

Female Sexual Dysfunction in Women living in Puerto Rico

Denisse Soto-Soto, MD*; Gabriella Rivera-Ortiz, MD*;
Claudia Rosado-Torres, MD*; Julianne Quintero, BS†;
Josefina Romaguera, MD, MPH, FACOG*;
Keimari Mendez, MD, MSc, FACOG*

Objective: To investigate female sexual function and its association with sociodemographic factors and comorbidities among Hispanic women in Puerto Rico (PR).

Methods: The study consisted of 2 phases. Phase 1 validated a Spanish version of the Female Sexual Function Index (FSFI) questionnaire with added sections that elicited sociodemographic information and medical history. Phase 2 involved a cross-sectional study in which the validated questionnaire was distributed at multiple gynecology clinics. The domains assessed included Desire, Arousal, Lubrication, Orgasm, Satisfaction, and Pain and were scored using the FSFI. Descriptive statistics characterized participant profiles, and we analyzed relationships with total FSFI scores using Wilcoxon–Mann–Whitney, Kruskal–Wallis, and Spearman correlation tests.

Results: Among 311 participants who completed the questionnaire, the prevalence of female sexual dysfunction (FSD) was 45.34% ($n = 141$), similar to estimates reported in the US (not including PR).

Most of the participants were younger than 40 years (56%, 173) and reported having partners (63%, 195). Desire was the most affected domain. Correlations were observed between FSD and both medical history (particularly ovarian insufficiency) and medication use (particularly beta-blocker use).

Conclusion: The high FSD prevalence in PR highlights the need for screening to improve characterization and treatment, ultimately enhancing patients' quality of life.

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Key words: Sexuality, Sexual Dysfunction, Puerto Rico, Caribbean, Hispanics

Female sexual dysfunction (FSD) is an abnormality or disruption of the dynamic female sexual response that is perceived by the individual as causing personal distress. Sexual health is crucial to the well-being of individuals and can impact relationships, self-esteem, and mental health (1,2). To meet diagnostic criteria for FSD, a patient must report 1 or more of the following symptoms: low desire, diminished arousal, difficulty reaching orgasm, or dyspareunia. There is a variety of potential causes of FSD, including physical, psychological, and social factors. Treatment options for FSD may include medication, psychological therapy, and/or lifestyle changes, depending on the condition's underlying cause (2,3).

Because FSD is a complex condition with multiple presentations and several confounding medical comorbidities, it is challenging to estimate its prevalence accurately. Numerous tools have been developed to assess female sexual function, and notably, the Female Sexual Function Index (FSFI) has risen to prominence as one of the most widely utilized screening instruments. The FSFI is a 19-item self-report questionnaire designed to assess key domains of sexual function. A score of ≤ 26.55 is commonly used as a threshold for potential sexual dysfunction. However, it is important to note that the FSFI cannot be employed as a diagnostic tool, as it does not assess distress in patients, nor does it exclude comorbidities as potential causes of symptoms (1,4).

According to previous studies, the prevalence of FSD in women of reproductive age worldwide has been estimated to be

approximately 41% (5), similar to the approximately 40% reported in the US (1,6). The underreporting and undertreatment of FSD are common due to stigma and embarrassment. Thus, the true prevalence of FSD in the US may be higher than reported. There is a lack of epidemiological studies on FSD in Hispanic women. This study aimed to determine the prevalence of FSD—defined by an FSFI score ≤ 26.55 —among Hispanic women living in Puerto Rico (PR) and to identify correlations with demographic and medical characteristics. We hypothesized that women in PR are at increased risk of sexual dysfunction due to their higher prevalence of medical comorbidities.

Methods

This cross-sectional study was approved by the University of Puerto Rico Medical Sciences Campus (UPR-MSC) Institutional Review Board (IRB; protocol #2290033754). Participants were

*Department of Obstetrics and Gynecology, School of Medicine, University of Puerto Rico Medical Sciences Campus, San Juan, Puerto Rico; †School of Medicine, University of Puerto Rico Medical Sciences Campus, San Juan, Puerto Rico

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Address correspondence to: Keimari Mendez, MD, Department of Obstetrics and Gynecology, University of Puerto Rico School of Medicine, PO Box 36-5067, San Juan, PR 00936-5067. Email: keimari.mendez@upr.edu

required to provide informed consent before completing the questionnaire.

