Determinants of coital frequency and adaptations during pregnancy in a South-western Nigerian town

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Abstract
Objective: To determine the trends in the frequency of coital intercourse in pregnancy, the factors responsible for these changes and adaptations by couples in Sagamu, Southwestern Nigeria.

Methods: This cross-sectional survey, examined the determinants of coital sexual frequency and adaptations for coitus in pregnancy among 364 pregnant women attending antenatal clinic at the Olabisi Onabanjo University Teaching Hospital, Sagamu.

Results: Decline in coital frequency occurred in 51.3% of respondents; with increasing maternal age (p=0.016, 95% CI=0.013-0.017), monogamous marriage setting (p<0.001), duration of marriage (p<0.001) and lack of awareness of HIV status (p<0.001) having significant deterrent effects. Parity (p=0.355, 95% CI=0.345-0.364) and co-habitation with spouse (p=0.094, 95%CI=0.088-0.099), however had no similar effect. Although sexual dysfunction was observed (29.6% of respondents), this decline in frequency was caused mainly by uncomfortable position (51.7%). Consequently, the commonest change noted was a decreased use of the man-on-top position from 83.4% of the participants before pregnancy; to 32.7% during pregnancy. Most of the participants (76.6%) recommended continued coital activity in pregnancy.

Conclusion: Coital sexual decline in pregnancy observed in Sagamu is less prevalent than reported and physical discomfort is mainly responsible for this decline. Health care providers can help couples maintain positive sexual behaviour in pregnancy against STIs and HIV.

Keywords: Coitus, sexual intercourse, pregnancy adaptation, sexual dysfunction.

Introduction
The physiological and psychological changes associated with conception and the socio-economic environment of a pregnant woman, may affect greatly her response to coital sexual intercourse; an obligation which remains a sensitive part of her marital relationship. Sexual response and activity have continually generated interest among obstetricians in contemporary practice. Although sexual dysfunction was observed (29.6% of respondents), this decline in frequency was caused mainly by uncomfortable position (51.7%). Consequently, the commonest change noted was a decreased use of the man-on-top position from 83.4% of the participants before pregnancy; to 32.7% during pregnancy. Most of the participants (76.6%) recommended continued coital activity in pregnancy.

Coital sexual decline in pregnancy is an issue that is not often discussed and when it is, opinions vary. Females generally tend to have decreased libido compared to men outside pregnancy. It is clear that physical and psychological changes in the pregnant women are responsible for some of the changes in sexual function and response. Although the male partners also experience psychological changes, there...
is a disproportionate impact on their sexual drive and behavior when their partners are pregnant.\textsuperscript{6,8,15} Decreased interest and response to advances or complete refusal by either partner may not be without consequences. Refusal by a pregnant woman to have sex with her husband may be detrimental to her as studies have implicated this as one of the reasons for intimate partner violence.\textsuperscript{10,19}

Events around pregnancy, health care interventions received and how a couple copes can have significant impact on the pregnancy outcome and future well-being of the family. Health care providers are often faced with situations in which expert advice is required by a pregnant woman or her partner regarding attitudes and adaptations for coital intercourse and the potential advantages and demerits. The physical changes of pregnancy are usually obvious, but the connection between these changes and sexuality often is not clear, either for the physician or the patient. Normal physiology therefore becomes a source of numerous deterrent to sexual activity.

Previous studies have often laid more emphasis on the occurrence of sexual dysfunction and decline in coital sexual frequency, but information on the reasons for reduction in coital frequency in pregnancy is scanty. The adaptations as well as the source of knowledge on these adaptations by couples to mitigate these coital challenges are also not commonly reported.

A clear understanding of the experiences of these pregnant women, their attitudes and coping strategies may guide counseling and help proffer appropriate behavior change models to deal with health challenges related to sexual function in pregnancy.

Objectives

To determine the trends in the frequency of coital intercourse in pregnancy, the factors responsible for these changes and adaptations by couples in Sagamu, Southwestern Nigeria.

Methods

This cross-sectional study was conducted at the antenatal clinic of the Olabisi Onabanjo University Teaching Hospital, Sagamu. Data was obtained over a five month period, using an interviewer-administered semi-structured questionnaire which was adapted from a previous study.\textsuperscript{15} All the questionnaires were completely filled and returned.

