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Factor Analysis Of Third Trimester Pregnant Women's Perceptions And The Influence Of Abstinence From Sexual Intercourse

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Abstract

Background: Pregnancy is a physiological process accompanied by physical, psychological, hormonal, and social changes. During the third trimester, many pregnant women develop different perceptions regarding sexual Intercourse Myths and misconceptions often lead women to abstain from sexual activity due to fear of harming the fetus or triggering complications. However, sexual intercourse is generally considered safe in uncomplicated pregnancies. Objective: To analyze the relationship between third trimester pregnant women's perceptions and sexual abstinence behavior. Methods: This quantitative analytic study employed a cross-sectional design involving 120 third-trimester pregnant women attending antenatal care at a primary healthcare center. Data were collected using validated questionnaires and analyzed using Chi- square tests. Results: Most respondents had negative perceptions regarding sexual intercourse during pregnancy (56.7%), while 61.7% reported abstaining from sexual intercourse. There was a statistically significant relationship between perception and sexual abstinence behavior (p=0.001). Conclusion: Pregnant women's perceptions significantly influence sexual abstinence during the third trimesters. Improving antenatal education May help correct misconceptions and support healthy marital relationships during pregnancy.

Keywords: Perception; Third Trimester Pregnancy; Sexual Intercourse; Sexual Abstinence; Pregnancy.

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1. Introduction

Pregnancy is a physiological process that lasts approximately 40 weeks and is characterized by various anatomical, physiological, hormonal, psychological, and social changes in the mother. These changes occur as the body adapts to support the growth and development of the fetus until delivery. Entering the third trimester, these changes become more apparent, such as uterine enlargement, weight gain, back pain, fatigue, sleep disturbances, increased urinary frequency, and anxiety before delivery. These conditions not only affect the mother's physical health but also impact the couple's sexual life.

Sexual activity during pregnancy is an important part of reproductive health and the quality of marital relationships. In a normal, uncomplicated pregnancy, sexual intercourse is generally safe until delivery. However, many couples still have concerns about sexual activity during pregnancy, especially in the third trimester. These concerns include the belief that sexual intercourse can cause miscarriage, premature labor, premature rupture of membranes, fetal infection, bleeding, or injury to the baby. Most of these beliefs stem from myths, the experiences of others, and information not based on scientific evidence.

Perception is the process by which an individual receives, interprets, and assigns meaning to information, thus influencing their attitudes and behavior. Pregnant women's perceptions of sexual intercourse are influenced by various factors, including education level, knowledge, culture, religion, previous pregnancy experiences, husband's support, and information obtained from health professionals and social media. Positive perceptions will encourage pregnant women and their partners to maintain safe sexual relations, appropriate to the pregnancy's circumstances. Negative perceptions may lead couples to avoid sexual intercourse even when there are no medical contraindications.

The phenomenon of abstinence from sexual intercourse among pregnant women is still widespread in various regions in Indonesia. Abstinence during pregnancy is often due to fear of harming the fetus, discomfort due to physical changes, decreased libido, or cultural beliefs passed down through generations. Furthermore, prolonged abstinence from sexual activity can impact marital harmony, increase psychological stress, and reduce a couple's quality of life if not accompanied by effective communication.

The role of healthcare professionals, particularly midwives, is crucial in providing counseling on sexual health during pregnancy. Education provided during antenatal care is expected to dispel various myths prevalent in society and increase pregnant women's understanding of conditions that permit and require cessation of sexual intercourse. Comprehensive counseling is not only aimed at the pregnant woman but also involves the husband so that both parties have the same understanding regarding sexual activity during pregnancy.

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Various studies have shown that pregnant women's perceptions are related to sexual behavior during pregnancy. Pregnant women with negative perceptions tend to abstain from sexual intercourse more frequently than those with positive perceptions. However, research findings from various regions indicate variations influenced by social and cultural characteristics, education levels, and access to reproductive health information. Therefore, research on the relationship between pregnant women's perceptions in the third trimester and sexual abstinence remains relevant, particularly at the primary healthcare level, such as community health centers.

