

RESEARCH ARTICLE

SEXUAL LIFE DURING PREGNANCY AND AFTER CHILDBIRTH: A SURVEY OF 540 WOMEN IN MOROCCO

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Abstract

Aims: To measure the impact of pregnancy and postpartum on the woman's sexuality on the woman's sexuality and on the couple's life by using the measurement tools for less severe maternal morbidity proposed by the WHO in 2018 at the level of the prefecture of Marrakech.

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Methods: The analysis focused on self-reported and test-diagnosed maternal morbidities in general and sexuality in particular. This study involved 540 pregnant and postpartum women at primary health care facilities.

Results: For the two groups of prenatal and postnatal consultation women, the average age was 30 years, the proportion of women having their first child was 14.10% -14.43% in the two urban and rural groups, compared to those with between 2 and 4 children (+76% in both groups). No woman reported a stillbirth. In rural areas (99.01% of CPNs, 97.94% of CPONs) and in urban areas (98.08% of CPNs, 100% of CPONs), most women reported being married, compared to only 1.56% in CPNs and 2% in CPONs. Who said they had no husband. Urban women were the least likely to be illiterate (32.05% in CPN and CPON against 38.61 in CPN and 51.55 in CPON, in rural areas). While most women were unemployed (90.66% in CPN and 94.47% in CPON), the percentage of employed women in urban areas is higher than in rural areas (12.82% in CPN and 8.97% in CPON, against 3.96 % in CPN and 3.96% also in CPON).

Conclusion: Based on these findings, the approach supports the appropriateness of implementing sexuality measurement in prenatal and postnatal care to improve the quality of care for women and to promote communication and continuity of care. However, time, resource, and coordination constraints must be considered for implementation at the primary care level.

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Introduction

Maternal mortality is only part of the overall burden of maternal ill health, as it excludes maternal morbidity [1]. The burden of maternal morbidity is not yet known [5]. WHO estimates that for every maternal death recorded, 20 to 30 women suffer morbidity. Of these cases, a quarter may suffer serious and permanent sequelae. Maternal morbidity

Corresponding Author: Hanane Hababa Address: National School of Public Health Rabat Morocco. represented by health problems experienced by women during pregnancy, delivery and postpartum contribute to thisburden [6].

According to these same authors, these after-effects can affect women physically, mentally, sexually, in their ability to function (cognition, mobility, participation in society), their body image and their socio-economic status.

The measurement of less severe maternal morbidity presents many challenges for women during pregnancy and postpartum, and for the organization of health services. The maternal morbidity burden also remains substantial, especially in comparison with mortality, although estimates vary. In view of this situation, there is a greater awareness at the global level of the plight of women who have complications associated with pregnancy or childbirth and who may continue to have problems in the long term. In 2018, The Maternal Morbidity Working Group agreed on the following definition of maternal morbidity: "any health condition attributed to and/or complicating pregnancy and childbirth that has a negative impact on the woman's wellbeing and/or functioning".

Despite this large number of complications, there is little in-depth research on maternal morbidity. The range of conditions is so broad that studies often focus on the most serious and lethal causes of obstetric morbidity and/or on a single disease [2].

Sexual dysfunction is one of these causes. In the absence of knowledge on the consequences of maternal morbidity on women's sexual life we conducted a study with the purpose of identifying the available evidence on any sexual impairment associated with complications from pregnancy and childbirth.

During pregnancy and childbirth, several disorders may occur: post-traumatic stress disorder, postpartum depression, physical and emotional disabilities, and sexual dysfunction [4–7]. Women who suffered complications during pregnancy and childbirth may present clinical and psychological disorders that may last for long time [8]. Thus, these conditions may lead to deterioration of quality of life and adverse effects on both mother and child.

Several factors may influence and affect the health and quality of life of women who had episodes of less severe Maternal Morbidity.

Sexual health is a state of physical, mental and social well-being in relation to sexuality, and the World Health Organization (WHO) also considers its quality as a health indicator [10]. In this context, sexual dysfunction in fact may be considered a consequence of maternal morbidity [11]. However, in Morocco, there are not many studies addressing this issue.

General medical disorders and treatments may interfere with sexual motivation, desire, subjective arousal and excitement, orgasm, pleasure, and freedom from pain [7, 12–14]. Any increased delay in resuming sexual intercourse after childbirth, could be considered as an important issue on female sexual response, since it is caused by an altered hormone level condition.

