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FACTORS ASSOCIATED WITH SEXUAL DISSATISFACTION AMONG COUPLES IN KINSHASA, DEMOCRATIC REPUBLIC OF THE CONGO

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Abstract:
Background: Sexual satisfaction is a key component of individual well-being and harmony in a couple. However, sexual dissatisfaction remains underexplored in sub-Saharan Africa, particularly in the Democratic Republic of Congo. This study aimed to identify factors associated with sexual dissatisfaction among couples in Kinshasa. **Methods:** A community-based cross-sectional study was conducted over a 15-day period in six randomly selected neighborhoods of Kinshasa. Adults aged 18–64 years living in marital or cohabiting relationships were included using a two-stage probabilistic sampling method. Sexual satisfaction was assessed using the Index of Sexual Satisfaction (ISS). Independent variables included sociodemographic, medical, psychological, relational, sociocultural, and aesthetic factors. Data were collected through face-to-face interviews using a structured questionnaire. Multivariable logistic regression analysis was performed to identify independent factors associated with sexual dissatisfaction. Adjusted odds ratios (aORs) with 95% confidence intervals were reported. **Results:** A total of 454 participants were included, of whom 56.6% were women. The median age was 34 years (IQR: 28–43). The prevalence of sexual dissatisfaction was 20%. In multivariable analysis, factors significantly associated with sexual dissatisfaction included poor sexual communication (aOR = 14.31; p < 0.001), moderate communication

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(aOR = 15.78; p < 0.001), high stress levels (aOR = 2.78; p = 0.002), infidelity (aOR = 2.01; p = 0.032), and sexual conflicts (aOR = 5.28; p < 0.001). Among women, key determinants included sociocultural stigma, shame associated with sexuality (aOR= 4.41; p=0.035), negative beliefs about contraception (aOR=3.99: p=0.041) and vulvar aesthetic concerns (aOR = 14.85), while the fact that women could speak out about sexual desire was protective (aOR = 0.13). Concerning male-related factors, premature ejaculation (aOR = 3.48; p = 0.028) and interest in genital cosmetic surgery (aOR = 4.56; p = 0.005) were significantly associated with dissatisfaction in couples. **Conclusion:** Sexual satisfaction among couples in Kinshasa is strongly influenced not only by relational and psychosocial factors but also by genital aesthetic concerns, particularly among women. These findings highlight the need to integrate vulvar body image, sociocultural norm deconstruction, and sexual education into comprehensive care.

Keywords: sexual dissatisfaction, couple relationships, genital aesthetics, cosmeto-gynecology, Democratic Republic of Congo

1. Introduction

Sexual satisfaction constitutes a key component of individual well-being and marital harmony (1, 2). It is defined as an emotional response arising from the subjective evaluation of one's sexual life (4, 5), integrating past experiences, current expectations, and future aspirations (3). As a central dimension of sexual health and quality of life (6, 7), it contributes to psychological and relational balance. Conversely, its impairment is associated with marital conflicts, psychological distress, and reduced overall well-being (8, 9).

The determinants of sexual satisfaction are multidimensional and differ by sex. In women, dissatisfaction is frequently influenced by restrictive sociocultural norms, limited knowledge of one's body, and persistent taboos, whereas in men, body image and performance anxiety play a major role (10, 11). Clinical assessment relies on validated instruments, and management involves complementary approaches, including intra-couple communication, psychosexual interventions, sexual education, and, when necessary, medical or surgical treatments (12–16).

Globally, sexual dissatisfaction is common, affecting an estimated 15% to 50% of women (17). Although often underreported, it is associated with significant consequences, including marital conflict and impaired psychological well-being, and may also increase the risk of sexually transmitted infections, particularly in contexts of intimate partner violence characterized by coercion and reduced ability to negotiate safe sex (17). In Europe, a recent survey reported that 35% of women in France consider themselves dissatisfied with their sexual life, a rate higher than that observed in several neighboring countries (19). In the United States, sexual health disorders, including sexual

dissatisfaction, are a major factor affecting intimate life among older women, although only 22% seek professional care (18).

The literature identifies a range of factors associated with sexual dissatisfaction, including anatomical, medical, psychological, relational, and sociocultural dimensions (28). Certain targeted therapeutic interventions can improve sexual function. For example, colporrhaphy improves desire, orgasm, and sexual satisfaction in women with genital prolapse, highlighting the benefit of correcting anatomical abnormalities in selected cases (29). These findings support integrated approaches combining education, psychosexual management, and tailored medical interventions.

In Sub-Saharan Africa, reported sexual satisfaction rates range from 34% to 45.8% (22–24), reflecting a substantial burden in contexts where cultural and religious norms often restrict the expression of sexual difficulties and access to care. In the Democratic Republic of Congo, data remain limited. A study conducted in Goma, a city in the North East of the country, highlighted an association between sexual dissatisfaction, marital conflicts, and psychological distress (25). In Kinshasa, despite high sociocultural diversity and rapid urbanization that may influence marital dynamics, scientific evidence remains scarce (25).

