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Original Research Article

Benefits of sexual practice during pregnancy: myth or reality? Comparative study and outcome of childbirth in Douala (Cameroon)

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ABSTRACT

Background: Pregnancy is the term used to describe the period in which a foetus develops in the uterus and lasts 40 weeks measured from the last menstrual period. Anatomic and physiologic changes in pregnant women usually make couples to change their emotional and sexual activities that may impact childbirth. There are few studies in our setting that describe the roles of sexual practice during pregnancy and maternal-foetal outcomes of childbirth.

Objective of this study aimed at assessing the benefits of sexual practice during pregnancy in a target population and to assess the outcome.

Methods: We carried out a comparative cross-sectional study from February 2018 to May 2018, at the maternity of Laquintinie Hospital in Douala. Socio-demographic, obstetric, sexual history in pregnancy, birth and neonatal data were collected using a structured questionnaire. Univariate and multivariate analyses were conducted at a 95% confidence interval.

Results: A total of 300 respondents completed study and 69.6% were favourable to sexual intercourse during pregnancy. Induction or augmentation of labour was common in the unfavourable group [OR: 2.52 (1.53-4.15); p=0.004]. Almost one in two participants gave birth by caesarean section and the indications for caesarean section were similar in both groups. Participants without sexual intercourse in pregnancy had a 9-fold increased risk of perineal tears [OR: 8.99 (4.02-10.1); p=0.001] and 5.4-fold risk of cervical tears [OR: 5.44 (2.44-8.73); p=0.0001].

Conclusions: Sexual practice in pregnancy appears to be protective against excessive use of oxytocin, perineal and cervical tears.

Keywords: Childbirth, Outcome, Pregnancy, Prejudice, Sexual practice

INTRODUCTION

Pregnancy is the set of phenomena that take place between fertilization and childbirth during which the embryo and then the foetus develop in the uterus.¹ During this period, the body modifications and the emerging identity changes will lead the woman and her partner to redefine their emotional and sexual relationship.^{2,3} Sexual practice

during pregnancy is greatly influenced by ethnic, cultural and religious beliefs.³

Some pregnant women and their partners are most often afraid of damaging their foetus, having a miscarriage or even having a premature birth.² This is how we notice a decrease in libido, a refusal of coitus.⁴ When asked if sexual practice is permitted during pregnancy and if there

would be no consequences that would result in order to carry it through, several studies have been conducted around the world.⁵

In Iran, a study by Kafaei et al found that sexual intercourse or contact with sperm did not affect the type of delivery (caesarean or vaginal delivery).⁶ Torkestani et al in 2012, still conducted in Iran, a study which revealed that 39.45% of women were afraid of having an abortion if they had sex during pregnancy.⁷ In India, a study carried out by Chhabra and Verma reveals that 30.61% of sexually active women have started premature labour.⁸ Tan et al in Malaysia found in a study in 2006 that long-term sexual relations were influenced by the perception of ethnic beliefs.⁹ In Brazil, the Txikaos Indians believe that without sperm, there would be an abortion because the child is no longer viable.¹⁰ In the Peruvian Andes, intercourse is stopped after 7 months for fear that the penis may touch the child and flatten his nose.¹⁰

In certain ethnic groups in Africa, sexual intercourse is essential for the proper development of the foetus. For example, in Zaire, Burkina Faso, Côte d'Ivoire and Ghana, the foetus would need seminal fluid or "growth milk" to feed and form.¹⁰ In Nigeria penetration helps prepare for labour while continually keeping the genital tract open.¹⁰ On the other hand, in certain ethnic groups, sexual intercourse is stopped during pregnancy: in Gabon after 5 months of pregnancy, sexual intercourse makes the child dirty at birth; after 8 months the sperm could even cause fever in the foetus.¹⁰ A study by Dao et al in Burkina Faso found that 92.6% of women thought it was possible to have sex during pregnancy and 63.2% of them thought that there would be no consequences for the unborn child.¹¹ In Nigeria, Orji et al found that sexual desire remained unchanged in 60% of pregnant women and that the frequency decreased in 64% of cases.¹² Andima still in Nigeria finds that 44.3% think that sexual intercourse during pregnancy widens the vagina and facilitates labour and for 30.2% of his sample there would be an abortion at the start of pregnancy.¹³

In Cameroon, Foumane et al found that sexually active women had a normal labour and a lower rate of caesarean section.¹⁴

From previous studies, it is clear that sexual practice during pregnancy is a subject of controversy, with heterogeneous and divergent data according to the geographical area. We therefore deemed it useful to examine this theme for the purposes of clarification and scientific documentation on the gestation of Douala.