The subjectivity and complexity of sexual function led to the development of several instruments for its evaluation, the following are the main known and used ones. The Female Sexual Function Index (FSFI) is a questionnaire to be applied to evaluate the female sexual response fields (phases or components of sexual response): sexual desire, sexual arousal, vaginal lubrication, orgasm, sexual satisfaction and pain [16]. Intimacy Relationship Scale (IRS) was designed to assess sexuality among couples after childbirth [17]. As part of this study, the tools for measuring maternal morbidity proposed by the WHO were used.

The objective of this study is to measure the impact of pregnancy and pregnancy and postpartum on the sexuality of the woman and the on the life of the couple and to evaluate the quality of the information and about female sexuality during pregnancy and postpartum.

Method

The present study took place at the level of the prefecture of Marrakech. It is part of the Marrakech-Safi Region. This is a qualitative and quantitative study which was carried out following the test of tools for measuring maternal morbidity on 540 women in the pre and postnatal period. Thirty interviews were carried out with health professionals: 27% for general practitioners, 66% of midwives, and 7% of nurses. The majority, or 76%, were female. The average age was 43 years and 60% of the participants have a seniority between 10 and 20 years. This study concerned:

- 1. Health professionals involved in the care of women during pregnancy, childbirth and postpartum at the primary health care network level.
- 2. Midwife surveyors who participated in the administration of the maternal morbidity measurement tools (OMMM).
- 3. Those responsible at the central (Population Directorate), regional (Regional Health Director, public health service manager, mother and child health program manager), provincial level with responsible at the level of the Health Facilities Network Department (Head of the Health Facilities Network Department, and animator of the pregnant woman care program), and at the local level (Midwives and nurses responsible for the Pregnant woman care program).

Results

For the two groups of prenatal and postnatal consultation women, the average age was 30 years, the proportion of women having their first child was 14.10% -14.43% in the two urban and rural groups, compared to those with between 2 and 4 children (+76% in both groups). No woman reported a stillbirth. In rural areas (99.01% of CPNs, 97.94% of CPONs) and in urban areas (98.08% of CPNs, 100% of CPONs), most women reported being married, compared to only 1.56% in CPNs and 2% in CPONs. Who said they had no husband. Urban women were the least likely to be illiterate (32.05% in CPN and CPON against 38.61 in CPN and 51.55 in CPON, in rural areas). While most women were unemployed (90.66% in CPN and 94.47% in CPON), the percentage of employed women in urban areas is higher than in rural areas (12.82% in CPN and 8.97% in CPON, against 3.96% in CPN and 3.96% also in CPON).

Antenatal care	Urban (n=156) (%)	Rural (n=101) (%)	Total (n=257) (%)
Maternal Age,	31.32 ± 5.97	30.28 ± 7.10	30.9 ± 6,45
<20	8 (8)	5 (3)	13 (5)
20-34	60 (59)	95 (61)	155 (60)
≥35	33 (33)	56 (36)	89 (35)
Marital status			
Has partner	153 (98.08)	100 (99.01)	253 (98.44)
No partner	3 (1.92)	1 (0.99)	4 (1.56)
Education			
Primary or less	101 (64.75)	75 (74.25)	176 (68.48)
Secondary	50 (32.05)	24 (23.76)	74 (28.79)
Higher	5 (3.21)	2 (1.98)	7 (2.72)
Literacy			
Cannotread	50 (32.05)	39 (38.61)	89 (34.63)
Can read parts of sentence	70 (44.87)	35 (34.65)	105 (40.86)
Can readwhole sentence	36 (23.08)	27 (26.73)	63 (24.51)

Table 1: Characteristics of antenatal care study population ½.

Table 2: Characteristics of antenatal care study population 2/2.

