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Invited Review

The socio-cultural aspects of sexual medicine: recommendations from the Fifth International Consultation on Sexual Medicine (ICSM 2024)

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Abstract

Introduction: The intersection of culture, history, religion, traditions, laws, political trends, and evolving attitudes affects sexual expression and acceptance or rejection of sexual practices. Clinicians and clinical care are affected by these factors as well, although clinicians are not always aware of the way in which their training, their own experiences and attitudes influence the way in which they approach patients. In this paper, we contextualize and then describe 2 areas of sexual practices and 1 area of sexual difficulty that sexual medicine clinicians encounter in their practice, namely, the practice of female genital mutilation/cutting, penile circumcision, and the experience of unconsummated marriages.

Materials and Methods: Given the emerging knowledge of the socio-cultural aspects of sexual medicine, we conducted a narrative review of the extant literature through wide searches in PubMed, Google, and on global websites relevant to this topic, such as the World Health Organization, the United Nations, and others. The content of this paper was reviewed by all the authors, discussed where disagreements occurred, or additional perspectives were needed, and further literature was incorporated.

Results: We describe known practices of female genital cutting/mutilation and penile circumcision, their perceived benefits, and harms, but also with a view to the importance of patient empowerment and respect for self-determination. We discuss unconsummated marriages as the result of often culturally determined insufficient sex education and guidance, as well as clinical resources.

Discussion: We recommend that clinicians approach patients with both curiosity and cultural humility and that the International Society for Sexual Medicine (ISSM) adopt a strong ethical perspective as a part of the ongoing discourse on these practices and experiences.

Keywords: culture; sexuality; female genital mutilation/cutting; penile circumcision; unconsummated marriage; ethics; informed consent.

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Recommendation statements	Strength of recommendation
Sexuality, religion, tradition, and culture	
1. Clinicians should be aware of the patient's cultural context, recognizing that members of the same couple may not have the same beliefs; recommendations should respect the possibility that patients do not wish there to be a conflict between their beliefs and treatment recommendations.	**Strong**
2. Clinicians should be aware of healthy local practices, such as Kunyaza in Central Africa—a way of stimulating the vulva using the phallus and which is known to be highly pleasurable and triggers female orgasm.	**Strong**
3. Clinicians should be aware of potentially harmful cultural beliefs that may trigger or aggravate sexual dysfunction, such as dhat which finds semen wastage during wet dreams, masturbation, or in urination unacceptable	**Strong**
5. Clinicians should be aware of practices within religious groups that mitigate guilt and shame, for example, about sexual desire, thus preventing harmful psychological effects.	**Weak**
6. Clinicians should evaluate potential harm, based on scientific evidence rather than personal beliefs and practices, for example, virginity testing.	**Strong**
7. Clinicians should be aware of their own personal and cultural biases and resist negative judgment about cultural practices with which they are unfamiliar.	**Strong**
Female genital mutilation/cutting (FGM/C)	
1. Defibulation is a first-line intervention for those with Type III FGM/C to facilitate physiological micturition, passage of menstrual blood, vaginal delivery, penetrative intercourse, etc. It is crucial to consider each patient's individualized and cultural goals, the timing of surgical intervention, and the option of "partial" defibulation	**Strong**
2. Clitoral reconstructive surgery lacks high-quality evidence supporting its efficacy, garners complex ethical considerations, and warrants cultural nuance; therefore, thorough, methodological, and multidisciplinary evaluation is crucial.	**Weak**
3. Maintaining an impartial, patient-centered, and evidence-based approach in counseling is critical.	**Strong**
4. Clinicians should acknowledge their responsibility in tertiary harm reduction, including combating intergenerational effects of societal othering, marginalization, and bias experienced by our patients.	**Weak**
5. Clinicians should be aware of "quadruple jeopardy" and avoid discrimination in their practice ("quadruple jeopardy" is defined as discrimination based on patients' gender, race, religion, and migration status).	**Weak**
6. Our education should prioritize cultural awareness, humility, trauma-informed care, and respect for human dignity.	**Strong**
7. Patient-centered, multidisciplinary, and interprofessional care is essential to the delivery of trauma-informed care to women living with FGM/C.	**Strong**
Penile circumcision	
1. Clinicians should discuss penile circumcision in the light of up-to-date evidence regarding its potential benefits and harms.	**Strong**
2. Clinicians should inquire about the cultural and religious imperatives of their patients so that they can respectfully discuss penile circumcision in that context.	**Strong**
3. Clinicians should perform and encourage performance of medical penile circumcision in a clinically sanitary and safe setting.	**Strong**
4. Clinicians should discuss with parents the issue of consent that is not available to infants and minors.	**Strong**
5. ISSM should provide guidance on how to discuss the cultural, traditional, and religious issues, as well as ethical issues, as they relate to penile circumcision.	**Weak**
6. ISSM should encourage researchers who are members of the society to study further "circumcision regret" in order to provide evidence for counseling to patients and parents and potentially suggest change in practice.	**Strong**
7. ISSM should continue to review evidence assessing the methods of promoting voluntary penile circumcision and the impact of voluntary penile circumcision on the prevention of HIV and HPV transmission in order to provide up to date guidance.	**Weak**
Unconsummated marriages	
1. Clinicians should learn about the cultural context of unconsummated marriages.	**Strong**
2. Clinicians should recognize that causes of unconsummated marriages can be multifactorial.	**Strong**
3. Clinicians should learn about the currently known evidence-based multidisciplinary treatments for unconsummated marriages.	**Strong**
4. Primary care clinicians should provide pre-marital sexual health counseling for individuals and couples.	**Weak**
5. ISSM should promote pre-marriage sexual health education & counseling that begins during secondary education in schools and in primary care practices.	**Strong**
6. ISSM should develop webinars and/or workshops to educate clinicians about unconsummated marriages and relevant treatment.	**Strong**

Introduction

During the past 30 years, there has been an increased focus on patients' experience of their health conditions, their bodies, self-perceptions, preferences for healthcare, and barriers to healthcare receipt. The concept of "person-centered planning" was first recommended in 2001 by the American Institute of Medicine, an independent, non-profit organization that works outside of government to provide unbiased and authoritative advice to decision-makers and the public. The concept aimed at empowering individuals with health conditions to guide care in accordance with their values and utilize the resources of the healthcare system and the community in order to achieve their goals.[1] Person-centeredness easily incorporated the concept of a biopsychosocial approach to medicine, which was first coined in 1980 by Engel as a way of recognizing that every disease reflected a person with a psychological makeup in a social environment.[2] As patient empowerment and respect for patient autonomy gained ground, more factors were brought to bear. The notion of health disparities militated for the inclusion of social, economic, and historical factors to gain a full perspective. Finally, given the current multicultural nature of most societies, we recognize the influence of cultural factors on the patient's experience of healthcare. A model in cancer proposed that socio-cultural factors include a combination of social norms, religious beliefs, and cultural values.[3] Today, we also include race and ethnicity. The dynamic intersection of all the above-mentioned factors leads to patients' optimal or suboptimal healthcare experiences and outcomes. In addition to these factors, there has been recent discourse that considers how the socioecological framework encompassing the social determinants of health and the societal structures and systems exerts a downstream effect on health and well-being.[4,5]

