

Factors Associated with Female Sexual Problems among Women attending Cairo University Hospital

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Abstract

Background: Sexuality is an important and complex health problem that affects the quality of life and general well-being for men, women, and public health.

Methods: Descriptive Correlation design was adopted to assess factors associated with female sexual problems on 361 women aged from 18-42 years old that were recruited from about 3284 women who attended gynecological and family planning outpatient clinic at Cairo University hospital, Egypt. Data were collected using semi-structured interview schedule to assess female general history and female's sexual problems.

Results: The current study revealed that 57.3% of the sample had sexual problems including vaginal dryness, lack of genital sensation during sexual activity, lack of sexual desire, lack of orgasm, pain during sexual activity and lack of sexual satisfaction were 42.9%, 15.8%, 25.5%, 36.01%, 32.7% and 47.8% respectively. Also, the result revealed that, 60% felt sexual desire at least once a week. There was a negative correlation between female sexual problems and types of house, years of marriage, differences between sexual knowledge and actual sexual experience ($p=0.01$, $p=0.05$, $p=0.02$ respectively). Moreover, there was a positive statistical significant correlation between female sexual problems and women's age, using contraception, families' interference, and female genital mutilation ($p=0.04$, $p=0.03$, $p=0.01$, $p=0.05$ respectively). Surprisingly, there were no statistical correlation between female sexual problems and women' educational level, occupation, number of children, pelvic surgeries, genital tract infection, and emotional closeness ($p=0.31$, $p=0.40$, $p=0.33$, $p=0.23$, $p=0.45$, $p=0.06$ respectively).

Conclusion: We still have no statistical results regarding the real picture of this problem, because of the sensitivity of dealing with the sexual problems whether in male or female. It is a social issue that needs further researches in the future and counseling program to manage sexual problems at the primary health care.

Keywords: sexual problems, sexual dysfunction, female, factors

Background: Sexuality is an important and complex health problem that affects the quality of life and general well-being (Walsh, 2004). Sexual problems have a significant importance for men, women, and public health. It is characterized by disturbance in sexual desire and psychophysiological changes associated with the sexual response cycle in men and women. The prevalence of sexual dysfunction ranged from 30% to 63% worldwide (Laumann et al., 1999; Hisasue et al., 2005; and El Nashar et al., 2007). Sexual dysfunction is more prevalent in women (43%) than men. It is estimated that 25%–63% of women suffer from sexual dysfunctions (Goldmeier 2000; and Safarinejad 2006). In Egypt, there are limited studies on the prevalence of sexual dysfunction among women. In a study done by Al Atrash, et al (2014) reported that female sexual dysfunction was diagnosed in 75 of the 101 patients (74%); 86% reported hypoactive sexual desire, 60 % reported sexual arousal disorder in women with lower urinary tract symptom.

Female sexual dysfunction is associated with various demographic characteristics, including age and educational achievement, fertility status, hormonal levels, sexual knowledge and behaviors, family planning methods, physical and mental health (Lewis et al., 2004; and Laumann et al., 2005). Also, most sexual dysfunctions arise from a poor relationship with the partner, ignorance about sexuality and sexual technique, a low sexual drive, or performance anxiety. In addition, female circumcision is one of the traditional practices that is still performed in Egypt and is a possible cause of female sexual dysfunction (FSD) (El Nashar et al., 2007). Also, Ramezani (2014), stated that women of different racial groups demonstrate different patterns of sexual dysfunction which is attributed to the different racial, ethical, cultural factors and customs in different communities.

Moreover, sexual dysfunction is still a taboo subject in many countries (Hassanin et al., 2010). Cultural and religious values, inadequate sex education, restricted discussion with health professionals about sexual problems, and feelings of embarrassment may complicate women's chances of receiving help and consultation from healthcare institutes (El Nashar et al., 2007).

Significant

Sexual relationships are an important aspect of life for all people. An important possible consequence of sexual intercourse is the conception. Sexual dysfunction is considered one of the major factors which threaten the reproductive health in an indirect way, as this dysfunction prevent the sexual intercourse, so this decreases the chance for conception. In Egypt, cultural and traditional beliefs are a male dominant culture, which leads to

difficulty in dealing with this disorder. So, we still have no statistical results regarding the real picture of this problem, because of the sensitivity of dealing with the sexual relation between male and female.

