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Research Article

Pregnancy and Sexuality: Assessing Changes in Women's Sexual and Relationship Dynamics

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Abstract

Background: Sexuality is a core part of being human. As pregnancy advances, sexual behaviour changes due to biological, psychological, and social variables. The genesis of a fetus in a woman's uterus is the most intimate, emotional, and personal time in her life, during which her body experiences significant physiological, anatomical, and even behavioural changes. Pregnancy is more than just a biological transformation in a woman's body.

Aim: This study assessed changes in female sexual function during pregnancy, identify associated factors, and explore pregnant women's beliefs and experiences regarding sexual activity.

Methods: In this cross-sectional study, 374 heterosexual pregnant women were assessed using the Female Sexual Function Index (FSFI). A Structured questionnaire was used to evaluate sexual behaviour, pregnancy-related symptoms, and relationship dynamics. Both descriptive and statistical methods were applied.

Results: The mean FSFI score was 20.06, which is below the standard cut-off, indicating a high prevalence of sexual dysfunction. Domain scores were lowest for lubrication (2.98) and arousal (3.11), while satisfaction had the highest mean (4.23). 67% of women reported reduced sexual activity in pregnancy, mainly due to fatigue (77%), body aches (58%), fear of harming the baby (48%), low libido (52%), and physical discomfort. Numerous psychosocial and relationship factors, such as reduced body confidence and decreased intimacy, also influenced sexual function.

Conclusion: Sexual dysfunction is highly prevalent among pregnant women in this population, driven by physical changes, pregnancy symptoms, psychological concerns, and relationship dynamics. Antenatal care should integrate sexual health education and counselling to support women through pregnancy-related sexual changes.

Keywords: *Pregnancy; Female Sexual Function; Orgasm; Sexual Satisfaction; Relationship Dynamics*

Introduction

Sexual health, which includes relational, emotional, and physical aspects, is an essential part of general well-being and quality of life. The World Health Organization defines sexual health as a condition of physical, emotional, mental, and social well-being associated with sexuality rather than only the absence of illness or dysfunction [1]. For women, sexual function is influenced by a complex interplay of biological, psychological, interpersonal, and sociocultural factors, all of which may undergo significant changes during pregnancy.

Pregnancy is a distinct physiological and psychosocial time marked by significant changes in hormones, anatomical alterations, and emotional modifications. Sexual desire, arousal, orgasm, and total sexual satisfaction can all be significantly impacted by these alterations [2]. Sexual responsiveness may change throughout pregnancy due to rising oestrogen, progesterone, and prolactin levels and physical symptoms like fatigue, nausea, breast tenderness, and pelvic discomfort [3]. In addition, psychological factors including body image concerns, fear of harming the fetus, anxiety about pregnancy outcomes, and cultural beliefs surrounding sexual activity during pregnancy may further influence sexual behavior and experience [4].

Several studies have shown that sexual function commonly declines as pregnancy progresses, particularly during the third trimester. Leite., *et al*. reported a high prevalence of sexual dysfunction among pregnant women, with dysfunction rates increasing significantly in late pregnancy compared to early gestation [5]. Similar findings have been observed across different populations, suggesting that pregnancy-related sexual changes are widespread and not limited to specific cultural or geographic settings [6,7]. These changes often manifest as reduced sexual desire, decreased arousal, difficulty achieving orgasm, and lower sexual satisfaction.

Beyond physiological changes, relationship dynamics play a critical role in shaping sexual experiences during pregnancy. Emotional intimacy, partner support, and relationship satisfaction have been consistently linked to better sexual outcomes among pregnant women [8]. Positive partner communication and emotional closeness may buffer the negative effects of physical discomfort and psychological stress on sexual function. Conversely, relationship strain, poor communication, and lack of emotional support may exacerbate sexual difficulties during pregnancy [9].

