# Prevalence and Associating Factors of Sexual Dysfunction in Women Who Use Intrauterine Device (IUD) for Contraception

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***Objective:*** *To study the prevalence and associating factors of sexual dysfunction in Thai women using contraception with intrauterine device (IUD).*

***Material and Method:*** *A cross-sectional study was conducted in IUD users at the Family Planning Unit, Siriraj Hospital. Data were recruited between October 2012 and June 2013. The participants answered the questionnaires to collect demographic, obstetric-gynecological data, and female sexual function index (FSFI) score.*

***Results:*** *Two hundred seventy one IUD users participated in this study. The mean age was 32.1±7.1 years old, mean body mass index (BMI) was 24.1±5.3 kg/m$^2$. The prevalence of sexual dysfunction in IUD users was 50.9%. The associating factor that affected the sexual dysfunction significantly was observed in BMI group (p-value 0.033). Subgroup analysis illustrated that the underweight group had more sexual dysfunction. The lowest FSFI score was observed in the underweight group. The score was 23.50±4.52. The significant domains were found to be desirable and arousal domains.*

***Conclusion:*** *The prevalence of female sexual dysfunction in the period after IUD using was 50.9%. The BMI was a significant associating factor. Underweight women showed higher trend of sexual dysfunction than other group, especially in the desire and arousal domain.*

***Keywords:*** *Sexual function, Female sexual function index (FSFI), Intrauterine device (IUD)*

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One of the problems of sexual life is being faced with the issue of family planning. There are several ways to control fertilities, including oral contraceptive pills (OCPs), contraceptive injections, implants, intrauterine devices (IUD), and female sterilization[1]. One study in Iran showed that choosing the suitable contraceptive method has a probable effect on the sexual relationship[2].

Intrauterine device (IUD) is the common contraceptive method, especially in women who want the long-term contraception. Besides that, the non-hormonal IUD has no side effect upon systemic hormonal functions as do other contraceptive methods. The IUD is divided into two types. The early version is a non-medicated IUD or inert IUD. The latter is a medicated IUD that can release the pharmaceutical agent out for improving the contraceptive efficiency[3]. The recent data from the family planning unit of Department of Obstetrics and Gynaecology, Faculty of Medicine Siriraj Hospital found that there are about 300 new IUD users and 2,000 follow-up cases per year. There was one study in Beijing, China, which showed that the most popular contraception was the intrauterine device at 39.6%[4]. In addition to this, many previous studies showed that there was no statistical significance of orgasm function between before and after periods of IUD usage[5,6]. However, some women refuse IUD because of concerns about their effect on sexual life. They feel that an IUD in the uterus and a string in the vagina are foreign to them. They may affect the feeling of the partners while they are having sexual intercourse. Fleming KL et al found that 46% of the women who were not interested in IUD usage did not want to have something foreign in their body. Therefore, 25% of these women thought that an IUD might hurt them[7].

One study by Martin-Loeches M et al found that there was no difference in the decrease of sexual desire among the group of women who use OCPs and

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IUDs[8]. A previous study of Esposito K and colleagues showed the association of body weight with sexual function in women. They presented findings that sexual function was significantly lower in overweight women compared with normal weight[9]. On the other hand, that the results of obesity had no significant relationship with female sexual dysfunction was reported by Kadioglu P et al[10]. According to the type of IUD and the duration of IUD uses, there was no significant difference of the prevalence of sexual function[5,11].

Although many previous studies support the advantages of IUD uses, many women are still concerned about the effect of IUD on their sexual life and the satisfaction of their partners. The main aim of this study is the determination of the prevalence of sexual dysfunction in Thai women who used contraception with IUD. In addition, the other outcomes would be analyzed for any associating factors of the female sexual dysfunction in IUD user.

The Female Sexual Function Index (FSFI) is a multi-dimensional self-evaluation instrument for evaluation of female sexual dysfunction. There are 19 items for six domains, including sexual desire, sexual arousal, lubrication, orgasm, sexual satisfaction, and dyspareunia. The cut-off point to diagnose the female sexual dysfunction is less than or equal to 26 points[12,13]. Thai version was used and already confirmed validity and reliability to evaluate the female sexual function[14].

