

Assess Sexual Disorders and Urinary Incontinence among Asymptomatic Women

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Abstract

Sexuality is a process that involves the integration of different organ systems and requires neurologic, vascular and endocrine coordination. This study **aimed** to determine the various types of sexual and urinary disorders among asymptomatic woman in different social levels and identify the high-risk factors, which will be more likely to have these sexual and urinary disorders. **Descriptive analytic design** was used for this study. A systematic random sample was consecutively recruited in this study, conducted in Minia University Hospitals **Results:** mean age of studied group was 30.2 ± 6.3 years, more than half of them lives in urban area, near to half of them have university education and their marriage aged ranged between 15- 24 years and mean of marriage period 10.09 ± 7.0 years. Regarding total score of female sexual function index the majority of studied group not FSD and the minority of them FSD. Also, there were negative fair association between studied age and sensation of pain during sexual activity, and the marriage period with desired, arousal, satisfaction domain, and total FSFI. **Conclusion:** The most frequent dysfunction domains among studied group were sexual pain 22.0%, followed by 16.0% sexual desire, then 14.0% sexual arousal, 11.0% lubrication domain, 10.9% orgasm, 5.0% satisfaction domain, and 10.6% of them had FSD. The main risk factor can lead to FSD were age of studied group and duration period of marriage. **Recommendation:** Develop training program for asymptomatic women with sexual disorders and urinary incontinence to know the most frequent dysfunction and how to deal with it.

Keywords: Asymptomatic Women, Sexual Disorders, Urinary Incontinence,

Introduction

Female sexual dysfunction (FSD) is defined as an umbrella term for disorders of libido, arousal, orgasm, and sexual pain that lead to personal distress or interpersonal difficulties also it can be defined as a disturbance in or pain during the sexual response (*Mamdouh et al., 2015*). It is a common problem, affecting 30–78 % of women (*Jaafarpour et al., 2013*) and has received mixed responses from clinicians, theoreticians, and researchers. FSD is a multi-causal and a multi-dimensional medical problem that adversely affects physical health and emotional well-being (*Berman et al., 2003*)

The incidence of FSD varies widely probably because of differences in the defining criteria of sexual dysfunction and factors affecting it, i.e., the population involved, cultural background, socio-economic level and quality of psychosexual relationships (*Ibrahim et al., 2013*).

Mamdouh et al., (2015) in a cross-sectional survey conducted in Alexandria, Egypt. They found that FSD in more than half of the women surveyed (53.7%). Domain scores suggestive of sexual difficulties ranged from the highest prevalent difficulty related to desire (82.2%) to the least prevalent one of poor satisfaction (33.4%). Age above 40 years (odds ratios [OR] 3.1; 95% CI 1.9 to 4.8), fewer years of education (OR 2.0; 95% CI 1.3 to 3.2) and having fewer number of sexual intercourse per week (OR 4.6; 95% CI 3.0 to 6.9) were the potential predictors for the presence of possible FSD among the current sample after using logistic regression.

Urinary incontinence (UI) defined by the International Continence Society (ICS) an organization with a global health focus that works through education and research to improve QoL in people with urinary, bowel, and pelvic floor disorders as the complaint of any involuntary leakage of urine. Also, ICS stated that in each specific circumstance, urinary incontinence should be further described by specifying relevant factors such as type, frequency, severity, social impact and effects on quality of life. The measures used to

contain the leakage should be described together with whether or not the individual sought or desired help because of urinary incontinence (*Ford, et al., 2017*).

El-mowafy et al., (2015) studied the prevalence of degree, duration and types of urinary incontinence among middle age women and the risk factors associated with urinary incontinence among middle age women. They found that the overall prevalence of UI was 66.5%. The prevalence of mixed, urgency, and stress UI was 68.6%, 24.1 % and 7.3%, respectively. The degree of mild, moderate and severe UI was 47.6%, 43.3% 9.1% respectively. They added that 37.7%, 31.4% of the study sample who had urinary incontinence were 45-49 & 55-60 years respectively. In addition, the results show that there was significant positive association between UI and family history of urinary incontinence (odds ratio [OR] = 2.275); Myomectomy (OR = 3.809). Moreover, The results of their study showed that there was a strong significant correlations between degrees of urinary incontinence and body mass index and dietary intake(tea, coffee and marjoram) with P -value <0.001. Additionally, strong significant correlations was found between duration of urinary incontinence and age, and body mass index.

