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FREQUENCY OF SEXUAL DYSFUNCTION IN MARRIED WOMEN OF REPRODUCTIVE AGE IN PAKISTAN

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Abstract

Background: *Female sexual dysfunction is a significant issue with regard to the reproductive and psychological health of a woman, which is underreported in most developing nations because of cultural and social stigma.*

Objective: *To estimate the occurrence of sexual dysfunction among married women of reproductive age in one of the tertiary care hospitals in Pakistan.*

Methods: *The cross-sectional research was performed at the Department of Obstetrics and Gynecology, Memon Medical Institute Hospital (MMIH), Karachi, between March 2025 and June 2025. The sample of 200 married women aged between 18 and 45 years old used the non-probability consecutive sampling. A structured questionnaire that contained demographic data and the Female Sexual Function Index (FSFI) to measure sexual functioning was used to capture data. Individuals with disorders of sexual health, including serious psychopathic disorders and cancer, were not permitted to attend the study. SPSS version 26 was utilized to analyze data, whereas the frequencies and percentages were calculated by means of descriptive statistics.*

Results: *The 200 respondents found that 86 women (43 percent) had sexual dysfunction according to the FSFI scores. The most frequently reported issues were reduced sexual desire (39%) and arousal difficulties (34%), orgasmic dysfunction (31%), lubrication problems (28%), and pain during sexual intercourse (26%). Sexual dysfunction was detected in various age groups and reproductive histories.*

Conclusion: *Among married women who are reproductive, sexual dysfunction is prevalent and is a significant yet under-recognized area of reproductive health. Awareness, counseling, and regular screening should be enhanced in the gynecological practice in order to ensure the sexual health of women and to improve the overall quality of life.*

INTRODUCTION

Sexual health is a vital factor of total well-being and quality of life in women, especially within the reproductive years, where physiological and psychological factors, combined with relational

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factors, play a significant role in intimate relations (1). The common definition of female sexual dysfunction (FSD) is a disruption of sexual desire, arousal, lubrication, orgasm, satisfaction, or pain, which results in personal distress or interpersonal difficulty. It is known that FSD is a major yet unreported health issue among women within the reproductive age bracket across the globe (2). Women are often unable to talk openly about sexual health issues, especially in conservative cultures, due to cultural barriers, lack of awareness, and social stigma. A meta-analysis and systematic review found that a significant percentage of women have some type of sexual dysfunction throughout their reproductive years, and this implied that the disorder is prevalent and clinically relevant among diverse groups of people (3). A study done on women who have endured chronic illnesses like diabetes has also established that sexual dysfunction may influence marital satisfaction, emotional well-being, and general living standards.

In South Asian populations, the research studies also present the significance of integrating sexual health in marriage relations, and that sexual dysfunction has adverse effects on intimacy and marital harmony. Besides, the age during the reproductive years has been linked to progressive changes in sexual functioning and sexual quality of life in married women (4). There are a few biological and medical disorders that lead to the development of sexual dysfunction among women. Certain long-term diseases like autoimmune diseases, endocrine disorders, and metabolic diseases can directly influence sexual desire and physiological sexual reactions. Indicatively, a study that was carried out on women with rheumatoid arthritis has revealed that pain, fatigue, and the impact of medication could greatly affect sexual functioning and intimate relations (5). Equally, women with type 2 diabetes mellitus are likely to develop hormonal imbalances, neuropathy, and vascular complications, which may result in impaired sexual functioning and reduced libido (6). In addition to the medical factors, psychological distress and relationship factors have a significant role in female sexual health.

The research undertaken on married women of reproductive age in the Middle East and other parts of the world has reported that sexual distress is mostly attributed to the emotional well-being, satisfaction in the marriage, and communication between married partners (7). In others, sexual dysfunction can go as far as causing marriage failures like unconsummated marriages, the effects of which can be deadly in terms of reproductive events and psychological well-being (8). Sexual and reproductive health of women in Pakistan and other developing nations is a complicated factor that depends on the interaction of social, cultural, and healthcare factors. The structural barriers to access to reproductive health services by many women are also a significant issue, especially with the marginalization of vulnerable groups. The national demographic statistics have revealed that there is an inequality in the use of reproductive health services by Pakistani women, particularly those who are disabled or have limited socioeconomic status (9).