## Material and Method

This is a cross-sectional study based on a questionnaire research. The research was conducted in 271 women who attended at the Family Planning Unit of the Department of Obstetrics and Gynaecology, Faculty of Medicine Siriraj Hospital, Bangkok, Thailand. Data were collected between October 2012 and June 2013. The present study was approved by the Siriraj Institutional Review Board (SIRB). The number of the certificate of approval was Si493/2012.

The inclusion criteria were reproductive women who had contraception with IUD, ages between 18 and 45 years old, Thai language users, having regularity sexual experiences before and after IUD uses and no pelvic organ abnormality. Pregnant women and women who had severe hypertension, severe diabetes mellitus or severe heart disease were excluded. The women who had hormonal treatment and psychotropic drugs also were excluded. All women who were appropriate for inclusion and exclusion criteria were informed by the research's staffs. After these women signed the consent, each woman was taken to a private room for answering the three major data sections by themselves, which included the following: demographic data (age, ethnic, education, income, occupation, and marital status), obstetric-gynecological data, and sexual function by filling in FSFI questionnaire. The women answered the Thai version FSFI by themselves in six domains that were subdivided into 19 items. The women took time for answering about 15 to 20 minutes for answering the questions. All other interventions of routine or necessary practices were provided to all women. Each item was ranged in score from zero or one to five. Each score was multiplied by the domain factor. The total score was the sum of all items. A total score of less than or equal to 26 points was determined as female sexual dysfunction. After the women completed the questionnaires, the data were kept in a separated file and confidential record. Furthermore, the data did not identify an individual person and the file was coded by each study code. The data were analyzed when completely collected.

### *Sample size calculation*

The sample size of 271 was calculated by the solution for the prevalence by using 5% of maximum allowable error (d = 0.05). The prevalence of female sexual dysfunction in a previous study was (p = 0.208)[11] and $Z_\alpha$ was the standard value ($Z_\alpha$ = 1.96). Incomplete data was added as 10%.

### *Definition*

Sexual dysfunction was classified by FSFI score. The cut-off point to diagnose the female sexual dysfunction is less than or equal to 26 points[12,13]. Definition of obesity and the cut off point for body mass index was used in the definition for Asian population[15,16]. The subgroup were categorized into underweight, normal weight, overweight and obesity, which classified by the cut-point of body mass index (BMI) as follows; less than 18.5, 18.5-22.9, 23.0-24.9 and $\geq$25.0 kg/m$^2$, respectively.

### *Statistical analysis*

Analyzing data was done by the SPSS program version 18.0. The collected data were normally distributed by test of normality using Kolmogorov-Smirnov test. Categorical data were shown by number or percentage. Continuous data were calculated by using mean $\pm$ standard deviation (SD). The prevalence of female sexual dysfunction was proposed by number and percentage. Subgroup

analysis was calculated for comparing the sexual function in each factor by using Pearson Chi-square test. Comparison of means in each FSFI score was done by using ANOVA due to normal distribution of data. The multiple comparisons in factor's group were repeated by Post Hoc test and Bonferroni method. The p-value <0.05 was considered statistically significant.

## Results

Two hundred seventy one users of IUD were enrolled into the present study. Demographic data and baseline characteristics were shown in Table 1. Mean age was 32.1±7.1 years old. Mean BMI was in the overweight group by 24.1±5.3 kg/m$^2$. For education were mainly university graduates by 36.2%. The average duration of IUD insertion was 1.1±1.0 years. Most of the participants were Buddhists. The most prevalent occupation of participants; 45.0% was employee, 21.0% were homemakers, and 20.0% were shopkeepers. More than half of the population (60.9%) had savings financial status. Parity was first time (56.4%) in most. In addition, the majority route of delivery was normal vaginal delivery by 90.8%. The multiload copper IUD (MLCu375) was the most often type of IUD used at 68.3%.

