to do so.[3,4,5,17] Babazadeh *et al*. reported that only 24.2% of women in Iran sought and received information on the advisability of sexual activity during pregnancy from their physicians or midwives, and 75.8% were not comfortable starting the conversation.[5] Therefore, the physicians should be encouraged to initiate and encourage an open and free discussion on sex in pregnancy with the antenatal mothers in order to improve their sexual functioning during pregnancy.

About 35.9% of our respondents felt that sex was not safe in pregnancy and should be discouraged. This is significantly different from the accounts of Bello *et al.* and Adinma among women in the South-West and South-East regions of the country, respectively.[12,13] The immediate consequence of this finding includes impaired sexual response and function among the women with the attendant negative implications for family health. It is not surprising therefore, that a significant number of the women (2 out of every 3) reported a reduction in sexual activity with the attendant potential negative implications for marital harmony and sexual health as men have been reported to engage in extramarital sexual activities when their female partners are pregnant.[18,19] This therefore, further justifies counseling on healthy sexual life during pregnancy among Nigerian pregnant women as well as the safety and utility of sex in pregnancy at the antenatal clinics as well as in the communities.

It is important to focus on the nurses and improve the content and mode of delivery of sex education in pregnancy, since they are the main source of information on sex in pregnancy for the pregnant women.

A significant number of the women reported that their partners were also worried about the safety of sex in pregnancy. This is expected to

affect the sexual activity during pregnancy by reducing the sexual response and performances of these men. As the African culture is largely patriarchal with a male dominance, men's disposition to sexual and reproductive health issues determines to a great extent the family's orientation and practices. There is need to include the men in the counseling on the safety of sex in pregnancy both at the antenatal classes and within the communities through sensitization and advocacy visits.

A majority of the women felt that it is justified to deny their husbands sex on the basis of pregnancy although they agreed that denying them sex could lead to marital disharmony. This shows that with good counseling, the women's perception and practice about sex in pregnancy will improve.

CONCLUSION

There was a high rate of poor perception of the safety of sex in pregnancy among the studied population mainly based on the assumption that sex in pregnancy can lead to miscarriage and other problems in pregnancy. We recommend the incorporation of sex in pregnancy education into the routine antenatal classes.

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