Original Article

Investigating the Relationship Between Women's Attitude Toward Motherhood and Sexual Desire in Pregnant Women: A Cross-Sectional Study

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Abstract

Objective: Pregnancy is one of the most important, influential, and critical periods in the lives of women and families. Women's attitudes toward pregnancy and motherhood can greatly impact how they face challenges during pregnancy. Many transformations occur in women's sexual lives during this period. Previous studies have reported conflicting results regarding sexual desire during pregnancy and various factors that affect women's attitudes toward motherhood. Therefore, we decided to investigate the relationship between these factors.

Materials and methods: This cross-sectional study with descriptive and analytical objectives was conducted on 124 pregnant women referred to comprehensive health service centers. The research instruments included the Socio-Demographic and Obstetric Questionnaire, the Scale of Attitudes toward Motherhood and Pregnancy, and the Hulbert Sexual Desire Questionnaire.

Results: This study revealed a direct and significant relationship between the attitude toward the role of the mother and sexual desire in pregnant women (M1: 17.4±57.06, M2: 5.31±32.5, r=0.473; p<0.001). Also, the results showed that the sexual desire of pregnant women is average (32.5±5.31), and the attitude toward the role of the mother is low (57.06±17.4).

Conclusion: The results of the study showed that any improvement in attitudes toward motherhood and pregnancy enhanced sexual desire. It seems necessary to screen women and men in terms of attitudes toward motherhood and sexual health and factors affecting it during pregnancy.

Keywords: Attitude Toward Motherhood; Sexual Desire; Pregnancy

Introduction

Pregnancy is one of the most important, influential, and critical periods in the lives of women and families. This period brings many changes for the woman, her sexual partner, their relationships, their performance as a couple, and also for the whole family (1). Pregnancy and childbirth bring women into a stage of life where they are forced to change

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their attitudes, roles, responsibilities, daily activities, and family relationships (2). Some mothers enjoy the challenges of motherhood and child care, so these women cope with the changes during pregnancy more easily. Studies show that the attitude of mothers toward the role of parents during pregnancy affects the growth and development of children. Also, women with a better and more positive attitude toward pregnancy and motherhood have children with higher cognitive development scores (3). Mothers who have a positive attitude toward their role as mothers have better self-esteem and body image during pregnancy and after delivery (4), and the rate of postpartum depression is lower in these women (5).

According to a study conducted at Cambridge University, maternal awareness and a positive attitude regarding the fetus during pregnancy are associated with health-promoting behaviors (6).

Another important challenge that couples experience in this period is marital relations. A review study shows that the quality of marital relationships and sexual desire changes in the transition to the parental role (7). Sexual desire is a facet of sexuality that varies among individuals and across time. A study proved that couples experience a significant decrease in expressing affection between themselves during pregnancy (8). Research also shows that pregnancy and postpartum periods can either enhance sexual desires between couples or, conversely, have a negative effect on their relationship and sexual desires (9, 10).

Several factors during pregnancy affect the sexual relations of couples. The research findings indicate a conflict between motherhood and sexual desires, with the majority of women stating a lack of sexual desires post-motherhood. Research also shows that this negative attitude toward sexual relations has a negative effect on various factors, including sexual desire and the sexual health of mothers and their husbands (1, 7, 10).

Sexual desire is influenced by physical problems, depression, isolationism, anxiety, fear, emotional instability, duality of feelings, and disorder in sexual relations that arise after pregnancy. Following pregnancy, there are changes in self-image, beliefs and values, priorities, behavior patterns, communication with others, and problem-solving skills (11).

