# SOME ASPECTS OF SEXUAL KNOWLEDGE AND SEXUAL BEHAVIOUR OF LOCAL WOMEN — RESULTS OF A SURVEY: XI: SEX AND PREGNANCY

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## SYNOPSIS

**477 women were interviewed in the immediate postpartum period about their sexual functioning and activity during pregnancy.**

**Only 6.5 percent (31 patients) had coitus till term whereas 9.2 percent (44 patients) abstained from coitus throughout pregnancy.**

**A discussion about the sexuality of pregnancy and possible complications and precautions follows.**

## INTRODUCTION

The human female undergoes a complicated series of physical, hormonal and psychological changes during pregnancy and the response to these changes is variable.

Little research has been done to evaluate the effects of pregnancy on sexuality. The pregnancy year contributes both to the elevation and depression of both male and female sexuality. These changes represent changes well beyond response levels evidenced in the non pregnant state (1,2,3).

Although in most mammalian species females do not seek sexual intercourse during pregnancy, in certain primates and in humans, sexual intercourse does occur during this period. For human females sexual intercourse during pregnancy is exceedingly common (4).

## METHODS AND RESULTS

477 postnatal patients of Toa Payoh Hospital were interviewed by the author during their early post-partum days on their sexual activity during the period of their pregnancy.

Table I shows the period during which these women had sexual intercourse.

**TABLE 1**

**SEX IN PREGNANCY**

| Duration of Pregnancy (in Months) | Number Having Intercourse | Percentage |
|---|---|---|
| 0 | 44 | 9.2 |
| 1 | 2 | 0.4 |
| 2 | 19 | 3.4 |
| 3 | 46 | 9.8 |
| 4 | 42 | 8.9 |
| 5 | 52 | 10.9 |
| 6 | 80 | 16.9 |
| 7 | 100 | 21.0 |
| 8 | 45 | 9.6 |
| 9 | 16 | 3.4 |
| 10 | 31 | 6.5 |
| Total | 477 | 100 |

9.2 percent had never had any sexual intercourse throughout the duration of their pregnancy ie they abstained from coitus once pregnancy was confirmed.

6.5 percent carried on with coitus till term. In fact in a few, labour was provoked by coitus.

The largest number (21.0 percent) had coitus till the seventh month of pregnancy and then discontinued for various reasons.

## DISCUSSION

Little is known of the physiological and psychological patterns of sexual response during pregnancy. Some of the difficulties are due to lack of knowledge especially about the changes in sexual responses. Bodily changes, mood changes, medical advice and a host of other factor affect the reactions with which a couple engages in sexual activities during pregnancy and the puerperium.

Pregnancy has an adverse effect on sexual relationships. Sexual desire, frequency of coitus and degree of eroticism all decline during the first trimester, relatively increase by the second trimester and early third trimester but are still below the prepregnancy baseline. There is again a decline in the late third trimester. Somatic factors and fall in libido contribute to this decline (1).

For most women coital activity declines once pregnancy is discovered and the orgasmic consistency, sexual interest and non coital behaviour are all similarly affected. The decrease in non coital behaviour suggests that more than attitudes and comfort with sexuality are involved (4). Despite the steady decrease in sexual behaviour for most women some did increase their activity thereby reflecting the highly individualistic nature of human sexuality and response to pregnancy. Most professionals and pregnant women do desire more information concerning the physiological and emotional aspects of sexual activity during pregnancy.

Most women described in the first trimester little or no enjoyment for sex compared with the months prior to conception. Libido was reduced in early pregnancy in some; for some this was unchanged and a smaller number described an increase. However in the third trimester there was a marked fall in coital frequency and a decline in sexual enjoyment and libido.

The overall impression is that sexual interest and activity decline as pregnancy progresses and many weeks or months elapse after delivery before marital libido returns to normal. The greater the activity during pregnancy the closer to the time of delivery do they tend to continue to have coitus (5).

Fifty percent of couples do have sexual intercourse at some time or other during pregnancy (6). Only 9.2 percent in this study had completely refrained from sexual intercourse during pregnancy.

Frequency of coitus is definitely reduced in pregnancy. Variable and strong psychological factors are involved whereas the gynaecological factors involved tend to be less and weak. The decline in frequency is more affected by physical status than medical advice (6). The overall pattern during the first and second trimester are very similar and as many do describe an increase in frequency of sexual intercourse in midpregnancy as those who report a reduction. But reduction of frequency is more marked and more prominent than enjoyment.