The lack of context-specific data in Kinshasa remains a barrier to implementing strategies adapted to local realities. In this context, the present study aims to identify factors associated with sexual dissatisfaction among married couples in Kinshasa. A better understanding of these determinants will inform prevention strategies, enhance clinical management, and support context-appropriate interventions.

2. Methods

2.1 Study design and setting

A community-based cross-sectional study was conducted in Kinshasa, the capital city of the Democratic Republic of Congo, a large metropolitan area with over 15 million inhabitants and considerable sociocultural diversity.

Data collection was carried out over a 15-day period in six randomly selected neighborhoods from different communes: Mbala (Selembao), Kimwenza (Mont-Ngafula), Musey (Ngaliema), Baobab (Ngaba), Lokole (Lingwala), and Mabinda (Kimbanseke).

2.2 Study population and selection

The study population consisted of individuals in married or cohabiting relationships residing in Kinshasa.

Participants were included if they were in a marital or consensual union, aged between 18 and 64 years, had resided in Kinshasa for at least six months, and provided informed consent.

Individuals with severe mental disorders, major communication impairments, or severe illness at the time of data collection were excluded.

2.3 Sample size and sampling procedure

The sample size was calculated using the single population proportion formula with a 95% confidence level, a margin of error of 5%, and an assumed prevalence of 50% due to the absence of prior local data. The minimum required sample size was 384 participants.

A two-stage probabilistic sampling technique was used. In the first stage, six communes were randomly selected, followed by the random selection of one neighborhood per commune. In the second stage, households were selected using systematic sampling after household listing.

A total of 180 households were visited, and eligible couple members within each household were invited to participate.

2.4 Variables

The dependent variable was sexual satisfaction (yes/no), assessed using a validated scale.

Independent variables included: sociodemographic characteristics, gynecological, obstetric, and medical factors, male partner-related factors, relational variables, psychological variables, sociocultural factors, aesthetic and functional factors

2.5 Operational definitions

Sexual satisfaction was assessed using the Index of Sexual Satisfaction (ISS), composed of 9 Likert-scale items (score range: 0–45). Participants scoring below the mean were classified as sexually dissatisfied.

Depressive and anxiety symptoms were assessed using the PHQ-2 and GAD-2 scales. Standard clinical definitions were used for erectile dysfunction, premature ejaculation, and delayed ejaculation.

2.6 Data collection procedure

Data were collected using a structured questionnaire administered through face-to-face interviews by trained male and female interviewers.

A two-day training session was conducted for data collectors to ensure standardization and sensitivity in handling the topic.

2.7 Data quality assurance

The questionnaire was pretested among 20 couples in a non-selected area, and necessary adjustments were made. Daily supervision and verification of completeness and consistency were ensured throughout data collection.

2.8 Statistical analysis

Data were collected electronically using SurveyCTO, exported to Microsoft Excel, and analyzed using STATA software.

Descriptive statistics were used to summarize participant characteristics. Bivariate analysis was performed using Pearson's chi-square test and Student's t-test. Variables with $p \leq 0.20$ were included in a multivariable logistic regression model.

Results were expressed as adjusted odds ratios (aORs) with 95% confidence intervals. Statistical significance was set at $p < 0.05$.

2.9 Ethical considerations

The study was approved by the Ethics Committee of the School of Public Health of the University of Kinshasa (Reference: ESP/CE/27B/2026**)**.

Written informed consent was obtained from all participants. Confidentiality and anonymity were strictly maintained, and interviews were conducted in private settings. Participants' safety was prioritized, and interviews were discontinued if any risk arose.