The prevalence of sexual dysfunction in women who had contraception with IUD was 50.9%. Table 2 showed associating factors of sexual dysfunction. Only one factor had statistically significant difference. The group of BMI showed statistical significance (p-value 0.033). There were no statistical significant differences in the duration of IUD insertion, type of IUD, age, parity, income, time of IUD, and mode of delivery (p>0.05).

Table 3 illustrated FSFI score in women who used IUD as stratified by BMI. The lowest FSFI score was 23.50±4.52 in underweight group. The FSFI domains of each BMI category had significance in the desire and arousal domain.

Evaluation of FSFI scores in desire and arousal domain comparing within BMI group. The desirable score was statistically significant within each group (p-value 0.003). There were differences between the underweight group and the other three groups (p-value 0.003 compared with normal weight, p-value 0.005 compared with overweight and p-value 0.013 compared with obese group). Arousal score indicated significant differences between underweight and either overweight or obese groups by p-value which were 0.042 and 0.033, respectively.

**Table 1.** Baseline characteristic data of total 271 participants

| Characteristic | Mean ± SD or n (%) |
|---|---|
| Age (years) | 32.1±7.1 |
| 18-24.9 | 48 (17.7) |
| 25-34.9 | 120 (44.2) |
| 35-45 | 103 (38.1) |
| Body weight (kg) | 60.2±14.6 |
| Height (cm) | 157.8±6.2 |
| BMI (kg/m$^2$) | 24.1±5.3 |
| Underweight | 29 (10.7) |
| Normal weight | 105 (38.7) |
| Overweight | 37 (13.7) |
| Obese | 100 (36.9) |
| Duration of IUD insertion (years) | 1.1±1.0 |
| <1 | 170 (62.7) |
| 1-2 | 63 (23.2) |
| >2 | 38 (14.1) |
| Duration of marriage (years) | 9.3±5.7 |
| Religious | |
| Buddhism | 265 (97.8) |
| Islam | 6 (2.2) |
| Education | |
| Primary | 29 (10.7) |
| Secondary | 37 (13.7) |
| High school | 77 (28.4) |
| Vocation | 30 (11.0) |
| University | 98 (36.2) |
| Occupation | |
| Housewife | 57 (21.0) |
| Employee | 122 (45.0) |
| Farmer | 6 (2.2) |
| Shopkeeper | 54 (20.0) |
| Government official | 32 (11.8) |
| Income | |
| Not enough | 12 (4.4) |
| Enough | 94 (34.7) |
| Saving | 165 (60.9) |
| Route of delivery | |
| Normal delivery | 246 (90.8) |
| Cesarean delivery | 25 (9.2) |
| Type of IUD* | |
| CuT380A | 11 (4.1) |
| MLCu250 | 75 (27.6) |
| MLCu375 | 185 (68.3) |
| Parity | |
| 0 | 8 (3.0) |
| 1 | 153 (56.4) |
| ≥2 | 110 (40.6) |
| Time of IUD | |
| First time | 235 (86.7) |
| Any time | 36 (13.3) |

* IUD = intrauterine device, CuT380A is copper IUD in T figure and has 380 mm$^2$ of copper wire, MLCu250 is multiload copper IUD which has 250 mm$^2$ of copper wire, MLCu375 is multiload copper IUD which has 375 mm$^2$ of copper wire

