

Assessment the Female Sexual Function among Libyan Women at Tripoli, Libya, 2024

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Abstract

Background: The sexual function is an essential aspect of life for women irrespective of age because it is closely correlated with overall wellbeing and relationship satisfaction. Female Sexual Dysfunction (FSD) is a common public health issue that is defined as one or more problems of female sexual desire, arousal, orgasm and/or sexual pain/discomfort that leads to significant distress. **Aim:** This study aimed to assess the female sexual function among Libyan women. **Methods and materials:** This descriptive cross-sectional study was carried out at Tripoli University Hospital over six months duration between January and June 2024. It included 314 female participants who attended the hospital during that period. The data underwent analysis and prescription via a computerized program of SPSS version 24. **Results:** The most frequent age range was between 26 to 35 years accounting for 54.8% (172). The mean duration of marriage was 7.42 years \pm 7.228 SD. The majority of participants were multipara accounting for 79.9% (251). Based on the classification of female sexual dysfunction severity, 41.7% (131) of participants had mild to moderate severity followed by 32.2% (101) had mild severity with an overall female sexual dysfunction rate of 81.2% (255). Based on female sexual function characteristics, 28.3% (89) had abnormal desire, 22% (69) had abnormal arousal, 55.4% (174) had abnormal lubrication, 24.5% (77) had undetected orgasm, 23.2% (73) had inappropriate satisfaction and 19.1% (60) had pain. **Conclusion:** The overall rate of female sexual dysfunction among Libyan women was (81.2%) which is considered high but with low severity, (41.7%) had mild to moderate dysfunction followed by (32.2%) with mild dysfunction. These findings had significant effects on sexual life and marital status which require a basic strategy approach to increase sexual awareness and marital counseling among couples and to avoid adverse sexual dysfunction conse-

quences such as divorce, marital problems, insufficient sexual satisfaction, and psychosocial concern.

Keywords

Female Sexual Function Index, FSFI, Classification of Female Sexual Dysfunction Severity, Libya

1. Introduction

The sexual health is considered a condition of physical, mental, emotional and social wellbeing related to sexuality, not merely the absence of dysfunction or infirmity and the World Health Organization has considered female sexuality as an important component of women's health as well as a basic human right [1].

The sexual function is an essential aspect of life for women irrespective of age because it is closely correlated with overall wellbeing and relationship satisfaction [2]-[4].

The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) defines sexual dysfunction as a disorder of a heterogeneous group characterized by clinically significant disturbances in sexual response or the experience of sexual pleasure [5].

Female Sexual Dysfunction (FSD) is a common public health issue that is defined as one or more problems of female sexual desire, arousal, orgasm and/or sexual pain/discomfort that leads to significant distress [6] [7].

Globally, the worldwide prevalence of sexual dysfunction among women reached (38%) compared to men reached (28%). Although, the prevalence is high compared to men, low attention is paid to female's sexual problems [3] [8].

There is a wide range of causative factors and etiologies that contribute to FSD with complex interactions of biological and psychosocial components such as age, level of education, and partner relationships [9].

The prevalence of FSD varied according to different population groups, age ranges and countries which were reported to be ranged between 24% to 63% [10].

A systematic review and meta-analysis (2016) documented that the prevalence of female sexual dysfunction among women of reproductive age reached 41% worldwide [11].

Also, the incidence of short-term postpartum sexual dysfunction had identified to be reached between 22% to 86% as well as an increasing rate of dyspareunia after assisted vaginal delivery (forceps or vacuum) on compared to spontaneous vaginal delivery or cesarean section [12] [13].

Several studies have identified that the sexual dysfunctions can be a reason for infertility or can be triggered by infertility and women are more affected compared to men. Also, infertility treatment is reported to cause stress in partners, which can result in sexual dysfunctions [14] [15].

During menopause period, it is widely accepted that sexual function worsens independently of age and the sexual dysfunction in this time of life from various predisposing, precipitating and maintaining factors, which may be of biological, psychological and socio-cultural origin [16] [17].

Therefore, the first line of therapeutic strategies for menopause-related sexual dysfunction includes education and addressing modifiable factors [18].

Also, few studies have reported a decline in sexual function following hysterectomy, which is estimated to be between 15% - 37% of women [19] [20].