Data were collected from 2019 through 2021 at gynecology clinics affiliated with UPR-MSU, Metropolitan Hospital, and Hospital UPR Dr. Federico Trilla. Additional data were collected at the private practice of Dr. Keimari Mendez, gynecologist/obstetrician. Inclusion criteria consisted of females aged 21 years old or older who were sexually active within the 6 months prior to their gynecologic evaluation and were living in PR at the time of the study. Individuals were excluded if they could not read or write in Spanish or had an intellectual disability. The study consisted of 2 phases.

Phase 1 involved translating the FSFI questionnaire to Spanish and validating a version suitable for the Puerto Rican community. Questions were added to the FSFI to collect demographic characteristics, including age, sex, relationship status, sexual orientation, and municipality of residence in PR. Clinical history included the number of vaginal deliveries; psychiatric, cardiologic, gastrointestinal, rheumatologic, urologic, and respiratory conditions; obesity; ovarian insufficiency (OI); cancer (gynecologic and non-gynecologic); gynecologic anomalies; and nutritional disorders. In the medication section, participants were asked about their use of antidepressants, oral contraceptive pills, antihistamines, finasteride, antiepileptics, medicinal marijuana, prescription opioids, beta-blockers, benzodiazepines, illicit drugs, and chemotherapy. The questionnaire was validated using a pilot test taken by 30 participants who spoke Spanish and lived in PR. An evaluation sheet with a comment box was provided for feedback. Data were reviewed by research personnel, and the questionnaire was finalized and approved by the IRB. The questionnaire consisted of 28 items, 19 from the FSFI and 9 additional items assessing demographics.

Phase 2 consisted of a cross-sectional study. The 28-item anonymous questionnaire was completed by participants who met the inclusion criteria during their gynecologic appointments. The FSFI portion of the questionnaire assessed the following 6 domains of sexual function: Desire, Arousal, Lubrication, Orgasm, Satisfaction, and Pain. These items are scored on a 5-point Likert scale ranging from 1 to 5. A high score indicates a high level of sexual dysfunction. Fifteen of the items include zero as an option for participants who wish to report no sexual activity or no attempts to start intercourse. Questionnaires were scored using the FSFI domain and full-scale scores. A full-scale score ≤ 26.55 is suggestive of FSD. The total full-scale score can range from 2 to 36 points.

Statistical analysis

Descriptive statistics were used to summarize the participants' demographic data, clinical history, medications utilized, and FSFI scores. No sample calculations were done. Unadjusted relationships between independent variables and the total test score were assessed using the 2-sample Wilcoxon–Mann–Whitney rank-sum test, the Kruskal–Wallis rank test, or Spearman's correlation test, depending on the nature of the variable. A *P* value of .05 or less was considered an indicator of a significant difference for all tests. Statistical analysis was performed using Stata, version 14.2 (StataCorp, College Station, Texas, USA).

Results

During Phase 1, 30 participants evaluated the translated survey, including the added demographic and medical history sections. The participants had no suggestions for changes. The demographic variables added included age, relationship status, sexual orientation, and municipality of residence in PR. The medical history section, as previously described, captured information that included their gynecologic, psychiatric, cardiac, gastrointestinal, rheumatologic, urologic, respiratory, oncologic, and nutritional diseases or conditions and medications.

A total of 311 participants completed Phase 2 of the study. The descriptive analysis summarized the demographic and clinical characteristics of our study population. Table 1 shows that most of the participants (56%) were under 40 years old and that 63% had a partner. With respect to sexual orientation, 96% of the participants identified as heterosexual, with the remaining 4% identifying as non-heterosexual.