Significance of the study

Female sexual dysfunction (FSD) has been reported in 46% of women with lower urinary tract symptoms (LUTS). FSD is a common health problem that remains under-investigated, especially in Eastern communities, where discussion of the issue is considered a taboo. Female sexual dysfunction (FSD) is age-related, progressive and extremely common, affecting 30–50% of women worldwide and in Egypt, a study conducted in Lower Egypt reported a prevalence of FSD of 46 %. (*Buckey and Lapitan, 2010*). The absence of clear research in Egypt and other developing countries on sexual and urinary complaints among a symptomatic woman motivated the researcher to discover the types and incidence of these complaints, proposing the ideal

nursing care regarding it and know the health seeking behavior of women. From this point the researcher conduct this study.

Aim of the Study

This study aims to:

1. Determine the various types of sexual and urinary disorders among asymptomatic woman in different social levels.
2. Identify the high risk factors, which will be more likely to have these sexual and urinary disorders.

Research Question:

- What are the factors that disturb urinary and sexual function among woman in different social levels?

Subjects and Methods

Research Design

Descriptive analytic design was used for this study.

Sample

A systematic random sample was consecutively recruited in this study. The sampling population consisted of all women who are staff members or employees or workers in Minia University hospitals their total number was 350 women who's married and in reproductive age (15-49years).

Setting

This study was conducted on staff members, employees, and workers in Minia University Hospitals (Obstetrics, Gynecological and Children University Hospital-Minia University Hospital-Cardio Thoracic University Hospital-Dental University Hospital-Urological University Hospital)

Tools of Data Collection:

Data of this study was collected by using three tools

Tool I: Structured Assessment Sheet: This tool was developed by the researcher after reviewing the related literature and it was designed to assess patients' socio demographic characteristics such as age, residence, level of education age at marriage and duration of marriage .

Tool II: Female sexual function index (FSFI): This questionnaire consists of 19 questions about sexual feeling and responses during the past 4 week and the woman check only one box question. It six domains of sexual function desire domain (2 questions), arousal domain (4 questions), lubrication domain (4 questions), orgasm domain (3 questions), satisfaction domain (3 questions), and pain domain (3 questions).

Scoring system:

The individual domain scores and full scale (overall) score of the FSFI can be derived from the computational formula outlined in the table below. For the individual domain scores, add the scores of the individual items that comprise the domain and multiply the sum by the domain factor and added the six domain scores to obtain the full scale score.

Domain	score range	Dysfunction scores
Desire domain	2- 10	≤ 4.28
Arousal domain	0- 20	≤ 5.08
Lubrication domain	0- 20	≤ 5.45
Orgasm domain	0- 15	≤ 4.05
Satisfaction domain	2 - 15	≤ 5.04
Pain domain	0 - 15	≤ 5.51
FSF	4 - 88	≤ 26.55

Tool III: PISQ- sexual function for woman with: pop, Urinary Incontinence: this questionnaire consists of 20 question and structure of 2 section first section for those who are not sexually active and second section for those who are sexually active.

Validity and Reliability

The tools were tested for content validity by a Jury of three experts in the field of the study. The tools tested for internal reliability were 0.88, 0.74, and 0.76 respectively.

Procedure

An official letter was sent from the Dean of the Faculty of Nursing at Minia University to Head Manager of Minia University Hospitals, asking for permission to collect data.

Interview Phase: the aim and nature of study was briefly explained through direct personal communication with the participant and formal consent was obtained from the participant (verbal or written) before inclusion in the study this phase was taken about 10 minutes.

Implementation Phase: the investigator was explained to the participant who was agreed to participate in the study how to fill the questionnaire this phase was taken about 15- 20 minutes.

- Data was collected two days / week (Saturday, Sunday), at official work time.