Cultural competence became a framework with which clinicians were to implement the awareness of the complexity of each patient's experience. In her discussion of the cultural competence vs cultural humility, Agner cites Awaad's definition of cultural competence as "the knowledge that is specific to each culture, self-reflection on one's own culture, and the ability to create a balance between adherence to cultural norms and introduction of new frames of reference."[6,7] Typically, this has meant that clinicians should strive to be aware of all the relevant aspects of their patients' backgrounds, recognize their own biases, and use that knowledge to sensitively approach a clinical interaction. Culture, as applied here, can reflect national origin, but it can also reflect traditional beliefs of an ethnic group, a common experience of racial and/or religious groups, and those who live with disabilities. Culture can also mean the within-group understandings of people with a variety of sexual expressions and gender identities. Cultural competence, while necessary, has been shown sometimes to lead to unintended negative outcomes. Causadias demonstrated that in some cases, psychological outcomes were over-assigned cultural causes, thus unintentionally adding a barrier to recognizing the need of a patient to receive psychological healthcare.[5]

In recent years, socio-political discourse has led to a deeper understanding of the structural inequities that affect specific populations due to historical trends that embraced slavery, colonization, and the adherence to caste systems. These structural inequities have been demonstrated in education as unique pressures that impede optimal educational outcomes, and in healthcare as precursors of poorer health outcomes.[8,9] Agner advocates for "cultural humility," an approach that takes into account power dynamics that have remained as vestiges of historical oppression of some populations, generally populations of color, and dominance of others who have been, traditionally, White. Treyalon and Murray-Garcia defined cultural humility as "a lifelong, learning-oriented approach to working with people with diverse cultural backgrounds and a recognition of power dynamics in health care." In contrasting the theoretical frameworks of these 2 concepts, Agner highlights the fact that "cultural competence expects providers to be adept and knowledgeable, while cultural humility recognizes gaps in knowledge without shame, and provides an opportunity for deeper engagement with patients."[6,10] Although one might consider these 2 concepts as mutually exclusive, or one may consider cultural humility as simply an advancement on cultural competence, they are, in fact, complementary and both should be pursued by clinicians who wish to provide optimal care to their patients.

Application of this perspective can be noted in this paper. Employing cultural humility in the sexual health care of patients upholds the 4 ethical standards of medical ethics: Autonomy, Beneficence, Non-maleficence, and Justice. Upholding these principles means that the patients' rights, wishes, and needs will be the paramount objective of clinicians' care. In ordinary terms, this means that patients have a right to be educated and informed ahead of any treatment so that they can decide what will be done to their bodies, that the benefit to the patient is the clinician's primary goal and that harm will be avoided to the extent possible, and that all patients will be treated justly, without any manner of discrimination.

It should be noted that the areas of sexual difficulties chosen for this manuscript are not exhaustive but simply illustrate the impact of culture on how such difficulties are viewed and/or what remedies are available. We chose to focus on areas that are relatively defined and circumscribed. More complex areas, such as paraphilic disorders, deserve a fuller exploration and analysis in the cultural context than was possible here.

Materials and methods

Understanding the cultural aspects of sexual medicine is an emerging field of knowledge. In this paper, we conducted a narrative review of the extant literature. The authors conducted wide searches in PubMed, Google, and on global websites relevant to this topic, such as the World Health Organization, the United Nations, and others. The content of this paper was reviewed by all the authors, discussed where disagreements occurred, or additional perspectives were needed, and further literature was incorporated. We report not only on the available research findings but also on perspectives on the issues in sexual medicine where opinions vary and are evolving as evidence becomes available. Recommendations were drafted by authors of each section, then modified by all author consensus, and finalized, using the Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) system. Since evidence for interventions in this area of sexual dysfunction is not mature and statistical analyses could not be conducted, we focused on the GRADE discussion of the balance of benefits and harms of interventions that is more suitable for the available evidence. This discussion takes into account factors such as patient preferences, quality of life, and social equity and relies on an evaluation of cohort

studies, case-controlled studies, and expert opinion for reach recommendations.[11,12]

Results

Sexuality, religion, tradition, and culture

Background

Sexuality is a complex experience with biopsychosocial components. However, sexual expression and ultimately the ability to have a satisfying experience depend on their coexistence with the environmental influences that can either promote pleasure and satisfaction or compromise both. Sexual practices derive meaning from people's worldview developed over centuries and passed down from one generation to another. Also called sexual traditions, communities express the lived beliefs as culture, which is the acceptable way of life in any community. Sexual cultures are not only dynamic over time but may also be practiced differently by members of a community with some members, in fact, not adhering to the known culture in their private bedroom practices.[13] It is important to remember that the evaluation of sexual practices accepted by one cultural group by another cultural group is always subject to bias.

As if culture and sexuality were not diverse and complex enough, religious and legal considerations further come into play. For example, homosexuality and premarital and extramarital sex are illegal in some countries. Spiritualizing an already culturized sex can be confounding, given the diversity of religions, varying interpretations, and levels of adherence to the beliefs. This makes it almost impossible to predict what is socially acceptable to any one person from any cultural background[14].

What is considered sexual, romantic, acceptable, chaste, and moral varies from one individual to another and may be connected to experiences as well as to interpretations by families of origin within the wider cultural and religious contexts. Societies do issue rules and even put penalties for nonadherence but only to the extent that practices go against some general enacted regulations and laws. They do not necessarily apply to the details of sexual practices in the privacy of peoples' homes. Such details are hard to legislate. For example, it is impossible to adjudicate whether sex happens in darkness or in light; the extent of foreplay, and whether consent to penetrate can be asserted in the middle of the sexual act; whether oral, anal, or vaginal sex is preferred or acceptable; whether certain sexual positions are allowed; whether accompanying views and feelings or vaginal secretions are associated with pleasure or displeasure, etc.

