Leaving No-Woman's-Land

For too long, the science and clinical practice of women's sexual health have been neglected. Changes are needed to improve research agendas, health care worker training, and care protocols.

Lindy: *About two years after my surgery for ovarian cancer, I had a moment that I remember with utter clarity: I was standing by the kitchen counter, looking down at a magazine article about menopause, and I read this sentence: "After the surgery, I found myself in a wasteland of desperate, incoherent blog posts, trying to understand my condition now that, technically, nothing was wrong with me at all." I gasped and thought,* Oh my God, this is me. *Chemotherapy combined with a ruptured disk had left me with nerve damage that caused lower back and leg problems that prevented me from even walking fast. Getting out of bed and getting dressed was a painful marathon each morning. Everything below my chest seemed to be in rebellion. My bowels did not work well. The skin of my vulva was so sensitive I could barely touch it. Every night, I woke drenched in sweat. I felt like I had the flu all the time, and sex was impossible. I could not fully comprehend that I was no longer the person I had previously considered myself to be. And in that moment when I did confront the terrifying gulf between who I was and who I used to be, I had no idea how to begin to recover.*

My cancer was discovered following surgery to remove an ovarian cyst. My doctor explained that I needed another surgery immediately: a complete hysterectomy and removal of ovaries. I was almost 50, and grateful for the excellent care and the good prognosis. What no one mentioned to me was the very real possibility—according to some studies of survivors of pelvic cancer—that I would never be able to have an orgasm again or that I would experience other sexual dysfunctions.

Illustration by Shonagh Rae

In all the meetings and consultations about what to expect, the impact of the procedure on sexual pleasure never came up.

I am grateful to my doctors—I owe them my life. But they were silent about the sexual side effects of my treatment. Trained and immersed in a culture unused to acknowledging women's pleasure, my doctors' avoidance of the topic led me to believe that, given the magnitude of having survived cancer, asking for anything more was outside the norm. And, in a country where women's sexual health is increasingly viewed through the lens of a political struggle over reproductive health care rather than feeling pleasure, my predicament left me in a no-woman's-land.

After that realization, I set off to find doctors on my own, and I've been able to find support that has eliminated or amended what I felt that day at my kitchen counter. Now, a decade along, my body is working pretty well again. But it's been almost a lost decade for me. I am sure I am not the only woman to be bewildered by sexual issues that my medical caregivers were unprepared to address.

We three authors have given the area of women's sexual health a lot of thought—Elkins-Tanton as a patient, Kling as a doctor, and Collina as an educator—and believe that the health science community, is, at long last, in a position to fully embrace this neglected but key component of health and well-being.

The science and clinical practice of women's sexual health has long been tangled in moral, legal, and political angst around both sex and reproduction; that angst is intensified by a popular culture that sees women's sexual pleasure as simultaneously frightening and highly marketable. It's a loop of avoidance: research dollars steer clear of the treacherous whirlpool of female sexuality, limiting what we know. Medical education doesn't make time for what little is known, and since it's not much, clinicians don't raise the issue with patients. That silence sends a clear message to women: their sexual health does not matter. And the avoidance continues.

This neglect is compounded for people who have trouble accessing medical care or come from marginalized backgrounds. Trans women and other sexual and gender minority communities face an even deeper silence about sexuality, as well as blatant discrimination that impacts all aspects of their health. What's more, perceptions about race, weight, and many other factors shape the conversations that happen in the clinician's office. Add time constraints and myriad cultural taboos around talking about sex, and you have a perfect recipe for ignoring sexual health.

And yet, now is a crucial moment for women's health research to break this cycle—both by ensuring that research priorities reflect the importance of women's sexual health and by finally incorporating sexuality into medical education and practice. More than 30 years after the National Institutes of Health established the Office of Research on Women's Health, researchers have a much clearer understanding of sex as a biological variable and the remarkable variety of sex and gender expression. There remains a significant gender gap in health care research, but efforts are underway to rectify historical underinvestment. The Biden administration has launched the first White House Initiative on Women's Health Research. This summer, the US Department of Health and Human Services committed $100 million to transformative research and development in women's health. Both are important steps toward a future where women's health is robustly researched and better understood, but unless specific actions are undertaken to include women's sexual health, today's culture of neglect and avoidance will be perpetuated.

