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# Pregnant women's discourses about sexuality during pregnancy: Possibility for health promotion

## *Discursos de gestantes sobre a sexualidade na gestação: possibilidade para promoção da saúde*

***Ana Vitória Pereira de Freitas[1*], Daniele Pereira Soares[2], Maria Raquel Antunes Casimiro[1], Maria Berenice Gomes Nascimento[1], Fabiana Ferraz Queiroga Freitas[1], Marcelo Costa Fernandes[1]***

[1]Federal University of Campina Grande, Teacher Training Center, Nursing Academic Unit, Cajazeiras, Paraíba, Brazil.
[2]School of Medical Sciences of Paraíba/Municipal Health Department, Joao Pessoa, Paraíba, Brazil.

***Corresponding author**: Ana Vitória Pereira de Freitas – *E-mail*: anavitoriafreitas68@gmail.com

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**ABSTRACT**
To analyze the discourses of pregnant women about sexuality during pregnancy in a Basic Family Health Unit. This is a descriptive study with a qualitative approach, carried out with 14 pregnant women in prenatal care in a Basic Health Unit in the city of Cajazeiras, Paraíba, Brazil. For data collection, semi-structured interviews were used, after the approval of the Ethics and Research Committee. The Collective Subject Discourse was used to organize and analyze the results. During the subjects' discourses, we found a lack of knowledge about the concept of sexuality, what it means as pleasure, and well-being in the possibility of self-esteem of pregnant women; moreover, the fear of hurting the baby during the sexual act, pain as an obstacle to sexual intercourse during pregnancy, and the importance of their partners' active participation throughout the gestational period. In this way, it is important that educational practices be strengthened throughout the prenatal period in order to expand pregnant women's knowledge about sexuality.

**Keywords:** Sexual Behavior. Pregnancy. Sexuality.

**RESUMO**
Analisar os discursos das gestantes sobre a sexualidade na gestação em uma Unidade Básica de Saúde da Família. Trata-se de estudo descritivo com abordagem qualitativa, realizado com 14 gestantes em acompanhamento pré-natal em uma Unidade Básica de Saúde da cidade de Cajazeiras, Paraíba, Brasil. Para a coleta de dados, utilizou-se entrevista semiestruturada, após a aprovação do Comitê de Ética e Pesquisa. Empregou-se o Discurso do Sujeito Coletivo para organização e análise dos resultados. Identificou-se, no decorrer dos discursos, a falta de conhecimento acerca do conceito de sexualidade, a sexualidade como prazer e bem-estar na possibilidade para autoestima da gestante, o medo de machucar o bebê durante o ato sexual, dores como obstáculo para relações sexuais durante a gestação e a importância da participação ativa do parceiro no período gestacional. Dessa maneira, é importante que, durante o pré-natal, as práticas educativas sejam reforçadas, para ampliar o conhecimento sobre a sexualidade.

**Palavras-chave:** Comportamento sexual. Gravidez. Sexualidade.

## INTRODUCTION

Pregnancy is a stage that encompasses several transformations in the life of women, which can modify their physical and emotional dimensions and have an impact on their sexuality.[1] When talking about bodies and sexuality, there are aspects to be considered beyond biological ones. This must be based on the understanding of women's experiences and the sociocultural context in which they are.

During the gestational period, women undergo several physiological changes that directly impact her sexual behavior: During the three quarters, there may be either a decrease or an increase in pregnancy symptoms such as heartburn, fatigue, nausea, pain, swelling, constipation, vomiting, physical limitations, and pressure on the uterus.[2]

In addition, changes in body image are linked to the feeling of a woman's feeling desired, and may become a barrier to the expression of her sexuality.[3] In this context, women's sexuality is still surrounded by taboos and prejudices, so much so that the lack of guidelines on the subject may directly affect couple's quality of life and their sex life.

Sexuality is included in the basic needs of the human being, contributing widely to his biopsychosocial well-being. In addition, each subject has a unique way to experience their sexuality, so during pregnancy, it would be necessary to follow up to promote the healthy intimate relationship of couples.[3]

Furthermore, sexuality is inserted in the care plan of the pregnant woman during prenatal care, even if she does not express doubts.[4] This should occur because many women present barriers such as insecurity, fear, and shame to discuss this subject.