**Table 2.** Associating factors affected sexual function in participants

| Factor | n | Sexual function n (%) | | p-value* |
|---|---|---|---|---|
| | | Normal (n = 133) | Dysfunction (n = 138) | |
| Duration of IUD insertion (years) | | | | 0.198 |
| <1 | 170 | 77 (45.3) | 93 (43.7) | |
| 1-2 | 63 | 33 (52.4) | 30 (47.6) | |
| >2 | 38 | 23 (60.5) | 15 (39.5) | |
| Type of IUD | | | | 0.555 |
| CuT380A | 11 | 7 (63.6) | 4 (36.4) | |
| MLCu250 | 75 | 38 (50.7) | 37 (49.3) | |
| MLCu375 | 185 | 88 (47.6) | 97 (52.4) | |
| BMI (kg/m$^2$) | | | | 0.033 |
| Underweight | 29 | 10 (34.5) | 19 (65.5) | |
| Normal weight | 105 | 44 (41.9) | 61 (58.1) | |
| Overweight | 37 | 22 (59.5) | 15 (40.5) | |
| Obese | 100 | 57 (57.0) | 43 (43.0) | |
| Parity | | | | 0.330 |
| 0 | 8 | 4 (50.0) | 4 (50.0) | |
| 1 | 153 | 81 (52.9) | 72 (47.1) | |
| ≥2 | 110 | 48 (43.6) | 62 (56.4) | |
| Age (years) | | | | 0.935 |
| 18-24.9 | 48 | 23 (47.9) | 25 (52.1) | |
| 25-34.9 | 120 | 58 (48.3) | 62 (51.7) | |
| 35-45 | 103 | 52 (50.5) | 51 (49.5) | |
| Income | | | | 0.702 |
| Not enough | 12 | 5 (41.7) | 7 (58.3) | |
| Enough | 94 | 49 (52.1) | 45 (47.9) | |
| Saving | 165 | 79 (47.9) | 86 (52.1) | |
| Time of IUD | | | | 0.633 |
| First time | 235 | 114 (48.5) | 121 (51.5) | |
| Any time | 36 | 19 (52.8) | 17 (47.2) | |
| Mode of delivery | | | | 0.594 |
| Normal delivery | 246 | 122 (49.6) | 124 (50.4) | |
| Cesarean delivery | 25 | 11 (44.0) | 14 (56.0) | |

* Pearson Chi-square test

**Table 3.** FSFI score in women who used IUD as stratified by body mass index

| FSFI domain | Score in each BMI group (mean ± SD) | | | | p-value* |
|---|---|---|---|---|---|
| | Underweight (n = 29) | Normal (n = 105) | Overweight (n = 37) | Obese (n = 100) | |
| Desire | 2.66±0.88 | 3.22±0.77 | 3.29±0.72 | 3.15±0.68 | 0.003 |
| Arousal | 3.30±1.00 | 3.79±0.90 | 3.90±0.92 | 3.83±0.85 | 0.027 |
| Lubrication | 4.28±1.04 | 4.60±0.93 | 4.73±0.88 | 4.73±0.98 | 0.138 |
| Orgasm | 4.28±1.32 | 4.46±1.05 | 4.60±1.08 | 4.62±0.95 | 0.401 |
| Satisfaction | 4.45±0.84 | 4.44±0.87 | 4.69±0.99 | 4.59±0.72 | 0.353 |
| Pain | 4.51±1.17 | 4.48±0.96 | 4.49±1.21 | 4.85±0.97 | 0.050 |
| Total score | 23.50±4.52 | 25.10±4.01 | 25.72±3.93 | 25.80±3.95 | 0.036 |

Underweight = BMI <18.5 kg/m$^2$, Normal range = BMI 18.5-22.9 kg/m$^2$, Overweight = BMI 23.0-24.9 kg/m$^2$, Obese = BMI ≥25.0 kg/m$^2$
* ANOVA test

**Discussion**

The female sexual dysfunction is more complex than in males. Besides the changes in anatomy and physiological functions of the body, the factors also concluded emotion, environments and the couples' relationship that had an effect on the sexual life. According to these reasons, sexual life is one of the important issues in couples. However, since the couples had to face decisions about their family planning, the choosing of contraception should also be concerned about the effects on sexual functions.

The prevalence of female sexual dysfunction in the group of participants was 50.9%. This result was different from previous results. Skrzypulec V et al study in European women found the prevalence of female sexual dysfunction in IUD users was 20.8%[11]. Although both studies used the same FSFI score, there were many different factors. The factors were observed in cultures, society, races, and lifestyle that affected the sexual function. Among the European couples, they always expressed their feeling and shared sexual experiences, which might make them having good sexual function. In contrast to the Asian population, who opening up about their feelings was less than European and American women.

