

The determination of health practices and the sexual quality of life during the prenatal period

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Abstract

Objective: The aim of this study is to determine health practices and sexual quality of life of women during the prenatal period.

Methods: The study was conducted with 312 pregnant women without threatened preterm labor who admitted to the clinic of obstetrics and gynecology in a state hospital in the Mediterranean region between June and September 2019. The data were collected by the Descriptive Features Form, the Health Practices in Pregnancy Questionnaire and the Sexual Quality of Life-Female Questionnaire.

Results: It was found in the study that 93.6% of the pregnant women were married, 69.2% of them had planned pregnancy and 54.7% of them underwent prenatal care for more than 4 times. The mean scores of the Health Practices in Pregnancy Questionnaire and the Sexual Quality of Life-Female Questionnaire were 87.55±5.49 and 63.88±5.95, respectively. It was observed that the health practices of the pregnant women who were younger and underwent prenatal care for more than 4 times were better. Also, it was found that the pregnant women in the 2nd and 3rd trimesters had higher scores than those in the 1st trimester.

Conclusion: The health practice levels of the pregnant women are low while the levels of sexual quality of life are moderate in the study.

Keywords: Prenatal period, health practices, sexual life, nurse.

Özet: Prenatal dönemde sağlık uygulamaları ve cinsel yaşam kalitesinin belirlenmesi

Amaç: Bu çalışmanın amacı prenatal dönemdeki kadınların sağlık uygulamaları ve cinsel yaşam kalitesinin belirlenmesidir.

Yöntem: Haziran-Eylül 2019 arasında Akdeniz bölgesindeki bir devlet hastanesinde kadın hastalıkları ve doğum polikliniğine başvuran, erken doğum tehdidi bulunmayan 312 gebe kadınla yürütüldü. Veri toplamada Tanıtıcı Özellikler Formu, Gebelikte Sağlık Uygulamaları Ölçeği ve Cinsel Yaşam Kalitesi Ölçeği-Kadın Formu uygulandı.

Bulgular: Araştırmada gebelerin %93.6'sının evli olduğu, %69.2'sinin gebeliğinin planlı olduğu ve %54.7'sinin 4 defadan fazla doğum öncesi bakım aldığı saptandı. Gebelikte Sağlık Uygulamaları Ölçeği puan ortalaması 87.55±5.49, Cinsel Yaşam Kalitesi Ölçeği-Kadın Formu puan ortalaması 63.88±5.95 idi. Genç yaşta olan ve 4'ün üzerinde doğum öncesi bakım alan gebelerin sağlık uygulamalarının daha iyi olduğu görüldü. Ayrıca 2. ve 3. trimesterdeki gebelerin, 1. trimesterdekilere göre daha yüksek puan aldığı saptandı.

Sonuç: Çalışmada gebelerin sağlık uygulamaları düşük, cinsel yaşam kalitesi ise orta düzeydedir.

Anahtar sözcükler: Prenatal dönem, sağlık uygulamaları, cinsel yaşam, hemşire.

Introduction

Pregnancy is a period in which women undergo many physiological changes and prioritized care should be provided. A great part of the reasons deteriorating the maternal health is associated with deviation of perinatal and postnatal periods from the normal.^[1]

Approximately 3/4 of the maternal deaths is caused by the preventable gestational reasons.^[1,2] In this case, most of these deaths can be prevented with a good prenatal care. Women should be informed about both the bodi-

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ly changes during pregnancy and prenatal tests and examinations, and they should adopt health practices during prenatal care. Nurses provide training and consultancy to pregnant women and their spouses and help them to have a healthy baby by providing accurate and complete information to couples about the health practices that may affect pregnancy and labor.^[1] Prenatal health practices can be defined as the activities affecting gestational outcome and involving the health of pregnant woman, fetus and newborn. These practices include non-smoking, undergoing dental care, balanced diet and proper weight gain, not consuming alcohol and illegal substances, having training about pregnancy and labor, regular exercising, and avoiding risky sexual behaviors or exposure to other infection agents.^[3]

