

Determinants of Female Sexual Function: The Impact of Educational Level, Body Mass Index, and Menopausal Status

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Research Article

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Abstract

Objective

This study evaluated sexual function among sexually active women attending a university hospital urology outpatient clinic using the Female Sexual Function Index (FSFI) and investigated its associations with body mass index (BMI), menopausal status, and educational level.

Methods

This cross-sectional observational study included 87 sexually active women. Age, BMI, menopausal status, and educational level were recorded, and sexual function was assessed using the FSFI. Associations between BMI and total and domain-specific FSFI scores were evaluated using Spearman correlation analysis. Scores were compared by menopausal status using the Mann–Whitney U test and by educational level using the Kruskal–Wallis test. Multivariable linear regression analysis was performed to identify independent predictors of total FSFI score.

Results

BMI was not significantly correlated with total or domain-specific FSFI scores (all $p > 0.05$). No significant differences were observed between premenopausal and postmenopausal women (all $p > 0.05$). Educational level was significantly associated with total FSFI score ($p = 0.0348$) and arousal domain score ($p = 0.0153$), with higher educational levels corresponding to higher scores. In multivariable analysis, educational level was positively associated and age was negatively associated with total FSFI score, whereas BMI and menopausal status were not significant predictors.

Conclusion

BMI and menopausal status were not significant determinants of female sexual function in this cohort. Conversely, educational level was independently associated with overall sexual function, particularly arousal, suggesting that female sexual health may be influenced by sociocultural as well as biological factors.

Brief Summary

Higher educational level was associated with better female sexual function, particularly arousal, whereas body mass index and menopausal status showed no significant associations.

Introduction

Female sexual health plays a critical role in quality of life, relationship satisfaction, and psychological well-being. The World Health Organization (WHO) defines sexual health not merely as the absence of

sexual dysfunction, but as a state of physical, emotional, mental, and social well-being in relation to sexuality¹.

Female sexual function is a multidimensional construct comprising several domains, including sexual desire, arousal, lubrication, orgasm, satisfaction, and pain. Impairments in one or more of these domains are collectively defined as female sexual dysfunction (FSD).

Female sexual dysfunction is more prevalent than commonly assumed and may occur at different stages of life. Various sociodemographic variables (such as age and educational level), biological factors (including menopausal and hormonal status), and body image–related factors may influence both the prevalence and severity of these disorders^{2,3}.

Although body mass index (BMI) is a simple parameter commonly used to assess obesity, its relationship with sexual function is complex. In individuals with higher BMI, the risk of sexual dysfunction may increase through psychobiological mechanisms such as hormonal alterations, reduced libido, low self-esteem, and negative body image⁴.

Menopause is associated with significant physiological changes that may influence sexual function. Decreased estrogen levels, vaginal dryness, atrophy, reduced libido, and dyspareunia are among the conditions commonly linked to menopausal transition. However, the impact of menopause on sexual function is not limited to biological mechanisms alone, but is also shaped by psychosocial factors⁵.

In addition, a woman's educational level represents an important determinant that may influence her perception of sexuality, communication about sexual issues, and help-seeking behavior. Women with higher levels of education and greater health literacy have been reported to possess increased awareness of sexual health, a better ability to recognize sexual dysfunction, and greater utilization of professional support services⁶.

In this study, female sexual function among women presenting to a urology outpatient clinic was evaluated using the Female Sexual Function Index (FSFI). The relationships between FSFI scores and factors such as body mass index (BMI), menopausal status, and educational level were statistically analyzed. The aim of the study was to explore the potential impact of these variables on female sexual health and to promote the broader use of the FSFI in urology outpatient settings.

Materials and Methods

The data for this cross-sectional observational study were collected in the Urology Outpatient Clinic between January 2025 and April 2025 and were retrospectively evaluated. Women aged 18–65 years who had been sexually active within the previous three months and who voluntarily and completely completed the Female Sexual Function Index (FSFI) questionnaire were included in the study. The study protocol was approved by the relevant institutional ethics committee (decision no. 780-780-01) and was conducted in accordance with the principles of the Declaration of Helsinki.

Participants were required to be married or to have a regular sexual partner.