Sample Size

A sample size of 330 pregnant women was obtained using the Leslie-Kish formula for single proportions\textsuperscript{19} and based on prevalence numbers from a previous study\textsuperscript{20} and a level of significance set at 5%. The computed sample size was increased by 10% to account for anticipated subject non-response.

Three hundred and sixty four pregnant antenatal clinic attendees, selected by simple random sampling, participated in the study and inclusion criteria were; a currently viable gestation and that the participant had a partner. Exclusion criteria included pregnant women in whom coital sexual intercourse was contraindicated for medical reasons. Verbal consent was obtained from all participants before administering the questionnaire to complete anonymously and returned to a desk in the reception, before leaving the clinic.

Coital sexual dysfunction was considered as; loss of libido, lack of desire for sex, lack of interest in sex or presence of pain during intercourse.

The data obtained was analyzed with SPSS version 17 software. The results were tested for statistical significance thus: t- test was used for continuous variables while chi- square was used for categorical variables. The level of statistical significance was set at p-value of ≤0.05.

Results

Most of the participants were aged 20-39 years (80.1%), and were in their third trimester at the time of interview (53.1). The respondents were mostly nulliparous (53.2%), while 17% were grand multiparous. Majority of them (74.1%) were in monogamous marriages and they cohabited with their partners (83.5%). The respondents were mainly skilled workers (48%) and had up to tertiary level of education (55.2%). More than half of the participants were unaware of their HIV status (54.3%).

Increasing age, educational level, duration of marriage and increasing gestational age, had a statistically significant diminishing effect on coital sexual frequency in pregnancy. The male partner as the pre-pregnancy sex initiator and decreased libido had significant adverse effects on coital sexual frequency in pregnancy.

Respondents who were unaware of their HIV status tend to have decreased sexual intercourse during pregnancy (58.5%), while most of those aware of their HIV status had no change in coital frequency (47.1%). Parity and co-habitation with spouse however did not have any statistically significant effect on coital frequency in pregnancy. (table 2)

With respect to the coital practices in pregnancy, most of the respondents experienced decline in coital frequency during pregnancy and the main reason given was 'uncomfortable position'. The commonest change in position for coitus was from the man-on-top position before pregnancy to the: from-behind position during pregnancy. (table 3)

Fear of a miscarriage occurring (40.3%) and vaginal bleeding during pregnancy (36.1%) were the major reasons for discouraging sexual intercourse in pregnancy. (table 4)
### Table 1 Factors influencing the variations in frequency of coitus in pregnancy

<table>
<thead>
<tr>
<th>Variable</th>
<th>No change n (%)</th>
<th>Increased n (%)</th>
<th>Decreased n (%)</th>
<th>Total (100%)</th>
<th>P-value</th>
</tr>
</thead>
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<td></td>
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<tr>
<td>20-29</td>
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<tr>
<td>30-39</td>
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<td>Total</td>
<td>2 (25.0)</td>
<td>9 (40.4)</td>
<td>1 (13.8)</td>
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<td><strong>Parity: 0</strong></td>
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<td>&gt;4</td>
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<td>Total</td>
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<td>32 (39.0)</td>
<td>15 (45.5)</td>
<td>109 (32.5)</td>
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<td><strong>Educational level</strong></td>
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<td>34 (18.4)</td>
<td>91 (49.2)</td>
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<td>54 (16.1)</td>
<td>172 (51.4)</td>
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<td><strong>Family Setting</strong></td>
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<td></td>
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<td>Monogamous</td>
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<td>39 (15.9)</td>
<td>115 (47.0)</td>
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<td>Polygamous</td>
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<td>12 (16.4)</td>
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<td>0 (0.0)</td>
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<tr>
<td>Separated/Divorced</td>
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<td>0 (0.0)</td>
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<tr>
<td>Total</td>
<td>107 (32.1)</td>
<td>54 (16.2)</td>
<td>172 (51.7)</td>
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<td><strong>Years Married</strong></td>
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<td>&lt;5</td>
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<td>24 (20.5)</td>
<td>42 (35.9)</td>
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<tr>
<td>5-10</td>
<td>17 (23.0)</td>
<td>6 (8.1)</td>
<td>51 (68.9)</td>
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<tr>
<td>&gt;10</td>
<td>24 (21.1)</td>
<td>21 (18.4)</td>
<td>69 (60.5)</td>
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<td>Total</td>
<td>92 (30.2)</td>
<td>51 (16.7)</td>
<td>162 (53.1)</td>
<td>305</td>
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</table>

