

SEXUAL FREQUENCY SATISFACTION: AN INITIAL APPROACH TO SEXUALITY FOR WOMEN TREATED IN PRIMARY HEALTH CARE

SATISFAÇÃO COM FREQUÊNCIA SEXUAL: ABORDAGEM INICIAL SOBRE SEXUALIDADE PARA MULHERES ATENDIDAS NA ATENÇÃO PRIMÁRIA

SATISFACCIÓN CON LA FRECUENCIA SEXUAL: UNA APROXIMACIÓN INICIAL A LA SEXUALIDAD PARA MUJERES ATENDIDAS EN ATENCIÓN PRIMARIA

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Abstract: OBJECTIVE: To assess women's perception about sexual satisfaction in relation to the frequency of sexual intercourse. METHODS: A cross-sectional study was conducted in four primary care units in the city of Ribeirão Preto (São Paulo, Brazil) between January 2022 and February 2023, employing face-to-face interviews and the "U on Sex" questionnaire. RESULTS: A total of 388 women (32.4 ± 9.7 years) were included. Most self-identified as White (53.6%), were in a stable relationship (54.6%), had more than 10 years of education (75.7%), were paid employment (62.8%), and reported satisfaction with their sexual frequency (76.5%). Greater sexual satisfaction was observed among those with previous psychoactive substance use ($p < 0.01$), without comorbidities ($p = 0.04$), or who identified as bisexual ($p = 0.03$). In contrast, dissatisfaction was associated with lack of desire in intercourse ($p = 0.02$) or their partner's extramarital relationship ($p = 0.02$). Higher frequency of intercourse, orgasm occurrence, and sexual initiative were significantly associated with satisfaction with sexual frequency ($p < 0.05$). CONCLUSION: Sexual satisfaction was associated with prior substance use, absence of comorbidities, and bisexual orientation. The question "Are you satisfied with your sexual frequency?" proved to be a simple and useful strategy to address sexuality in primary care.

Keywords: Sexual Health; Reproductive Health; Primary Health Care; Sexuality.

Resumo: OBJETIVO: O objetivo deste estudo foi descrever a percepção da satisfação sexual de mulheres em relação à frequência das relações sexuais. MÉTODOS: Trata-se de um estudo transversal realizado em quatro unidades de atenção primária de Ribeirão Preto (SP), entre janeiro de 2022 e fevereiro de 2023, com entrevistas presenciais e aplicação do questionário "U on Sex". RESULTADOS: Foram incluídas 388 mulheres ($32,4 \pm 9,7$ anos). A maioria se declarou branca (53,6%), com parceria estável (54,6%), com mais de 10 anos de escolaridade (75,7%), trabalho remunerado (62,8%) e estar satisfeita com a sua frequência sexual (76,5%). Foi observada maior satisfação com a frequência sexual entre as que já fizeram uso de substâncias psicoativas ($p < 0,01$), sem comorbidades ($p = 0,04$) ou bissexuais ($p = 0,03$). Em contrapartida, a insatisfação se associou a relações sexuais sem desejo ($p = 0,02$) ou relação extraconjugal da parceria ($p = 0,02$). Maior frequência de relações, maior taxa de orgasmo e maior iniciativa para o ato sexual estiveram significativamente associadas à satisfação com a frequência sexual ($p < 0,05$). CONCLUSÃO: A satisfação sexual associou-se ao uso prévio de substâncias, ausência de comorbidades e orientação bissexual. A pergunta "Você está satisfeita com a sua frequência sexual?" mostrou-se uma estratégia simples e útil para abordar a sexualidade na atenção primária.

Palavras-chave: Saúde Sexual; Saúde Reprodutiva; Atenção Primária à Saúde; Sexualidade.



