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# POSTPARTUM QUALITY OF SEXUAL LIFE: A STUDY ON RELATED FACTORS

# POSTPARTUM CİNSEL YAŞAM KALİTESİ: İLİŞKİLİ FAKTÖRLER ÜZERİNE BİR ÇALIŞMA

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**Abstract**

This study aimed to determine the quality of sexual life and the biopsychosocial factors affecting it in the postpartum period. This descriptive and cross-sectional study was conducted in a province with predominantly rural sociocultural characteristics, at a university hospital and a state hospital. The sample consisted of 149 women in the fourth month postpartum. Data were collected using a Personal Information Form, the Postpartum Fourth-Month Personal and Sexual Life History Form, and the Sexual Quality of Life–Female (SQOL-F) scale. Descriptive statistics and appropriate parametric and non-parametric tests were used for data analysis. The mean SQOL-F score of the participants was 69.69±1.88. Significant associations were found between sexual quality of life and educational level, employment status, income level, partner's educational level, place of residence, type of marriage, body mass index, satisfaction with physical appearance, pre-pregnancy sexual intercourse frequency, and the presence of postpartum sexual problems ($p<0.05$). No significant relationship was observed between sexual quality of life and mode of delivery or breastfeeding status. In conclusion, sexual quality of life in the postpartum period appears to be associated with the interaction of biological, psychological, and social factors. These findings highlight the importance of addressing sexuality as an integral component of postpartum care and providing women-centered, holistic counseling services tailored to individual needs.

**Keywords:** Postpartum care, Postpartum period, Sexual health, Sexual quality of life, Women's health

**Öz**

Bu çalışma, postpartum dönemde kadınların cinsel yaşam kalitesini ve ilişkili biyopsikososyal faktörleri belirlemek amacıyla yapılmıştır. Tanımlayıcı ve kesitsel tipteki araştırma, taşrada bir üniversite hastanesi ve bir devlet hastanesinde yürütülmüştür. Araştırmanın örneklemini belirtilen hastanelerde doğum yapan 149 kadın oluşturmuştur. Veriler, Kişisel Bilgi Formu, Postpartum 4. Ayda Kişisel ve Cinsel Yaşam Öykü Formu ve Cinsel Yaşam Kalitesi Ölçeği–Kadın (SQOL-F) kullanılarak toplanmıştır. Verilerin analizinde tanımlayıcı istatistikler ile uygun parametrik ve non-parametrik testler kullanılmıştır. Kadınların SQOL-F puan ortalaması 69.69±1.88 olarak bulunmuştur. Kadınların eğitim ve gelir düzeyi, çalışma durumu, eşin eğitim düzeyi, evlilik şekli, yaşanılan yer, beden kitle indeksi, fiziksel görünümden memnuniyet, gebelik öncesi cinsel ilişki sıklığı ve postpartum dönemde cinsel sorun yaşama durumuna göre SQOL-F puan ortalaması arasında istatistiksel olarak anlamlı bir fark saptanmıştır ($p<0.05$). Doğum şekli ve emzirme durumuna göre kadınların SQOL-F puan ortalamaları karşılaştırıldığında anlamlı bir fark bulunmamıştır ($p>0.05$). Sonuç olarak postpartum dönemde cinsel yaşam kalitesi; biyolojik, psikolojik ve sosyal faktörlerin etkileşimiyle şekillenmektedir. Bu bulgular, postpartum bakım hizmetlerinde cinselliğin bütüncül bir yaklaşımla ele alınması ve kadınların bireysel gereksinimlerine duyarlı danışmanlık hizmetlerinin sunulmasının önemini ortaya koymaktadır.