Waterhouse (1993) indicated that sexuality should be addressed in numerous aspects of nursing care. Many nurses have difficulty providing patients with care in the area of sexuality, and usually do not address sexual concerns unless the patient asks specific questions. In a study that explored the attitudes of healthy individuals toward physicians and nurses discussing sexual concerns with clients, most subjects thought discussing sexual concerns with nurses was appropriate, and they thought that physicians should discuss sexual concerns with clients.

Research Question

What are the factors that might associate female sexual problems?

Methods

Descriptive Correlation design was adopted to assess factors associated with female sexual problems on 361 women aged from 18-42 years old that were recruited from about 3284 women who attended gynecological and family planning outpatient clinic at Cairo University hospital, Egypt. Data were collected from March to June 2014. Women with the following criteria were recruited; full acceptance to participate in the study and free from mental and medical disorders. As well, women who refused to participate in the study or pregnant or those within 2 months post partum or menopause or had hypothyroidism or hyperthyroidism were excluded from the study. After official permission was granted from the director of the maternity and gynecological hospital, written informed consent and information about the purpose of the study were given to the women invited to participate in the study. The women were informed that their participation in the study is voluntary and they were given a guarantee of anonymity. They were informed that they are free to withdraw from study at any time.

Tools

A semi-structured interview schedule designed and developed by the researcher based on the available review of literature studies and medical and nursing experts' opinion. The questionnaire was submitted to five expertises in obstetrics and gynecology, andrology and maternity nursing to ensure content validity. Few modifications were carried out based on the expertise's opinion. It contained two main parts: I) Female general history and; II) Female's sexual history.

I. Female general history included: 1) sociodemographic characteristics such as age, educational level, occupation, years of marriage, type of housing, , the degree of husband and wife families interference in their marital life and residency as well as the habits (smoker, alcoholic, drug abuse, etc.). 2) Obstetric profile includes data about genital mutilation, mode of previous delivery, number of children, history of pelvic surgery and its type, contraceptive history. **II. Female's sexual history included data about** 1) Source of female's sexual knowledge; 2) Female sexual problems (lack or reduced sexual desire; frequency of sexual activity; arousal difficulty; lubrication difficulty; inability to achieve orgasm; pain during intercourse; and 3) Woman-husband general relationship. The women were interviewed by the researcher in a private room in the outpatient clinic to ensure confidentiality, and the researcher asked the woman in Arabic and recorded her answers. Each subject interview lasted from 45-60 minutes.

Pilot Study

A Total of (10) woman was recruited for a pilot study to investigate data collection tool for its clarity, suitability as well as the acceptability by the women.

Statistical Analysis

Data was coded for entry and analysis using SPSS statistical software package version 18. Data was presented using descriptive statistics in the form of frequencies and percentages. Interval and ratio variables were presented in the form of means and standard deviations. As well, correlation coefficient was used to determine factors associated with female sexual problems. Significance level was chosen as ($p < 0.05$).

Results

This study was carried out to assess factors associated with female sexual problems on 361 women. The women age range was 18- 42 years old with a mean age of 29.67 ± 6.22 years. Most of the sample was educated (88.9%) with different level of education and 63.98% were house wife. The majority of the sample was living in urban area (93.9%) and only 26.03% was living in small house with one bedroom (table,1).

Table (1): Frequency Distribution of Sociodemographic Characteristics of the Sample

Variables	Frequency (N= 361)	Percent
Educational level		
Can't read & write	39	10.8
Primary	84	23.27
Secondary	173	47.92
University	65	18.01
Occupation		
House wife	231	63.99
Working	130	36.01
Residency		
Urban	339	93.91
Rural	22	6.09
Type of housing		
large house (more than one bedrooms)	216	59.83
small house (one bedroom for the couple only)	94	26.04
one bedroom for them and their children	51	14.13

Regarding to the number of children, 30.2% of the sample had no children and 25%% had more than two children. Moreover, the mean marriage life duration was 6.13+4.7 years, 45.8% reported husband's family interference in their marital relationship and 68.02 % of them had adequate general communication in their marital life. Most of the sample was circumcised (95.01%), more than half (65.9%) used contraception, 26.8% had pelvic surgery and 33.7% had genital tract infection. Concerning mode of delivery, 68.14% delivered vaginally with no complication during delivery (96.7%) (table, 2). In relation to parity, 30.2 % of the women were nulliparous, 18.8% of them were primiparous, 26% para 2, 15.8 % para 3, and 9.2% of them were para 4 (figure, 1).