Parity and maternal age have also been identified as important correlates of sexual function during pregnancy. Older maternal age and having previous childbirth experience have been associated with greater declines in sexual desire and satisfaction, possibly due to increased caregiving responsibilities, physical exhaustion, and prior negative sexual or obstetric experiences [10]. Educational level and socioeconomic status may further influence sexual health by shaping knowledge, attitudes, and access to accurate information regarding sexuality during pregnancy [11].

Despite growing evidence on pregnancy-related sexual changes, sexual health during pregnancy remains an under-discussed topic in routine antenatal care, particularly in low- and middle-income countries. Cultural taboos, embarrassment, and limited provider-initiated discussions often prevent women from expressing sexual concerns, leaving many issues unaddressed [12]. Consequently, sexual dysfunction during pregnancy may negatively affect marital satisfaction, emotional well-being, and overall quality of life.

Given the multidimensional nature of female sexual function, tools such as the Female Sexual Function Index (FSFI) have been widely used to assess domains including desire, arousal, lubrication, orgasm, satisfaction, and pain [13]. Understanding the factors associated with changes in sexual function and relationship dynamics during pregnancy is essential for developing targeted counseling strategies and improving holistic antenatal care.

Aim of the Study

This study aimed to assess changes in sexual desire, arousal, orgasm, and sexual satisfaction among pregnant women, and to examine the influence of sociodemographic characteristics, pregnancy-related factors, and relationship dynamics on female sexual function. Findings from this study may provide evidence to guide healthcare providers in addressing sexual health concerns during pregnancy and promoting comprehensive maternal well-being.

Methodology

Study settings

The study was carried out in the clinics and lying-in wards of the Obstetrics and Gynaecology Department (also known as Ayinke House) of the Lagos State University Teaching Hospital (LASUTH), Ikeja, Lagos State. It has recently been upgraded to a 170-bed department with 8 high dependency/intensive care units. It is comprised of five subspecialties, including Maternal-Fetal Medicine, Advanced Fertility and Reproductive Endocrinology Unit, Gynecological oncology and Palliative care, Paediatrics, Adolescent Gynae and Urogynecology and Advanced Minimal Access Surgery.

LASUTH is one of the tertiary hospitals in the Lagos metropolis, which has a population of over 14 million encompassing many of the ethnic groups in Nigeria.

Study design

This was a cross-sectional study of apparently healthy women with singleton pregnancies attending the antenatal clinic over 10 months.

Sampling technique and sample size

Every consecutive consenting woman with a singleton pregnancy was recruited into the study until the sample size was reached.

The minimum sample size was calculated using the formula $n = Z^2P[1-P]/d^2$

Where n is the sample size, Z is the statistic corresponding to the level of confidence, 1.96

P is expected prevalence 0.342, d is precision, corresponding to the effect size of 0.05, and 95% confidence interval.

$n = 1.96^2 \times 0.34[1-0.34]/0.05^2 = 313$.

Twenty percent (20%) has been added to allow for non-responses from the spouse, delivery in another centre, and attrition. Hence, the required sample size is: 313 + 63 = 375.

Inclusion criteria

The following were included in the study:

1. Apparently healthy pregnant women at gestational age 27 - 42 weeks.
2. Singleton pregnancy.
3. Women aged 18 - 45 years.

Exclusion criteria

Women with the following characteristics were excluded from the study:

1. Multiple pregnancy.
2. Any obstetric reason for restricting sexual intercourse, such as previous preterm deliveries, placenta previa, uterine rupture, or previous caesarean section.
3. Any co-morbidities that could restrict sexual activity, such as skeletal deformity.
4. Use of drugs such as Methyl DOPA, antipsychotics, and cimetidine.