Other cultural issues, including consanguinity marriages and early marriage, can also have an impact on the reproductive health outcome of women and marriage processes that can indirectly impact sexual functioning (10). In addition, qualitative research, which had been carried out among women with chronic medical conditions in Pakistan, shows that sexual health issues are usually not discussed openly during the routine examination given by the patients and the health caregivers (11). This failure to communicate is one of the reasons why sexual dysfunction is underdiagnosed and underreported in women. Sexual dysfunction among married women is also closely related to reproductive health problems, including infertility, hormonal imbalance, and gynecological complications. Psychological stress, low self-esteem, and marital conflict are also often associated with infertility and can have an adverse impact on sexual relationships. Pakistan-based studies conducted in hospitals have also established several risk factors for infertility, including hormonal imbalance, infections, and lifestyle factors (12). Studies carried out in neighbouring Middle Eastern nations have also found that the prevalence of female sexual

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dysfunction was significant and the predictors were age, education, and chronic illness (13).

Pakistani local studies have also noted that infertility has become an increasing issue in public health, and with social pressure and cultural expectations, the couples that are affected by infertility are experiencing more emotional distress (14). This kind of stressor can result in low sexual satisfaction and also be the cause of sexual dysfunction in married women who are of reproductive age. The reproductive behavior and family structure, along with the marriage expectations, also influence the sexual experiences of women in matrimony. The implications on physical health of women and mental well-being may be influenced by short birth intervals, high fertility expectations, and low reproductive autonomy. Research studies on married women in Karachi have established that the patterns of reproductive behavior, such as closely spaced pregnancies, are linked to various health complications that indirectly affect the sexual health and marital satisfaction (15). Furthermore, community-based studies have also shown that gynaecological diseases such as infections and menstrual diseases are frequent among married women and can affect sexual functioning and intimate relationships in a negative way (16).

The social expectations on fertility and bearing of children could also affect the perception of women about sexual relationships, especially in those societies in which motherhood is closely associated with marriage stability (17). Although there is an increasing awareness of sexual health as part and parcel of reproductive health, scanty information exists concerning the reality of incidence and causes of sexual dysfunction among reproductive-age Pakistani married women. Since the subject is culturally sensitive and there is little research in this field, learning the burden of sexual dysfunction among Pakistani women is crucial towards enhancing reproductive health-related services and marital well-being. Clinical intervention on sexual health issues is also likely to lead to improved marital relationships, mental health, and quality of life among women. Therefore, this research intends to establish the prevalence of sexual dysfunction among married reproductive-age women in Pakistan and to provide evidence that can be used in future reproductive health policy and intervention.

Objective: To calculate the prevalence of sexual dysfunction in married women within the reproductive age group visiting the Gynecology Department of Memon Medical Institute Hospital (MMIH), Karachi and to establish the demographic and reproductive-related factors.

MATERIALS AND METHODS

Study Design: A cross-sectional descriptive study.

Study Setting: Department of Obstetrics and Gynecology, Memon Medical Institute Hospital (MMIH), Karachi, Pakistan.

Duration of Study: March 2025 to June 2025.

Sample Size: The WHO sample size calculator was used to estimate the total sample size of 200 married women of reproductive age by estimating the prevalence of female sexual dysfunction to be about 45, a 95 percent level of confidence, and a margin of error of 7 percent.

Inclusion Criteria: The study included pregnant women who were between 18 and 45 years old and those attending the antenatal clinic or those hospitalized at the Department of Obstetrics and Gynecology of Department of Obstetrics and Gynecology, Memon Medical Institute Hospital Pakistan, The study was Receiving the ethical approval IRB/MMIH/2023.37 date 08-11-2023 of the Institutional Review Board (IRB) of Memon Medical Institute Hospital Pakistan, in a span of Four months, following the consent of the synopsis by the College of Physicians and Surgeons Pakistan (CPSP) was approved from March 2025 to June 2025, clinic during the study period and were in a married state were included. Individuals who were willing and able to participate and had sex in the last three years were enrolled in the study. Only women who had been married for at least one year were included to ensure that there was sufficient sexual and marital exposure.

