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Original Research Article

Patterns and predictors of female sexual dysfunction among women of reproductive age attending the gynaecology clinic at Rivers State University Teaching Hospital

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ABSTRACT

Background: Female sexual dysfunction is prevalent globally, yet sexuality remains taboo in many societies, leading to infrequent discussions between women and physicians. This study assessed the patterns and predictors of female sexual dysfunction among reproductive-age women attending the gynaecology clinic at Rivers State University Teaching Hospital, Nigeria.
Methods: This cross-sectional study involved 375 reproductive-age women recruited from the hospital's gynaecological outpatient department. Data were collected via a pre-tested, interviewer-administered, semi-structured questionnaire that gathered socio-demographic information, psychological factors (anxiety, stress, and depression), and categorized levels of sexual dysfunction as low, moderate, or high. Analysis was performed using SPSS version 20, with significance set at $p<0.05$.
Results: Many pregnant participants were in their prime reproductive years. The prevalence of sexual dysfunction was 3.5% for low, 95.4% for moderate, and 1.1% for high levels. Younger age and higher education were significantly associated ($p<0.05$) with lower dysfunction, and stress was significantly linked ($p<0.05$) to sexual dysfunction, whereas anxiety and depression were not.
Conclusions: Given the high prevalence of sexual dysfunction and its impact on quality of life, healthcare providers should routinely assess sexual function and offer professional support to enhance women's sexual well-being.

Keywords: Female, Psychological, Reproductive age, Sexual dysfunction

INTRODUCTION

Female sexual dysfunction is prevalent in all populations and cultures globally.[1] It is a multifactorial condition that has physiological, psychological, anatomical, medical, and social components.[2] Female sexual dysfunctions (FSD) are group of disorders of sexual desire, arousal, orgasm and sexual pain which lead to significant personal distress.[3] It can be said that it is any problem that may be encountered in the sexual response cycle that deviates from a woman's normal range of functioning.[4] Psychological, relational and environmental factors are regarded as being of paramount importance in influencing sexual function and behavior.

Certainly, a composite approach to women's sexuality requires more than the mere understanding of a physiological process. The bio-psychosocial model is

essential to comprehend and interpret the way the different phases of the sexual response (arousal, desire, orgasm and satisfaction) are connected to each other in the context of partnership and society.[5]

The hormonal mechanism driving the menstrual cycle and fertility span plays a major role in motivating women to engage in sexual activity, both mentally and physically. Several studies have been carried out that shows that sexual dysfunction seems to be a very frequent health problem which has been observed in 25% to 92% of women.[6-9] The sexual function can be affected by age, education, chronic diseases, pregnancy and parity.[7,10]

Although sexual dysfunction can occur in both genders, available studies reveal that it is more prevalent among women. In a study undertaken in the gynecological outpatient's unit of a teaching hospital in south west Nigeria, most (85.6%) of the women respondents had at least one form of sexual dysfunction. The commonest dysfunction was arousal sensation (62.4%) while the least was pain (3.4%).[11] A study in Kano state Nigeria found the prevalence of female sexual dysfunction to be 86.0%, with desire disorder as the most prevalent occurring in (91.8%), of the women studied, followed by disorders of lubrication (84.8%), arousal (80.7%), pain (66.4%), orgasm (41.5%) and satisfaction (31.6%).[12] In Iran, a study on FSD carried out among 300 newly married women revealed a prevalence of FSD of 66%. The frequency of sexual dysfunction was 33% for arousal, 31% for pain, 28.7% for desire, 23% for satisfaction, 16.3% for orgasm dimensions and 3% for vaginal lubrication.[13]

There is evidence that many people who experience sexual dysfunction find it difficult to ask for professional help, especially females.[14] A study carried out among educated working women in Abuja revealed that up to 42% of the respondents were not aware that FSD could be managed.[15] Additionally, sexuality is a subject not to be discuss in many societies, and women and physicians do not routinely discuss sexual health matters. All these underlines the need to improve awareness of FSD in our environment.

Therefore, this study was carried out to assess the patterns and predictors of female sexual dysfunction among women of reproductive age attending the gynaecology clinic at Rivers State University Teaching Hospital, Nigeria.

