SEXUAL MEDICINE REVIEWS REVIEW

Female Sexual Dysfunction Among Muslim Women: Increasing Awareness to Improve Overall Evaluation and Treatment

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ABSTRACT

Introduction: Muslim women are an increasingly underserved population in the United States and worldwide. Diagnosis and treatment of female sexual dysfunction bring unique challenges because of the conservative nature of those practicing the religion. Several cultural and religious codes of conduct affect sexual behavior and the dysfunction that can ensue.

Aim: To assess and describe the types of sexual dysfunction that have been found in Muslim women internationally and encourage a better understanding of their issues to enhance health care delivery.

Methods: A comprehensive review of the literature through Ovid and PubMed was performed in search of articles reviewing female sexual dysfunction, Muslim women, and Islam.

Main Outcome Measures: A brief explanation and review of the interpretations of sexuality within Islam are discussed. The link is made between conservative sexual relations and interpretations and the types of sexual dysfunction experienced. Female sexual dysfunction is explored in relation to how female chastity is extolled and how cultural procedures continue despite the ethical and health concerns related to them.

Results: Most Muslim women experience sexual dysfunction similar to other women, including arousal, desire, and orgasmic disorders related to organic and psychologic factors. Sexual pain disorders might be more prevalent in this population, particularly concerning unconsummated marriage. There are special concerns related to maintaining virginity and preserving the hymen until marriage. Female genital cutting, practiced by some Muslim countries, has potential sexual consequences.

Conclusion: Understanding Islamic views on sexuality and how they can affect sexual dysfunction in Muslim women is critical in opening lines of communication with patients and approaching female sexual dysfunction impartially. Although some issues that arise might introduce ethical dilemmas for the provider, having the cultural competence to address these issues will facilitate improved health care delivery. **Rahman S. Female Sexual Dysfunction Among Muslim Women: Increasing Awareness to Improve Overall Evaluation and Treatment. Sex Med Rev 2018;X:XX–XX.**

Key Words: Muslim Women; Female Sexual Dysfunction; Vaginismus; Islam; Hymenoplasty; Dyspareunia

INTRODUCTION

The current changing political and social climate in the United States, particularly with regard to Muslim immigrants and refugees, has brought increasing attention to treating and caring for Muslim patients in America. According to the Pew Research Center, the number of hate crimes against Muslims in America is increasing and Muslims are feeling threatened in the United States, which can affect their access to medical care. This report indicates that 3/4 of Muslim adults (75%) say there is "a lot" of discrimination against Muslims in the United States, which is a view shared by 7 of 10 adults in the public (69%). Nearly 1/4 of Muslims in the United States (23%) believe that discrimination from Islamophobia and xenophobia is the most important problem facing Muslims in the United States today.[1] According to the Institute of Medicine, there are still "quality chasms" that exist for minority groups in the United States owing to the lack of cultural competence by many health care providers and lack of education and understanding of certain underserved and under-represented groups.[2] Muslim women in America compose 1 of these growing groups.

Muslims are followers of Islam, a monotheistic religion that is 1 of the fastest growing religions in the United States, with 1.6 billion followers globally. Muslims are from different cultural

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backgrounds and countries that span the globe. The largest population of Muslims is in Indonesia, with more than 160 million followers. Arabic-speaking populations, including those living near the Persian Gulf and in north African countries, constitute 15% of the world's Muslims, and those living in the Indian Subcontinent (Pakistan, India, and Bangladesh) constitute 33% of the world's Muslims. The number of Muslims living in the United States is 4 to 7 million, with nearly half this population (47%) being women.[2] This makes for great diversity in these patients with regard to generational differences, culture, and even religious diversity. American Muslim women have diverse and plural experiences. It can be challenging to provide culturally competent health care to this population of women without relying on media stereotypes of the "oppressed nature" of Muslim women. For example, the 2nd-generation American-born Shi'ite Muslim patient of Pakistani descent who has adopted American culture and has similar sexual experiences as other American women might look different than the Saudi Arabian immigrant who is dressed modestly and is a practicing Sunni Muslim who prefers to see only a female provider with her husband who always accompanies her visits. Generalizations about Muslim women can misguide the health care provider in the diagnosis and treatment of patients.[3]