The pregnant woman's focus on herself and the fetus often leads to a decrease in attention toward her husband and other children, occasionally resulting in feelings of resentment toward them. Changes in sexual desire and fear of miscarriage and fetus damage lead to a decrease in sexual relations during this period (7). Also, the changes in body image and physical discomfort experienced by pregnant women can contribute to a decline in social activities and connections with friends and acquaintances. Moreover, the increased financial needs within the family due to pregnancy and preparations for the newborn's arrival can potentially result in financial strain. Pregnant women may avoid household duties and regular plans due to changes in their physical and psychological condition, which can lead to undesirable reactions and behaviors. This, in turn, affects all dimensions of marital satisfaction, including sexual relations, child-rearing, financial matters, conflict resolution, and communication. They influence pregnancy and establish the basis for a disruption in the sexual desire of a pregnant woman (12).

However, several studies revealed that most pregnant women experience moderate to high sexual desire during pregnancy. Factors such as education, income, job stability, planned pregnancy, and history of infertility are related to the level of marital satisfaction and sexual desire (13, 14).

The effects of hormones during pregnancy, including estrogen and progesterone, lead to common problems, including breast tenderness, nausea and vomiting, fatigue, and pelvic discomfort, all of which are effective in reducing sex drive in women. Women often report experiencing an increase in sexual desire during the second half of pregnancy due to hormonal fluctuations and the resolution of these problems (14).

Previous research has reported conflicting results regarding sexual desire during pregnancy (11, 12, 14, 15), as well as various factors that influence women's attitudes towards their role as mothers. One of the most important factors is sexual desire, which may continue even years after childbirth. Therefore, recognizing the influences on women's sexual desire, such as their perception of motherhood, can lead to an increased focus on this issue by healthcare systems and prompt the development of counseling and interventions in educational programs.

Materials and methods

This cross-sectional study with descriptive-analytical objectives is based on 124 pregnant women referring to comprehensive health service centers. The inclusion criteria in this study included pregnant women with their first or second pregnancy, whose education level was middle school or higher, who did

not have any physical and mental problems during pregnancy, and who did not take drugs affecting libido. Women who were divorced, unmarried, or had a history of using nerve and psyche-affecting drugs were not included in the study. The sample size in this study was determined based on a previous study (4), with a correlation coefficient of r=0.25. Considering a 95% confidence level and 80% statistical power, the sample size for this study was calculated to be 124 individuals.

This study was conducted after approving the plan and obtaining the code of ethics from the ethics committee. A two-stage approach was used for the sampling process. Initially, five centers were chosen from 25 urban, comprehensive health service centers through a systematic random sampling technique. The centers were numbered 1-25, and sampling started with intervals of 5 from a random number (as the first center). Then, within the database, pregnant mothers were selected by a simple random method using www.random.org, and 28 mothers were selected from each database. In this way, the list of pregnant women was prepared based on health records in each center. Then, the required number of samples was randomly selected from the prepared list. Using the phone registered in each file, the researcher called the mothers, and after giving the necessary explanations about the research, the people were invited to participate. In the face-to-face meeting, the goals, benefits, and method of conducting the study were fully explained to the women, and those who wanted to participate were required to provide written informed consent. Then, the participants completed the research questionnaires. It should be noted that the mothers were given the necessary explanations regarding the confidentiality of the information. The place of the interview was separate and confidential for each person, and the time to complete the questionnaires was when the mothers went for routine care during pregnancy or an invitation for a face-to-face meeting.

This research used the Social and Midwifery Personal Characteristics Questionnaire, the Attitude toward Motherhood and Pregnancy Questionnaire (PRE-MAMA), and the Hulbert Sexual Desire Questionnaire.

This questionnaire, designed by the research team, includes questions about the participant and his husband's age, duration of marriage, education, and occupation, income adequacy, satisfaction with married life, level of support from his husband and family, gestational age and gender of the fetus and obstetrical history.

This questionnaire was designed by Ilska in 2014. The questionnaire has 11 items, each scored on a 4-point scale (1=never and 4=very much). Factors influencing pregnancy compatibility and the mother's role encompass attitudes toward the child, caregiving, and self-perceptions as a mother. It measures the scoring of questions 3, 4, and 10 done in reverse. The minimum score is 11, and the maximum score is 44. Ilska reported this questionnaire's Cronbach's alpha coefficient as 0.71 (16). The calculated Cronbach's alpha value in this study was 0.47.

