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Patterns of Female Sexual Dysfunctions Among Married Women in Ilorin, Nigeria: Implications for Health Workers

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Abstract

Sexual dysfunction is a defect in a person's sexuality, and this has become a major issue faced by married women in this contemporary age. It has greatly disrupted the serene atmosphere of many marriages as well as a married woman's quality of life and has led to many divorces. The purpose of this study was to determine the patterns of female sexual dysfunction as expressed by married women in Ilorin, Nigeria. Variables such as age, level of education, and religion were also examined. The study adopted a descriptive survey method. An adapted instrument entitled Patterns of Women Sexual Dysfunction Questionnaire (POWSDQ) was used to gather data for the study. A total of 210 married women participated in the study and the respondents were drawn through the use of simple random sampling technique. The demographic data was analysed using percentage while the null hypotheses were tested with Pearson's Product Moment Correlation (PPMC), t-test and ANOVA at 0.05 alpha level. Findings from the study revealed that the patterns of sexual dysfunction among married women in Ilorin, Nigeria were sexual arousal disorder, sexual orgasmic disorder, and sexual pain disorder. Age influenced women's views of patterns of sexual dysfunction however, level of education and religion did not. It was recommended that health counsellors and other health practitioners should help women to know both the patterns of sexual dysfunction and its impact on their health, emotions, and their marriage. Health counsellors should endeavour to educate women about sexual dysfunction and how it can be managed.

Keywords: Sexual dysfunction, Women, Patterns, Marriage, Sexual Health, Mental Health, Heath Workers, Ilorin, Nigeria

Introduction and Background

Sexuality is an essential human instinct that is inherent in every individual's life. It plays a primary role in reproduction process and guarantees human survival. An individual's sexuality is the product of the developments and changes engendered by puberty, social norms and expectation. Human sexuality is viewed as human accumulation of information, development of attitude and behavior and formation of beliefs towards sex. Sexuality refers to the expression of love feelings between a male and female. It is a key factor which allows for satisfying physical experience following increased oxytocin and endorphin (Sexuality Information and Education Council of the United States, 2015).

Sexual functioning is a critical part of quality life in humans which shows that they are biologically and emotionally healthy (Graziottin et al., 2011; Ojanlatva et al., 2010). It is the constellation of mental aspects of sexuality that involves sexual desires, sexual arousal and sexual fantasies. However, impairment to a woman's sexual function is referred to as a female sexual dysfunction (FSD). Female sexual dysfunction is the impairment in the supposed body during the phases of sexual activities (Nwagha et al., 2006). It is a challenge that develops during sexual response phase which inhibits or impair a woman's ability to partake in or be satisfied with sexual intercourse (Chen et al., 2013; Marthol et al., 2014).

Sexual dysfunction is categorized into two types: (i) primary sexual dysfunction which implies that the individual has never achieved appropriate sexual response (ii) secondary sexual dysfunction occurs when a person at a time experienced appropriate sexual responses but subsequently experiences poor sexual functioning (Oshodi et al., 2010). Adequate sexuality is a major part of wellness in women, considering the fact that women's sexual dysfunction is complex; it includes not having the desire, getting aroused and reaching orgasm (Carreiro et al., 2016, Pizzarossa et al., 2017). According to Arts (2014), sexual dysfunction affects millions of women globally and it is characterized by women's

inability to have appropriate desire for sex, not able to get sexually aroused, inability to reach orgasm as well as experiencing pains during sexual intercourse.

There is a link between physical challenges, psychological difficulties and sexual dysfunction. Part of the physical challenges leading to sexual dysfunction in female include drug/ substance abuse, diabetes mellitus, renal failure, kidney issues, heart diseases, hormonal balance and menopausal problems as well as side effects of some medications (Association of Reproductive Health Professionals {ARHP}, 2015). Furthermore, psychological challenges leading to sexual dysfunctions in females could be stress from work or family, mental disorders such as anxiety and depression or Post Traumatic Stress Disorder (ARHP, 2015). The patterns of sexual dysfunctions in women could present as critical sexual disorder symptoms which covers desire (need for sexual activities); arousal (bodily response to and readiness for sexual activities) orgasm (which is the peak of sexual satisfaction). According to World Health Organization (2014), in addition to desire, arousal and orgasm, the list of sexual dysfunction includes pain during sexual activities.