Based on this description, this study aims to analyze the relationship between the perceptions of pregnant women in their third trimester and their sexual abstinence behavior at community health centers (Puskesmas). The results are expected to inform the development of reproductive health education programs for pregnant women and their partners, thereby improving the quality of antenatal care and supporting maternal and family health.

2. Research Methods

This study employed a quantitative analytical approach using a cross-sectional design to examine the relationship between pregnant women's perceptions during the third trimester of pregnancy and sexual abstinence behaviour. A cross-sectional design was considered appropriate because both the independent variable, namely pregnant women's perceptions regarding sexual intercourse during pregnancy, and the dependent variable, namely sexual abstinence behaviour, were measured simultaneously during a single period of observation without any follow-up. This design allows the relationship between variables to be identified efficiently while providing a snapshot of the phenomenon under investigation at a particular point in time. The quantitative approach was adopted because the study generated numerical data obtained from structured questionnaires completed by the respondents. The collected data were subsequently analysed using appropriate statistical methods to determine whether a statistically significant relationship existed between pregnant women's perceptions and sexual abstinence behaviour. Therefore, this design was considered suitable for analytical epidemiological research aimed at identifying factors associated with specific health-related behaviours.

The study was conducted at a Community Health Centre (Puskesmas) providing antenatal care (ANC) services for pregnant women. The research site was selected purposively because community health centres serve as primary healthcare facilities with a relatively large number of antenatal visits by women in their third trimester of pregnancy, thereby facilitating respondent recruitment and ensuring adequate sample representation. The research was carried out between January and March 2026, covering the preparation

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phase, administrative procedures for research approval, instrument testing, data collection, data processing, statistical analysis, and report preparation. Data collection was undertaken during routine antenatal care visits. Prior to participation, all respondents received a comprehensive explanation regarding the objectives, benefits, and procedures of the study, as well as their right to refuse participation or withdraw from the study at any stage without affecting the healthcare services they received.

The study population comprised all pregnant women in their third trimester who attended antenatal care services at the selected Community Health Centre during the study period. Eligible participants were women with a gestational age between 28 and 40 weeks, who had a husband, were willing to participate by signing a written informed consent form, were able to read and write Indonesian, and had no communication difficulties. Pregnant women with obstetric complications contraindicating sexual intercourse, including placenta previa, antepartum haemorrhage, premature rupture of membranes, incompetent cervix, or threatened preterm labour, were excluded from the study. Respondents who failed to complete the questionnaire or who withdrew before completion of data collection were also excluded. The final sample consisted of 120 respondents, with the required sample size determined using the Slovin formula at a 5% margin of error. This sample size was considered representative of the target population and sufficient to analyse the relationship between pregnant women's perceptions and sexual abstinence behaviour during the third trimester. Respondents were recruited using a consecutive sampling technique, whereby every eligible pregnant woman attending antenatal care services during the study period was invited to participate consecutively until the predetermined sample size had been achieved.

The independent variable in this study was pregnant women's perception regarding sexual intercourse during the third trimester of pregnancy. Perception was defined as the mother's beliefs, opinions, and assessments concerning the safety of sexual intercourse during pregnancy, its perceived benefits, possible risks to the fetus, and beliefs shaped by personal experiences, cultural values, religious beliefs, and information received from healthcare professionals. The dependent variable was sexual abstinence behaviour, defined as the decision of pregnant women and their partners to refrain from sexual intercourse during the third trimester of pregnancy, either temporarily or throughout the remaining pregnancy. Operationally, pregnant women's perception was measured using a 20-item questionnaire and classified on an ordinal scale into positive or negative perceptions. Sexual abstinence behaviour was measured using a 10-item questionnaire and categorised on a nominal scale as either "Yes" or "No."