This trend goes further to give meaning to who a sex partner can be; for example, in one culture, sexual relations between cousins may be acceptable, and, in others, they may be considered incest. In some cultures, consent to have sex in a marriage is not seen as mandatory while, in others, it is a criminal offense to pursue such sex without consent. In some cultures, diversity in sexual orientation is acceptable while it is highly contested in others. There are also controversies around polygamy and age of consent for sex and marriage. Other highly contested practices include genital modifications such as labial elongation, insertion of herbs to enhance scarring and tightening of the vagina, both penile circumcision and female genital cutting, and subincision of the penis.[15,16] Attitudes toward masturbation and the "spillage of semen" also vary as do attitudes toward the meaning and societal value of female sexual desire.

Metaphysical aspects of sex can become salient in some cases where a link is created between sexual acts and the supernatural—the gods and the forces of nature. As such, sexual pleasure may have a different spiritual meaning; semen may be viewed differently, and the sexual act may be an expression and exchange with supernatural forces. Sex may be ritualized to represent communication with supernatural powers, cleansing of sinful acts, and release from evil forces. Individuals involved in the sexual acts may lose autonomy to the power of the invoked spirit and therefore the ability to make choices in the whole process.[15]

Application to sexual medicine

As sexual cultures and practices are very diverse, practitioners of sexual medicine must be cognizant of this and acknowledge their own biases in order to understand each client individually. Often, sexual partners do not share the same beliefs, and this can be a source of disharmony and even dysfunction. Seeking to understand the patient's worldview is a critical step in meeting their treatment needs. Further, culture and religion do influence help-seeking behaviors for sexual concerns as well as adherence to treatment. When treatment recommendations and patients' beliefs are discordant, clinicians should approach the conversation with respect for the patient's beliefs and autonomy and, jointly, search for solutions that are acceptable to the patient. When recommendations involve cultural adaptations, this is likely to be challenging for both the provider and the patient(s); this conversation must be approached with respect for the patient's autonomy in making decisions.

When treating a patient from a different culture or a religious tradition, it is important for the clinician to learn about traditional sexual practices within that culture that enhance healthy sexuality. Migration to high-income countries and intracontinental or internal migrations expose native health professionals to patients with sociocultural realities that are new to them.[17] An example is a practice in Central parts of Africa called *Kunyaza*, which is a way of stimulating the vulva using the phallus. The stimulation is known to be highly pleasurable and triggers female orgasm.[18] Sexual medicine practitioners should be aware of such practices and, where enough evidence exists, even be able to educate their clients about such practices as part of a healthy sexual repertoire beyond the culture of origin.

Although religion is often associated with sexual conservatism, which may promote guilt, shame, and self-stigma in those who go against the grain, it is not always true that the affected end up with anxiety, depression, or other psychiatric concerns. Yehuda et al., in their study of religious, Jewish, single men, found that strong religiosity was not necessarily associated with greater guilt and shame and concluded that there could be adaptive elements within a religion to safeguard individuals from psychological harm.[19] Understanding such adaptive elements could help in promoting healthy sexuality, especially because sexual guilt is negatively correlated with sexual desire.[18]

Clinicians should be conscious of their own personal cultural biases and should desist from considering cultural practices that are foreign to them as dangerous or unsuitable unless there is scientific evidence to support that view. At the same time, they should prevent and care for individuals who could

be at risk or have undergone harmful sexual practices, based on scientific evidence rather than beliefs about the practices. An example of a practice that is considered a violation of human rights by the World Health Organization (WHO) is virginity testing. Virginity testing is performed by inspecting the hymen for tears or its size of opening, and/or by inserting fingers into the vagina (the "two-finger" test). Both techniques are practiced under the belief that the appearance of the female genitalia can indicate a girl's or woman's history of sexual activity. The WHO states that there is no evidence that either method can prove whether a woman or girl has had vaginal intercourse or not. (https://www.who.int/publications/i/item/WHO-RHR-18.15). Studies show that this practice is inaccurate and causes psychological trauma. It compromises the girl's or the woman's well-being and social standing. According to the WHO, this is a violation of a woman's rights.[20] Similarly, a culturally based belief can result in somatic symptoms and promote or aggravate sexual dysfunction. For example, the *Dhat syndrome*, common in India and Southeast Asia, but present in other parts of the world, has been described as a set of symptoms, such as fatigue, weakness, loss of appetite, guilt, and anxiety, that follow the waste of semen (culturally meaning the loss of energy) during wet dreams, masturbation, or urination. Arafat describes Dhat as derived from Sanskrit and "the ancient vedic depiction of body fluids called 'dhatus'; among the seven different body fluids, semen is perceived to be most precious." Those who suffer from *Dhat syndrome* tend to come from conservative religious backgrounds. They tend to hold the belief that semen is necessary to the body's health, and its loss through nocturnal emission or masturbation will lead to negative physical, emotional, or sexual outcomes. Arafat notes that because patients' symptoms diminish with the treatment of anxiety and depression, psychoeducation and support, and that research has not fully established this concept, the syndrome may just be seen as a culturally based depression. If this is the case, it would be important that clinicians review their own potential bias when making this diagnosis.[21-23] Finally, the Koro syndrome, most prevalent in East and Southeast Asia, is characterized by the belief, based on mythology, by both men and women that their genitals are shrinking and will be retracted into the body, finally resulting in death to which they respond by intense anxiety. According to Strong et al., it can be successfully treated with psychoeducation and anxiolytic medication.[24]

Female genital mutilation/cutting

Background

Over 230 million women and girls worldwide have experienced female genital mutilation/cutting (FGM/C). Female genital mutilation/cutting is a global phenomenon, with nationally representative data available for over 30 countries and documented instances in at least 92 countries.[25,26] As defined by the World Health Organization (WHO), FGM/C involves the partial or total removal of female external genitalia for non–medically indicated reasons, categorized into 4 main types.[27] Generally, Type I involves the excision of the clitoral glans and/or hood; Type II entails the cutting of the labia with or without cutting of the clitoris; Type III (infibulation) entails the suturing of the labia to occlude the vaginal orifice; and Type IV encompasses miscellaneous procedures such as pricking, piercing, scraping, or burning of the genital area. Female genital mutilation/cutting practices vary across cultures and regions, encompassing differences in the age of cutting, type of cutting, and the identity of the practitioner. Globally, Types I, II, and IV comprise approximately 90% of cutting, with Type III accounting for over 10%.[28] Girls may generally undergo FGM/C anywhere from infancy to 15 years old, performed by traditional practitioners or even medical professionals.

FGM/C poses a multitude of health risks, varying in severity, depending on factors such as the type and extent of cutting, the degree of medicalization, and other relevant considerations. These risks include obstetric, gynecologic, urologic, sexual, and psychological harm to health and well-being.[27] While organizations such as the WHO and the Inter-African committee advocate for the use of the word "mutilation" to signify the severity of the practice, other professionals advocate for the use of the word "cutting" in pursuit of more neutral terminology and less stigmatization of the person.[29] In this discussion, we will employ the term female genital mutilation/cutting (FGM/C) to acknowledge the ongoing debate surrounding the terminology of this practice.