Table 1. Sociodemographic characteristics and Female Sexual Function Index score

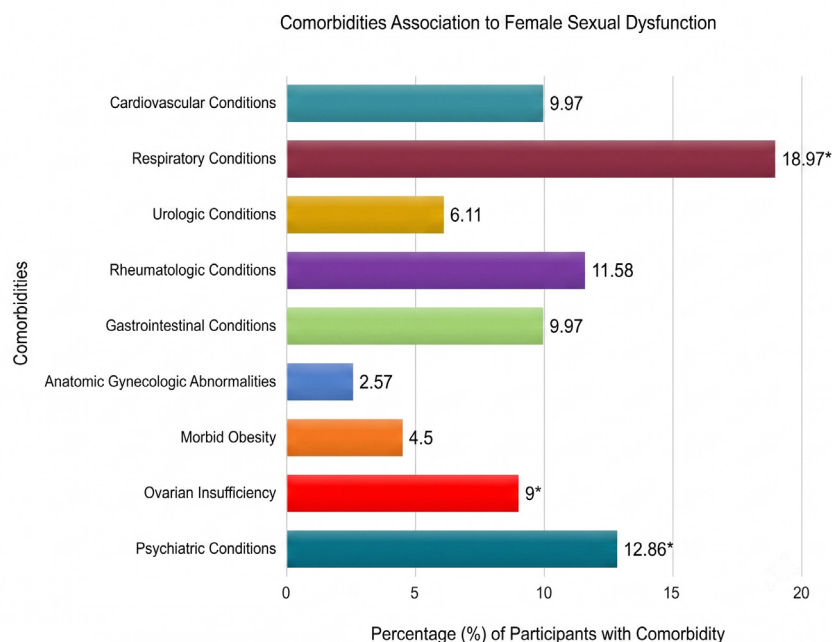
	n (%)	FSFI mean	<i>P</i> value
<i>Age by category</i>			
21–30	87 (28.16)	26.26	.0006*
31–40	86 (27.83)	27.15	
41–50	79 (25.57)	24.14	
51–60	40 (12.94)	21.56	
61–70	17 (5.50)	22.53	
<i>Civil status</i>			
Partner	195 (62.70)	26.40	.0563
No partner	116 (37.30)	23.14	
<i>Sexual orientation</i>			
Heterosexual	288 (96.32)	25.32	.1880
Homosexual/bisexual	11 (3.68)	21.56	
<i>PR region</i>			
North	215 (69.13)	25.11	.764
Other region	96 (30.90)	25.32	

Abbreviations: FSFI, Female Sexual Function Index; PR, Puerto Rico.

**P* < .05

Regarding comorbidities, the participants reported a range of conditions, as shown in Figure 1. Most notably, 18.97% reported respiratory conditions, followed by 12.86% with psychiatric conditions, 11.58% with rheumatologic conditions, 9.97% with cardiac conditions, 9.97% with gastrointestinal conditions, and 9% with OI. Figure 2 shows participants' medication use: antihistamines (17.36%), antidepressants (8.68%), medical cannabis (7.07%), oral contraceptives (5.79%), beta-blockers (5.79%), benzodiazepines (3.22%), and opioids (1.93%).

Based on their having FSFI total scores of ≤ 26.55 , 45.34% of our participants were classified as likely having FSD. We evaluated the 6 sexual function domains individually, with the results shown in Figure 3. The average FSFI domain scores were as follows: 3.80 for Desire, 4.11 for Arousal, 4.26 for Lubrication, 4.20 for Orgasm,

Figure 1. Comorbidities association to Female Sexual Dysfunction

Psychiatric conditions (N = 40), ovarian insufficiency (N = 28), morbid obesity (N = 14), anatomic gynecologic abnormalities (N = 8), gastrointestinal conditions (N = 31), rheumatologic conditions (N = 36), urologic conditions (N = 19), respiratory conditions (N = 59), cardiovascular conditions (N = 31). *P < .05. Each condition was analyzed as an individual entry.

4.55 for Satisfaction, and 4.25 for Pain. In our cohort, the average full-scale score on the FSFI questionnaire was 25.18.

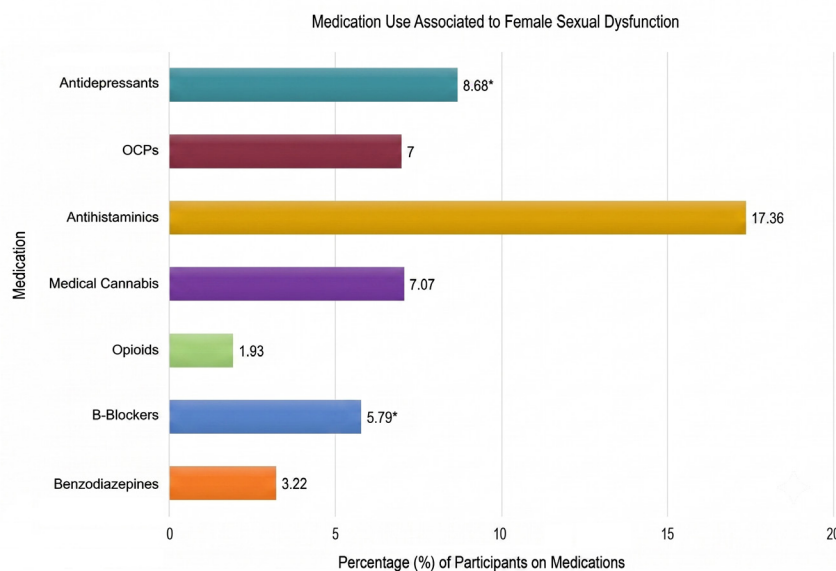
To explore associations between various factors and FSFI full-scale scores, we conducted univariate analyses. Age and FSFI full-scale scores exhibited a statistically significant association ($P = .0006$), with increasing age highly correlated with decreased FSFI full-scale scores (Spearman's $\rho = -0.195$). On the other hand, there was no statistically significant difference between civil status and FSFI full-scale scores ($P = .056$) based on comparisons between participants with partners and those without partners. Similarly, no statistically significant difference was observed in FSFI scores between individuals identifying as heterosexual and those identifying as homosexual or bisexual ($P = .056$). Only 11 individuals identified as homosexual or bisexual, which may have affected these results. Two individuals who identified as asexual were excluded, as sexual desire manifests differently in asexual individuals compared with others

