Understanding Female Sexual Anatomy

An Educational Guide to the Clitoral Complex, Vulva, Vagina, Pelvic Floor and Female Sexual Response

By Dr. Nizamuddin Qasmi
Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

BUMS – Hamdard University, Delhi
MD, CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

Why Understanding Female Anatomy Is an Important Part of Sexual Health

In my clinical practice, I frequently meet women and couples who have been married for years yet have never received clear, medically accurate education about female sexual anatomy.

A woman may know where the uterus is but may not understand the difference between the **vulva and vagina**. A couple may believe that the visible tip of the clitoris is the complete organ. Some women worry that their labia look abnormal because they are not symmetrical. Others believe that orgasm should occur automatically from vaginal intercourse and conclude that something is medically wrong if additional stimulation is required.

These misunderstandings can contribute to unnecessary anxiety, sexual dissatisfaction, painful intercourse, difficulty reaching orgasm, relationship conflict and inappropriate treatment.

This is why I consider **anatomical education itself an important part of sexual healthcare**.

A major 2026 review of female sexual anatomy emphasized that the mons pubis, labia, vulvar vestibule, clitoris, vestibular bulbs and vagina each have anatomical and neurovascular features that may contribute to sexual arousal, pleasure and orgasm. The authors specifically concluded that better knowledge of female anatomy can improve patient education and the treatment of sexual dysfunction.

The World Health Organization also describes sexual health as more than the absence of disease. It includes physical, emotional, mental and social well-being and the possibility of safe, pleasurable and respectful sexual experiences.

Therefore, although this article may appear within a disease or sexual-health section, **female anatomy itself is not a disease**. This is an educational topic intended to help patients

understand normal anatomy, normal variation and the conditions that may interfere with sexual or reproductive health.

First Understand the Difference: Vulva Is Not the Same as Vagina

This is probably the single most important anatomical distinction.

The term **vulva** refers to the external female genital region.

The **vagina** is the muscular canal located inside the body.

According to ACOG, the vulva includes the labia majora, labia minora, vestibule, clitoris and the openings of the urethra and vagina. The visible portion of the clitoris is the glans, while much of the clitoral structure extends more deeply.

When a patient tells me:

“Doctor, I have burning in my vagina,”

I first determine where the symptom actually occurs.

Is it on the labia?

At the vaginal entrance?

Around the clitoris?

Inside the vagina?

Near the urethral opening?

Deep inside the pelvis?

These areas have different anatomy and different diseases.

Correct terminology therefore improves diagnosis.

The Main Structures of the Female External Genitalia

The external genital area includes several interconnected but distinct structures: the **mons pubis, labia majora, labia minora, clitoral hood and clitoris, vulvar vestibule, urethral opening, vaginal opening, Bartholin glands, paraurethral or Skene glands and perineum**. Modern imaging and anatomical literature recognizes all of these as important regions when evaluating normal anatomy and vulvar disorders.

Each structure has its own function.

Some primarily protect delicate tissue.

Some participate in sexual sensation.

Some assist lubrication.

Some are involved in urination.

Others contribute to reproductive or pelvic function.

The female genital region should therefore not be thought of as one single organ.

The Mons Pubis

The **mons pubis** is the fatty, hair-bearing area over the pubic bone.

Its primary function is protective cushioning of the structures underneath.

Its appearance can vary with:

age,

body weight,

hormonal status,

pregnancy,

and individual anatomy.

It is part of the vulva and should not be confused with the clitoris or labia.

Labia Majora: The Outer Folds

The **labia majora** are the outer folds of the vulva.

They contain skin, fatty tissue, blood vessels, nerves, sweat glands, sebaceous glands and hair follicles after puberty.

Their size, thickness, pigmentation and symmetry vary considerably between women.

They protect the more delicate internal vulvar structures.

There is **no single medically correct appearance** for the labia.

Labia Minora: The Inner Folds

The **labia minora** are the inner folds surrounding the vulvar vestibule.

They contain numerous blood vessels and sensory nerves and can participate in sexual sensation.

They vary tremendously in:

length,

width,

shape,

pigmentation,

surface texture,

and symmetry.

One side may naturally be longer than the other.

The labia minora may remain inside the outer labia or extend substantially beyond them.

Both can be normal.

ACOG specifically states that there is a wide range of normal genital appearance, that labia can be uneven, and that the labia minora commonly extend beyond the labia majora.

A 2026 systematic review of almost 1,000 women similarly documented substantial inter-individual variation in labia-minora dimensions and concluded that greater awareness of this diversity may help reduce unnecessary interventions.

This is an important body-image issue.

A woman should not assume that her anatomy is abnormal merely because it looks different from an illustration, photograph or another woman's anatomy.

The Vulvar Vestibule

Inside the labia minora lies an area called the **vestibule**.

This region contains the openings of both the:

urethra, through which urine passes,

and the **vagina**.

The vestibule also contains glandular openings and highly sensitive tissues.

Because the vestibule contains important sensory and hormonally responsive tissues, disorders affecting it can produce:

burning,

pain with touch,

painful penetration,

or hypersensitivity.

One condition involving this region is **vestibulodynia**, which may cause significant pain at the vaginal entrance despite little visible abnormality.

Understanding the vestibule is therefore important not only for anatomy education but also for diagnosing sexual pain.

The Clitoris: The Most Misunderstood Structure in Female Sexual Anatomy

Most people are aware of the small visible structure located near the upper junction of the labia minora.

That is only the visible portion.