Women's sexual health

The World Health Organization defines sexual health as "a state of physical, emotional, mental, and social well-being in relation to sexuality." It specifically notes that this goes beyond "the absence of disease, dysfunction, or infirmity."

Sexual health is completely distinct from reproductive health, although they can be related. We are sexual beings throughout our adult lives, not just during our so-called reproductive years. And of course, desire and sexual expression are shaped by gender norms as well as power and privilege.

Research suggests that sexual function is linked to overall well-being. It has been documented that impaired sexual functioning can be associated with depression; it's also associated with decreased quality of life, relationship dissatisfaction, and poor self-image. When surveyed, older women report that sexual enjoyment is important for their overall health.

But, as a group, women are not experiencing sexual well-being. One study using data from 1992 found that 43% of women reported experiencing a sexual problem (most commonly, low desire) compared to 31% of men. A 2008 study again found that 43% of women reported sexual problems, and 22% reported that the problem caused them personal distress. In other words, one in five women is experiencing sexual-related distress. For some women, this is debilitating. And while we strongly caution against any numeric or goal-oriented definition of sexual health, it is worth noting that a gendered "orgasm gap" is well established; women in heterosexual relationships experience orgasm less frequently than men in heterosexual relationships (and less than both women and men in same-gender relationships), with cis women experiencing 22–30% fewer orgasms than cis men during heterosexual sex.

Women's sexual health care

Despite the prevalence of sexual concerns among women, physicians rarely ask about them, and when patients themselves raise the issue, clinicians often give the impression of indifference. A 2003 study of 3,800 women found that over half said their physicians did not seem like they wanted to hear about their problem, found it interesting, or appreciated its significance. Fifty-one percent indicated their physician was reluctant to treat the problem. When asked, clinicians cite time constraints, fear of offending the patient, inadequate training, a belief it's unimportant, and/or insufficient knowledge. And they may not have much to go on: a global study of medical society guidelines for sexual dysfunction found that 61% of such materials focused on men's issues.

Another reason for doctors' reticence may be that clinicians have limited educational opportunities for learning about sexual health. Sexual health and wellbeing are not adequately covered as part of a standard medical school education. Even though many medical societies recommend including sexual health education in medical training, programs training nurse practitioners, midwives, physicians, and physician assistants dedicated only 3–5 hours to human sexuality and sexual function education, according to a 2024 survey. In a study of US obstetrics and gynecology resident physicians, most agreed that sexual health training was important, but fewer than half could describe disorders of sexual function or list medications that impact it.

This is not simply a sex problem; it is a gender problem. Men's sexual health is treated with erectile dysfunction drugs, along with other interventions, as an issue of physiology, pleasure, and identity. In 1992, the National Institutes of Health convened a consensus panel on the subject of male "impotence" that recommended changing the term to "erectile dysfunction," while stating that it was "an important public health problem," deserving of more research. Today there are at least 26 drugs approved by the US Food and Drug Administration (FDA) for treating male sexual problems (although many are variations on the same kind of treatment), including an over-the-counter erectile dysfunction gel approved just last year. Three decades of advertisements for Viagra and other biomedical approaches have undoubtedly made the conversation about sexual dysfunction in men easier for patients and doctors.

Meanwhile, the FDA has struggled to even define sexual problems in women and approved very few related products. Female anatomies and sexual experiences require unique exploration. We're not saying there must be parity in the number of related products. But it's worth asking why sexual function and pleasure are viewed by the medical field as a core element of men's identity but not women's. Perhaps it is because persistent cultural narratives suggest that women don't care about sexual pleasure as much as men. However, there is growing evidence that women's and men's biological capacity for sexual response is comparable, and the gender gaps we see in sexual desire may have to do with how desire is conceptualized and measured. There is still so much to learn.

