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Resumption of Sexual Activities Post-Childbirth: Examining the Relationship Between Perceptions of Male Partners of Young Women and Their Timing of Sexual Resumption in Bongo District

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Abstract

Background: Postpartum sexual activity is frequently resumed earlier than is recommended in low-resource settings, endangering the health of the mother. Postpartum decision-making is heavily impacted by partner-related and cultural factors, especially in rural and patriarchal environments. Previous research has been focused on the perspectives of women, with little consideration given to the potential influence of male partners on postpartum sexual behavior.

Aim: This study aimed to assess husbands' awareness of the health implications of early postpartum sexual resumption and their willingness to delay sexual activity until their wives are physically and emotionally ready in the Bongo District.

Methods: Utilizing a quantitative cross-sectional design, data were collected from 92 male partners of young women aged 18-50 years through a closed-ended questionnaire, which included Likert-scale items measuring perceptions related to postpartum sexual health.

Results: Descriptive statistics revealed a moderate awareness of physical changes post-childbirth and a lower knowledge of common issues like hormonal fluctuations. Additionally, husbands exhibited a strong willingness to support their wives, with high scores for prioritizing their feelings about intimacy and emotional support. Regression analysis indicated a significant relationship between husbands' knowledge levels and their attitudes toward sexual resumption indicating a variance in attitudes.

Conclusion: This study emphasized the importance of men's knowledge and attitudes on postpartum sexual health, as well as their desire to support their spouses during the recovery phase.

Keywords: *Childbirth, nursing, postpartum, sexual resumption, young women*

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INTRODUCTION

Women experience several social transformations upon becoming mothers, frequently involving significant alterations to intimate and sexual interactions [1]. Although maternal health care addresses numerous physical and mental transformations in women, it has been shown that some women report dissatisfaction in their relationships post-partum [1]. A literature study indicated that whereas numerous research has examined the sexual experiences of postpartum women none have addressed the impact on male partners or husbands [1].

Jambola and his colleagues reported that many postpartum women lack understanding or guidance on their sexual health during pregnancy, especially on when to start having sex following birth [2]. Pregnancy, birth, and motherhood all greatly affect women's postpartum sexual well-being [2]. Though they may not feel sexually motivated, women are advised to have sex as soon as possible after giving birth before six weeks in many parts of the world. They do this for additional purposes, such as to satisfy their partners' needs or to prevent arguments resulting from a variance in sexual desire, to maintain their personal and conjugal relationship.

One important and sometimes overlooked component of postpartum care is the start of sexual activity after childbirth [3, 4]. In a cultural context like the Bongo district, normative and societal influences can affect a person's sexual health and well-being more than most elements of postpartum care can [5]. Postpartum health literature covers many of the physical, mental, and relational changes following childbirth that could affect sexual intimacy and satisfaction [6].

Looking at sexual function in women, studies have shown that post-partum satisfaction levels significantly differed from those levels during pregnancy [7]. Post-birth, women exhibited higher mean degrees of sexual pleasure; values during pregnancy differed statistically significant. The writers noted that post-birth sexual satisfaction was better, however, mean values for sexual desire, sexual arousal, and vaginal lubrication dropped. On the other hand, during the post-birth period, women reported having more mean levels of orgasm [8]. Although the sexual function itself was somewhat similar between periods, all mentioned levels of sexual function were generally higher during pregnancy than post-birth. The author's observations on the dynamic interrelations of variables of sexual health and well-being during the transition to motherhood inspired more studies to better grasp these changes. Research on post-partum sexual relations would be beneficial to both partners when women and their spouses experience changes in sexual function at the same time.

Meltzer-Brody *et al.* claim that for women experiencing several pressures that could negatively impact mental health, the postpartum period can be a complex and vulnerable time [9]. A qualitative study found that dads with PPD felt inadequate and helpless, which had an impact on their mental health and relationships, including their ability to be sexually intimate with their partners. Having maternal PPD makes things more complicated since maternal sadness is often accompanied by paternal PPD. This makes it hard for the couple to get back together sexually and emotionally. How the dads see their role and how they're feeling affects their sexual desire and behavior after giving birth. Stress and mood swings are major factors in stalling or cutting back on sexual activity [77]. Since the psychological strain of new obligations and depressive symptoms frequently show up as irritation, weariness, and lower libido, emotional stress, mood swings, and sexual desire in men after giving birth are intimately related [77]. While emotions of inadequacy and fear about parenting contribute to withdrawal from intimacy, mood swings and emotional

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discomfort decrease sexual attraction and responsiveness [78]. This intricate interaction emphasizes how crucial it is to identify the father's mental health conditions to promote positive emotional and sexual interactions following childbirth.

Particularly during the first three months postpartum, women run a higher risk for the beginning and/or aggravation of mental disorders including mood disorders, anxiety disorders, and psychosis [10]. This increased susceptibility of women during the postpartum time should also be taken into consideration when considering sexual health and intimacy, particularly about issues with couples starting sexual activity once again after childbirth. Anecdotal experiences of spouses of primiparous women regarding their wives' sexual resuming post-birth indicate that the couple's sexual navigation of the ups and downs in women's mood, anxiety, or other mental issues during the postpartum time is essentially crucial for sexual resumption. For instance, a woman's desire for intimacy, sexual satisfaction, and general sexual function may change if she is under emotional and psychological stress from her postpartum mental health. Likewise, the way husbands help their wives during that transforming event can be influenced by their values and awareness of the prospective mental health issues. This study is to investigate how knowledge levels, attitudes, and behaviors of husbands in the Bongo district could either support or hinder women's experiences of returning to sexual engagement at this period of their lives. All things considered, knowledge of the mental health issues noted by [9] is pertinent to the more general conversation on sexual health and intimacy in postpartum periods; it can be used to direct treatments meant to strengthen the sexual relationship between both partners in the postpartum period.

Married satisfaction and intimacy are correlated with sexual satisfaction in pregnant couples and it is also observed that both sexual relations and affectionate dimensions can affect married satisfaction [10]. Postpartum sexuality has also raised issues for clinicians, with significant ramifications for marriage. First-time mothers should be especially aware of significant changes in closeness [11]. All of this will be crucial for the knowledge of the emotive character of sexual satisfaction and closeness throughout the transition to motherhood, which becomes of paramount relevance to grasp the experiences of men married to primiparous women.

Cultural and religious expectations help to shape women's perspectives on sexuality and childbirth [12]. Many of these societies do not encourage conversations about sexual relationships; men's sexual desires are more freely expressed than women's. Most women are often discouraged from expressing their sexual desires within conventional wisdom [13]. Studies show that many men find it difficult to grasp the physical and psychological changes their spouse experiences following childbirth, which can lead to misinterpretation and fear about starting sexual activity [14]. Ignorance of either psychological or physiological changes could result in lower sexual satisfaction for both parties as well as tension in the marriage.

Men's opinions on sex after a child's birth differ significantly and are much influenced by their experiences as well as society's views. The negative attitudes of a partner could aggravate a woman's sense of inadequacy during sexual contact [15]. Furthermore, sex between couples during this period will underline the importance of good communication, help to overcome fear about returning to sexual contact, and foster connection [16]. Practices aimed at scheduling couples to resume sexual contact throughout the transition into parenting are sometimes structured with greater clenches and recommendations from society, relationships, or health professionals. Often for women, some research indicates many couples resume sexual activity sooner than advised by

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health professionals, which has physiological effects [17]. This supports a strong case made for couples regarding counseling and education about continuity with safe practices during the postpartum period needing conjugal support theory.

For postpartum women, the consequences of strolling back to sexual engagement are complex and multifarious [18]. Resuming sexual relationships too early has been reported by researchers to have negative physical and psychological consequences [19]. This is crucial in creating treatments meant to support postpartum women's general health and well-being as well as normal sexual functioning. All things considered; this is a significant field of study for the comeback of sexual activity following childbirth. Examining knowledge, attitudes, and practices of husbands in the Bongo district will contribute to the evidence-guiding interventions to better Healthcare for new families, health, and well-being, thus advancing the way we consider this vital area of postpartum care.