**Anahtar Kelimeler:** Postpartum bakım, Postpartum dönem, Cinsel sağlık, Cinsel yaşam kalitesi, Kadın sağlığı

## 1. Introduction

The postpartum period is a critical stage in a woman's life, marked by physiological, psychological, hormonal, and social changes. During this time, sexual life is affected by perineal trauma related to the mode of delivery, hormonal changes, breastfeeding, fatigue, anxiety, and changes in relationship dynamics. The literature reports that 40–90% of women experience decreased sexual desire, dyspareunia, vaginal dryness, and decreased sexual satisfaction in the first year postpartum (Eryılmaz & Şentürk Erenel, 2023; Güler & Erbil, 2022; Koç & Oskay, 2015; Türk & Erkaya, 2019). Hormonal changes, particularly high prolactin and decreased estrogen levels due to breastfeeding, cause sexual dysfunction such as vaginal dryness, difficulty arousing, and decreased libido (Gutzeit et al., 2020; O'Malley et al., 2018). In addition to hormonal changes, episiotomy, perineal tears, or pelvic floor muscle weakness during the physical healing process can also cause pain during sexual intercourse (Atlıhan et al., 2025; Rodaki et al., 2022; Serati et al., 2010).

Psychosocial factors are also determinants of postpartum sexual life quality. During this period, adaptation to the parenting role, fatigue, changes in body image, relational satisfaction, spousal support, and mental health problems such as postpartum depression and anxiety are variables that strongly affect the quality of sexual life (Aksu & Çevik, 2023; Gutzeit et al., 2020). Therefore, sexuality in the postpartum period is a multidimensional phenomenon that should be addressed holistically, not only physiologically but also within a biopsychosocial framework (Hajimirzaie et al., 2021).

Sexual life quality; Sexual life is a broad concept encompassing a woman's sexual functions, feelings about sex, satisfaction, and relationship with her partner. Identifying changes in these areas during the postpartum period is crucial for meeting women's holistic health needs. While numerous studies in the literature examine different dimensions of postpartum sexual life, the majority have focused on sexual function and sexual dysfunction and have been conducted in urban areas. Research addressing the quality of sexual life in rural areas, where cultural norms, traditional family structures, and attitudes towards sexuality are more pronounced, remains limited. This study was conducted to determine the quality of women's sexual life in the postpartum period and the biological, psychological, and social factors that may be associated with it.

## 2. Materials and Methods

*2.1. Studying Type*

This study was conducted as a descriptive and cross-sectional study.

*2.2. Population and Sample*

The study was conducted in the maternity units of a provincial University Hospital and a State Hospital after obtaining the necessary ethical and institutional permissions. The population of the study consisted of postpartum women who gave birth at the aforementioned hospitals during the study period (1 December 2011 – 30 March 2012). The sample comprised women who delivered in these two hospitals between the specified dates, met the research criteria, and voluntarily agreed to participate in the study (N=149). According to the post hoc power analysis conducted at the end of the study, using the correlation model between the two scales (Exact test) and Cohen's recommendation for a medium effect size (p H1=0.3), a statistical power of 0.96 (1−β=0.96) was achieved with 149 participants (Lower/Upper Critical r = −0.16/0.16). The inclusion criteria were having given birth at the specified hospitals, being between 18 and 49 years of age, living with their spouse, and having no diagnosed sexual dysfunction. The exclusion criteria were the presence of a diagnosed sexual dysfunction, any serious obstetric or systemic health condition that could affect sexual life during the postpartum period, a diagnosed psychiatric disorder, not living with a spouse, reporting a significant life event affecting sexual life, and the presence of communication difficulties that could prevent participation in the data collection process.

*Data Collection Instruments*

The study data were collected using the Personal Information Form, the Postpartum 4th-Month Personal Characteristics and Sexual Life History Form, and the Sexual Quality of Life–Female (SQOL-F) questionnaire.

*Personal Information Form*

Developed in line with the literature and administered during the first interview, this form consisted of open- and closed-ended questions addressing participants' sociodemographic characteristics, obstetric history, general health status, and sexual life history (Serati vd., 2010; Symonds vd., 2005; Tuğut & Gölbaşı, 2010).

