

## Sexual Problems among Young Married Women Attending Primary Health Care Facilities in Cairo, Egypt: An Exploratory Study

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**Abstract:** This study was done to explore sexual health problems among young married women and their health seeking behavior and the readiness of primary health care service providers to address the sexual health problems. The study was exploratory used qualitative research methods; through in-depth interviews with 21 young married women aged 18-24 years; and 11 health service providers (doctors and nurses). Results revealed that, among the women who were interviewed, More than half reported that they had experienced sexual problems. Women reported that sexual problems resulted in frequent conflicts at home. While most women agreed that counseling on sexual issues from a medical professional would be acceptable, many set specific criteria for how such services should be provided. All of the health service providers (HSP) reported that they do not have enough information or skills they need to provide counseling on issues related to sexuality. In conclusion: sensitive issues related to sexuality remains challenging. However, it is both feasible and crucial to continue to collect evidence in this area. Efforts are needed to build the capacity of primary health care service providers and to test promising measures such as promoting premarital sexual counseling.

**Key words:** Sexual Dysfunction • Primary Health Care • Health Service Providers • Health Seeking Behavior • Young married women

### INTRODUCTION

Sexuality is considered to be one of the most significant factors affecting women's health. It is also a major indicator of life satisfaction affecting couples' level of mental health [1]. Practical background studies indicate that Masters, Johnson and Kaplan were among the first to deal with the systematic study of human sexual behavior. They considered four sexual attributions as (desire) arousal, plateau, orgasm and resolution [2]. Rosen *et al.* [4] refers to six female sexual functions as desire, arousal, lubrication (wetness), orgasm, satisfaction and pain. Women's sexual dysfunction (WSD) is a group of disorders associated with desire, arousal, orgasm and painful sex (dyspareunia and vaginismus). It is more prevalent among women than men [5, 6].

WSD is a common health problem and its prevalence is estimated at 25–76% in the USA. Despite variations in the prevalence rate of WSD in different communities, especially Eastern communities, it is underestimated due to cultural taboos and misconceptions surrounding female

sexual functions [7]. WSD affects 30–50% of women worldwide [8, 9]. In Egypt, a study conducted in Lower Egypt reported a prevalence of WSD of 46% [10] and in Upper Egypt, 76.9% of the studied population [11]. However, restrictions around discussion of sexuality, along with a general “culture of silence” around women's sexuality and reproductive health means that women's sexual problems are rarely discussed, detected or resolved [12]. WSD is associated with negative effects on women's interpersonal relationships, quality of life, overall well-being and general family stability. Research also suggests that the lack of a healthy intimate relationship may contribute to a range of health issues, including infertility and psychosomatic illnesses [13].

Sexual inexperience, lack of knowledge and inadequate spousal communication can lead to stressful sexual encounters, anxiety, sexual pain and even reproductive tract injuries [14]. Female genital mutilation/cutting (FGM/C), may also contribute to sexual problems as it has been found to be associated with loss of sexual desire, painful intercourse and lower

satisfaction, in addition to psychological problems, such as anxiety and depression [15, 16]. In Egypt, 91% of women aged 15–49 years have been circumcised despite banning of this practice by the government [17].

Evidence suggests that despite the high prevalence of WSD these problems most frequently go undetected in primary health care services in general. Therefore, improvement of knowledge and skills in general practice as well as contextual changes are suggested solutions for better management of sexual dysfunctions [18, 19]. Despite universal taboos restrict discussions of women's sexuality in public discourse, education and family settings alike, however, in medical settings; it was found that sexuality-related questions and concerns were common among family planning clients in Egypt. Furthermore, many people are willing to discuss their sexual problems with doctors during routine primary care visits [20, 21]. Yet, the question of whether the primary healthcare professionals are willing or able to deal with such issues remains unexplored.

Very little is known about the forms of WSD in Egypt, effects on women's lives; or women's health seeking behavior to address those problems. There is also little information about primary health care service providers' willingness or capacity to address these issues. The current study had objectives to explore sexual health problems among young married women and their effect on women's lives, identify possible socio-behavioral factors associated with such problems, assess the women's health seeking behavior in relation to sexual health problems and assess the readiness of primary health care service providers to address the sexual health needs of young married women.

## **MATERIALS AND METHODS**

**Study Settings:** The study was conducted in three Ministry of Health and Population (MOHP) Primary health care (PHC) facilities in Cairo Governorate.