2.10 Participant flow

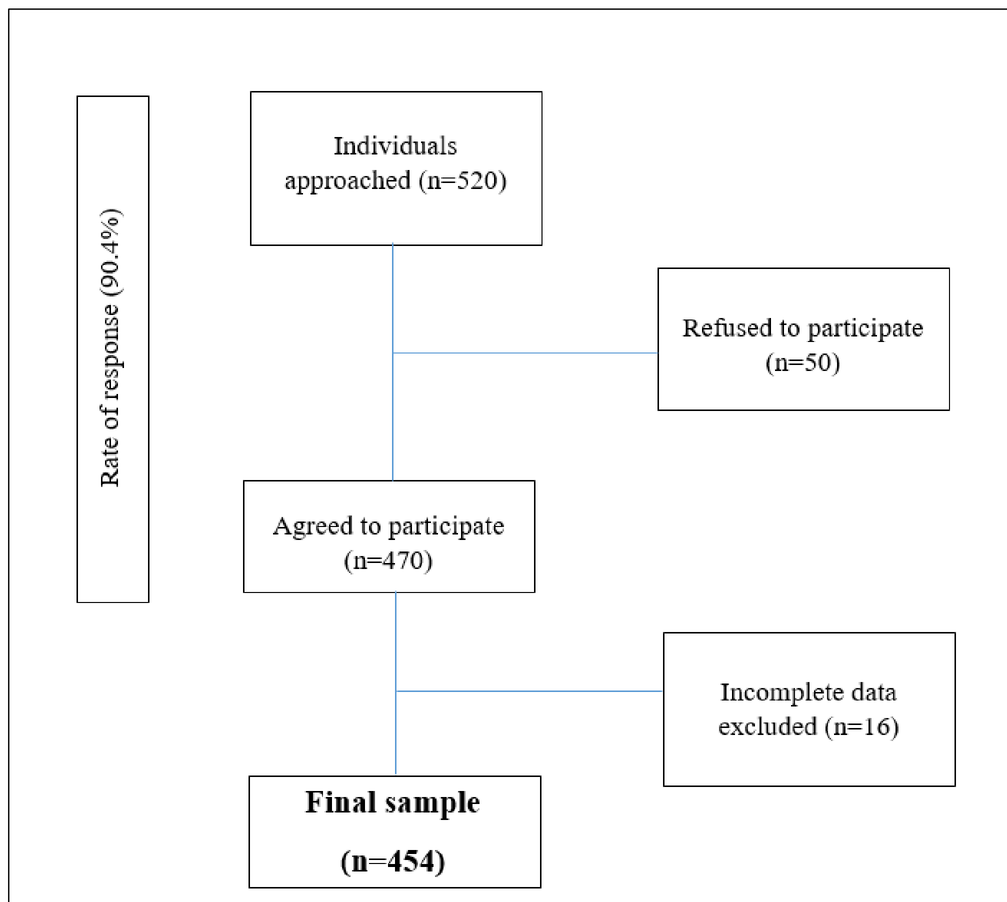

Figure 1: Participants flow

3. Results

3.1 Prevalence of sexual dissatisfaction

Overall, 20% of participants reported sexual dissatisfaction (10.8 % for women and 9.2 % for men) (Figure 2).

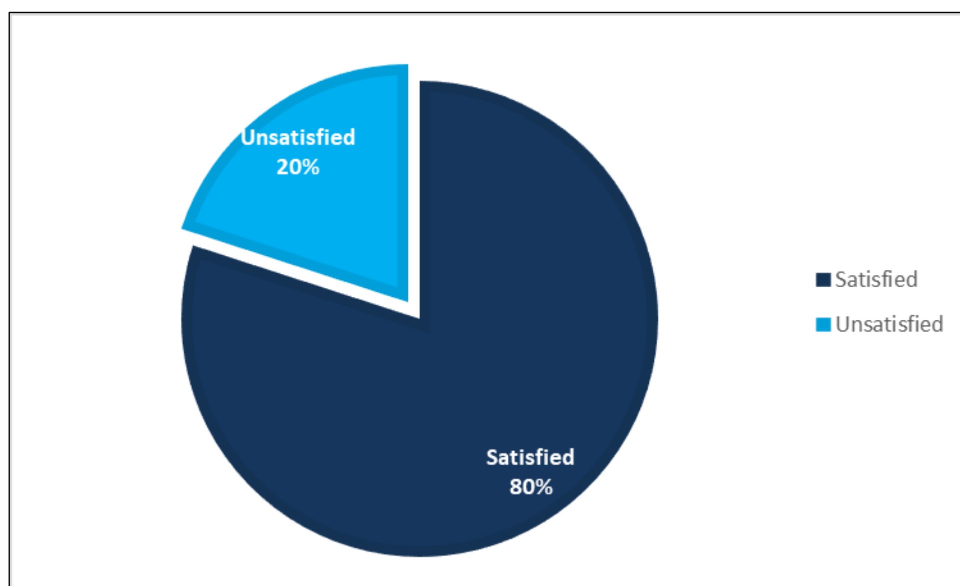

Figure 2: Prevalence of sexual dissatisfaction

3.2 Sociodemographic characteristics

A total of 454 participants were included, comprising 257 women (56.6%) and 197 men (43.4%). The median age was 34 years (IQR: 28–43). Regarding marital status, the majority of participants were married (67.3%), followed by those in a common-law union (32.7%). Participants were predominantly engaged in informal economic activities, including trade (29.5%) and artisanal work (21.6%) (Table 1).

Table 1: Sociodemographic characteristics of participants

Variables	Effectifs (454)	Pourcentage (%)
Gender		
Female	257	56.6
Male	197	43.4
Participant age (years)		
Median (IQR)	34 (28-43)	
Marital status		
Married	304	67.3
Cohabiting	150	32.7
Education level		
High Education	118	26
Secondary	247	54.4
Primary	80	17.6
None	9	2

Occupation		
Unemployed	13	4.7
Student	1	0.4
Housewife	49	17.6
Trade/Informal Sector	82	29.5
Artisan/Worker	60	21.6
Professional /Executive	10	3.6
Public sector employee	41	14.8
Security forces	22	7.9

3.3 Gynecological and obstetric characteristics

Among women (n = 257), 90.7% had a history of childbirth, with a median parity of 4 (IQR: 2–4). Vaginal delivery was the most common mode (70.8%).

Perineal trauma was reported by 50.6%, and 34.2% had undergone gynecological surgery.