*Postpartum 4th-Month Personal Characteristics and Sexual Life History Form*

This form was developed by the researchers based on an extensive literature review and expert opinions in the field of women's health and midwifery. The form included 20 items evaluating postpartum personal characteristics, sexual life patterns, timing of resumption of sexual activity,

sexual frequency, sexual problems, partner-related factors, and other variables affecting sexual life. The form consisted predominantly of structured and semi-structured questions and was administered during the second face-to-face interview conducted at the fourth month postpartum (Serati vd., 2010; Symonds vd., 2005; Tuğut & Gölbaşı, 2010).

*Sexual Quality of Life–Female (SQOL-F)*
The SQOL-F scale was developed by Symonds et al. (2005), and its Turkish validity and reliability study was conducted by Tuğut and Gölbaşı (2010). The scale consists of 18 items rated on a 6-point Likert scale, with each item evaluated based on the previous four weeks. Higher scores indicate a better quality of sexual life (Symonds et al., 2005; Tuğut & Gölbaşı, 2010). In this study, the scale's Cronbach's alpha value was calculated as 0.86.

*2.3. Data Collection Procedure*
The Personal Information Form was administered face-to-face at the hospital to women who had given birth and voluntarily agreed to participate in the study. Contact information was obtained from participants who consented to a follow-up interview at four months postpartum, and appointments were scheduled via telephone. An appointment was scheduled for the second visit, during which the Postpartum 4th-Month Personal Characteristics and Sexual Life History Form and the SQOL-F were administered face-to-face; the interviews were conducted either in the participants' homes or at family health centers. The postpartum follow-up was conducted at four months after delivery, as this time frame was considered sufficiently distant from childbirth to allow women to have resumed sexual activity, while also being close enough to reduce recall bias.

*2.4. Data Analysis*
Data analysis was performed using the SPSS statistical software package. Descriptive statistics (number, percentage, mean, and standard deviation) were used for data evaluation. The normality of continuous variables was assessed using the Kolmogorov–Smirnov test, skewness–kurtosis values, and histogram plots. Variables demonstrating normal distribution were analyzed using parametric tests, whereas non-normally distributed variables were evaluated with non-parametric methods. Accordingly, one-way analysis of variance (ANOVA) was applied when comparing SQOL-F scores across more than two groups of independent variables, and the Tukey HSD test was used to identify the source of significant differences. For non-parametric analyses, the Kruskal–Wallis and Mann–Whitney U tests were employed. Pearson's chi-square test was used for categorical variables. Correlation analysis was conducted to examine the relationships between selected characteristics of women and SQOL-F scores. A $p$ value of $<0.05$ was considered statistically significant.

*2.5. Limitations of the study*
This article is derived from the author's master's thesis, entitled "Quality of Sexual Life in Postpartum Women and Factors Affecting It," accepted at Sivas Cumhuriyet University, Institute of Health Sciences in 2012 with thesis number 336761. It was limited to women who could be reached within a specific time frame. The study was conducted in a single region and included two hospitals predominantly serving populations with rural/provincial sociocultural characteristics; therefore, the findings cannot be generalized to other regions of Türkiye or populations with different cultural backgrounds. Additionally, due to the sensitive nature of sexuality, some participants may not have responded to the questions fully or honestly, which may have led to reporting bias.

## 3. Results
The mean total score on the Sexual Life Quality Scale for women participating in the study at the fourth postpartum month was 69.69±1.88, and it was determined that the scores obtained from the scale ranged from 22-100 (Table 1).
The average age of the participants was 28.26±5.29, and the average age of their spouses was 31.83±5.44. 44.3% of the women had completed primary education, 66.4% were unemployed, and 74.5% lived in the city center. Regarding income, it was determined that 64.4% of the participants had income equal to their expenses. 40.3% of the women had been married for 4–9 years, and 55.7% had married through arranged marriages (Table 2)

**Table 1.** Mean SQOL-F scores of women at the fourth postpartum month

| | Mean | SD | Min. | Max. |
|---|---|---|---|---|
| SQOL-F | 69.69 | 11.88 | 22.0 | 100.0 |