Nausea and vomiting are mainly responsible for the loss of libido and diminished coital frequencies. Some women did report an increase in libido. Fear of injury to conceptus affected the physical response for many women while for some there was no apparent change in interest or effectiveness of performance, with some having increased sexual tensions and desires for an increased coital frequency. Multipara do note very little changes in their levels of sexual interest od effectiveness of performance (3).

Somatic complaints are associated with the sexual organs mainly eg dry vagina, feeling smaller and making penetration painful or a feeling of numbness interfere with the experiencing of orgasm.

Another was the fear of harming the foetus or provoking a miscarriage. This interfered with the readiness to engage in coitus and is a more compelling reason than physical symptoms (1). These factors held true for this study too.

### Second Trimester

After the first trimester, the lessening of tension and vaginal tightness and fear of miscarriage tend to disappear. There is an improvement by the second trimester in that more women begin again to obtain enjoyment from sex.

A large percentage of women do report "considerable interest" or "very high interest" in sex than at any stage during pregnancy. Most reports (1,3,4,5) indicate a heightened frequency in the second trimester or no decline in sexual tension. In fact Masters and Johnson (3) reported a generally marked increase in eroticism and effectiveness of performance regardless of age and parity. Not only is there an increased interest for sexual encounters but also increased pleasure for sexual encounters, fantasy and sex dream contents and a demand for a generalised effective sexual relationship.

Increased masturbatory rates too are reported compared to the first trimester of pregnancy (1). In fact four women did only masturbate during pregnancy having never indulged in such activities previously.

Coital frequency and sexual satisfaction are increased compared to the first trimester.Nausea, heartburn and constipation all do ease considerably but

genital tenderness and discomfort do interfere with sexual relations.

Due to change in the abdominal shape, coital posture adjustment becomes necessary. Further coital movements have to be restricted and these restrictions do interfere with sexual satisfaction. Fear of harming the foetus, though less, continues to be a factor to be contented with (1).

In general there is an improvement somewhat in sexual relations compared to the first trimester.

### Third Trimester

In those three months before and after delivery, there is a marked reduction in sexual activity.

Many women report a sharp reduction in sexual activity (either cessation or frequency below once per week) and this even occurs in those who had previously had high levels of sexual intercourse (1). Over fifty percent do abstain from coitus in the eight lunar month. In this study only 19.5 percent reported so.

Many pregnant women report a marked decrease in sexual interest and activity especially in the last half of pregnancy. After the seventh lunar month coital frequency is independent of the length of marriage and indeed Masters and Johnson (3) say it is individual in the third trimester. Many women feel more relaxed and find coitus more enjoyable than in the earlier stages in spite of their heaviness and clumsiness. Fear of hurting the baby has considerably aborted but despite this most refrain from sexual intercourse in the last two months to avoid premature labour or infection (1).

As the delivery date approaches, activity, fatigue and sleeplessness produce a marked reluctance to engage in sexual intercourse. A few women did express frustration and resentment at having to abstain from sexual intercourse just when they had started to find it to be more enjoyable.

Many women feel that their husbands are reacting to their altered physical appearance adversely by avoiding intercourse. Concern for their physical comfort and fear of injury to the foetus are other factors to be considered as well (2). The sexuality of women varies in a way to confirm concept that the sexuality of the male and female are in reciprocal relationship (5). Frequency of sexual intercourse decreases and drops drastically in the last trimester.

In general, it can be stated that child bearing diminishes sexual activity and enjoyment in primigravidae for at least a year after delivery. Frequency is related to age and the older and longer married are less active. Coital frequency is independent of race, religion, education, negative feelings regarding pregnancy, whether or not pregnancy was planned or not (4).

Many women continue with sexual intercourse during pregnancy for fear that their partners would become unfaithful even though some have negative feelings about continuing with sexual activity.

### Orgasmic Frequency

There is a shift in the percentage of sexual acts leading to orgasm as pregnancy progresses. Usually there is a decline in the strength or intensity of orgasm compared to orgasmic intensity before pregnancy. A small number of women do report increased orgasmic intensity (1,4,5) at all stages and this was true in this study too. About 35 percent of women are reported to be multi-orgasmic during pregnancy, in one study.

### Other Sexual Behaviours

There is a shift to abstaining from masturbation, more so in the primigravidae than multipare (according to Masters and Johnson) (3).

In the later stages of pregnancy there is a general loss of libido for both coital and non-coital activities. The decline for the latter behaviour suggests that factors other than attitude are involved.