A complex issue of mother health, postpartum sexual health, and rehabilitation has lately attracted more attention. After childbirth, women's sexual activity usually changes to include lower libido, dry vagina, dyspareunia (pain during intercourse), and a general drop in sexual satisfaction [20, 21]. These variations are influenced by physical, psychological, hormonal, and relational elements as well. Research indicates that hormonal changes especially a decline in estrogen levels following nursing cause vaginal shrinkage and dryness, which can significantly affect sexual comfort and desire [22, 23].

Additionally, highly important for postpartum sexual recovery are psychological elements. Often mentioned as possibly influencing sexual desire and behavior are anxiety, postpartum depression, exhaustion, and body image problems. Postpartum depression and a delayed return to sexual activity [24, 25, 20] were linked by therefore underlining the significance of including mental health within postpartum treatment [25]. Changes in the couple's chemistry, lack of sleep, and new parental duties could all tax intimacy and sexual activity even more.

The mode of birth significantly impacts postpartum sexual health. Vaginal deliveries, particularly those associated with perineal injury, episiotomies, or instrumental intervention, have been correlated with increased reports of pain and prolonged postponement of sexual activity. Post-cesarean deliveries may lead to persistent postpartum sexual issues due to the impact of psychiatric disorders and the recovery from abdominal surgery on sexual function. While the body typically recuperates within six weeks post-delivery, numerous women discover that it may require several months to attain pre-pregnancy levels of sexual readiness and enjoyment [26].

Women said they feel unprepared for postpartum sexual changes and get little coaching. According to Serrano and his colleagues, honest, nonjudging conversations on sexual health should be had by doctors and new mothers both during prenatal and postpartum appointments [27]. Inconsistent treatment as well as the absence of clear rules for handling postpartum sexuality help to accentuate the stigma attached to the subject.

Customized, culturally sensitive, and all-encompassing postpartum sexual health has become more in demand recently. Effective in helping women negotiate this change have included psychoeducation, pelvic floor physical therapy, and sexual psychotherapy. Moreover, it has been found that including partners in talks and treatments enhance communication, relationship happiness, and sexual results [20]. Future studies on a range of demographics and situations as

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well as long-term postpartum sexual health patterns will help to further guide evidence-based policy and support for new mothers.

Postpartum symptoms can significantly impact a woman's physical, mental, and sexual well-being. One of the most frequently referenced postpartum issues affecting sexual activity is dyspareunia, commonly referred to as painful intercourse. Studies conducted in Australia, and England have revealed that postpartum women, particularly those who experienced perineal trauma during delivery, exhibited dyspraxia [79] [80] [81]. Six months postpartum, women who experienced episiotomy or perineal lacerations reported higher incidences of sexual pain, as indicated by a quantitative study conducted by Rodaki and his friends [28]. Similarly, a comprehensive study by Opondo and his colleagues demonstrated that insufficient healing and perineal injury can extend pain duration, hence influencing the frequency of sexual activity and heightening anxiety regarding resuming sexual relations [29].

Hormonal changes brought about after childbirth greatly affect sexual dysfunction. Especially in breastfeeding, the drop in estrogen levels can thin and dry the vaginal walls, which increases the pain during sexual activity. According to Smetanina breastfeeding women typically experience reduced vaginal lubrication, diminished sexual desire, and increased pain during intercourse compared to non-lactating women [30].

Postpartum depression (PPD), associated with diminished sexual desire and relationship issues, is a well-documented consequence. Chen and others assert that individuals with PPD frequently encounter fatigue, body image concerns, and diminished self-esteem, all of which adversely affect sexual interest and satisfaction [31]. Furthermore, Brummelte emphasized the necessity of early diagnosis and treatment, since untreated postpartum depression (PPD) may lead to enduring sexual dysfunction [32].

Other pelvic floor disorders, such as urine incontinence, may complicate postpartum sexual activity. Individuals with stress urine incontinence refrain from engaging in sexual activity due to concerns about leakage. Westerik-Verschuuren *et al.* reported that 12–35% of postpartum women experiencing pelvic floor issues expressed dissatisfaction with their sexual lives, attributing this to feelings of guilt and diminished confidence [33].

Although not typically seen as medical disorders, fatigue, and sleep deprivation significantly impact postpartum sexuality. Emotional detachment and diminished sexual desire may arise from the physical demands of childbirth and the obligations associated with baby care. According to phenomenological research conducted by [34] new mothers typically attributed their dissatisfaction and delayed resumption of sexual activity to stress and fatigue.

A crucial aspect of postpartum care that influences physical recovery, emotional well-being, and interpersonal relationships is the resumption of sexual activity following childbirth. Medical counsel generally recommends addressing this topic with caution, creativity, and originality. The six-week threshold is standard in therapeutic settings, despite studies indicating that women's resumption of sexual activity significantly varies according to delivery type, complications, and individual traits.

Most research indicates that physical healing significantly influences postpartum sexual behavior. Women who have cesarean sections or suffer major perineal injuries following vaginal delivery,

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for example, usually report a delayed return to sexual activity due to pain, discomfort, fear, or healing concerns [28].

Apart from physical ability, contemporary recommendations and studies also encompass psychological and emotional preparedness as a basic factor. Common causes of lowered sexual desire are hormonal changes, postpartum depression, body image issues, and weariness. These problems should be discussed in postpartum visits by medical practitioners. The World Health Organization and numerous national health authorities have advised comprehensive postpartum treatment including sexual health counseling even if implementation varies greatly between healthcare systems [35].

New studies highlight the importance cultural views and relationship circumstances play in postpartum sexual resuming. Research conducted in countries with different social backgrounds indicates that some women may participate in sexual activities before they are emotionally or physically ready because of pressure from their partners and society. Medical advice suggests open communication between couples and doctors more and more to guarantee mutual comprehension and lower guilt or responsibility [36]. The paper argues that even current rules should be more evidence-based and culturally sensitive. Few studies provide particular guidance on how to manage challenges such as dyspareunia, painful sex, and libido fluctuations following the six-week postpartum period.

Traditional ideas about postpartum sexual abstinence have been recorded in many civilizations, including those of Africa, Asia, and parts of Latin America [37]. These points of view are based on societal, religious, and cultural norms impacting postpartum activities and sexual behavior [38]. For many African nations, for instance, postpartum sexual abstinence is not just a personal goal but also a social norm routinely backed by elders and cultural organizations [39].

Popular knowledge is that the health of the mother, the child, and even the husband can suffer if sexual activity is started too soon after delivery. For some societies, for instance, having intercourse before the baby is weaned could cause malnutrition or diarrhea [40].

Postpartum abstinence is also associated in some customs with ideas of ceremonial purity and cleanliness [41]. Sometimes women are considered "impure," hence having sex is not advised until following specific ceremonies or cleansing rites following delivery [42]. These concepts protect mothers' health and child welfare in settings where access to modern healthcare is limited, therefore fulfilling both symbolic and practical purposes.

Ferina *et al.* also claim that postpartum sexual norms are much shaped by religion [43]. Usually lasting forty days in Islamic and Christian faiths, the period of lochia corresponds with the necessary intervals of postpartum abstinence. While these religious views stress bodily recovery, cultural interpretations could significantly transcend the years. Breaking these laws could lead to allegations of bad luck to the family or social shame in many civilizations. Common consequences of this social pressure on marriages are well known; occasionally it leads to adulterous contacts or the temporary separation of spouses during the period of abstinence.

Though with noble intentions, some historical ideas could have unanticipated effects in the present era. Research on prolonged periods of abstinence without mutual permission has demonstrated that these may sour relationships and lead to infidelity or discontent [44].

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Moreover, some women are starting to question conventional wisdom by deciding to make medically informed decisions about postpartum recovery and sexual activity because of better access to knowledge and healthcare. Even though many nations still adhere to cultural norms, women could feel under pressure to follow conventional schedules independent of their own or the state of their health.

People's willingness and capacity to keep sexual contact have been found to often be influenced by emotional readiness, body image problems, anxiety, and fear of pain or re-injury [45, 46]. These components are especially clear among people healing from events that change their physical or psychological state since sexual functioning is not just a physical activity but is also closely related to mental and emotional wellness.