**Study Design:** Exploratory qualitative in-depth study

**Study Population:** In-depth, semi-structured interviews were conducted with twenty one married women between the ages of 18 and 24 who visited PHCs for health care for themselves or their children and eleven primary health care service providers (physicians and nurses) employed at the above PHC facilities. Young married women were selected as sexual relation is linked to marriage in Eastern

countries and the legal age for marriage in Egypt is 18 years. Those young women could remember all issues confronted with starting the marital /sexual life.

**Sampling and Sample Size:** A purposive sample of twenty one young married women aged 18-24 years attending primary health care unites (3 unites) for different reasons (e.g. antenatal care, postpartum care, family planning, child care, or outpatient services) were in-depth interviewed (7 clients per clinic). In addition, in-depth interviews were conducted with 11 health service providers (HSP), including at least one physician and two nurses per center. The nurses' included; family planning, maternal and child health and family medicine nurses.

**Data Collection:** After taking verbal informed consent, PHC clients were invited to take part in the in-depth interviews as they exited the clinics. After obtaining the women's informed consent, researchers conducted the in-depth interviews in a quiet private place in the clinic. Interviews with HSP were conducted during break time or after clinic hours. Interviews were audio-taped and notes were taken. All interviews were conducted by experienced female researchers who have backgrounds in both medicine and qualitative data collection and have completed a research Ethics course.

The researcher developed the interview guides following a systematic literature review. The guides and data collection procedures were pilot tested with four pilot interviews (two clients and two HSP) recruited from Kasr El-Aini Ob/Gyn clinic, a clinic that was not part of the study. The pilot test demonstrated that the questions were easily understood and that the flow was smooth with no changes required. Each recorded interview lasted between 25-45 minutes.

The interview guides covered the following themes for the clients: socio-demographic characteristics, experience of women sexual problems, types, husband-wife communication about sexual problems, discussion with other family members; Impact of women sexual problems in their lives and relations with husband; Health care seeking behaviors regarding sexual problems. Themes for the SP included: socio-demographic and work characteristics: specialty, duration of work, Age, marital status, number of children,.... etc.; Knowledge of sexual health problems; Experience with women who have sexual health problems; Perceived competence and willingness to provide services to help women with sexual health problems; The needs for training in sexual health regarding topics and methods of training.

**Data Analysis:** Data coding and analysis was completed by the researcher. An initial reading of the transcripts was undertaken to identify the key themes emerging from the data: that is, an inductive coding approach was taken. The researcher was particularly concerned with identifying key themes relating to participants sexual disorders. A series of codes and sub-codes were designed on the basis of the more prominent themes and additional codes were developed throughout this process as further themes were identified through a closer reading of the transcripts. Particular attention was paid to both the similarities of participants' experiences, but also to the diversity of experience.

**Ethical Considerations:** In order to protect the privacy of interviewed participants, no full personal names or identifiers were recorded on audio tapes or interview transcripts.

All potential participants were assured that their participation in the study was completely voluntary and that they could quit at any time during the study. Participants who agreed to participate in the study were asked to sign the informed consent statement. Those who were unable to read or write, or who agreed to participate, but were reluctant to sign, were asked to give verbal consent, while a witness, such as a friend of the client or a service provider signed the form along with the interviewer.

Prior to the beginning of this study, the proposal and the in-depth guidelines were reviewed and approved by Population Council Institutional Review Board.

## RESULTS

In the following section, we provided an overview of the key themes and findings of this research in relation to our participants.

### **Young Married Women:**

**Socio-demographic Characteristics of Married Women Participants:** Of the women who participated, four were between the ages of 18-20 and 17 were aged 21-24. Most of the clients had basic education either primary (4/21), or preparatory (5/21), few secondary/diploma (2/21), few were illiterate (4/21) and some had high/university education (6/21). As to the educational status of the husbands of the interviewed women, some of them had basic education either primary (3/21), or preparatory

(3/21), most had secondary education (secondary/diploma) (8/21), few were illiterate (2/12) and some had high/university education (5/21).

All of the women who took part in the interviews were mothers and have one to three children. The youngest child of most of the women (13/21) was less than one year old.

Almost all of the women described themselves as housewives or reported that they did not work for cash, while all reported that their husbands were working in low to middle income jobs; employee in the university, driver, worker in a pharmacy, doorman, accountant, secretary and painter.