METHODS

This was a cross-sectional comparative study carried out at the maternity unit of Laquintinie hospital, Douala (LHD) for a duration of 4 months from February 2018 to May 2018 with two arms formed in relation to the

prejudices favorable or not to sexual practice during the pregnancy.

Study population

Target population

It was made up of women received in postpartum consultation or staying after childbirth at the Laquintinie hospital maternity unit.

Inclusion criteria

Included were those who had unprotected sex during their pregnancies, who expressed agreement to participate in the study and had a workable obstetric record.

Exclusion criteria

Excluded were all those participants who did not adhere to the study as much as those whose obstetric record was unusable, as well as those who had protected sex after their fertilization.

Sampling

We carried out a non-exhaustive consecutive type sampling.

Data collection equipment and procedure

The data were collected using a pre-tested questionnaire as well as the use of obstetric records and prenatal follow-up books. The variables of interest for this study are mentioned below.

Socio-demographic

Age, type of occupation, religion, region of origin, marital status, area of residence, and level of education

Obstetrics

Pregnancy, parity, and histories of previous pregnancies.

Sexual practice during pregnancy

Prejudices, the frequency of sexual intercourse depending on the term of the pregnancy, and complications linked to sexual practice during pregnancy.

Data on delivery

Route of delivery, foetal presentation, dilation on admission, station on admission, condition of the membranes, colour of the amniotic fluid (AF) at rupture, use oxytocin (OCT), mode of onset, and maternal complications during childbirth.

Data on the characteristics of the newborn at birth

Apgar score, pathologies detected at birth, and foetal death.

Statistical analysis

The data were entered and analyzed by software Epi info version 3.5.1, Microsoft excel 2013 and statistical package for the social sciences (SPSS) version 20.0. The variables were compared using the Fisher test. The mean values were expressed with their 95% confidence interval and the threshold for statistical significance was $p < 0.05$. Univariate and multivariate analyses checked for associations.

Ethical considerations

Respect for medical ethics and deontology is an integral part of this study, which strives to respect the following aspects: ethical clearance has been obtained from the institutional authority of the University of Douala, authorization from the General Director of the LHD to set up the study has been obtained, and each woman received

an information and consent sheet which was sent to her explained with signature for those who joined the study.

RESULTS

At the end of the data collection, we recruited 320 nannies and new-borns; we excluded 20 of them who did not consent to the study and enrolled 300 including 207 (69%) having prejudices favorable to sexual activity in pregnancy and 93 (31%) reluctant to practice sexual activity during pregnancy, therefore constituting two matched arms for this study. The turnout was 93.75% (Figure 1).

Socio-demographic characteristics of the study population

In our series, the age varied between 15-45 years with an average of 27.27 ± 6.2 years; the majority age group was (25-30) with no significant difference in the two groups ($p > 0.05$). The respondents of the two groups were mostly single and of secondary education but without any statistical difference observed between them [OR: 0.66 (0.39-1.11); $p = 0.342$] [OR: 0.4 (0.2- 0.81); $p = 0.750$] (Table 1).