More often than not, men are baffled that sex which seems very pleasurable to them is not enjoyable to their wives. This is explained by the fact that married women who have sexual dysfunction express lack of interest in sex. Men will be concerned about what is wrong with their wives and often think that they married a frigid woman or someone who does not have feelings for them at all. This creates confusion in men due to ignorance about women's sexuality (Yahaya et al., 2015). Therefore, this study examined the patterns of sexual dysfunctions in women as expressed by married women in Ilorin metropolis.

Sexual dysfunction is a major concern among married women. It has modified the attitudes of many married women towards their partners in marriage in a negative way. Most husbands felt dissatisfied with their wives being unable to please them sexually. Consequentially, this has affected climate and quality of marriage. So, it appeared that a

woman who has lost the desire to have sex with her husband must have pushed her husband to promiscuity and infidelity thereby, resulting into distrust and instability in marriage. Therefore, sexual dysfunction in women has contributed to numerous divorce cases, spousal conflicts and infidelity in men. It is worrisome that these problems among couples have not been addressed and FSD continues to affect marriages nonstop.

Few scholars have researched on the sexual dysfunction in women as expressed by married women. For instance, Salonia (2014) found that women aged above 60 years had some form of sexual dysfunction and suggested that a critical review of the problem needed medical and therapeutic attention. Also, McCool (2016) made a systematic review and meta-analysis of sexual dysfunction of women and concluded that most women having sexual dysfunction have suffered or are witnessing either unstable homes or have been divorced. This justified the fact that women who have negative attitude to sexual activities are prone to having broken homes. Furthermore, Fajewonyonmi (2007) carried out research on sexual dysfunction among female patients of reproductive age in a hospital setting in Nigeria and found out that most women who experience pain during sex, preferred not to share their challenges with their partners or seek medical attention. Apparently, lots of women do not perceive such pain as a dysfunction but as a circumstance tied to stress and other environmental conditions. Similarly, Abdullahi et al (2013) revealed that a high population of women having sexual dysfunction use sexual stimulants in compensation for their inability to get aroused. Also, studies conducted by Nwagha et al. (2014), Olakunle (2003), Oniye (2005) revealed that sexual dysfunction was highly prevalent and that arousal and vaginismus were the common types of sexual dysfunction occurring in Nigeria. As a follow-up to the above research, this study examined the patterns of sexual dysfunctions among married women in Ilorin, Nigeria. The findings of this study will be of immense benefit to married women, health counsellors, health educators, other health workers and researchers. Thus, the study also provided answers to the following research

question: what are the patterns of female sexual dysfunction among married women in Ilorin, Nigeria? The study also tested the hypotheses that age will not significantly influence the expression of married women on the patterns of female sexual dysfunction in women; level of education will not significantly influence the expression of married women on the patterns of female sexual dysfunction in women and religion will not significantly influence the expression of married women on the patterns of female sexual dysfunction in women.

Methodology

In this study, the descriptive research design was adopted to give a clearer picture of the patterns of female sexual dysfunction. The total population for this study comprised all married women residing in the three Local Government Areas (LGAs) of Ilorin Metropolis, Ilorin, namely: Ilorin West, Ilorin East, and Ilorin South. While the exact number of married women across the three LGAs is not static, they represent a significant and diverse population across numerous communities in the metropolis. The target population consisted of married women in selected communities within the three LGAs who were accessible and willing to participate in the study. To obtain a representative sample, a multistage sampling technique was employed as follows: stage One – Selection of Local Government Areas: All the three Local Government Areas (Ilorin West, Ilorin East, and Ilorin South) were purposely included in the study. Stage Two – Selection of Communities: Using a simple random sampling technique, two (2) communities were selected from each LGA, making a total of six (6) communities. Stage Three – Selection of Respondents: In each of the six selected communities, thirty-five (35) married women were selected using the simple random sampling technique, resulting in a total sample size of 210 respondents (6 communities × 35 married women = 210). This sampling method ensured that the selected participants were fairly distributed across the three LGAs, thereby increasing the generalizability and reliability of the findings within Ilorin Metropolis.