Pilot Study

A pilot study was conducted on 10 % of total sample to test the tools for the clarity, applicability, feasibility, then necessary modifications was carried out and the results will be included from the study.

Ethical Consideration:

The study was conducted after the approval of research committee of the college. Permission to conduct the study was obtained from the faculties' responsible authority after explanation of the aim of the study. Informed consent was obtained from participants after explanation of the aim of the study. In addition to patient's privacy and confidentiality of response was considered during collection of data. Finally, the patient has the right to refuse to participate in the study.

Statistical Design

Statistical analysis was done by using Statistical Package for the Social Science (SPSS 20.0). Quality control was done at the stages of coding and data entry. Data were presented by using descriptive statistics in the form of frequencies and percentage for qualitative variables, and mean & standard deviation (SD) for quantitative variable. Chi square (χ^2) was used to test the association between two qualitative variables or to detect differences between two or more proportions

and the sample size large. Fisher's exact test used to test the association between two qualitative variables or to detect differences between two or more proportions and the sample size

is small. Graphs were done for data visualization using Microsoft Excel. Correlation coefficient test was also used and statistical significance was considered at $p \leq 0.05$.

Results

Table (1): Distribution of personal data of studied group (n= 350).

Personal data		No.	%
Age (year)			
15 -		14	4.0
20 -		63	18.0
30 -		94	26.9
35 - 40		179	51.1
Mean ± SD		30.2 ± 6.3 year	
Residence			
Rural		147	42.0
Urban		203	58.0
Educational level			
Illiterate		3	.9
Read and write		7	2.0
Basic & Secondary education		169	48.3
University education		171	48.9
Age at marriage (years)			
15-		168	48.0
25-		151	43.1
35 - 45		31	8.9
Mean ± SD		21.1 ± 6.5 year	
Marriage period (years)			
< 5		123	35.1
5 -		101	28.9
10 -		50	14.2
15 -		38	10.9
20-		30	8.6
25-30		8	2.3
Mean ± SD		10.09 ± 7.0	

Table (1): demonstrated that mean age of studied group was 30.2 ± 6.3 years, 58% of them lives in urban area, 48.9% have university education, 48.0% of them marriage aged ranged between 15- 24 years and mean of marriage period 10.09 ± 7.0 years.

Table (2): Assessment of sexual dysfunction according to female sexual dysfunction index among studied group (n= 350).

FSFI items	No sexual functional		Sexual dysfunctional		Min- max	Mean ± SD
	No.	%	No.	%		
Desire domains	294	84.0	56	16.0	2- 10	6.6 ± 1.9
Arousal domains	301	86.0	49	14.0	.0-20	13.2 ± 5.5
Lubrication domains	312	89.1	38	10.9	.0-20	10.6 ± 4.2
Orgasm domains	312	89.1	38	10.9	.0 - 15	8.5 ± 3.4
Satisfaction domains	332	94.9	18	5.1	2- 15	10.8 ± 2.9
Pain domains	273	78.0	77	22.0	.0- 15	7.3 ± 3.5
Total FSFI	315	90.0	35	10.0	4- 88	56.9 ± 17.4

Table (2) demonstrated that mean scores of total FSFI was 56.9 ± 17.4 among studied group, satisfaction domain was 10.8 ± 2.9 , and desire and arousal domain were 6.6 ± 1.9 . Also, the most frequent dysfunction domains were sexual pain 22.0%, followed by 16.0% sexual desire, then 14.0% sexual arousal, 11.0% lubrication domain, 10.9% orgasm, and 5.0% satisfaction domain.

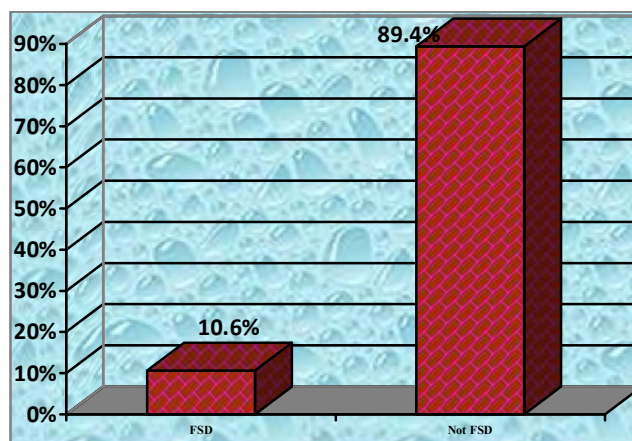


Figure 1: Distribution women responses regarding total score of female sexual function index (n= 350).
 Figure (1): illustrated that 89.4% of studied group not FSD and 10.6% of them FSD.