Common conditions included pelvic infections (30.5%) and endometriosis (18.7%). Sexual dysfunction symptoms were frequent, including dyspareunia (47.9%) and vaginal dryness (51%) (Figure 2). Nearly half of the participants used contraceptive methods, with minimal reported impact on sexual satisfaction.

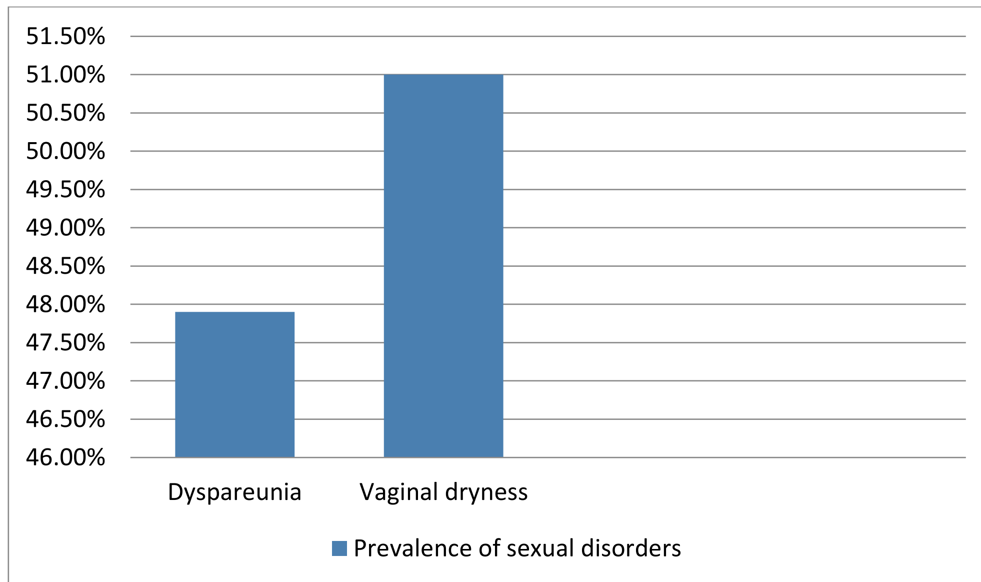

Figure 3: Sexual disorders

3.4 Sexual taboos

Although most participants (81.7%) did not consider sexuality shameful, strong taboos remained. Masturbation was considered immoral by 83.7%, and 48.3% believed refusing sex was unacceptable.

Approximately one-third (33.1%) reported that these taboos influenced their sexual life (Figure 4).

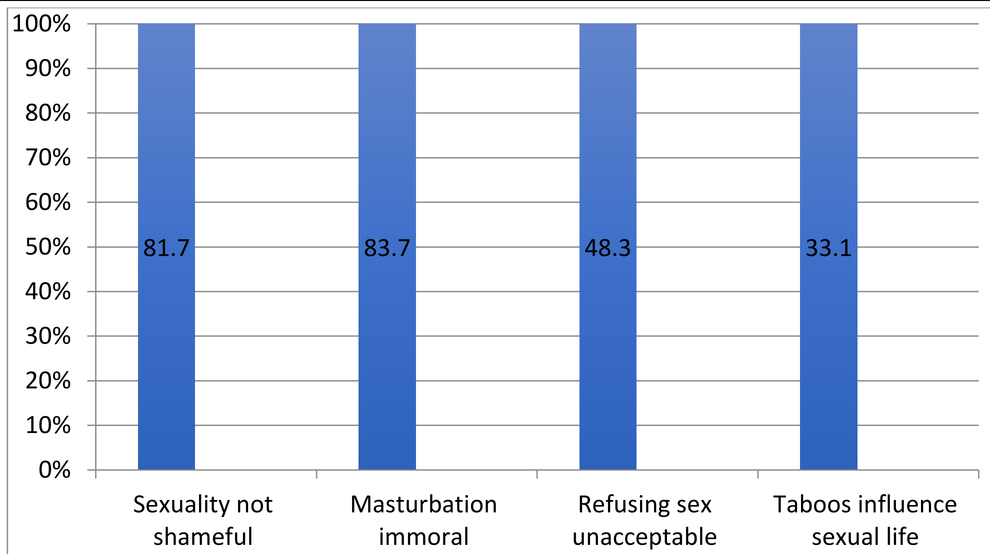

Figure 4: Prevalence of sexual taboos and their perceived impact on sexual life

3.5 Religion and media influence

Religion influenced sexual life in 53.3% of participants.