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Data were collected using a structured questionnaire consisting of three complementary sections. The first section obtained respondents' demographic and obstetric characteristics, including age, educational attainment, occupation, gestational age, parity, duration of marriage, history of pregnancy complications, and sources of information regarding sexual intercourse during pregnancy. The second section measured pregnant women's perceptions using a 20-item questionnaire with a four-point Likert scale ranging from strongly agree to strongly disagree. The questionnaire assessed respondents' perceptions regarding the safety of sexual intercourse during pregnancy, potential risks to the fetus, perceived benefits, maternal comfort, cultural and religious influences, and beliefs related to pregnancy myths. Total scores were subsequently categorised into positive or negative perceptions using the median score as the cut-off point. The third section consisted of a 10-item questionnaire assessing sexual abstinence behaviour, including sexual activity during the third trimester, frequency of sexual intercourse, reasons for abstinence, and factors influencing couples' decisions regarding sexual activity during pregnancy.

Before data collection, all research instruments were pilot-tested among 30 pregnant women with characteristics similar to those of the study participants but who were not included in the final sample. Instrument validity was evaluated using the Pearson Product Moment correlation test, with questionnaire items considered valid when the calculated correlation coefficient exceeded the critical r-value of 0.361 at a significance level of 5%. Instrument reliability was assessed using Cronbach's alpha coefficient, with values of 0.70 or above indicating acceptable internal consistency. The perception questionnaire demonstrated a Cronbach's alpha coefficient of 0.89, while the sexual abstinence questionnaire yielded a coefficient of 0.86, indicating that both instruments possessed excellent reliability for measuring the study variables.

Data collection was conducted through a systematic procedure. Initially, permission to undertake the study was obtained from the relevant educational institution, local health authorities, and the head of the participating Community Health Centre. The researcher subsequently coordinated with the maternal and child health (KIA) coordinating midwife to determine the schedule for respondent recruitment and questionnaire administration. Eligible respondents attending antenatal care services were approached, informed about the objectives and procedures of the study, and invited to provide written informed consent before participation. Respondents completed the questionnaire independently within approximately 20–30 minutes. Whenever clarification was required, the researcher explained the meaning of the questions without influencing the respondents' answers.

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Following completion, each questionnaire was checked for completeness before coding and data entry were performed.

The collected data were processed systematically through several sequential stages, including editing to verify the completeness and consistency of respondents' answers, coding by assigning numerical values to each variable, data entry into the Statistical Package for the Social Sciences (SPSS), data cleaning to identify and correct potential entry errors, and tabulation to organise the data into frequency distribution tables prior to statistical analysis.

Data analysis consisted of univariate and bivariate analyses. Univariate analysis was performed to describe respondents' demographic characteristics and the distribution of each study variable using frequencies, percentages, means, standard deviations, minimum values, and maximum values. Bivariate analysis was conducted to examine the relationship between pregnant women's perceptions and sexual abstinence behaviour using the Chi-square test because both variables were categorical in nature. Statistical significance was determined at a p-value of less than 0.05, whereas a p-value of 0.05 or greater indicated no statistically significant association. The strength of the relationship was further evaluated by calculating the Odds Ratio (OR) together with the corresponding 95% Confidence Interval (CI), thereby estimating the likelihood of sexual abstinence among women with negative perceptions compared with those with positive perceptions.

This study was conducted in accordance with internationally recognised ethical principles governing health research, including respect for persons, beneficence, non-maleficence, and justice. Ethical approval was obtained from the authorised Health Research Ethics Committee prior to data collection. All respondents received a comprehensive explanation regarding the objectives, benefits, and procedures of the study, together with information concerning their right to refuse participation or withdraw from the study at any time without affecting the healthcare services they received. Written informed consent was obtained from every participant before enrolment. To maintain confidentiality, respondents' identities were replaced with identification codes, and all collected information was used exclusively for research purposes. The findings are presented only in aggregate form without revealing any personal identifying information, thereby ensuring participants' privacy and confidentiality throughout the research process.

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3. RESEARCH RESULTS AND DISCUSSION

a. Research result

A total of 120 pregnant women in their third trimester who underwent antenatal care (ANC) check-ups at a community health center (Puskesmas) during the study period met the inclusion criteria and agreed to participate. All questionnaires were returned complete so that all data could be analyzed.