The myths and taboos surrounding sexuality during pregnancy, along with the lack of knowledge of pregnant women, generate prejudice in relation to the subject.[5] Also, there is the difficulty in health professionals' ability to identify and approach sexuality and build interpersonal relationships in a careful, welcoming way that creates a the bond throughout consultations.[6]

Ultimately, this study guiding question is posed: What are the discourses of pregnant women about sexuality during pregnancy?

This research presents the relevance of contributing to understanding the perceptions and feelings of the pregnant woman about her sexuality to stimulate an integral vision of pregnant women's health and promote better quality of life. This study aims to analyze the discourses of pregnant women about sexuality during their pregnancies at a Basic Family Health Unit.

## METHODOLOGY

This study has a descriptive nature and a qualitative approach. This is a part of the final project of the undergraduate course in Nursing at the Federal University of Campina Grande, Cajazeiras campus, entitled “Knowledge and experiences about sexuality in pregnancy”.

This study was carried out at the Basic Health Unit (BHU) Francisco Valiomar Rolim (Sol Nascente) in Cajazeiras city (Paraíba state), Brazil. This BHU is a reference center in the field of academic activities, such as supervised internship. This is the reason of choice of this BHU as this study scenario.

The population of this research included 14 women undergoing prenatal care. The participants were selected for convenience because they were linked to the aforementioned UBS in which the researcher was a supervised internship. In this way, pregnant women were invited to participate in the research shortly after their consultation.

The inclusion criteria were: the subjects had to be pregnant women registered and linked to the BHU; they had to be either primiparous or multiparous aged between 18 and 35 years; they had to be performing follow-up in prenatal consultations regularly; and they had to be of a gestational age between 8 and 40 weeks. The exclusion criteria were: the presence of obstetric disease in the current pregnancy (such as preeclampsia and eclampsia, premature rupture of membranes, hemorrhages, isthmus-cervical insufficiency, alloimmunization, and contagious diseases that require isolation and/or absolute rest); also, the presence of cognitive deficit preventing the understanding of the issues. The number of participants was defined by the theoretical saturation sampling of data collection, which includes the closure of the admission of participants when a new element is no longer found.[7]

Data collection took place between September and October 2021. It was carried out through an individual interview at the BHU, in the nurse's office, to ensure the participants’ privacy. To confirm participation in the research, interviewees were asked to sign a Free and Informed Consent Form (FICF). A semi-structured script was used as a guide. It was composed of two parts: The first one contained sociodemographic questions to outline the profile of the participants; the second one presented subjective questions about how the subjects viewed sexuality, how they related sexuality and pregnancy, as well as their experiences of sexuality during the pregnancy period.

For the recordings, a mobile phone voice recorder application was used to enable multiple plays after data collection and better contextualize the information obtained before

beginning transcriptions. This process facilitated analyzing the collected data. Each interview lasted about 25 minutes.

In order to proceed with the transcription and analysis of the data collected in the interviews, the methodological process of Collective Subject Discourse (CSD) was adopted, which uses qualitative data of discourses that represent collective thought, for better organization of the Central Idea (CI).[8] This is a complex process because it enables to characterize a collective thought based on individual discourses and finally, clarify the social representation present in them.

The CSD enables data analysis via collected statements. Later, CIs are extracted along with their respective key expressions (KEs). The discourse is established in the first person of the singular; thus, the essence of the testimony is revealed.[8]

Through the investigation of a common discourse found in CIs and KEs based on existing individual discourses, CSD produces the social subject and collective discourse. This defines a social speak as if it were an individual being, using objective, clear, and standardized procedures that are susceptible to criticism and contestation.[8]

Therefore, this methodology facilitates the interpretation of the interviewees' speeches, which represent their groups. This may enable access to their routine knowledge without reducing them to numbers and valuing the construction of a shared, collective meaning.