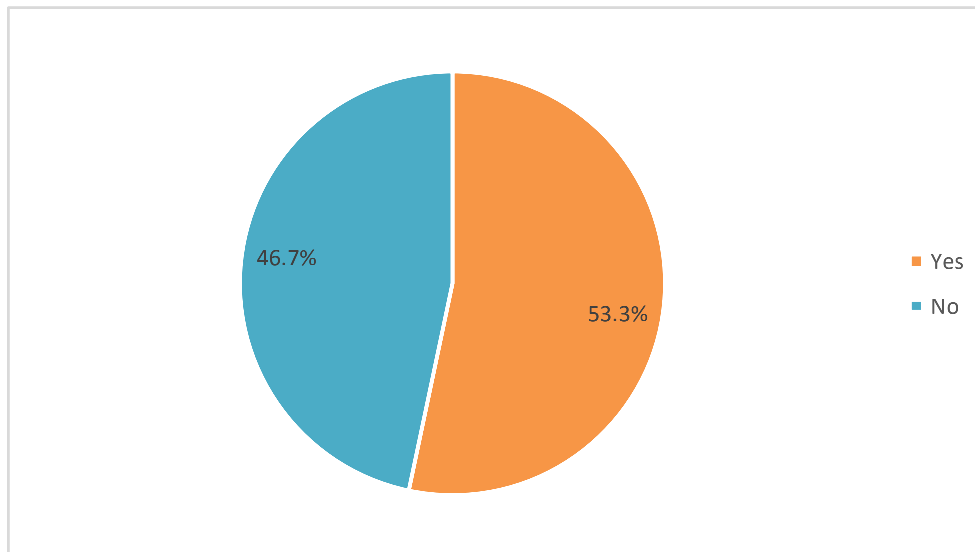

Figure 5: Religion influence on sexual life

Exposure to pornographic content was generally low to moderate. Reported effects mainly concerned frequency of intercourse (46%) and sexual practices (27%).

3.6 Female aesthetic and functional factors

More than half of women (56.4%) perceived vaginal widening after childbirth. While most reported no vulvar aesthetic concerns (72%), 40.9% used traditional vaginal tightening methods.

Perception of the partner's genital appearance was largely positive.

Table 2: Female aesthetic and functional factors fonctionnels féminins

Variables	Effectifs (257)	Pourcentage (%)
Female perception of post-partum changes in vaginal diameter		
Yes	131	56.4
Slightly	102	43.6
Concerns regarding the appearance of the vulva		
Yes	32	12.5
Slightly	40	15.6
No	185	72
History of female genital mutilation (FGM)		
Yes	5	2.0
No	252	98.0
Use of traditional methods to tighten the vagina		
Yes	105	40.9
No	152	59.1
Perception of partner's genital appearance		
Very unpleasant	7	2.7
Rather unpleasant	6	2.3
Neither pleasant nor unpleasant	45	17.5
Rather pleasant	62	24.1
Very pleasant	131	51.0
Prefer not to answer	6	2.3

3.7 Multivariable analysis (couple)

After adjustment, the following factors were independently associated with sexual dissatisfaction:

- Poor sexual communication (aOR = 14.31; p < 0.001),
- Moderate communication (aOR = 15.78; p < 0.001),
- High stress levels (aOR = 2.78; p = 0.002),
- Infidelity (aOR = 2.01; p = 0.032),
- Sexual conflicts (aOR = 5.28; p < 0.001).

Conversely, lower frequency of sexual intercourse was associated with reduced odds of dissatisfaction (Table III).

Table 3: Multivariable analysis of factors associated with sexual dissatisfaction (couple)

Variables	Crude OR (95% CI)	p	Adjusted OR (95% CI)	p
Presence of depressive symptoms		0.124		0.113
Yes	1.48 [0.90–2.45]		0.56 [0.27–1.15]	
No	1	–	1	–
Sexual communication with partner				
Poor	16.29 [8.13–32.61]	<0.001	14.31 [6.15–33.26]	**<0.001**
Moderate	13.77 [7.01–27.02]	<0.001	15.78 [7.34–33.94]	**<0.001**

Good	1	–	1	–
High stress level		<0.001		**0.002**
Yes	3.54 [2.14–5.88]		2.78 [1.44–5.34]	
No	1	–	1	–
Frequency of sexual intercourse				
Rarely	0.47 [0.27–0.81]	0.006	0.16 [0.07–0.37]	**<0.001**
Regularly	0.24 [0.12–0.50]	<0.001	0.17 [0.07–0.45]	**<0.001**
Frequently	1	–	1	–
Presence of real or perceived infidelity in the couple		<0.001		**0.032**
Yes	3.79 [2.32–6.18]		2.01 [1.06–3.78]	
No	1	–	1	–
Presence of sexual-related couple conflicts		<0.001		**<0.001**
Yes	5.02 [3.04–8.28]		5.28 [2.52–11.07]	
No	1	–	1	–

3.8 Multivariable analysis in women

Table 4: Multivariable analysis of factors associated with sexual dissatisfaction among women

Variables	**Crude OR (95% CI)**	**p**	**Adjusted OR (95% CI)**	**p**
Mode of delivery				
Vaginal delivery	1	–	1	–
Cesarean section	3.37 [1.13–9.99]	0.029	0.61 [0.07–5.71]	0.67
Both	3.67 [1.79–7.52]	<0.001	0.87 [0.24–3.19]	0.834
Gynecological surgery (cystectomy, myomectomy, fistula repair, hysterectomy)		<0.001		0.068
Yes	4.08 [2.13–7.82]		2.86 [0.92–8.83]	
No	1	–	1	–
Perception that pain during sexual intercourse is abnormal		0.055		0.808
Yes	1.80 [0.99–3.46]		1.15 [0.38–3.49]	
No	1	–	1	–
Contraception involves both partners		<0.001		0.588
Yes	0.34 [0.18–0.66]		0.72 [0.23–2.33]	
No	1	–	1	–
Female orgasm may vary		<0.001		0.525
Yes	0.27		1.55	