Concern about female sexual dysfunction among women who used IUDs is the aim of the present study. Although the study presented a higher prevalence of female sexual dysfunction than was found in previous study among European women, this prevalence was less than the previous result in Thai women. Few studies in Thai women showed the prevalence of female sexual dysfunction. Im-Aim C et al revealed that 71.2% of pre-pregnancy women and 87.7% of pregnant women had sexual dysfunction[17]. In another study in the Department of Family Medicine, Ramathibodi Hospital showed 92% of the married Thai female patients in the Family Medicine Unit had at least one type of sexual dysfunction[18]. The lower prevalence in this present study might be caused by a different population. Furthermore, some studies even collected the data from recall memories, which might be uncertain information.

In the subgroup analysis, the factors associated with prevalence of female sexual dysfunction had no difference in group of age, duration of IUD insertion, type of IUD, parity, mode of delivery, income, and time of IUD. Skrzypulec V et al reported the sexual dysfunction among women using levonorgestrel intrauterine system did not differ from those using other IUDs[11]. Regarding the duration of IUD insertion associated with sexual function, mean FSFI score showed no significant difference between screening and 12 months later reported by Bastianelli C et al[5]. Although the same result was found in duration and type of IUD, research about other issues was never established.

Focusing on the significant differences in FSFI score, there was one factor associating with female sexual dysfunction in women who used IUDs. When the FSFI score in the subgroup of BMI were analyzed, a significant difference in the desirable domain (p-value 0.003) and arousal domain (p-value 0.027) occurred. The total FSFI score in underweight group had the lowest score (23.50±4.52). As the analysis within this group indicated, underweight had the lowest FSFI score in the desirable and arousal domain when compared with other BMI groups. According to the study of Pinheiro AP et al they found an association between low BMI and loss of libido, sexual anxiety, and sexual relationship[19]. Low body weight or underweight women could impair the physiological functioning of sexual organs. An alternative explanation was that a lower BMI group had more medical illness. This might be associated with more profound body image dissatisfaction, distortion, depression, and discomfort with their partners' physical contact. They also experienced with loss of libido and elevation of sexual anxiety. On the other hand, Yaylali GF et al showed negative correlation between BMI and orgasm or satisfaction domain[20]. In a previous study, Esposito K et al found an association of body weight with sexual function in women. The result was a FSFI score strongly correlated with BMI in aspects of arousal, lubricant, orgasm, and satisfaction. They also showed that FSFI score was significantly lower in overweight women as compared with normal weight women[9]. Although FSFI score was lower in higher BMI, this study exhibited no significant difference among the groups of normal weight, overweight and obese women. This could be explained through using a BMI score according to Asian populations. Using the difference cut point might cause the different results. Regarding sexual dysfunction, the authors expressed that FSFI score was not different among the group of normal weight, overweight and obese women. That the results of obesity had also no significant relationship with female sexual dysfunction was reported by Kadioglu P et al[10]. Nevertheless, contraception with IUDs has many advantages since long-term contraception has good compliance, and no systemic hormonal effect. The

disadvantages were observed in higher sexual dysfunction in low BMI group. Therefore, risk and benefit should be of concern when choosing the proper contraceptive method for each woman.

Limitations were found in the recent study. The research was a cross sectional study. If a prospective research was performed, it could show the change of female sexual function in women who had been using IUDs in the period of time since period before IUD using until each selected time such as 3, 6, 12 months. There were a few samples in some factors that might have an effect on the result. A further study should be conducted.

**Conclusion**

The prevalence of female sexual dysfunction in the period after IUD using was 50.9%. Because the underweight group had significant lower FSFI score in aspects of both desire and arousal domains, contraception with IUD in underweight women should be of concern in sexual function problems.

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**What is already known on this topic?**

Intrauterine device (IUD) is the common contraceptive method, especially in women who want the long-term contraception. Besides that, the non-hormonal IUD has no side effect upon systemic hormonal functions, as do other contraceptive methods. Some women refused IUD insertion. They feel that an IUD in the uterus and a string in the vagina are foreign to them. They may affect the feeling of the partners while they are having sexual intercourse.

The prevalence of female sexual dysfunction had no significant difference among the period before and after IUD using that found in the previous study.