Important components influencing either support or hindrance of sexual resuming are partner communication and emotional connection. Studies reveal that couples who have honest and caring communication about their needs, wishes, and fears are more likely to have good results when it comes to choosing backup sexual activity [47]. On the other hand, bad communication can lead to emotional distance and worry, therefore aggravating the difficulty or length of the process. When a partner provides emotional support, the relationships between higher sexual satisfaction and less psychological stress expose the link between relational dynamics and sexual recovery [2].

Moreover, influencing sexual resumption are societal and cultural standards. Sometimes people feel great pressure to resume sex at the "appropriate" time and form, which can intensify feelings of inadequacy, guilt, or failure should expectations be not satisfied [48]. Given rising social criticism of sexual activity following illness or pregnancy, women could be particularly affected by these conventions. Therefore, addressing sexual recovery in research and therapeutic practice completely depends on a culturally sensitive approach.

Male perspectives on postpartum sexual resuming have received quite little scholarly attention; most studies on the subject concentrate on the experiences and health effects of women [49, 50, 51]. Research on how men think and feel about having sex once again after giving birth has started with a lack of honest discussions on postpartum sexuality has caused men to feel dissatisfied or emotionally detached [52, 53, 54, 55].

According to qualitative research carried out in Iran, many husbands have little understanding of the mental and physical changes that women experience after childbirth [82]. This often influences their perspectives and expectations for having sex again [56, 57, 58]. Men's perspectives are heavily influenced by gender stereotypes and cultural expectations, which can lead to postpartum conflict, stress, or misinterpretation. Furthermore, research shows that, while some men demonstrate empathy and understanding, others may become confused or abandoned as a result of reduced contact. Couples failing to have open discussions about their sexual ambitions and preparation is a common theme in the literature. Insufficient medical professional counseling or education frequently exacerbates the issue. Interventions that promote couple-centered education and communication have been shown to improve postpartum sexual satisfaction and mutual understanding.

Research on coping mechanisms for sexual abstinence or delayed restart reveals a variety of psychological, social, and behavioral techniques that people use in different situations. According to research, religious and cultural attitudes frequently have a significant impact; people employ

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moral principles, social standards, and spiritual activities to encourage abstinence [59, 60, 55]. Social support from partners, friends, or counseling services is an important protective factor that helps people deal with issues including emotional loneliness, peer pressure, and sexual impulses [61].

Significant physiological, psychological, and social changes that follow childbirth [39, 35] affect a couple's relationship, especially their sex life. Among the several factors influencing the complex and global topic of resuming sexual activity after childbirth are mother recovery, cultural norms, religious beliefs, relationship dynamics, access to health education following childbirth, and cultural, social, and medical factors [62, 63].

Following childbirth, resuming sexual activity needs a major adjustment by both partners, formed by an interplay of cultural, psychological, and biological factors. Culturally, cultural conventions and gender expectations may pressure women to resume sexual interactions early, frequently without considering their physical or mental fitness, while traditional beliefs or religious practices may prescribe specific postpartum activities. Psychologically, difficulties such as postpartum depression, anxiety, body image worries, fear of pain, or poor relationship communication can dramatically impair a woman's desire or capacity to re-engage in intimacy [64]. This suggests that many women might be more vulnerable to postpartum sepsis, short birth intervals, and unplanned pregnancies [49]. Better postpartum counseling is globally needed to ascertain the best time to resume sexual activity and both partners' comfort and readiness levels should be taken into account while making this decision [38, 62, 58]. [38] and [65] claim that postpartum sexual activity restarts at greater rates in Western countries such as the US and the UK, where rates are 90 and 89 percent respectively. Though this interval may vary depending on unique healing processes and problems during childbirth, medical guidance recommends postponing sexual activity for 4–6 weeks [66].

According to a Nigerian survey, 67 percent of women started having sex on average eight weeks after giving birth; 77 percent of them said their husbands' request was the main reason. Similarly, research done in Ethiopia revealed that thirty-6.6% of women began having sex once more six weeks following childbirth [62]. Once more, 105 (21.6%) of postpartum women who visited a postnatal clinic at a National Referral Hospital in Uganda answered a cross-sectional survey and stated having sex once more before six weeks following delivery [67].

Early resuming of sexual activity after childbirth (before six weeks postpartum) was linked with the education level, occupation, and parity of the participants as well as the spouse's education level, baby age, and use of family planning [67]. Even if respondents in a descriptive-qualitative study of new fathers needed support to be comfortable in their new family environment, the results revealed that respondents were ready to wait for both partners to be ready before having sex. Unlike the preconception of male sexuality, the fathers' opinions on sexual life included all kinds of intimacy and interaction [54].

Two significant reasons include poor postpartum counseling and limited access to contraception. Moreover, the necessity of proximity and maintaining marriage harmony could come first than health concerns. This tendency has important consequences for mental stress, unexpected pregnancies, and infections among other things. Among the several approaches required to solve this issue are enhancing healthcare education, promoting gender equality, and so increasing access to family planning resources. This study sought to investigate the impact of the return of sexual

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behaviors after childbirth on the spouses of young women in the Bongo District of the Upper East Region.

The problem of early sexual resumption after childbirth in Bongo District is urgent and timely since trends on birth are changing among young mothers in their first few years of marriage, and worrying consequences are emerging. Along with maternal health issues and marital conflict, there are also unwanted repeat pregnancies and delayed recovery postpartum, certainly aggravated by having sexual contact before medically suggested time frames. These outcomes don't happen in a vacuum; it's because of structural gender norms and a glaring absence of male involvement in maternal health education. In the Bongo District, early postpartum sexual resumption is increasingly observed among young mothers. This trend has led to negative consequences, including repeat pregnancies, poor recovery outcomes, and marital strain. Despite these risks, male partners' roles in influencing this behavior remain under-researched. This behavioral pattern suggests a critical gap exists, specifically the absence of research looking at male partners' perspectives and their impact on these decisions. Therefore, this research is important because it will examine how the beliefs and expectations of husbands of young women in Bongo District affect the timing of sexual resumption, eventually leading to the creation of culturally sensitive, gender-inclusive postpartum care policies recommending optimal health-seeking behaviors associated with reproductive outcomes, and the health of the family as a whole.

The objectives of this study were to:

1. Assess the knowledge level of husbands regarding the effects of early sexual resumption after childbirth in the Bongo district.
2. Find out the level of husbands' willingness to wait for their wives to feel ready to resume sexual activities after childbirth.
3. Ascertain whether there is a significant relationship between husbands' knowledge level of postpartum sexual health and their attitudes toward postpartum sexual resumption.

METHODS AND MATERIALS

The study utilized a quantitative approach to examine the relationships between demographic variables and male partners' perceptions of the resumption of sexual activities after childbirth. The research had a cross-sectional design, which looked at data collected at one point in time. The cross-sectional design was acceptable, given that this study examined male partners' perceptions related to the resumption of sexual activity; the study also examined demographic factors: age, education, and duration of the relationship. Participants were selected using purposive sampling based on the inclusion criteria of being male partners of young women residing in the Bongo District.

Data were collected through a closed-ended questionnaire that collected demographic variables and perception variables related to the resumption of sexual activity. The questionnaire included 5-point Likert scale questions (1 = Strongly Disagree to 5 = Strongly Agree) measuring perceptions of postpartum sexual health and readiness. Demographic variables collected included age, educational level, relationship duration, and number of children. Before data collection, informed consent was acquired from all participants. This entailed a full understanding of the purpose of the study their right to withdraw from the study at any time, and the confidentiality of their responses. Ethical clearance for the study was obtained from the research and ethics committee of the Faculty

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of Health and Allied Sciences of the Regentropfen University College. The data were securely stored and used only for research purposes. The data collection occurred in March (March 1 – 30). Participants were recruited from community health centers in the Bongo District. Trained research assistants administered the questionnaire in private consultation rooms to ensure confidentiality and encourage honest responses. A pilot study was carried out with a small sample of individuals to ascertain the clarity of the questionnaire, and the instrument's reliability data were computed at 0.87 using Cronbach's alpha. The validity of information was established through expert review and with the assistance of feedback from professionals. The present methodology illustrated a structured approach to explore male partners' perceptions of resuming sexual activity after the birth of a child, specifically focusing on the effect of demographic information. The use of quantitative data collection and analysis informed through responses served as a meaningful complement to the information obtained from other types of postpartum experiences.