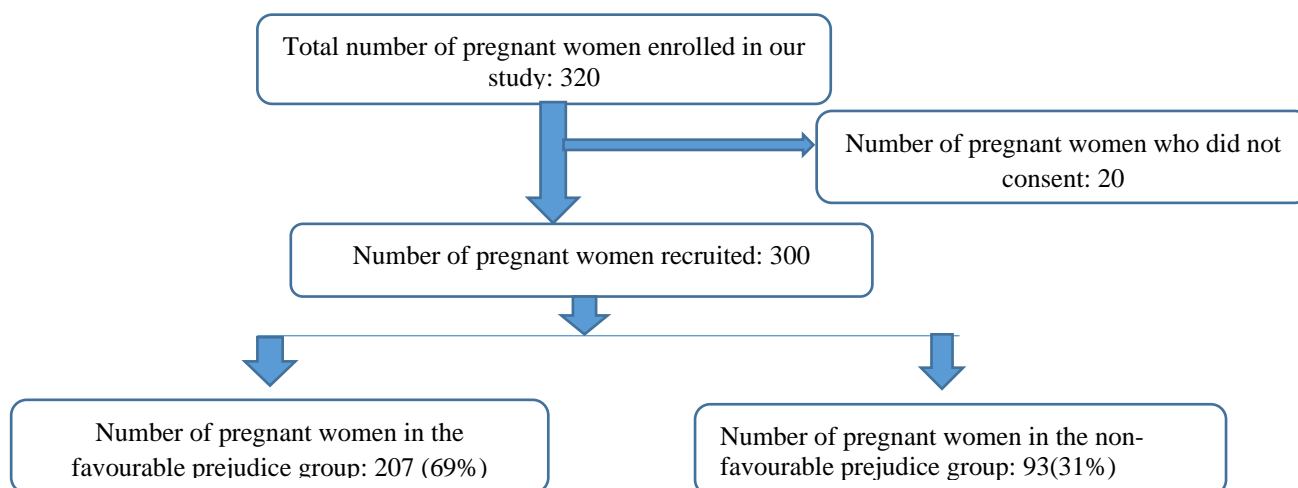


Figure 1: The stages of recruiting pregnant women for the study.

Table 1: Distribution of the target population according to age group, occupation, region of origin, religion, marital status, level of education.

Variables	FP n=207, N (%)	NFP n=93, N (%)	OR (95% CI)	P value
Age (years)				
15-20	22 (10.63)	15 (16.13)	0.73 (0.32-1.67)	0.210
20-25	46 (22.22)	23 (24.73)	1.36 (0.6-3.1)	0.675
25-30	69 (33.33)	28 (30.11)	1.68 (0.76-3.7)	0.650
30-35	45 (21.74)	18 (19.35)	1.7 (0.72-3.99)	0.677
35-40	17 (8.21)	6 (6.45)	1.93 (0.62-6.03)	0.610
40-45	8 (3.86)	3 (3.23)	1.82 (0.42-7.89)	0.789
Occupation				
House-wife	73 (35.27)	30 (32.26)	1.4 (0.76-2.58)	0.681
Scalarised	54 (26.09)	31 (33.33)	0.72 (0.39-1.33)	0.275
Civil servant	31 (14.98)	14 (15.05)	0.91 (0.43-1.94)	0.987

Continued.

Variables	FP n=207, N (%)	NFP n=93, N (%)	OR (95% CI)	P value
Others	49 (23.67)	18 (19.35)	1.12 (0.56-2.23)	0.464
Region of origin				
Centre	21 (10.14)	19 (20.43)	1.33 (0.4-4.39)	0.240
East	7 (3.38)	8 (8.60)	0.79 (0.29-2.59)	0.061
Far north	5 (2.42)	2 (2.15)	2.86 (0.42-9.67)	0.890
Littoral	31 (14.98)	21 (22.58)	1.69 (0.53-5.37)	0.143
North	3 (1.45)	5 (5.38)	0.69 (0.12-3.99)	0.054
North-west	13 (6.28)	1 (1.08)	1.99 (1.53-4.45)	0.054
West	116 (56.04)	28 (30.11)	4.73 (1.58-13.14)	0.003
South	6 (2.90)	7 (7.53)	0.98 (0.22-4.35)	0.075
South-west	5 (2.42)	2 (2.15)	2.86 (0.82-9.05)	0.890
Religion				
Animist	1 (0.48)	2 (2.15)	0.16 (0.01-1.3)	0.182
Others	17 (8.21)	13 (13.98)	0.41 (0.18-0.91)	0.144
Catholic	135 (65.22)	42 (45.16)	2.46 (1.1-5.48)	0.036
Muslim	7 (3.38)	6 (6.45)	0.89 (0.24-3.29)	0.237
Presbyterian	44 (21.26)	23 (24.73)	0.6 (0.33-1.11)	0.555
Jehovah witness	3 (1.45)	7 (7.53)	0.39 (0.13-0.45)	0.069
Marital status				
Single	121 (58.45)	63 (67.74)	0.66 (0.39-1.11)	0.342
Married	85 (41.06)	29 (31.18)	1.53 (0.91-2.57)	0.199
Widow (er)	1 (0.48)	1 (1.08)	0.34 (0.02-4.99)	0.561
Level of education				
Primary	19 (9.18)	20 (21.51)	2.47 (1.22-5.01)	0.006
Secondary	122 (58.94)	52 (55.91)	0.4 (0.2-0.81)	0.750
Higher education	63 (30.43)	18 (19.35)	1.49 (0.8-2.76)	0.088
None	3 (1.45)	3 (3.23)	0.43 (0.08-2.2)	0.314