Religion & culture

The practice of FGM/C holds diverse meanings across cultural, historical, religious, and gendered contexts. Its origins trace back to ancient Africa, pre-dating the spread of the Abrahamic religions of Christianity, Judaism, and Islam, with documented instances dating as far back as an Egyptian papyrus from 165 BCE.[30,31] Although direct mention is absent in the Koran or the Bible, the practice persists within certain Muslim and Christian communities in Africa, as well as among select Muslim groups in the Arabian Peninsula, Malaysia, India, Indonesia, and Ethiopian Jews.[30]

While not explicitly endorsed in the primary religious texts, such as the Koran,[32] "Sunna circumcision" finds reference in Islamic supplementary texts such as *the Hadith*.[33-35] This practice may serve as religious justification for FGM/C within certain Islamic traditions, such as among the Dawoodi Bohra community who practice "khatna," which consists of cutting or nicking the prepuce of the clitoris.[36,37] It is key to note, however, that the majority of Muslim countries do not traditionally engage in FGM/C practices.

In various communities, FGM/C holds multifaceted significance.[32,38-48] Among the Omdurman community in Sudan and Somalia, it upholds the tradition of pre-marital virginity preservation.[49] In several ethnic groups, it is viewed as a means to curb sexual desires.[50] In Sierra Leone, FGM/C is a ritualistic process of female identity transformation into Bondo society, while among the Maasai ethnic groups of Kenya and Tanzania, it symbolizes a significant rite of passage from childhood to adulthood.[49,51]

Some literature on FGM/C is heavily influenced by Western colonial perspectives, often grounded in frameworks about race, gender, health, identity, and sexuality that may not universally apply.[45,52,53] When caring for a person with FGM/C, it is imperative to possess sociocultural competence and cultural humility when interrogating the multifaceted contexts in which FGM/C is practiced across diverse cultures, prioritizing the lived experiences of those directly impacted by it.

A tradition in transition

Cultural practices, including the application of FGM/C, continually evolve in response to changing ideologies and global influences.[49] Notably, there has been a discernible shift toward medicalization in some countries, with trained healthcare professionals taking over the role of traditional

practitioners. This transition is observed particularly in countries like Sudan, Indonesia, Guinea, and Egypt, where midwives, nurses, or physicians now perform the procedure.[54] Furthermore, there is a noticeable trend moving away from Type III FGM/C, considered the most severe form, toward less severe variants like Type I. For instance, in Khartoum, Sudan, there has been a significant increase in "Sunna circumcision," a term indicating Type I, II, or IV, from 19% prevalence in 2014 to 59% in 2018, indicating a departure from the previously prevalent "pharaonic circumcision," a term indicating Type III.

Similar trends emerge when migrants move from regions where FGM/C is prevalent to areas where it is less common, often resulting in a reduction or cessation of the practice.[55] Migrants face conflicting pressures ("push-and-pull dynamic"), with factors such as tradition, cultural identity, and familial expectations influencing its perpetuation, while changes in societal norms, legal frameworks, and acculturation hinder its continuation.[56-58] Nevertheless, evidence suggests a widespread abandonment of FGM/C among migrants in the Global North.[30,39,45] Among migrants with FGM/C, a study in Oslo revealed a 70% inclination toward abandoning the practice, while a cross-sectional study of Somalis in Norway indicated a trend toward adopting the socio-cultural norms and values against FGM/C of their adopted Western homes after residing for 4 or more years.[30,39] Research among Somali communities in Canada and London demonstrated a growing opposition to FGM/C, influenced by evolving interpretations of Islamic teachings.[30,59] It is crucial to acknowledge the dynamic experiences of migrants who have experienced FGM/C, many of whom grapple with a "double shame"—where in their countries of origin, not undergoing FGM/C is deemed shameful, while in their new host countries, having undergone FGM/C is also considered shameful.[56]

Conversely, nuanced sociopolitical dynamics may contribute to the increase in the practice of FGM/C among certain communities.[49] Singling out FGM/C for eradication may lead a society to regard the practice as a defining characteristic of its identity.[49,60,61] For example, when Christians banned the practice of FGM/C in Kenya, the Kikuyu ethnic group rebelled against the British government and re-adopted FGM/C, in a more severe form of clitoral cutting, as a form of nationalistic and anti-colonial protest.[49,62,63] Similarly, the practice of FGM/C has returned to the Jola community in Senegal as a response to globalization.[48,49] Recently, Gambia has proposed a bill to reverse the ban on FGM/C, stating "the West should stop imposing issues on us... for practicing our religiously given rights and cultural beliefs."[64] This reversal was rejected by lawmakers in July 2024.

Genital modifications

Various terminologies and definitions have been proposed to broadly discuss (non) consensual and (non) therapeutic genital modifications, regardless of the individual's gender and sex. For example, Fusaschi coined the term "gendered genital modifications (GGMs)," which encompasses FGM/C, surgery after FGM/C, penile circumcision, gender reassignment surgery, intersex surgery, and "cosmetic" genital surgery.[38,65]

When considering forms of genital cutting, the specific emphasis in global and academic discourse on FGM/C as the sole form of violence against women and girls (VAWG) exacerbates social and political divides, often labeling certain practices as outdated while portraying others as modern.[38,66] The selective criminalization and stigmatization of FGM/C as the sole "immoral" form of genital cutting, often portrayed in charged language as "barbaric," unfairly condemns African female genital modifications while overlooking their Western counterparts, as well as penile circumcision and non-consented surgeries on intersex genitals.[4,38,67-70] Of note is the fact that the Intersex Society of North America recommends that genital modification be subject to the child's ability to make an informed decision about his or her body.[71] This recommendation is not always followed by the American medical establishment.[72]

This contrast underscores a distinct perspective when examining other forms of genital modification worldwide, in adults and children. These latter procedures are often viewed as surgical modifications for promoting health, modernity, and personal empowerment or as expressions of religious or cultural freedom. Gender reassignment surgery, for instance, is praised for aligning individuals' anatomy with their identity.. Meanwhile, genital cosmetic procedures like labiaplasty, clitoral or clitoral hood reductions, and vaginal tightening, which entail comparable genital alterations to FGM/C, are increasingly sought after by adults and adolescents seeking aesthetic genital enhancements in Western contexts.[73] Indeed, between 2016 and 2019, 20% of labiaplasties conducted in the United States were found to have been performed on girls under 18 years of age.[74]

The focus, therefore, should not be on which forms of gendered genital modifications (GGMs), a term recently coined by Fusaschi, are more "morally" acceptable than others, but rather the extent to which the individuals being cut desire the procedure and are capable of consenting to it.[75] Thus, the violation of the fundamental right to consent over one's body and genital autonomy of children is a concern, irrespective of their sex or gender.