### Sex and Abortion

Healthy pregnant women (and their men) fear sexual intercourse may damage the foetus (abnormalities, blindness, etc).

There is a void in our knowledge of the relationship between coitus and orgasm and abortion (spontaneous). Orgasm is stronger in many women during pregnancy but psychological factors must be definitely responsible (because there is no further fear of pregnancy) (7).

Factors besides biology of gestation do determine the sexual behaviour pattern during pregnancy. Among factors to be considered are a woman's feeling towards parenthood, the quality of her marriage, culturally defined expectations, pre-existing sexual attitudes and individual consideration like medical complications and concern regarding miscarriage or genetic abnormalities in the foetus (2).

It is difficult for a doctor too often to take a stand and give advice on this matter (ie coitus in pregnancy) for on this rests the physical and mental life of the mother and unborn child and also the happiness of a marriage. Sexual activity appears to be safe throughout pregnancy in almost all patients but most texts and physicians are sceptical and silent regarding the safety of normal sexual activity in pregnancy especially in the later weeks (8).

Depending on the stage of pregnancy, it is possible that coitus can bring on abortion, premature delivery or labour pains of normal birth. There is no way of knowing in what percentage of cases the womb expels its contents after and because of coitus. The danger appears to be greatest in the first three months and especially in females with a special type of constitution and tendency to miscarriage or premature labour (9).

Fear of mishap is more often expressed through traditional and sexual taboos and is a more spontaneous type of fear than one learnt by reading books or from others and is perpetrated more on circumstantial evidence than any objective data. This feeling is akin to the protective feeling (of the mother) towards her unborn baby. A specific form of this is the withholding of orgasm which tends to be an image of releasing of the foetus (1).

Masters and Johnson (3) and others (8) reported that there is no necessity to abstain from coitus so far as damage to the pregnancy on purely mechanical grounds are concerned. Moreover in advocating abstinence one has to consider the effects of long term male continence as many men find three months an excessive period for continence and the adverse effect continence will have on marital relationships. Further Masters and Johnson reported of husbands having been unfaithful to their wives when the latter were pregnant and unable to be sexually active.

During orgasm the uterus does contract and these contractions are more intense with non-coital orgasm (eg masturbation) in both pregnant and non pregnant women. If this is true then there is a possibility of orgasm being a causative factor in miscarriages in susceptible women. Javerts (7) strongly supports a possible relationships of female orgasmic experiences (in the first trimester) and miscarriages. Thus it is justified to advise those who have had repeated miscarriages to avoid sexual stimulation to

orgasm no matter what the source (2,7).

There appears to be a relationship of abortion to coitus with orgasm (7). The belief that sexual intercourse produces abortion dates from antiquity various advices have been given eg. avoid coitus at expected period time or only to have coitus after the fourth month gestation etc.

Some women deny that frequent orgasm in them causes any mishap whereas others blame coitus as a cause of bleeding. Some miscarraiges do follow orgasms. Unmarried mothers seldom abort (because of lack of opportunity for coitus) whereas nearly twenty five percent of spontaneous abortions are from newly married primigravidae. The orgasmic experience (causing engorgement of the endometrium and decidua) rather than coitus perse may be a detrimental factor. Some habitual aborters do even report that the sight of the male approaching them does cause the uterus to contract. Further very few of the habitual aborters are sexually frigid and most are very passionate women (7).

Habitual aborters tend to abort more frequently if they have coitus than if coitus is not practised. With coitus prohibited in a subsequent pregnancy the majority do go to term. Sexual abstinence is the main part of the therapeutic regimen for habitual aborters. For some coitus is followed by uterine contractions and bleeding and ultimately spontaneous abortion. Coitus reminds them of this past incident. From these can be concluded the possibility of sexual intercourse causing uterine contractions but the real value of abstinence is the avoidance of orgasm (and the uterine contractions) (7).

The general view is to advise abstinence throughout pregnancy in habitual aborters.

### Male Sexuality in Pregnancy

Thirty percent of couples do not anticipate the changes in libido that occur during pregnancy and find it hard to adjust. Husbands take the change in sexual activity as a temporary necessity but this could also be due to their own diminished sexual desires (1).

Husbands gradually withdraw from initiating sexual activity with their wives towards the late second trimester or early third trimester.

Fears expressed by the male are concommitant with that in the female and libido does decrease notably, progressively and even more notably than does frequency of sexual activity.