SD: Standart Deviation

**Table 2.** Distribution of women according to their sociodemographic characteristics

| Variable | n % | SQOL-F Mean ± SD | Statistical Value | Significant Difference |
|---|---|---|---|---|
| **Education level** | | | | |
| Primary school[a] | 66 (44.3) | 65.53±17.43 | F = 5.849 | a<c |
| High school[b] | 39 (26.2) | 68.04±21.51 | p = 0.004 | |
| University and above[c] | 44 (29.5) | 77.38±15.77 | | |
| **Employment status** | | | | |
| Employed[a] | 50 (33.6) | 77.65±15.39 | t = 14.875 | a>b |
| Not employed[b] | 99 (66.4) | 65.66±19.03 | p < 0.001 | |
| **Spouse's education level** | | | | |
| Primary school[a] | 51 (34.2) | 64.53±16.90 | F = 11.622 | a<c |
| High school[b] | 51 (34.2) | 65.46±20.79 | p < 0.001 | b<c |
| University and above[c] | 47 (31.6) | 79.86±13.88 | | |
| **Place of residence** | | | | |
| Rural[a] | 8 (25.5) | 50.13±16.81 | t =18,093 | a<b |
| City center[b] | 111(74.5) | 73.30±18.02 | p < 0,001 | |
| **Income Status** | | | | |
| Income less than expenses[a] | 35 (23.5) | 62.49±20.01 | KW=6.863 | a<c |
| Income equal to expenses[b] | 96 (64.4) | 71.48±17.48 | p=0.032 | b<c |
| Income more than expenses[c] | 18 (12.1) | 74.10±18.08 | | |
| **Method of Marriage** | | | | |
| Arranged Marriage[a] | 66 (44.3) | 63.85±17.24 | t=12.413 | a<b |
| By Meeting and Agreeing[b] | 83 (55.7) | 74.33±18.65 | p=0.001 | |
| **Age Mean ± SD:** 28.26±5.29 | | | | |
| **Spouse's age Mean ± SD:** 31.83±5.44 | | | | |

F: One Way ANOVA (The Tukey test was used in the posthoc analysis), t: Independent Sample t test, KW: Kruskal Wallis H test, NOTE: In posthoc analysis, letters (a, b, c) were used to indicate differences between groups.

Table 2 presents the mean SQOL-F scores according to women's sociodemographic characteristics. As shown in the table, a statistically significant difference was found between groups according to educational level ($F = 5.849$; $p = 0.004$). Women with a university degree or higher had significantly higher mean SQOL-F scores (77.38 ± 15.77) compared with women who had completed primary education (65.53 ± 17.43).

In addition, the mean SQOL-F score of employed women (77.65 ± 15.39) was significantly higher than that of unemployed women (65.66 ± 19.03) ($p < 0.001$). Similarly, women whose spouses had a university-level education or higher had significantly higher SQOL-F scores (79.86 ± 13.88) compared with those whose spouses had completed high school (65.46 ± 20.79) or primary education (64.53 ± 16.90) ($p < 0.001$).

A statistically significant difference was also observed between women living in urban areas and those residing in rural areas. Women living in city centers had higher mean SQOL-F scores (73.30 ± 18.02) than women living in rural areas (59.13 ± 16.81) ($p < 0.001$).

When SQOL-F scores were examined according to income status, women whose income exceeded their expenses had significantly higher scores (74.10 ± 18.08) compared with the other income groups ($p = 0.032$). Furthermore, women who married by mutual acquaintance and consent had significantly higher mean SQOL-F scores (74.33 ± 18.65) than those who married through arranged marriage (63.85±17.24) ($p=0.001$) (Table 2).

When women's pre-pregnancy sexual life characteristics were examined, those who reported having sexual intercourse more than 10 times per month before pregnancy had a mean SQOL-F score of 81.30±13.57, whereas women who reported having sexual intercourse fewer than four times per month had a mean score of 56.41±18.69. The difference between the groups was statistically significant ($F = 15.861$; $p < 0.001$).