METHODS

The study population for this analytical and cross-sectional study consisted of 375 women in their reproductive age attending the gynecological clinic of the Rivers State University Teaching Hospital, Nigeria between June 1 and December 31, 2024. All consenting participants who attended the clinic during the study period were recruited. Individuals with chronic medical conditions like diabetes mellitus, hypertension, or on any medication that affects sexual function were excluded. Chronic alcoholics or those who smoke were also excluded as they affect sexual function in various ways. Individuals who declined consent were also excluded.

Eligible women who were in the clinic's waiting room were approached. After having discussed the study's objectives, responsibilities, and the procedures involved, the volunteers who chose to participate signed the informed consent form and were immediately asked to complete a questionnaire. Two female research assistants were trained on the use of the survey instrument and a pre-tested, interviewer-administered, semi-structured questionnaire was used to obtain information on socio-demographic characteristics of the women respondents which includes information on age, education and employment status. Information on level of sexual dysfunctions and psychological factors (anxiety, stress and depression) was also collected and level of FSD among the respondents were categorized into low, moderate and high level of sexual dysfunctions.

Data processing and analysis

Data were cleaned, cross-checked, and verified for accuracy. Statistical analysis was done using SPSS software version 20.0. Data were summarized using descriptive statistics such as mean, frequency tables and percentages. Inferential statistics such as ANOVA and logistic regression were used to determine statistical differences and associations between variables. Level of statistical significance was set at $p<0.05$.

Ethical considerations

Ethical approval was obtained from Rivers State University Teaching Hospital institutional review board (IRB) and from the sectional head of the department. Informed consent was also obtained from the pregnant women before the commencement on the interview.

RESULTS

The socio-demographic analysis of the women of reproductive age attending a Nigerian teaching hospital presented in Table 1 shows that 141 (37.6%) of the respondents were in the age ranges between 20-29 years, 160 (42.7%) were between 30-39 years and 9.1% were between 40-49 years old. Majority (82.4%) of the women have attained tertiary education, indicating a well-educated sample population and 17.1% had attained secondary level of education. More than half (66.1%) of the women respondents were employed in the private sector, 14.1% employed in the public sector, that is government-employed and 19.7%, were unemployed.

Table 1: Socio-demographic characteristics of pregnant women respondents.

Variables	Frequency	Percentage
Age (years)		
Less than 20	40	10.7
20-29	141	37.6
30-39	160	42.7
40-49	34	9.1
50 and above	0	0.0
Educational qualification		
No formal education	0	0.0
Primary	2	0.5
Secondary	64	17.1
Tertiary	309	82.4
Employment status		
Unemployed	74	19.7
Employed with private	248	66.1
Employed with public	53	14.1
Self-employed	0	0.0
Total	375	100

Table 2: Prevalence and patterns of FSD among the pregnant women respondents.

Variables	Frequency	Percentage
Sexual		
Low	47	12.5
Moderate	230	61.3
High	98	26.1
Arousal		
Low	22	5.9
Moderate	124	33.1
High	229	61.1
Lubrication		
Low	16	4.3
Moderate	277	73.9
High	82	21.9
Orgasm		
Low	14	4.4
Moderate	174	46.4
High	187	49.9
Satisfaction		
Low	39	10.4
Moderate	322	85.9
High	14	3.7
Pain		
Low	40	10.7
Moderate	306	81.6
High	29	7.7
FSD overall		
Low	13	3.5
Moderate	358	95,4
High	4	1.1
Total	375	100

Table 3: Social-demographic factors and female sexual dysfunction (FSD) among women of reproductive age.