FP=favorable prejudice, NFP=non favorable prejudice, N=total number, n=category number, %=percentage, OR=odd ratio, CI=confidence interval

Obstetric characteristics

Our respondents were multi-gravid and multiparous for the most part in the two groups but without statistical difference for these variables ($p>0.05$). The majority gestational age in our series fell within the period of term (37 and 40 weeks) and 16 pregnancies (7.72%) ended preterm in the sexually favorable against 9 (9.67%) in the paired group (Table 2). For favorable prejudice (FP) group: minimum=1; maximum= 9; mean=2.6; standard deviation (SD)=1.54. For non favorable prejudice (NFP) group: minimum=1; maximum=10; mean=2.41; SD=1.49.

The majority of pregnant women were between their second and third gestation. In the group of women with FP, a woman had on average 2.6 pregnancies ± 1.54 , a minimum of one pregnancy and a maximum of 9 pregnancies against an average of 2.41 ± 1.49 , a minimum of a pregnancy, and a maximum of 10 pregnancies in the group of women with NFP.

Sexual characteristics

The data on sexual practice in pregnancy were heterogeneous and varied according to the term and the group.

Before the 28th week of amenorrhea (WA), the respondents in the group with NFP mainly had one coitus per week as opposed to the group with FP which had an admitted frequency of 2 to 3 coitus per week but without significant statistical impact [OR: 2, 94 (1.57-5.52) ($p=0.086$)] (Table 3). The coital frequency of the gestational period from 28 WA to 36+6 WA was identical to the previous one in the two groups with however a statistically significant difference from the FP [OR: 5.1 (2.42-10.75) ($p=0.004$)] (Table 3). Eventually, sexual practice suffered a decline and 80.6% (167) of our series (207) had sexual intercourse per week (Table 3).

Parturition characteristics

Induction was artificial (balloon placement and lower pole detachment) in the majority of cases in our series in the order of 69.6% (209 cases) with significant use of oxytocin in the group not favorable to sexual practice during pregnancy [OR: 2.52 (1.53-4.15) $p=0.004$]. On admission, the majority of pregnant women (62.66%) in both groups were in the active phase. The mean dilation in women with FP was 4.23 ± 2.5 cm compared to 4.49 ± 2.49 cm in those who were reluctant to sexual activity during pregnancy; the fetal station was predominantly ≥ 4 on admission in the two groups in our series. The membranes were

predominantly intact on admission in the two paired groups (Table 4); almost one in two pregnant women in our series gave birth by caesarean section and the indications for caesarean section were invariably the same in both arms (Table 5). However, we found a significant association between maternal complications and reluctance to sexual activity; this increased the risk of perineal tears by nine times [OR: 8.99 (4.02-10.1) p=0.001] and more than five times to cervical tears [OR: 5.44 (2.44-8.73) p=0.0001]; cases of uterine rupture were

twice as many as in the opposite group and six times as many cases of postpartum hemorrhage but without statistically significant impact (Table 6).

Characteristics of the new-born

We found no statistically significant difference in fetal well-being in the two groups (Apgar score, malformation and death) (Tables 7-9).