### Table 2 Factors influencing the variations in frequency of coitus in pregnancy

<table>
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<tr>
<th>Variable</th>
<th>No change n (%)</th>
<th>Increased n (%)</th>
<th>Decreased n (%)</th>
<th>Total (100%)</th>
<th>P-value</th>
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<td><strong>Gestational age at interview</strong></td>
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<tr>
<td>First trimester</td>
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<td>33 (45.2)</td>
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<tr>
<td>Third trimester</td>
<td>51 (33.6)</td>
<td>20 (13.2)</td>
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<tr>
<td>Total</td>
<td>93 (32.9)</td>
<td>52 (18.4)</td>
<td>138 (48.7)</td>
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<tr>
<td><strong>Sex drive/libido</strong></td>
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<td>No change</td>
<td>29 (24.0)</td>
<td>25 (20.7)</td>
<td>67 (55.3)</td>
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<td>Increased</td>
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<td>Decreased</td>
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<td>172 (52.1)</td>
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<td><strong>Cohabitation with spouse</strong></td>
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<td>50 (17.7)</td>
<td>139 (49.1)</td>
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<td>No</td>
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<tr>
<td><strong>Sex Initiator before pregnancy</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Husband</td>
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<td>46 (16.0)</td>
<td>160 (55.8)</td>
<td>287</td>
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<td>Wife</td>
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<td>5 (25.0)</td>
<td>6 (30.0)</td>
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<td></td>
</tr>
<tr>
<td>Either</td>
<td>19 (76.0)</td>
<td>3 (12.0)</td>
<td>3 (12.0)</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>109 (32.8)</td>
<td>54 (16.3)</td>
<td>169 (50.9)</td>
<td>332</td>
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<tr>
<td><strong>Awareness of HIV status</strong></td>
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<tr>
<td>Yes</td>
<td>65 (47.1)</td>
<td>19 (13.8)</td>
<td>54 (39.1)</td>
<td>138</td>
<td>0.001</td>
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<tr>
<td>Total</td>
<td>106 (33.0)</td>
<td>54 (16.8)</td>
<td>161 (50.2)</td>
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</table>
### Table 3: Coital practices in pregnancy

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage (%)</th>
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<tbody>
<tr>
<td><strong>Variation in coital frequency in pregnancy</strong></td>
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<tr>
<td>No change</td>
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<td>33.5</td>
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<tr>
<td>Increased</td>
<td>54</td>
<td>16.1</td>
</tr>
<tr>
<td>Decreased</td>
<td>172</td>
<td>51.3</td>
</tr>
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<td><strong>Reasons for reduction in frequency coitus</strong></td>
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<tr>
<td>Chronic fatigue</td>
<td>38</td>
<td>16.4</td>
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<tr>
<td>Uncomfortable position</td>
<td>120</td>
<td>51.7</td>
</tr>
<tr>
<td>Nausea/Vomiting</td>
<td>19</td>
<td>8.2</td>
</tr>
<tr>
<td>Reduced desire/libido</td>
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<td>11.2</td>
</tr>
<tr>
<td>Worry about bleeding</td>
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<td>8.6</td>
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<tr>
<td>Others</td>
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<td>3.9</td>
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<tr>
<td><strong>Occurrence of coital dysfunction in pregnancy</strong></td>
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<tr>
<td>Yes</td>
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<td>29.6</td>
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<tr>
<td>No</td>
<td>255</td>
<td>70.4</td>
</tr>
<tr>
<td><strong>Coital problems encountered during pregnancy</strong></td>
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<td></td>
</tr>
<tr>
<td>Pain/uncomfortable position</td>
<td>53</td>
<td>50.0</td>
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<tr>
<td>Chronic fatigue</td>
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<td>39.6</td>
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<tr>
<td>Nausea/vomiting</td>
<td>8</td>
<td>7.5</td>
</tr>
<tr>
<td>Vaginal bleeding</td>
<td>3</td>
<td>2.8</td>
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<td><strong>Adaptations in position for coitus</strong></td>
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<tr>
<td>Before pregnancy</td>
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<td></td>
</tr>
<tr>
<td>Man-on-top</td>
<td>301</td>
<td>83.4</td>
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<tr>
<td>Woman-on-top</td>
<td>16</td>
<td>4.4</td>
</tr>
<tr>
<td>From-behind</td>
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<td>8.3</td>
</tr>
<tr>
<td>Others</td>
<td>14</td>
<td>3.9</td>
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<tr>
<td>During pregnancy</td>
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<td>Man-on-top</td>
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<td>32.7</td>
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<tr>
<td>Woman-on-top</td>
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<td>9.2</td>
</tr>
<tr>
<td>From behind</td>
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<td>45.5</td>
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<tr>
<td>Others</td>
<td>45</td>
<td>12.6</td>
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</table>