The exclusion criteria included a history of neurological or psychiatric disorders, regular medication use due to systemic diseases, and incomplete responses on the FSFI questionnaire. Based on these criteria, the final study sample consisted of 87 participants.

Sociodemographic and clinical data, including age, body mass index (BMI), menopausal status, and educational level, were obtained through medical records and participant questionnaires. The evaluated variables included age (years), height (cm), body weight (kg), body mass index (BMI), menopausal status (present/absent), and educational level (primary school, middle school, high school, and university).

Body mass index (BMI) was calculated as body weight in kilograms divided by the square of height in meters (kg/m²). (Tables 1–3)

Table 1
Demographic Characteristics of the
Participants

Characteristic	Value
Mean Age (years)	37.3 ± 7.8
Mean Body Mass Index (BMI)	25.6 ± 3.5
Non-menopausal (%)	88.5%
Menopausal (%)	11.5%

Table 2
Distribution of Educational Levels

Educational Level	Number of Participants	Percentage (%)
High School	33	37.9
Primary School	28	32.2
University	18	20.7
Middle School	8	9.2

Table 3
Distribution of BMI Categories

BMI Category	Number of Participants	Percentage (%)
Normal Weight	40	46.0
Overweight	37	42.5
Obesity Class I	9	10.3
Obesity Class III	1	1.1

Sexual function was assessed using the Female Sexual Function Index (FSFI), a validated instrument with demonstrated Turkish validity and reliability⁷. The FSFI consists of 19 items and evaluates six domains: desire, arousal, lubrication, orgasm, satisfaction, and pain.

Domain scores were calculated using the domain-specific weighting coefficients defined in the original scoring algorithm, and the total FSFI score was obtained by summing the weighted domain scores (range: 2–36).

Statistical analysis

Statistical analyses were performed using IBM SPSS Statistics version 25.0. The normality of the distribution of continuous variables was assessed using the Shapiro–Wilk test. Descriptive statistics were presented as mean $\pm$ standard deviation (SD) and frequency (%).

Differences in FSFI scores according to menopausal status were analyzed using the Mann–Whitney U test. Differences in FSFI scores according to educational level were evaluated using the Kruskal–Wallis test, and post-hoc analysis (Dunn’s test) was performed for statistically significant results.

A p-value < 0.05 was considered statistically significant. The relationship between body mass index (BMI) and the total and domain scores of the Female Sexual Function Index (FSFI) was examined using Spearman correlation analysis.

Results

The mean $\pm$ standard deviation values of the total and domain-specific FSFI scores according to BMI categories, along with the results of the Kruskal–Wallis test, are presented in Table 4. Notably, near-significant differences were observed in the arousal ($p = 0.083$) and orgasm ($p = 0.079$) domain scores, suggesting a possible trend toward decreasing scores with increasing BMI. However, no statistically significant differences were detected between the groups for the other FSFI domains ($p > 0.05$). (Table 4)

Table 4
FSFI Scores According to BMI Categories

FSFI Domain	Normal Weight (Mean $\pm$ SD)	Overweight (Mean $\pm$ SD)	Obese (Mean $\pm$ SD)	H (Kruskal)	p-value
Total Score	22.98 $\pm$ 6.20	24.29 $\pm$ 6.46	25.35 $\pm$ 11.81	0.79	0.673
Desire	3.10 $\pm$ 0.95	3.31 $\pm$ 1.20	2.82 $\pm$ 1.20	2.01	0.366
Arousal	3.33 $\pm$ 1.22	3.76 $\pm$ 1.15	3.18 $\pm$ 1.01	4.98	0.083
Lubrication	4.30 $\pm$ 1.45	4.61 $\pm$ 1.69	3.55 $\pm$ 1.25	1.50	0.472
Orgasm	4.07 $\pm$ 1.41	4.23 $\pm$ 1.41	3.72 $\pm$ 0.89	5.07	0.079
Satisfaction	4.27 $\pm$ 1.30	4.16 $\pm$ 1.54	4.16 $\pm$ 1.20	0.83	0.659
Pain	3.92 $\pm$ 1.29	4.26 $\pm$ 1.52	4.04 $\pm$ 1.38	0.48	0.786
No statistically significant differences were observed in the total FSFI score or any of its subdomains (desire, arousal, lubrication, orgasm, satisfaction, and pain) across BMI categories (all p-values > 0.05).					