Table 2: Distribution of the target population according to parity and gestational age.

Variables	FP n=207, N (%)	NFP n=93, N (%)	OR (95% CI)	P value
Parity				
Primiparous	78 (37.68)	34 (36.56)	1.05 (0.63-1.74)	0.883
Multiparous	129 (62.32)	59 (63.44)	0.95 (0.57-1.7)	0.910
Gestational age (GA)				
28-33	5 (2.42)	2 (2.15)	1.59 (0.24-9.57)	0.890
33-36	11 (5.32)	7 (7.53)	0.63 (0.09-4.19)	0.469
37-40	149 (71.98)	63 (67.74)	1.5 (0.50-4.07)	0.686
Above 41	42 (20.28)	21 (22.58)	1.27 (0.43-3.72)	0.689

FP=favorable prejudice, NFP=non favorable prejudice, N=total number, n=category number, %=percentage, OR=odd ratio, CI=confidence interval

Table 3: Distribution of the target population according to sexual practice during pregnancy before 28 WA, between 28 and 37 WA and at 37 WA.

Variables	FP n=207, N (%)	NFP n=55, N (%)	OR (95% CI)	P value
Before 28 WA				
1*/week	76 (36.7)	38 (69.1)	0.34 (0.18-0.64)	0.001
2-3*/week	100 (48.3)	17 (30.9)	2.94 (1.57-5.52)	0.086
4* and above	31 (15.0)	-	-	-
Total	207 (100.0)	55 (100.0)	-	-
Between 28 WA and 37 WA				
1*/week	83 (40.1)	45 (81.8)	0.20 (0.1-0.42)	0.0001
2-3*/week	94 (45.4)	10 (18.2)	5.1 (2.42-10.75)	0.004
4* and above	30 (14.5)	-	-	-
Total	207 (100.0)	55 (100.0)	-	-
At 37 WA and above				
1*/week	120 (58.0)	47 (85.5)	0.34 (0.15-0.75)	0.023
2-3*/week	60 (29.0)	8 (14.5)	2.94 (1.31-6.45)	0.062
4* and above	27 (13.0)	-	-	-
Total	207 (100.0)	55 (100.0)	-	-

FP=favorable prejudice, NFP=non-favorable prejudice, N=total number, n=category number, %=percentage, OR=odd ratio, WA=weeks of amenorrhea

Table 4: Distribution of the target population by mode of labor onset, use of oxytocin, cervical dilatation, fetal station at admission and state of membranes.

Variables	FP n=207, N (%)	NFP n=93, N (%)	OR (95% CI)	p value
Mode of onset				
Spontaneous	67 (32.37)	24 (25.81)	1.38 (0.8-2.39)	0.340
Artificial	140 (67.63)	69 (74.19)	2.03 (1.08-3.83)	0.029
Use of oxytocin				
Yes	61 (29.76)	48 (51.61)	2.52 (1.53-4.15)	0.004
No	144 (70.24)	45 (48.39)	-	-

Continued.

Variables	FP n=207, N (%)	NFP n=93, N (%)	OR (95% CI)	p value
Cervical dilatation on admission				
Latent phase	78 (37.68)	34 (36.56)	1.05 (0.63-1.74)	0.883
Active phase	129 (62.32)	59 (63.44)	0.95 (0.57-1.7)	0.910
Station at admission				
<2	14 (6.8)	-	9(9.7)	0.399
2-4	39 (18.8)	-	21(22.6)	0.503
≥4	154 (74.4)	-	63(67.7)	0.531
State of membranes				
Intact	146 (70.53)	72 (77.42)	0.7 (0.4-1.24)	0.517
Ruptured	61 (29.47)	21 (22.58)	1.43 (0.81-2.52)	0.291

FP=favorable prejudice, NFP=non favorable prejudice, N=total number, n=category number, % percentage, OR=odd ratio, CI=confidence interval

Table 5: Distribution of the target population according to the delivery route.