While PHC provides a range of services, the vast majority of women (16/21) said that their visit on the day of the interview was to obtain care for a child; two women indicated that they visited the clinic for antenatal care, one for family planning one for pregnancy test and one to receive required paper for marriage.

**Marriage Characteristics:** About half of the women reported that they had married as adolescents, between the ages of 14 and 19. There was substantial variation in the duration of their marriage, which ranged from seven months to seven years. Likewise, the duration of engagements prior to marriage ranged from 2 months to 3 years.

In describing how they got married, the majority (15/21) of women indicated that their marriages had followed the traditional arranged marriage practice, following communication between their family and their husband's family. However, few (6/21) women described their marriage as "a love story." Most of the women (18/21) said that they had agreed to be married and three women said they got married against their will.

Most of the women (14/21) indicated that they were well-acquainted with their husbands before marriage. The overwhelming majority (19/21) of women reported that they were ill-informed and unprepared for marital life. More than half (12/21) of the women said that no one had talked to them about marriage, sexual relations or the wedding night prior to their marriages. Those who had any information indicated that it had been acquired from sources outside of their families, such as friends, TV, the Internet or books.

Fourteen women were using a family planning method: seven were using IUD, five were using oral contraceptives and two relied on contraceptive injections

to avoid pregnancy. Of the women using contraceptives, few reported side effects of the method used, such as IUD threads interfering with husband's sexual satisfaction.

**Participants' Knowledge about Sexual Relations Before Marriage:** Only 9 out of the 21 women stated that they had some information about sexual relations before marriage. TV, sisters, other relatives, friends and the internet were the main sources of information, while one woman mentioned school books and another noted that a female dermatologist had provided her with comprehensive information. Notably, one only named her mother as a source of information about sexual relations.

Most women who stated that they had information about sexual relations considered such information as incomplete, incorrect and disturbing.

One reported that the information she got from her friend had been a source of substantial trauma: *"My friend told me that the wedding night is terrible. The process of hymen defloration is very painful. Accordingly, I felt severe distress during my wedding night. Hymen defloration was not successful. Hymen defloration was done by a doctor under general anesthesia, three months after marriage."*

**Partners' Communication/interaction:** Some of the interviewed women raised important issues about their husbands' behaviors being the main reasons for wives to lose sexual desire and fail to reach orgasm after each intercourse. These issues/behaviors include; addiction, premature ejaculation and reciprocated communication/interaction.

*"My husband is an addict, intercourse is rare and in most of the time he cannot complete the action or usually end with premature ejaculation."* Woman, 20 years old preparatory education house wife

*"My husband asks for frequent intercourse, while I have no desire for sex. He usually enforces me to respond to him."* Woman, 19 years old primary education housewife

Two interviewed women revealed that they do not have the skills to express their desire for sex or to demonstrate some signs /acts that make sex as mutual pleasure.

*"Sometimes I feel the desire to have sex with my husband, but I am embarrassed to ask him about that."* 20 years old, with preparatory education housewife

**Participants' Perspectives on FGM/C:** For the vast majority of women (18/21), FGM/C appeared to be both a physical and a social factor: the procedure was itself a source of pain and discomfort and, likely, a contributing factor to symptoms of sexual disorders. At the same time, many were aware of and, in some cases, embraced, the belief that the value of FGM/C was in its ability to hinder women's sexual pleasure. Of the 21 women, all but three had undergone FGM/C. Among women who had undergone the procedure, women often spoke about the pain they felt during or after the procedure, with many also speaking about their experiences of psychological distress and embarrassment. The women who endorsed FGM/C (10/18) did so in terms that suggested that curtailing women's sexual desire was a positive effect.

*"Female circumcision is necessary for successful marital life. A circumcised woman is not keen to ask her husband to have sexual intercourse that could be a burden to him."* 24 years old, high education, housewife

Among those circumcised women 8 out of 18 women expressed their dissatisfaction from such tradition and pointed out to the negative impact of FGC on sexual life

*"Circumcision is an old fashion tradition, it makes the woman has less desire for sexual intercourse"*

The three uncircumcised women reported that they did not suffer from the sexual problems that were common among other women.