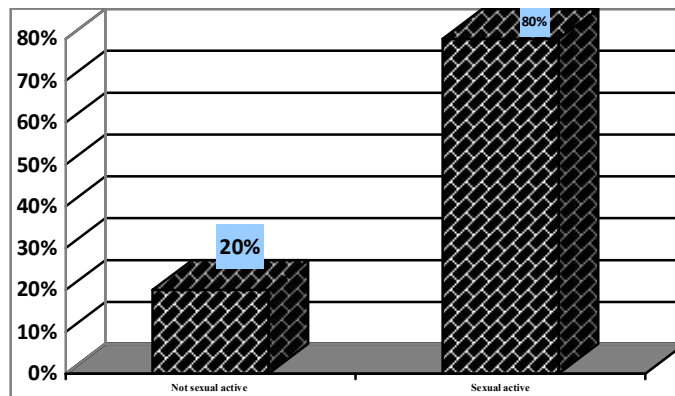


Figure 2: Distribution of Sexual Function for Woman with Urinary Incontinence (n= 350)
 Figure (2): illustrated that 80% of studied ample was sexual active and 20% of them did not.

Table (3): Distribution of reasons of sexual inactivity and sexual life feeling among sexual inactive women (n= 70).

Items	No.	%
Reasons of sexually inactivity		
No partner	31	44.3
No Interest	43	61.4
Urinary incontinence problems	44	62.9
*Other health problems	32	45.7
Pain	46	65.7
Fear of leaking urine and/or stool and/or a bulging in the vagina	4	5.7
Sexual life feeling		
Frustrated	48	68.5
Sexually inferior	43	61.4
Angry	33	47.2
Satisfy	15	21.4
Adequate	15	21.4
Bothersome	8	11.4

*Genital prolapse problems,

Table (3): presented that 65.7% of studied who was not sexual active due to pain followed by 62.9% due to bladder or bowel problems or due to prolapse, then 61.4% not interest. Regarding feeling about their sex life 64.5% of studied who was not sexual active was frustrated and 61.4% was sexual inferior.

Table (4): Relations between female sexual function index and women’s personal data (n= 350).

Personal data	FSD (n= 37)		Not FSD (n=313)		Fisher	P - value
	No.	%	No.	%		
Age (year)						
15 -	1	2.7	13	4.2	8.646	.034*
20 -	2	5.4	61	19.5		
30 -	7	18.9	87	27.8		
35 - 40	27	73.0	152	48.6		
Residence						
Rural	11	29.7	136	43.5	X ² 2.557	.110 NS
Urban	26	70.3	177	56.5		
Educational level						
Illiterate	0	.0	3	1.0	4.173	.383 NS
Read and write	2	5.4	5	1.6		
Basic & Secondary education	18	48.6	151	48.2		
University education	17	45.9	154	49.2		

NS = not statistically significance difference * statistically significance

Table (4): demonstrated that there were no statistically significance differences between female sexual function with residence and educational level of participant but there was statistically significance differences between female sexual dysfunction with their age in which women aged between 35 – 40 years had female sexual function higher in which P – value ≤ .034.

Table (5): Correlation between domains of female sexual function index and age, age at marriage, and marriage period (n= 280).

FSFI items	Age		Age at marriage		Marriage period	
	r	P	r	P	r	P
Desire	-.205	.000**	.116	.03*	-.310	.000**
Arousal	-.121	.024*	.096	.072	-.310	.000**
Lubrication	-.105	.061	.077	.149	-.195	.000**
Orgasm	.092	.087	.119	.026*	-.226	.000**
Satisfaction	-.132	.01*	.202	.000**	-.296	.000**
Pain	-.269	.000**	.045	.402	-.205	.000**
Total FSFI	-.180	.001**	.127	.018	-.315	.000**

*Correlation is significant at the 0.05 level ** Correlation is significant at the 0.01 level.