Furthermore, geographic region, obstetric history, and several clinical conditions demonstrated no statistical significance in FSFI scores. However, participants with psychiatric conditions, respiratory conditions, or OI, as well as those who used antidepressants or beta-blockers, showed statistically significant differences in FSFI full-scale scores.

These individuals had lower scores. Conversely, no statistically significant differences in FSFI scores were observed for patients with cardiac conditions, gastrointestinal conditions, gynecologic cancer, or gynecologic anomalies, or in those who used oral contraceptives, antihistamines, medical marijuana, opioids, or benzodiazepines.

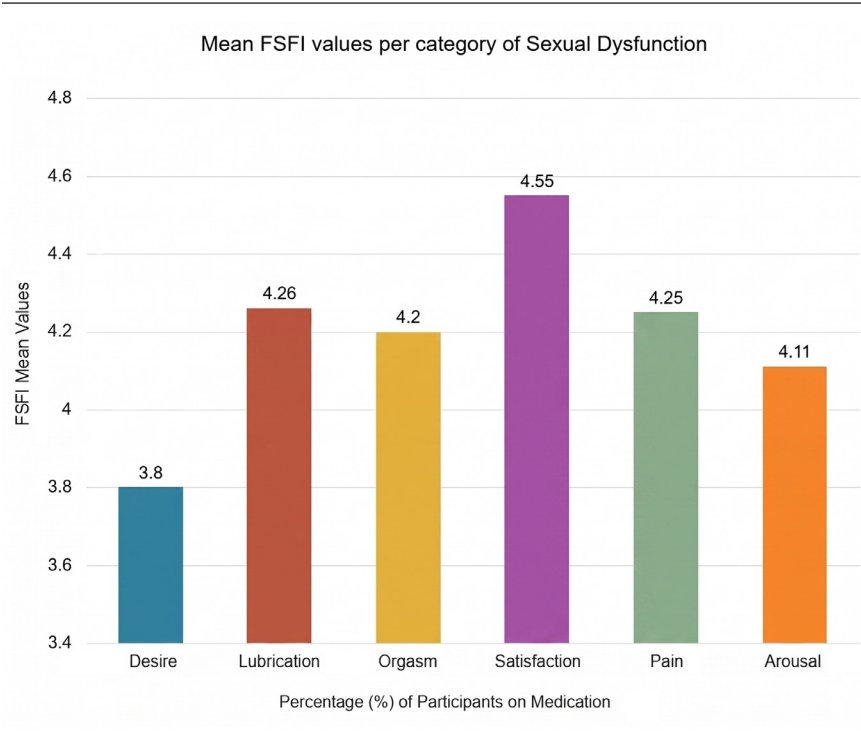
Discussion

This study assessed the sexual function of women in PR. Forty-five percent ($n=141$) of participants met the criteria for FSD based on the FSFI full-scale score, with a mean FSFI score of 25.18. Our study also found a statistically significant correlation between age and FSFI scores. Compared to studies conducted outside PR, our

Figure 2. Medication use associated to Female Sexual Dysfunction

Abbreviation: OCP, oral contraceptive pill. Benzodiazepines (N = 10), beta-blockers (N = 18), opioids (N = 6), medical cannabis (N = 22), antihistamines (N = 54), oral contraceptive pills (N = 18), antidepressants (N = 27). *P < .05. Each condition was analyzed as an individual entry.