RESULTS AND DISCUSSION

Demographic Information of Respondents

This aspect of the results captures information relating to the respondents' age groups, religious denomination, educational level, occupation, years and type of marriage, and number of children. Interpreting the research results in the context of this demographic information helps us to identify how each of these demographics significantly influences the responses provided by the respondents.

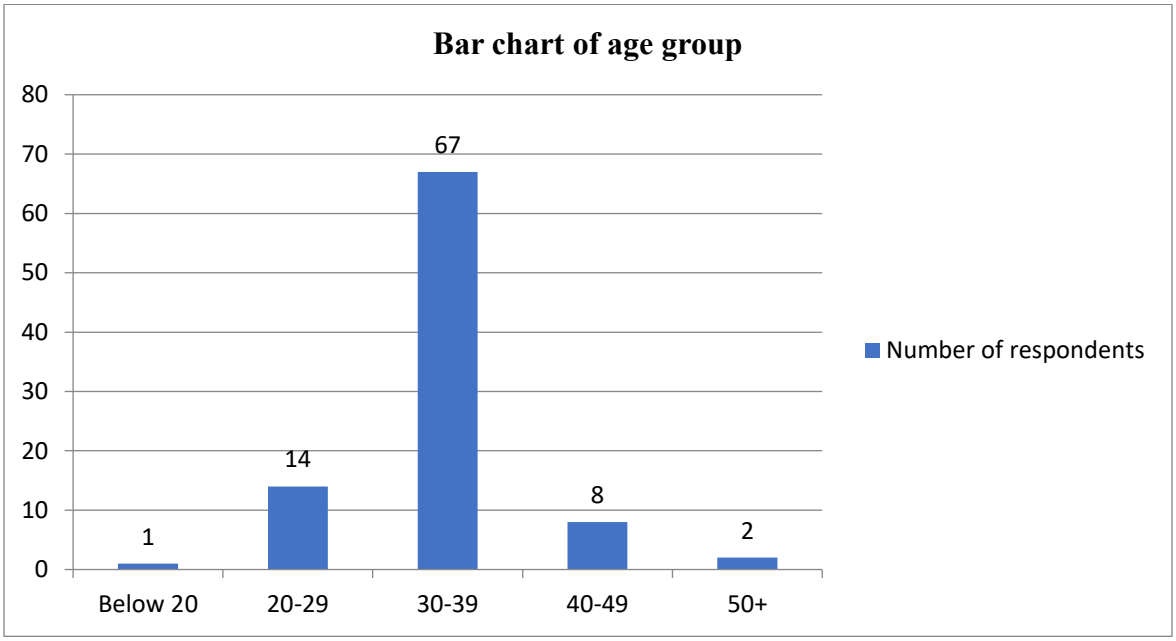

Figure 1: Age Group Demographic Information of Respondents

Source: Field data (2025)

The age distribution of respondents reveals considerable disparities in perceptions of resuming sexual activity after motherhood. One respondent is under the age of 20, 14 are between the ages of 20 and 29, 67 are between the ages of 30 and 39, eight are between the ages of 40 and 49, and

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two are 50 and older. Younger respondents were more represented in responses favoring earlier resumption; however, further statistical testing is needed to confirm significance.

This candor can ease discussions regarding intimacy after childbirth, allowing people to communicate their desires and worries. In contrast, the majority of respondents (67) are between the ages of 30 and 39, a cohort that is generally distinguished by a combination of fresh viewpoints and practical experience. These people may hold more traditional beliefs, which leads to caution while discussing or engaging in sexual behaviors shortly after childbirth. The 8 respondents aged 40-49 and the 2 over 50 may have even more conservative beliefs, driven by societal standards prevailing throughout their early years. This might lead to reluctance or embarrassment in discussing intimacy, which can influence their relationships. Overall, age has a considerable impact on how people approach the topic of postpartum sexuality, shaping their expectations and experiences in the Bongo District.

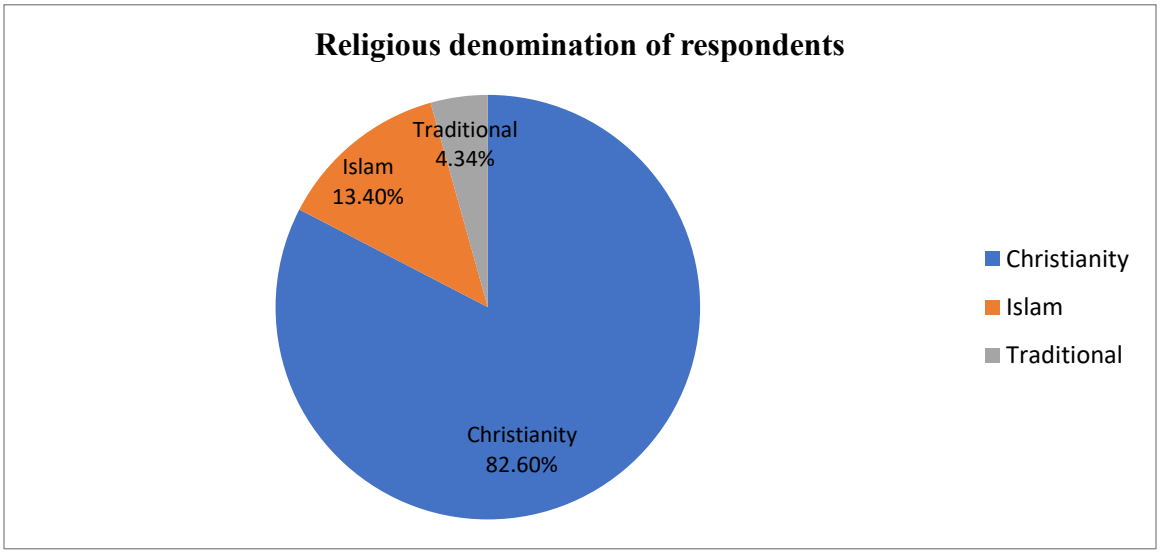

Figure 2: Religious Denomination Demographic Information of Respondents

Source: Field data (2025)

Respondent' opinions on sexual behavior following childbirth are much influenced by their religious affiliations [52]. Among the responders, 83 are Christians, 13 say they are Muslims, and 4 follow traditional religions. Those from more orthodox backgrounds especially within the Christian community may see the resuming of sexual relations following childbirth as inappropriate until a specific period has elapsed. Many times, this viewpoint stems from lessons stressing spiritual and familial obligations, which could cause shame or anxiety in new mothers. Given that 83 respondents identify as Christians, this group is probably going to have a significant influence on the general opinions in the Bongo District on intimacy following childbirth. The 13 Muslims and 4 individuals from traditional religions may also hold similar conservative views, but their smaller numbers suggest that their influence may be less pronounced. The religious context shapes how respondents approach postpartum sexuality, highlighting the need for sensitive support that acknowledges these beliefs and their impact on well-being and relationship dynamics.