When the differences in total and domain-specific FSFI (Female Sexual Function Index) scores according to participants' educational levels were examined, the total FSFI score showed a statistically significant difference across educational levels ($p = 0.0348$). The arousal domain score also differed significantly according to educational level ($p = 0.0153$).

However, no statistically significant differences were observed for the other FSFI domain scores ($p > 0.05$). (Table 5)

Table 5
Relationship Between Educational Level and FSFI Scores (Kruskal–Wallis Test)

FSFI Domain	High School (Mean ± SD)	Middle School (Mean ± SD)	University (Mean ± SD)	Primary School (Mean ± SD)	H (Kruskal)	p-value
Total Score	24.73 ± 5.36	18.72 ± 9.51	25.89 ± 4.38	21.98 ± 6.64	8.62	0.0348
Desire	3.33 ± 1.05	3.07 ± 1.26	3.34 ± 1.07	2.87 ± 1.09	3.308	0.3465
Arousal	3.76 ± 1.18	2.36 ± 1.45	3.90 ± 0.97	3.25 ± 1.01	10.426	0.0153
Lubrication	4.50 ± 1.18	3.71 ± 1.99	4.82 ± 0.93	3.96 ± 1.52	5.173	0.1596
Orgasm	4.29 ± 1.19	3.25 ± 1.76	4.56 ± 0.99	3.81 ± 1.52	6.511	0.0892
Satisfaction	4.31 ± 1.30	3.35 ± 1.95	4.60 ± 0.82	4.08 ± 1.53	2.963	0.3973
Pain	4.31 ± 1.37	3.05 ± 1.90	4.51 ± 1.05	3.81 ± 1.34	5.85	0.1191
This table presents the mean ± standard deviation of total and subdomain FSFI scores according to participants' educational levels, together with the results of the Kruskal–Wallis test. Statistically significant differences were observed between educational groups for the total FSFI score (p = 0.0348) and the arousal subdomain (p = 0.0153). The orgasm subdomain demonstrated a difference approaching statistical significance (p = 0.0892). These findings suggest that higher educational attainment may be associated with better outcomes in certain dimensions of female sexual function.						

These findings suggest that educational level may be an influential factor affecting both overall female sexual function and sexual arousal.

When the total and domain-specific FSFI (Female Sexual Function Index) scores were evaluated according to menopausal status, participants were categorized into two groups: premenopausal (absence of menopause) and postmenopausal (presence of menopause). No statistically significant differences in FSFI scores were observed between these two groups. (Table 6)

Table 6
Differences in FSFI Scores According to Menopausal Status (Mann–Whitney U Test)

FSFI Domain	Premenopausal (Mean ± SD)	Postmenopausal (Mean ± SD)	U (Mann–Whitney)	p-value
Total Score	23.78 ± 5.92	21.31 ± 9.27	417.0	0.6749
Desire	3.23 ± 1.07	2.64 ± 1.14	492.5	0.1467
Arousal	3.53 ± 1.13	3.27 ± 1.55	397.0	0.8778
Lubrication	4.36 ± 1.32	4.02 ± 1.76	409.5	0.7482
Orgasm	4.12 ± 1.31	3.96 ± 1.77	359.5	0.7375
Satisfaction	4.26 ± 1.33	3.80 ± 1.78	431.5	0.5333
Pain	4.12 ± 1.34	3.72 ± 1.80	420.5	0.6374
This table presents the mean ± standard deviation of total and subdomain FSFI scores according to menopausal status, together with the results of the Mann–Whitney U test. No statistically significant differences were observed in FSFI total or subdomain scores between premenopausal and postmenopausal women (all p-values > 0.05). Although the desire subdomain score was higher in premenopausal women, the difference did not reach statistical significance (p = 0.1467). These findings suggest that menopausal status was not significantly associated with female sexual function as measured by the FSFI.				