Age (years)	Edu. qual.	Employ status	Mean	Std. dev.	N	Uni test (f)	Sig
Below 20	Secondary	Employed with private	43.0000	5.86515	6		
		Employed with government	55.0000	0.00000	2		
		Total	46.0000	7.44504	8		
	Tertiary	Unemployed	73.6000	35.39491	5		
		Employed with private	53.0417	3.54449	24		
		Employed with government	55.6667	4.04145	3		
		Total	56.5000	15.11675	32		
	Total	Unemployed	73.6000	35.39491	5		
		Employed with private	51.0333	5.70833	30		
		Employed with government	55.4000	2.88097	5		
		Total	54.4000	14.48040	40		
20-29	Primary	Employed with private	37.0000	0.00000	2		
		Total	37.0000	0.00000	2		
	Secondary	Unemployed	40.7500	5.67576	8		
		Employed with private	48.9231	8.04634	13		
		Employed with government	36.5000	13.27906	4		
		Total	44.3200	9.47242	25		
	Tertiary	Unemployed	45.0435	11.51473	23		
		Employed with private	51.0385	7.40558	78		
		Employed with government	46.7692	11.09920	13		
		Total	49.3421	9.09812	114		
	Total	Unemployed	43.9355	10.41133	31		
		Employed with private	50.4409	7.67472	93		
		Employed with government	44.3529	12.06721	17		
		Total	48.2766	9.36643	141		
30-39	Secondary	Unemployed	38.0000	0.00000	2		
		Employed with private	53.0000	2.47656	16		
		Employed with government	38.0000	4.73286	6		
		Total	48.0000	7.81303	24		
	Tertiary	Unemployed	43.7143	8.82697	28	3.189	0.014
		Employed with private	51.0581	5.98499	86		
		Employed with government	50.7727	6.89328	22		
		Total	49.5000	7.36760	136		
	Total	Unemployed	43.3333	8.63966	30		
		Employed with private	51.3627	5.61785	102		
		Employed with government	48.0357	8.34214	28		
		Total	49.2750	7.43014	160		
40-49	Secondary	Unemployed	43.0000	0.00000	2		
		Employed with private	40.0000	14.62874	5		
		Total	40.8571	12.03368	7		
	Tertiary	Unemployed	35.3333	11.32549	6		
		Employed with private	49.8333	2.85431	18		
		Employed with government	50.6667	2.30940	3		
		Total	46.7037	8.29650	27		
	Total	Unemployed	37.2500	10.20854	8		
		Employed with private	47.6957	7.89957	23		
		Employed with government	50.6667	2.30940	3		
		Total	45.5000	9.29076	34		
Total	Primary	Employed with private	37.0000	0.00000	2		
		Total	37.0000	0.00000	2		
	Secondary	Unemployed	40.6667	4.77367	12		
		Employed with private	48.5500	8.42143	40		
		Employed with government	40.3333	10.28090	12		

Continued.

Age (years)	Edu. qual.	Employ status	Mean	Std. dev.	N	Uni test (f)	Sig
		Total	45.5313	9.04305	64		
	Tertiary	Unemployed	45.8065	15.85264	62		
		Employed with private	51.1748	6.17379	206		
		Employed with government	49.8537	8.31433	41		
		Total	49.9223	9.41161	309		
	Total	Unemployed	44.9730	14.73322	74		
		Employed with private	50.6371	6.72940	248		
		Employed with government	47.6981	9.57678	53		
		Total	49.1040	9.49964	375		

Table 4: Regression analysis of psychological factors (stress, anxiety, and depression) and female sexual dysfunction in pregnant women respondents.

	Unstandardized coefficients		Standardized coefficients	t	Sig.
	B	Std. error	Beta		
(Constant)	38.135	3.232		11.798	0.000
Anxiety	0.048	0.093	0.030	0.520	0.604
Stress	0.454	0.110	0.224	4.129	0.000
Depression	-0.056	0.056	-0.060	-1.003	0.317

The prevalence and patterns of FSD among the women respondents revealed that in the sexual domain, 12.5%, 61.3% and 26.1% were observed to have low, moderate and high level of dysfunction respectively. In the arousal domain, 5.9%, 33.1% and 61.1% of the women demonstrated low, moderate and high level of dysfunction respectively. The lubrication aspect of sexual function shows that 4.3%, 73.9% and 21.9% of the respondents were observed to have low, moderate and high level of sexual dysfunction respectively. Orgasmic function of the women sexuality was observed to be low, moderate and high among 4.4%, 46.4% and 49.9% respectively. In the satisfaction domain, 10.4%, 85.9% and 3,7% of the women studied demonstrated a low, moderate and high level of sexual dysfunction respectively. As respects to pain aspect of sexual activity, 10.7%, 81.6% and 7.7% of the pregnant women studied demonstrated a low, moderate and high level of sexual dysfunction respectively. The overall prevalence of FSD among the respondents shows that majority (95.5%) had moderate level of sexual dysfunction and 1.1% of the women had high level of sexual dysfunction.