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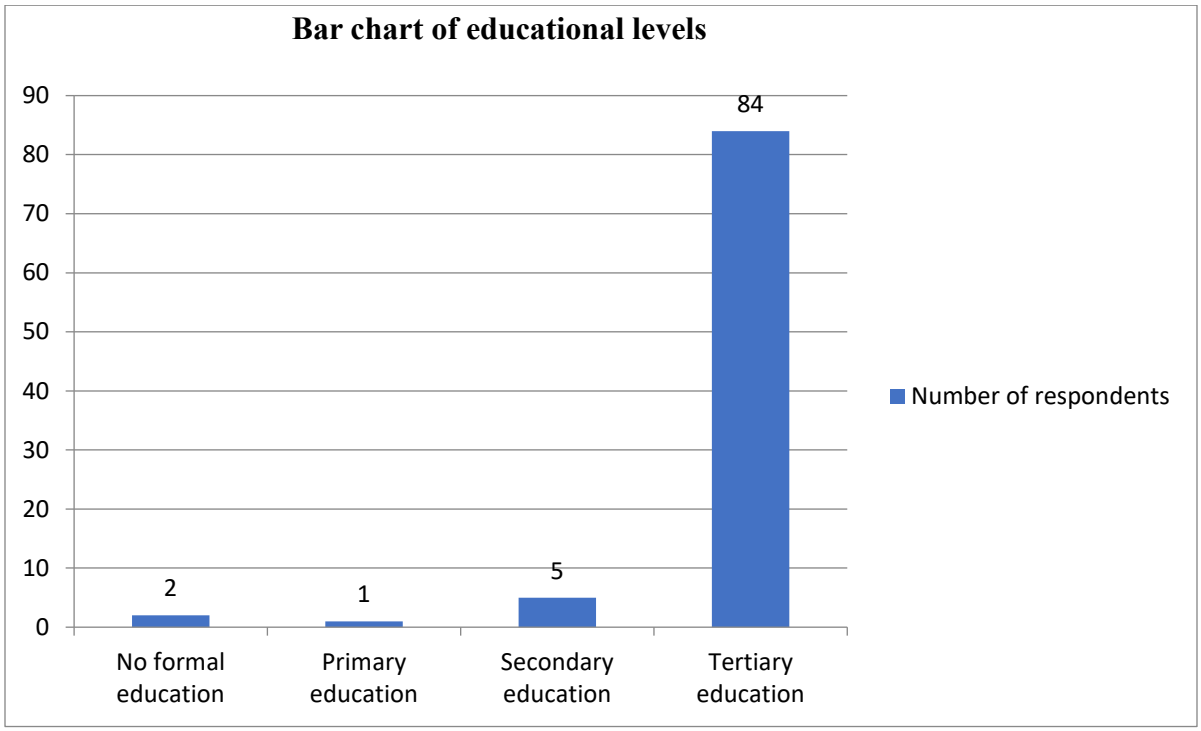

Figure 3: Educational level demographic information of respondents

Source: Field data (2025)

The educational background of respondents is closely linked to their knowledge and attitudes toward sexual health and postpartum sexuality. Individuals with higher educational attainment, particularly those with tertiary education, are often more informed about reproductive health [68]. This knowledge can lead to more positive perceptions regarding the resumption of sexual activities after childbirth. With 84 respondents holding tertiary degrees, this group is likely to engage in healthier dialogues about intimacy, effectively communicating their expectations and concerns with their partners [68].

In contrast, the 2 individuals with no formal education and the 1 with primary education may have limited access to information about sexual health, which could result in misconceptions or hesitance in discussing intimacy post-childbirth. The 5 respondents with secondary education may fall somewhere in between, potentially benefiting from some level of awareness but lacking the comprehensive understanding that higher education can provide. Overall, the educational level of respondents plays a crucial role in shaping their attitudes toward postpartum sexuality, emphasizing the importance of accessible sexual health education to support all individuals, regardless of their educational background.

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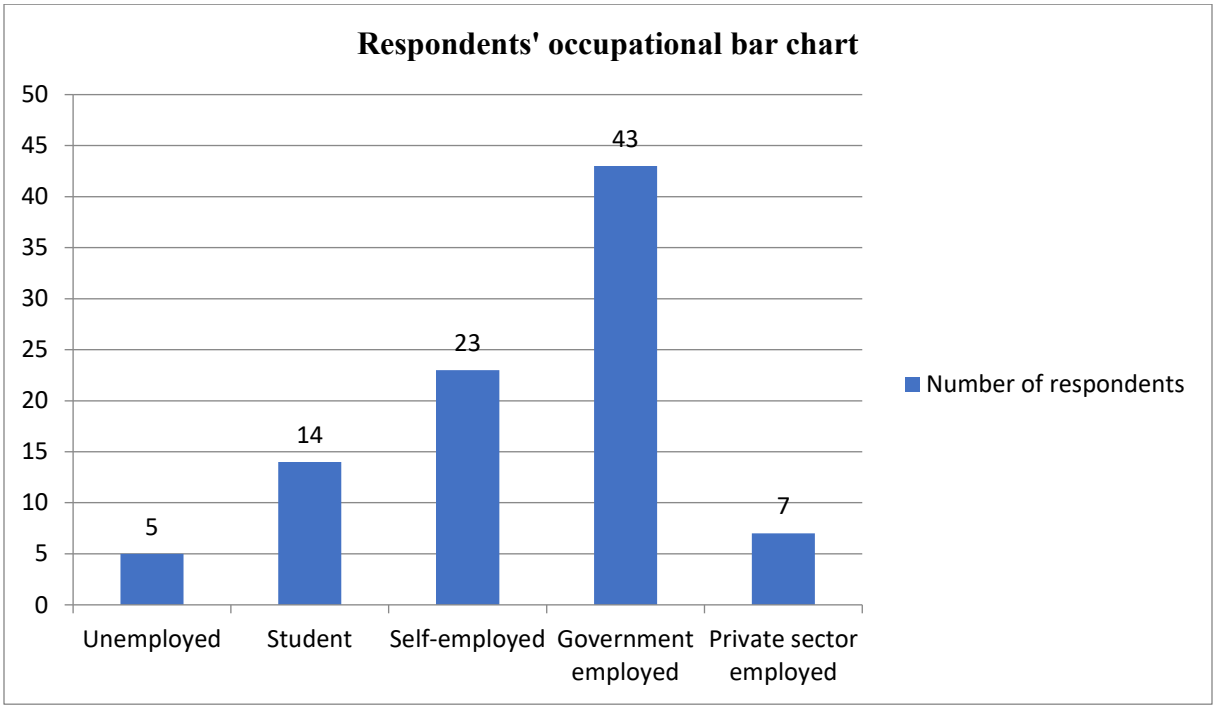

Figure 4: Occupational Demographic Information of Respondents

Source: Field data (2025)

The occupation of respondents significantly influences their perspectives on managing familial and sexual responsibilities. Working partners, particularly those in government and self-employed positions, may feel societal pressure to resume sexual activities post-childbirth, often driven by expectations to balance work and family life.

With 43 respondents employed by the government and 23 self-employed, these groups may navigate the complexities of intimacy while managing their professional obligations. Conversely, those in more flexible job roles, such as the self-employed, may prioritize emotional and physical recovery after childbirth, allowing them to take the time needed to communicate and negotiate their needs with their partners [83]. This flexibility can foster a healthier dialogue about intimacy, promoting a supportive environment for discussing expectations and concerns. Students, with 14 respondents, may also face unique challenges as they balance academic responsibilities with new parenting roles, potentially complicating their approach to postpartum sexuality. Meanwhile, the 5 unemployed individuals may experience different dynamics, possibly focusing more on emotional recovery without the added pressures of professional demands. In summary, the occupational landscape among respondents highlights the importance of support systems in navigating postpartum sexuality, as different job roles can shape individuals' experiences and attitudes toward intimacy after childbirth.

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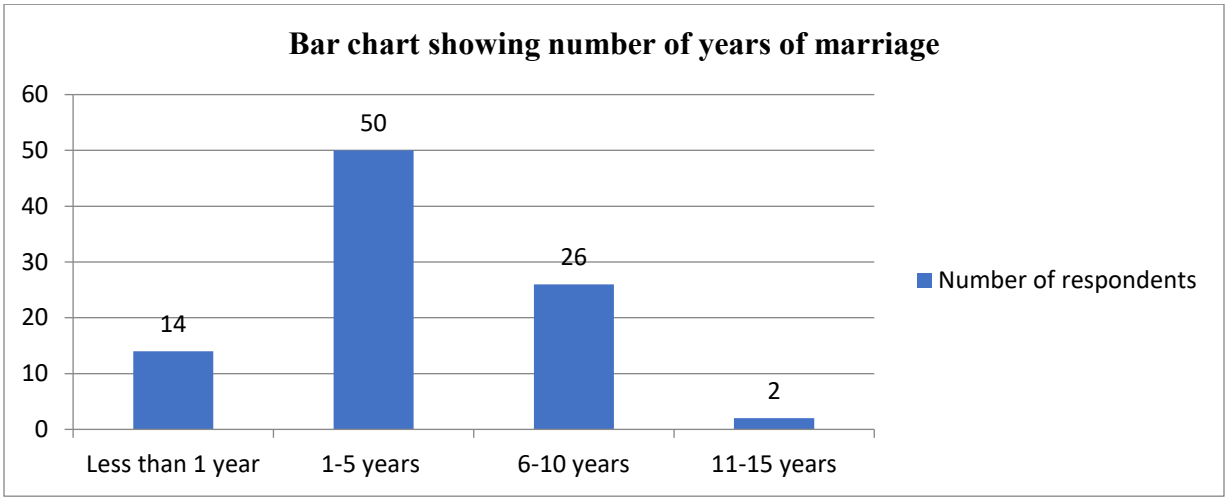

Figure 5. Respondents' Number of Years of Marriage

Source: Field data (2025)

Respondents' impressions of starting sexual activities after motherhood are much shaped by the years they had been married. Having built trust and good communication over the years, those in long-term marriages frequently show more ease and openness in talking about intimacy. Couples that value emotional connection and mutual understanding may find a more laid-back attitude to sexual activity following motherhood resulting from this stability. On the other hand, those in shorter or more recent marriages could be unsure and anxious, maybe resulting from a lack of clear communication styles. This dynamic emphasizes the significance of relationship lifetime in promoting good attitudes regarding postpartum intimacy since it might complicate negotiations of sexual needs and expectations.