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Resumen: OBJETIVO: Describir la percepción de la satisfacción sexual de las mujeres en relación con la frecuencia de las relaciones sexuales. MÉTODOS: Estudio transversal realizado en cuatro unidades de atención primaria de Ribeirão Preto (São Paulo, Brasil), entre enero de 2022 y febrero de 2023, mediante entrevistas presenciales y aplicación del cuestionario "U on Sex". RESULTADOS: Se incluyeron 388 mujeres ($32,4 \pm 9,7$ años). La mayoría se autodeclaró blanca (53,6%), con pareja estable (54,6%), más de 10 años de escolaridad (75,7%), trabajo remunerado (62,8%) y satisfacción con la frecuencia sexual (76,5%). Se observó mayor satisfacción entre quienes habían utilizado sustancias psicoactivas ($p < 0,01$), no presentaban comorbilidades ($p = 0,04$) o tenían orientación bisexual ($p = 0,03$). En contraste, la insatisfacción se asoció con relaciones sexuales sin deseo ($p = 0,02$) o relación extraconyugal de la pareja ($p = 0,02$). Una mayor frecuencia de relaciones, más orgasmos y mayor iniciativa sexual se asociaron significativamente con la satisfacción con la frecuencia sexual ($p < 0,05$). CONCLUSIÓN: La satisfacción sexual se asoció con el uso previo de sustancias, la ausencia de comorbilidades y la orientación bisexual. La pregunta "¿Está satisfecha con su frecuencia sexual?" demostró ser una estrategia simple y útil para abordar la sexualidad en la atención primaria.

Palabras clave: Salud Sexual; Salud Reproductiva; Atención Primaria de Salud; Sexualidad.

Introduction

Sexuality is still an insufficiently addressed topic within the context of women's health care. Women's health indicators in Primary Health Care (PHC) are mainly related to the number of screening tests collected and performed prenatal consultations (Brazil, 2007), while more sensitive issues, such as sexual complaints and dysfunctions, may be neglected. In addition, the lack of adequate professional training in the field often makes health providers feel uncomfortable when addressing aspects related to sexuality or sexual health with their patients (Brazil, 2013).

According to a Brazilian survey involving more than 7,000 individuals, nearly half of Brazilian women present some type of sexual dysfunction, and more than 30% report sexual desire dysfunction (Abdo et al., 2002). Nevertheless, both the clinical approach and scientific production regarding this topic remain scarce (Edelman et al., 2015; Ketzer et al., 2022).

Sexuality and sexual satisfaction among women in PHC, outside the reproductive or gender-related context, have been poorly documented in the literature (Edelman et al., 2015; Ketzer et al., 2022). One study evaluated men's sexual and reproductive health in PHC using a qualitative approach and discussed the relationship between men and health care services, focusing on gender issues and the invisibility of men in primary care settings (Telo & Witt, 2018).

Human sexuality is understood as comprising four phases: desire, arousal, orgasm, and resolution. The experience of sexual pleasure and fulfillment is multifaceted, resulting from the interaction between subjective, emotional, and relational factors that go beyond merely quantitative criteria (Basson, 2001).

However, sexual satisfaction is not directly related to sexual frequency, although one cannot assume that this relationship does not occur in the perception of satisfaction with the frequency, whether high or low. This happens because sexual satisfaction may be associated with a variable frequency, if it is perceived as adequate and gratifying for the woman's sexual experience.

Therefore, the aim of this study was to describe aspects related to the sexual and reproductive health of women treated in PHC, using an objective approach to assess the perception of sexual satisfaction in relation to the frequency of sexual intercourse.

Methods

This was a cross-sectional study conducted in four PHC units in Ribeirão Preto, São Paulo, Brazil, using a convenience sample between January 28, 2022, and February 20, 2023. The acronym SUPREMA (SexUality and REproductive Planning of Women in Primary Health Care in Ribeirão Preto) was adopted for this study. At the time of data collection, Ribeirão Preto had approximately 728,400 inhabitants and a high Human Development Index (IBGE, 2024).

The SUPREMA Project aimed to evaluate women’s sexual and reproductive health, as well as the risk of sexual dysfunction. Women older than 18 years who had attended at least one gynecological consultation in PHC in the previous year and who had been sexually active in the last 12 months were included. Women up to 3 months postpartum, illiterate women, and transgender women were excluded. For sample size calculation, a prevalence of 34% of sexual desire dysfunction was assumed, according to a Brazilian population study (Abdo et al., 2002). Considering a significance level of 5%, 336 participants would be required. Assuming a 10% loss rate, the inclusion of a total of 370 participants was estimated. All participants signed an informed consent form, and the study was approved by the Ethics Committee of the Hospital das Clínicas of Ribeirão Preto (CAAE: 486225215.5.0000.5440).