Additionally, women who reported no sexual problems prior to pregnancy had significantly higher mean SQOL-F scores (75.23±17.81) compared with those who reported experiencing sexual problems (63.25±17.78) ($p<0.001$). However, no statistically significant differences were found in SQOL-F scores according to changes in sexual intercourse frequency during pregnancy or the presence of sexual problems during pregnancy ($p > 0.05$) (Table 3).

**Table 3.** Distribution of women according to their sexual life characteristics before and during pregnancy

| Variable | n % | SQOL-F Mean ± SD | Statistical Value | Significant Difference |
|---|---|---|---|---|
| **Frequency of sexual intercourse before pregnancy:** | | | | |
| More than 10 times a month[a] | 32 (21.5) | 81.30±13.57 | F=15.861 p=0.000 | a>c a>d b>d |
| 7-10 times a month[b] | 45 (30.2) | 74.98±13.92 | | |
| 5-6 times a month[c] | 32 (21.5) | 67.23±19.00 | | |
| Less than 4 times a month[d] | 40 (26.8) | 56.41±18.69 | | |
| **Sexual problems before pregnancy** | | | | |
| Yes[a] | 69 (46.3) | 63.25±17.78 | t=16.771 p<0.001 | a<b |
| No[b] | 80 (53.7) | 75.23±17.81 | | |
| **Frequency of sexual intercourse during pregnancy:** | | | | |
| Decreased compared to pre-pregnancy | 124(83.2) | 69.60±17.61 | KW=3.769 p=0.152 | - |
| No change compared to pre-pregnancy | 22 (14.8) | 67.57±24.35 | | |
| Increased compared to pre-pregnancy | 3 (2.0) | 88.86±6.17 | | |
| **Sexual problems during pregnancy (n=131)*** | | | | |
| Yes (decreased libido, pain, etc.) | 72 (55.0) | 69.60±17.61 | KW=3.769 p=0.152 | - |
| No | 41 (32.9) | 67.57±24.35 | | |
| Did not have intercourse during pregnancy | 18 (12.1) | 88.86±6.17 | | |

*This is the number of women who had sexual intercourse during pregnancy. Percentages are evaluated on a scale of 'n'. **This is the number of women who experienced sexual problems during pregnancy. Percentages are evaluated on a scale of 'n'. F: One Way ANOVA (The Tukey test was used in the posthoc analysis), t: Independent Sample t test, KW: Kruskal Wallis H test, NOTE: In posthoc analysis, letters (a, b, c, d) were used to indicate differences between groups.

In the evaluation based on birth and postpartum characteristics, the mean SQOL-F score of women who gave birth between 38–42 weeks of gestation (71.67±17.08) was significantly different from those who gave birth between 35–37 weeks (p=0.004). No significant difference was found between the type of birth and sexual life quality scores (p=0.838). Among women who underwent episiotomy, those who experienced problems at the suture site had a statistically significant mean SQOL-F score (48.60±20.55) compared to those who did not experience problems (73.49±15.59) (p=0.000). However, no significant relationship was found between experiencing problems at the cesarean section incision site and sexual life quality (p=0.993) (Table 4).

**Table 4.** Mean SQOL-F Score of women according to certain characteristics of birth and postpartum

| Variable | n (%) | SQOL-F Mean ± SD | Statistical Value | Significant Difference |
|---|---|---|---|---|
| **Birth Week** | | | | |
| 35-37th week[a] | 43 (29.0) | 64.93±21.76 | t=3.972 p=0.048 | a<b |
| 38-42nd week[b] | 106 (71.0) | 71.67±17.08 | | |
| **Type of delivery** | | | | |
| Normal vaginal | 22 (14.8) | 67.55±4.65 | F=10.177 p=0.838 | - |
| Assisted vaginal | 58 (38.9) | 69.78±18.46 | | |
| Cesarean section | 69 (46.3) | 70.29±18.11 | | |
| **Episiotomy suture problems (n=49)*** | | | | |
| Yes[a] | 8 (16.4) | 48.60±20.55 | t=15.365 p<0.001 | a<b |
| No[b] | 41 (83.6) | 73.49±15.59 | | |
| **Cesarean section incision site problem (n=69)**** | | | | |
| Yes | 6 (8.7) | 70.23±16.17 | t=0.000 p=0.993 | - |
| No | 63 (91.3) | 70.29±18.41 | | |