Finally, the management of female sexual dysfunction is individualized with variable treatment models including hormones and various drugs. However, no single treatment has been established as a gold standard for female sexual dysfunction [21].

In Libya, insufficient data regarding the rate of female sexual dysfunction was found because of stigma and strict cultural discrepancies as well as some religious beliefs which contributed to difficulty and complexity in dealing with sexual life and sexual awareness during marriage.

Therefore, this study aimed to assess the female sexual function among Libyan women at Tripoli University Hospital during 2024.

2. Methods and Materials

This descriptive cross-sectional study was carried out at Tripoli University Hospital over six months duration between January and June 2024.

The study included 314 female participants who attended the hospital during that period, and the selected participants were recruited using a simple random sampling technique.

Regarding the sample size determination: Because of the novelty of this study and the unknown prevalence of female sexual dysfunction among Libyan females, the recruited sample was identified and confined to the duration of the study.

The data was collected from all participants during an interview by investigators (Seven Co-authors) and all investigators were educated and counseled regarding how to communicate and ask the participants by supervisors' guidance, the selection of participants via simple random techniques from different departments for participants who fit the inclusion criteria, these precautions followed by investigators to guide them and standardization the questionnaire collection process.

Inclusion criteria: Married female participants included nurses, physicians, visitors of patients presented in different departments, and female patients who attended the various hospital departments except the obstetrics and gynecology departments.

Exclusion criteria: Patients who attended the obstetrics and gynecology department, pregnant women, unmarried women, and participants who refused to enter the study.

The data was collected through two questionnaires. The first questionnaire contained relevant personal data of participants prepared by investigator (first author had designed the traditional socio demographic questions and she tested the

validity and reliability of the questionnaire which was appropriate) Appendix 1 and the second questionnaire included a standardized international questionnaire of female sexual index scoring system which composed of detailed 19 items classified into six domains included desire, arousal, lubrication, orgasm, satisfaction and pain condition [22].

The female sexual dysfunction severity had been classified into five categories severe (2 - 7.2), moderate (7.3 - 14.4), mild to moderate (14.5 - 21.6), mild (21.7 - 28.1), and no FSD (28.2 - 36) [23].

The data underwent analysis and prescription via a computerized program of SPSS version 24. The descriptive analysis included frequency and percentage summarized in graphical and tubular manner as well as inferential statistics of Chi square test were used.

The P-value of less than 0.05 was considered a statistically significant result.

3. Results

This study included 314 female participants at Tripoli University Hospital during 2024.

Out of 314 female participants, the most frequent age range was between 26 to 35 years accounting for 54.8% (172), and the mean age was 34.75 years \pm 7.595 SD with the minimum age being 20 years while the maximum age was 57 years.

58.6% (184) of participants had a university educational level, followed by 32.5% (102) of them had a secondary school educational level and 58.9% (185) of participants were employers. (Table 1)

Table 1. Participants characteristics, Tripoli university hospital, Tripoli, Libya, 2024.

Variables (n = 314)	F/%
Age	
<25 years	25 (8%)
26 - 35 years	172 (54.8%)
36 - 45 years	91 (29%)
>45 years	26 (8.3%)
Educational level	
Primary school	10 (3.2%)
Secondary school	102 (32.5%)
University	184 (58.6%)
Others	18 (5.7%)
Occupation	
Employers	185 (58.9%)
Housewives	129 (41.1%)

The mean duration of marriage was 7.42 years \pm 7.228 SD with the minimum duration was eight months while the maximum duration was 37 years, and 58.3% (183) of them were less than five years duration. (Figure 1)

The majority of participants were multipara accounting for 79.9% (251) while 20.1% (63) of them were nullipara. (Figure 2)