Women seeking medical care at these health units during the recruitment period were invited to participate in the study. Those who agreed the Informed Consent form, and underwent direct interviews to obtain sociodemographic characteristics, general health data, obstetric history, reproductive planning, and assessment of sexual satisfaction, including questions from the “U on Sex” questionnaire. “U on Sex” is a questionnaire developed and validated in Portuguese to facilitate the objective assessment of sexual problems in PHC, helping direct cases requiring specialized care (Scalco, 2019). It consists of three questions evaluating sexual intercourse frequency, orgasm frequency, and the woman’s initiative during sexual activity.

Collected data were analyzed using means and standard deviations as measures of dispersion for continuous variables, while absolute numbers and frequencies were used for categorical variables. Missing data or questions participants chose not to answer were excluded from analysis. Regarding satisfaction with sexual frequency, women were divided into two groups: “satisfied” and “unsatisfied.” Chi-square and Fisher’s exact tests were used to compare groups, and Pearson’s correlation was applied to evaluate the relationship between “U on Sex” variables and satisfaction with sexual frequency. Rx64 4.3 software was used for statistical analysis, adopting a significance level of 5%.

Results

A total of 725 women were invited to participate in the study between January 2022 and February 2023, of whom 391 were initially included. Three participants were excluded for not answering the question regarding sexual satisfaction, resulting in a final sample of 388 women. The mean age was 32.4 ± 9.7 years. Most participants (206; 53.1%) were in the reproductive period, self-identified as White (208; 53.6%), and were married or in a stable relationship (212; 54.6%). The majority of the sample also had more than 10 years of education (294; 75.7%), paid employment (244; 62.8%), and reported having a religion (more than 70%). The comparison between the “satisfied” and “unsatisfied” groups is presented in Table 1.

Table 1 - Comparison of sociodemographic characteristics according to satisfaction with sexual frequency among study participants in Ribeirão Preto, São Paulo, Brazil, 2025 (n=388)

Variables	Satisfied with sexual frequency (n=297)	Unsatisfied with sexual frequency (n=91)	p
Age (years)			
18-39	166 (55.9%)	40 (44.0%)	0.05*
40-64	115 (38.7%)	48 (52.8%)	
≥65	16 (5.4%)	3 (3.3%)	
Race/Ethnicity			
White	162 (54.5%)	46 (50.5%)	0.82*
Brown	123 (41.4%)	42 (46.2%)	
Black	6 (2.0%)	1 (1.1%)	
Asian	6 (2.0%)	2 (2.2%)	
Marital status			0.17*
Single/widowed/separated	129 (43.4%)	47 (51.6%)	
Married/stable relationship	168 (56.6%)	44 (48.4%)	
Education (years)			
Up to 4	6 (2.0%)	2 (2.2%)	0,91*

5–9	65 (21.9%)	21(23.1%)	
10–12	140 (47.1%)	39 (42.9%)	
≥13	86 (29.0%)	29 (31.9%)	
Employment			
Yes	182 (61.3%)	62 (68.1%)	0,24*
No	115 (38.7%)	29 (31.9%)	
Religion			
Yes	212 (71.4%)	68 (74.7%)	0,53*
No	85 (28.6%)	23 (25.3%)	

* Chi-square test.

Regarding lifestyle habits and clinical variables, greater satisfaction with sexual frequency was observed among women who had previously used psychoactive substances ($p<0.01$) and among those who did not report health problems ($p=0.04$). No significant associations were found with the remaining clinical variables (Table 2).

Table 2 - Comparison between lifestyle habits, clinical variables, and sexual satisfaction, Ribeirão Preto, São Paulo, Brazil, 2025 (n=388)

Variables	Satisfied with sexual frequency (n=297)	Unsatisfied with sexual frequency (n=91)	p
Smoking	57 (19.2%)	21 (23.1%)	0.42*
Alcohol consumption	148 (49.8%)	47 (51.7%)	0.76*
Substance use	36 (12.1%)	2 (2.2%)	<0.01**
Reported health problems	99 (33.3%)	41 (45.1%)	0.04**
Use of anxiolytics or antidepressants	49 (16.5%)	16 (17.6%)	0.81*
Having leisure time	228 (76.8%)	67 (73.6%)	0.54*
Engaging in physical activity	106 (35.7%)	33 (36.3%)	0.92*
Having personal time	223 (75.1%)	67 (73.6%)	0.78*

* Chi-square test, ** Fisher's exact test.