Reasons given for withdrawing from sexual activity are not consistent but fear of injury to their wives and/or foetus and a lack of knowledge are reasons given. Most wives do suspect that their husbands are reacting to their loss of sexual attractiveness. For some husbands, quickening (first movement of the child) and first obvious signs of pressure do disturb sexual intimacy and inhibit their sexual initiativeness. Some husbands do feel frustration and resentment at having to abstain from sexual intercourse precisely when they find it more enjoyable. A few husbands are attracted by the obvious maternal qualities of their wives' abdomen while others do long for their wives' non pregnant looks (1,2,6).

In fact 12-15 percent of husbands do turn to extramarital sources for sexual outlet during the period of their wives' pregnancy and postpartum period (2,6).

Many couples are forced to adopt a position for sexual intercourse which is new and unfamiliar to them in late pregnancy and fifty percent do replace sexual intercourse by sexual caressing reciprocal in nature and about thirty percent of males do increase their masturbatory rates.

If sexuality is satisfactory prior to pregnancy it continues to remain so but degenerates if it were not so before pregnancy. Also if the pregnancy is a planned one, sexuality tends to be more stable than if it were coincidental.

Previous pregnancy mishaps do decrease desire during the three trimesters and also in the first trimester in cases of miscarriage and especially in the second and third trimesters in cases of previous early interruption of pregnancy (6).

### Postpartum Sexuality

There is a great deal of anxiety concerning the resumption of sexual activities after childbirth and though some women have increased desire they discourage its occurrence for fear of soreness at the episiotomy site (1).

The timing of return to coital activity concerns both the male and female and the problem is complicated by slow healing of the episiotomy wound, granulation tissue, persistent vaginal bleeding and discharge, postpartum depression or difficulties in adjusting to parenthood (first child).

Sexual intercourse can be resumed after a few weeks but it is important to individualise the matter and consider the psychological state of the couple and possible sexual guilt as a result of obstetric mishaps eg stillbirth or congenital abnormality (2).

Many weeks or months do elapse after delivery before maternal libido returns to normal. Nearly all women do resume coital activity by three months after delivery and some even before the first postnatal check up at six weeks. Nevertheless there is a persisting fall in frequency of sexual intercourse over the entire year due to fear, physical problems, discomfort and impaired enjoyment (5).

Sexual intercourse perse may be less important to the mother once she has conceived and had a baby. The husband may feel resentful toward the child (for being an intruder).

Fifty percent of those who resume sexual intercourse by two months after delivery complain that tension, fatigue or physical discomfort or sore episiotomy interfere with the achievement of prepregnancy levels of sexual interaction.

Suckling initiates sexual stimulation and a rapid return to coition is reported by actively nursing mothers. Female eroticism is directly related to the act of nursing (3). Those who breast feed report higher interest in sexual activity since breast feeding induces sexual eroticism and orgasm sometimes and many women do feel guilty about this form of eroticism.

Fatigue, weakness, pain on sexual intercourse, vaginal discharge and fear of injury lower libido and interfere with the ability to relax at sexual intercourse and achieve orgasm.

Some women are worried about changes in the sexual organs eg vaginal muscles tighter and make sexual intercourse painful or stretched and fear this may interfere with their husbands sexual enjoyment. The trauma of labour and delivery are linked by some directly with impaired sexual functioning eg soreness or impression of being sewn up wrongly (1).

Reasons for non resumption of coital activity by six to eight weeks are because of not having had a postnatal check up as yet, soreness over the episiotomy site, fatigue and lack of time. However if the husband is affectionate and suggestive the couple tend to resume coitus earlier (1).

### When to Start Coitus After Delivery (5)

Those who start sexual intercourse earliest complain of less pain and soreness. Persisting discomfort and pain is a prominent sequelae of childbirth for many women and at three months many do still have

such complaints.

At any time twenty to twenty-five percent do complain of tenderness as interfering with their sex lives. As many as thirty percent think that sexual counselling would be helpful.

Childbirth diminishes sexual activity for at least a year in primipara after delivery.

**Coitus in Late Pregnancy**

Information on the effects of sexual intercourse in the final weeks of pregnancy in relation to pregnancy outcome is not available.

The prevailing opinion is that sexual behaviour and response during pregnancy in some way are related to the untoward gestational complications. This opinion is based on scanty inferential data. Most texts and physicians are sceptical and silent about the safety of normal sexual activity in pregnancy especially in the later weeks and the relationship of premature delivery to it.

Some counsel their patients to abstain from coitus during some part of late pregnancy but little is known of the effects of coitus on pregnancy. Though a relationship between sexual intercourse and spontaneous rupture of the membranes is suspected no reports have completely resolved these issues (1,8).