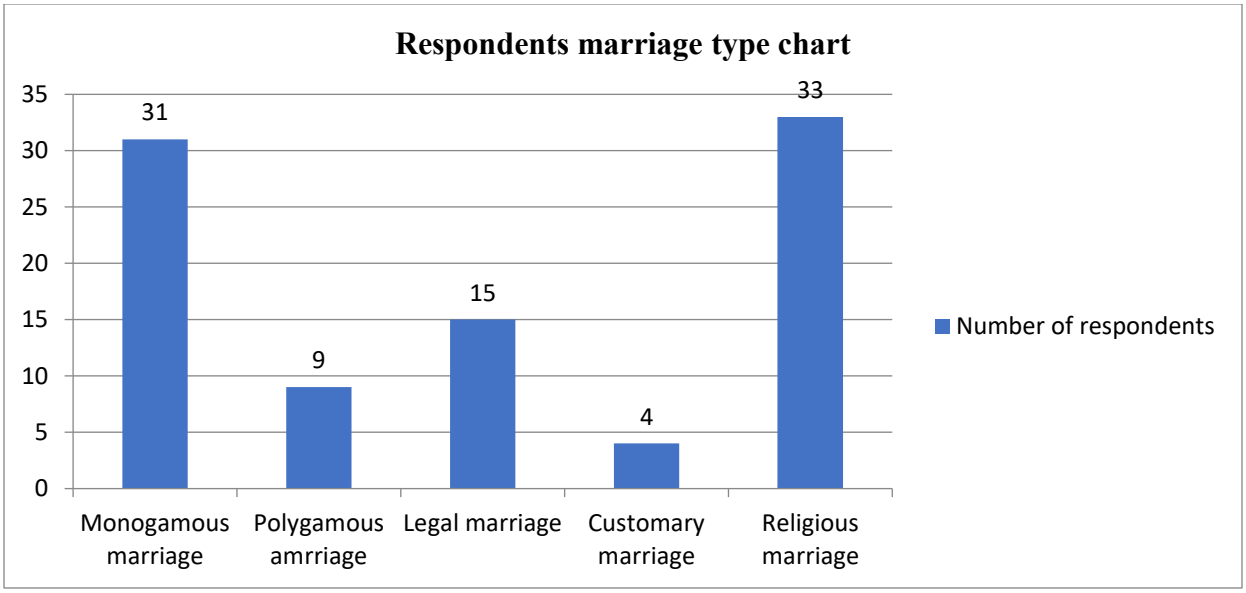

Figure 6 Respondents' Marriage Type

Source: Field data (2025)

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The data on respondents' marriage types demonstrates a varied range of marital structures that greatly influence their opinions on intimacy after childbirth. People who are in legal and monogamous marriages, which combined make up a sizable percentage of the respondents, might feel more stable and candid while talking about intimacy. Since these relationships frequently emphasize mutual understanding and commitment, this can create a supportive environment for negotiating sexual needs after childbirth. Respondents in traditional and polygamous marriages, on the other hand, can experience particular difficulties. The nine people in polygamous relationships may have to negotiate intricate relationships that can make talking about intimacy difficult and possibly cause feelings of rivalry or jealousy. The four responders in traditional relationships, meantime, might run across cultural norms that affect how they view postpartum sex. According to their religious traditions, the 33 respondents in religious marriages might also encounter different expectations, which could influence how they feel about closeness. The interaction of these variables emphasizes how respondents' attitudes on postpartum sexual health can be greatly influenced by the kind and structure of their marriage, highlighting the need for specialized treatment that takes into account the various marital circumstances seen in the Bongo District.

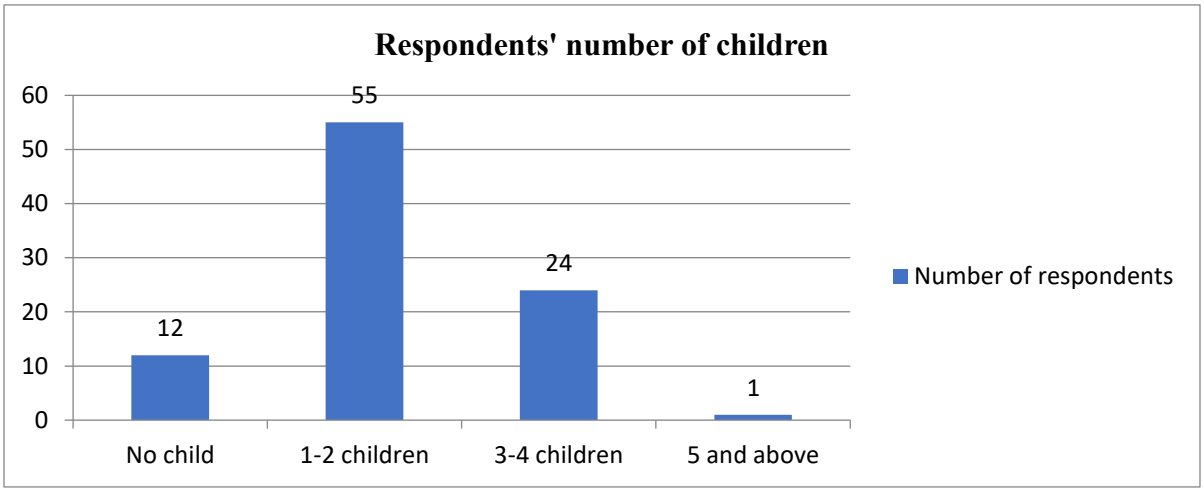

Figure 7: Number of Children of Respondents

Source: Field data (2025)

Based on the demographic information, 12 of the respondents do not have any children, 55 have one to two children, 24 have three to four children, and only one has five or more children. The data shows that most of the people who answered (about 69%) have between one and two children. This means that a lot of them are probably just starting to be parents. When these first-time or almost-new parents resume sexual activities after giving birth, they feel a range of emotions, such as anxiety and uncertainty about how to handle intimacy while adjusting to their new roles [69, 70]. On the other hand, the 24 people who answered who had three to four children may have felt more comfortable talking about and controlling their sexual health and relationships because they had done so before [71]. The single responder with five or more children gives a unique view. They probably have a lot of experience, but they may also find it harder to balance closeness with the needs of a bigger family. Overall, this data shows that having kids can have a big effect on

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how people feel about sexuality after giving birth. It also shows that different parenting groups in the Bongo District have different needs for help and education.