Table (2) Frequency Distribution of the Sample According to their Obstetrical Characteristics

Variable	Frequency (N= 361)	Percent
Female genital mutilation		
Yes	343	95.01
No	18	4.99
Contraception		
Yes	238	65.9
No	123	34.1
Pelvic surgery		
Yes	97	26.8
No	264	73.2
Genital tract infection		
Yes	122	33.7
No	239	66.3
Mode of delivery		
No delivery	109	30.19
Vaginal delivery	246	68.14
Cesarean section	6	1.67

(Figure, 1) Distribution of the Sample According to their Parity

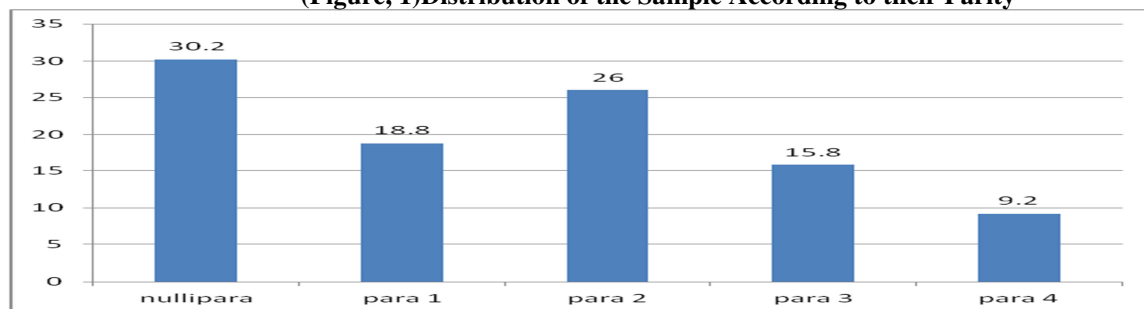


Figure 2. Female sexual problems.

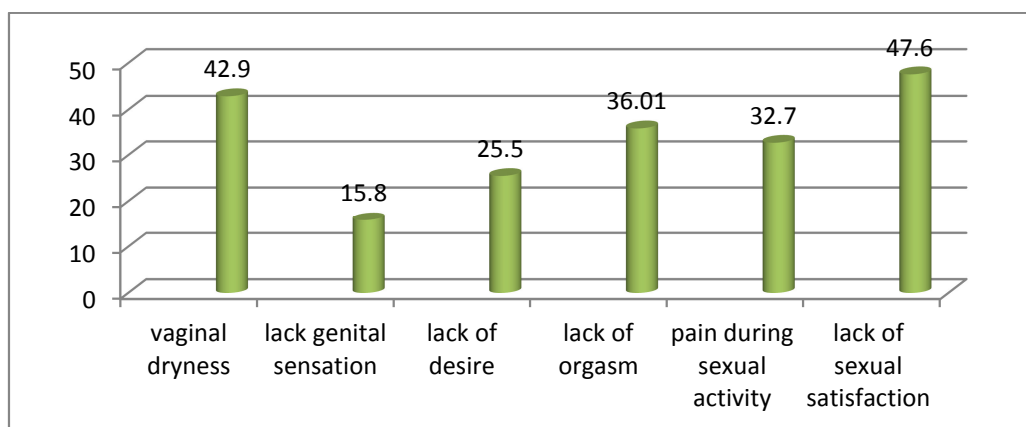
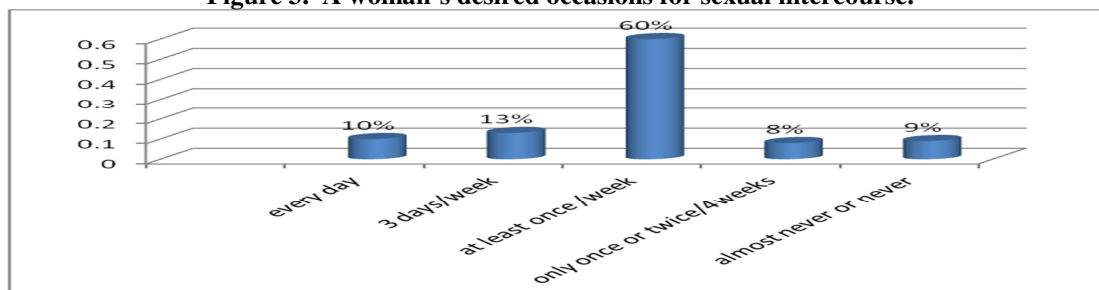