Table (5): proved that there were negative fair association between studied age and sensation of pain during sexual activity($r = -.269$; $P - \text{value} \leq .000$), and the marriage period with desired, arousal, satisfaction domain, and total FSFI ($r = -.310$; $P - \text{value} \leq .000$; $r = -.296$; $P - \text{value} \leq .000$ & $r = -.315$; $P - \text{value} \leq .000$ respectively).

Discussion

The International Continence Society (ICS) defines urinary incontinence (UI) as a complaint of any involuntary loss of urine. Urinary incontinence is considered a public health problem and affects the quality of life (QoL) of thousands of women (Haylen, Ridder, and Freeman, 2010). These debilitating conditions interfere with social wellbeing, psychological, occupational and domestic aspects and are also related to sexual complaints (Santana, Aoki, and Auge, 2012). According to the World Health Organization, female sexual dysfunction (FSD) is defined as an inability to derive satisfaction from the sexual act (Abdo, et al., 2002). Female sexual dysfunction is a prevalent health problem that has been inadequately investigated in the Arab world. In Egypt, the prevalence of FSD among women is limited. (Hassanin, et al., 2010). So the aim of this study was to determine the various types of sexual and urinary disorders among asymptomatic woman in different social levels and identify the high risk factors, which will be more likely to have these sexual and urinary disorders.

The present study pointed to the mean age of participants was 30.2 ± 6.3 years and more than half of them ranged between 35 – 40 years. This result accordance with El-Mowafy et al., (2015) studied the prevalence of degree, duration and types of urinary incontinence among middle age women and the risk factors associated with urinary incontinence among middle age women. They found that that 37.7%, 31.4% of the study sample who had urinary incontinence was 45-49 & 55-60 years respectively.

This result in the same line with Milsom, (2009) mentioned that the prevalence estimates for middle-aged or older women are 25-45% for any urinary incontinence and 5–15% for daily incontinence.

Also concerning to residence of studied sample more than half of them come from urban area. This results in the same line with a recent study done by Ismail et al., (2017) investigated the prevalence and possible risk factors that may cause FSD Assiut University Hospital, Assiut, Egypt and to study women attitude towards their sexual dysfunction aged between 18 and 55 years who had visited the hospital for routine check-up, women accompanying other patients and non-medical female hospital staff, mentioned that more than half of women participated in their study come from urban area.

This result due to middle Egypt women not go to obstetric physician only if they suffering from severe illness.

Furthermore; concerning to age at marriage near to half of studied women 15- < 25 years with mean 21.1 ± 6.5 year and the highest proportion of women reported that they had been married for less than 5 years. This result consistence with Mamdouh et al., (2017) in a cross-sectional survey conducted in eight family planning clinics in Alexandria, Egypt to determine the prevalence and risk factors for FSD reported that nearly half of the women were married at age 20-29 years. The highest proportion of women (28.8%) reported that they had been married for five years or less. In addition study done by Ismail et al., (2017) mentioned near to one third of studied sample duration of marriage was less than 5 years.

This result due to obligatory rules from the governorate regarding age at marriage must be more than 18 years.

Regarding the most frequent domain of female sexual dysfunction in this result was sexual pain domain near to one quarter of the women studied followed by sexual desire domain then arousal domain and the minority have dysfunction in lubrication, orgasm and satisfaction domains. This result in the same line with Mollaoglu, Tuncay, and Fertelli, (2013) evaluated sexual dysfunction and the factors that affect sexual dysfunction in women with chronic disease in Cumhuriyet University's internal medicine clinics, Turkey according to the Female Sexual Function Index (FSFI) Index component scores showed that the majority of women experienced pain during intercourse (80%), had orgasm (79%) and satisfaction (75%) problems and had loss of sexual desire (71%). In addition, there were also impairments of arousal (50%) and lubrication (46%).