Women who reported sexual intercourse without desire or who reported extramarital sexual relationships by their partners showed a higher prevalence of dissatisfaction with sexual frequency ($p=0.02$ and $p=0.02$, respectively; Table 3). On the contrary, no significant associations were observed between satisfaction regarding sexual frequency and contraceptive use ($p=0.34$), having children ($p=0.06$), living with children ($p=0.26$), planned pregnancy ($p=0.34$), early sexual debut ($p=0.65$), personal history of sexually transmitted infections ($p=0.86$), or history of extramarital relationships by the participant herself ($p=0.06$) (Table 3).

Table 3 - Sexual and reproductive characteristics of study participants in Ribeirão Preto, São Paulo, Brazil, 2025 (n=388)

Variables	Satisfied with sexual frequency (n=297)	Unsatisfied with sexual frequency (n=91)	P
Contraceptives			0.34*
Yes	174 (58.6%)	46 (50.5%)	
No	49 (16.5%)	22 (24.2%)	
Menopause	73 (24.6%)	23 (25.3%)	
Did not answer/other	1 (0.3%)	0	
Has children			0.06*
Yes	256 (65.9%)	71 (18.2%)	
No	41 (10.5%)	20 (5.1%)	
If yes, lives with them?			0.26**
Yes	150 (50.5%)	38 (41.8%)	
No	53 (17.8%)	22 (24.2%)	
	94 (31.6%)	31 (34.1%)	

Did not answer/other Unplanned pregnancy			0.34*
Yes	55 (18.5%)	23 (25.3%)	
No	167 (56.2%)	45 (49.5%)	
Did not answer/other Sexual debut < 15 years			0.65*
Yes	75 (25.3%)	23 (25.3%)	
No	31 (10.4%)	8 (8.8%)	
Sexual Orientation	266 (89.6%)	86 (94.5%)	0.03*
Heterosexual	3 (1.0%)	3 (3.3%)	
Homosexual	28 (9.4%)	2 (2.2%)	
Bisexual			0.86*
History of STI	72 (24.2%)	22 (5.6%)	
Yes	224 (75.1%)	69 (17.7%)	
No	1 (0.3%)	0	
Did not answer			
Have you ever had an extra-marital relationship?			0.06*
Yes	0	2 (2.2%)	
No, but have had in the past	37 (12.5%)	9 (9.9%)	
Never	258 (86.9%)	80 (87.6%)	
Did not answer	2 (0.7%)	0	
Partner had an extramarital relationship			0.02*
Yes	89 (30.0%)	40 (44.0%)	
No	203 (68.4%)	51 (56.0%)	
Sex against one's will			0.02*
Yes	183 (61.6%)	68 (74.7%)	
No	114 (38.4%)	23 (25.3%)	

Legend: STI: Sexually Transmitted Infection * Chi-square test, ** Fisher's exact test.

Regarding the "U on Sex" results, all 388 participants completed the questionnaire. A significant association was observed between the three evaluated parameters (frequency of sexual intercourse, orgasm rate, and initiative for sexual activity) and satisfaction with sexual frequency. Satisfied women reported a higher frequency of sexual intercourse ($p < 0.01$), higher orgasm rates ($p = 0.01$), and greater initiative during sexual activity ($p = 0.01$), as demonstrated in Table 4. In addition, a positive correlation was observed between satisfaction with sexual frequency and the "U on Sex" variables of frequency ($r = 0.37$; 95% CI: 0.28–0.46) and orgasm ($r = 0.13$; 95% CI: 0.03–0.22).