Figure 3. Mean FSFI values per category of sexual dysfunction (N = 311)



Abbreviation: FSFI, Female Sexual Function Index

prevalence was found to be similar. A systematic review and meta-analysis of 138 studies published in 2016 estimated the prevalence of FSD in women of reproductive age worldwide at approximately 41% (5), which is slightly lower than the prevalence observed in our study population. Similarly, among women of reproductive age, the US has an estimated FSD prevalence of 43% (1,6). The somewhat higher prevalence observed in our cohort could be due to several reasons. Because the questionnaire was provided during gynecologic appointments, it is reasonable to assume that a significant number of participants might have had gynecologic problems, had medical conditions, and/or used medications, any one of which could affect sexual function in any of the 6 FSFI domains. That being the case, there may have been an overestimation of the prevalence of FSD in our cohort. Conversely, given that our study consisted of women under 40 years of age and that older age has been associated with decreased sexual function, it is possible that the younger age distribution may have biased the cohort toward higher FSFI scores and potentially underestimated the prevalence of FSD among the Puerto Rican population. However, many of the previously quoted studies focus on women of reproductive age, typically defined as those under 50 years old. Therefore, it could also be assumed that age might not significantly interfere with our results.

A cross-sectional study exploring sexual dysfunction in women in PR with inflammatory bowel disease was published in 2020. Using the FSFI questionnaire, 1000 patients diagnosed with Crohn's disease or ulcerative colitis participated and had a mean

sexual function score of 21.92, indicating sexual dysfunction among these Puerto Rican women. This study, like ours, also noted a decline in sexual function in women with increasing age, shedding light on FSD within this subset of the Puerto Rican population (7). These findings align with existing literature that suggests that women experience a decrease in sexual function with age (8,9). As women age, alterations in female anatomy, genitourinary function, hormonal levels, and societal roles can affect sexual function, desire, and the frequency of sexual activity. These changes encompass menopause, which leads to diminished vaginal lubrication and atrophy due to decreased estrogen levels, changes in libido, shifts in social perspectives, and an increased incidence of urogynecological pathology (8). Notably, older adults experiencing a decline in sexual desire or frequency of sexual activity often report lower overall well-being than those who do not (9).

Ovarian insufficiency, also known as ovarian failure, constitutes a multifaceted disorder characterized by reduced estrogen levels and menstrual irregularities owing to compromised ovarian function (10). This diagnosis had a substantial impact

on sexual health in our study, with 9% of the participants having FSFI scores within the FSD range. These findings are consistent with studies showing a 3-fold higher risk of FSD among patients with OI compared to women without the diagnosis, with similar sociodemographic characteristics (11). This association is not surprising, given that low estrogen levels have been associated with impaired vaginal health, which can result in dyspareunia due to reduced vaginal lubrication, diminished sexual arousal, and atrophy. Women experiencing these physiological symptoms may subsequently develop anxiety and decreased self-esteem, which can have a negative impact on their social interactions. (12).

Correlations between FSD and psychiatric conditions and between FSD and medications were assessed. In our study, 12.86% (N = 40) of the women with psychiatric conditions and 8.68% (N = 27) of the women who used antidepressants had low FSFI scores. Previous literature has established a strong association between depression, anxiety, and FSD, although causality remains unconfirmed (2). Recent research suggests that the presence of any 1 of these 3 conditions in women with FSD can increase the likelihood of their experiencing symptoms of the others, highlighting the importance of routine screening for comorbidities (2). Additionally, the use of psychiatric medication has been linked to sexual dysfunction, but this is challenging to assess due to the inherent association between psychiatric conditions and sexual dysfunction (2). Our findings indicate significant differences in FSFI scores based on the presence of a psychiatric condition and the use of antidepressants. Nevertheless,

these results emphasize the need for comprehensive assessment and management strategies for those experiencing any of these conditions.

Recent studies also demonstrated a higher prevalence of sexual dysfunction in both male and female patients with asthma than in healthy counterparts, underlining the complex, multifactorial nature of this respiratory disease (13). These findings align with the observations made in a separate study conducted in New York, in which sexual limitations ranked among the most frequently reported issues by asthma patients, emphasizing the importance of addressing these concerns comprehensively (14). Our study also reports similar findings, with 18.97% of the women in our study with respiratory conditions having lower FSFI scores. It is crucial to acknowledge the substantial disparities in asthma prevalence among various racial and ethnic groups—including those residing in regions such as PR—which experience alarmingly high rates. The current prevalence of adult asthma in PR is 11.4% (15), underscoring the urgency of exploring the broader impact of this respiratory condition on the well-being of these populations.