Impact on sexual function

Before evaluating the impact of FGM/C on sexual function, it is important to acknowledge that female sexual dysfunction is a more general problem, regardless of FGM/C. In fact, women without FGM/C experience sexual dysfunction at a rate of approximately 43%.[76-78] Sexuality, defined by the WHO as involving "the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors," can thus be difficult to assess in those with FGM/C as the experience of the cutting can intersect with many of these domains.[79,80] Indeed, a retrospective study of 110 women with FGM/C found that 82 had experienced additional traumas, such as rape, forced marriage, or war violence, all of which can negatively impact sexual health and response.[81]

Nonetheless, sexual dysfunction remains a lived reality for many with FGM/C. At this time, the literature reveals inconsistent or contradictory findings. Some meta-analyses and studies report increased sexual dysfunction in those with FGM/C, while others do not and report preserved capacity for pleasure and orgasm.[82-88] Studies are limited by the heterogeneity of data, lack of differentiation between types of FGM/C, and usage of the Female Sexual Function Index that has not yet been validated for use in populations or cultures with FGM/C. Consequently, the research evidence has yet to establish in what circumstances it is reasonable to interpret that there is a causal relationship between FGM/C and sexual dysfunction.

While it is crucial not to diminish the potential risk of sexual harm associated with the cutting, it is also important to challenge the prevailing misconception that all cut women are unable to enjoy sex. Notably, when assessing remnant anatomy, evidence has revealed the preservation of most erectile tissues in those with FGM/C. MRI scans reveal that even in cases of severe FGM/C with excision of the external clitoris, the internal clitoral body may be intact or partially affected, while the clitoral bulbs remain preserved.[56,89-91] Therefore, dissemination of these widespread myths of definitive sexual dysfunction and iatrogenic pathologizing of women who have undergone FGM/C, especially within the framework of global anti-FGM/C initiatives, can have harmful consequences, potentially instilling in young women the belief that such difficulties are inevitable for them.[80] Healthcare providers must stay mindful of this intricate terrain to effectively convey precise information backed by evidence-based research. Through this approach, they can significantly contribute to fostering positive self-esteem and body image among women with FGM/C while also avoiding the perpetuation of damaging stereotypes that depict them as "mutilated" and incapable of deriving sexual pleasure.

Treatment & care

In caring for individuals with FGM/C, it is essential to adopt a comprehensive, patient-centered, and individualized approach rather than solely focusing on the state of the genitals. This entails, depending on the setting and needs, assembling a multidisciplinary team comprising gynecologists, urologists, psychologists, pelvic floor therapists, sexual therapists, and other specialists to address diverse patient needs effectively, as well as engaging the patient's partner when beneficial and appropriate and the patient agrees. Recognizing the profound impact of psychological well-being on sexual health and conducting thorough cognitive and medical assessments are crucial for identifying suitable candidates for invasive surgical interventions, thereby avoiding unnecessary procedures. Moreover, it is imperative to provide patients with evidence-based, patient-centered information to empower them to make informed decisions about their bodies and their health throughout the treatment process.

Surgical considerations

Among surgical treatment options for FGM/C are two prominent interventions: defibulation and clitoral reconstructive surgery.

Defibulation is an essential surgical intervention for patients with Type III FGM/C, involving the incision of scar tissue to expose the vaginal introitus, urethral meatus (partial defibulation), and possibly the glans clitoris if uninjured (total defibulation). This procedure is indicated to facilitate physiological micturition, alleviate chronic urinary tract infections and obstructed micturition, enable the passage of menstrual blood, and facilitate vaginal delivery and penetrative intercourse, as well as gynecologic and obstetric procedures such as cervical screening. While the specific timing of this procedure may be negotiable based on the age, social, clinical, and psychological circumstances, as well as the requisite skill and scope of practice of the provider, surgical defibulation may be performed for all infibulated patients. It is a relatively simple procedure that can be performed at any life stage under local, regional, or general anesthesia. However, it may be feared or not desired by the patient as it brings several anatomic, physiologic, and cultural changes. There have been instances where patients request reinfibulation after childbirth, a procedure criminalized or not medically indicated in many countries.[56] Some women may experience distress and cognitive dissonance between functional improvement and changes in genital appearance after defibulation. In certain cases, defibulation may even trigger the resurgence of posttraumatic stress disorder (PTSD) from the original cutting during childhood.[92-95] Therefore, it is crucial to consider each patient's individualized goals, the timing of surgical interventions, and, where permitted, the option of "partial" defibulation for those seeking functional improvement while preserving aspects of their desired genital appearance.[96] Additionally, it is vital to assess healthcare providers' training and scope of practice to mitigate complications.[97] Preceding and following the surgery with detailed information, time, support, and appropriate medical documentation is also imperative.[98]

Clitoral reconstructive surgery (CRS) is increasingly performed with the aim of improving sexual function, restoring genital appearance, and reducing clitoral pain.[80,99,100] The procedure involves removing scar tissue and externalizing part of the body of the clitoris to create a neo-glans. Often advertised as a "solution" to FGM/C and being widespread in Europe, the procedure lags behind high-quality evidence supporting its efficacy.[99,101-106] Studies conducted so far have been limited to single-center studies without control groups and standardized evaluations, with short-term follow-up of no more than 1 year. Even though, in conjunction with psychosexual care, CRS appears to improve sexual response, body image, and, when applicable, pain in certain populations, both the Royal College of Obstetricians and Gynecologists and the WHO refrain from endorsing CRS due to the lack of robust evidence supporting its effectiveness.[80,107,108] The ethical implications of CRS raise questions about whether it replaces 1 form of medically unnecessary cutting with another, potentially reinforcing the stigmatization of women as "mutilated" or "sexually impaired" in need of "fixing".[80]

Due to the limited evidence, complex ethical considerations, and culturally nuanced significance of surgeries like CRS, thorough patient evaluation by practitioners is crucial.[103,109] Methodological assessments with multilingual validated instruments with documented cross-cultural equivalency should be pursued, and algorithms developed to guide surgeons in identifying appropriate candidates for surgery. While CRS may be clinically indicated, especially in cases of chronic pain such as clitoral neuromas, many patients seeking CRS could find their concerns addressed through alternative treatments. Research indicates that when multidisciplinary care is available before surgery, CRS is performed in less than 20% of women initially requesting it.[101,109,110] Many women who have undergone FGM/C may not be aware they still have a clitoris, may assume a complete lack of sexual function, or may attribute sexual distress to FGM/C instead of to other causes. Counseling, psychosexual and physical therapy, health education, and dispelling cultural misconceptions about the clitoris can often meet their needs.[101,103,109-111] In addition, ongoing developments of existing reconstructive surgical techniques have considerable potential to bring new insights.