The instrument for this study was an adapted questionnaire titled Patterns of Women Sexual Dysfunction Questionnaire (POWSDQ). The psychometric properties of the instrument have been tested and proven to have demonstrated excellent internal consistency when administered within 2–4 week using test-retest or analysis of stability for each sub-scale (McCrae–et al., 2011). Discriminant validity was significant for all sub-scales, as well as the summary score. It has been validated both in healthy women and women with chronic medical conditions. This instrument was developed to measure sexual dysfunctions in women and their sexual activeness over the prior 4 weeks. Also, the use of the questionnaire was informed and guided by the study research objectives and research questions. Furthermore, for this study, the adapted questionnaire was divided into two sections: Section A elicited information on the biographical data of the respondents while in section B, the respondents were asked to indicate their experiences on the patterns of sexual dysfunction based on sexual arousal, sexual interest and vaginal pain. The overall items for the questionnaire were fifteen.

To ascertain the validity of the instrument for this study, the drafted questionnaire was presented to three experts in the Departments of Health Promotion and Guidance and Counselling for scrutiny and approval. Their corrections, suggestions and constructive criticisms were effected and the final questionnaire was adjusted to be valid enough for this study. To ascertain the reliability of the instrument used in this study, the test re-test method was adopted. The questionnaire was administered twice on the respondents at interval of four weeks. The two set of scores were subjected to the Pearson's Moment Correlation and the result yielded a coefficient of 0.86 which was considered adequate for a study of this nature. The instrument was scored using the four-point Likert type rating scale of Strongly Agree (4 point), Agree (2 point), Disagree (3 point), and Strongly Agree (1 point). The mean score of 2.5 and above was used to ascertain the items that depict the

patterns of sexual dysfunction. An aggregate mean score was also used to determine the patterns of sexual dysfunction among the participants.

The researchers personally administered the questionnaire to the married women in all the sampled communities for the study in Ilorin metropolis. The purpose of the study was explained to the respondents for proper understanding. The administration was carried out in a period of two weeks before the data from the questionnaire was correlated and analyzed. In line with the National Statement on Ethical Conduct in Human Research (2007), the researchers sought the consent of the participants and ensured confidentiality of the responses given; the participants were asked not to write their names. The participants were also treated with utmost respect. IBM SPSS software was used to analyse the data. Percentages were used to analyse the demographic data to answer research questions raised. The t-test and Analysis of Variance (ANOVA) were used for testing the hypotheses at the 0.05 level of significance. Questionnaires were administered to 210 sampled women however, only 201 copies of completely filled questionnaire were used for analysis of the data. The demographic data of the respondents entails the distribution of respondents by the moderating variables such as age, level of education and number of children.

Results

Biographic Information

This section presents the results of data obtained from the respondents in percentages. The analysis of the respondents based on their age shows that 50 (24.9%) were within the age range of 18-27 years, 91 (45.3%) who were the majority were within the age range of 28-37 years while 60 (29.8%) were within the age of 38 years and above. The respondents' level of education was analyzed, and it showed that majority of the respondents 101 (50.2%) had tertiary education while 70 (34.8%) had either primary or secondary school

certificate. Only 30 (15.0%) did not have any formal education. Based on the respondents' religion, 12 (5.9%) of the respondents were African Traditional worshipers, 92 (45.8%) Christians while 97 (48.3%) were Muslims.

Answering of Research Question

Research Question: What are the patterns of female sexual Dysfunction in women as expressed by married women in Ilorin metropolis?

Table 1: Mean Scores, Standard Deviation and Rank Order on the Patterns of Female Sexual Dysfunction in Women that are Related to Sexual Arousal Disorder

SN	Statement	Mean	SD	Rank
2	Not having sexual or erotic thoughts or fantasies.	2.83	.987	1st
1	Not having interest in sexual activity	2.80	.932	2nd
4	Not feeling any arousal for sex at all	2.74	.913	3rd
3	Not reciprocating to my partner's attempt to initiate sex	2.73	.927	4th
5	Being afraid of becoming sexually aroused	1.96	.943	5th

Aggregate mean score: 2.61.

According to Table 1, item 2 (Not having sexual or erotic thoughts or fantasies) was ranked 1st with M=2.83 and SD=.987, while item 1 (Not having interest in sexual activity) ranked 2nd with M= 2.80 and SD=.932. Further, item 4 (Not feeling any arousal for sex at all) ranked 3rd with M=2.74 and SD=.913 and the least on the ranking was item 5 (Being afraid of becoming sexually aroused), which ranked 5th with M=1.96 and SD=.943. The aggregate average mean was 2.61.