Mean, SD and three-way ANOVA analysis of the influence of social-demographic factors (age, educational qualification and employment status) in Table 3 revealed that in the 40-49 age group, secondary-educated unemployed women report a mean FSD score of 43.00, while those in private employment report 40.00, showing relatively low dysfunction. Tertiary-educated women who are unemployed report a lower mean FSD score (35.33), while those employed in private and government positions show significantly higher scores of 49.83 and 50.67, respectively. The three-way ANOVA test result (F=3.189, p=0.014) indicated a statistically significant influence of these socio-demographic factors on FSD.

Examining the individual contributions of the psychological factors, stress emerges as the most significant predictor of FSD. The unstandardized coefficient (B) for stress was 0.454, meaning that for each unit increase in stress, FSD is expected to increase by 0.454 units. The standardized beta coefficient (β) of 0.224 further reinforces that stress has the strongest relative contribution among the three psychological factors. The t-value of 4.129 and a highly significant p value of 0.000 confirm that stress is a statistically significant predictor, emphasizing its substantial role in exacerbating sexual dysfunction.

Anxiety, in contrast, has a negligible impact on FSD, with an unstandardized coefficient (B) of 0.048 and a standardized beta (β) of 0.030. The t-value of 0.520 and a p value of 0.604 indicate that anxiety does not significantly contribute to variations in FSD. This suggests that while anxiety may be present in affected individuals, it does not independently drive the severity of sexual dysfunction.

Similarly, depression does not show a significant contribution to FSD in this model. With an unstandardized coefficient (B) of -0.056 and a standardized beta (β) of -0.060, depression appears to have a minimal and even slightly negative association with FSD. The t-value of -1.003 and a p value of 0.317 further confirm that depression does not significantly predict FSD within this sample.

DISCUSSION

The overall prevalence of FSD among the respondents shows that majority (95.4%) had moderate level of sexual dysfunction and 1.1% had a high level of FSD. This prevalence of FSD in this study is higher than 43.0%

reported in United States, 46.2% in Iran, and 53.5% found in Enugu, Nigeria.[16-18] However, just like this study, some previous study has also reported high FSD level among women. Prevalence of FSD was found to be 86.0% among Women Attending the family planning clinic at Aminu Kano Teaching Hospital.[12] A prevalence of 72.8% was similarly reported in a prospective survey among Ghanaian females.[19] The high prevalence in this study may probably be due to the fact that open discussions on sexual problems and sex education are considered frowned at due to sociocultural reasons in our environment. Therefore, women having sexual dysfunction might not be aware of it or be bold to seek professional help. They may even be too shy to discuss their problems with anyone because of the social implications of these discussions, allowing the problem to persist. Although, in the same country, the lower prevalence in the Enugu study might also be due to differences in the study areas. Being in a university campus could expose women to sexual education and this might explain the lower levels of SD found there. Similarly in the United States, the respondents might have been exposure to sex education and less rigid sociocultural practices. Hence, sex education has been proposed as one of the preventive strategies for FSD, though further studies need to be done to determine its role in reducing the prevalence of FSD.

In this study, age seems to play a crucial role in the experience of FSD, as younger women under 20 years show a moderate level of dysfunction compare to those in their 40s. Lower level of sexual dysfunction among younger women has also been reported.[9,18,20] It should be noted that with the hormonal changes that occur with increasing age, the prevalence of FSD would increase. This sex hormone affects libido, vaginal lubrication, and distortion of the pelvic anatomy, which may result in difficult sex.[11] Additionally, teenage and younger women ordinarily may reach a better index of sexual function. Curiosity regarding sexual intercourse, novelty about the recently started sexual relationship and belief that nothing bad could possibly happen having no children may have driven adolescents to have better sexual activity. On the other hand, older women may have some unusual factors; most of them already had one or more children, exhaustive workload (the job, domestic activities, caring for the children and the husband). The ripple effect of these could in fact impacted on sexual performance.