Consequently, when counseling patients, it is imperative to maintain an impartial, patient-centered, and evidence-based approach.[101] This involves informing patients about the limited evidence regarding the procedure and the potential for

harm. Research indicates that in a minority of cases undergoing CRS, there is a risk of decreased sensation and potential psychological triggering. Given that CRS addresses an ancient trauma, it may precipitate a relapse of PTSD, particularly if pain management is inadequate.[112,113] Therefore, prioritizing an unbiased, patient-centered, and evidence-driven approach in counseling is crucial for informed decision-making.[114]

Harm reduction

While global attention rightly emphasizes primary prevention efforts to eliminate FGM/C and safeguard children, other forms of harm often remain overlooked. Presently, while global public health prioritizes primary prevention of female minors, the medical literature often focuses on secondary prevention, addressing the health issues of persons already living with FGM/C, such as chronic pain and obstetric and gynecologic morbidity, including sexual dysfunction. While both are vital, it is equally essential to acknowledge our responsibility in tertiary harm reduction. This includes combating the intergenerational effects of societal othering, marginalization, and bias experienced by our patients.[115]

Many migrant women living with FGM/C face what is termed as "quadruple jeopardy"—discrimination based on their gender, race, religion, and migration status.[45] Unlike FGM/C, these aspects are often visible in public spaces, adding to their stigmatization and isolation. Studies reveal that while FGM/C status alone does not predict psychological distress, discrimination does.[45] This discrimination extends beyond pre-healthcare experiences, such as trauma or violence leading to migration, to within healthcare settings. Even in the West, healthcare providers' racial and ethnic biases hinder appropriate care for patients. Furthermore, African women seeking medical care in the United States confront the historical trauma of slavery, magnifying their healthcare challenges. Research shows that these patients engage in "emotional health work" to navigate potential trauma from physicians, stemming from the stigmatization they face in their new host country.[116] This emotional preparation includes seeking open-minded physicians, connecting with other patient's experiences, and managing overwhelming feelings before clinical encounters. Recognizing our role in tertiary prevention, interventions must be holistic, sensitive, and multidisciplinary. Our education should prioritize cultural awareness, humility, trauma-informed care, and respect for human dignity to address these deep-rooted issues effectively.[117]

Conclusion

While significant progress has been made in academia and healthcare regarding FGM/C, there remains a pressing need to advance global health equity for all individuals living with complications of the practice in different parts of the World. As healthcare providers, it is crucial to recognize our own perspectives on sexuality and be mindful of our positionality. Prioritizing respectful care, patients' rights, embracing cultural humility, fostering knowledge, and implementing trauma-informed approaches are paramount. Understanding the historical legacies of the practice and marginalized groups in healthcare settings is essential, as is acknowledging the intersectionality of migrants' identities to provide effective care. Confronting internal biases and acknowledging power dynamics within the patient–provider relationship is vital, centering the lived experiences of FGM/C patients and ensuring that our language empowers rather than marginalizes them. In doing so, we can strive toward a healthcare landscape that truly honors the dignity and rights of all individuals who have undergone FGM/C.

Penile Circumcision

Background

Penile circumcision is one of the oldest and most common surgical procedures worldwide, with complex clinical, sexual, and socio-cultural implications.[118] Penile circumcision is a surgical procedure to remove the foreskin from the human penis, either in part or in full. Stehr reported that the main reasons to perform the procedure were: social, cultural, or religious purposes, assumed medical benefit, and what is called "routine- circumcision" made in newborns with the belief of preventing future diseases through facilitating hygiene.[119]

Morris et al. estimated a global prevalence of penile circumcision at 37%-39%, reporting that approximately half of the circumcisions were performed for religious and cultural reasons.[120] In the beginning of the 21st century, about 60% of all male newborns in the United States and 100% newborns in South Korea were submitted to "routine circumcision."[119]

The word circumcision derives from the Latin "circum," which means "around," and "caedere," which means "to cut."[121] The oldest available records date this procedure back to at least 6000 years BC.[121] Morgan traced the origins of circumcision as a cultural practice. It is a part of an ancient rite practiced by many tribes whereby the young male gives proof of his ability to endure pain. If he passes this test with fortitude, he is then accepted into the tribe as a fully developed adult with the attendant privileges.[122] Male infant circumcision is a religious commandment in Judaism and Islam, and it is common in some Eastern Orthodox and other Christian churches of Africa. It has been exported to many parts of the world.[122-124] Concerns about pain have been noted because most of those ritual procedures are done with no anesthesia. A review of 23 studies assessing infant pain suggested, based on the findings of 2 studies that employed the Neonatal Infant Pain Scale, that infants experience a pain level of 3 on a scale of 0-6 that is not effectively relieved by analgesic interventions.[125 126].

Complications of circumcision

In medical settings, penile circumcision has been used as a treatment for phimosis, recurrent balanitis, balanoposthitis, and small penile tumors or to prevent sexually transmitted infections. The largest proportion of the research focuses on the medical benefits of circumcision and the low complication rate of the procedure when done by trained professionals (around 4%).[127] In a review of 19 478 penile circumcisions in 4 major medical centers in Israel, Chaim reports a rate of 0.34% of complications with no difference between medical and ritual infant circumcisions.[126]

Circumcision as a prevention

Circumcision gained most attention during the human immunodeficiency virus (HIV) epidemic when findings from randomized controlled trials suggested that HIV transmission had lower rates among circumcised men vs intact men.[128,129] The World Health Organization (WHO) embraced these findings and subsequently, voluntary male circumcision programs were implemented in countries with high levels of HIV infection.[130] More recent reviews of the research suggested that temporal trends showed that HIV rates in the selected

countries began to decline prior to the implementation of these programs. In addition, counseling about circumcision was not well implemented, which raised ethical questions about the voluntary nature of the circumcision. Finally, at least early on, young boys were offered circumcision before they were old enough to consent. This latter practice has now been stopped. The authors concluded that improved and effective counseling might provide the same benefit as circumcision.[131,132]

