Mangoes and bullets: Medicine for all?

- Contemporary recommendations for action on medicine, healthcare and sexuality in the SWANA region

1 What is the problem?

Sexuality in Arabic-speaking countries is often associated with a taboo, lack of education and control of the sexuality of often female and queer bodies. While feminists in Western countries and in the global North desire and usually achieve liberation from such controlling structures, this is often not possible for women and other people from the FLINTA community in Arabic-speaking countries, as they are usually financially, socially and emotionally dependent and, in the worst case, run the risk of losing their livelihood or, in rare cases, even their lives. Therefore, the text focuses on knowledge from the global South, especially from the SWANA region (South-West Asia & North Africa), in the hope that it will resonate with people from the global North who are working in the context of medical secondment programmes or in medical development policy, whether full-time or on a voluntary basis, and are active in the region in question.

In Arabic-speaking countries, sexuality is a familial and social issue and therefore difficult to live out individually (7). The lack of intercultural and intersectional sensitivity of medical staff and the lack of awareness of the realities of patients' lives, which is often reflected in treatment recommendations that are inappropriate for the patient, can therefore only be detrimental to the success of treatment. This can be measured, for example, by the lack of utilisation of breast cancer and cervical cancer screenings by Muslim women* and women* with a history of migration (13).

1.1 Virginity and virginity test

Sexuality in Arabic-speaking countries is often controlled by the preservation of virginity of biologically female bodies. This can have religious (1), social and cultural reasons. In this context, virginity is recognised by the presence of the hymen - also known colloquially as the "hymen".

"hymen" - is defined (3). Thus, the loss of the hymen is also socially associated with the loss of virginity and thus the first sexual intercourse (3). The fact that sexual intercourse can also take place in forms other than vaginal penetration is not taken into account. It is therefore possible that young women* allow their partner to satisfy them anally in order to avoid the loss of the hymen. The presence of the hymen and the false definition of virginity based on it determines not only the life and reputation of the woman*, but also that of the whole family. To avoid this, given structures try to control a woman's* sexuality so that she* remains a virgin until marriage. Accordingly, unmarried women* also avoid using tampons and having a gynaecological examination just to ensure the integrity of the hymen (16). Dating and going out with male friends is also often rare and difficult to accept (3). Rebelling against this or

freely living one's sexuality outside of marital structures can lead to the loss of the woman's* livelihood, as she is often financially, socially and emotionally dependent on her family and partner. In addition, the women concerned feel a "debt of obligation" towards their families and their culture, so that they* develop feelings of guilt when having sex outside of marriage (3).

In order to guarantee a given "virginity", the woman* is often subjected to a so-called

"virginity test" is often carried out on women*. This is an examination by a given gynaecologist that confirms the presence of the hymen and, in the best-case scenario, virginity. As a feminist gynaecologist from other structures, carrying out a "virginity test" can be

"virginity test" can be rejected on the basis of one's own feminist approaches. Would this not support and maintain the misogynistic structures that control women's* sexuality?

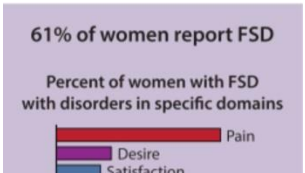
1.2 Hymen reconstruction

The situation is similar with hymen reconstruction. If the woman* has had illegitimate vaginal penetrative sexual intercourse, there is a great fear of the "virginity test" and the unfortunately believed myth of "blood on the bed sheet". This is the idea that penetrating the hymen causes an injury and therefore drops of blood that are supposed to be visible on the bed sheet. In order to adorn themselves with a supposed virginity, affected women* are often willing to undergo hymen reconstruction. This is a surgical procedure in which a supposed hymen is constructed using supposed drops of blood. This allows the woman* to "prove" her virginity and has nothing to fear. In this case, too, the treating gynaecologist may be in conflict with their own feminist approaches. This also raises the question of whether the problematic structures are being supported by such a procedure. In addition, there are general surgical risks as with any other surgical procedure, such as bleeding, infections, etc. These thoughts can quickly lead to a lack of understanding on the part of the treating person.