This questionnaire was invented by Halbert in 1992. The questionnaire contains 25 items, which measure the subject's sexual desire. Clinical therapists widely use sexuality questionnaires to measure sexual and marital problems and in scientific research. Each item is graded using a Likert scale with 5 degrees: 1 = always (I always have this tendency), 2 = often (I have this tendency most of the time), 3 = sometimes (Sometimes I have such a desire), 4 = rarely (I rarely have such a desire), and 5 = never (I never have such a desire). Therefore, the scores of this questionnaire are obtained by summing the scores of 25 items. Questions 1, 3, 5, 7, 8, 9, 11, 10, 12, 13, 17, 18, 19, and 20 are scored inversely (always=5 to never=1). The minimum and maximum score of sexual desire is between 25 and 125, and a high score indicates a high level of sexual desire in the subjects (17).

Data were analyzed after collection with SPSS version 24 software. Descriptive statistics, including mean (standard deviation), were used to describe social-individual characteristics, attitudes toward maternal role, and sexual desire. In bivariate analysis, Pearson and Spearman's correlation test and chi-square test were used to determine the relationship between sexual desire and attitude toward the role of motherhood and pregnancy in multivariate regression analysis.

Results

The study's findings specified that the mean age of pregnant women was (29.21±6.95) and the mean age of husbands was (33.79±7.56). The length of marriage was (5.31±5.52), and the gestational age was (9.00±24.26). The results indicated that there is a significant relationship ($p<0.05$) between the mother's gestational age and the sexual desire of pregnant women (Table 1).

Table 1: The relationship between the attitude toward the mother's role and sexual desire with demographic factors in pregnant women referring to comprehensive health centers (quantitative variables)

Variables	Mean±SD	Parental Attitudes toward Maternity and Pregnancy	Index of Sexual Desire
Age of pregnant women	29.21±6.95	r=0.066, P<0.466	r=0.0.01, P<0.9
Spouse's age	33.79±7.56	r=0.108, P<0.234	r=-0.002, P<0.98
Length of marriage	5.52±5.31	r=0.117, P<0.194	r=0.012, P<0.89
Gestational age	24.26±9.00	r=0.129, P<0.154	r=0.23, P<0.01
interval between deliveries	4.37±5.11	r=0.212, P<0.144	r=0.137, P<0.349

The results of Table 2 demonstrated that about 16.1% of pregnant women had a history of abortion. Almost 41.9% of mothers and 42.7% of fathers had a university education. Most mothers were housewives (77.4%), and their husbands were self-employed (49.2%). About 44.4% were satisfied with their married life. Most mothers received support from their husbands (42.2%) and families (50.8%). 60.9% of the pregnant women had no history of childbirth. However, among the women who had a history of childbirth, about 29% had a cesarean delivery, and 48.4% had an instrumental delivery through forceps or vacuum.

There is a significant relationship between the mother's education, spouse's occupation, family income, satisfaction with married life, level of family support, baby's gender according to parents' wishes, type of previous birth, sex during pregnancy, and attitude toward the mother's role (P<0.05). Also, there was a significant relationship (p<0.05) between satisfaction with married life, sex of the baby according to parents' wishes, type of previous delivery, concern about sex, and sexual problems in married life with the sexual desire of pregnant women (Table 2).

The total scores obtained from sexual desire showed that most items mentioned by pregnant women were in options such as "I feel that sex is not an important aspect of the relationship I share with my partner" (69), "I try to avoid having sex with my partner" (66), "I feel I want sex less than most people" (64.6), "I think my energy level for sex with my partner is too low" (63.8) (Table 3).

