SUMMARY AND CONCLUSIONS

The World Association for Sexual Health concluded that, sexuality is an integral part of the personality of every human being and full development of sexuality is essential for individual, interpersonal and societal well being. So, sexuality is an important part of health and well-being. Pregnancy is a special period in the life of the women that is characterized by physical, hormonal and psychological changes that, in conjugation with social and cultural influences, affect women's sexuality and couple's sexual relationship. A healthy sexuality during pregnancy is necessary for the parental transition that occurs in that period.

Specific changes that occur in each pregnancy trimester have significant influences on sexual behavior. A reduction in sexual intercourse frequency, desire and satisfaction occurs in many women as pregnancy progress, particularly during third trimester, compared with pre-pregnancy.

There are numerous physical and psychological factors that may justify this. Hormonal changes (increased estrogen, progesterone and prolactine), cause nausea and breast tenderness, which, in addition to fatigue, exhaustion and anxiety, may contribute to general feebleness and difficulty to become aroused. It is understandable that sexual practices decreased. Moreover, self consciousness about a growing girth leads to a gradual change in a pregnant women's self-image that influence her self confidence, while posing physical limitations to perform some sexual positions. Length of intercourse and ability to experience orgasm decrease during later phases of pregnancy compared with pre-pregnancy.

Over the past few years, there has been growing interest among health care providers in quantifying female sexual dysfunction during pregnancy, not only in the direct effects of pregnancy but also in the impact of pregnancy or the adaptation to pregnancy has on the woman's overall-well being.

Despite the increasing number of epidemiologic studies, there are no sufficient data in medical literature regarding prevalence of sexual dysfunction during pregnancy in our Arabic countries. Based on this premise the present study aimed to evaluate the female sexual dysfunction during pregnancy on 300 healthy pregnant women. (100 pregnant women in each pregnancy trimester). Conducted between December, 2010 and December, 2011 from obstetrics' clinic in Benha University Hospital.

The FSFI questionnaire was used in this study as, it is a valid and accurate measure of the female sexual function. This questionnaire comprises 19 questions that evaluate six different domains of sexual function including (desire – arousal – lubrication – orgasm – satisfaction and pain). The FSFI score ≤ 26.5 is the cutoff point for women with sexual dysfunction.

In this study the female sexual dysfunction showed significant alterations throughout pregnancy. In the first trimester it was high (68%); in the second trimester, it presented a slight decrease (51%) and in the third, there was a very significant increase (72%). These results reassert, the influence of pregnancy on women sexual function and activity as observed in other studies.

The present study, results showed that the sexual function is affected during pregnancy with a significant change in all FSFI domains

in first and third trimesters in both age groups – even though this decrease was more easily noticed among young age group (<30) and that the prevalence of sexual dysfunction is high during pregnancy.

The desire domain show, no significant difference between trimester. While, arousal, lubrication and orgasm domains were found to be significantly decreased in the first and third trimesters. Pain found to be increased significantly in first trimester. Although there was significant decrease of FSFI domains, most women were satisfied with their emotional closeness to their partner, with their relationship and with their sex life in general.

Also, results showed no effect of variables such as work, education, gravidity or parity on female sexual dysfunction.

Sexual conflicts during pregnancy can cause serious disruption in the relationship of the couple. Based on this statement, healthcare providers in charge of prenatal care should provide orientation regarding sexual issues. Which should reinforce sexual response during pregnancy, contributing in this way, to the well being of the couple in question.

Now we note that, during pregnancy, sexuality seems to have rules of functional habits which can be related to this period of human life to determine changes and adjustments in the couple's sexual patterns. Perhaps in the future we will discover that what now is diagnosed as dysfunctional may actually be the common sexual behavior in pregnancy, although this may be a reason for many women or couples to suffer.