1.3 Sexual dysfunctions

Sexual dysfunctions are just as common and relevant among Arabic-speaking and Muslim women* as among other women and FLINTA persons globally. What distinguishes them, however, is the high prevalence of dyspareunia, which inevitably leads to a lack of sexual intercourse (2, 11). Certain religious or cultural upbringings can cause a

dissonance with one's own sexual identity. For example, strict and rigid religious structures in childhood can lead to sexual dysfunction later on (1). A lack of sexual education often leads to feelings of shame and fear, including a phobia of vaginal penetration, which ultimately leads to an impairment of sexual fulfilment (14). In this study, married women from the Gaza Strip were interviewed about their sexual dysfunction. Statistically, no significance was found between sexual dysfunction and the parameters polygamy, frequency of sexual intercourse, age of the woman and man, occupation of the woman and man, educational status, abortions in the past, number of children, duration of marriage and use of contraceptives. Instead stressful life experiences, a low socioeconomic background and poor living conditions are more likely to be the cause (11). The parameters of cultural taboos, lack of sexual education, family influence, etc. are specifically associated with pain during sexual intercourse (15).



Maasoumi R et. al, 2019

1.4 STDs - sexually transmitted infections and contraceptives

Even if the topic of sexuality is very taboo and is controlled by social expectations, it cannot be ruled out that illegitimate, possibly same-sex sexual intercourse is still practised. The problem here is that a lack of sexual education and difficult access to contraceptives, such as condoms and wipes, as well as HIV prevention measures make it easier to contract sexually transmitted infections, especially in the case of risky sexual behaviour (25). For example, young men are afraid of being scrutinised in the pharmacy when buying condoms or being asked about their relationship status (22, 24). As same-sex life is not seen as normal in almost all Arabic-speaking countries, it can be assumed that, for example, leaking cloths will not be found. In addition, ignorance among young people increases the risk that they will engage in unprotected sexual intercourse (19). Not only ignorance, but also disinformation is an issue. HIV is labelled as a disease of "other countries". This is justified by the fact that these countries have no sexual morals and would therefore contract HIV.

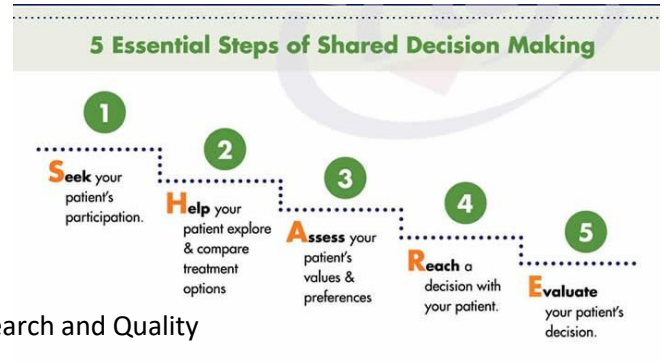
https://wisevoter.com/country-rankings/std-rates-by-country/

In Egypt, for example, there have been calls for years for comprehensive sexual education in the education system. However, this is met with incomprehension: young people would be motivated to engage in promiscuity and illegitimate sexual intercourse (17). The incidence of sexually transmitted sexually transmitted infections in Arabic-speaking countries are comparable to those in Western countries. These data need to be scrutinised. The great shame and fear of social consequences as well as the ignorance and disinformation about sexually transmitted infections suggest a high rate of unreported cases.

2 What needs to change?

2.1 Get to know the realities of patients' lives!

As with any form of patient treatment, the concept of shared decision-making is essential. This requires dealing with the realities of the patient's life. Religion plays a major role here. Contrary to Western stereotypes, it is not only Muslim women and FLINTA people who live here, but also a minority of Christian, Jewish and other religiously orientated people. Since religions also have guidelines on sexuality and pregnancy, these should be learnt by medical staff. However, it should be noted that religious people are not a homogeneous group, but are individually interpret and live out the guidelines. A certain awareness of this increases cooperation between patient and doctor, gives the patient a sense of autonomy and prevents compliance failure. In addition to religion, cultural factors should also be prioritised. Myths, misunderstandings or simply cultural wishes and traditions that are valuable to the local community can have an impact on sexuality. Of course, other factors should not be forgotten, such as socio-economic background, educational status, financial situation and thus any financial dependence on other people, sexual orientation and sexual behaviour, relationship status and family situation.



The SHARE Approach, Agency for Healthcare Research and Quality

Intercultural skills among medical staff have been proven to improve patient healthcare, including in gynaecology and obstetrics (2, 12, 26)!