Moreover, Ibrahim et al., (2013) assessed sexual function among married women and determined associated risk factors for sexual dysfunction among 509 married females 20–59 years old. Sexual dysfunction was assessed using female sexual function index (FSFI). Reported that desire and Orgasm domains were the most affected with 52.8 % of the participants having sexual dysfunction.

In addition; In Japanese study by Sako, et al., (2011) that assessed whether lower urinary tract symptoms (LUTS) affect sexual function in Japanese females by using a multi-component questionnaire was mailed to 576 female hospital workers. They reported sexual pain disorders were the most frequent domain 58% of the 101 women. Finally study done in El Fayoum city by El-Tahlawi, et al., (2018) reported the most frequently dysfunction was pain domain (43.3%).

Contradicted with this result El Atrash et al., (2014); Mamdouh et al., (2015) they reported sexual desire disorders were the most frequent domain (86% & 82.2% respectively) also, Esfehni, et al., (2016) Sexual dysfunction was observed to be most frequent in domains of sexual desire (49.2%), sexual arousal (43.2%), orgasm (38.6%), lubrication (36%), sexual pain (35.2%) and sexual satisfaction (26.1%), respectively.

It may be due to difference in level of education and awareness regarding the sexuality subject, the nature of studied populations and methods of data collection.

Concerning mean score of total FSFI was 56.9 ± 17.4 among studied sample, satisfaction domain was 10.8 ± 2.9 , pain domain was 7.3 ± 3.5 desire and arousal domain were 6.6 ± 1.9 . These results in the same line with Alataş, Özkan, and Ögce, 2013 assessed the effect of overactive bladder syndrome (OAB) on the sexual life in asymptomatic continent women, reported that patients were determined as 28 continent women with OAB, 89 women without OAB. In the women without OAB mean scores of arousal, orgasm, and total FSFI are the same with these results while mean scores of desired and satisfaction domain in this study was simply higher than them also, pain sensation was lower among this sample.

It may be due to difference in level of education and awareness regarding the sexuality subject, the nature of studied populations and methods of data collection.

Concerning to prevalence of female sexual dysfunction was estimated at 10.0% of the studied women has it. This result accordance with **Burri and Spector, (2011)** estimated the prevalence and comorbidity of recent and lifelong FSD and identified potential psychosocial and behavioral risk factors in a nationally representative sample of UK women. Reported that female sexual dysfunction has been estimated at 5.8% in the United Kingdom.

Contradicted to this result study done by **Mamdouh et al., (2017)** in a cross-sectional survey conducted in eight family planning clinics in Alexandria, Egypt to determine the prevalence and risk factors for FSD. They found that FSD in more than half of the women surveyed (53.7%). In additional study done by **Mostafa et al., (2018)** assessed the prevalence and patterns of female sexual dysfunction (FSD) among overweight and obese premenopausal women in Beni-Suef, Egypt reported precisely, 42 (28%) of women had FSD. Finally a recent study done by **El-Tahlawi, et al., (2018)** estimated prevalence of FSD and its related factors in El Fayoum city included 508 married females (above 21 years old) from the attendants of the health care facilities (outpatient clinic of Dermatology, STDs and andrology of faculty of medicine, El Fayoum University, Primary health care and Maternity and child health in EL Fayoum city) found that the prevalence of FSD among studied group was 61.2% versus 38.8% had normal sexual function.

It could be due to variations in diagnostic criteria, types of studied populations, and data collection methods used.

Concerning women who were sexually active, more than three quarters of studied sample was sexually active and near to one quarter of them did not. This result consistent with **Karbage et al., (2016)** assessed the impact of socio-demographic characteristics in the sexual function of Brazilian women with UI. Reported that 70.1% of their studied sample with sexual activity and 29.9% of them without sexual activity.

Regarding leakage of urine and/or stool with any type of sexual activity among participants those sexually active the minority reported usually or always fears from it. This result contradict with **Karbage et al., (2016)** demonstrated that among sexually active women, approximately 58% of respondent women answered that the fear of leakage interferes negatively during the sexual intercourse sometimes, usually or always. These differences may be due to different environmental and cultural factors.