Table 2: Mean Scores, Standard Deviation and Rank Order on the Patterns of Female Sexual Dysfunction in Women that are Related to Sexual Orgasmic Disorder

SN	Statement	Mean	SD	Rank
3	Not interested in discussing about reaching orgasm	2.95	.964	1st
4	Inability to maintain wetness till the completion of sexual activity	2.89	.942	2nd
2	Dryness in the sexual organ before or during sexual activity	2.85	.943	3rd
5	Feeling of pain in the womb or abdomen after reaching orgasm	2.80	.899	4th
1	Not reaching orgasm during sexual activity	2.74	.941	5th

Aggregate mean score: 2.83.

Table 2 showed that item 3 (Not interested in discussing about reaching orgasm) ranked 1st with M=.2.95 and SD=.964. Item 4 (Inability to maintain wetness till the completion of sexual activity) ranked 2nd with M=2.89 and SD=.942 while item 5 (Feeling of pain in the womb or abdomen after reaching orgasm) ranked 4th with M=2.80 and SD=.899. The aggregate average mean was 2.83.

Table 3: *Mean Scores, Standard Deviation and Rank Order on the Patterns of Female Sexual Dysfunction in Women that are Related to Sexual Pain Disorder*

SN	Statement	Mean	SD	Rank
5	Feeling of pain in the clitoris when touched during sexual activity.	2.87	1.031	1st
2	Feeling the tightening or tensing of the sexual organ during sexual activity	2.77	.918	2nd
4	Feeling of pain when urinating few days after having sexual intercourse.	2.69	.911	3rd
1	Feeling of pain in the pelvic during or after sexual activity	2.67	.845	4th
3	Feeling the tightening or tensing of the sexual organ during sexual activity	2.61	.825	5th

Aggregate mean score: 2.72.

According to table 3, item 5 (Feeling of pain in the clitoris when touched during sexual activity) ranked 1st with M=2.87 and SD=1.031, while item 2 (Feeling the tightening or tensing of the sexual organ during sexual activity) ranked 2nd with M=2.77 and SD=.918. Additionally, item 4 (Feeling of pain when urinating few days after having sexual intercourse) ranked 3rd with M=2.69 and SD=.911 whereas item 3 (Feeling the tightening or tensing of the sexual organ during sexual activity) ranked 5th with M=2.61 and SD=.825. The aggregate average mean was 2.72.

Testing of Research Hypotheses

In this study, the null hypotheses were tested with t-test and ANOVA at 0.05 significance level. The results are presented thus;

Hypothesis One:

Age will not significantly influence the expression of married women on the patterns of female sexual dysfunction in women.

Table 4: Analysis of Variance on the View of Respondents on Sexual Dysfunction Based on Age.

Source	SS	Df	MS	Calc. F-ratio	Crit. F-ratio	p-value
Between Group	625.97	2	312.89	12.50*	3.00	.000
Within Group	4937.54	198	24.93			
Total	5563.34	200				

Table 4 shows that married women of different ages in Ilorin Metropolis presented with diverse views on sexual dysfunctions. This was supported by the calculated F-ratio of 12.50 which is greater than the critical F-ratio of 3.00 (p-value .000 < 0.05 level of significance). Therefore, the null hypothesis, which stated that there would be no significant difference in the view of respondents on sexual dysfunction based on age was rejected. However,

Duncan Multiple Range Test (DMRT) was carried out as a post-hoc test to determine the magnitude of difference of respondents view on sexual dysfunctions.

Table 5: Duncan Multiple Range Test on the View of Respondents on Sexual Dysfunction Based on Age.

Age	N	Group	Mean	Duncan's Grouping
18-27	50	1	31.88	A
28-37	91	2	31.59	A
38 and Above	60	3	36.55	B

Table 5 shows that groups 1 and 2 with mean scores of 31.88 and 31.59 respectively, differed from group 3 with the mean score of 36.55. Therefore, the age range between 38 years and above was responsible for the difference noted in the ANOVA in table 4.

Hypothesis Two:

Level of education will not significantly influence the expression of married women on the patterns of female sexual dysfunction in women.

Table 6: Analysis of Variance Table on the View of Respondents on Sexual Dysfunction Based on Level of Education.

Source	SS	Df	MS	Calc. F-ratio	Crit. F-ratio	p-value
Between Group	11.39	2	5.6	0.20	3.00	0.93
Within Group	5551.95	198	28.0			
Total	5563.34	200				

Table 6 shows the calculated F-ratio of .20 which is less than the critical F-ratio of 3.00 (p-value .20 > 0.05 level of significance). Therefore, the null hypothesis which states that the significant difference in the patterns of sexual dysfunction expressed by married women in Ilorin metropolis on the basis of level of education is accepted. This means that regardless of the level of education, married women had the same view of sexual dysfunction.