Unemployed women across all education levels had lower dysfunction level and higher education correlates with lower levels of dysfunction. This was in consonant with previous studies who reported that high level of education was associated with reduced risks of sexual dysfunction during pregnancy.[21,22] However, Adefisan et al in their study in south west, Nigeria found a higher education to be related to female sexual dysfunction, which may be because it is the highly-educated women used hospital services there than in our environment and more than the uneducated. Nevertheless, it has been documented that the higher the level of female education the higher the probability that they can discuss reproductive health issues with their partner.

In this study, stress as a psychological factor demonstrated a statistically significant (p=0.000) predictor of FSD. This implies that higher stress levels significantly contribute to greater sexual dysfunction. This finding is in tandem with previous studies observed that stress has been found to negatively influence all aspects of women's sexual function (sexual interest, arousal, lubrication, desire, orgasm) and to be significantly correlated with dyspareunia and vaginismus.[12,24,25]

The psychological factor of depression was observed to have no statistically significant impact on sexual function in the respondents studied. Although, Mostafa et al, reported that depression showed significant negative correlations with desire, satisfaction, and total domains of FSD in women.[26] Nevertheless, this finding underscores the critical role that stress plays in impairing sexual health among women of reproductive age. Increased physiological and emotional stress may lead to arousal difficulties, decreased libido, and other forms of sexual dysfunction. Hence, stress management appears to be a crucial area of intervention. This finding aligns with existing literature that links stress symptoms to decreased sexual desire, diminished arousal, and an overall decline in sexual satisfaction. In this study, anxiety as a psychological factor does not significantly predict sexual dysfunction in pregnant women. This implies that while anxiety may be present, it does not necessarily contribute to sexual dysfunction in the population studied.

CONCLUSION

The prevalence of female sexual dysfunction is high in the study population showing that female sexual dysfunction actually should be of great concern. The necessary physiologic, anatomic and psychologic changes in women with age increase can become potential challenge to the frequency and pleasure of sex. longitudinal or qualitative research work with a larger sample frame may offer new horizons on the underlying psychological processes related to the sexuality of women of reproductive age. Since sexual satisfaction is an important health marker to the quality of life of women, health care providers should carefully assess the female sexual function and provide professional help for the women to deal with the bodily transformation and necessary adaptations.

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REFERENCES

1. Lema VM. Female sexual dysfunction and gynaecological practice: Report of six cases. East Afr Med J. 2012;89(9):312-7.