Pregnant women's attitudes toward motherhood and pregnancy in the items "Have you been looking forward to caring for your baby's needs?" (66.1%), "Have you been feeling happy that you are pregnant?" (55.6%), "Has the thought of breast-feeding your baby appealed to you?" (53.2%) were good (Table 4).

According to the results, sexual desire in pregnant women was average (17.4±57.06), and women's attitude toward motherhood was low (32.5±5.31). Pearson's correlation test showed that there is a positive and statistically significant relationship (P<0.001) between women's attitudes toward motherhood and sexual desire in pregnant women (Table 5).

Discussion

The present study was conducted to investigate the relationship between women's attitudes toward the role of motherhood and sexual desire in pregnant women. This study showed that the average score of sexual desire in pregnant women is average, and the attitude of women toward the role of mother is at a low level. Similar findings have been mentioned in many studies, such as Carvalho's study, which raises the marital relationship as one of the challenges of motherhood and among the problems of primiparous mothers, and it emphasizes the strengthening of interventions by service providers to empower mothers and their families (2). Sockol shows the association between maternal attitudes and psychological distress, depression, and anxiety among first-time mothers (8). Research indicates that a mother's confidence in her ability to fulfill her maternal role positively influences her attitude towards motherhood. This confidence is cultivated through self-efficacy in key aspects of motherhood, such as bonding with the baby, engaging in interactions, developing competence in maternal behaviors, and finding joy in mother-infant interactions (18).

Our study's results reveal concerns, including anxiety about potential harm to the mother or child and challenges associated with motherhood among expectant mothers. These concerns, which have a direct impact on decreased sexual desire, can be caused by significant changes in the body's physiology, endocrine glands, brain function, immune system function, and behavior that begin during pregnancy and continue until postpartum (5).

Table 2: The relationship between the attitude toward the mother's role and sexual desire with demographic factors in pregnant women referring to comprehensive health centers (qualitative variables)

Demographic variables		N (%)	Parental Attitudes toward Maternity and Pregnancy	Index of Sexual Desire
Mother's education	Guidance	22 (17.7)	df=60	df=138
	High school	15 (12.1)	P<0.003	P<0.157
	Diploma	35 (28.2)		
	University	52 (41.9)		
Spouse's education	Guidance	26 (21)	df=60	df=138
	High school	16 (12.9)	P<0.071	P<0.071
	Diploma	29 (23.4)		
	University	53 (42.7)		
Mother's job	Housekeeper	96 (77.4)	df=60	df=138
	Employed	26 (21)	P<0.949	P<0.345
Husband's job	Freelance job	61 (49.2)	df=60	df=138
	Employee	37 (29.8)	P<0.006	P<0.110
	The driver	15 (12.1)		
	Other	11 (8.9)		
Sufficient family income	Enough	47 (37.9)	df=40	df=92
	Relatively enough	46 (37.1)	P<0.012	P<0.205
	Insufficient	31 (25)		
Satisfaction with married life	Completely satisfied	55 (44.4)	df=40	df=92
	Relatively satisfied	44 (35.5)	P<0.001	P<0.02
	Dissatisfied	25 (20.2)		
Amount of spousal support	Very good	56 (45.2)	df=60	df=138
	Good	52 (41.9)	P<0.075	P<0.423
	Relatively good	12 (9.7)		
	Not good	4 (3.2)		
Amount of family support	Very good	63 (50.8)	df=60	df=138
	Good	51 (41.1)	P<0.028	P<0.515
	Relatively good	9 (7.3)		
	Not good	1 (0.8)		
Baby's gender	Girl	62 (50.2)	df=40	df=92
	Son	61 (49.8)	P<0.758	P<0.982
Is the baby's gender according to your wishes?	Yes	93 (75)	df=20	df=46
	No	31 (25)	P<0.001	P<0.048
History of delivery	Yes	48 (39.1)	df=40	df=90
	No	73 (60.9)	P<0.007	P<0.750
Type of previous delivery	NVD	28 (22.6)	df=40	df=92
	Cesarean	36 (29)	P<0.013	P<0.005
	Instrumental delivery	60 (48.4)		
History of abortion	Yes	20 (16.1)	df=20	df=46
	No	104 (83.9)	P<0.098	P<0.397
Have you experienced any health problems during pregnancy?	Yes	20 (16.1)	df=40	df=92
	No	104 (83.9)	P<0.661	P<0.157
Do you have sex during pregnancy?	Yes	116 (93.5)	df=20	df=46
	No	8 (6.5)	P<0.047	P<0.650
Did you experience sexual problems during pregnancy?	Yes	18 (14.5)	df=20	df=46
	No	106 (85.5)	P<0.590	P<0.096
Did you feel anxious about sex?	Yes	14 (11.3)	df=20	df=46
	No	110 (88.7)	P<0.145	P<0.035
Did you have any sexual problems during your married life?	Yes	10 (8.1)	df=20	df=46
	No	114 (91.9)	P<0.112	P<0.003