*This is the number of women who underwent episiotomy; percentages are calculated based on 'n'.
**This is the number of women who had a cesarean section; percentages are calculated based on 'n'.
F: One Way ANOVA, t: Independent Sample t test

When some characteristics were examined in the fourth month postpartum, a statistically significant difference was observed between body mass index and sexual life quality scores (p<0.001). There was a statistically significant difference between the mean SQOL-F score of women with

underweight/normal BMI (76.25±17.01) and the mean SQOL-F score of obese/morbidly obese women. A statistically significant difference was found between the SQOL-F scores of women who were satisfied with their physical appearance (76.99±16.15), those who were moderately satisfied (70.94±15.40), and those who were dissatisfied (53.66±17.96) (p<0.001). No statistically significant relationship was found between breastfeeding status, use of family planning methods, and time of initiation of sexual intercourse and sexual life quality (p>0.05).

A statistically significant difference was found between the mean SQOL-F score of women who reported a decrease in the frequency of sexual intercourse compared to pre-pregnancy (47.46±17.93) and those who reported an increase in frequency (79.61±13.97) (p=0.005). A statistically significant difference was determined between satisfaction with sexual life and SQOL-F scores (p=0.05). A statistically significant difference was found between the mean SQOL-F score of women who reported experiencing sexual problems in the postpartum period (65.50±19.22) and those who did not experience problems (78.57±13.89) (p=0.000) (Table 5)

**Table 5.** Mean SQOL-F scores of women according to some characteristics in the fourth month postpartum

| Variable | n (%) | SQOL-F Mean ± SD | Statistical Value | Significant Difference |
|---|---|---|---|---|
| **BMI (Body Mass Index)** | | | | |
| Underweight/Normal[a] | 77 (51.6) | 76.25±17.01 | F = 25.364 | a>b |
| Overweight[b] | 50 (33.6) | 64.87±18.93 | p < 0.001 | a>c |
| Obese/Morbidly Obese[c] | 22 (14.8) | 57.67±14.86 | | |
| **Satisfied with physical appearance** | | | | |
| Satisfied[a] | | | | a>b |
| Moderately satisfied[b] | 69 (46.4) | 76.99±16.15 | F = 23.746 | a>c |
| Not satisfied[c] | 45 (30.2) | 70.94±15.40 | p < 0.001 | b>c |
| | 35 (23.4) | 53.66±17.96 | | |
| **Breastfeeding status** | | | | |
| Breastfeeding | 126 (84.6) | 70.65±18.54 | KW = 1.896 | - |
| Not breastfeeding | 23 (15.4) | 64.38±19.24 | p = 0.169 | |
| **Using family planning methods** | | | | |
| Not using | 44 (29.6) | 69.21±19.01 | t = 0.039 | - |
| Using | 105 (60.4) | 69.88±18.69 | p = 0.843 | |
| **Timing to start sexual intercourse:** | | | | |
| Weeks 3-5 | | | | |
| Weeks 6-8 | 45 (30.2) | 73.63±19.12 | KW = 3.744 | - |
| Weeks 9 and later | 79 (53.0) | 68.09±17.13 | p = 0.154 | |
| | 25 (16.8) | 66.97±21.94 | | |
| **Frequency of sexual intercourse compared to before pregnancy:** | | | | a>b |
| Decreased[a] | 71 (62.4) | 47.46±17.93 | KW=50.599 | a>c |
| Unchanged[b] | 14 (26.2) | 66.01±14.48 | p=0.005 | b>c |
| Increased[c] | 12 (11.4) | 79.61±13.97 | | |
| **Sexual life satisfaction** | | | | a>b |
| Satisfied[a] | 73 (49.0) | 79.61±13.97 | KW=50.599 | a>c |
| Moderately satisfied[b] | 52 (34.9) | 66.01±14.48 | p=0.005 | b>c |
| Not satisfied[c] | 24 (16.1) | 47.46±17.93 | | |
| **Sexual problem** | | | | |
| Yes[a] | 96 (64.4) | 65.50±19.22 | t=18.032 | |
| No[b] | 53 (35.6) | 78.57±13.89 | p<0.001 | a<b |