Figure 3. A woman's desired occasions for sexual intercourse.



Sexual Problem

The results demonstrated that 57.3% of the sample had sexual problems. The frequency of vaginal dryness, lack of genital sensation during sexual activity, lack of sexual desire, lack of orgasm, pain during sexual activity and lack of sexual satisfaction were 42.9%, 15.8%, 25.5%, 36.01%, 32.7% and 47.8%, respectively (fig.2). More than half of the sample (66%) had no sexual knowledge before marriage and 87% indicated that sexual education before marriage is very important. Also, the result revealed that, 60% felt sexual desire at least once a week, 13% indicated three times per week, and 75% had high level of sexual desire (fig. 3).

Table (3) Factors Which May Associate with Female Sexual Problems

Factors associated with female sexual dysfunction	r	p
Women' age	0.26	0.04*
Women' education	-0.11	0.31
Women' occupation	0.08	0.40
Type of house	-0.24	0.016*
Years of marriage	-0.23	0.053*
Number of children	0.09	0.33
Pelvic surgeries	-0.12	0.23
Genital tract infection	-0.07	0.45
Using of contraceptive methods	0.22	0.03*
FGM	0.18	0.05*
Families' interference	0.32	0.013*
Emotional closeness	-0.24	0.064
The adequacy of sexual knowledge	0.24	0.01*
Difference in S. knowledge & actual experience	-0.28	0.02*
Time of obtaining sexual knowledge	0.196	0.05*

*Statistically significant

Factors Which May Associate with Female Sexual Problems

Table (3) had shown that types of house, years of marriage, differences between sexual knowledge and actual experience had a negative correlation with female sexual problems ($p=0.01$, $p=0.05$, $p=0.02$ respectively). Moreover, there was a positive statistical significant correlation between female sexual problems and women's age, using contraception, families' interference, adequacy of sexual knowledge, time of obtaining sexual knowledge and female genital mutilation ($p=0.04$, $p=0.03$, $p=0.01$, $p=0.01$, $p=0.05$, $p=0.05$ respectively) (table, 3). Surprisingly there was no statistically significant association between women' educational level, occupation, number of children, pelvic surgeries, genital tract infection, emotional closeness and female sexual problems ($p=0.31$, $p=0.40$, $p=0.33$, $p=0.23$, $p=0.45$, $p=0.06$ respectively).

Discussion

Sexual dysfunction is defined as a disturbance in sexual response cycle (American Psychiatric Association, 1994). The family as the center and core of all human societies is based on the sexual instinct (Amirkhan et al., 2014). Female sexual problems haven't received much attention as men sexual problems especially in Arab countries. This may be due to cultural and religious values, inadequate sex education, restricted discussion with health professionals about sexual problems, and feelings of embarrassment may complicate women's chances of receiving help and consultation from healthcare providers (El Nashar et al., 2007). The current study tried to assess factors associated with female sexual problems among women attending Cairo university hospitals.

The current results demonstrated that more than half of the sample had sexual problems and the most sexual problems were vaginal dryness, lack of sexual desire, lack of orgasm, pain during sexual activity and lack of sexual satisfaction. This matched with Elnashar, et al., (2007), who conducted a cross sectional study on 1000 women in the Dakahlia Governorate, Egypt, and found that (68.9%) of women had sexual problems and loss of desire was the most common sexual problem among participants (49.6%), followed by orgasmic problems (43%), while arousal problems and dyspareunia occurred in 36% and 31.5%, respectively. Moreover, the findings were consistent with Daker-White and Crowley (2003) who performed a cross-sectional study on 216 men and 191 women attending Department of Genitourinary Medicine, University of Bristol, UK and found that 69% of women had sexual problems. In addition, El Atrash, et al., (2014) assessed sexual dysfunction in Egyptian women with lower urinary tract symptoms. They reported that disorders of arousal, orgasm, lubrication, satisfaction and sexual pain were more common in those with lower urinary tract symptoms. Moreover, Hassanin et al. (2010) in a sample from Upper Egypt revealed that female sexual dysfunction was identified in 76.9% (462/648) of their study population.