Table 3: Frequency distribution of sexual desire of pregnant women referring to comprehensive health centers

Sexual Desire	All of the time	Most of the time	Some of the time	Rarely	Never	Total scores
	N (%)	N (%)	N (%)	N (%)	N (%)	
1. Just thinking about having sex with my partner excites me. (R)	17(13.7)	25 (20.2)	38 (30.6)	35 (28.2)	9 (7.3)	48.4
2. I try to avoid situations that will encourage my partner to want sex.	9(7.31)	10 (8.1)	46 (37.1)	37 (29.8)	22(17.1)	60.2
3. I daydream about sex. (R)	10 (8.1)	25 (20.2)	48 (38.7)	17 (13.7)	24(19.4)	53.6
4. It is difficult for me to get in a sexual mood.	7 (5.61)	23 (18.5)	41 (33.1)	29 (23.4)	24 (19.4)	57.6
5. I desire more sex than my partner does. (R)	14 (11.3)	19 (15.3)	40 (32.3)	33 (26.6)	18 (14.5)	58.5
6. It is hard for me to fantasize about sexual things.	7 (5.6)	18 (14.5)	37 (29.8)	35 (28.2)	27 (21.8)	50.2
7. I look forward to having sex with my partner. (R)	20 (16.0)	37 (29.8)	38 (30.6)	26 (21.0)	3 (2.4)	46.6
8. I have a huge appetite for sex. (R)	19 (15.3)	26 (21.0)	37 (29.8)	38 (30.6)	4 (3.20)	46
9. I enjoy using sexual fantasy during sex with my partner. (R)	20 (16.1)	34 (27.4)	43 (34.7)	11 (8.9)	16 (12.9)	31.4
10. It is easy for me to get in the mood for sex. (R)	20 (16.1)	31 (25.0)	38 (30.6)	28 (22.6)	7 (5.6)	43.8
11. My desire for sex should be stronger.	9 (7.3)	26 (21.0)	44 (35.5)	33 (26.6)	12 (9.7)	52.2
12. I enjoy thinking about sex. (R)	9 (7.3)	36 (29.0)	39 (31.5)	32 (25.8)	8 (6.5)	45.2
13. I desire sex. (R)	14 (11.3)	34 (27.4)	48 (38.7)	24 (19.4)	4 (3.2)	43.6
14. It is easy for me to go weeks without having sex with my partner.	10 (8.1)	20 (16.1)	34 (27.4)	39 (31.5)	21 (16.9)	57.8
15. My motivation to engage in sex with my partner is low.	9 (7.31)	14 (11.3)	33 (26.6)	46 (37.1)	20 (16.1)	59.6
16. I feel I want sex less than most people.	4 (3.2)	17 (13.7)	35 (28.2)	36 (29.0)	32 (25.8)	64.6
17. It is easy for me to create sexual fantasies in my mind. (R)	12 (9.71)	19 (15.3)	52 (41.9)	25 (20.2)	16 (12.9)	52.4
18. I have a strong sex drive. (R)	11 (8.9)	32 (25.8)	43 (34.7)	31 (25.0)	7 (5.6)	47.8
19. I enjoy thinking about having sex with my partner. (R)	17 (13.7)	40 (32.3)	44 (35.5)	17 (13.7)	6 (4.8)	40.6
20. My desire for sex with my partner is strong. (R)	13 (10.5)	40 (32.3)	35 (28.2)	30 (24.2)	6 (4.8)	44.8
21. I feel that sex is not an important aspect of the relationship I share with my partner.	5 (4.0)	4 (3.2)	45 (36.3)	29 (23.4)	41 (33.0)	69
22. I think my energy level for sex with my partner is too low.	8 (6.5)	13 (10.5)	38 (30.6)	30 (24.2)	35 (28.2)	63.8
23. It is hard for me to get in the mood for sex.	3 (2.4)	27 (21.8)	31 (25.0)	40 (32.3)	23 (18.5)	60.2
24. I lack the desire necessary to pursue sex with my partner.	5 (4.0)	25 (20.2)	36 (29.0)	34 (27.4)	24 (19.4)	59
25. I try to avoid having sex with my partner.	4 (3.2)	13 (10.5)	37 (29.8)	37 (29.8)	33 (26.6)	66