Table 4 - Comparison of "U on Sex" questionnaire results according to satisfaction with sexual frequency, Ribeirão Preto, São Paulo, Brazil, 2025 (n=388)

"U on Sex" Questionnaire	Satisfied with sexual frequency (n=295)	Unsatisfied with sexual frequency (n=91)	P
Sexual frequency per month			<0.01*
<2 times	34 (11.5%)	38 (41.8%)	
2-11 times	161 (54.6%)	49 (53.9%)	
≥12	100 (33.9%)	4 (4.4%)	
Orgasm (in every 10 sexual encounters)			0.01*
7 times or more	157 (53.2%)	39 (42.9%)	
2-6 times	105 (35.6%)	31 (34.1%)	
0-1 times	33 (11.2%)	21 (23.1%)	
Takes initiative for sexual activity (in every 10 sexual encounters)			0.01*
7 times or more	35 (11.9%)	17 (18.7%)	
	170 (57.6%)	36 (39.6%)	

2–6 times	90 (30.5%)	38 (41.8%)
0–1 time		

* Chi-square test

Discussion

This study identified that, in a sample of women treated in PHC in the countryside of São Paulo, the presence of comorbidities, exposure to unwanted sexual intercourse, and a history of partner infidelity were associated with greater rates of complaints of dissatisfaction with sexual frequency. Despite this, most participants reported being satisfied with their sexual frequency. Psychoactive substance use and bisexual orientation were associated with greater satisfaction with sexual frequency.

Sociodemographic and lifestyle variables were not significantly associated with satisfaction regarding sexual frequency, nor were previous STI history or contraceptive use. Although the participants' mean age was 32 years, nearly half of the sample was in the climacteric period or older age groups. This proportion may have contributed to the higher presence of comorbidities, consequently reducing sexual desire and sexual frequency (Davis et al., 2008).

Furthermore, the climacteric and aging are associated with an increased diagnosis of sexual dysfunctions (Abdo et al., 2002; Davis et al., 2008). Although sexual frequency is not a direct diagnostic criterion for sexual dysfunctions, it may be used as a parameter reflecting perceived improvement in sexual quality of life. This assumption is supported by studies involving postmenopausal women, in which testosterone therapy increased sexual frequency in cases of hypoactive sexual desire, which can be interpreted as an improvement in sexual function (Davis et al., 2008; Karaahmet & Bilgiç, 2024).

Interestingly, parameters usually associated with quality of life, such as “having time for oneself,” “engaging in physical activity,” and “having leisure time,” were not associated with greater sexual satisfaction. Likewise, antidepressant and anxiolytic use did not show significant associations. Antidepressants are known to increase the risk of sexual dysfunction, particularly related to desire (Lee et al., 2010). However, appropriate treatment of conditions such as depression and anxiety may compensate for this impact, resulting in improved sexual function, which may explain the absence of association found.

There is no robust evidence regarding the impact of contraception on the diagnosis of sexual dysfunctions. Female sexual response is multifactorial, influenced by psychosocial factors, such as contraceptive security against unplanned pregnancy, and biological factors, such as testosterone production and bioavailability (Both et al., 2019). Previous studies suggest that contraception does not exert a relevant negative impact on young and single women (Huang et al., 2020), which corroborates our findings, considering that most participants were in the reproductive period.

Our study identified a low prevalence of dissatisfaction with sexual frequency, in contrast to the estimated 34% prevalence of sexual dysfunction in Brazil (3). Satisfaction with sexual life may itself be considered a criterion for sexual dysfunction, since diagnosis depends on personal distress associated with the complaint (França et al., 2023). Despite using an initial and less specific instrument, the positive association between sexual complaints assessed by the “U on Sex” questionnaire and sexual satisfaction reinforces the applicability of this tool in PHC.

Similarly, having children, living with them, and the occurrence of unplanned pregnancies were not associated with greater sexual dissatisfaction. However, the literature indicates that these factors may affect the couple's sexual life. During pregnancy, women may experience insecurity regarding bodily changes and concerns about their partner's reaction, whereas after childbirth parental demands and caregiving overload may reduce intimacy, decrease available time for sexual activity, and favor sexual dysfunctions, especially those related to desire and satisfaction (Abdolrasulnia et al., 2010). Moreover, female sexual satisfaction is modulated not only by biological factors, but also by psychological and relational aspects, such as marital bonding, emotional support, and partner involvement during and after pregnancy, all of which are fundamental for maintaining sexual health (Oliva et al., 2025).