Exclusion Criteria: The study also excluded women who were pregnant during the study, those who were severely mentally ill, those who were

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diagnosed with a malignancy, and those who were undergoing treatment for a known sexual dysfunction. Women who were not keen on taking part were also left out.

Methods

Consecutive recruitment of married women who met the inclusion criteria was done in the outpatient department after institutional ethical review committee consent was obtained. Each participant signed an informed consent form as written after the explanation of the goals and confidentiality of the research. The structured and pre-tested questionnaire was used to collect data. The questionnaire was divided into two parts: the first part, which measured demographic factors like age, marriage duration, level of education, and reproductive history, and the second part, which measured sexual function using the Female Sexual Function Index (FSFI), which is a validated measure and evaluates variables like desire, arousal, lubrication, orgasm, satisfaction, and pain. By conducting the questionnaire in a confidential place, participants were comfortable, and this also guaranteed confidentiality. The scores were given based on standardized FSFI guidelines, and there was a cutoff point that determined sexual dysfunction. The analysis and data input were done in SPSS version 26, where descriptive statistics were used to identify the frequencies and percentages.

Results

The population used in the study was 200 married women of reproductive age, who were studied at the Department of Obstetrics and Gynecology, Memon Medical Institute Hospital (MMIH), Karachi. The average age of the subjects was 31.4 ± 6.2 years, and the majority of the women were between 26 and 35 years. Most of the participants were housewives, and most of them had been married for over five years. The level of education among the participants was different, and a significant number of participants had finished their secondary education. The population data showed that women visiting the outpatient clinic were a heterogeneous group that represented the reproductive segment of the population.

Table 1: Demographic Characteristics of Participants (n=200)

Variable	Category	Frequency (n)	Percentage (%)
Age (years)	18–25	38	19.0
	26–35	96	48.0
	36–45	66	33.0
Education	No formal education	52	26.0
	Primary	58	29.0
	Secondary	60	30.0
	Higher	30	15.0
Duration of Marriage	1–5 years	70	35.0
	6–10 years	82	41.0
	>10 years	48	24.0

Reproductive characteristics were analyzed, and it was observed that most of the women had two or more children. One-third of the respondents had a history of gynecological complaints, including vaginal infection, menstrual abnormalities, or pelvic pain. It was a lower percentage among those who had a history of infertility or reproductive health problems.

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Table 2: Reproductive Characteristics of Participants (n=200)

Variable	Category	Frequency (n)	Percentage (%)
Number of Children	None	28	14.0
	1–2	92	46.0
	≥3	80	40.0
Gynecological Complaints	Yes	64	32.0
	No	136	68.0
History of Infertility	Yes	22	11.0
	No	178	89.0

Sexual functional assessment with the Female Sexual Function Index (FSFI) showed that a significant percentage of the participants reported some sexual dysfunction. In total, 86 women (43%) and 114 women (57%) were diagnosed with sexual dysfunction and normal sexual functioning based on the FSFI cutoff score, respectively. Declines in sexual desire and arousal issues were the most common reported issues in various spheres of sexual functioning.

Table 3: Frequency of Sexual Dysfunction (n=200)

Sexual Function Status	Frequency (n)	Percentage (%)
Sexual Dysfunction	86	43.0
Normal Sexual Function	114	57.0

Follow-up analysis of FSFI domains revealed that the reduced sexual desire was reported by 39 percent of women, and the problems with arousal were reported by 34 percent. The participants had problems with lubrication (28 percent) and orgasmic problems (31 percent). Its prevalence was about 26 percent among women who experienced pain during intercourse, and this affected their general sexual satisfaction in a negative way.