Antenatal care	Urbain (n=156) (%)	Rural (n=101) (%)	Total (n=257) (%)
Employed			
No	136 (87.18)	97 (96.04)	233 (90.66)
Yes	20 (12.82)	4 (3.96)	24 (9.34)
Travel time to facility, min			
<15	55 (35.26)	24 (23.76)	79 (30.74)
15-30	55 (35.26)	29 (28.71)	84 (32.68)
30-60	40 (25.64)	29 (28.71)	69 (26.85)
>60	6 (3.85)	19 (18.81)	25 (9.73)
Parity	2.76 ± 1.10	2.68 ± 1.36	$2.73 \pm 1,21$
1	24 (15.38)	19 (18.81)	43 (16.73)
2-4	124 (80)	73 (72)	197 (76)
\geq 5	8 (5.13)	9 (8.91)	17 (6.6)

Postpartum care	Urbain (n=156) (%)	Rural (n=97) (%)	Total (n=253) (%)
Maternalage, y	29.78 ± 6.00	29.77 ± 6.23	29.77 ± 6.08
<20	3 (2)	2 (2)	5 (2)
20- 34	101 (65)	61 (63)	162 (64)
≥35	52 (33)	34 (35)	86 (34)
Marital status			
Has partner	156 (100)	95 (97.94)	251 (99.21)
Not partner	0 (0.00)	2 (2.06)	2 (2)
Education			
Primary or less	104 (66.67)	81 (74.25)	185 (73.13)
Secondary	43 (27.56)	14 (14.43)	57 (22.53)
Higher	9 (5.77)	2 (2.06)	11 (4.35)
Literacy			
Cannotread	50 (32.05)	50 (51.55)	100 (39.53)
Can read parts of sentence	72 (46.15)	29 (29.90)	101 (39.92)
Can readwhole sentence	34 (21.79)	18 (18.56)	52 (20.55)
Employed			
No	142 (91.03)	97 (100)	239 (94.47)
Yes	14 (8,97)	4 (3.96)	14 (5.53)
Travel time to facility, min			
<15	61 (39.10)	30 (30.93)	91 (35.97)
15-30	52 (33.33)	29 (29.90)	81 (32.02)
30- 60	36 (23.08)	23 (23.71)	59 (23.32)
>60	6 (4.49)	15 (15.46)	22 (8.70)
Parity	2.76 ± 1.10	2.68 ± 1.36	$2.73 \pm 1,21$
1	22 (14.10)	14 (14.43)	36 (14.23)
2-4	127 (81.41)	73 (75.25)	200 (76)
≥ 5	7 (4.48)	10 (10.30)	17 (6.71)

Table 3: Characteristics of the postpartum care study population.

Table 4: Prevalence of obesity, number, and leading conditions identified during antenatal and postpartum care visits.

	Urbain	Rural	Total
Antenatal care	(n=156)	(n=101)	(n=257)
Satisfaction sexuelle			
Non	64 (41.03)	62 (61.39)	126 (49.03)
Oui	92 (58.97)	39 (38.61)	131 (50.97)
Raisons de l'insatisfactionsexuelle			
Problèmelié à l'intérêt pour le sexe	83 (53.20)	43 (42.57)	126 (49.03)
Problèmelié à la diminution de la	56 (35.89)	22 (21.78)	78 (30.35)
sensation génitale			
Problème de lubrificationvaginale	3 (1.92)	1 (0.99)	4 (1.55)
Problèmed'orgasme	49 (31.41)	19 (18.81)	68 (26.45)
Dyspareunie	68 (43.58)	13 (12.87)	81 (31.51)
Consultation post-natale	(n=156)	(n=97)	(n=253)
Satisfaction sexuelle			
Non	138 (88.46)	77 (79.38)	215 (84.98)
Oui	18 (11.54)	20 (20.62)	38 (15.02)
Raisons de l'insatisfactionsexuelle			
Problèmelié à l'intérêt pour le sexe	139 (89.10)	76 (78.35)	215 (84.98)
Problèmelié à la diminution de la	17 (10.89)	26 (26.80)	43 (16.73)
sensation génitale			

Problème de lubrificationvaginale	0 (-)	2 (2.06)	2 (0,79)
Problèmed'orgasme	14 (8.97)	18 (18.55)	32 (12.64)
Dyspareunie	43 (27.56)	24 (24.74)	67 (26.48)

The results of the present survey showed that the majority of the women interviewed suffered from sexual dissatisfaction 49.03% (n=126) in PNC and 84.98% (n=215) in PoNC. This problem was more pronounced among PNC women and especially among PoNC women in urban areas (88.46%, n=138). The most frequently mentioned reasons for sexual issatisfaction were problems related to interest in sex (49.03%), dyspareunia (31.51%) and problems related to decreased genital sensation (30.35%).