During prenatal period, sexual desires and sexual intercourse frequency vary depending on the gestational period. Nausea, vomiting, fatigue, sleeping orientation, bodily changes, breast pain, tenderness and frequent urination usually lead to the reduced sex drive in the first trimester. The complaints start to decrease in the second trimester, and pelvic congestion increases. The sexual desires increase in mother who adapts to pregnancy. The growing fetus and physical complaints in the last trimester may cause sex drive to reduce. As the labor date approaches, the fear of having pain during labor, infection fear and the perceptions about experiencing abnormal conditions during sexual intercourse may have an impact on the sexual life of the couples.^[1] The reasons such as the sex perception of the couples, cultural norms, lack of information, the idea of parenthood, negative thoughts about sex and the thought that baby may get hurt can have a negative impact on the sexual life during pregnancy.^[4] Unlike the myths, fetus does not suffer from the sexual intercourse if the hygienic conditions are good and there are no conditions such as placenta previa or premature rupture of membranes. Muroid plaque which provides protection against infections and amniotic sac which acts like an air bag prevents fetal trauma. In addition, the increased blood flow during sexual intercourse and elevation in the hormones during and after the orgasm affect fetal health positively.^[5,6] Nurses should inform couples during the prenatal follow-ups on their concerns about sex and encourage them to discuss it. They should encourage women to share their concerns with their spouses by initiating a safe communication, and tell them that sexual inter-

course is not harmful for fetus. It should be explained to the couples that sexuality is not limited with the sexual intercourse, but they may also express their intimacy to each other by caressing, hugging, and kissing.^[1]

This study was planned to determine the health practices and sexual quality of life of women during prenatal period.

Methods

The study type

This is a descriptive and cross-sectional study.

Study population and sample

The study population comprised of all pregnant women without threatened preterm labor who admitted to the outpatient clinic of obstetrics and gynecology in a state hospital in the Mediterranean region. The study sample comprised of 312 pregnant women without threatened preterm labor who admitted to the outpatient clinic of obstetrics and gynecology between June and September 2019 and accepted to participate in the study. The pregnant women who accepted to participate in the study were included in the research by the improbable randomized sampling method.

Data collection

In order to collect the data of the pregnant women, the descriptive features form, “The Health Practices in Pregnancy Questionnaire” and “The Sexual Quality of Life-Female Questionnaire” were used. The pregnant women who were literate and had no problem with Turkish language were included in the study while the pregnant women with the threatened preterm labor were excluded.

Descriptive Features Form

The form created by the researchers includes 15 questions collecting the socio-demographic and obstetric characteristics of the pregnant women.

The Health Practices in Pregnancy Questionnaire (HPPQ)

It was developed by Lindgren^[3] in 2005, and its Turkish validity and reliability analysis was done by Er^[7] in 2006. Turkish validity and reliability form of the questionnaire has 33 items. The items between 1 and 16 comprise of responses in the 5-point Likert

type varying between “never, rarely, occasionally, frequently, always”. For the questions between items 17 and 33, appropriate answers scored between 1 and 5 were provided. The total score is calculated by the sum of all items. The score range of the questionnaire is 33–165. Higher scores indicate that health practices are good. Cronbach’s alpha coefficient was found 0.74 in the validity analysis of the questionnaire.^[7] In our study, Cronbach’s alpha coefficient was 0.71.

The Sexual Quality of Life–Female Questionnaire (SQOL–F)

It was developed by Symonds et al.^[8] in 2005 for the evaluation of sexual quality of life. Turkish validity and reliability analysis of the questionnaire was done by Tuğut and Gölbaşı in 2010. It was reported that the reliability coefficient of the total item score of SQOL–F was $r=0.32$ – 0.67 , and Cronbach’s alpha coefficient was 0.83. Tuğut and Gölbaşı^[9] used a scoring system between 1 and 6 in their study. In this scoring system, the minimum score is 18 and the highest score is 108. In order to convert the questionnaire score into 100, the following formula is used: $(\text{raw score obtained in the questionnaire} - 18) \times 100/90$. As the score obtained in the questionnaire increases, the sexual quality of life increases as well. In our study, Cronbach’s alpha coefficient was 0.77.

Statistical analysis

The data of the study were analyzed by SPSS 20.0 (SPSS Inc., Chicago, IL, USA) and percentage, frequency, one-way ANOVA and independent groups t-test were used. The significance level was considered $p<0.05$.

The ethics aspect of the study

The ethical approval of the study was obtained from the Non-Invasive Clinical Researches Ethics Committee of İstanbul Medipol University (Ethics Committee approval no. 10840098-604.01.01-E.19312). The study was conducted in accordance with the Declaration of Helsinki, and written and verbal consents of the cases were received.

Results

In our study, we found that 50.3% of the cases were between 32 and 38 years old, the educational level of 55.1% of them were primary school or below, and 52.6% of them were living in the county. Of the pregnant women, 93.6% were married, and 56.4% had a moderate

level of income. It was found that 69.2% of the cases were planned pregnancies, half of the pregnant women were in the 2nd trimester and 54.7% of them underwent prenatal care for more than 4 times (**Table 1**).

The mean scores of HPPQ and SQOL–F are given in the **Table 2**, which are 87.55 ± 5.49 and 63.88 ± 5.95 , respectively.