Loss of libido is the reason given by many for the reduced coital and non coital sexual behaviour. Some couples however do have coitus comfortably till the onset of labour (4). 6.5 percent (31 women) in this study carried on with coitus till term. Those women with a low interest in sexuality may use the discomfort and fears to avoid a tense situation and begin abstinence earlier than is customary. Those with high sexual investment will carry on with coitus till close to the expected delivery date and are more likely to use erotic play during the abstinence period (1).

Vasocongestion is more marked in pregnancy and vaginal lubrication is increased. The contractions at orgasm develop continuous tonus. The vagina feels smaller at times and penetration is painful or numbness of the vagina makes the experiencing of climax difficult. Some women do report increased climax capacity at sexual intercourse in pregnancy compared to the non pregnant states (10).

Some patients do contend that sexual intercourse is followed by uterine contractions. In females cystitis and bacteriuria are associated with frequent coitus and the relationship of bacteriuria and premature labour is possibly the fact that both are side efffects of coitus. Women without a steady coital parnter have a lower incidence of premature delivery compared to those with regular partner (11).

Opinion varies regarding the deleterious effects of orgasm in late pregnancy. In some women orgasm causes painful uterine contractions and other discomforts but does not induce labour (7).

Masters and Johnson (3) reported as rare the possibility of a uterine response leading to premature labour. Pugh and Fernandez (12), considering coitus alone (and not orgasm) concluded that coitus had no deleterious effect. Javert (7) asserted that spontenous abortion is due to frequent multiple orgasms and that children born in pregnancies where the parents refrained from coitus have a higher IQ. Lumner (13) from his review of the literature asserted that coitus during pregnancy is associated with multiple deleterious effects including abortion and mental retardation.

Goodlin (14) reported that orgasm after thirty two weeks gestation was a more common occurrence in those who deliver prematurely than at term.

There is a fifteen percent risk of premature labour and premature rupture of membranes after thirty five weeks and this rises to twenty percent in those with a previous history of premature delivery though eighty five percent of the latter havè been non orgasmic after thirty two weeks gestation. Women with premature labour often have a marked loss of libido and reduced sexual activity even before the onset of uterine contractions. The increased frequency of orgasm in those who deliver prematurely suggests a possibility of a relation of orgasm being a factor in the aetiology of premature labour (14)

Female orgasm in the third trimester may initiate labour or may have a close relationship to the onset of labour. It is hard to be definite if this factor is involved in premature labour. But till now there has been no definite association shown between coitus, orgasm or other sexual experiences and the onset of labour (2).

Serum oxytocin levels are raised in orgasmic coitus. Also there is a possibility that this (oxytocin) and prostaglandins in the semen may induce labour. But in women who masturbate to orgasm (and the contractions at masturbation are more intense than coital orgasmic uterine contractions) no prostaglandin is involved in initiating the painful uterine contractions. The orgasmic contractions and not prostaglandins or coitus perse are responsible for the uterine contractions at orgasm (4).

Many patients complain of lower abdominal pain, painful uterine contractions, pelvic discomfort and backache after orgasm (15).

Besides premature delivery orgasmic coitus has been said to be responsible for deceleration of foetal heart rate (5). Also does orgasm in early gestation have any effect on foetal growth leading to an immature infant at term ie retarded foetal development from early gestation.

Women who are sexually active in the last four weeks of pregnancy have a higher incidence of some indication of foetal distress (ie meconium staining or low Apgar Score). The mechanism involved is premature labour, premature rupture of membranes or maternal neonatal infection (1).

We have also to consider the possible role of coitus and/or orgasm in those cases of unexplained intra uterine death.

Labour initiation is possible in the last two months, when the uterus is very irritable with orgasmic contractions (17).

Some women refrain from being orgasmic for fear of harming their baby or because orgasm is painful or because of fear of starting labour.

Premature labour or premature rupture of membranes may be induced by non orgasmic sexual stimulation too. Traditionally infection, premature labour, premature rupture of membranes, antepartum haemorrhage, puerperal morbidity, foul lochia and fever and possible cervical trauma and bleeding have been attributed to coitus. However coitus has not been shown to be responsible for the various complications of late pregnancy, delivery or puerperium. Further, anterpartum coitus is not a factor in the production of puerperal infection (12).

There is a need for further study and it is prudent to advise orgasm avoidance during certain pregnancies in gravidae with ripe cervix at the thirty two weeks gestation for those with a poor reproductive history.