Concerning factors that disturb urinary and sexual function among woman there was statistically significance differences between female sexual dysfunction and their age in which women aged between 35 – 40 years. This result due to mean age of participant was 30.2 ± 6.3 years that lead to increase risk factor to FSD

This result in consistent with **Hassanin et al. (2010)** patients with FSD were significantly more likely to be older than 40 years, have sexual intercourse fewer than 3 times a week, have been married for 10 years or more, and have 5 children or more. Age of the women maintained a statistically significant positive relationship with FSD in the regression model (odds ratio 1.39; 95% CI, 1.26–1.53). In additional to study done by **Ibrahim et al., (2013)** mentioned the total FSFI score of B 26.55 was the cutoff value for diagnosis of FSD

and female age, duration of marriage were found to be significant associated factors with FSD, in **Tekin, et al., (2014)** study, evaluated women in the reproductive ages, and although their participants were not in menopause, observed that advancing age in women negatively affected the sexual functions. Also, **Mamdouh et al., (2015)** reported that age above 40 years (odds ratios [OR] 3.1; 95% CI 1.9to 4.8) was the potential predictors for the presence of possible FSD among the current sample after using logistic regression.

In the **Esfehani, et al., (2016)** reported that there were a significant correlation was observed between duration of relationship with partner, increase female age and prevalence of FSD. Common belief suggests that sexual disorders tend to be more prevalent in middle-aged women, as well as those ageing ≥ 27 years (**Aslan, et al., 2008, Ibrahim, 2013**). Increased prevalence of FSD is mainly associated with age due to decreased sex drive, reduced sexual intercourse and vaginal dryness caused by menopause (i.e., low estrogen secretion) (**Castelo-Branco, Cancelo, Chedraui, 2007**).

Regarding women educational level as factors disturb urinary and sexual function among woman there was no statistically significance differences between female sexual dysfunction and their educational level. Contradicted to this result many studies performed abroad have shown the association of low educational level with sexual dysfunction (**Chedraui, et al., 2009 & Safarinejad, 2006**).

This simple discrepancy and variations with our findings could be due to some factors. For example due to differences in ethnicity and culture

Studies from India & Brazil suggested that the prevalence of FSD rises with woman's lower education attainment (**Singh, et al., 2009; Aggarwal, et al., 2012**) However, some other research from developing countries reported an association between higher education and the reported rates of FSD (**Sidi et al., 2007; Fajewonyomi BA, Orji EO, Adeyemo, 2007**) and **Echeverry et al., 2010**) which identified low education level as a predictor for sexual complaints, and this finding was confirmed by another study in this regard, **Esfehani, et al., (2016)** study revealed that low education level has a significant effect on the manifestations of FSD.

Another factors that disturb urinary and sexual function among woman is duration period of marriage there was negative fair association between female sexual dysfunction and its. This finding correlates well with that of **Ozerdoğan et al., (2009)** who showed that an increase in parity negatively affected the sexual functions. As factors associated with the number of children, also the woman's advancing age and type of delivery negatively affected the sexual functions. Likewise, **Tekin, et al., (2014)** showed that with an increase in the number of children, the sexual functions decreased ($p=0.049$).

Conclusion

Based on the findings of the current study the following conclusions can be drawn: The most frequent dysfunction domains among studied group were sexual pain 22.0%, followed by 16.0% sexual desire, then 14.0% sexual arousal, 11.0% lubrication domain, 10.9% orgasm, 5.0% satisfaction domain, and 10.6% of them had FSD. The main risk factor can lead to FSD were age of studied group and duration period of marriage. Moreover, there were negative fair association between studied age and sensation of pain

during sexual activity, and the marriage period with desired, arousal, satisfaction domain, and total FSFI.

Recommendations

Based on the study findings, the following recommendations are proposed:

- Develop training program for asymptomatic women with sexual disorders and urinary incontinence to know the most frequent dysfunction and how to deal with it.
- All asymptomatic women with sexual disorders and urinary incontinence should identify their age is main risk factors of FSD.
- Expand public awareness through mass media about sexual disorders and urinary incontinence among asymptomatic women.

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