Table 1. The distribution of the pregnant women according to the descriptive features.

Descriptive features (N=312)		n	%
Age	18–24	70	22.4
	25–31	66	21.2
	32–38	157	50.3
	39 and above	19	6.1
Education level	Primary education and below	172	55.1
	Secondary education	106	34.0
	University and above	34	10.9
Place of residence	City	55	17.6
	County	164	52.6
	Village	93	29.8
Marital status	Married	292	93.6
	Single	20	6.4
Income level	High	68	21.8
	Moderate	176	56.4
	Low	68	21.8
Pregnancy type	Planned pregnancy	216	69.2
	Unplanned pregnancy	96	30.8
Month of gestation	1, 2, 3 months	48	15.4
	4, 5, 6 months	156	50.0
	7, 8, 9 months	108	34.6
Number of pregnancy	1	105	33.7
	2	101	32.4
	3	82	26.3
	4 and more	24	7.7
Number of children	None	105	33.7
	1–2	183	58.7
	3–4	24	7.6
Number of prenatal care	Less than 4 times	84	27.0
	4 times	57	18.3
	More than 4 times	171	54.7
The history of sexually transmitted disease	Yes	18	5.8
	No	294	94.2

Table 2. The mean scores of the Health Practices in Pregnancy Questionnaire (HPPQ) and the Sexual Quality of Life–Female Questionnaire (SQOL–F).

Questionnaires	Minimum	Maximum	Mean	SD
HPPQ	74.00	116.00	87.55	5.49
SQOL–F	43.33	80.00	63.88	5.95

Table 3. The comparison of the scores of the Health Practices in Pregnancy Questionnaire and the Sexual Quality of Life–Female Questionnaire according to the descriptive features of the pregnant women.

Descriptive features (N=312)				HPPQ Mean±SD	SQOL–F Mean±SD
Age*	18–24	a	70	90.20±7.01	63.96±5.51
	25–31	b	66	87.74±5.03	62.86±6.64
	32–38	c	157	88.14±5.29	64.11±6.02
	39 and above	d	19	88.00±5.28	65.20±4.09
Test statistics				2.703	1.044
p-value				0.046	0.373
Significant difference				a>b,c,d	
Education level*	Primary education and below		172	87.11±5.10	63.35±5.60
	Secondary education		106	88.14±6.20	64.31±6.57
	University and above		34	87.91±4.93	65.22±5.50
Test statistics				1.122	1.841
p-value				0.295	0.190
Place of residence*	City		55	87.21±5.56	64.30±5.57
	County		164	87.81±5.12	63.81±5.75
	Village		93	87.27±6.02	63.76±6.55
Test statistics				0.406	0.165
p-value				0.667	0.848
Marital status†	Married		292	87.55±5.42	75.46±5.47
	Single		20	87.45±6.53	76.00±3.44
Test statistics				2.701	4.071
p-value				0.932	0.665
Income level*	High		68	88.01±5.56	64.44±5.84
	Moderate		176	88.68±5.92	63.68±5.97
	Low		68	88.55±5.54	63.83±6.08
Test statistics				0.336	0.397
p-value				0.715	0.363
Pregnancy type†	Planned pregnancy		216	87.54±5.59	75.33±5.42
	Unplanned pregnancy		96	87.56±5.28	75.86±5.22
Test statistics				0.022	1.659
p-value				0.981	0.420
Month of gestation*	1, 2, 3 months	a	48	88.22±5.53	73.68±4.89
	4, 5, 6 months	b	156	87.22±5.50	75.97±5.34
	7, 8, 9 months	c	108	87.72±5.47	75.61±5.46
Test statistics				0.693	3.426
p-value				0.501	0.034
Significant difference				b,c>a	
Number of pregnancy*	1		105	88.51±5.87	63.70±5.92
	2		101	86.52±5.07	63.55±6.21
	3		82	87.43±5.46	64.21±6.16
	4 and more		24	88.04±5.08	64.95±4.17
Test statistics				2.358	0.475
p-value				0.072	0.700
Number of children*	None		105	88.51±5.87	63.70±5.92
	1–2		183	86.93±5.25	63.84±6.18
	3–4		24	88.04±5.08	64.95±4.17
Test statistics				2.900	0.436
p-value				0.057	0.647
Number of prenatal care*	Less than 4 times	a	84	88.81±5.03	77.03±5.89
	4 times	b	57	88.52±4.08	76.24±5.94
	More than 4 times	c	171	91.54±6.20	76.00±5.53
Test statistics				10.298	1.685
p-value				0.000	0.153
Significant difference				c>a,b	
The history of sexually transmitted disease†	Evet		18	87.88±3.34	77.55±3.88
	Hayır		294	88.55±5.87	75.37±5.42
Test statistics				5.045	1.988
p-value				0.637	0.093

*One-way ANOVA, †Independent groups t-test. HPPQ: The Health Practices in Pregnancy Questionnaire; SQOL–F: The Sexual Quality of Life–Female Questionnaire.