Regarding the associations between FSD and hypertension, this study revealed no significant correlation. However, a more detailed examination of women using beta-blockers revealed a pronounced negative impact on the sexual function of these women. Beta-blockers are medications that are commonly prescribed for the management of cardiovascular diseases, including hypertension and arrhythmias. Notably, adults living in PR experience a significantly elevated incidence of cardiovascular disease (16). Multiple studies have delved into the impact of cardiovascular disease, treated or untreated, on female sexual function (17). Evidence suggests that the use of beta-blockers may adversely affect sexual function in women. A cross-sectional study (18) found that 69.2% of women using beta-blockers experienced FSD, a notably higher percentage compared with the 42.7% prevalence of patients not using beta-blockers to manage essential hypertension. These findings underscore the importance of proactive screening in populations with a high burden of cardiovascular disease and suggest the potential value of interventions or medication adjustments to enhance the management of FSD.

The main strength of this study, which is the first to first to assess the prevalence of FSD in Hispanics living in PR, is that it provides a baseline for other studies to further investigate both sexual dysfunction and its potential associations with other medical conditions and medications in this population. While our study provides valuable insights, it has limitations. First, the FSFI is not a diagnostic tool. However, prior studies that have attempted to estimate the prevalence of sexual dysfunction have similarly used questionnaires and validated instruments to classify participants as having sexual dysfunction. Although similar rates were reported between US (not including PR) studies and our study, certain conditions and medications in our cohort were associated with higher FSD prevalence as measured by the screening instrument. The questionnaire assessed the presence or absence of psychiatric conditions as a general category, but not specific psychiatric diagnoses or medications. The only medications asked about were antidepressants and benzodiazepines, excluding other psychiatric medications such as antipsychotics and lithium.

Additionally, respiratory conditions were grouped without a distinction being made between asthma, pulmonary hypertension, and other respiratory conditions. Our findings highlight the importance of assessing multifaceted aspects of sexual health and tailoring interventions to address individualized needs. Future research should examine these multifaceted and interrelated factors to contribute to the understanding of female sexual function and guide targeted interventions for improved quality of life.

Conclusion

This study is the first to investigate the prevalence of FSD in Hispanic women living in PR. The FSFI questionnaire classified 141 participants in the study cohort as having FSD. Our analysis of associations between various factors and FSFI scores identified statistically significant correlations, with age, respiratory conditions, OI, and the use of antidepressants or beta-blockers showing an association with lower FSFI scores among these groups. However, further research is required to clarify these correlations and reach definitive conclusions.

Our findings emphasize the importance of assessing sexual function in the Hispanic female community. These results are consistent with previous studies demonstrating the high prevalence of sexual dysfunction in women. Furthermore, study suggests that FSD prevalence among Puerto Rican women is comparable to that observed in other populations, providing valuable context for understanding sexual health in this group.

Resumen

Objetivo: Investigar la función sexual femenina entre mujeres hispanas en Puerto Rico (PR), correlacionándola con datos sociodemográficos y comorbilidades. **Métodos:** El estudio constó de dos fases. La primera fase validó una versión en español del cuestionario del Índice de Función Sexual Femenina (FSFI, por sus siglas en inglés), con secciones adicionales para datos sociodemográficos e historial médico. La segunda fase implicó un estudio transversal en el que el cuestionario validado se distribuyó en múltiples clínicas de ginecología. Los dominios evaluados incluyeron deseo, excitación, lubricación, orgasmo, satisfacción y dolor, puntuados mediante el FSFI. Las estadísticas descriptivas presentaron los perfiles de los participantes y las relaciones con las puntuaciones totales se analizaron mediante las pruebas de correlación de Wilcoxon-Mann-Whitney, Kruskal-Wallis y Spearman. **Resultados:** El cuestionario fue completado por 311 participantes, revelando una prevalencia de disfunción sexual femenina (FSD, por sus siglas en inglés) del 45.34% (141), similar a los EU no incluyendo a PR). La mayoría de los participantes tenían menos de 40 años (56%, 173) y reportaron tener pareja (63%, 195). El deseo fue el dominio más afectado. Se encontraron correlaciones entre la FSD, el historial médico y el uso de medicamentos, en particular con la insuficiencia ovárica y el uso de betabloqueadores. **Conclusión:** La alta prevalencia de FSD en PR resalta la necesidad de realizar pruebas de detección para perfeccionar la caracterización y el tratamiento y mejorar la calidad de vida de los pacientes.

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