



## INTRODUCTION

Sexuality is a complicated part of each of us that includes physical and psychological expressions of pleasure and intimacy. Culture, religious, beliefs and family tradition all affect who we are sexually. The World Association for Sexual Health also 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 (*World Association for Sexual Health, 2008*).

In addition, according to the World Health organization, sexual health is a state of physical, emotional, mental, and social stability (*World Health Organization, 2002*). Sexuality may change with age, experience and health conditions so sexual health is achieving sexual satisfaction however is most comfortable for the person (*De Judicibus & McCabe, 2002*).

Pregnancy is a special period in the life of women that is characterized by physical, hormonal and psychological changes that in conjugation with social and cultural influences, affect women's sexuality and couples' sexual relationship. This reinforces the role of pregnancy as a stimulus for partners to search for new ways to enhance mutual emotional connection, intimacy and close physical affinity, in order to share physical sexual pleasure and satisfy each other's sexual needs. A healthy sexuality during pregnancy is necessary for the parental transition that occurs in that period (*Polomeno, 2000*).

Several international studies have indicated that the nonpregnant female population has high rates of sexual dysfunction ranging from 30% to 49% (*Spector & Carey, 1990; Fugl-Meyer, 1999; Laumann et al.,*



1999; *Abdo et al., 2004 and Nobre & Pinto-Gouveia, 2006*). A prevalence of reduced sexual interest ranging from 57% to 75% has been reported to occur during pregnancy (*Ryding, 1984; Sayle et al., 2001 and Fok et al., 2005*).

There are controversies regarding the variables that are positively associated with sexual dysfunction during pregnancy: Some reports have pointed out reduced sexual frequency with increasing maternal age (*Fok et al., 2005*), while others did not find such association (*Haines et al., 1996 and Pauls et al., 2008*). The results are still controversial regarding parity (*Fok et al., 2005; Gruszecki et al., 2005 and Witting et al., 2008*), gestational age (*Reamy et al., 1982; Pongthai et al., 1998; Uwapusitanon & Choobun, 2004 and Senkumwong et al., 2006*) and body mass index (*Esposito et al., 2008*). Still other studies have pointed out a positive association between sexual dysfunction during pregnancy and urinary incontinence (*Beji et al., 2003 and Cohen et al., 2008*).

The difference in results regarding the variables associated with sexual dysfunction during pregnancy are probably due to use of different methodological approaches and to the variability of the populations investigated (*Lann et al., 1994 and Laumann et al., 1994*).

According to *Gokyildiz & Beji, (2005) and Shojaa et al., (2009)*, the various beliefs and cultures can affect sexual function, that is, they can be dominant factors in various results obtained when the sexual function of some couples are analyzed, especially when sexual function is compared between western and Asian. Thus, the identification of factors associated with sexual dysfunction during pregnancy in different countries may permit important comparisons of results that emphasize cultural aspects. The evaluation of variables that influence sexual



function during pregnancy could be essential to develop guidance that will permit to improve the sexual life of pregnant women. In addition, few investigations are available about sexual function in pregnant women, especially with the use of validated instruments (*Quadr et al., 2005 and Yasan & Gumlrigen, 2009*).