In the multivariable linear regression analysis, educational level and age were found to be independently associated with the total FSFI score. In contrast, body mass index (BMI) and menopausal status did not show a statistically significant association with sexual function. (Table 7)

Table 7
Multivariable Linear Regression Analysis for Factors Associated with FSFI Total Score

Variable	β	95% CI	p-value
Age	-0.299	-0.517 – -0.081	0.008
BMI	0.289	-0.104–0.683	0.147
Menopausal status	1.813	-3.109–6.735	0.466
Educational level	1.546	0.455–2.637	0.006
A multivariable linear regression analysis was performed to identify independent predictors of FSFI total score. The analysis demonstrated that educational level (β = 1.546, p = 0.006) and age (β = -0.299, p = 0.008) were independently associated with FSFI total score. In contrast, BMI (p = 0.147) and menopausal status (p = 0.466) were not significantly associated with sexual function.			

Use of Artificial Intelligence Tools

During the preparation of this manuscript, the authors used ChatGPT (OpenAI, San Francisco, CA, USA) for language editing, grammar checking, and improving the clarity and fluency of sentences. The final

content of the manuscript was reviewed and approved by the authors, who take full responsibility for the accuracy of the data and the integrity of the study.

Discussion

Our study aimed to evaluate the biological and sociodemographic factors influencing female sexual function through a comprehensive approach. The findings, consistent with the existing literature, indicate that female sexual health is influenced not only by physiological factors but also significantly shaped by psychological, social, and cultural determinants^{1,8}.

In our study, no significant correlation was observed between body mass index (BMI) and FSFI scores. Although several studies have reported an increased risk of sexual dysfunction among women with higher BMI, it has been suggested that this relationship may not be direct and that mediating factors may play an important role^{9,10}. Esposito et al. reported that obesity may be associated with sexual dysfunction in women; however, this relationship appears to be indirectly influenced by psychological factors such as depression, low self-esteem, and negative body image⁴. Indeed, some studies have demonstrated that increasing BMI may be associated with significant reductions in FSFI scores¹¹.

However, recent studies have suggested that anthropometric measures reflecting visceral adiposity, such as waist circumference and visceral adiposity indices, may be associated with female sexual function^{12,13}. In the present study, waist circumference was not measured, and BMI was used instead.

In the analysis based on educational level, statistically significant differences were observed in both the total FSFI score and the arousal domain score. These findings suggest that sexual function tends to improve with increasing levels of education. This association may be explained by the fact that women with higher educational attainment may have better access to sexual health information, experience lower levels of sexual stigma, and establish healthier communication with their partners⁶.

Furthermore, previous studies have demonstrated that women with higher educational levels and greater health literacy tend to have greater awareness of sexual dysfunction and are more likely to seek professional help for sexual health problems^{6,14}.

According to the findings of our study, increasing educational level appears to be associated with greater sexual awareness, improved body image, better communication skills, and higher levels of sexual health knowledge among women. However, it is also possible that women with higher educational attainment may have better understood and more accurately responded to the FSFI questionnaire, which might have influenced our results.

On the other hand, lower educational levels may be associated with limited sexual health education. In addition, women with lower educational attainment may be more likely to live in sociocultural environments where patriarchal gender roles are more dominant and where discussing sexuality is considered a social taboo. In this context, educational level should be considered not only as an

individual characteristic but also as a sociocultural indicator with multidimensional effects on sexual function¹⁴.

In the multivariable regression analysis, age and educational level emerged as independent determinants of female sexual function. In particular, the negative association observed between age and FSFI scores in our study is consistent with previous reports indicating that sexual function may gradually decline with advancing age, likely due to hormonal changes, comorbid conditions, and psychosocial factors. (Table 7)

Furthermore, the identification of educational level as an independent determinant suggests that female sexual health cannot be explained solely by biological aging. Instead, sociocultural factors, including health literacy, sexual awareness, and communication with a partner, may also play an important role in shaping sexual well-being. These findings are consistent with previous studies demonstrating that both aging and psychosocial determinants have significant effects on female sexual function, and that multidimensional assessment tools such as the FSFI are widely used to evaluate these complex influences^{15,16}.

In our study, menopausal status was not found to have a statistically significant effect on sexual function. Several factors, including duration of menopause, use of hormone replacement therapy, and relationship dynamics, may influence sexual function during this period. In addition, variables such as social support, partner relationships, and individual expectations in the postmenopausal period may mitigate the potential effects of menopause. Therefore, menopause should not be considered solely as a single determining factor but rather as a multidimensional transitional process in women's sexual health⁵.