	[0.14–0.51]		[0.40–5.97]	
No	1	–	1	–
Discussing sexuality can improve the couple's relationship		0.033		0.934
Yes	0.26 [0.08–0.89]		1.12 [0.08–16.15]	
No	1	–	1	–
A woman expressing sexual desire is not immoral		0.103		0.331
Yes	1.69 [0.89–3.18]		1.86 [0.53–6.49]	
No	1	–	1	–
Talking about sexuality with one's partner is shameful		<0.001		**0.035**
Yes	11.54 [5.57–23.88]		4.41 [1.11–17.57]	
No	1	–	1	–
A woman should express her sexual desire		0.011		**0.017**
Yes	0.42 [0.22–0.82]		0.13 [0.02–0.69]	
No	1	–	1	–
Acceptance of sexual pleasure in a respectable woman		0.025		0.165
Yes	0.44 [0.22–0.90]		3.55 [0.59–21.32]	
No	1	–	1	–
The man should always initiate sexual intercourse		<0.001		0.645
Yes	7.72 [3.80–15.68]		0.71 [0.16–3.08]	
No	1	–	1	–
Having sexual difficulties is shameful		<0.001		**0.001**
Yes	17.05 [7.68–37.85]		10.30 [2.79–37.99]	
No	1	–	1	–
Contraceptive use decreases moral value		<0.001		**0.041**
Yes	11.61 [5.73–23.56]		3.99 [1.06–15.00]	
No	1	–	1	–
Sexual intercourse must follow strict rules (positions, timing)		0.004		0.927
Yes	2.68 [1.36–5.30]		0.94 [0.23–3.84]	
No	1	–	1	–
Religious influence on sexual life		0.064		0.43
Yes	1.84 [0.97–3.53]		0.58 [0.15–2.24]	
No	1	–	1	–
Voluntary exposure to pornographic content		0.03		0.062

Yes	2.01 [1.07–3.77]		2.86 [0.95–8.60]	
No	1	–	1	–
Perceived vaginal widening after childbirth		<0.001		0.51
Yes	5.12 [2.29–11.46]		0.59 [0.13–2.76]	
A little	1	–	1	–
Vulvar aesthetic concerns				
Yes	1	–	1	–
A little	8.05 [2.68–84.18]	<0.001	14.85 [2.64–83.55]	**0.002**
No	0.44 [0.16–1.21]	0.113	4.15 [0.82–21.08]	0.086
Perception of partner's genital appearance				
Rather/very unpleasant	1	–	1	–
Neither pleasant nor unpleasant	0.56 [0.16–1.93]	0.355	0.47 [0.07–3.30]	0.446
Rather/very pleasant	0.06 [0.02–0.21]	<0.001	0.19 [0.03–1.39]	0.101

Independent risk factors included:

- Shame associated with discussing sexuality (aOR = 4.41)
- Perceiving sexual difficulties as shameful (aOR = 10.3)
- Negative beliefs about contraception (aOR = 3.99)
- Vulvar aesthetic concerns (aOR = 14.85)

A protective factor was:

- The fact that women could speak out about sexual (aOR = 0.13) (Table 10).

4. Discussion

This study investigated factors associated with sexual dissatisfaction among couples in Kinshasa. The prevalence of sexual dissatisfaction (20%) observed in this study is lower than that reported in many international studies, where it typically ranges between 30% and 45% [31, 32].

In sub-Saharan Africa, higher prevalences have been reported, including 33% in Nigeria [33], 44% in Ethiopia [34], and 39% in Kenya [35]. This discrepancy may be explained by the relatively young age of the study population, the predominance of stable relationships, and potential underreporting due to sociocultural norms surrounding sexuality.

4.1 Psychosocial and relational factors

The most strongly associated factors were poor sexual communication, high stress levels, infidelity, and sexual conflicts.

Sexual communication is consistently identified as a key determinant of both relational and sexual satisfaction [36, 37]. In this study, the strength of association was particularly high (aOR = 14.31), exceeding that reported in Western studies (aOR typically ranging from 3 to 6) [36]. This suggests that in this sociocultural context, communication barriers may play an even more critical role.

Similarly, stress and relational conflicts are well-established contributors to sexual dysfunction [38]. The observed association between perceived infidelity and sexual dissatisfaction is consistent with findings from Ghana and South Africa, where infidelity significantly disrupts couple dynamics and sexual well-being [39].

4.2 Female-related factors

Contrary to several studies reporting associations between obstetric factors (such as cesarean section, multiparity, or perineal trauma) and sexual dysfunction [40–42], no independent association was observed after adjustment in this study. This finding suggests that psychosocial determinants may outweigh purely biological factors in this setting.