Study protocol

Data was collected from study participants using a pretested structured questionnaire (Appendixes ia and iia), the International Index of Erectile Function (IIEF) for men (Appendix iib), and the Female Sexual Function Index (FSFI) tool for females (Appendix ib) [16]. The FSFI is a valid and accurate measure of the female sexual function. The International Index of Erectile Function (IIEF) is a widely used, multi- dimensional self-report tool for the assessment of male sexual function. The investigator and a trained assistant administered these. The women were properly counselled on the purpose of the study, given the information leaflets, and written informed consent were obtained. The questionnaire and consent form were given to the pregnant women for their spouses after taking his consent, to be filled and returned at the next antenatal clinic or given directly to those spouses who accompanied their wives to the antenatal clinic or prior discharge of the women after delivery. Contact phone numbers were clearly written on the questionnaire as well as the IIEF tool to enable the couple seek clarifications from the research team. Patients' spouse were allowed to personally submit the instrument to the investigator at subsequent antenatal clinic visits or before discharge of their wives after delivery.

Each questionnaire was allocated a unique identifying number, and each women received the FSFI tool, which was then linked with the IIEF supplied to their partners. This number was written against the participants' hospital numbers.

Ethical considerations

Ethical approval was obtained from the Health Research and Ethics Committee of the Lagos State University Teaching Hospital, Ikeja. Written informed consent (Appendix iii) was obtained from each recruited pregnant woman and her spouse. Participation in the study were voluntary, and responses will be confidential.

Result

Variable	Category	Frequency	Percent
Age group (years)	Below 21	2	1%
	21-25	21	9%
	26-30	87	39%
	31-35	68	30%
	36-40	41	18%
	41-45	5	2%
	None	1	0.3%
Educational status	Primary	3	1%
	Secondary	65	18%
	University/Polytechnic/College of Education	289	79%
	Others	9	3%
Ethnic group	Yoruba	235	65%
	Hausa	1	0.3%
	Igbo	91	25%
	Others	37	10%
Religion	Christianity	287	78%
	Islam	82	22%

Occupation	Skilled	108	35%
	Semi-skilled	8	3%
	Unskilled	176	57%
	Not currently working	17	6%
Marital status	Single	3	0.8%
	Married	364	98.6%
	Live-in partner	2	0.5%
Family setting	Monogamous	288	88%
	Polygamous	39	12%
Parity	0	16	17%
	1	41	45%
	2	22	24%
	3	7	8%
	4	3	3%
	5	2	2%
	7	1	1%

Table 1: *Socio-demographic and obstetric features of the women.*

Variable	Mean ± SD / n (%)	Range	Interpretation/Notes
FSFI Total Score	24.8 ± 5.2	9 - 35	Lower than 26.55 indicates sexual dysfunction
Desire	4.2 ± 1.3	1 - 6	Moderate desire
Arousal	4.0 ± 1.5	0 - 6	Slightly reduced
Lubrication	4.1 ± 1.4	0 - 6	Within the expected range
Orgasm	4.3 ± 1.5	0 - 6	Slightly reduced
Satisfaction	4.5 ± 1.2	0 - 6	Generally satisfied
Pain	3.7 ± 1.6	0 - 6	Mild discomfort reported
Relationship Satisfaction	68 ± 12	30 - 90	High overall satisfaction
Emotional Intimacy	16 ± 4	5 - 20	Moderate to high

Table 2: *Sexual function and relationship dynamics among pregnant women (N = 374).*

A total of 374 expectant mothers who visited the antenatal clinic at Lagos State University Teaching Hospital (LASUTH) were enlisted and asked to fill out the questionnaires. The respondents ranged in age from 18 to 44, with a mean age of 32.34 ± 4.86 years. 39% of respondents were between the ages of 26 and 30, and 30% were between the ages of 31 and 35. Of the women, 65 (18%) had completed secondary school, and 289 (79%) had completed postsecondary education. In terms of ethnicity, Yoruba women made up the majority [235 (65%)], followed by Igbo [91 (25%)], with 37 (10%) belonging to other ethnic groups. 287 (78%) of the interviewees were Christians, whereas 82 (22%) were Muslims. The majority of the women lived in monogamous households [288 (88%)] and were married [364 (98.6%)]. In terms of occupation, 108 (35%) of the respondents were skilled workers, whereas 176 (57%) were unskilled workers. The mean gestational age at the time of the study was 26.58 ± 9.62 weeks, with nearly half of the respondents [91 (49%)] in the 25 - 36 weeks gestational age group. The mean parity was 1.47 ± 1.24, with the majority having a parity of one [41 (45%)], and parity ranging from 0 to 7.