Hypothesis Three:

Religion will not significantly influence the expression of married women on the patterns of female sexual dysfunction in women.

Table 7: Analysis of Variance Table on the View of Respondents on Sexual Dysfunction Based on Religion

Age	SS	df	MS	Cal. F-ratio	Crit. F-ratio	Decision
Between group	109.23	3	36.41	1.31	2.60	Accepted
Within group	5454.11	197	27.68			
Total	5563.34	200				

*Significant, $p<0.05$

Table 7 shows that the calculated F-ratio was 1.31 while critical F-ratio was 2.60. Since the calculated F-ratio was less than the critical F-ratio at 0.05 alpha level, the hypothesis was rejected. This means that there was a significant difference in the view of Respondents on Sexual Dysfunction based on religion therefore, the hypothesis is rejected.

Discussion

The patterns of female sexual dysfunction as expressed by married women in Ilorin Metropolis were: Sexual Arousal Disorder; Sexual Orgasmic Disorder and Sexual Pain Disorder. The finding of the study showed that many women do not often have sexual or erotic thoughts or fantasies; have less interest in sexual activity; some may not feel any arousal for sex at all, may not reciprocate to their partner's attempt to initiate sex, while some are afraid of becoming sexually aroused. Similarly, the finding showed that women were not interested in discussing about reaching orgasm; have inability to maintain wetness till the completion of sexual activity; experience dryness in the sexual organ before or during sexual activity; feel pain in the womb or abdomen after reaching orgasm and not reaching orgasm during sexual activity. Furthermore, during sex, women have feelings of pain in the clitoris when touched during sexual activity; experience tightening or tensing of the sexual organ; have feelings of pain when urinating even few days after having sexual

intercourse; experience pain in the pelvic during or after sexual activity and feeling the tightening or tensing of the sexual organ during sexual activity. This finding is consistent with the study by Grover et al (2012), which reported that 95% of participants experienced decreased sexual desire, 60% had reduced arousal, 37.5% reported decreased lubrication, 63.8% experienced low orgasmic response, 55% had decreased satisfaction, and 25% reported pain during sexual activity. Similarly, the finding of this study supports the study of Thatikonda et al. (2022) which revealed that difficulties in different domains of sexual functioning are prevalent among women with non-psychotic disorders. This finding could be that as women age, they become less interested in sex partly due to physiological make up, physical or emotional stress or certain underlying ailments.

The findings of this study revealed a significant variation in the patterns of sexual dysfunction among married women in Ilorin Metropolis, based on their age. This showed that age influenced the expression of women on the pattern of sexual dysfunction. It also means that married women of different ages have differing opinions on the patterns of sexual dysfunctions. This finding corroborates that of Ziaei-Rad et al (2010) who stated that women of higher age groups experienced elevated rates of sexual dysfunction. Similarly, the finding tallies with that of Thatikonda et al (2022) which revealed that sexual dysfunction in women is associated with increase in age. However, the finding of this study negates that of Clevland (2023) that sexual dysfunction in women can be present at any age. This could mean that the patterns of sexual dysfunction manifest more in older women as compared to younger women who have less responsibilities, are still agile and have less underlying health issues.

The finding of this study however showed no significant difference in the patterns of sexual dysfunction in women as expressed by married women in Ilorin Metropolis based on level of education. This implies that, married women of different level of education do not have

different views on the patterns of sexual dysfunctions. This finding negates Adegunloye et al (2010) who stated that women of higher educational level often develop lubrication and pain penetration disorder. This finding also negates Oniye (2005) who found out literate married women in Ilorin metropolis manifest several features of sexual dysfunction. Similarly, the finding does not support that of Thatikonda et al (2022) which revealed that sexual dysfunction manifests more in women with lower educational qualification. The finding of this study could be that all the respondents, despite not being the same in terms of educational level, have the same biological and social roles thus, their expressions over female sexual dysfunction may not differ.