Route of delivery	FP n=207, N (%)	NFP n=93, N (%)	OR (95% CI)	P value
Vaginal delivery	105 (50.72)	47 (50.54)	1.01 (0.62-1.65)	0.983
Caesarean delivery	102 (49.28)	46 (49.46)	0.99 (0.61-1.62)	0.983

FP=favorable prejudice, NFP=non favorable prejudice, N=total number, n=category number, % percentage, OR=odd ratio, CI=confidence interval

Table 6: Distribution of the target population according to obstetric trauma.

Accouchement	FP n=207, N (%)	NFP n=93, N (%)	OR (95% CI)	P value
Perineal tear				
Yes	9 (8.65)	23 (46.00)	8.99 (4.02-10.1)	0.001
No	95 (91.34)	27 (54.00)	-	1
Cervical tear				
Yes	1 (0.96)	8 (16.32)	5.44 (2.44-8.73)	0.0001
No	103 (99.03)	41 (83.67)	-	1
Vaginal tear				
Yes	8 (7.47)	2 (4.16)	0.52 (0.11-2.55)	0.453
No	99 (92.52)	46 (95.83)	-	1
Uterine rupture				
Yes	1 (0.93)	2 (4.25)	4.71 (0.42-9.91)	0.275
No	106 (99.06)	45 (95.74)	-	1
Post partum haemorrhage				
Yes	2 (1.94)	12 (25.53)	5.77 (0.51-9.23)	0.117
No	101 (98.05)	35 (74.46)	-	1

FP=favorable prejudice, NFP=non favorable prejudice, N=total number, n=category number, % percentage, OR=odd ratio, CI=confidence interval

Table 7: Distribution of the target population according to the characteristics of the newborn.

Variables	FP n=207, N (%)	NFP n=93, N (%)	OR (95% CI)	P value
Apgar at 1st min				
< 7	57 (27.54)	34 (36.56)	0.62 (0.37-1.05)	0.189
> 7	150 (72.46)	59 (63.44)	1.52 (0.9-2.56)	0.387
Apgar at 5th min				
< 7	23 (11.11)	14 (15.05)	0.71 (0.35-1.45)	0.368
> 7	184 (88.89)	79 (84.95)	1.42 (0.69-2.91)	0.736

FP=favorable prejudice, NFP=non favorable prejudice, N=total number, n=category number, % percentage, OR=odd ratio, CI=confidence interval

Table 8: Distribution of the target population according to the fetal anomalies detected.

Abnormalities discovered	FP n=207, N (%)	NFP n=93, N (%)	OR (95% CI)	P value
None	156 (75.36)	70 (75.27)	0.79 (0.3-2.09)	0.884
Neonatal asphyxia	17 (8.21)	6 (6.45)	1,25 (0.39-4.02)	0.644
Neonatal infection	25 (12.08)	11 (11.83)	0.8 (0.25-2.58)	0.997
Others	9 (4.35)	6 (6.45)	0.66 (0.19-2.31)	0.451

FP=favorable prejudice, NFP=non favorable prejudice, N=total number, n=category number, % percentage, OR=odd ratio, CI=confidence interval

Table 9: Distribution of the target population by fetal death.

Fetal death	FP n=207, N (%)	NFP n=93, N (%)	OR (95% CI)	P value
Yes	10 (4.83)	4 (4.30)	1.13 (0.34-3.74)	0.956
No	197 (95.17)	89 (95.70)	-	1

FP=favorable prejudice, NFP=non favorable prejudice, N=total number, n=category number, % percentage, OR=odd ratio, CI=confidence interval

DISCUSSION

Our comparative study sought to determine the benefit of sexual practice during pregnancy on childbirth.

On the socio-demographic level

Age

In our series, we had an average age of 27.27±6.28 years with extremes of 15 and 45 without a significant difference for the age groups. Our findings are in harmony with those of the literature as reported by Kafei et al.⁶

Type of occupation

The predominant occupation was housewives (35.27%) for the favourable prejudice group and school children (33.33%) for the non-favourable prejudice group. There was no difference between the types of occupation among the respondents; our data are similar to those of Kafei et al.