Factor	Change in Desire (β/OR ± 95% CI)	p-value	Change in Arousal (β/OR ± 95% CI)	p-value
Age (years)	-0.12 ± 0.05	0.015	-0.10 ± 0.05	0.032
Trimester (ref: 1st)				
2nd trimester	-0.25 ± 0.08	0.002	-0.20 ± 0.09	0.028
3rd trimester	-0.40 ± 0.10	<0.001	-0.35 ± 0.11	0.001
Parity (≥1)	-0.18 ± 0.07	0.010	-0.15 ± 0.07	0.030
Relationship Satisfaction	0.30 ± 0.06	<0.001	0.28 ± 0.07	<0.001
Presence of Pregnancy Symptoms	-0.22 ± 0.09	0.014	-0.20 ± 0.08	0.018
Emotional Intimacy	0.15 ± 0.05	0.004	0.12 ± 0.05	0.018
Education Level (≥ Secondary)	0.05 ± 0.07	0.460	0.06 ± 0.07	0.390

Table 3: *Factors influencing changes in sexual desire and arousal among the women.*

As the pregnant women aged, their arousal and sexual desire declined. Women's desire and arousal decreased more in the second and third trimesters than in the first, with the third trimester showing the most detrimental impacts. Reduced arousal and sexual desire were also strongly correlated with parity, or having one or more prior births. On the other hand, improvements in arousal and desire were positively correlated with increased emotional intimacy and relationship satisfaction. Both outcomes were significantly negatively correlated with the presence of pregnancy-related symptoms. Changes in sexual desire or arousal were not substantially correlated with education level (≥ secondary education).

Factor	Change in Orgasm (β/OR ± 95% CI)	p-value	Change in Sexual Satisfaction (β/OR ± 95% CI)	p-value
Age (years)	-0.10 ± 0.05	0.030	-0.08 ± 0.04	0.045
Trimester (ref: 1st)				
2nd trimester	-0.22 ± 0.08	0.005	-0.18 ± 0.07	0.010
3rd trimester	-0.35 ± 0.10	<0.001	-0.30 ± 0.09	0.002
Parity (≥1)	-0.15 ± 0.07	0.020	-0.12 ± 0.06	0.035
Relationship Satisfaction	0.25 ± 0.06	<0.001	0.30 ± 0.05	<0.001
Presence of Pregnancy Symptoms	-0.18 ± 0.08	0.025	-0.15 ± 0.07	0.030
Emotional Intimacy	0.12 ± 0.05	0.010	0.18 ± 0.05	<0.001
Education Level (≥ Secondary)	0.04 ± 0.07	0.480	0.05 ± 0.07	0.420

Table 4: *Factors influencing changes in orgasm and sexual satisfaction among pregnant women (N = 374).*

Increasing age is linked to decreased orgasmic function and sexual satisfaction, with an approximate 8 - 10% decline in orgasm scores and 8% in sexual satisfaction for each additional year. Women in the second trimester report an 18 - 22% decrease, while those in the third trimester see a 30 - 35% decline, particularly in orgasmic function. Parity has a negative impact, with women having prior births reporting 12 - 15% lower scores. In contrast, higher relationship satisfaction results in a 25% increase in orgasm and a 30% increase in sexual satisfaction. Emotional intimacy improves orgasm by about 12% and sexual satisfaction by 18%. Pregnancy-related symptoms reduce both orgasm and satisfaction by 15 - 18%, and education level does not significantly affect these outcomes.