*This is the number of women who underwent episiotomy; percentages are calculated based on 'n'
**This is the number of women who had a cesarean section; percentages are calculated based on 'n'
Average time to resumption of sexual intercourse: 40.93±1.27 days
F: One Way ANOVA (The Tukey test was used in the posthoc analysis), t: Independent Sample t test, KW: Kruskal Wallis H test (The Dunn test was used in the posthoc analysis), NOTE: In posthoc analysis, letters (a, b, c) were used to indicate differences between groups.

## 4. Discussion

In this study, women's sexual quality of life was found to be at a moderate level in the fourth month postpartum, and the factors associated with sexual quality of life were associated with biological, psychological, and sociodemographic variables. These findings are consistent with the existing literature emphasizing that sexuality in the postpartum period is not limited to physiological recovery alone but is also strongly influenced by psychosocial and relational factors (Aksu & Çevik, 2023; Gutzeit et al., 2020).

The study demonstrated that as women's educational level and their spouses' educational level increased, sexual quality of life scores significantly improved. Higher educational attainment may be associated with greater access to sexual health information, enhanced body awareness, and improved communication skills. Previous studies have similarly reported that women with higher educational levels are more likely to express sexual concerns during the postpartum period and report higher levels of sexual satisfaction (Güler & Erbil, 2022; Türk & Erkaya, 2019). Likewise, higher educational levels among spouses have been shown to positively influence sexual quality of life by enhancing partner support and relational harmony (Gutzeit et al., 2020).

The finding that employed women and those with better income status had higher sexual quality of life scores suggests that economic independence and social participation may be associated with higher self-esteem and better sexual life outcomes. The literature also highlights that reduced economic stress during the postpartum period has beneficial effects on psychological well-being and couple relationships (Aksu & Çevik, 2023; Zaręba et al., 2025). The higher sexual quality of life observed among women living in urban areas compared with those residing in rural settings may be related to differences in cultural norms, perceptions of privacy, and access to health services. In rural and provincial contexts, sexuality is often a more restricted topic of discussion, which may hinder the expression of sexual concerns (Türk & Erkaya, 2019).

When the relationship between type of marriage and sexual quality of life was examined, women who married by mutual acquaintance and consent demonstrated higher sexual quality of life compared with those who entered into arranged marriages. This finding suggests that premarital emotional closeness and communication may be associated with sexual harmony and satisfaction in the postpartum period. The literature consistently identifies relationship satisfaction and spousal communication as among the strongest predictors of postpartum sexuality (Gutzeit et al., 2020; O'Malley et al., 2018)

Evaluation of pre-pregnancy sexual life characteristics revealed that women who reported more frequent sexual intercourse and no sexual problems prior to pregnancy had higher sexual quality of life during the postpartum period. This finding indicates that may be associated with better postpartum sexual well-being on postpartum sexual well-being. Similarly, previous studies have reported that a history of sexual problems prior to pregnancy is associated with postpartum sexual dysfunction (Arampatzi et al., 2025; Güler & Erbil, 2022). The absence of a significant association between mode of delivery and sexual quality of life suggests that mode of delivery alone does not determine postpartum sexuality. Consistent with this finding, the literature reports inconsistent results regarding postpartum sexual outcomes following vaginal versus cesarean delivery (Rodaki et al., 2022; Serati et al., 2010). Some studies have indicated that cesarean delivery is associated with higher sexual function scores three months postpartum compared with vaginal delivery (Bağlar et al., 2025). However, evidence suggests that beyond the first six months postpartum, sexual quality of life is more closely related to obstetric interventions rather than mode of delivery itself (Hajimirzaie et al., 2021). For example, women experiencing complications related to episiotomy sutures have been shown to report significantly lower sexual quality of life, suggesting an association between perineal trauma and lower sexual quality of life (Demir et al., 2021). Numerous studies have emphasized that episiotomy-related pain and delayed healing contribute to dyspareunia in the postpartum period (Atlıhan et al., 2025; Serati et al., 2010).