R: Reverse scored items

Hormonal fluctuations that occur during pregnancy are significantly associated with a gradual decrease in libido in most women (7).

According to the results obtained in this study, there is a direct and statistically significant relationship between women's attitudes toward the role of motherhood and sexual desire during pregnancy.

Table 4: Frequency distribution of pregnant women referring to comprehensive health centers

Prenatal Attitudes Toward Motherhood and Pregnancy	Never	Low	Moderate	Very much
	N (%)	N (%)	N (%)	N (%)
1. Have you been worrying that you might not be a good mother?	36(29.0)	41(33.1)	27(21.8)	20(16.1)
2. Have you been worrying about hurting your baby inside you?	32(25.8)	42(33.9)	30(24.2)	20(16.1)
3. Has it worried you that you may not have time to yourself once your baby is born?	34(27.4)	48(38.7)	29(23.9)	13(10.5)
4. Have you regretted being pregnant?	59(47.6)	41(33.1)	17(13.7)	7(5.6)
5. Has the thought of wearing maternity clothes appealed to you?	4(4.8)	36(29.0)	48(38.7)	34(27.4)
6. Have you been feeling happy that you are pregnant?	7(5.6)	14(11.3)	34(27.4)	69(55.6)
7. Has the thought of having several children appealed to you?	24(19.4)	27(21.8)	48(38.7)	25(20.2)
8. Have you been looking forward to caring for your baby's needs?	7(5.6)	13(10.5)	22(17.7)	82(66.1)
9. Have you wondered whether your baby will be healthy and normal?	6(4.8)	21(16.9)	34(27.4)	63(50.8)
10. Have you felt that life will be more difficult after the baby is born?	28(22.6)	53(42.7)	29(23.4)	14(11.3)
11. Has the thought of breastfeeding your baby appealed to you?	2(1.6)	21(16.9)	35(28.2)	66(53.2)

Table 5: Correlation between women's attitude toward the mother's role and sexual desire in pregnant women referring to comprehensive health service centers

Variables	Mean±SD	Pearson Correlation
Index of Sexual Desire	57.06±17.4	r=0.473
Parental Attitudes toward Maternity and Pregnancy	32.5±5.31	P<0.001

These findings have been confirmed in various studies, including the Jawed-Wessel study that acknowledged that the desire to have sex during pregnancy significantly predicts sexual satisfaction, taking into account specific sexual behaviors (1). Beliefs and attitudes toward sexuality during pregnancy, as well as anatomical, physiological, and spiritual changes that women experience, affect sexual life during this period (10).