This leads to another aspect of women's sexual health: historically, compared to men's, it has gotten significantly less attention from researchers. And these disadvantages in funding and research may translate to fewer promising biomedical approaches in the pipeline—a recent search of clinicaltrials.gov revealed 875 trials involving the terms "sexual dysfunction" and "males" compared to 487 for the same term and "females."

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Inadequate sexual health education

Jewel: *When I was a resident, I had a fantastic mentor who blew my mind when she told me that women's sexual medicine could be part of my future practice. I had six years of formal medical schooling under my belt before I learned that sexual health was a medical specialty. Once I determined the focus of my clinical and research career, I started to see gaps in my training and knowledge. I had learned so little about the vulva, clitoris, sex hormones, and sexual health in general that I had to seek out additional training in these areas. The lack of training and clinical guidance is, I feel, in part driven by a lack of research investment. Ultimately, I found mentorship through colleagues at the Mayo Clinic and training through organizations such as the International Society for the Study of Women's Sexual Health, where I am now a fellow.*

And yet, in 2024, every week, patients tell me the same things: "I didn't know who to tell about this," or "I thought this pain was normal and I had to live with it." As a physician, I know that pain during sex is neither normal nor something that must be lived with—but clearly the news that FDA-approved treatments and other therapies are available has not made it into clinicians' offices across the country. The medical

establishment must do better by recognizing sexual health as important to a woman's identity and general well-being, beyond its role in reproduction and cervical cancer screening.

The limited information and help for women's sexual concerns inside doctors' offices is mirrored, and likely intensified, in the culture outside it. Many states do not provide sex education in public schools. Of the 38 states (and the District of Columbia) that mandate sex or HIV education, information is inadequate at best. A recent report by the Guttmacher Institute found that less than half of adolescents reported being informed of where to get birth control before they had sex for the first time. The trend is not even headed in the right direction; the same report found that adolescents were *less likely* to report receiving sex education on key topics from 2015–2019 than they were in 1995.

And when sex education occurs, it is not really about sexual health. The benefits of sexual health education for students, according to the Centers for Disease Control and Prevention, include a delay in first sexual intercourse, a reduction in the number of sexual partners, a decrease in unprotected sex, and improved academic performance. Yep, that's right: better grades.

The subject of sexual functioning, including arousal and orgasms, is largely left to the free market—i.e., pornography. According to a recent study of 1,300 teens, the average age of their first online porn experience is 12. Of the 44% who reported seeking it out intentionally, almost half describe online pornography as "helpful information about sex." Researchers don't know if there is any correlation between the use of porn and any specific harm, but it's fair to say the next generation deserves a better introduction to the wonderful world of consensual adult sex.

Considering the frame

Sara: *When my older sister got her first period, my mother burst into angry and fearful tears. So when my period came, I sensibly never mentioned it to anyone. But by the time I became a mother, I had read every page of* Our Bodies, Ourselves, *seen my cervix with my own speculum (it was an '80s thing), and worked at Planned Parenthood. My husband and I referred to genitals by their accurate names and strategically placed "progressive" sex education books around the house. We answered every sex question that came our way in a manner we would have called "sex-positive." So I admit feeling a bit defensive when my 20-something daughter mentioned that she never got a real sex education. Even at school? I asked. "Oh, that was just about disease, violence, and reproduction. Most sex has nothing to do with disease, violence, or reproduction."*

She sums up the problem perfectly. Why had our "blue" state not made that clear? Meanwhile, my students at Georgetown University, the Jesuit institution where I teach gender policy, know all about the dangers of sex. Many received abstinence-only sex education; most report learning only about contraceptives and sexually transmitted diseases. Every year, one or two of my students report making a public virginity pledge, promising to keep themselves "clean for marriage." In both my daughters' progressive upbringing and my students' more traditional ones, I see a common theme: sex is about avoiding catastrophe rather than feeling pleasure.