The finding of this study also showed no significant difference in the patterns of sexual dysfunction in women as expressed by married women in Ilorin Metropolis based on religion. The result showed that respondents who practice Islam, Christianity and African Traditional religion viewed the patterns of sexual dysfunction in the same manner. This finding does not support the finding of Bello et al (2011) who stated that religion and advancing age were independently identified to be associated with a desire problem. Absence of foreplay was independently associated with an arousal problem. Similarly, this finding is not in line with that of Ojomu et al (2007) whose findings showed that religion have significant impact on sexual desire problem. This line of finding could be that the pattern of sexual dysfunction is a biological function of an individual and not a function on one's religious belief, thus, this could explain why the respondents of this study were similar in their expressions.

Conclusion

Based on the findings of the study, it was therefore concluded that the patterns of sexual dysfunction among married women are sexual arousal disorder, sexual orgasmic disorder

and sexual pain disorder. Age influenced women's views of patterns of sexual dysfunction however, level of education and religion did not.

Based on the findings of the study, the following recommendations were made;

a. Health counsellors and other health practitioners should educate women on the patterns of sexual dysfunction and its impact on their health, emotions, and marital relationships.
b. Health counsellors should collaborate with other health professionals to provide both medical treatments and therapeutic interventions for women experiencing sexual dysfunction.
c. Married women should be encouraged to seek counselling sessions promptly when they begin to experience symptoms of sexual dysfunction. Early intervention can help reduce distrust and promote marital stability.
d. Husbands should also strive to be understanding and supportive when their wives experience sexual dysfunction. Couples are encouraged to seek medical and counselling assistance together, as this joint effort fosters mutual support and helps them work collaboratively to overcome sexual dysfunction and enhance their sexual relationship.

Implications of the Findings for Health Workers

Health workers should help women particularly those who are older in order to decrease the rate at which married women experience sexual dysfunction. This initiative could be implemented by sensitizing all women on the patterns of sexual dysfunction. Health counsellors and health educators and other health personnel should provide support to women by organizing female-based education programmes, workshops, seminars, and symposium for awareness creation on patterns of sexual dysfunction and the well-being of

females. Knowledge acquired through these forums will help to promote prevention of sexual dysfunction.

References

Abdullahi, H., & Tukur, J. (2013). Sexual stimulants and their effects on women of reproductive age group in Kano, Northern Nigeria. *Nigerian Journal of Basic and Clinical Sciences*, *10*, 13–16.

Adegunloye, O. A., Makanjuola, A. B., & Adelekan, M. L. (2010). Sexual dysfunction among secondary school teachers in Ilorin, Nigeria. *Journal of Sexual Medicine*, *1*(7), 3835–3844.

Association of Reproductive Health Professionals (ARHP). (2015). *Size up your sex life*. Retrieved from https://www.arhp.org

Bello, K. S. (2017). *Patterns and determinants of sexual dysfunction among adults with type 2 diabetes attending the general outpatient clinic of Ahmadu Bello University Teaching Hospital, Zaria, Nigeria* (Master's thesis). Ahmadu Bello University, Zaria.

Carreiro, A. V., Micelli, L. P., Sousa, M. H., Bahamondes, L., & Fernandes, A. (2016). Sexual dysfunction risk and quality of life among women with a history of sexual abuse. *International Journal of Gynecology & Obstetrics*, *134*, 260–263.

Chen, C. H., Lin, Y. C., Chiu, L. H., Chu, Y. H., Ruan, F. F., & Liu, W. M. (2013). Female sexual dysfunction: Definition, classification, and debates. *Taiwanese Journal of Obstetrics & Gynecology*, *52*, 3–7.

Dennerstein, L., Guthrie, J. R., Hayes, R. D., DeRogatis, L. R., & Lehert, P. (2008). Sexual function, dysfunction, and sexual distress in a prospective, population-based sample of mid-aged Australian-born women. *Journal of Sexual Medicine*, *5*, 2291–2299.

Fajewonyomi, B. A., Orji, E. O., & Adeyemo, A. O. (2007). Sexual dysfunction among female patients of reproductive age in a hospital setting in Nigeria. *Journal of Health, Population, and Nutrition*, *25*(1), 101–106.

Graziottin, A., & Leiblum, S. R. (2011). Biological and psychosocial pathophysiology of female sexual dysfunction during the menopausal transition. *Journal of Sexual Medicine*, *2*(Suppl 3), 133–145.