In the **Table 3**, HPPQ and SQOL–F scores were compared according to the descriptive features of the pregnant women. Accordingly, mean HPPQ scores of the pregnant women in the age group of 18–24 are higher than the other age groups in a statistically significant way. Also, mean HPPQ scores of the pregnant women who underwent prenatal care for more than 4 times are higher than the other groups in a statistically significant way. Mean SQOL–F scores of the pregnant women who are in the 2nd and 3rd trimesters are higher than those in the 1st trimester which is statistically significant.

Discussion

In our study, the mean score of the Health Practices in Pregnancy Questionnaire (HPPQ) was 87.55 ± 5.49 . The mean HPPQ score was 114.43 ± 17.90 in the study of Sis Çelik and Aksoy,^[10] 111.76 ± 18.53 in the study of Özcan and Kızılkaya Beji,^[11] and 112.64 ± 13.87 in the study of Çapık et al.^[12] The lowest score that a respondent can get is 33 while the highest score is 165 in HPPQ. Accordingly, the level of health practices of the pregnant women is low in our study.

We found in our study that the mean HPPQ scores of the pregnant women in the age group of 18–24 were higher than the other age groups. Similarly, Özcan and Kızılkaya Beji found in their study^[11] that the mean HPPQ scores of the pregnant women in the age group of 15–24 were higher than those of the pregnant women with advanced ages. In the study of Sis Çelik and Aksoy,^[10] the authors found that the mean HPPQ scores of the pregnant women in the age group of 25–34 were higher than those in the other age groups. They believed that young age group obtained information by looking up information about health practices in pregnancy.

Medical checks are the necessary practices from the beginning of pregnancy up to the labor for mother and newborn health. The indication of the sufficiency of prenatal care is the number of prenatal visits.^[11,13] In our study, the mean HPPQ scores of the pregnant women who underwent prenatal care for more than 4 times were higher than the mean scores of those who underwent prenatal care for 4 times or less. Sis Çelik and Aksoy^[10] found in their study that the mean HPPQ scores of the pregnant women who underwent prenatal care for more than 4 times were significantly higher.

In our study, the mean SQOL–F score of the pregnant women was 63.88 ± 5.95 . In their study, Kırıkkale^[14]

found that the mean SQOL–F score of the pregnant women was 81.59 ± 15.95 . We found that the mean SQOL–F scores reported in the study of Kırıkkale and two other international studies were higher than the mean score of our study.^[9,15] Considering that the maximum score one can get in SQOL–F is 100, the score of the sexual quality of life of the pregnant women included in our study is 63.88 ± 5.95 , which is a moderate level.

Hormonal, anatomical and physiological changes may appear as the factors affecting the sexual quality of life in pregnancy negatively. In accordance with these factors, sexual responses may change compared to the pregnancy period.^[14] Kodaz found in their study that the pregnant women had problems in their sexual lives due to the physical discomforts and physical changes in half of the cases, nausea and vomiting in nearly half of the cases, galactorrhea and tenderness in one third of the cases, religious or cultural thoughts in one seventh of the cases and negative reactions of the spouses of the pregnant women, and the frequency of sexual intercourse decreased during pregnancy and therefore their sexual quality of life was affected negatively.^[16] Similarly, Galazka et al. reported that the frequency of sexual intercourse and sexual activities decreased during pregnancy the lack of sexual drive increased, and that primiparous pregnant women experienced changes in sexual arousal, vaginal lubrication and orgasm especially in the third trimester.^[17] Another study reported sexual desire disorder in 88.9% of the pregnant women, sexual arousal disorder in 86.9% of them, vaginal dryness in 42.8% of them, orgasm disorder in 69.6% of them and sexual satisfaction disorder in 48% of them.^[18] In our study, we found that the mean SQOL–F scores of the pregnant women who were in the 1st trimester were significantly lower than the mean SQOL–F scores of the pregnant women who were in the 2nd and 3rd trimesters.

Conclusion

In our study, the level of health practices in pregnancy is low and the level of sexual quality of life is moderate. Also, the health practices of the pregnant women who are young and underwent prenatal care for more than 4 times are better. In terms the sexual quality of life, the scores of the pregnant women in the 2nd and 3rd trimesters are higher than the scores of those in the 1st trimester.

Conflicts of Interest: No conflicts declared.

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