### Table 4: Perception and attitude of respondents toward coitus in pregnancy

<table>
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<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
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<td><strong>Sources of information on coital adaptation</strong></td>
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<td>Doctor</td>
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<td>35.1</td>
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<tr>
<td>Nurse/midwife</td>
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<td>43.5</td>
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<tr>
<td>Relatives/friends</td>
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<td>4.3</td>
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<tr>
<td>Media-social/print</td>
<td>15</td>
<td>4.3</td>
</tr>
<tr>
<td>Not sure</td>
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<td>12.8</td>
</tr>
<tr>
<td><strong>Attitude towards coitus in pregnancy</strong></td>
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</tr>
<tr>
<td>Should be discouraged</td>
<td>72</td>
<td>19.8</td>
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<tr>
<td>Should be encouraged</td>
<td>279</td>
<td>76.6</td>
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<tr>
<td>Indifferent</td>
<td>13</td>
<td>3.6</td>
</tr>
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<td><strong>Reasons for discouraging coitus in pregnancy</strong></td>
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<tr>
<td>Previous miscarriage</td>
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<td>40.3</td>
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<tr>
<td>Vaginal bleeding in pregnancy</td>
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<td>36.1</td>
</tr>
<tr>
<td>Treatment for infertility</td>
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<td>11.1</td>
</tr>
<tr>
<td>Social/cultural/upbringing</td>
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<td>12.5</td>
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</tbody>
</table>
Discussion

Decline in coital sexual frequency in pregnancy is the trend among women in the Sagamu axis of Ogun state, southwestern Nigeria. This is in agreement with findings from several earlier studies, in other parts of Nigeria.10,11,22-26

Contrary to earlier observations of high prevalence of decreased coital activity in Eastern Nigeria and outside Africa,11-14 less proportion of women (51.3%) in Sagamu experienced this decline. A prevalence of 58% was reported by Bartellas et al in a study among Canadians.15

Maternal age (p=0.016, 95% CI=0.013-0.017), monogamous marriage (p<0.001), duration of marriage (p<0.001), lack of awareness of HIV status (p<0.001) and educational level (p=0.004, 95% CI=0.003-0.005.) had significantly negative effects on the frequency of coitus in pregnancy. Ahmed et al observed similarly, in an earlier study that age and duration of marriage were negatively correlated with frequency of coital sexual intercourse among Egyptian women.16

Participants whose male partners were the initiators of intercourse before pregnancy (p=0.001), had a significant reduction in frequency of sexual relations during pregnancy; Females generally tend to have decreased libido compared to men outside pregnancy, and it is the culture in south western Nigeria for the male to make the first move and it is generally socially unacceptable for the woman to do so. Reports from earlier studies reveal that husbands, rather than wives, are more likely to initiate sex during pregnancy.11 This study reveals that uncomfortable position was the commonest (51.7%) cause of decline in coital frequency among pregnant women in Sagamu. Other reasons included chronic fatigue from the pregnancy (16.4%) and reduced libido (11.2%).