Sexual practice during pregnancy and coital frequency depending on the term

Sexuality is intimate to 'ME' and its questioning even in the context of safe confidentiality is not a comfortable exercise for everyone. Our results were mixed and varied according to the group surveyed and to some extent the term. However, a constant was observed in the group with NFP; because regardless of the term, the average was single weekly coitus despite bodily and physiological changes, the weight of traditions and taboos (nausea, vomiting, fear of abortion, harm to the foetus, and lack of interest in pregnant women). On the other hand, the group favourable to the sexual practice in pregnancy showed a regressive evolution of the weekly sexual frequency thus passing from 2-3 coitus at 28 SA to 36 SA and 6 days to 1 weekly coitus at term (48.3% of the women had 2 to 3 sexual intercourse/week before 28 SA; 45.4% between 28 SA and 36 SA and 6 days, and 29% at term). Our findings are similar to the findings of Orji and Haywood.^{12,15}

Mode of induction of labour and use of oxytocin

The trigger was artificial (balloon placement and detachment of the lower pole) in the majority of the cases in our series in the order of 69.6% (209 cases) with significant use of oxytocin in the group not favourable to sexual practice in pregnancy [OR: 2.52 (1.53-4.15); p=0.004] which therefore exposed more than twice to the use of oxytocin: our data are similar to the work of Foumane et al (p<0.05) who report reluctance to sexuality as a determinant of the use of oxytocin during labour.¹⁴ Added to these the work of Kavanagh et al on the effect of sexual intercourse on stimulation of the lower segment, the endogenous release of post orgasmic oxytocin, including the action of prostaglandins contained in the sperm ejaculate.¹⁶

Delivery route

Regardless of the group matched in our series, almost one in two pregnant women delivered by caesarean and the indications were invariably the same in both groups (p=0.983). The findings of Tan et al go in the same direction.⁹

Obstetric characteristics

The African framework being potentially reproductive, more than 50% our series was made up of multi-gravid and multipara. This is contradictory to the study by Torkestani et al where the majority of women were nulliparous.⁷ The framework of his study seems to us to be the explanation.

Maternal prognosis and state of the newborn at birth

Maternal complications

Like Foumane et al, we did not find any statistical difference concerning the state of the membranes, the dilation, and the foetal station in the two groups.¹⁴ On the other hand, our findings relating to maternal complications are contrary to theirs because in our series, reluctance to

sexual activity exposed more than eight times to perineal tears [OR: 8.99 (4.02-10.1); p=0.001] and more than five times to cervical tears [OR: 5.44 (2.44-8.73); p=0.0001]; uterine rupture cases were found twice as often as in the opposite group and six times more cases of postpartum hemorrhage but without significant statistical impact.

In our opinion, this statistical gap probably stems from the differences observed in the two samples, but also from the subjective nature of some of the respondents' responses. But beyond the thesis and antithesis sequence of this analysis, it should be recalled that the data in the literature on the inappropriate use of oxytocin are the same as our findings and the latter cannot be a relevant argument. Unless there is a subsequent multi-centre cohort study better developed on this theme in order to identify certain elements of statistical confusion.

Apgar score

We found no significant statistical difference in foetal wellbeing in the two groups (Apgar score, malformation and death). Our findings are similar to that of Tan et al.⁹ This suggests that sexual activity has no effect on the state of the new-born.

Limitations of our study

The delicacy of the subject under study associated with the weights of our cultures constituted a handicap both in the enrollment and in the reliability of essentially declarative data.

A strong subjectivity emerges from it and therefore does not allow analyzes or relevant conclusions, because depending on the psychological profile, some respondents could reduce or increase the frequency of their weekly coitus and thus constitute significant biases.

CONCLUSION

At the end of our work we formulate the hypothesis that the sexual practice in pregnancy would protect from excessive use of oxytocin, cervical and perineal tears, postpartum haemorrhages and uterine ruptures. While promoting the sexual practice in pregnancy for more marital harmony, our findings however require subsequent multi-centre studies of cohort follow-up in order to discriminate certain variables of statistical confusion because the inappropriate use of oxytocin is known to be the cause of pelvic tears, postpartum haemorrhages by consecutive uterine atony rapid labour, foetal distress, without forgetting the practical profile of the birth attendant.

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