In addition, an association was observed between sexual frequency, orgasm rate, and initiative for

sexual activity, assessed through the “U on Sex” questionnaire, and satisfaction with sexual frequency, as well as a positive correlation between satisfaction and the instrument’s variables of frequency and orgasm. Therefore, the direct question “Are you satisfied with your sexual frequency?” may represent an objective strategy to initiate the clinical approach to sexuality.

Dissatisfaction may be related to both excessive and insufficient sexual activity, both of which may indicate a negative impact on sexual function, or even exposure to sexual intercourse against one’s will. Although the topic is clinically relevant, patients and health professionals face difficulties initiating this conversation (Abdolrasulnia et al., 2010; Oliva et al., 2025). Despite sexuality already being considered an expected competency in medical and gynecological training programs (Abdolrasulnia et al., 2010; Sobacki et al., 2012; Febrasgo, 2019), in competency-based Family and Community Medicine curricula, for example, emphasis is placed on sexuality during the pregnancy-puerperal cycle, but there is little mention of women’s sexual health in general or of sexually and gender-diverse populations (such as lesbian, bisexual, and transgender women) (SBMFC, 2015).

Women from sexually diverse populations tend to present lower prevalence rates of sexual dysfunctions, particularly those related to desire and orgasm. The plurality of sexual practices and experiences, associated in some cases with substance use, such as in the context of chemsex (use of psychoactive drugs to enhance, prolong, or facilitate sexual activity), may contribute to this phenomenon (Maxwell, Shahmanesh & Gafos, 2019). In this study, a greater proportion of dissatisfaction was observed among heterosexual women when compared to bisexual women, reinforcing the need for further investigation of this group. However, the greater satisfaction observed among bisexual women may be related to factors such as diversity of affective-sexual experiences, less rigid gender role norms, or greater communication regarding sexual preferences (Santo, Nonato & Silva, 2022). These hypotheses were not directly evaluated in this study and do not allow causal inference. Interpretation of these findings should consider the possibility of unmeasured confounding variables.

Regarding psychoactive substance use, the type, frequency, and context of use were not detailed; therefore, it is not possible to infer a direct effect of these substances on sexual function. These associations may reflect sociocultural factors, greater behavioral liberalism, or greater openness in reporting satisfaction, rather than a direct pharmacological effect.

It should be emphasized that this study is one of the few seeking to understand women’s perspectives in PHC, a setting in which women’s demands should include sexuality as an aspect of quality of life. Objectively, the guiding question used in the analysis demonstrates that it is possible to investigate aspects of sexuality that are commonly not addressed in routine practice without causing discomfort. The effectiveness of this approach still needs to be confirmed by multicenter studies including populations with different socioeconomic and cultural profiles.

The socioeconomic profile of the sample represents a limitation of this study, since it consisted predominantly of women with higher educational attainment and workforce participation, living in a municipality with a high Human Development Index, which may not directly represent the reality of other PHC services in Ribeirão Preto. This profile may limit the generalization of the findings to populations treated in more vulnerable PHC contexts, where adverse social determinants may differently influence sexuality and perceptions of satisfaction. Although sociodemographic, clinical, and behavioral variables were considered, other factors relevant to sexual satisfaction, such as relationship quality, communication between partners, mental health, and a history of sexual or intimate partner violence, were not explored in depth.

The cross-sectional design prevents establishing causality between the associated variables and satisfaction with sexual frequency, restricting interpretations to associations. The “U on Sex” instrument has not been validated for transgender women or different sexual orientations, and the question regarding intercourse “without desire” does not allow differentiation between spontaneous and responsive desire, nor inference of coercion or violence. Nevertheless, satisfaction with sexual frequency proved to be a simple and potentially useful clinical marker for initiating discussions on sexual health in PHC and should be complemented by broader assessments in future studies, preferably multicenter studies with more diverse samples.

Conclusion

In a sample of women treated in PHC in Ribeirão Preto, sexual satisfaction was associated with previous substance use, absence of comorbidities, and bisexual sexual orientation. In contrast, reporting lack of desire in intercourse, having comorbidities, or having experienced partner infidelity were associated with dissatisfaction regarding sexual frequency. The question “Are you satisfied with your sexual frequency?” was associated with frequency of intercourse, orgasm occurrence, and initiative to engage in sexual activity, representing a feasible and potentially effective clinical strategy to introduce discussions about sexual health in PHC.

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