This study was initiated after approval of the project by the Research Ethics Committee (REC) of UFCG, Cajazeiras campus, under the number of Opinion 5.017.270, respecting the requirements of Resolution 466/2012 of the Ministry of Health[9]. Also, in order to maintain the confidentiality of the information, the name of each participant was replaced by a flower name: Cherry Blossom, Tuberose, Azalea, Orchid, Begonia, Camellia, Bromelia, Rose, Tulip, Hydrangea, Lotus, Amaranth, Amaryllis, and Carnation.

## RESULTS

When analyzing the sociodemographic profile of the participants, the following distribution regarding the age group is evidenced: Eight (57%) of the pregnant women are in the age group from 20 to 30 years. Regarding marital status, 14 (100%) reported having a steady partner. Regarding the number of children, seven (50%) reported having one to two children. Regarding their education background, only six women (44%) reported having completed high school, and two (14%) reported having attended or completed higher education. Regarding the number of pregnancies, five of them (36%) reported being in their first pregnancy; eight of

them (57%) had two to three pregnancies; and only one of them (7%) reported having more than four pregnancies.

Regarding the senses present in the discourses, it was possible to identify five main Central Ideas (CI), which will be exposed and analyzed with their respective DSC.

**CI 1: Sexuality with emphasis on sexual act**

CSD 1: *To me, sexuality is sex (laughs). Sexuality with the partner, right? In the relationship during pregnancy… the frequency is very low. I can't explain, I think this is about sex, I think it's normal, right? I am ashamed! (Laughter) I understand that it's like nature, we have to have sex. For me it is something very important, but since I found out (about my pregnancy), I haven't had sex with him. I believe this is about individual sex between man and woman. I get kind of afraid to do this, you know? But normal (sex), I find it harder because of pregnancy. I think it's really about sex, right? Mine, with my partner.*

The first CI depicts the participants' perception of the concept of sexuality with an emphasis on sexual act. A total of eight participants (Cherry Blossom, Tuberose, Azalea, Orchid, Begonia, Rose, Hydrangea, and Lotus) form the Collective Subject Discourse (CSD).

**CI 2: Sexuality, pleasure, and well-being: Possibility for self-esteem of the pregnant woman**

CSD 2: *I always try to get a lot of information on the issue of sexuality, because I think it is one of the crucial points in the life of the human being… from the issue of the sexual act in itself to the mind issue, it has to do with sexual desire, your hormones, libido, everything… yes, I think there's a lot to it, this is about self-esteem, your relationship with yourself… well-being in general. Today, at age 28, married, I think sexuality involves sex, pleasure, and love. Oh, I think that's very important in the relationship, right? I didn't feel different, there is no difference, I had always been respected from the moment when I found out that I was pregnant and everything, and the person I live with knew that things were going to change over the months, and thank God we have respect, companionship, conversations, and that makes me very calm.*

The second CI presents an approach on sexuality, pleasure, and well-being linked to the pregnant women's self-esteem. This was composed based on the discourses of four participants (Carnation, Amaryllis, Lotus, and Begonia), characterizing CSD 2.

**CI 3: Fear of hurting the baby and sexual abstinence as an alternative**

CSD 3: *In my other pregnancy, it was the same way, I do not feel good at doing, I am afraid to hurt the baby because of this hardening feeling I get. It's been a roller coaster since the beginning of my pregnancy, because I felt so confused and full of questions about motherhood, life changes, lots of concerns about the baby, I am afraid of getting hurt, I was concerned about my body, too, then I left my "self" aside, and this affected a lot, I couldn't think about my partner. It is a very different experience, I find it very difficult during pregnancy, I don't do it all the time. I get so (laughs)… Before it was normal, but now that I'm pregnant, I get more worried, even if they say there's no contraindications or anything. I stopped because it was just my choice, you understand? Just to be careful.*

The third IC represents the feeling of fear of hurting the baby while experiencing sexuality and sexual abstinence as a resolution, which enabled making the CSD via four participants' data (Carnation, Tulip, Rose, and Bromelia).