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Legal theorist Katherine M. Franke points out that women's sexuality is often framed as either a matter of dependency or danger, rendering their "actual experience of pleasure invisible." But the scientific, medical, and educational establishments need to recognize that when women's sexuality is largely invisible in exam rooms and classrooms, confusion and fear can fill the void. The recent Supreme Court decision that allows states to ban abortions launched a wave of fear about the role of government in sexual and reproductive health, adding to the narrative that sex is a potential disaster for women.

But progressive policies concerning women's sexuality also echo gloom and doom. The movement to address campus-level sexual violence has been profoundly important in preventing real and ongoing harm. But Title IX training programs about how not to get raped or how to monitor the sexual safety of others frame sex as a lurking disaster. It's also a depressing way to start college. The #MeToo movement called out powerful abusers and achieved some much-deserved justice, but it was a national conversation about women's sexual shame

and pain. Being a survivor is better than being a victim, but neither would be better.

Today, the way women's sexual health is framed affects how it is researched and treated. If sexual health is largely about averting disaster rather than enhancing women's pleasure and well-being, women's sexual experiences will remain invisible. This will not bring about the advances in research, treatment, medical training, and medical care necessary to avoid no-woman's-land.

Reframing sexual health

Understanding how messy medical, cultural, and historical threads converge in bedrooms, exam rooms, and research labs is key to progress. Once the problem is understood, it can be reframed to recognize women's bodily autonomy and capacity for joy. Rather than sweeping pain and dysfunction under the rug or waiting for pharmaceutical companies to come up with a molecule (and an advertising campaign) that frames sexual health as a problem to solve, the research community and medical establishment should begin reframing women's sexual health as a subject for research and investment.

The process could start with creating a broad research roadmap, similar to the National Academies of Sciences, Engineering, and Medicine's recent report *Advancing Research on Chronic Conditions in Women*. This model is particularly useful for three reasons. First, the issue is female-specific. Women cannot rely on the many decades of research on males; sex-specific biological research is key to understanding the unique sexual needs of women.

Second, women's sexual health, like chronic debilitating conditions, does not fit well into current medical disease models. Women's sexual health problems are rarely about an acute disease of a single organ system. Sexual health is not simply gynecologic health; it can involve complex interactions of autoimmune, infectious, neurocognitive, musculoskeletal, and pain disorders—the same web of complexity relevant to understanding multiple chronic conditions.

And third, women's sexual health, like chronic health conditions, is impossible to understand without a health equity lens. Women's sexuality is steeped in gender biases and structural sexism; who defines sexual "problems," who is included in the research, and how sexual distress may be monetized will determine whether women benefit from research initiatives. For both sexuality and chronic conditions, social factors do more than impact the problem; sometimes, they *are* the problem. Here, the model provided by the National Academies' chronic conditions report could help navigate the complex scientific and political challenges that will inevitably come with exploring women's sexual health, paying attention not only to the circumstances that contribute to sexual problems but also to the benefits of addressing them. This goes beyond decreasing disfunction, disease, and pregnancy; a sexual health agenda should focus on joyful well-being. This is not "just" a women's problem—it could prove transformative for society at large.

Another important initiative should focus on training at medical regulatory organizations, medical schools, and medical associations. Curriculum standards need standardized sexual health and sexual well-being education. Clinical guidelines should systematically incorporate impacts on women's sexual health. Funding for programs that train future sexual health clinicians could also help close access gaps. Similarly, assuring that insurers, including Medicare, raise compensation for physicians so that women's health services are reimbursed at rates similar to men's could both address disparities now and ensure more care in the future.

Overall, when talking about sexual health, everyone in the medical, research, education, and policy spheres would do well to remember that it's more than reproduction, disease, and violence. Sexual health matters because sexual health *is* health. Good health means women can show up for themselves, their families, their friends, and their community, which benefits all of us. But until sexual health is acknowledged as its own end goal, it will not be achieved.

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