Some Muslim women who adhere to traditional Islamic values have health care needs that should be accommodated if possible. These include dietary restrictions, desiring female-only providers, special needs during fasting in the holy month of Ramadan, and other hygiene concerns related to prayers that might not be met owing to lack of knowledge by providers. Some studies have found that failure of health care providers in the West to accommodate the customs and practices of traditional Muslim women have led to diminished participation in certain programs such as breast cancer and cervical cancer screening.[3]

An aspect of health care that is particularly overlooked in women in general, but particularly in Muslim women, is that of sexual health and function. Sexual health and function are affected not only by biologic and psychologic factors but also by sociocultural factors that are reflected in religious belief and interpretations through different cultures. Female sexual dysfunction (FSD) should be assessed using the biopsychosocial model that considers the patient's culture, religion, social situation, and personal relationships. However, the provider also should remember the psychologic and neurochemical balance that affects sexual function.[4] For example, for most believers, religion provides a moral compass to follow, and within these rules and guidelines to live by, sexual behavior and attitudes are developed. It has been demonstrated that religious and conservative individuals can have an increased risk for sexual dysfunction but it is uncertain to what extent.[5]

Sexual abuse and intimate partner violence constitute a broader topic that should be addressed. It has been documented that victims of different types of sexual abuse can have altered sexual function. For example, Muslim women might may have specific types of gender-based violence perpetrated against them depending on their original culture and the geopolitical climate of the country of origin, particularly if they recently immigrated or are refugees (ie, "dowry deaths and burnings," rape as a war crime, "acid attacks," "honor killings," etc). These patients, just like any other victims of sexual abuse or intimate partner violence, should be approached in a sensitive manner with appropriate psychosocial support that is needed during the evaluation for sexual dysfunction.[6]

Some investigations have reported that when sexual dysfunction is assessed, interpretation and attitudes of sexual behavior can contribute more than the degree of religiosity. This explains why sexual dysfunction might be diagnosed, for example, in the Catholic patient who attended all-girl schools with a conservative and negative viewpoint about sex and the 2nd-generation Muslim American who was not allowed to date and was instructed to avoid sexual relations until marriage. Specifically, sexual dysfunction in these women is believed to be related to the ideals of waiting until marriage to have sex or being taught that sex is "bad." Although many dysfunctions described in this article can be seen in traditional religious groups of Christian, Jewish, Buddhist, or Hindu origin and many other cultures, this article focuses on Muslim women.[7]

METHODS

An in-depth search of Ovid Medline and PubMed databases and the ISSM website and journals was performed using the key words *female sexual dysfunction* and *Muslim* or *Islam*. An average of 29 articles was found. The search was expanded to identify certain predominately Muslim countries such as Iran, Malaysia, Saudi Arabia, Turkey, Indonesia, India, and Sub-Saharan Africa. Because certain types of sexual dysfunction were more common than others, an emphasis on sexual pain disorders, consequences of female genital cutting (FGC), and issues related to virginity became the focus of this descriptive review of 40 articles. Most articles were retrospective, with small samples being the major weakness in these articles.

RESULTS AND DISCUSSION

Sexuality and Islam

Understanding the interpretations of the teachings of Islam as it is practiced among women with regard to sexuality is vital. The *Holy Qur'an* (the holy book in Islam) and the *Hadith* (teachings from the Prophet Muhammad) guide the moral codes of practicing Muslims. In Muslim countries, *Shari'ah* (Islamic law) governs their way of life. Although there is a great deal of negative association in the media with this term, it is meant to provide Muslims with guidance on how to live a moral and ethical life consistent with the teachings of the *Holy Qur'an* and the *Hadith*. Muslim jurists provide interpretations of these teachings based on the situation, especially with regard to modern-day issues.[8]