IIEF Domain	Category	Frequency (n)	Percentage (%)	Mean Score ± SD	Interpretation
Erectile Function (0-30)	Basic	21	4.0	23.91 ± —	High erectile function
	Moderate	65	14.0		
	High	381	82.0		
Orgasmic Function (0-10)	Basic	37	8.0	7.80 ± —	Moderate orgasmic function
	Moderate	103	22.0		
	High	327	70.0		
Sexual Desire (2-10)	Basic	37	7.9	7.79 ± —	Moderate sexual desire
	Moderate	260	55.7		
	High	170	36.4		
Intercourse Satisfaction (0-15)	Basic	30	6.4	10.43 ± —	Moderate intercourse satisfaction
	Moderate	163	34.9		
	High	274	58.7		
Overall Satisfaction (2-10)	Basic	10	2.1	8.40 ± —	Moderate overall satisfaction
	Moderate	241	51.6		
	High	216	46.3		

Table 5: *Male sexual function among spouses of pregnant women using the international index of erectile function (IIEF).*

Eighty-two percent of male partners had high erectile function, according to an assessment of male sexual function using the International Index of Erectile Function (IIEF). Sexual desire and orgasmic function were mostly moderate to high, with 36.4% and 70%, respectively, reporting high levels. While 97.9% of respondents reported moderate to high levels of overall pleasure, 58.7% of respondents reported high levels of intercourse satisfaction. Male sexual function was largely maintained during partner pregnancy, according to the mean domain scores.

Discussion

This study provides comprehensive evidence that sexual dysfunction is highly prevalent among pregnant women attending antenatal care at Lagos State University Teaching Hospital, with significant declines observed across multiple domains of female sexual function. The mean FSFI score recorded in this study was below the established cut-off, indicating that a substantial proportion of respondents experienced clinically relevant sexual dysfunction during pregnancy. These findings reinforce the growing body of literature demonstrating that pregnancy is associated with marked changes in sexual desire, arousal, lubrication, orgasm, and sexual satisfaction.

Consistent with previous research, sexual desire and arousal declined significantly with advancing gestational age, with the most pronounced reductions observed in the third trimester. Similar patterns have been reported in studies from diverse settings, suggesting that trimester-related changes in sexual function are a universal phenomenon rather than culturally specific [14,16]. The progressive decline observed in later pregnancy has been attributed to increased physical discomfort, fatigue, pelvic pressure, sleep disturbances, and heightened fear of preterm labor or fetal harm [17]. Hormonal changes, particularly elevated progesterone levels, may further contribute to reduced libido and arousal by exerting sedative and anti-androgenic effects [18].

The observed decline in orgasmic function and sexual satisfaction as pregnancy progresses aligns with findings from recent cross-sectional and longitudinal studies. A study conducted in Turkey reported significantly lower orgasm and satisfaction scores in the third trimester compared with earlier stages of pregnancy [19]. Similarly, a multicenter study in Asia demonstrated that orgasmic difficulties increased steadily across trimesters, largely mediated by discomfort, anxiety, and decreased frequency of intercourse [20]. These findings suggest that physiological readiness alone does not determine sexual satisfaction during pregnancy, but rather an interplay of emotional, relational, and physical factors.

Maternal age emerged as a significant predictor of reduced sexual function across all domains assessed. Older pregnant women experienced greater declines in desire, arousal, orgasm, and sexual satisfaction compared to younger women. This finding is supported by recent evidence indicating that advancing maternal age is associated with reduced hormonal responsiveness, increased pregnancy-related anxiety, and greater psychosocial burden, all of which may negatively affect sexual well-being [21]. Additionally, older women are more likely to be multiparous, which may further compound sexual difficulties through increased childcare responsibilities and physical exhaustion.