In contrast, vulvar aesthetic concerns were strongly associated with sexual dissatisfaction (aOR = 14.85). Similar findings have been reported in studies from the Middle East and East Africa, highlighting the role of genital self-image in female sexual function [43, 44].

Cultural beliefs also emerged as key determinants. Perceptions linking sexuality to shame, negative attitudes toward contraception, and stigmatization of female sexual expression were significantly associated with dissatisfaction. These findings align with studies conducted in the Democratic Republic of the Congo, Cameroon, and Ethiopia, where patriarchal norms and sexual stigma limit female sexual autonomy and satisfaction [45–47].

4.3 Male-related factors

Among men, premature ejaculation (aOR = 3.48) was significantly associated with sexual dissatisfaction, consistent with studies across different regions identifying it as a major contributor to impaired sexual satisfaction within couples [48–50].

Interest in genital cosmetic surgery was also associated with dissatisfaction, reflecting underlying body image concerns. This finding is consistent with the literature suggesting that male genital self-perception influences sexual confidence and satisfaction [51].

4.4 Sociocultural and religious influences

Several sociocultural beliefs were significantly associated with sexual dissatisfaction, including shame surrounding sexual discussions, taboos on female pleasure, and norms assigning sexual initiative exclusively to men. These findings are consistent with studies

from Central and West Africa showing that restrictive gender norms negatively affect communication and sexual satisfaction [52, 53].

Religious influence, reported by more than half of participants, is comparable to findings in Nigeria and South Africa, where religiosity is associated with more normative sexual behaviors and, in some cases, reduced sexual well-being [54].

4.5 Media and pornography

Exposure to pornography was not independently associated with sexual dissatisfaction in this study, unlike findings from some Western contexts [55]. This may be explained by the relatively low level of exposure and the moderating influence of sociocultural norms.

4.6 Strengths and limitations

This study has several strengths. It is one of the few to explore sexual dissatisfaction in a community-based sample in Kinshasa, integrating a wide range of biological, psychological, relational, and sociocultural variables. The use of multivariable analysis allowed the identification of independent predictors.

However, some limitations should be acknowledged. The cross-sectional design does not allow causal inference. Self-reported data may be subject to social desirability bias, particularly given the sensitivity of the topic. Additionally, the relatively short duration of data collection and potential underreporting may have influenced prevalence estimates.

4.7 Implications and future directions

These findings highlight the importance of integrating psychosocial and sociocultural dimensions into sexual health interventions. Programs promoting sexual communication, reducing stigma, and improving sexual education could significantly improve sexual satisfaction.

Future research should explore longitudinal designs and intervention-based approaches, as well as qualitative studies to better understand cultural dynamics influencing sexual behavior.

Author	**Contributions**
Damien Mamanisini	Study conception and design, Data collection, Writing of the manuscript
Wivine Kavula	Data analysis, Critical revision of the manuscript draft
Josué Ozowa	Critical revision of the manuscript draft
Aimée Lulebo	Study conception and design
Esaie Muanda	Critical revision of the manuscript draft
Emmanuel Nzau	Overall supervision and guidance of the work

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Conflict of Interest Statement

The authors declare that they have no conflicts of interest. They received no financial support from any individual or institution. The arguments presented in this paper are based on evidence derived from data collected and analyzed for scientific research purposes.

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References

1. Joung M, et al. The determinants of marital satisfaction. J Fam Psychol. 2000.
2. Ziaei T, et al. Sexual satisfaction and its relation with marital satisfaction in married women. Iran J Public Health. 2014.

3. Haavio-Mannila E, Kontula O. Sexual satisfaction and dissatisfaction in Finland and Sweden. J Sex Res. 1997.
4. World Health Organization. Working definition of sexual health. Geneva: WHO; 2005.
5. Lawrance K, Byers ES. Sexual satisfaction in long-term heterosexual relationships. J Sex Res. 1995.
6. Sánchez-Fuentes MM, et al. The relationship between sexual satisfaction and subjective well-being. J Sex Res. 2014.
7. Oldsworth E, et al. Sexual satisfaction and psychological well-being in adults. J Health Psychol. 2018.
8. Ji Y, et al. Sexual dissatisfaction and marital conflict in Chinese couples. Arch Sex Behav. 2017.
9. Tayebi N, et al. Association between sexual satisfaction and mental health. Iran Red Crescent Med J. 2011.
10. Jurado A, et al. Cultural factors influencing female sexual dissatisfaction. Sexologies. 2020.
11. Da Silva MF, et al. Male sexual dissatisfaction and body image: a systematic review. J Mens Health. 2024.
12. Alves MT, et al. Prevalence of sexual dysfunctions and associated factors. Rev Saude Publica. 2008.
13. Rosen R, et al. The Female Sexual Function Index (FSFI): a multidimensional self-report instrument. J Sex Marital Ther. 1997;23(2):191–208.
14. Lo SST, et al. The International Index of Erectile Function (IIEF): validation and use. Int J Impot Res. 2019.
15. Schulz MS, et al. Evaluating sexual satisfaction and therapeutic strategies: a review. J Sex Med. 2024.
16. Dosch A, et al. Maudsley Global Sexual Satisfaction Scale and sexual well-being. Arch Sex Behav. 2016.
17. Haavio-Mannila E, Kontula O. Sexual trends in the Baltic Sea area. Helsinki: Population Research Institute; 1997.
18. Kishor S. Married women's risk of sexually transmitted infections in developing countries. Violence Against Women. 2012;18(7):829–53.
19. Lindau ST, Schumm LP, Laumann EO, et al. A study of sexuality and health among older adults in the United States. N Engl J Med. 2007;357(8):762–74.
20. IFOP. Les Françaises et leur vie sexuelle. Paris: Institut Français d’Opinion Publique; 2021.
21. Rahmani A, et al. Sexual satisfaction and its relation to marital happiness. Iran J Public Health. 2009;38(4):77–82.
22. Smith AMA, et al. Sexual and emotional satisfaction in relationships. Aust Fam Physician. 2012;41(10):770–4.