Also, more than half of the sample had inadequate sexual knowledge before marriage and the majority indicated that sexual education before marriage is very important. This may be related to that sexual education in Egypt and Arabic countries is an embarrassing issue. This congruent with Lau, Yang, Cheng, and Wang, (2006) who suggested that sexual knowledge, is a predictor variable to sexual problems in both males and females. Concerning frequency of sexual intercourse, the result indicated that, more than half of the sample felt sexual desire at least once a week and this matched with Elnashar, et al., (2007) who indicated that, the most common frequency of sexual intercourse reported among participants was two to four times per week and about third of the women (36.2%) mentioned that once per week is more convenient.

In relation to factors which may associate with female sexual problems, the result demonstrated that, types of house, years of marriage had a negative correlation with female sexual problems. The result suggested that sexual problems increased as the house size decreased and as the duration of marriage increased sexual response cycle decreased and sexual problems more prevalent. This finding is congruent with El nashar (2007) who reported in their study that lack of adequate privacy at home and low income were the most common aggravating factors for female sexual dysfunction in Lower Egypt.

Also, differences between sexual knowledge and actual experience had a negative correlation with female sexual problems. This may attributed to the Egyptian culture, especially in rural areas, which considers sexual knowledge is a private issue and socially forbidden for the female to talk on this issue with any one before marriage. So, sexual knowledge is allowed to be given to the female immediately before her wedding night by her mother or any closed married female relative and this knowledge usually are based on personal experience. In this respect, Kotb (2004) stated in her study “sexuality in Islam”, that there was a firm belief that facts about sex should be taught to children in a way that is age-appropriate both by the family and the school. Kotb concluded that, it is better to give the correct teaching rather than leave this to chance and to incorrect sources and to the concomitant feeling of guilt.

The current result indicated a positive statistical significant correlation between women’s age, using contraception, families’ interference, female genital mutilation, and female sexual problems. This in reference with Hassanin et al. (2010) who studied the prevalence and characteristics of female sexual dysfunction in a sample of women from Upper Egypt. They stated that the prevalence of sexual dysfunction was found to increase with increasing age. Also, the finding corroborates the report of Abd El-Hady and El-Nashar (1998) who found in their sample of 264 women in Benha City that circumcised women (75.8%) were more likely to have marital problems such as loss of sexual desire, dyspareunia, and lower satisfaction rate, in addition to psychological problems, mainly anxiety, depression, and hostility. In addition as the family interference increase, the female sexual problems increase. This is due to family pressure in making decision in the couple life. Also, Oniz et al., (2007), reported there are many factors that affect female sexual function including age, family planning methods, relationship with her spouse, sexual knowledge and socioeconomic status.

Surprisingly, the current result revealed no statistical correlation between women’ educational level, occupation, number of children, pelvic surgeries, genital tract infection, emotional closeness and female sexual problems. This in the same line with Hassanin et al. (2010) who mentioned that, the level of education of the women was not correlated with the incidence of sexual dysfunction. In contrast, Van Geelen et al. (1996) showed a positive correlation between level of education and sexual dysfunction, which was attributed to the possibility that a higher level of education may be associated with an increase in a woman’s ability to express her dissatisfaction. The difference between our findings and this study may, however, be attributed to a difference in cultural factors among the women studied.

Conclusion

In conclusion, female sexual problems don’t received more attention as male sexual problems among health care provider in Egypt and therefore warrants recognition as a significant public health issue, with a need for further research studies in different population and measuring different attributes. Also, we need to increase public awareness regarding sexual problems and its impact on their life and change culture view for the importance of sexual education especially for the new couples. Finally, studies of health care providers’ awareness and competency to discuss sexual issue are urgently needed, as most healthcare providers receive little or no formal training in this critical area. Develop and implement counseling program for those who complained from sexual problems at the primary health care units.

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