Grover, S., Shah, R., Dutt, A., & Avasthi, A. (2012). Prevalence and pattern of sexual dysfunction in married females receiving antidepressants: An exploratory study. *Journal of Pharmacology & Pharmacotherapeutics*, *3*(3), 259–265. https://doi.org/10.4103/0976-500X.99430

McCool, M. E., Zuelke, A., Theurich, M. A., Knuettel, H., Ricci, C., & Apfelbacher, C. (2016). Prevalence of female sexual dysfunction among premenopausal women: A systematic review and meta-analysis of observational studies. *Sexual Medicine Reviews, 4*, 197–212.

McCrae, R. R., Kurtz, J. E., Yamagata, S., & Terracciano, A. (2011). Internal consistency, retest reliability, and their implications for personality scale validity. *Personality and social psychology review: an official journal of the Society for Personality and Social Psychology, Inc, 15*(1), 28–50. https://doi.org/10.1177/1088868310366253.

National Health and Medical Research Council (NHMRC). (2007). *National statement on ethical conduct in human research* (updated 2018). Retrieved from https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018

Nwagha, U. I., Oguanuo, T. C., Ekwuazi, K., Olubobokun, T. O., Nwagha, T. U., & Onyebuchi, A. K. (2014). Prevalence of sexual dysfunction among females in a university community in Enugu, Nigeria. *Nigerian Journal of Clinical Practice, 17*, 791–796.

Ojanlatva, A., Mäkinen, J., Helenius, H., Korkeila, K., Sundell, J., & Rautava, P. (2010). Sexual activity and perceived health among Finnish middle-aged women. *Health and Quality of Life Outcomes, 4*, 29.

Ojomu, F., Thacher, T., & Obadofin, M. (2007). Sexual problems among married Nigerian women. *International Journal of Impotence Research, 19*, 310–316.

Olakunle, O. T. (2003). *Prevalence and patterns of female sexual dysfunction experienced by literate married women: A case study of Ifelodun Local Government Area of Ilorin* (Unpublished B.Ed. thesis). University of Ilorin, Ilorin, Nigeria.

Oniye, A. O. (2005). Manifestation of sexual dysfunction by literate married women: Implication for marital counselling. *Health and Fitness Journal International*, *4*(1&2). Retrieved from https://www.unilorin.edu.ng

Oniye, A. O. (2015). Sex and marriage. In L. A. Yahaya, M. O. Esere, J. O. Ogunsanmi, & A. O. Oniye (Eds.), *Marriage, sex and family counselling* (pp. xx–xx). Ilorin: Unilorin Press.

Oshodi, O. Y., Adeyemi, J. D., Oke, D. A., & Seedat, S. (2010). Sexual dysfunction among subjects with hypertension in a Nigerian teaching hospital. *Nigerian Quarterly Journal of Hospital Medicine*, *20*, 197–204.

Pizzarossa, L. B., & Perehudoff, K. (2017). Global survey of national constitutions. *Health and Human Rights*, *19*, 279–293.

Salonia, A., Munarriz, R. M., Naspro, R., Nappi, R. E., Briganti, A., & Chionna, R. (2014). Women's sexual dysfunction: A pathophysiological review. *BJU International*, *93*, 1156–1164.

Sexuality Information and Education Council of the United States (SIECUS). (2014). *Position statements on human sexuality*. Retrieved from http://siecus.org/index.cfm

Sexuality Information and Education Council of the United States (SIECUS). (2015). *Sex education state legislative year-end report: Top topics and takeaways*. Retrieved from http://www.siecus.org

Thatikonda, N. S., Ram, D., Rao, T. S. S., & Thatikonda, P. S. (2022). Sexual dysfunction in women with nonpsychotic disorders: A cross-sectional hospital-based study. *Indian Journal of Psychological Medicine*, *44*(5), 445–451. https://doi.org/10.1177/02537176211057399

United Nations Development Programme (UNDP). (2013). *Gender inequality index*. Retrieved from https://hdr.undp.org

World Health Organization (WHO). (2002). *Gender and human rights*. Retrieved August 5, 2014, from https://www.who.int

World Health Organization (WHO). (2014). *International classification of diseases (ICD)*. Retrieved November 12, 2014, from http://www.who.int/classifications/icd/en/

Yahaya, L. A., Esere, M. O., Ogunsanmi, J. O., & Oniye, A. O. (2015). *Marriage and family life counselling* (2nd ed.). Ilorin: Unilorin Press.

Ziaei-Rad, M., Vahdaninia, M., & Montazeri, A. (2010). Sexual dysfunctions in patients with diabetes: A study from Iran. *Reproductive Biology and Endocrinology*, *8*, 50.