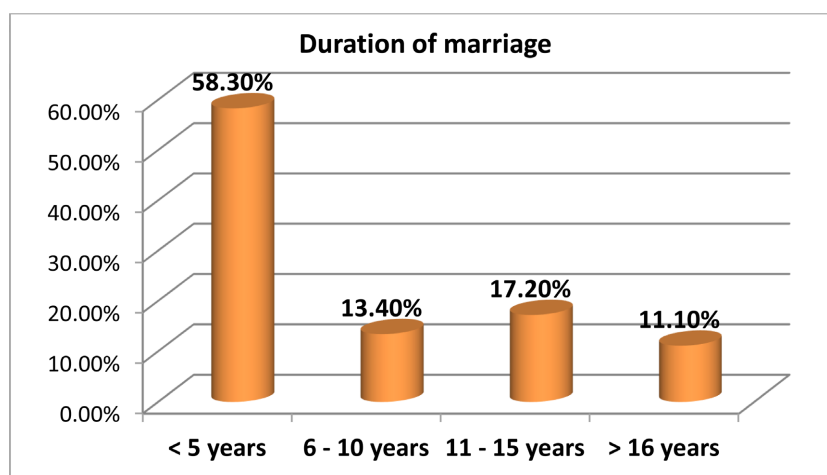


Figure 1. Duration of marriage distribution, Tripoli university hospital, Tripoli, Libya, 2024.

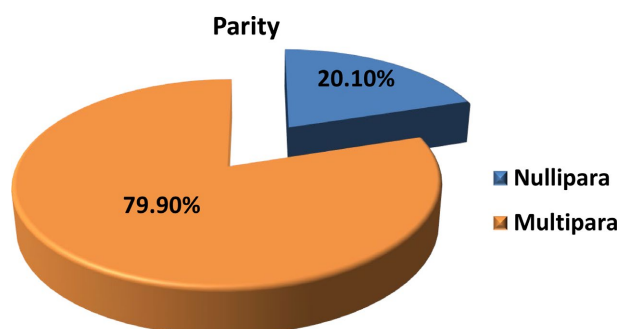


Figure 2. Parity distribution, Tripoli university hospital, Tripoli, Libya, 2024.

Based on history of gynecological diseases, 5.4% (17) of participants had pelvic inflammatory disease, 5.1% (16) had uterine fibroids, 1% (three) had polycystic ovarian syndrome and 0.3% (one) had ovarian cysts.

And based on history of chronic illness, 4.1% (13) of them had diabetes mellitus, 2.9% (9) had hypertension, 1% (three) had hyperthyroidism, 0.6% (two) had asthma and 0.3% (one) had human immunodeficiency virus infection.

Based on the husband characteristics, the mean husband age was 40.68 years \pm 8.502 SD with the minimum age was 27 years while the maximum age was 67 years.

Just 3.8% (12) of partners had hypertension, 2.9% (nine) had diabetes mellitus and 0.6% (two) had dyslipidemia.

And 29.6% (93) of them were smokers while 70.4% (221) were non smokers. (Figure 3)

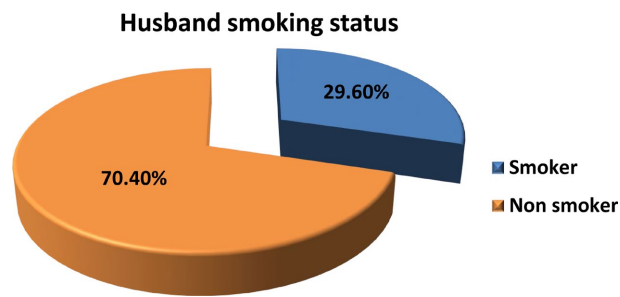


Figure 3. Husband smoking status distribution, Tripoli university hospital, Tripoli, Libya, 2024.

Based on the classification of female sexual dysfunction severity, 41.7% (131) of participants had mild to moderate severity followed by 32.2% (101) had mild severity with an overall female sexual dysfunction rate of 81.2% (255). (**Table 2**)

The mean calculated score was 23.361 ± 4.384 SD, with the minimum score was 7.10 while the maximum score was 33.7.

Based on female sexual function characteristics, 28.3% (89) had abnormal desire, 22% (69) had abnormal arousal, 55.4% (174) had abnormal lubrication, 24.5% (77) had undetected orgasm, 23.2% (73) had inappropriate satisfaction and 19.1% (60) had pain. (**Table 3**)

Table 2. Classification of female sexual dysfunction severity characteristics, Tripoli university hospital, Tripoli, Libya, 2024.