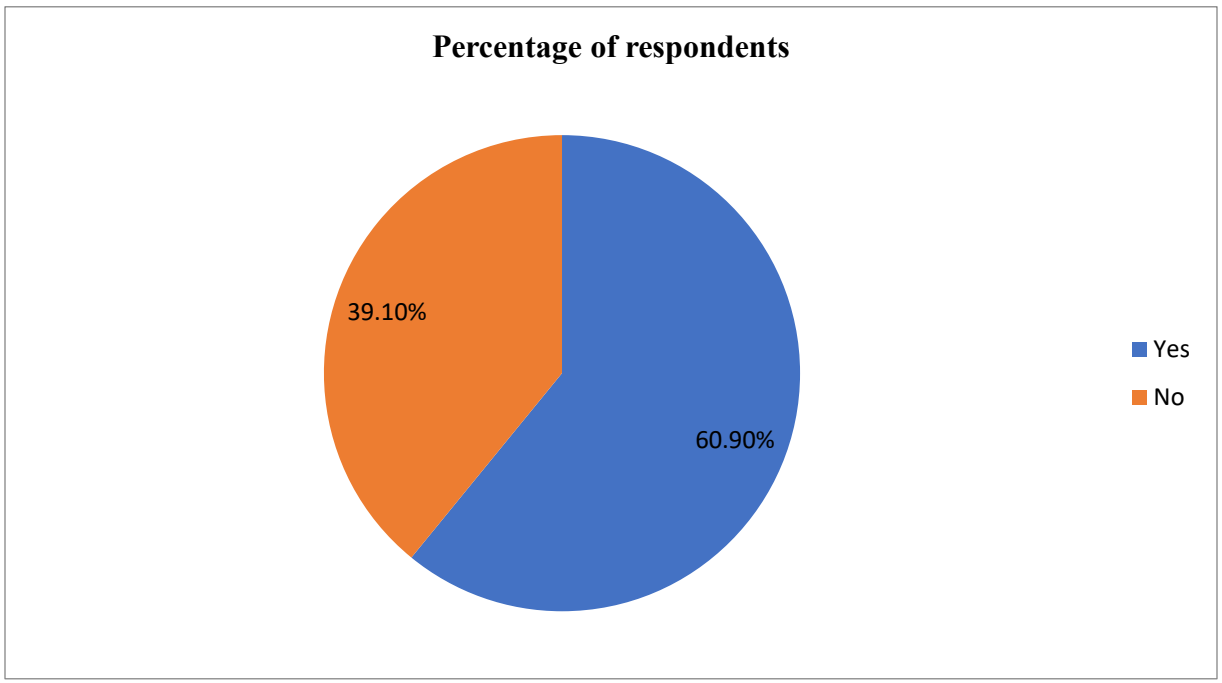

Figure 8: Percentage of Respondents

Source: Field data (2025)

In the field data, respondents were asked whether the child they were discussing was their first child. The results indicated that 39.1% of respondents reported that it was indeed their first child, while the remaining respondents indicated that it was not their first child. This statistic highlights a significant portion of new parents who may have unique experiences and challenges related to postpartum sexuality and parenting dynamics. Understanding whether it is a respondent's first child can provide insights into their perspectives on intimacy after childbirth. First-time parents often face different emotional and physical adjustments compared to those who have had previous children, which can influence their approach to sexual health and relationship dynamics. The data suggests that a notable number of respondents are navigating the complexities of parenthood for the first time, which may shape their attitudes and experiences regarding intimacy and support systems in the postpartum period. The results of the research were presented using Tables concerning the objectives of the research work. After the presentation of the results in the various Tables, a discussion section was introduced and, in that section, the results were discussed and related to relevant literature.

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Objective One: To Assess the Knowledge Level of Husbands Regarding the Effects of Early Sexual Resumption After Childbirth in the Bongo District.

Table 1: Assessment of Husbands' Knowledge Levels About Postpartum Sexual Health

S/no	Statements	Min	Max	M	SD	SK
1	I understand that physical changes can occur in my wife's body after childbirth.	1.00	4.00	3.11	.654	-.595
2	I am aware that it may take time for my wife to regain her sexual desire postpartum.	1.00	4.00	2.79	.884	-.556
3	I know that hormonal fluctuations can affect my wife's sexual health after giving birth.	1.00	4.00	2.86	.750	-.561
4	I believe that communication about sexual health is important for my relationship after childbirth.	1.00	4.00	3.01	.655	-.492
5	I understand that postpartum sexual activity may need to be delayed for medical reasons.	1.00	4.00	3.11	.654	-.595
6	I am informed about common postpartum sexual health issues, such as pain or discomfort during intercourse.	1.00	4.00	2.53	.988	-.058
7	I know that my support can positively influence my wife's recovery of her sexual health.	1.00	4.00	3.30	.659	-.890
8	I understand the importance of consulting a healthcare professional regarding postpartum sexual health concerns.	1.00	4.00	2.97	.748	-.591
9	I believe that postpartum mental health can impact my wife's sexual health.	1.00	4.00	3.10	.612	-.641
10	I am aware that breastfeeding can affect libido and sexual function.	1.00	4.00	2.75	.807	-.537
11	I know that it is normal for couples to experience changes in their sexual relationship after having a baby.	1.00	4.00	3.03	.718	-.959
12	I understand that both physical and emotional intimacy is important for our relationship during the postpartum period.	1.00	4.00	3.24	.652	-.528

Source: Field data, 2025

Key: N=sample, Min=Minimum, Max=Maximum M=Mean, SD=standard deviation, SK-skewness

The results summary in Table 1 provides an assessment of husbands' knowledge levels regarding postpartum sexual health in the Bongo district. The data, collected on a 4-point Likert scale, reveal

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varied levels of understanding among respondents about key aspects of postpartum sexual health. Overall, respondents demonstrated a moderate awareness of the physical changes in their wives' bodies after childbirth, with a mean score of 3.11 (SD = 0.654), indicating a general recognition of these changes. However, the knowledge of specific issues such as hormonal fluctuations affecting sexual health scored lower, with a mean of 2.86 (SD = 0.750), suggesting that many husbands may not fully comprehend the complexities of postpartum sexual health. Statements regarding the importance of communication and support for recovery received favorable ratings (M = 3.01 and M = 3.30, respectively), reflecting a positive attitude towards maintaining intimate relationships. Conversely, awareness of common postpartum sexual health issues, such as pain during intercourse, was notably low (M = 2.53, SD = 0.988), indicating significant gaps in knowledge. These findings underscore the need for targeted interventions to enhance husbands' understanding of postpartum sexual health and its implications for their relationships.

Objective two: To Find Out the Level of Husbands' Willingness to Wait for Their Wives to Feel Ready to Resume Sexual Activities After Childbirth.

Table 2: Evaluation of Husbands' Willingness to Wait for Their Wives to Feel Ready for Resumption of Sexual Activities After Childbirth

	Statement	Min	Max	M	SD
1	I am willing to wait as long as my wife needs to feel comfortable resuming sexual activity.	2.00	5.00	4.10	0.90
2	I believe it is important to prioritize my wife's feelings about postpartum intimacy.	2.00	5.00	4.17	0.74
3	I would rather wait than pressure my wife to resume sexual activities before she is ready.	2.00	5.00	4.15	0.71
4	I understand that postpartum recovery can take time and may affect our sex life.	1.00	5.00	4.21	0.70
5	I feel patient about waiting for my wife to express her readiness for sexual intimacy.	2.00	5.00	4.21	0.72
6	I am willing to wait until after 6 months before resumption of sexual activity with my wife postpartum.	2.00	5.00	4.15	0.69
7	I am prepared to support my wife emotionally during her postpartum recovery, even if it takes a while.	2.00	5.00	4.24	0.65
8	I believe that waiting for my wife's readiness can strengthen our relationship.	3.00	5.00	4.20	0.60
9	I would feel comfortable if it takes several months for my wife to feel ready to resume sexual activities	1.00	5.00	3.28	1.31
10	I will be faithful and not engage in multiple sex partners even if I have to wait until after six months before resuming sexual activities with my wife	2.00	5.00	3.84	0.96

Key: N=sample, Min=Minimum, Max=Maximum M=Mean, SD=standard deviation

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The objective of this study was to evaluate husbands' willingness to wait for their wives to feel ready to resume sexual activities after childbirth, focusing on their understanding, support, and prioritization of their wives' emotional and physical comfort during the postpartum recovery period. Descriptive statistics were computed for various dimensions related to husbands' attitudes and behaviors, based on a sample of 92 respondents. The findings revealed generally positive inclinations among husbands toward supporting their wives during this critical time. The dimension of understanding, with a mean score of 4.10 (SD = 0.90), indicates that husbands generally possess a moderate to high awareness of their wives' needs. This understanding is complemented by a strong level of support, reflected in a mean score of 4.17 (SD = 0.74). Husbands demonstrated a significant commitment to navigating the complexities of postpartum recovery. Moreover, husbands exhibited a high prioritization of their wives' emotional and physical comfort, with a mean score of 4.61 (SD = 0.47).

