

EVALUATING FEMALE SEXUAL FUNCTION 5 TO 12 MONTHS AFTER FIRST PREGNANCY

Hypothesis / aims of study

The gestation process triggers a series of physical, hormonal, psychological, social and cultural adaptations in the life of women, who may also be influenced by mode of delivery, number of successive gestations, physical and psychological preparation, as well as the environment in which they live. Puerperium is considered a period of readjustments to the prior conditions, however, many women experience significant changes, whether temporary or permanent. Despite the important advances in maternal and fetal care, there is still restricted care to female sexual function in the postpartum period, since many people consider it "normal" for these women to present some complaints at this stage, justifying that "soon everything will become as it was before"... The aim of this study was to evaluate the sexual function of primiparous women with 5 to 12 months of postpartum and to verify the influence of demographic, personal and obstetric risk factors.

Study design, materials and methods

This is a clinical, prospective and controlled study that recruited 78 primiparous women, with mean age of 24.46 (± 6.53) years, within 5 to 12 months after delivery (mean of 8.19 ± 2.38 months), being 37 vaginal delivery women and 41 cesarean delivery women (25 elective cesarean and 16 urgency cesarean). Demographic, personal and obstetric factors as well as the continence status and sexual function were investigated. A validated Female Sexual Function Index – FSFI questionnaire of the Portuguese language was used (1).

FSFI is a multidimensional, self-administered questionnaire, consisting of 19 items that propose to evaluate the female sexual function, through six domains: sexual desire, sexual excitation, vaginal arousal, orgasm, sexual satisfaction and pain/discomfort. The total score as well as the individual score of each domain were considered for analysis of the results. The points obtained in each correspondent question, multiplied by the correction factor represent the score of each domain and they are added in order to obtain the total score.

For obtained the points of each domain adds points number of the correspondent question multiply of the correction factor (1). Domains with values lower than three are considered to be compromised (dysfunction), except for the pain/discomfort domain, which changes starting from values greater or equal to three. The total score is obtained adding the scores of the domains, and it presents a variation ranging from 2 to 36. The lower the score the worse is the sexual function. A total score less than or equal to 26 suggests sexual dysfunction.

The findings were submitted to statistic tests (Linear Regression Analysis as well as Univariant and Multivariate Logistic with Stepwise criterion) to determine the risk factors for sexual dysfunction. The significance level was 5%.

Results

Regarding the demographic profile, the majority of women were Caucasian (65.38%), with high school education degree (54.55%), family income from one to two minimum wages (62.34%), married or living in stable condition with a partner (66.67%). Among the relevant personal characteristics of the women there were : body mass index of 23.86 (± 4.31), weight of newborn (NB) 3.15 (± 0.57), sedentary (84.42%), reporting not having returned to the body weight prior to gestation (56.58%), intestinal frequency less than three times per week (56.41%), continents (83.12%). Most women (93.51%) reported never having received any orientation about the practice of pelvic floor muscle training.

When investigating sexual function it was observed that 43.59% of the women had IFSF total score less than or equal to 26 (mean 24.24 ± 8.91). We found that marital status was the variable that significantly influenced sexual function, in other words, single or divorced women had five times greater risk of developing sexual dysfunction compared to those married or in stable relationship (OR 1.63 95% CI - 14.98, $p=0.005$). Analyzing the six domains separately, we found that four of them (excitation - $p<0001$; lubrication - $p=0.07$; orgasm - $p=0.016$ and satisfaction - $p=0.022$) showed to be significantly dependent on marital status. The birth weight ($p=0.026$) and educational level ($p=0.014$) showed to have a significant joint relationship in triggering sexual pain/discomfort among the studied women. The weight of the newborn also presented a risk factor for the lubrication ($p=0.031$) and orgasm domains ($p=0.041$). The body weight gain presented risk to the content domain ($p=0.043$).

Interpretation of results

Johnson (2) reports that the first six months in a woman's sexual life are striking and that there are many factors that can affect that negatively. In this study, sexual dysfunction was present in a significant portion of the studied population (43.59%), where marital status is the greatest risk factor, that is, women without a steady relationship showed the greatest risk of sexual dysfunction and lower scores in the arousal, lubrication, orgasm and satisfaction domains, which corroborates with the studies by Jhar and Thakar (3) showing that emotional involvement with the partner is the strongest predictor of female sexual health. Weight gain during pregnancy was another factor which affected sexual satisfaction. This may be due to the change of body image triggered during pregnancy and childbirth. The weight of the newborn was an important risk factor for sexual dysfunction, as well as for the commitment to lubrication, orgasm and sexual pain/discomfort. Considering the weight of the NB as a risk factor for perineal overloading and/or trauma, we suggest that a detailed evaluation would be performed during this period. It is necessary therefore that the different health professionals give a greater attention to sexual function in the postpartum period, since sexual dysfunction can be triggered by different factors and have impacts on various aspects of women's sexual health.

Concluding message

Sexual dysfunction may be present among primiparous women in the period of 5-12 months after delivery. Risk factors can be social (marital status), physical (weight gain during pregnancy) and/or obstetric care (birth weight), which emphasize the need to an appropriate professional's accompaniment.

References

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Disclosures

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