Dennerstein et al. reported that declining estrogen levels during the menopausal transition may particularly lead to impairments in the lubrication and arousal domains, and that these hormonal changes may contribute to sexual dysfunction during this period⁵. Furthermore, physiological conditions such as pelvic floor weakness and dyspareunia (pain during sexual intercourse) may also negatively affect sexual function during this stage of life¹⁷.

However, the impact of menopause on sexual life is not limited to physiological factors alone. Social support, the quality of the partner relationship, individual perceptions of sexuality, life satisfaction, and cultural norms are among the factors that play important roles in shaping sexual function during the postmenopausal period. Indeed, some studies have demonstrated that women who report positive relationships with their partners during the postmenopausal period tend to have higher levels of sexual function¹⁵.

In addition, hormone replacement therapy (HRT) has been reported to have beneficial effects on sexual function in women. However, variables such as duration of menopause, use of HRT, frequency of sexual activity, and partner-related factors were not evaluated in our study. This limitation may have restricted a more detailed examination of the potential relationship between menopause and sexual function.

Sexual function is an integral component of women's health and is shaped by relational, emotional, and cultural factors. Therefore, evaluating sexual function solely on the basis of physiological parameters would be insufficient. According to the World Health Organization (WHO), sexual health is defined not merely as the absence of disease, but as a state of physical, mental, and social well-being in relation to sexuality¹.

In this context, the Female Sexual Function Index (FSFI), a multidimensional instrument, represents a valuable tool for the assessment of female sexual function and should be more widely utilized in clinical practice¹⁶.

Study Limitations

This study has several limitations. First, it was conducted at a single center and included a relatively small sample size, which may limit the generalizability of the findings. In addition, the cross-sectional study design does not allow for the establishment of causal relationships between variables. Female sexual function was assessed using a self-reported questionnaire, which may introduce reporting bias.

Furthermore, as sexual health remains a sensitive topic in many societies, some women may have been reluctant to participate in the survey or to complete the FSFI questionnaire. This situation may have contributed both to the limited sample size and to potential inaccuracies in the responses provided.

Nevertheless, despite the relatively small sample size, the use of a validated multidimensional assessment tool (FSFI) and the application of multivariable regression analysis strengthen the robustness of the study findings. In addition, as this study was designed as an exploratory observational analysis, a formal sample size calculation was not performed.

Conclusion

This study demonstrates that female sexual function is a multidimensional construct influenced not only by biological factors but also significantly by psychosocial variables. No significant association was found between FSFI scores and body mass index (BMI), and menopausal status did not appear to have a marked effect on sexual function. In contrast, educational level was found to have a significant and positive influence on female sexual function.

The effect of education on sexual function may be related to several factors, including individual knowledge of sexual health, self-perception, communication skills, and cultural attitudes. Moreover, it is well recognized that individuals with higher health literacy tend to utilize healthcare services more effectively and experience less hesitation when discussing health-related concerns.

The absence of a significant association between menopause and sexual function in our study suggests that the menopausal experience may be shaped by factors such as individual differences, relationship dynamics, and health awareness. Some studies in the literature have reported that menopause may lead

to declines particularly in domains such as arousal and lubrication. However, it has also been suggested that variables such as social support and psychological adaptation may mitigate or buffer these potential adverse effects.

In light of these findings, focusing solely on physiological parameters is insufficient when clinically evaluating female sexual function. Factors such as an individual's educational level, relationship context, and psychosocial environment should also be taken into consideration. Sexual health education programs, counseling services, and community-based awareness initiatives for women may facilitate the early recognition and management of sexual dysfunction.

In conclusion, holistic, multidisciplinary, and culturally sensitive approaches are recommended for the evaluation and improvement of female sexual health. Validated assessment tools such as the Female Sexual Function Index (FSFI) play a crucial role in the objective evaluation of female sexual function, thereby contributing significantly to both clinical practice and research-based assessments.

Declarations

Disclosure

The authors report no relationships that could be construed as a conflict of interest.

Acknowledgment

Nothing to declare

Data availability statement

All authors take responsibility for all aspects of the reliability and freedom from bias of the data presented and their discussed interpretation.

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- [Table6FSFIMenopause.docxYEN.docx](#)
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