Table 4: Distribution of Sexual Dysfunction Domains (n=200)

Domain	Frequency (n)	Percentage (%)
Desire disorder	78	39.0
Arousal disorder	68	34.0
Lubrication difficulty	56	28.0
Orgasm difficulty	62	31.0
Pain during intercourse	52	26.0

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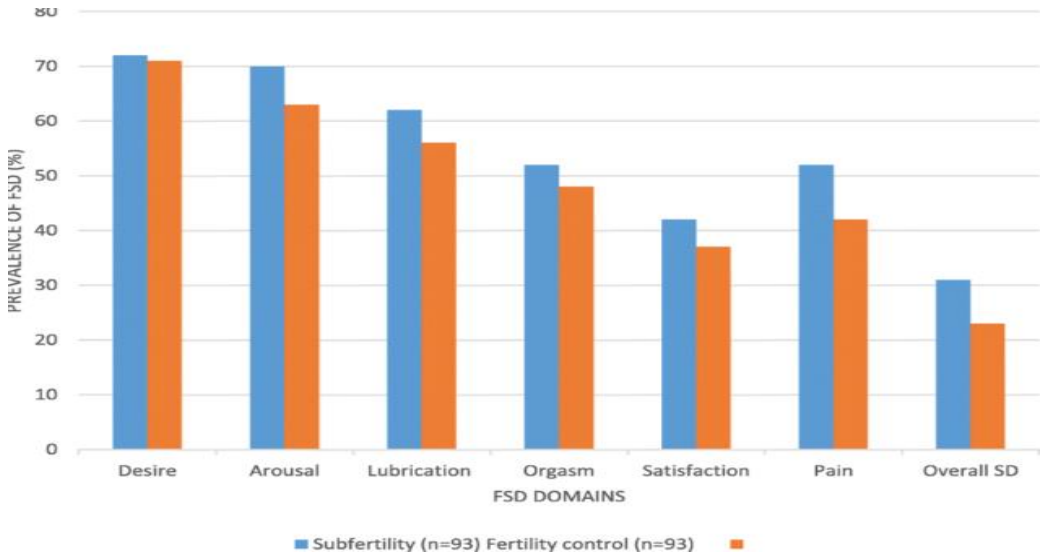

Graph: Overall Frequency of Sexual Dysfunction

The graphical illustration shows that the sexual dysfunction existed among a significant number of reproductive married women. The results indicate that almost half of the respondents have problems with one or more areas of sexual functioning, and the clinical and public health significance of female sexual health needs consideration within reproductive health care services is evident.

Discussion

Female sexual dysfunction is also becoming a major aspect of reproductive and mental health of women, but it is still a topic of under-discussion and underreporting in most developing nations, including Pakistan. The current research was intended to establish the prevalence of sexual dysfunction in married women in the reproductive age group using a tertiary care hospital. The results indicated that the Female Sexual Function Index (FSFI) showed that 43 percent of the participants had some level of sexual dysfunction. This prevalence is in line with the emerging literature on sexual dysfunction in the international literature, which noted that sexual dysfunction is prevalent among women of reproductive age. A systematic review and meta-analysis have indicated that female sexual dysfunction occurs in a significant number of women all over the world, and the prevalence rates have varied with different cultures, measurement instruments, and sample groups (1). On the same note, research that has been conducted on women with persistent medical ailments, including diabetes mellitus, has demonstrated that sexual dysfunction is significant and may severely affect quality of life and marital fulfillment (2).

The studies carried out in Pakistan have also shown that sexual health has a significant contribution to marital relationship experience, where sexual dissatisfaction may adversely affect intimacy and emotional connection between the husband and the wife (3). Among women of reproductive age, age has been determined as one of the significant determinants affecting sexual function. Though the reproductive age group is usually believed to symbolize optimal sexual health, alterations in physiology and psychology as one grows with age may affect sexual functioning and contentment. The population of the current study had mostly participants aged between 26 and 35 years, and sexual dysfunction was witnessed across the various age groups. Other studies have previously suggested that even during the reproductive age, aging could cause progressive changes in sexual desire, lubrication, and orgasmic capacities. In research done on married women, it

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was established that aging factors were strongly linked to lower sexual quality of life and high rates of sexual dysfunction (4).