Discussion

The results of our study corroborate those of two other studies [24, 25], on sexuality during pregnancy and postpartum. The first involved 570 pregnant women, interviewed at T1 (Fifth month of pregnancy), T2 (at 1 month postpartum), T3 (at 4 months postpartum) and T4 (at 12 months postpartum), and showed that at T1 and T2, the majority of women showed significantly less sexual activity and less sexual satisfaction. The second longitudinal cohort study just published in 2018 of 832 women prenatally and postpartum confirms this evidence. Indeed, nearly half of the women (46.3%) reported a lack of interest in sexual activity, 43% experienced a lack of vaginal lubrication, and 37.5% of the women included had dyspareunia six months after birth. The authors of both studies, suggest that practitioners provide family-centered maternity care, they should counsel couples on typical patterns of sexuality during pregnancy and postpartum, and on usual patterns during breastfeeding. Accurate information can help couples feel more comfortable during the transition periods before and after delivery. A discussion of expected changes in sexuality should be routinely introduced during prenatal care.

Strengths and limitations of the study

Strengths of the study

Our study is the first in North Africa to test the tools for measuring less severe morbidity proposed by the WHO [1]. It is the third in Morocco to deal with the subject of maternal morbidity and the first to deal with the measurement of less severe maternal morbidity in Morocco, especially to measure sexuality during pregnancy and postpartum.

Limitations of the study

Time constraints also limited us from making associations between certain variables and from integrating other populations such as husbands and family, associations, and other partners. Another limitation was the coordination withprivatephysicians.

Conclusion

As the international community focuses on reducing maternal mortality, there is an urgent need to define and measure maternal morbidity. This is an investment that no one can ignore. All countries must now move beyond survival to establish integrated health services that maximize women's health, well-being, and potential throughout their lives [26]. This reflects the full value of women as members of families, communities, societies and economies. This study supports the added value of maternal morbidity measurement tools in general and particularly the measurement of women's sexual health during pregnancy and after childbirth to meet the need for information, and comprehensive and integrated management that is part of the continuum of care. Although women interviewed report a high level of satisfaction with the maternal morbidity tools, and despite growing support for these tools from health professionals, managers, and international partners, adoption can take time. Reasons include limited available resources, lack of time to complete the tools as proposed by WHO, and buy-in from all health professionals. Based on the results of this study, we have proposed to key stakeholders ways to improve maternal health, starting with a broader approach to maternal health that addresses contemporary challenges and the most common complications. This means going beyond traditional models of maternity care where women are in contact with health systems only during pregnancy until six weeks after delivery. The provision of maternal health services can have a broader reach throughout a woman's life cycle, including premarital care, longer-term health care, and better integration of existing health programs and services. Maternal health and communicable and non-communicable disease programs should be synergistic. The proposed recommendations, as well as the simplified form to be integrated into the pregnancy and postpartum surveillance form already in place at the primary health care facility level, will help to have factual and comprehensive data on maternal morbidity and therefore facilitate decision-making. Investing in maternal morbidity will not only

prevent maternal and neonatal deaths, but also contribute to the well-being of the mother and her newborn and thus achieve the objective of sustainable development 3 by 2030.

Abbreviations

PoNC (Postnatal consultation); PNC (Prenatal consultation); GD (General Doctor); PHCN (Primary health care Network); OMM (Measuring maternal morbidity), WHO (Word Health Organization).

Declarations

Ethics approval and consent to participate

The research protocol was approved by the Ethics Committee for Bimedical Research under the Faculty of Medicine and Pharmacy of Rabat. All study participants signed a consent form before the start of the study.

Consent for publication

You will find in attachments the consents for the publication of the two authors.

Availability of data and material

All the database and material used in this study are available. We confirm that all methods were performed in accordance with the relevant guidelines and regulations. If someone wants to request the data from this study, he can contact: hababahanane@gmail.com

Competing interests

All authors declare no competing interest.

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Authors' contributions

Hanane Hababa searched the literature, extracted data, synthesized data and developed the first draft of the manuscript; Bouchra Assarag carefully checked the manuscript; To provided essential methodological advice. The authors have read and approved the final manuscript.

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