Univariate = analysis to determine the distribution of respondent characteristics, perceptions of pregnant women, and sexual abstinence behavior, as well as bivariate analysis using the Chi- square test to determine the relationship between perceptions of pregnant women in the third trimester and sexual abstinence.

1) Univariate Analysis

a) Respondent Characteristics

Respondent characteristics included age, education level, occupation, parity, and sources of information regarding sexual relations during pregnancy.

Table 1 Distribution of Respondent Characteristics

Characteristics	Frequency (n)	Percentage (%)
Age		
20–35 years	88	73.3
<20 or >35 years	32	26.7
Education		
Elementary–Middle School	29	24.2
Senior High School	56	46.7
College	35	29.1
Work		
Housewife	72	60.0
Work	48	40.0
Parity		
Primigravida	51	42.5
Multigravida	69	57.5
Resources		
Health workers	53	44.2
Social media	31	25.8
Family	22	18.3
Friend	14	11.7
Amount	120	100

Table 1 shows that the majority of respondents were aged 20–35 years (73.3%). Most had a high school education (46.7%), were unemployed or

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housewives (60.0%), were multigravida (57.5%), and obtained information about sexual intercourse during pregnancy from health workers (44.2%).

b) Perceptions of Pregnant Women in the Third Trimester

Table 2 Distribution of Pregnant Women's Perceptions

Perception	Frequency	Percentage
Positive	52	43.3
Negative	68	56.7
Amount	120	100

The study results showed that more than half of respondents (56.7%) had negative perceptions about sexual intercourse during the third trimester. These negative perceptions included beliefs that sexual intercourse could harm the baby, trigger premature labor, cause premature rupture of membranes, and increase the risk of miscarriage.

Respondents who have a positive perception believe that sexual intercourse can still be carried out during a normal pregnancy if there are no medical contraindications and approval has been obtained from a health worker.

c) Abstinence from Sexual Intercourse

Table 3 Distribution of Sexual Abstinence

Sexual abstinence	Frequency	Percentage
Yes	74	61.7
No	46	38.3
Amount	120	100

Based on Table 3, it is known that the majority of pregnant women in their third trimester abstain from sexual intercourse, namely 74 people (61.7%).

The main reasons respondents practice sexual abstinence include:

- fear of harming the fetus (71%)
- fear of premature birth (62%)
- feel uncomfortable due to changes in body shape (58%)
- family recommendation (39%)
- decreased sexual desire (37%).

These findings indicate that psychological factors and beliefs that develop in society are still the main reasons why pregnant women avoid sexual activity.

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2) Bivariate Analysis

Bivariate analysis was performed using the Chi- square test.

Table 4 Relationship between Perception and Abstinence from Sexual Intercourse

Perception	Abstinence	No Abstinence	Amount	*p-value*	Odds Ratio (OR)
Positive	20	32	52	**0.001**	**6.17**
Negative	54	14	68		
Amount	74	46	120		

Because the p value is <0.05, there is a significant relationship between the perception of third trimester pregnant women and abstinence from sexual relations.

The OR value of 6.17 shows that pregnant women who have negative perceptions have approximately six times greater chance of abstaining from sexual intercourse compared to mothers who have positive perceptions.

b. Discussion

1) Perceptions of Pregnant Women in the Third Trimester

The study results showed that the majority of respondents held negative perceptions about sexual intercourse during the third trimester. This situation illustrates that many pregnant women still believe sexual intercourse has the potential to harm the fetus and the pregnancy process. These negative perceptions generally stem from prevailing myths, the experiences of others, and a lack of accurate information about reproductive health during pregnancy. This finding aligns with research showing that fear of the impact of sexual intercourse on the fetus is a common reason pregnant women choose not to have sex.

Perceptions are also influenced by education level, culture, religious values, previous pregnancy experiences, and communication with partners. Pregnant women who receive information from health professionals tend to have more positive perceptions than those who only obtain information from their environment or social media without clear sources.