2.2 Educational work

Educational work is right and important (27)! The earlier and longer a person is sexually educated, the better and more sustainable it is (28, 30). Sex education gives the person concerned autonomy over their own body. Furthermore, unwanted pregnancies can be reduced, reduce the infection rates of sexually transmitted infections such as HIV, reduce the incidence of vaginismus and consequently promise a more beautiful sex life, enable a more conscious and safer way of dealing with one's own body and increase awareness of gender-specific diseases (19, 21, 29). In order to ensure successful sex education, it is necessary to look at the existing forms of sex education in the various Arabic-speaking countries, as these can vary greatly from country to country (18). The American College of Obstetricians and Gynecologists developed the following recommendations. Education should be medically accurate, evidence-based and age-appropriate. In addition, education should be provided not only about the anatomy of the body, gender-specific diseases, contraceptives to protect against unwanted pregnancy or sexually transmitted infections, but also about sexual violence and abuse, gender identities and sexual orientations, different forms and possibilities of relationships, communication with partners and consent (28).

2.3 Consideration of local possibilities and regulations

In order to familiarise yourself with the regulations and options on gynaecological issues in your country, we recommend using this database (www.sexualrightsdatabase.org/countires). It contains all the necessary information including information on the availability of contraceptives, legal regulations on abortion, etc. Looking into this ensures better health care by determining what health care looks like in the respective country and what gaps there are that can be filled. For example, the rate of sexually transmitted infections can be reduced by providing condoms (19). One's own understanding should always be reflected and it should not be assumed that Arabic-speaking countries are more regressive than Western countries. In Egypt, for example, various contraceptive options have been made available to women free of charge since September 2022 (24).

3. How can things change?

3.1 General examination conditions

When examining and treating Muslim women* in particular, it should be noted that they* have a much greater sense of shame and are therefore reluctant to expose their bodies and especially their genitals to strangers, regardless of the gender of the person performing the examination. Understandably, it becomes even more uncomfortable for the patient if the person is male (12). It would be important to focus on the patient's wishes and well-being. Furthermore, many avoid a gynaecological examination due to the fear that the hymen could tear (16). It is therefore important to only perform gynaecological examinations if there are sufficient indications.

3.2 "Virginity tests"

The WHO clearly calls for an end to so-called "virginity tests" and for medical staff and communities to be sufficiently informed about the lack of significance of the test (10). However, it cannot be ruled out that young women* will continue to insist on a test despite being informed and having sufficient knowledge about the lack of significance of the test. It can be assumed that this is due to the fear of not meeting social and familial expectations. As will be explained in more detail in the next point, in many cases it can lead to the loss of the woman*'s livelihood and in a few cases even her life. However, such situations do not preclude continuous education.

3.3 Hymen reconstruction

The dilemma that a gynaecologist from Western structures might feel has been explained in detail above. It must be emphasised that in this dilemma and the associated discussion, the voices and perspectives of the women* who are actually affected are barely heard (5).

The indication for hymen reconstruction must be assessed from the local cultural circumstances and not from one's own perspective, which is foreign to the local culture (4). This means that even if the treating person feels uncomfortable about playing into the hands of patriarchal structures through the surgical procedure, the women* affected are given a form of autonomy and security (3). They can therefore safely 'prove' that they are virgins and do not have to fear any consequences. It gives the women* concerned self-determination over their own bodies and sexuality and, in conservative rural areas such as Egypt, can rarely mean that their lives are spared (8). In this dilemma, the life and freedom of the woman* concerned have a higher priority than her own conscience and the risks of the intervention (6, 9). Where possible, care should also be taken to ensure that the patients concerned can receive hymen reconstruction regardless of their financial situation in order to avoid discrimination based on socioeconomic background. Another important point is religious categorisation.

The religious reference should not be forgotten, especially in the case of Muslim patients. How and whether hymen reconstruction is permitted in Islam is answered differently. We recommend this article (9) (https://www.sciencedirect.com/science/article/abs/pii/S1743609517312924).

3.4 Sex therapy

As mentioned above, cultural and religious upbringings play a major role in the development of anxiety and the associated sexual dysfunctions. This makes it all the more important for the treating person to develop an understanding of this and to demonstrate this understanding to the patient (15). This facilitates communication and the patient's willingness to undergo medical, physiotherapeutic or psychological treatment and thus improves the outcome. (1, 2, 15). Sexual education, education on the anatomy of the body, relaxation techniques or, if the patient agrees, individualised sex therapy are also helpful (1, 14).

*: Women are mentioned in many places. This refers to people in the FLINTA community who are read as women and have vaginas and vulvas. This includes not only cis women, but also trans men and intersex people. Nevertheless, I decided to use the word "woman" as there is an almost complete lack of recognition of gender identities outside the cis-heteronormative form in Arabic-speaking countries. Unfortunately, the studies cited also only speak of "women" without being able to categorise these people more closely.

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