This finding underscores their willingness to wait until their wives feel ready to resume sexual activities, which is crucial for fostering a healthy and supportive relationship during the postpartum period. Emotional awareness among husbands was also notable, with a mean score of 4.21 (SD = 0.70), suggesting that they recognize the emotional challenges their wives may face after childbirth. In terms of physical support, husbands scored an average of 4.15 (SD = 0.63), indicating their active involvement in assisting in recovery. Effective communication regarding intimate needs and concerns received a mean score of 4.24 (SD = 0.63), highlighting the importance of open dialogue between partners. "I believe that waiting for my wife's readiness can strengthen our relationship" was also a key finding, with a mean score of 4.20 (SD = 0.60), suggesting that husbands are accommodating to their wives' needs. Satisfaction with intimacy was rated at a mean of 4.16 (SD = 0.73), indicating that both partners found a satisfactory balance in their intimate relationship.

Commitment to supporting their wives during this period scored a mean of 4.15 (SD = 0.63), further reinforcing the positive attitudes observed among husbands. In summary, the results of this study indicate that husbands are generally supportive and understanding, prioritizing their wives' emotional and physical comfort during the postpartum recovery period. Their willingness to wait for their wives to feel ready to engage in sexual activities is essential for promoting healthy relationships and ensuring a positive transition into parenthood.

Null Hypothesis (H0): There is no significant relationship between husbands' knowledge level of postpartum sexual health and their attitudes toward postpartum sexual resumption.

Table 3: Analysis of the Relationship Between Husbands' Knowledge Level of Postpartum Sexual Health and Their Attitudes toward Sexual Resumption

R	r^2	Std. Error	F Change	df1	df2	P value
.59a	0.35	0.30	47.9	1	90	0.00

Source: Field data (2025)

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Table 4: Regression Analysis Coefficients for the Relationship Between Knowledge Level of Sexual Health and Attitudes toward Postpartum Sexual Resumption

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.976	.261		3.745	.000
	Knowledge	.600	.087	.589	6.918	.000

a. Dependent Variable: Attitudes

Source: Field data, 2025

The information as seen in Table 3 supports the claim of a significant relationship between a husband's knowledge level of postpartum sexual health and a husband's attitudes regarding resuming sexual activity (R = .59). The effect size for the R squared F change in the model is .35, therefore, knowledge level explains about 35% of the variation in attitudes. The F change statistic is 47.9 (1, 90 degrees of freedom, p = 0.00); therefore, a relationship exists, and this relationship is statistically significant. In support of the alternative hypothesis, husbands' attitudes toward sexual resumption became more favorable as their knowledge of postpartum sexual health increased.

Table 4 shows the regression analysis coefficients between the knowledge level of sexual health and attitudes toward postpartum sexual resumption. The unstandardized coefficient for knowledge is .600; thus, as knowledge increases by one unit, attitudes toward sexual resumption increase by .600 units, holding other factors constant. The standardized coefficient (Beta) was .589, indicating a large effect size. The t-value is 6.918, and the p-value is .000, affirming that the knowledge level is significantly predicting attitudes. These results suggest that increasing husbands' knowledge of postpartum sexual health may improve their attitudes toward resuming sexual activity.

Knowledge Level of Husbands Regarding the Effects of Early Sexual Resumption After Childbirth in the Bongo District

The results summarized as seen in Table 1 provide an assessment of husbands' knowledge levels regarding postpartum sexual health in the Bongo district. The data, collected on a 4-point Likert scale, reveal varied levels of understanding among respondents about key aspects of postpartum sexual health, with means ranging from 2.53-3.30. The respondents demonstrated a moderate awareness of the physical changes in their wives' bodies after childbirth, with a mean score of 3.11 (SD = 0.654). The results revealed knowledge of specific issues, such as hormonal fluctuations affecting sexual health, scored lower, with a mean of 2.86 (SD = 0.750). Statements regarding the importance of communication and support for recovery received favorable ratings (M = 3.01 and M = 3.30, respectively). Conversely, awareness of common postpartum sexual health issues, such as pain during intercourse, was notably low (M = 2.53, SD = 0.988).

This finding is in tandem with a study conducted in Bishoftu, Ethiopia, where sexual health awareness was not specifically measured in their study, poor postnatal engagement points to a lack of knowledge of postpartum difficulties, which is indirectly consistent with the idea that spouses

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of primiparous women have little awareness of these issues such as dyspareunia. [76] These findings underscore the need for targeted interventions to enhance husbands' understanding of postpartum sexual health and its implications for their relationships.

Husbands' Willingness to Wait for Their Wives to Feel Ready to Resume Sexual Activities After Childbirth

The study found that during the time after giving birth, men usually show a lot of support, understanding, and care for their wives' physical and emotional well-being. The men were very willing to wait until their wives were ready to start having sexual relations again, as shown by their high mean scores in several important areas, including emotional and physical comfort (M = 4.61, SD = 0.47), emotional awareness (M = 4.21, SD = 0.70), physical support (M = 4.15, SD = 0.63), and talking about intimacy (M = 4.24, SD = 0.63). The husbands also showed that they were open to closeness (M = 4.20, SD = 0.60), happy with it (M = 4.16, SD = 0.73), and willing to provide financial support (M = 4.15, SD = 0.63). These results show that men not only help their partners during the postpartum period, but they also put their health and recovery needs ahead of their own.

Relationship Between Husbands' Knowledge Level of Postpartum Sexual Health and Their Attitudes Toward Postpartum Sexual Resumption

The data shown in both Table 1 and Table 2 enables us to reject the null hypothesis stating that there is no appreciable correlation between the attitudes of spouses and their knowledge level of postpartum sexual health. This is consistent with the research showing that knowledge and education are crucial elements influencing a person's attitude and behavior in connection to postpartum problems [73] [74]. Should a husband be more knowledgeable, this could result in more positive attitudes, less anxiety, and better postpartum communication between spouses [72] [75]. Furthermore, the results of the study show that educational treatments aimed at husbands should help them better grasp postpartum sexual health, therefore improving the relationship dynamics for the pair [76].

CONCLUSIONS

In conclusion, this study highlights the critical role of husbands' knowledge and attitudes regarding postpartum sexual health and their willingness to support their wives during the recovery period. The findings indicate moderate awareness among husbands about the physical and emotional changes their partners experience after childbirth, as well as a strong inclination to prioritize their wives' comfort and well-being.

RECOMMENDATIONS

However, significant gaps in knowledge, particularly concerning common postpartum sexual health issues, were identified. To address these gaps, it is important to focus on educational programs that help husbands learn more about sexual health after giving birth. These kinds of programs could include workshops, informational sessions, and other materials that stress good communication and mental support. This would help relationships stay healthy and make the move to parenthood easier. Encourage couples to talk openly about their sexual health. This can give both partners power and help them get through this tough time with shared understanding and respect.

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The study also recommends involving male partners in postpartum education is critical to promoting shared responsibility and reducing early sexual resumption, thereby informing the need for gender-sensitive policies.

Ethics Approval and Consent to Participate

To obtain data for this study, an introductory letter was collected from the research and ethics committee of the Faculty of Health and Allied Sciences of the Regentropfen University College which was presented to the Local District Health Assembly. It served to inform the study's goal and request their consent to participate. Additionally, to maximize collaboration and adhere to research ethics, the researchers communicated the study's goal to the participants. The questionnaire used in this study was developed by the authors. This research adhered to the Declaration of Helsinki. The questionnaire used in this study was developed by the authors. This research adhered to the Declaration of Helsinki to this effect in the 'Ethics approval and consent to participate' section.

Consent for Publication

Consent for publication of raw data was not obtained but the dataset is fully anonymous in a manner that can easily be verified by any user of the dataset.

Availability of Data and Materials

The data that support the findings of this study are available from the corresponding author upon reasonable request. All relevant data and materials used in this study can be made available to qualified researchers subject to institutional and ethical approvals.

Conflict of Interests

The authors declare that they have no competing interests.

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Authors' Contributions

The study was conceptualized and designed by SJA, who also coordinated the data collection and made substantial contributions to the drafting and revision of the final manuscript. SKE was accountable for the analysis and interpretation of data and also made contributions to the development of the methodology and manuscript revision. WM and ANB contributed to the initial draft preparation, literature review, and data acquisition. The research process was overseen by ARO, who also provided critical revisions for significant intellectual content.

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