**Participants' Experience of Sexual Problems:** Women described their sexual problems in relation to a variety of social factors, including the fact that they and their husbands married unprepared for sex or marital life. Many participants spoke at length about their wedding nights as a particular source of stress. Participants discussed the social pressure that surrounded this first sexual encounter, as both their own and their husbands' families were expected to show evidence of the woman's successful "hymen defloration." In addition, the majority

reported that they experienced pain and bleeding on their wedding night (15/21) and three reported that they were unable to have sex, a problem that was so profound that they later sought surgical interference. Two women also described undergoing hymen defloration in front of relatives by their husband's finger - a practice known as Dokhla Balady - which they described as unhuman.

Among the women who were interviewed, most of the women (13/21) reported that they had experienced sexual problems. Four women who did not have sexual problems reported that their friends have sexual problems. Reported problems were mostly lacking of sexual desire or interest in sex and difficulties becoming sexually aroused or achieving orgasm. There was a consensus among all interviewed women that they do not feel orgasm during intercourse. On the other hand, husbands complete their sexual cycle without giving any interest in the feelings of their wives regarding satisfaction. Such situation builds the negative attitude among women towards sex. Additionally, it establishes a vicious cycle of loss desire/interest- responding to husbands sexual relation request-no sexual orgasm, etc. Despite husbands should play an active role to make sex in a mutual relation for pleasure, they blame the women that she is abnormal as she has no desire for intercourse. Such conditions are expressed in different ways by women.

*"I do not feel satisfaction with intercourse and my husband is not interested in that."* 24 years old, primary education, housewife

*"Despite my husband does sex with me every day, I do not get an orgasm and he blames me that I am like a "block of wood"* 24 years old, primary education, housewife

*"Sometimes, I feel sexual desire, but I am ashamed to ask him for that. Even when he is doing sex with me, I do not get orgasm due to premature ejaculation."* 20 years old, with preparatory education housewife

Further, of the 13 women who said they had experienced at least one sexual problem, most (9/13) reported that their problems had a negative effect on their lives including their relationship with their husbands. Among the issues that they attributed to their sexual problems were frequent conflicts at home in addition to aggression and mood swings on the part of their husbands. The rest of women who had experienced sexual problems (4/13) said that despite their own sexual

dissatisfaction, their lives and relationships with their husbands were stable and that they were pleased at being able to keep their husbands sexually satisfied.

*"I do not get an orgasm and not sexually satisfied, but I am pleased that my husband got happy."* 22 years old, with preparatory education housewife

**Culture of Silence – and Unmet Needs:** All of the women said that discussions around sexuality were rare in their daily lives, if not "prohibited." In addition, several suggested that education and discussion about sex would be inappropriate because, as one said, "*sexual relations is a normal, natural issue.*" A substantial minority (8/21) expressed discomfort with the idea of speaking about their sexual relationships, suggesting that relations with their husbands were private, confidential matters. Nonetheless, more than half (13/21) agreed that it would be appropriate to seek medical assistance for sexual dysfunction or disorder.

While most women agreed that counseling on sexual issues from a medical professional would be acceptable, many set specific criteria for how such services should be provided. For example, several women said that doctors should be trained to offer specialized services in a way that also included respectful, kind interpersonal treatment. Other suggestions included having female doctors available to treat women and male doctors to treat men. The participants also expressed several concerns about measures taken to ensure privacy and confidentiality, such as holding consultations in a private room and securing records so that the identities of people seeking care would be protected. Beyond changes in the way that care was delivered during normal clinic visits, participants called for establishing a hotline associated with the PHC that would provide access to specialized doctors; as well as establishing the requirement that premarital sexuality counseling not only be offered, but made compulsory for engaged couples.

### **Health Service Providers (HSP)**

**Background of HSP:** In depth interviews were conducted with 11 female HSP working at PHCs. These included five doctors, five nurses and one urban community worker. The doctors included one family medicine provider, two OB/Gyns and two general practitioners. They ranged in age from 31-54 years and had worked in the PHC for between one and a half to 23 years. The nurses had a

similar age range, from 31-56 years and they, too, had diverse levels of experience, ranging from two to 25 years. The urban community worker was 45 years old and working in the PHC for 18 years. Almost all providers except one were married and had children.

#### **HSP Perspectives on Sexual Disorders among Female**

**Clients:** The HSP named several common sexual problems encountered by female clients, including an inability to reach orgasm and absence of sexual desire, along with physical symptoms, including dyspareunia (painful intercourse) and bleeding, which they said was most common among newly married females. Some providers said that some clients reported sexual dysfunction-including impotence or weak erections - on the part of their husbands. While it was difficult to gain a clear sense of how providers had addressed these complaints, they did suggest that these husbands' problems were particularly common among diabetics and drug addicts.