An increase in body mass index and dissatisfaction with physical appearance during the postpartum period were associated with lower sexual quality of life. Disturbances in body image may be associated with reduced feelings of attractiveness, thereby diminishing sexual desire and satisfaction (Gillen et al., 2025). This finding aligns with previous studies demonstrating a significant relationship between postpartum body image and sexual satisfaction (Aksu & Çevik, 2023; Gutzeit et al., 2020).

The lack of a significant association between breastfeeding status and sexual quality of life suggests that hormonal changes do not result in sexual dysfunction to the same extent in all women. Although increased prolactin levels and decreased estrogen during lactation have been associated with vaginal dryness and reduced libido, these effects appear to be shaped by individual differences and psychosocial factors (Gutzeit et al., 2020; O'Malley et al., 2018). One study reported decreased sexual

quality of life among women in the second to fifth postpartum months, attributing this decline to hormonal changes and variations in breastfeeding frequency (Topaloğlu Ören & Yaşar, 2023). Dyspareunia, decreased sexual desire, and reduced sexual satisfaction are widely reported in the literature as common postpartum concerns associated with lower sexual quality of life (Eryılmaz & Şentürk Erenel, 2023; Koç & Oskay, 2015; Üstgörül & Yanikkerem, 2021). However, some studies have also suggested that breastfeeding may strengthen emotional bonding between partners and enhance sexual satisfaction among women (Adeli et al., 2025).

The findings of this study indicate that sexual quality of life appears to be associated with a complex interaction of biological, psychological, and social factors. These results highlight the necessity of addressing sexuality as an integral component of postpartum care rather than limiting follow-up to physical recovery alone. In this context, individualized, holistic, and midwife-led counseling approaches that are responsive to women's specific needs may play a critical role in supporting postpartum sexual well-being.

## 5. Conclusion

This study determined that women's sexual quality of life during the postpartum period was at a moderate level and was significantly associated with sociodemographic characteristics, pregnancy- and birth-related factors, body image, and postpartum sexual problems. Educational and income levels, employment status, type of marriage, episiotomy-related complications, and sexual problems experienced during the postpartum period emerged as key factors associated with sexual quality of life. In addition, the association between pre-pregnancy sexual life characteristics and postpartum sexual quality of life highlights the importance of preconception care in supporting women's sexual well-being across the reproductive continuum. Incorporating sexual health counseling into preconception care may contribute to strengthening postpartum sexual adjustment and overall well-being. These findings suggest that systematic assessment and counseling related to sexual health should be incorporated into routine postpartum care services. Integrating sexuality into standard postpartum follow-up by healthcare professionals may facilitate early identification of sexual difficulties and enable timely referral and intervention. Additionally, longitudinal studies involving populations with diverse sociocultural backgrounds are recommended to provide a more comprehensive understanding of postpartum sexual quality of life and its determinants.

## Ethics Committee Approval

Ethical guidelines were followed in the research, and the principles of the Helsinki Declaration were adhered to. Prior to the study, permission was obtained from the Provincial Health Directorate where the study was to be conducted, under number B10.4.1SM.4.60.00.09.774/391.15676 and dated 17.12.2010. However, since ethical committee approval was not mandatory at the time the study was conducted, ethical committee approval is not available.

## Author Contributions

Concept: ZG; Design and Supervision: ZG; Resources: VE; Data Collection and/or Processing: VE; Analysis and/or Interpretation: ZG, VE; Literature Search: VE; Writing – Original Draft: VE; Critical Review: ZG.

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## Conflicts of interest

The authors declare that there is no conflict of interest.

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