23. Zegeye B, Woldeamanuel GG, Negash W, Shibre G. Sexual satisfaction among married women in Northern Ethiopia. BMC Womens Health. 2023;23(1):112.
24. Olatayo AA, Kubwa OO, Adekunle AE. Sexuality in Nigerian older adults. Pan Afr Med J. 2015;22:315.
25. Amidu N, Owiredu WK, Gyasi-Sarpong CK, Woode E, Quaye L. Sexual dysfunction among married couples in Ghana. BMC Urol. 2011;11:3.
26. Zihalirwa J, et al. Conflits conjugaux liés à la sexualité à Goma. J Afr Sociol. 2018.
27. Mulenga J, Mbuyi L, et al. Influence of penile size on sexual satisfaction in Congolese couples. Afr J Reprod Health. 2019;23(4):101–8.
28. Loos A, Kabeya C, et al. Penile perception and partner satisfaction in Central Africa. Int J Sex Health. 2023;35(2):143–50.
29. Abu-Rayya HM, Abu-Rayya MH, et al. Sociocultural determinants of sexual satisfaction. J Psychol Hum Sex. 2007;19(3):53–74.
30. Shahghaibi S, Faizi S, Gharibi F. Effect of colporrhaphy on sexual dysfunction. Pak J Med Sci. 2013;29(1):157–60.
31. Laumann EO, Paik A, Rosen R. Sexual dysfunction in the United States. JAMA. 1999;281(6):537–44.
32. Nicolosi A, Laumann EO, Glasser DB, et al. Sexual behavior and sexual dysfunction in Europe and the US. Eur Urol. 2006;50:1012–18.
33. Oladiji JO, et al. Sexual dysfunction among women in Nigeria. Afr Health Sci. 2009;9(3):150–6.
34. Abdo C, et al. Prevalence of sexual dysfunction in Ethiopia. BMC Womens Health. 2016;16:82.
35. Khasakhala AA. Sexual dissatisfaction among Kenyan couples. Afr J Reprod Health. 2012;16(1):66–76.
36. Byers ES. Relationship satisfaction and communication. J Sex Marital Ther. 2005;31:193–209.
37. MacNeil S, Byers ES. Role of sexual communication. Arch Sex Behav. 2009;38:619–25.
38. Bancroft J, et al. Stress and sexual dysfunction. J Sex Res. 2003;40:266–72.
39. Amoateng AY, et al. Infidelity and marital satisfaction in Ghana and SA. Afr Soc Rev. 2017;21(2):5–25.
40. Barrett G, et al. Sexual health after childbirth. BJOG. 2000;107:186–95.
41. McDonald EA, et al. Mode of delivery and sexual function. Obstet Gynecol. 2014;123:771–8.
42. Malein G, et al. Pelvic floor trauma and sexual function. Int Urogynecol J. 2016;27:1669–75.
43. Herbenick D, et al. Genital self-image in women. J Sex Med. 2011;8:3339–49.
44. Kibret G, et al. Female genital self-image and sexual function in East Africa. Int J Gynaecol Obstet. 2019;147:310–6.

45. Tchokote H, et al. Sexual norms and beliefs in Cameroon. Pan Afr Med J. 2018;29:120.
46. Tamene A, et al. Shame and sexual dysfunction in Ethiopian women. Reprod Health. 2017;14:110.
47. Matondo PM. Sexual taboos in DR Congo. J Afr Cult Stud. 2019;31(3):325–36.
48. McMahon CG. Premature ejaculation. Lancet. 2004;361:761–73.
49. Serefoglu EC, et al. Burden of premature ejaculation globally. World J Urol. 2014;32:1359–66.
50. Ferenidou F, et al. Sexual dysfunction in African men. J Sex Med. 2008;5:1442–8.
51. Veale D, et al. Body dysmorphic disorder and genital concerns in men. Body Image. 2014;11:246–53.
52. Jewkes R, Morrell R. Sexual norms and gender inequality in Africa. Lancet. 2010;375:1680–7.