Providers described women who reported sexual problems to be of low socioeconomic status and educational attainment, having many children, unhappy marriages, young and newly married and/or having undergone FGM/C.

**HSP Views on Interactions with Clients:** In general, all HSP agreed that most of their clients were embarrassed to talk with them about their sexual problems. In the meantime, providers noted that they did not take the initiative to ask clients about their sexual problems, hence these issues were only addressed in cases where the client asks for advice or expresses a complaint about a specific sexual problem.

The providers respond to clients' questions as based on an analysis of possible causes, reporting that they provided medical, psychological and educational advice, as merited. Most of the providers (7/11) agreed that their job as primary health care service providers includes providing care and helping women to overcome sexual problems. However, most of the providers (9/11) indicated that they do not have the information or skills they need to provide counseling on issues related to sexuality. All HSP pointed out that education programs for doctors and nurses do not address issues related to sexual health. Mostly (9/11) said that even reproductive health providers – whose job description include counseling on sexual problems – do not typically have enough information to provide effective counseling.

*“We did not receive any type of training on counseling or managing sexual problems”*

Finally, several pointed out that the standards of practice for PHC do not include "counseling of couples for sexual health" as a part of routine care.

**HSPs' Capacity-building Needs:** Providers offered a number of suggestions for ways to both bolster their own skills in providing counseling on issues related to sexuality and to make this sort of service more available and inviting. All recommended that training should include a broad spectrum of topics related to sexuality and that it should be updated regularly to make sure that providers are able to give advice that their clients will find relevant. They also suggested that it would be useful for training on sexuality-related issues to include the communication skills that would enable them to address delicate issues. Among their major concerns was the question of how best to approach discussions related to sexuality with clients who come from conservative backgrounds.

Beyond the issue of building their own skills, providers also recommended changes to the way that the PHC overall addressed reproductive health issues. These recommendations included assigning a special room for counseling in PHC, advertising sexual services offered by the clinic and developing brochures and booklets that provide information on sexual health and marital relations. They also recommended that counseling should be delivered in separate sessions for male and female PHC clients.

## **DISCUSSION**

The current study is concerned with one of the most sensitive issues in women's health. Despite of its importance, such issue is not tackled at the family level or the medical school level. Therefore, in-depth understanding of those women's sexuality issues is crucial to the medical community. The negative impact of WSD on women's health and family life could influence the community welfare and productivity. Therefore, pre-marital and marital life and sexuality have to be considered on the agenda of public health programs.

The presented study triggered an important step towards including women's sexual health in the public health agenda. Despite the study provided qualitative

data to investigate WSD, the findings of the current study had been evidenced by quantitative studies conducted in Egypt and other countries. The current study raised the problems of sexual desire, arousal and orgasmic disorders. In agreement with our study different studies reported that desire and arousal disorders are the most frequently reported female sexual problems [22, 23]. Furthermore previous studies done in Egypt showed that hypoactive desire disorder (HDD), orgasmic disorder and arousal disorders in upper Egypt were estimated at 66.4%, 60.7% and 56.7% of the women in Upper Egypt [10] while in Lower Egypt were estimated at 49.6%, 43% and 36% respectively of the women in Upper Egypt [11].

As depicted from the presented study there were specific factors that predispose to WSD as age, women's sexual knowledge the relation between partners. The findings from the current study were in-line with other studies In USA [24] and Nigeria [25] which concluded that younger age was a risk factor for female sexual disorders. Furthermore, In Indian rural population poor sexual knowledge can also be a factor [26]. In addition, it was found that determinants of sexual satisfaction in women are the feel of desire for the Partner; receive the attention of the partner and to be able to satisfy the partner [27]. In the current study Almost all of the women encountered sexual problems had basic education either primary, preparatory or secondary/diploma and reported that they are housewives or did not work for cash, also their husbands were working in low to middle income jobs in agreement with our study, Studies done in both Nigeria [25] and Malaysia [28], reported an association between higher education and the lesser prevalence of female sexual disorders. Lower economic position due to lower education levels or low-income and with most housewives being dependent on their husband could induce stress which in turn affects sexual functioning. In the present study women who had experienced at least one sexual problem, mostly reported that their problems had a negative effect on their lives. In accordance with our study another studies stated that it often appears that sexual issues result from problematic or unsatisfactory relationships. However, it is often difficult to discern causality, i.e. which came first. However, the existing research suggests that treating relationship and sexual issues concurrently yields a better long-term outcome than considering them as separate issues [29]. On the other hand the study conducted by Trompeter *et al.* [30] indicated that emotional closeness during sex was

associated with more frequent arousal, lubrication and orgasm; such hearty relation leads to better sexual function and satisfaction. Marital behavior is so important that Yucel and Gassanov [31] claimed that marital infidelity occurs due to sexual problems in couples.