2. Anastasiadis AG, Davis AR, Ghafar MA, Burchardt M, Shabsigh R. The epidemiology and definition of female sexual disorders. World J Urol. 2002;20:74-8.
3. Basson R, Berman J, Burnett A, Derogatis L, Ferguson D, Fourcroy J, et al. Report of the international consensus development conference on female sexual dysfunction: definitions and classifications. J Urol. 2000;163(3):888-93.
4. Sobczak J. Female sexual dysfunction: Knowledge development and practice implications. Perspect Psych Care. 2009;45:161-72.
5. Nappi RE, Cucinella L, Martella S, Rossi M, Tiranini L, Martini E. Female sexual dysfunction (FSD): Prevalence and impact on quality of life (QoL). Maturitas. 2016;94:87-91.
6. Laumann EO, Paik A, Rosen RC. Sexual dysfunction in the United States: prevalence and predictors. JAMA. 1999; 281:537-44.
7. Çayan S, Akbay E, Boslu M, Canpolat B, Acar D. The prevalence of female sexual dysfunction and potential risk factors that may impair sexual function in Turkish women. Urol Int. 2004;72:52-7.
8. Oksuz E, Malhan S. Prevalence and risk factors for female sexual dysfunction in Turkish women. J Urol. 2006;175: 654-8.
9. Leite AP, Campos AA, Dias AR, Amed AM, De Souza E, Camano L. Prevalence of sexual dysfunction during pregnancy. Revist Assoc Méd Brasil. 2009;55:563-8.
10. Eryilmaz G, Ege E, Zincir H. Factors affecting sexual life during pregnancy in eastern Turkey. Gynecol Obstet Invest. 2004;57:103-8.
11. Ogunbode OO, Aimakhu CO, Ogunbode AM, Adebusoye LA, Owonikoko KM. Sexual dysfunction among women in a Nigerian gynecological outpatients unit. Trop J Obstet Gynaecol. 2019;36(1):61-6.
12. Abdullahi HM, Abdurrahman A, Ahmed ZD, Tukur J. Female sexual dysfunction among women attending the family planning clinic at Aminu Kano Teaching Hospital: a cross-sectional survey. Niger J Basic Clin Sci. 2019;16:32-7.
13. Alimohammadi L, Zarei F, Mirghafourvand M. Factors associated with sexual dysfunction in newly married women referred to the urban health centres of Zanjan, Iran: a cross-sectional study. Int J Women's Health Reprod Sci. 2018;6(4):477-82.
14. Ekele BA. Sexual dysfunction. In: Kwawukume Emuveyan EE, eds. Comprehensive Obstetrics in the Tropics. 1st edn. Dansoman, Accra: Asante and Hitcher Printing Press Limited; 2002:182-186.
15. Aisuodionoe-Shadrach OI. Perceptions of female sexual health and sexual dysfunction in a cohort of urban professional women in Abuja, Nigeria. Niger J Clin Pract. 2012;15:80-3.
16. Jaafarpour M, Khani A, Khajavikhan J, Suhrabi Z. Female sexual dysfunction: prevalence and risk factors. J Clin Diagn Res. 2013;7:2877-80.
17. Berman JR. Physiology of female sexual function and dysfunction. Int J Impot Res. 2005;17(1):S44-51.
18. Nwagha UI, Oguanuo TC, Ekwuazi K, Olubobokun TO, Nwagha TU, Onyebuchi AK, et al. Prevalence of sexual dysfunction among females in a university community in Enugu, Nigeria. Niger J Clin Pract. 2014;17(6):791-6.
19. Amidu N, Owiredu WK, Woode E, Addai-Mensah O, Quaye L, Alhassan A, et al. Incidence of sexual dysfunction: A prospective survey in Ghanaian females. Reprod Biol Endocrinol. 2010;8:106.
20. Derogatis LR, Burnett AL. The epidemiology of sexual dysfunctions. J Sex Med. 2008;5:289-300.
21. Faruk K, Erkan E, Onder M, Eyup K, Akin SA, Sefa R. Prevalence and correlates of female sexual dysfunction among Turkish pregnant women. Turk J Urol. 2016;42(3):178-83.
22. Guendler JA, Katz L, Flamini MEDM, Lemos A, Amorim MM. Prevalence of sexual dysfunctions and their associated factors in pregnant women in an outpatient prenatal care clinic. Rev Bras Ginecol Obstet. 2019;41(9):555-63.
23. Adefisan AS, Awoleke JO, Olofinbiyi BA, Aduloju OP, Okunola TO, Adefisan OO, et al. Sexual dysfunction and related factors during pregnancy at a tertiary health facility in Southwestern Nigeria. J Adv Med Med Res. 2021;33(4):49-58.
24. Laganà AS, La Rosa VL, Rapisarda AM, Valenti G, Sapia F, Chiofalo B, et al. Anxiety and depression in patients with endometriosis: impact and management challenges. Int J Women's Health. 2017:323-30.
25. Fiala L, Lenz J, Adamik Z, Sajdlova R, Kestlerova D, Vetvicka V. Psychological hallmarks of endometriosis with emphasis on sexual dysfunction, stress, anxiety and depressive symptoms. Int Clin Pathol J. 2023;10(1):45-8.
26. Mostafa RM, Abd Elfatah RE, Khalil OK, Saad H. M. Sexual function and related endocrinological and psychological aspects in pregnancy: A controlled study. Suez Canal Univ Med J. 2021;24(2):144-54.

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