It is necessary to de-emphasise abstinence in late weeks of pregnancy since coitus is of little significance provided the gravida is comfortable during intercourse.

It has not been possible to establish a link between sexual habits with or without orgasm and adverse effects such as premature labour, premature rupture of membranes and low birth weight infants. There is a link if the gestation is below the thirty eight weeks and if the sexual experience is less than twenty four hours

prior to labour and delivery.

There is no relationship of orgasm and premature rupture of membranes. Further, orgasmic experience is more frequent in those delivering at term.

Thus we can conclude by saying that normal sexual activity has no major adverse influence pregnancy. In the absence of obvious complications like bleeding, premature rupture of membranes or threatened premature labour there is no contraindication to normal sexual activity throughout pregnancy (8).

Women rarely follow advice to abstain from coitus out of consideration of needs of their partners. Also abstinence adversely may impose stress and strain on the patient's partner relationship. So it is advisable not to suggest restrictions without a valid reason.

### Coital Positions

There is a decrease in the intensity of sexual expression during pregnancy due to physical discomfort, fear of injury to the baby, loss of interest, awkwardness in having coitus, recommendation of physician, loss of attractiveness in woman's own mind, recommendation of a person other than physician (6) (eg mother, colleague).

There is a marked fall in the use of the male superior position and increase in other positions especially side to side as pregnancy progressed. Variability of coital position tended to fall throughout pregnancy but there is no association between coital frequency and the position used.

### Other Sex Behaviour

Many women are upset by the fall in libido and this is the reason for reduction in coital and non coital sexual behaviour. There is a large shift to abstain from masturbation. The more active in coitus are more likely to abstain from masturbation. This was not borne out in this study as very few women did masturbate. Clitoral orgasm has to be minimised (4).

Cunnilingus has been proven to be associated with sudden death due to air embolism by blowing intentionally or inadvertently. Further there is a marked increase in vascularity during pregnancy and this enhances risk of air embolism.

Positions have to be adjusted to take pressure off the woman's abdomen — both for psychological reasons and to obviate discomfort and later to avoid pressure on the cord and transmitted pressure on deep abdominal muscles.

Standard male superior position with moderate extension or modified side to side rear entry or women seated man facing her and kneeling and standing positions are recommended. Also possible are woman astride side saddle facing, knee chest rear entry. Most in this study used the male superior position with moderate extension.

Woman astride (coitus inversus) or hyperflexion or extreme hyperextension are not recommended.

Penile intromission as a primary (mechanical) cause of abortion has not been proven. Secondary mobilisation of the uterine expulsion mechanism is a possibility (3,10).

Concern about abortion in early pregnancy or premature labour during late phases of pregnancy has also been expressed. Habitual abortion is a well known reason to abstain but any pushing for abstention has to be balanced against the heightened emotional and sexual needs of many gravidae especially during the second trimester and weighed against any marriage disruptive potential of impaired lengthy abstinence.

Reasons for advice against coitus are usually infection danger as the genital tract is more vulnerable and vascular in pregnancy. Further, it is possible that small lacerations at coitus could cause bleeding.

Some women (and men) do object to coitus because of the abdominal distension but appropriate attitudes and positions will avoid such pressure. Further, the risk of infection "flaring up" after coitus is often quoted. This possibility is least if both partners habitually wash and clean their genitals.

Towards term the possibility of inducing labour has to be considered.

The reasons for sexual intercourse are mainly psychological and whether the woman herself desires sexual intercourse in pregnancy. If prior to pregnancy the sexual relationship has been lukewarm and gratification of the woman at sexual intercourse is moderate and inadequate, she will be adverse to coitus. However if the relationship is strong, the desire remains strong (9). Absolute prohibition of coitus should be advised after the membranes rupture or the cervix has dilated.

Also if there is any threat of miscarriage or suspicion of placenta praevia.

Cunnilingus has to be banned to avoid inadvertent air embolism (10).

## CONCLUSION

Female orgasm in the last weeks has to be avoided if onset of premature labour is a worry. No nipple stimulation or coitus should be allowed for habitual aborters.

So if the woman is healthy, the uterus has no tendency to premature labour, there is no subfertility, the pregnancy is a non precious pregnancy and if all care and consideration is taken during the act (avoid deep penetration) and excessive stimulation of the vulva and vagina are avoided then, it is safe to have sexual intercourse throughout pregnancy. If both partners are absolutely clean, then the risks to the woman are not markedly increased.

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