Few studies in Thai women showed the prevalence of female sexual dysfunction. Im-Aim C and colleagues revealed that 71.2% of pre-pregnancy women had sexual dysfunction. No previous study found the prevalence of sexual dysfunction in Thai women who used IUDs.

**What this study adds?**

The prevalence of female sexual dysfunction in the group of participants was 50.9%. There was significant difference in the BMI group. IUD usages in underweight women should be concerned.

The prevalence of sexual dysfunction in women who used IUDs was less than the prevalence of sexual function in the previous study. It might conclude that there was no effect of IUD on sexual function.

In the national policy, women could be suggested to use IUDs due to no more sexual dysfunction, no hormonal side effect and long term uses. Choosing the suitable contraceptive method is a good effect on the sexual relationship and sexual desire.

**Potential conflicts of interest**

None.

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## *ความชุกและปัจจัยที่สัมพันธ์กับเพศสัมพันธ์ที่ผิดปกติในสตรีที่ใช้ห่วงอนามัยเพื่อคุมกำเนิด*

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***วัตถุประสงค์:*** *เพื่อศึกษาความชุกและปัจจัยที่สัมพันธ์กับของเพศสัมพันธ์ที่มีความผิดปกติในสตรีที่ใช้ห่วงอนามัยเพื่อการคุมกำเนิด*

***วัสดุและวิธีการ:*** *เป็นการศึกษาเชิงพรรณนาชนิดตัดขวางในสตรีที่คุมกำเนิดด้วยการใส่ห่วงอนามัย ที่มารับบริการที่หน่วยวางแผนครอบครัวของภาควิชาสูติศาสตร์-นรีเวชวิทยา โรงพยาบาลศิริราช ระหว่างเดือนตุลาคม พ.ศ. 2555 ถึง เดือนมิถุนายน พ.ศ. 2556 ผู้เข้าร่วมการศึกษาจะต้องตอบแบบสอบถามที่ครอบคลุมข้อมูลเกี่ยวกับลักษณะทั่วไป ประวัติทางด้านสูตินรีเวช และแบบสอบถามประเมิน female sexual function index (FSFI)*

***ผลการศึกษา:*** *จำนวนผู้เข้าร่วมการศึกษาทั้งหมดคือ 271 ราย ของสตรีที่ใช้ห่วงอนามัย มีอายุเฉลี่ย 32.1±7.1 ปี มีค่าดัชนีมวลกาย 24.1±5.3 กก./ม.$^2$ ความชุกของสตรีที่ใช้ห่วงอนามัยคุมกำเนิดที่มีความผิดปกติทางเพศสัมพันธ์เท่ากับร้อยละ 50.9 ดัชนีมวลกายเป็นปัจจัยที่สัมพันธ์กับการมีความผิดทางเพศสัมพันธ์อย่างมีนัยสำคัญ (ค่า p เท่ากับ 0.033) การวิเคราะห์ในกลุ่มย่อยแสดงกลุ่มที่มีดัชนีมวลกายที่อยู่ในเกณฑ์น้อยกว่าปกติ มีความผิดปกติทางเพศสัมพันธ์มากกว่าเกณฑ์ดัชนีมวลกายกลุ่มอื่น ๆ ค่าคะแนน FSFI มีค่าน้อยที่สุดในสตรีกลุ่มที่มีดัชนีมวลกายน้อยกว่าปกติ โดยมีคะแนนเท่ากับ 23.50±4.52 หัวข้อที่พบว่ามีความแตกต่างอย่างมีนัยสำคัญคือ ความต้องการและการกระตุ้นทางเพศ*

***สรุป:*** *ความชุกของความผิดปกติทางเพศสัมพันธ์ในสตรีที่ใส่ห่วงอนามัยเพื่อการคุมกำเนิดเท่ากับร้อยละ 50.9 โดยค่าดัชนีมวลกายที่อยู่ในเกณฑ์น้ำหนักน้อยกว่าปกติมีแนวโน้มที่จะมีเพศสัมพันธ์ที่ผิดปกติมากกว่าเกณฑ์น้ำหนักอื่น ๆ โดยเฉพาะในหัวข้อความต้องการและการกระตุ้นทางเพศ*