Seeking medical consultation for WSD by the women interviewed in the PHC facilities was addressed in the study and reported that women who experienced sexual problems do not seek treatment for these disorders. These findings confirm and extend previous research, which has identified that a significant proportion of people who experience sexual problems do not seek treatment for these [32]. However, the qualitative methodology adopted allowed a more in-depth understanding of the underlying factors for women who did not seek care for their sexual problems, the women stated may reasons as embarrassment, potential shamefulness, not believed that there is medical specialty in sexuality, money constrains, cultural factors considering it as a house secret not allowed to be discussed, it is allowed only to talk about sexual problems only with her husband or her mother.

The role of the primary health care (PHC) service providers in sexual counseling is essential for prevention and control of WSD. Therefore, HSP had been included as partners/stakeholders in the current study. Our findings indicate that sexual health represents a very difficult topic for HSP to address proactively within primary care consultations. Similarly doctors in Europe and other countries rarely ask patients about their sexual health during a routine consultation even though patients would appreciate this [33, 34]. The reluctance to initiate a discussion about sexual health is a dual interaction between patients and HSP. This may be in part affected by patients' barriers such as embarrassment, lack of knowledge and indirect presentation of the disease. On the other hand our study stated that due to the lack of appropriate medical training on sexual problems, doctors encounter difficulties in the management and treatment of these disorders. These findings supported by 2 studies stated that physicians often feel unqualified to treat patients with sexual dysfunctions and there is a need for more professional and patient education as well as relevant secondary care services [19, 35]. Other study stated other barriers as limited availability to refer to secondary care, fears about 'opening a flood gate', patient embarrassment, poor knowledge and inadequate training and skills [36].

In the current study Gender of the HSP is an important issue in providing sexual counseling services. Overall, a preference for same-gender consultations about sexual health issues was identified. This was seen as a patient preference and was consistent for both physicians and nurses. This finding agree with a study done by Stokes [37] who reported that most people prefer consultations about sexual issues with a health professional of the same gender and age as themselves.

In the current study different strategies had been suggested by HSP to improve access of women to sexuality-related information in the PHC. Other studies suggested different strategies as Use of leaflets to reduce the barriers of direct face-to-face communication with HSP during discussing sexual issues. Group discussions of sexual issues; give power to the patients through active participation in discussing sexual problems and exchange of experiences [38].

### CONCLUSIONS

WSD are one of the most sensitive problems among Egyptian young married women (18-24y). The most common WSD are lack of desire and non-achieving orgasm. However, these problems go unaddressed due to cultural and religious taboos, limited discussion with health professionals and feelings of embarrassment. Those suffering from sexual disorders don't often seek medical advice.

Primary health care service providers endorsed the idea of providing counseling on sexuality to their clients. However, most of the HSP felt that they lacked both the technical knowledge and communication skills to provide high quality sexual counseling to their clients. Efforts are needed to build the capacity of primary health care HSP to address the sexual health needs of young married women.

**Implications:** The study findings reflect the current sexual health scenario among Egyptian women and also signify the need for more studies in the field of sexology. The findings may serve as a good foundation for the policy makers and health program managers to take necessary steps so as to improve the role of health care facilities to provide quality comprehensive care to women including sexual counseling. Integration of sexual health/sexology in the medical and nursing school curricula is pivotal. Inclusion of the science of sexology in the training of undergraduate and postgraduate medical students should be considered, in order to meet the

increasing need for trained professionals in this specialty. Additionally the incorporation of "socially intelligent counseling on sexual health" in the standard of practice in primary health care, could ensure the commitment of HSP in providing such services on a scientific basis. The health system could capitalize on opportunities of contact with women attending primary health care facilities, to initiate "socially intelligent counseling on sexual health". Such type of counseling could be integral part of all medical services to women, as sexual disorders are linked with psychosomatic disorders.

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