The role of circumcision in the prevention of penile cancer was examined in a systematic review and meta-analysis by Larke et al. They found that circumcision in childhood/adolescence reduced the risk of invasive penile cancer in the future, but this effect could be mediated partly by decreasing the incidence of phimosis.[133] Tang and Spiess suggest that since penile cancer is a rare neoplasia, related to presence of human papillomavirus (HPV) and poor hygiene conditions, the use of non-surgical practices, such as HPV vaccination and education to improve hygiene habits, could help reduce the incidence of penile cancer without using circumcision as a public healthcare policy.[134]

The question of the adverse effect of circumcision on sexual function and pleasure has also been considered. Some researchers argued that the loss of nerve endings can lead to diminished sensitivity of the glans.[135-137] However, reports about the impact of circumcision on sexual satisfaction suggest that there is no evidence that circumcision negatively affects sexual desire, erectile function, time to ejaculation, or orgasm. A meta-analysis of 10 studies with a total sample of 9317 circumcised and 9423 uncircumcised men concluded that there was no significant association or differences between circumcision and sexual function such as sexual desire, dyspareunia, premature ejaculation ejaculatory latency time, and orgasm difficulties.[138] Although in the past, circumcision was prescribed to improve sexual function by improving premature ejaculation, a systematic review with meta-analysis assessed whether the surgical prepuce removal has an effect on the ejaculation timing. Twelve studies were included in the meta-analysis, containing a total of 10 019 circumcised and 11 570 uncircumcised men. Based on the findings, the authors concluded that circumcision does not have an effect on premature ejaculation.[139] Similarly, Morris and Krieger, in a systematic review of 94 publications that included 49 original studies and 4 reviews, 2 of which conducted meta-analyses, reported that studies rated as of the highest quality concluded that male circumcision, completed either in infancy or in adulthood, does not have a negative effect on sexual pleasure and satisfaction and, in fact, may enhance it.[140]

Finally, ethical considerations were raised by Earp in two seminal papers on genital cutting (2021, 2023), Earp exhorts clinicians and researchers to consider the rights of children who undergo genital alterations before they are old enough to consent, urging providers to center genital autonomy and informed consent. In parallel, however, a Jewish or Muslim child could be deprived of participation in the family's religious and cultural traditions were he unable to participate in ritual circumcision, raising questions of the scope of parental authority and cultural and religious freedoms.[141] This discussion raises important issues at the intersection of ethics, culture, religion, history, gender inequality, law, and global politics. Relevant to that discussion is emerging research that suggests that a proportion of circumcised men may grieve the loss of their foreskin and experience disenfranchisement by their parents who had them circumcised at birth.[142] While the authors acknowledge the online study's many limitations, these findings raise questions that will need to be answered in future, better-controlled studies.

Conclusion

Penile circumcision has been a traditional, ritual aspect of some world religions and ethnic groups for many centuries. It has been adopted in some countries as a routine infant surgery with the explicit purpose of improving the child's physical health and genital appearance or adhering to one's religious or cultural tradition. Recent research has shown that the health benefits of circumcision are minimal and that those same proposed benefits may be able to be achieved by non-surgical strategies. The belief that circumcision negatively affects sexual function has not been upheld through research. While circumcision has traditionally not been seen as particularly harmful, the potential for negative mental health and sexual outcomes of men who, as adults, are unhappy with having been circumcised in infancy raises the issue of body autonomy and informed consent. A debate about the right to body autonomy and informed consent vs a right to participate in family, religious, or ethnic traditions vs a political perspective on the meaning of penile circumcision in societal power continuum will continue to be an aspect of the socio-cultural issues in sexual medicine.

Unconsummated marriage

Background

Unconsummated marriage (UCM) is defined as a difficulty of the newly wedded couple to engage in successful coitus. Unconsummated marriage has been referred to as "honeymoon impotence," 'first night impotence," "wedding night impotence," "first-night erectile dysfunction," and "failure of defloration."[143,144] It frequently occurs in the first few nights/days of marriage.

Studies indicate that UCM is a prevalent problem all over the world.[145] However, the exact prevalence of this condition is not available. Unconsummated marriage is reported to be most prevalent in Asian and Middle Eastern countries. In societies with ample opportunity for premarital coitus, UCM is extremely rare.[146] However, it is estimated that up to 1% of all couples treated at infertility clinics in the United States have not consummated their marriage.[147] Different studies have reported a prevalence ranging from 7% to 63.9% in different societies.[146,148,149] In non-western societies, it is the reason for sexual and andro-gynecological visits, with an incidence varying from 8% to 17% in different geographical areas.[144] In a study of 10 977 patients requesting treatment for various sexual concerns in India, 9% presented with UCM.[150-152] Masters and Johnson reported a UCM of 17 years duration.[153] If left untreated, it may run a chronic course. At Dr. Promodu's Institute of Sexual & Marital Health Pvt. Ltd, the longest case of UCM successfully treated lasted 21 years.[151] A 22-year-long UCM was also reported in India.[154] Unconsummated marriage may cause distress, frustration, depression, anxiety, adjustment problems, and marital discord and can often result in divorce.

Unconsummated marriage is a barrier not only to achieving sexual health and well-being but also to achieving reproduction. Reproductive and sexual health care is often costly and often not covered by insurance. Such facilities are rarely available in government hospitals. Hence, people are forced to rely on private hospitals and specialized clinics, where the

costs depend on their expertise and facilities. Especially for people from low- and middle-income countries, it may become difficult to afford the cost.

Socio-cultural factors and lack of sexual experience or education, particularly in rural areas, result in a couple's inability to have penetrative sex and "consummate the wedding." Couples do not immediately seek medical help due to feelings of shame or social stigma. The male often presents with an inability to achieve or maintain an erection sufficient for vaginal penetration. Sometimes, the non-penetration is due to the woman's fear or pain during the attempt of penetration in the absence of anatomical causes (eg, genital malformations or infibulation). The male is often blamed for the nonconsummation of marriage, which eventually may lead to marital discord, separation, or divorce.

Sociocultural aspects

Sexual problems develop due to multifactorial etiologies such as physical, psychological, social, cultural, and religious factors and the moral background of an individual or a couple. These determine sexual thoughts, beliefs, attitudes, expectations, and behavior. In different societies, different social constructs related to sexuality and gender roles exist. In some of the Asian and Middle-Eastern societies, sexual contacts outside marriage are considered a sin. In India, sexual relationships before or outside marriage are prevented by religious rules, moral value systems, and cultural taboos. The person who enters into a sexual relationship before marriage is perceived as a bad person or condemned for spoiling virginity/chastity. If other members in the family or neighborhood find out, the family may become disgraced. The individual may find it difficult to get a suitable match during the search for a partner in an arranged marriage. Historically, sexual contact before marriage has led to severe punishments and even murder of the accused. Due to the above cultural scenario, many men and women avoid being engaged in sexual relationships before marriage and they lack practical experience. Parents force children to concentrate on their studies. Many conservative families maintain a very religious and strict atmosphere. Children are not allowed to go against these value systems or cultural mores. At the same time, there is a lack of preparation for engaging in a sexual relationship through sex education that may result in anxiety and fear of sexual activity in a newly wedded couple, leading to erectile dysfunction, dyspareunia, or vaginismus.