Variables (n = 314)	Frequency (N)	Percentage (%)
Severe (2 - 7.2)	7	2.2%
Moderate (7.3 - 14.4)	16	5.1%
Mild - moderate (14.5 - 21.6)	131	41.7%
Mild (21.7 - 28.1)	101	32.2%
N FSD (28.2 - 36)	59	18.8%

Table 3. Female sexual function characteristics, Tripoli university hospital, Tripoli, Libya, 2024.

Variables (n = 314)	Normal	Abnormal
Desire	225 (71.7%)	89 (28.3%)
Arousal	245 (78%)	69 (22%)
Lubrication	140 (44.6%)	174 (55.4%)
Orgasm	237 (75.5%)	77 (24.5%)
Satisfaction	241 (76.8%)	73 (23.2%)
Pain	254 (80.9%)	60 (19.1%)

Highly statistically significant results were reported on the relationship between female sexual function characteristics and classification of female sexual function severity with a P-value of <0.001 .

Although there were statistically significant results on the relationship between educational level and female sexual dysfunction (P-value ≤ 0.001) insufficient perception of sexual life was reported despite their high educational level.

Similar statistically significant results on the relationship between female sexual dysfunction and age (P-value ≤ 0.001), but irrespective of participants' age the female sexual function perception was identical.

4. Discussion

Sexual dysfunction is a complex event that affects the physical, social, and psychological determinants of women's life [24].

Therefore, the female sexual function index (FSFI) is considered the gold standard for assessing female sexual function [25].

The current study assesses the female sexual function of 314 participants who attended the Tripoli University Hospital in 2024.

This study found that the prevalence of female sexual dysfunction was 81.2% (255) with 41.7% of participants having mild to moderate severity followed by 32.2% having mild severity. Although the high prevalence of female sexual dysfunction has a minor severity, which can be explained by the disorientation of participants regarding the sexual components which contributed to low perception of sexual function, feeling discomfort in answering the questions due to stigma and strict cultural beliefs regarding this topic. The possible cultural beliefs include the limitation of sexual awareness due to social restriction, feelings of shame and guilt of discussing sexual life, high stigma on talking about sexual life and misperception, and hidden thoughts related to sexual life.

Our results were higher than Ismail SA *et al.* study (2021) in Egypt which reported that 67.8% of participating women had sexual dysfunction with 20.4% of them having mild dysfunction and 41.6% of them having mild to moderate dysfunction [23].

While on Ibine B *et al.* study (2020) in Ghana reported that 48.3% of patients had sexual dysfunction with 27.6% having moderate to severe dysfunction [26].

And Mishra VV *et al.* study (2016) in India found that the prevalence of female sexual dysfunction was 55.55% [27].

Rahman S study (2018) reported that most Muslim women expressed variable degrees of sexual dysfunction particularly pain disorders and this concern is related to several risk factors such as psychological and cultural roles [28].

Despite the high education level in the present study accounted for 58.6% but the sexual function orientation was low, these results are consistent with Fajewonyomi BA *et al.* study (2007) in Nigeria which found that female sexual dysfunction was more prevalent among higher educated women accounted for 43.4% [29].

Also, the female age was reported to have significant adverse effects on sexual life particularly among middle age. This study detected that 51.3% of sexually active women expressed sexual dysfunction, which was documented to be raised with aging [30] [31].

The limitation of the study was centered on short duration of study, while the strength of the study was the good sample size, which can represent the population.

5. Conclusions

The overall rate of female sexual dysfunction among Libyan women was (81.2%) which is considered high but with low severity, (41.7%) had mild to moderate dysfunction followed by (32.2%) had mild dysfunction.

These findings had significant effects on sexual life and marital status which require a basic strategy approach to increase sexual awareness and marital counseling among couples and to avoid adverse sexual dysfunction consequences such as divorce, marital problems, insufficient sexual satisfaction, and psychosocial concern.

Barriers and strategy for female sexual counseling:

1. The recommended strategy:

1) Integrate training programs for obstetrics and gynecology physicians to improve their knowledge regarding sexual medicine and empower communication skills with targeted patients.

2) Activate marital and social counseling sessions along with psychologists and sociologists.

3) Encourage affected patients to express sexual problems freely and manage them promptly.

2. The expected barriers:

1) The expected barriers to female sexual awareness will be social restrictions and limited sexual medicine clinics.

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Ethical Approval

Ethical approval was obtained from the hospital, and consent was obtained from all participants included in the study.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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