2) Abstinence from Sexual Intercourse

This study showed that 61.7% of respondents chose to abstain from sex during the third trimester. This figure indicates that sexual abstinence remains quite high among pregnant women.

The decision to abstain from sexual intercourse is largely based on fear of possible bleeding, premature rupture of membranes, infection, or premature labor. However, in a normal, uncomplicated pregnancy, sexual intercourse is generally considered safe until delivery if there are no medical contraindications. A decrease

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in sexual activity in the third trimester often occurs due to a combination of physical, psychological, and social factors.

3) The Relationship Between Perception and Abstinence from Sexual Intercourse

Square test showed a significant relationship between the perceptions of pregnant women in the third trimester and the behavior of abstaining from sexual intercourse (p=0.001). Odds Value The ratio of 6.17 shows that mothers with negative perceptions are much more likely to avoid sexual intercourse than mothers with positive perceptions.

These findings reinforce the theory that perception is a determinant of health behavior. When someone believes that an action could harm themselves or their fetus, they are more likely to avoid that action, even if this is not necessarily supported by scientific evidence.

The results of this study also align with those of Beveridge et al., who found that fear of the impact of sexual intercourse during pregnancy was associated with the decision to abstain from sexual activity. Another study in Indonesia also reported that the majority of pregnant women in their third trimester had perceptions that influenced their decision to abstain from sexual intercourse during pregnancy.

4) Research Implications

The findings of this study demonstrate the importance of improving reproductive health education in antenatal care. Counseling regarding sexual intercourse during pregnancy should be included in routine antenatal care (ANC) services so that pregnant women and their partners receive accurate information about safe pregnancy conditions for sexual intercourse and conditions that are contraindicated.

Midwives, as primary care providers, play a crucial role in identifying misperceptions, providing evidence-based education, and involving husbands in counseling. This approach is expected to reduce anxiety, improve couple communication, and facilitate informed decision-making during pregnancy.

4. Conclusion And Suggestions

a. Conclusion

This study shows that the majority of pregnant women in their third trimester at the Community Health Center (Puskesmas) have negative perceptions about sexual intercourse during pregnancy. These perceptions are primarily related to the belief that sexual intercourse can harm the fetus, cause premature rupture of membranes, trigger

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premature labor, or lead to pregnancy complications. Furthermore, most respondents also chose to abstain from sexual intercourse during the third trimester.

A bivariate analysis using the Chi- square test showed a significant relationship between the perceptions of pregnant women in the third trimester and abstinence from sexual intercourse ($p = 0.001$). Pregnant women with negative perceptions were more likely to abstain from sexual intercourse than those with positive perceptions.

These findings indicate that perception is a crucial factor influencing sexual behavior during pregnancy. Inaccurate perceptions are generally influenced by limited knowledge, prevailing myths, personal experiences, cultural beliefs, and a lack of accurate information from healthcare providers. Therefore, increased education about sexual health during pregnancy needs to be part of antenatal care so that pregnant women and their partners receive accurate information and are able to make informed decisions based on their medical conditions.

b. Suggestion

The findings of this study provide practical implications for healthcare services, healthcare professionals, pregnant women, and future research. Community health centres are encouraged to strengthen antenatal care by providing structured education on reproductive health and sexual activity during pregnancy. Midwives and other healthcare professionals should offer comprehensive counselling involving both pregnant women and their partners to promote informed decision-making and support a positive pregnancy experience.

Pregnant women are encouraged to seek accurate information from qualified healthcare providers and make decisions regarding sexual activity based on their health condition and professional medical advice rather than misconceptions or myths. Future studies should involve larger and more representative samples from multiple healthcare facilities and explore additional factors, such as maternal knowledge, anxiety, partner support, cultural beliefs, religiosity, and the quality of antenatal counselling. Longitudinal or cohort study designs are also recommended to provide stronger evidence regarding factors associated with sexual abstinence during pregnancy.

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