Assessment and treatment

In a couple that presents with an UCM, a biopsychosocial approach to assessment and treatment is essential as the problem is multifactorial. Both partners need to be evaluated for sexual problems to arrive at a correct diagnosis and to map out a treatment plan. Investigations may include a physical examination, blood tests, hormone assays, and ultrasound or imaging tests. Assessment has to be approached sensitively. When conducting a physical examination, the specialist must consider the possibility that the prospect of a vaginal examination may increase the female patient's anxiety about penetration. The importance of a psychological and couple assessment cannot be overstated. In most cases, sex education and couple counseling will be an important, if not the most important, component of treatment. When the female patient reports extreme fear of penetration, trauma assessment is necessary to account for all possible causes. Treatment may include medication, surgery, physical therapy, sex therapy, marital therapy, or counseling depending on the diagnosis, severity, and chronicity of problems. These procedures are costly and treatment may be discontinued due to financial difficulties without the couple attaining the desired result.

Psychological methods of treatment such as sex education, couple sex therapy, and other counseling on related, nonsexual issues can help resolve the UCM. These are time-consuming procedures and require multiple sessions extending over a few months. Unlike medicines, the cost of psychological procedures is high depending on the session duration, seniority, and expertise of the therapists, and the couple's ongoing motivation to continue to engage in treatment. If a surgical procedure, such as vaginal dilatation or hymenectomy in cases of imperforate hymen, is carried out, it should be done in the context of counseling so that related psychological issues can be addressed. Therapists need to tailor an individualized therapeutic package for each couple. The findings of a single-institution study of couples with UCM suggest that a combination of inpatient couple sex therapy, marital therapy, CBT, and medications was the most effective method of treatment for UCM.[152]

Lack of care regulation

Compared to high-income nations, medical and psychological facilities are limited in low- and middle-income countries. As the public health service system does not provide treatment for sexual health problems, and hospitals/clinics run by qualified professionals are rarely available, the public is at risk for financial and sexual exploitation by easily available self-proclaimed but unqualified non-professionals.

Social implications

Unconsummated marriage has far-reaching consequences not only for the couple and family but also for society. An UCM may lead to marital conflict and divorce, as well as rift between the families. Divorce cases at the family courts may last several years, which causes a financial burden to families. Until the court case is resolved, partners cannot remarry and thereby lose precious years when they could enjoy a sexual life and benefit from the most effective reproductive period. To get a suitable match for a second marriage also becomes difficult at an older age.

Prevention: need for awareness and sexual education

Sexual health is a basic biological human need as well as a right. According to the WHO, sexual health "is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."[155] However, it is controlled and determined by the socio-cultural and religious attitudes and the prevailing norms in each society. In many low- and middle-income societies, talking openly about sexual matters is still considered a taboo. This predisposes young people to anxiety and sexual dysfunction when they marry that is hard to mitigate due to stigma and unavailable resources. Sex education and raised awareness of the issue of UCM will help the couple seek an early intervention when they identify a difficulty in consummating marriage.

Conclusion

Patients presenting with a UCM need a careful assessment from a biopsychosocial and cultural perspective as the reasons for the condition of the sexual relationship may be multifactorial. Intervention should follow the findings of the assessment. Even when there is a medical reason, individual and couple counseling will help the individual and the couple recover from the psychological impact and potential trauma of an UCM. There is a need for building public awareness of these issues in societies where this is prevalent. There is a need to provide readily available guidance for couples. Given the lack of sexual health services in low- and middle-income countries, it would be beneficial if ISSM could develop a digital program that would offer guidance to individuals and couples who are coping with this condition and as well as to clinicians who see patients with this presentation.

Discussion

Diverse sexual practices and sexual dysfunctions have been reported throughout the world. How they are experienced, perceived, and treated is governed by ethnic, racial, traditional, and religious mores. Because cultures, traditions, and religions evolve in a political world where power and laws are factors that affect everyone, structural issues that affect sexual health must also be taken into consideration.

In this paper, we touched on several topics, female and penile genital cutting and UCM, and provided recommendations based on the most current evidence and thinking. These are but a few examples of sexual medicine practices that should routinely include ethical considerations. Specifically, the panel recommends that ISSM should expand ethical considerations to include gendered genital mutilation or cutting (GGM/C) that impacts individuals across gender and sex, to be more inclusive of gender equity, genital autonomy, parental authority, and informed consent. ISSM should address GGM/C in a multifaceted manner to include legal, ethical, medical, surgical, cultural, and religious considerations. More broadly, given the profound impact of sexual medicine interventions on patients' physical, psychological, relational, social, religious, and, indeed, legal and political well-being, ethical considerations should become an umbrella concept that overarches all sexual medicine practice in order to assure that patients experience the benefit of inclusion, fairness, autonomy, and improvement in their lives as a result of sexual medicine care. ISSM has an opportunity and responsibility to advance an ethical approach to sexual medicine education and to the treatment of sexual dysfunctions.

The strengths of this paper include the deep clinical knowledge of the expert authors and the availability of observational research, the availability of some randomized trials, and published ethical discourse relevant to some of the topics we covered. At the same time, the understanding of the impact of culture on clinical care is only emerging—a limitation that calls for further research.

Conclusions

It is important that clinicians who practice in the complex domain of sexual medicine approach all their patients with cultural humility so that they, the clinicians, can continuously learn to provide patient-centered care. ISSM can have a positive role in promoting cultural humility through education and mentorship.

Author contributions

Conceptualization: All. Content draft: Sexuality, religion, and culture (J.O.), Female genital mutilation/circumcision (J.A., C.A.-J., N.S.), Male circumcision and unconsummated marriages (K.P.), Introduction, Methods, and Discussion (D.W. and S.G.). Statistical analysis: NA. Scientific review and editing: All. Recommendations: All.

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Conflicts of interest

D.W. has a contract with Movember as a consultant.

A.P. is a consultant for and received grant funding from Boston Scientific, is a member of the Advisory board Marius Pharmaceuticals and of the Advisory board The Coach: Men's Health App, is a Consultant to Endo Pharmaceuticals Advisory board, and FirmTech, is on the Advisory board of PhalloFill, a Consultant for MenMD, and Investor in ByteMD.

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