Co-habitation with spouse (p=0.094, 95% CI=0.088-0.099), did not have a statistically significant effect on the frequency of sexual intercourse in pregnancy. This is in contrast with findings by Bello et al in a study conducted at Ibadan which showed that cohabitation with spouse predicted sexual intercourse in pregnancy.17

Similarly, the parity of the respondents had no statistically significant effect on the frequency of coitus in pregnant women in Sagamu (p=0.355, 95% CI=0.345-0.364), again in contrast with findings among Egyptian women where a significant correlation was found.20

Although a decrease in libido was observed to have a significant negative effect on coital frequency, in pregnancy (p<0.001), this decrease in libido was also observed with advancing pregnancy, although the relationship is not statistically significant (p=0.089, 95% CI=0.084-0.095). This is in agreement with findings by Bartellas et al where a reduction in sexual desire, sexual enjoyment, frequency of orgasm, and decline in contribution to initiation of intercourse were noted by women, but did not change by trimester.15

A report by Onah et al revealed that 41.9% of husbands of pregnant women experienced decreased libido and decreased sexual satisfaction, during their partner’s pregnancy in eastern Nigeria and this may be responsible for the prevalence (28%) ofextramarital sexual relationships observed in that study.17 Sexual dysfunction was observed among 29.6% of the participants, a value much less than the 38-43% reported among non-pregnant women.20-26 This finding is also much less than 58% observed in pregnancy by Leite et al, in Brazil,33 68.8% observed by Ahmed et al in Egypt and 90.8% reported by Kuljarusnont et al among Thai women,32 but within 25%-92% widely reported in literature.33-37

Adaptations in position was the main coping strategy employed by the participants, since the major deterrent to coital sexual frequency was discomfort from the awkward positional challenge of the pregnant abdomen. The commonest change noted was a reduction in use of the ‘man-on-top’ position from 83.4%, before pregnancy; to 32.7% of the participants during pregnancy. There was also an increase in use of the; ‘from-behind’ position from 8.3% before pregnancy, to 45.5% of the participants during pregnancy.

The commonest sources of information on these adaptations and coping with coitus in pregnancy are from health workers (cumulatively 78.6%): nurse/midwives (43.5%) and doctors (35.1%). Previous studies have also shown that 76% of pregnant women would welcome discussion on sexuality in pregnancy during antenatal clinic visits.33 This further stresses the role of the health care giver in helping couples cope with the challenges of coitus in pregnancy and the need to include sexual health in the care of the pregnant women.

While most of the participants (76.6%) would recommend continued coitus with husband or a faithful partner in pregnancy, 19.8% would not and 3.4% were indifferent. The commonest reason given by respondents, who felt that coital frequency should reduce, is concern about a miscarriage occurring (40.3% of participants) after penetrative intercourse.

The discrepancy between the participants’ attitude towards coitus in pregnancy and actual practise is worth pointing out. Whereas about three-quarters (76.6%) of the respondents affirmed that coitus should be encouraged during pregnancy, more than half (51.3%) admitted to reducing the frequency of coital activity in actual practise. This gap represents an opportunity for intervention targeted at translating attitude to practice in this regard.

Some limitations of this study should be taken into account when interpreting the findings. The personal nature of some of the questions in the interviewer- administered questionnaires could have influenced the responses due to participants’ reluctance to divulge such information to strangers. However, they were assured of confidentiality and no identification of respondents was made on the questionnaires.

Furthermore, the perspective and practice of the men was not ascertained in this study, which would have given a more balanced outlook on the issue. The qualitative nature of this study also precluded identification of the reasons underlying their coital practice during pregnancy. The use of qualitative rather than quantitative research methods may thus help to highlight important contextual issues.
Conclusion
There is a decrease in coital sexual frequency with advancing pregnancy, among pregnant women in Sagamu, South-Western Nigeria due mainly to physical discomfort and the chronic fatigue associated with pregnancy. Sexual dysfunction is not as common as widely reported and health workers have a significant role to play in helping couples adapt to changes in pregnancy that determine occurrence of coital sexual intercourse.

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