Moreover, chronic inflammatory conditions like rheumatoid arthritis have also been associated with sexual impairment because of pain, fatigue, and mobility that can disturb intimate relationships (5). Metabolic conditions, especially diabetes mellitus type 2, are additional causes of sexual dysfunction due to vascular, neurological, and hormonal weaknesses in sexual reaction (6). There are also psychological and relational factors that are very important in the sexual health of women. Sexual experiences in marriage largely depend on emotional intimacy, marital satisfaction, and sexual communication between spouses. Women can develop sexual distress but be hesitant to get medical assistance in those societies where very little is said about sexual matters. Research that has been conducted in relation to sex among married women in the neighbouring countries has reported that sexual distress is directly associated with marital satisfaction and psychological well-being (7). In other instances, extreme sexual dysfunction can be the cause behind the unconsummated marriages that could cause infertility issues and emotional torment among the couples (8).

These results point to the intricate nature of the interaction between psychological, relational, and biological factors when it comes to having an impact on sexual health outcomes. The sexual and reproductive health of women is also affected by the sociocultural setting of Pakistan. Access to the information about reproductive health, social stigma about sexual discourse, and gender norms may not allow women to communicate about sexual issues. National demographic surveys have found that there are inequalities in the use of reproductive healthcare services among women in Pakistan, especially those with socioeconomic disadvantages or disabilities (9). Other cultural factors, like consanguinity marriages, can also have an impact on reproductive health and family relations, which in turn can indirectly impact marital relations and sexual functioning (10). In addition, qualitative research studies on Pakistani women with chronic medical conditions indicate that there is a low rate of discussing sexual health issues during clinical visits since patients and medical practitioners do not discuss such sensitive issues (11).

Other factors that are related to sexual dysfunction include reproductive health conditions such as infertility and female reproductive disorders. A state of infertility may cause a lot of psychological pressure to the couple, especially in societies where bearing a child is closely linked to marriage security and acceptance in society. Research carried out in Pakistan at hospitals has cited several medical and lifestyle causes of infertility among married people that include hormonal imbalances, infections, and late childbearing (12). Other comparable studies have been carried out on the Middle Eastern population, where a large percentage of female sexual dysfunction was noted, and some predictors that were observed included age, chronic disease, and psychosocial stress (13). Pakistan local evidence shows that infertility also causes emotional distress and tension in marriage, which can also affect sexual satisfaction in women with infertility (14).

Women also have sexual experiences that are affected by the reproductive patterns and family dynamics. Lack of reproductive autonomy, high fertility expectations, and short birth intervals can have an adverse impact on the physical health and sexual well-being of women. A cross-sectional survey of married women in Karachi has indicated that closely spaced pregnancies are linked to several reproductive health problems, which are indirectly associated with sexual relations (15). Moreover, gynecological morbidities in married women have been noted to be high in the community-based research, with infections, menstrual disorders, and pain in the pelvis, all of which could be contributing factors to sexual discomfort and dissatisfaction (16). The attitude of women towards sexual relationships in marriage is further guided by social pressures on fertility and childbearing. Within the context of most cultures, sex is usually coupled with reproduction and not pleasure, an aspect of reproduction that restricts the freedom of women to express their sexual desires and interests (17). Comprehensively, the conclusion of the current research is that sexual

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dysfunction is a fairly prevalent phenomenon in married Pakistani women of childbearing age and a neglected but significant aspect of reproductive health.

Conclusion

The current research proved that in Pakistan, sexual dysfunction is relatively prevalent among married women within a reproductive age group and at a tertiary care hospital. Almost half of the respondents had challenges in one or more sub-areas of sexual functioning, such as desire, arousal, lubrication, orgasm, and pain during sex. These results show that female sexual dysfunction is a significant but widely neglected aspect of female reproductive health. The sexual dysfunction may be developed due to biological, psychological, relationship, and sociocultural factors, which include chronic illnesses and gynecological issues. Females in most of the conservative cultures, such as Pakistan, are not open to discussing sexual issues with medical practitioners due to cultural hindrances and ignorance. This makes the condition underdiagnosed and untreated. The introduction of sexual health evaluation in regular gynecological checkups, enhancing patient education, and facilitating open discussion between couples and the medical staff could be useful in preventing sexual dysfunction among women at an early stage.

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