**CI 4: Pain as an obstacle to sexual intercourse during pregnancy**

CSD 4: *I feel too much pain in my private parts. When I was pregnant with my first son, I didn't feel anything… Oh my God! It hurts too much! Then, the less my husband comes for me, the better I think; during intercourse, that's when I feel pain. I wouldn't mind if he didn't come close to me. I feel a lot of pain in my lower belly areas. The doctor said that he (the baby) was in transverse lie, so, I feel a lot of pain, that's why I've avoided it many times. Belly pains from the beginning of pregnancy until now at the end. The chest becomes very sensitive, uncomfortable, belly pains since the beginning of pregnancy, leg pains, the big belly, makes it too difficult. I don't like it because my belly foot always gets hard, it hurts too much. At first, it is boring because we don't feel like doing anything, then things get back to normal; and in the end, (the baby) got too heavy and a pain in the foot of the belly, then I just couldn't.*

The eight participants that make up CI 4 (Cherry Blossom, Azalea, Camellia, Orchid, Begonia, Tulip, Amaranthus, and Carnation) reported the occurrence of pain during pregnancy, with emphasis on increased pain during sexual intercourse. They pointed out negative aspects that consider a great hindrance to the experience of sexuality with their partner.

**CI 5: Importance of the active participation of the partner in the gestational period**

CSD 5: *As the months go by, it changed, right? Because we start to look at each other in another way, we are carrying another being, our son, many things change, but I found things went smoothly. But for things to go smoothly like (my pregnancy), I think a person has to have a partner who is with you and understand that this is just a phase. What has really made sexuality*

*easier during pregnancy is the relationship I have with my partner, of affection, of feeling supported, of being praised: It helps a lot in the matter of feeling closer to him. I consider a positive experience, my partner is quite patient, I was very lucky. It is very nice, so it was very quiet. I think that only in the end could I not do more. I didn't feel different, there's no difference at all. I had always been respected since the moment when I found out that I was pregnant and everything, and the person I live with knew that things were going to change over the months, and thank God we have respect, companionship, conversations, and that makes me very calm.*

Finally, according to IC 5, the four participants (Begonia, Lotus, Amaranth, and Amaryllis) reported the importance of their partners' support and participation while dealing with the changes brought by the gestational period.

## DISCUSSION

In the course of DSC 1, the participants' lack of knowledge about the concept of sexuality is identified. Pregnant women characterized sexuality with emphasis only on pleasurable activities through the genitals, causing damage in the way they perceive and experience this essential element for quality of life. Still, negative perspectives on the issue of sexual desire, frequency and comfort are observed.

The sexual habit of the pregnant woman becomes a situation that must be adapted to various hormonal, physiological and metabolic rhythms, and it is these alterations that justify the greatest vulnerability to the emergence or exacerbation of sexual difficulties.[10]

The lack of knowledge of body factors and the presence of myths and taboos propagated on sexuality can generate negative influences on pregnant women's experiences. This causes a decrease in their desire, interest, discomfort, and reduced sexual frequency.[11]

Sexuality is not only linked to sexual act, because it encompasses eroticism, intimacy, sexual orientation and reproduction. It is understood and manifested through thoughts, intimacy, desires, attitudes, fantasies, beliefs, behaviors, values, and relationships. It is influenced by biopsychosocial, historical, cultural, economic, religious, and spiritual dimensions.[12]

Thus, the importance of understanding and propagation of the concept of sexuality in its integrality gains importance at this stage of women's lives. It encompasses physical and psychological aspects. Finally, it is believed that understanding concepts and how one's body works can minimize negative events and reduce the apprehensions that may arise during the performance of the sexual act.

Many women do not know their own body, and this ignorance can lead to sexual dysfunctions. For this reason, disseminating knowledge through sex education, makes it possible, in a very effective way, that several problems related to sexuality are remedied; this enables progress for women to enjoy and relate to their own sexuality and of those around them, in a respectful, conscious, and balanced way.[13]

Knowing that all participants of the study perform prenatal consultations often, the lack of attention from health professionals when addressing this issue deserves highlight. This characterizes a failure in the promotion and guidance of pregnant women's sexual health.