Zamiri et al.'s study showed a direct relationship between self-esteem and attitude toward motherhood, pregnancy, and body image among pregnant women (4). The results of the mentioned study show the effect of increasing self-esteem in significantly improving the attitude toward motherhood and body image, as well as the role of mental health counseling in improving the self-esteem of pregnant women. In this regard, Carol's study states that mothers have less sexual activity than non-mother women and a more negative attitude toward sex. However, the remarkable aspect is that the mothers had a strong desire to improve their current conditions (9). In this study, we also examined the relationship between demographic variables and attitudes toward motherhood and sexual desire. We concluded that there is a statistically significant relationship between the mother's education, wife's occupation, family income sufficiency for living expenses, satisfaction with married life, level of family support, the sex of the baby according to the wishes of the parents, the type of previous delivery, and the sexual relationship during pregnancy with the attitude toward the role of mother.

Also, there was a statistically significant relationship between mother's age, satisfaction with married life, baby's gender according to parents' wishes, type of previous delivery, concern regarding sexual relations, and sexual problems in married life with sexual desire of pregnant women. In a similar study conducted by Malari, increasing age, fear of abortion and gestational age (trimester of pregnancy), satisfaction with body image before and during pregnancy, frequency of intercourse, and satisfaction with sexual foreplay have significant associations with low sexual desire and sexual distress. These findings show the importance of comprehensive attention to all these factors when screening for sexual health during pregnancy (19). Rahimian claims that physical performance, emotional problems, and general health have a positive and significant relationship with sexual desire in pregnant women (20). Factors such as age, mother's self-confidence, level of education, perceived social support, depression, number of pregnancies, anxiety, marital status, mother's personality traits, childbirth experience, health status and temperament of the baby, and social support from spouse and family members and health workers influence the competence and attitude toward the role of the mother (21).

In line with these studies, Eskandari also considers multiple sexual changes in pregnant women and their husbands to be related to gestational age, medical disorders, physical changes, psychological and emotional factors, and background factors and emphasizes sexual health education during pregnancy (22). According to Fernández-Carrasco, pregnancy affects the sexual desire of men and women. Men have higher levels of sexual desire during pregnancy compared to women, and women have lower sexual desire in the first trimester of pregnancy (12). However, Jamali believes that sexual dysfunction in pregnant women increases with increasing gestational age so that most disorders can be observed in the third trimester. In his opinion, pregnant women and their husbands need counseling regarding physical and psychological changes during pregnancy (23). Mental health changes, obstetric violence (including lack of caregiver support, privacy violations, instrumental deliveries, and episiotomies); relationship issues (including lack of partner support, lack of intimacy, and domestic violence); physical changes (including birth trauma and negative body image); and role conflict (including role incompatibility, breastfeeding, and lack of sleep) can also affect women's performance (24).

The primary strength of this research lies in its focus on a topic often overlooked in discussions of pregnancy challenges, influenced by our community's cultural and social norms. So, even in the health care packages, the problems of women's attitudes toward motherhood and sexual desire during pregnancy are not mentioned. Another advantage of this research is the heterogeneous social profile of the participants,

which can prevent bias in the results. In explaining the limitations of this study, cultural structures can be mentioned as a confounding factor that can stop the participants from answering the questions correctly and reduce the clarity of the results. To overcome this limitation, the researchers sampled a range of health centers with diverse social and economic backgrounds.

Conclusion

According to the findings of this study and similar studies, it seems necessary to screen women and men in terms of sexual health and factors affecting it during pregnancy. Based on the screening results, behavioral educational interventions can be effective in improving the attitude toward the role of the mother, as well as strengthening couples' sexual desire and their physical, mental, and social health. It is suggested that similar studies be conducted in different populations with different personal and social characteristics. Additionally, converting studies from descriptive to interventional is crucial for obtaining trustworthy results.

Conflict of Interests

Authors declare no conflict of interests.

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