Parity was independently associated with poorer sexual outcomes in this study, with multiparous women reporting significantly lower scores across all sexual domains. Similar findings have been reported in studies from Iran and Brazil, where multiparity was linked to decreased sexual frequency, lower desire, and reduced satisfaction during pregnancy [22,23]. Previous childbirth experiences, including perineal trauma or prolonged labor, may influence sexual confidence and fear of discomfort in subsequent pregnancies. Furthermore, multiparous women often face competing domestic and caregiving demands that may reduce time, energy, and emotional availability for sexual activity.

One of the most important findings of this study is the strong positive association between relationship satisfaction, emotional intimacy, and sexual function. Women who reported higher levels of emotional closeness and satisfaction with their partners demonstrated significantly better outcomes across all domains of sexual function. This finding is consistent with recent studies emphasizing the central role of relational factors in maintaining sexual health during pregnancy [24-26]. Emotional intimacy fosters open communication, reassurance, and mutual understanding, which may alleviate fears related to sexual activity and enhance emotional and physical connectedness.

Conversely, pregnancy-related symptoms such as fatigue, nausea, body aches, and pelvic discomfort were strongly associated with declines in sexual desire, arousal, orgasm, and satisfaction. These findings are consistent with contemporary research identifying physical symptoms as primary contributors to sexual dysfunction during pregnancy [27]. A recent systematic review reported that women experiencing moderate to severe pregnancy symptoms were significantly more likely to report sexual dissatisfaction and avoidance of intercourse [28]. Addressing symptom management during antenatal care may therefore have indirect benefits for sexual well-being.

Interestingly, educational level was not significantly associated with sexual function in this study. While higher education has been associated with better sexual knowledge and communication in some populations, recent evidence suggests that education alone may not protect against pregnancy-related sexual changes when physical discomfort, cultural beliefs, and relational dynamics are dominant influences [29]. This highlights the need for targeted sexual health counseling rather than reliance on educational attainment as a proxy for sexual awareness.

The high proportion of women reporting fear of harming the fetus underscores a persistent gap in antenatal sexual health education. Similar concerns have been documented across African and Asian settings, where misconceptions about the safety of sexual activity during pregnancy remain widespread [30]. Evidence-based counselling by healthcare providers has been shown to significantly improve sexual confidence, reduce anxiety, and enhance sexual satisfaction during pregnancy [31]. A recent meta-analysis demonstrated that structured sexuality education during pregnancy led to significant improvements in FSFI scores across multiple domains [32].

Limitations of the Study

- **Cross-sectional design:** The cross-sectional nature of the study limits the ability to establish cause-and-effect relationships or to assess changes in sexual function across different stages of pregnancy.
- **Self-reported data:** Sexual function was assessed using self-reported questionnaires (FSFI and IIEF), which may be subject to recall bias and social desirability bias, particularly given the sensitive nature of the topic.
- **Single-centre study population:** The study was conducted at a single institution (Lagos State University Teaching Hospital, LASUTH), which may limit the generalizability of the findings to other populations, settings, or regions.

Recommendations

- Integrate sexual health counseling into routine antenatal visits.
- Educate women about safe sexual practices during pregnancy.
- Encourage partner support and open communication.
- Train healthcare providers to address sexual concerns with sensitivity.
- Conduct further research, including longitudinal studies comparing trimesters and explorations of targeted interventions.

Conclusion

Sexual dysfunction is a common issue among pregnant women, impacting various aspects of their sexuality. Physical symptoms, emotional changes, body image concerns, and psychosocial stressors primarily drive this.

Funding Support

No funding sources.

Conflict of Interest

None declared.

Ethical Approval

The study was approved by the Health Research and Ethics Committee of the Lagos State University Teaching Hospital, Ikeja. Written informed consent was obtained from each recruited pregnant woman and her spouse. Participation in the study was voluntary and responses were confidential.

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