From this perspective, the relevance of sexual education during the gestational period must be pointed out. The prenatal consultations enable health professionals to share knowledge, create bonds, clarify doubts, and guide women and their partners about the likely changes in sexual behavior.[14,15,16]

The CSD 2 helped understand the concept of sexuality and the how encompassing this topic is, alongside its various manifestations like self-esteem. In addition, the importance of this aspect for their relationships must be acknowledged. Their partners' bonds and participation in this journey become positive points for achieving a healthy and harmonious affective/sexual experience.

The concept of sexuality goes beyond what is propagated by society. It encompasses a complex and important dimension in the existence of women experiencing this in different ways during their lives. This is especially true for the pregnancy period. Due to intense physiological and psychological changes, women tend to experience greater emotional fragility, requiring attention and support.

In addition, their body appearance and the way pregnant women perceive themselves during pregnancy may generate significant repercussions on their quality of life and well-being. For this reason, there must be professional monitoring to approach their new bodies and minimize possible negative feelings emerging from this situation.[17]

It is of paramount importance to understand the breadth of the concept of sexuality, which reaches the sense of exchange of affections and maintenance of the self-esteem of the woman. Pregnant women must be educated about the changes resulting from pregnancy so that they will be emotionally ready for these changes. They must first place themselves as women, allowing themselves to be loved, feel pleasure, and adapt their sexuality to this stage of life, respecting the limits established by their bodies.[18]

A survey conducted with 437 Iranian pregnant women showed that overall marital satisfaction improves sexual function in pregnant women and decreases sexual dysfunction. It was found that good sexual intercourse that may result in married satisfaction of the couple has a great role in family success and harmony.[19]

It is believed that the way pregnant women view the concept of sexuality and the way they are seen by her partner promote better management of the changes they may experience. This causes them to continue feeling sexually desired, generating feelings of satisfaction and decreasing interference in the couple's sexual expression.

In CSD 3 it was possible to highlight the fear of pregnant women in performing sexual activities because they believe that their babies may be harmed due to the act of penetration. Based on this cultural concept, they use sexual abstinence as an alternative, which highlights their poor education, their lacking knowledge about human anatomy, and how hard it may be for them to find ways to make sex acts pleasurable without letting concerns affect the couples' intimate interaction.

Many myths, taboos and misinformation about sexuality are associated to the gestational period: many pregnant women and their own partners still have the unfounded belief that intercourse may injure the baby or cause harm such as abortion, prematurity, or malformation. This may lead pregnant women to not experience their sexuality.[20]

Therefore, during pregnancy, sexuality ends up being negatively affected in societies that view it and advise about it inappropriately, turning erroneous superstitions into common behaviors.[21]

During the literature review, it was found that even though there is no direct interference with the baby during sexual intercourse in pregnancy, women are still afraid that their fetuses suffer some injury.[22] This fear of hurting the baby during sexual intercourse can directly influence the well-being and sexual health of the couple in order to leave intimacy weakened and lead the relationship to disinterest.[23]

A study carried out with 80 pregnant women who were seen at the outpatient clinics of two public maternity hospitals in Rio de Janeiro found that 35% of the women reported fear or insecurity of engaging in sexual intercourse during pregnancy. It was also found that the fear of hurting the baby and fear of anticipating childbirth were reasons that led to decreased sexual intercourse.[24]

Engaging in sexual practices during pregnancy has always been surrounded by prejudice and has a very strong cultural basis, perpetuating the intention of protecting the fetus and the

direction of the woman to be a unique and exclusive figure of being a mother. It becomes evident that such situations can be harmful to the couple and cause crises, so guidance by health professionals is needed.

The participants who make up DSC 4 reported the occurrence of pain during pregnancy, emphasizing the increase in pain during sexual intercourse; and pointed out negative aspects that consider great hindrance for the experience of sexuality with their partner. These negative symptoms are widely cited during the study as the main barriers that cause both the decrease of sexual desire and, consequently, a reduction in intercourse frequency.

During the gestational period, women are affected by many sexual dysfunctions that are directly related to the emergence of discomfort during vaginal penetration; other factors mentioned are a decrease in lubrication, tiredness, and absence of libido and arousal.[25]

A study with 20 pregnant women who were attending a Basic Health Unit in São Paulo city showed that most of the participants reported having sexual desire but presented small pain in the vagina and abdomen during sexual intercourse, making this moment uncomfortable. Other participants reported not having sexual desire and feeling afraid.[20]

Another study involving 50 pregnant women who were in prenatal consultations at the Pará State University School of Health revealed that, despite claiming good sexual function related to satisfaction and quality of sex life, most (54%) presented pain during sexual intercourse.[26]

Due to the anatomical and physiological changes in the body of pregnant women and the concerns about the health of the baby, there is a decrease in the sexual habit. This was mainly associated in the third trimester of pregnancy, when they often experience a significantly greater pain than in the previous quarters.[27]

Several factors may contribute to the occurrence of this pain and discomfort, such as the numerous transformations that may occur in the bodies and minds of women's throughout their pregnancies. Some of them are recurrent at each trimester. In the participants' discourses, we identified a decrease or the cancellation of sexual desire, as well as hormonal factors such as abdominal weight and volume. This may characterize indications of female sexual dysfunction.

Consequently, there must be a renewal of pleasure by experimenting with positions that are more comfortable for the couple. Also, sensations, stimuli, and perceptions throughout the whole body should be fully experienced. These interactions between the couple strengthen intimacy and maintain eroticism in women.[11]

Finally, according to DSC 5, the four participants reported the importance of their partners' support and participation while dealing with the changes caused by the gestational period. It was found that expressing engagement of both partners for adaptations, as it is essential that pregnant women feel loved and respected by their partners, generates positive points for couples' affective intimacy.

It should be noted that partner participation during pregnancy and puerperium provides a positive consequence in the promotion of women's health. This represents a source of emotional support, affection, and attention, going beyond follow-up in consultations and examinations.[28-29]

On the one hand, the partners' presence during prenatal consultations is of paramount importance for better understanding of the changes of his partner and ways of adequacy for safe sexual activity; on the other hand, professionals must provide information that expands the concept of sexuality to help make couples' relations and intimacy more satisfying.[30]

This means that couples can have an intimate life during pregnancy if they adapt to the physical transformations that women will face and respect for their limitations and fears, thus benefiting the pregnancy and their relationship.[31]

Men play a central role during all phases of adaptation, since their involvement and psychological support have a strong influence in women's coping with the difficulties faced in the expression of sexuality.

The prenatal consultations are a useful way of strengthening health promotion, since they are ideal moments for health education by exchanging and building knowledge so that pregnant women can have autonomy over their bodies and health.[32]

From this perspective, the service and approach of the health professionals who serve these women should be specific. It should focus on the individuality of each consultation and seek to demystify the fears and taboos they may have regarding their sexuality[33] to increase health promotion.

## CONCLUSION

In this study, it was possible to analyze the discourses of pregnant women about sexuality during pregnancy. This analysis showed that most participants did not know the concept of sexuality, characterizing it only as the sex act. In addition, they reported pain during pregnancy, especially during sex, as well as false beliefs, such as a fear of injuring their babies during sexual intercourse.

However, it was found that some pregnant women understood sexuality more broadly, emphasizing their self-esteem. They also mentioned the importance of their partners' active participation while they are dealing with the transformations of the gestational period.

It must be pointed out that the findings obtained in this investigation have limitations, since data collection was carried out with pregnant women from only one Basic Health Unit. Moreover, these results are part of the reality of a specific municipality, which hinders generalizations. Nevertheless, the discourses of pregnant women bring out a representation of sexuality that may be applied in other contexts of Brazil. This enables professionals from various areas of collective health, especially those involved in women's health in all their life cycles, to turn their eyes to this topic, begin to approach it, and ultimately, promote full care.

Given the above, strengthen the strategies of health education in the prenatal period must be strengthened. Not only should this occur in an individual scope that encompasses the partner, but also in a collective one. This may be a key tool to demystify sexuality, exchange knowledge and share experiences in order to expand the possibilities of health promotion.

Finally, it is recommended that continuing training of professionals working in Family Health Teams be carried out so that they can share appropriate knowledge about sexuality, resolve possible doubts, and empower women in their journey of learning about their own bodies and the changes that occur in the pregnancy cycle.

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