The clitoris is a larger, three-dimensional erectile and sensory organ with deeper components extending beneath the surface.

Current anatomical literature describes the clitoris as a complex structure with extensive innervation and important relationships to the urethra, vestibular bulbs, pubic structures and surrounding tissues.

This is one of the most important anatomical facts for patients and couples to understand.

Is "Clitoral Network" the Correct Medical Term?

Patients increasingly encounter phrases such as **"clitoral network"** or **"clitoral complex"** on social media.

These expressions can be useful educationally, but they are not always precise anatomical terms.

A 2025 structured review performed by the Society of Gynecologic Surgeons Pelvic Anatomy Group found that terminology surrounding the clitoris and vestibular bulbs remains inconsistent in medical literature and proposed greater standardization.

Therefore, when I use the phrase **clitoral network**, I mean it in an educational sense: the clitoris, its sensory nerves and blood supply, and its functional relationship with neighboring vulvar and erectile tissues.

It should not be interpreted as one formally recognized anatomical organ containing every nearby structure.

For example, the **vestibular bulbs are separate erectile structures**, although they lie very close to and function alongside the clitoris. Detailed dissection confirms that their erectile tissue is anatomically distinct from the clitoral corpora cavernosa.

This distinction allows us to teach anatomy accurately without oversimplifying it.

The Glans Clitoris: The Visible Portion

The **glans** is the portion most people recognize as the clitoris.

It is visible externally near the upper junction of the labia minora.

It contains extremely rich sensory innervation and plays a major role in sexual sensation.

However, it represents only part of the complete clitoral structure.

The glans is partly protected by a fold of tissue called the **clitoral hood or prepuce**. ACOG specifically notes that the visible glans is only part of a structure extending more deeply into the body.

The Clitoral Hood

The **clitoral hood** is the fold of tissue that partly covers and protects the glans.

Its appearance and mobility differ between women.

Like foreskin covering the glans of the penis, it protects sensitive tissue from continuous direct friction.

The hood should usually move to some degree over the glans.

Sometimes scarring or adhesions can restrict this movement.

Clitoral Adhesions and Phimosis

In some women, the clitoral hood becomes adherent to the glans.

This may occur without symptoms, but in others it can contribute to:

clitoral pain,

hypersensitivity,

reduced sensation,

difficulty with arousal,

or reduced orgasmic response.

Modern research increasingly recognizes **clitoral adhesions or clitoral phimosis** as conditions worth assessing in women with appropriate symptoms.

A 2026 systematic review found that procedures used in carefully selected women may reduce pain and improve sexual-function scores, but the quality of available evidence remains low and recurrence is not uncommon.

Therefore, women should not attempt aggressive self-treatment or assume that the hood must always fully expose the glans.

A clinician should evaluate troublesome symptoms.

The Body of the Clitoris

Behind the glans is the **clitoral body**.

This contains paired erectile tissues known as the **corpora cavernosa**.

During sexual arousal, blood flow increases and the erectile tissues become engorged.

A 2025 physiological review describes relaxation of smooth muscle within clitoral erectile tissue during arousal, resulting in increased blood flow and enlargement of clitoral tissue.

This is one reason female arousal should not be thought of only in terms of vaginal lubrication.

There is also a genuine erectile response.

The Crura: The Deeper "Roots" of the Clitoris

The clitoral body divides into two elongated structures known as the **crura**, or roots.

These extend along the pubic bones.

They are part of the clitoris and contain erectile tissue.

Therefore, the clitoris is not merely a tiny external point.

It has considerable anatomical depth.

Understanding the crura is one reason modern anatomical diagrams look very different from older textbook illustrations that showed only the external glans.

The Vestibular Bulbs

On either side of the vaginal entrance lie paired erectile structures known as the **vestibular bulbs**.

During sexual arousal, these tissues can become engorged with blood.

They lie close to the clitoris and urethra, but contemporary anatomical work confirms that they are **separate structures rather than simply extensions of the clitoris**.

A 2026 review of critical vulvovaginal structures includes the vestibular bulbs among the tissues potentially contributing to sexual arousal and orgasm.

So when educating patients, it is reasonable to explain that female genital arousal involves a **larger erectile region**, but precision matters.

The Clitoris Is Richly Innervated

Clitoral sensation is supplied largely through branches of the pudendal nerve, particularly the **dorsal nerves of the clitoris**, together with additional autonomic nerve pathways.

Modern research confirms extremely rich clitoral innervation.

A 2023 human histological study directly counted axons in the dorsal clitoral nerves. It estimated an average of approximately **10,280 myelinated axons** supplying the glans when both sides were considered, while noting that unmyelinated and other nerve contributions were not included.

Other anatomical studies using different methods have produced somewhat different counts and distributions, illustrating that nerve anatomy is complex and cannot be reduced to one popular number.

Therefore, the frequently repeated statement that the clitoris has **"exactly 8,000 nerve endings"** should not be treated as an established anatomical fact.

The scientifically safer statement is:

The clitoris is densely and richly innervated, and modern human studies demonstrate thousands of sensory axons.

Why Clitoral Nerve Anatomy Matters Clinically

Understanding these nerves is not merely academic.

It matters during:

pelvic surgery,

vulvar surgery,

clitoral procedures,

reconstructive surgery,

treatment following genital trauma,

and evaluation of loss of genital sensation.

Current surgical anatomy studies emphasize preservation of the dorsal clitoral nerve region because damage can affect sensation and sexual function.

This is another reason cosmetic or genital surgery should never be approached as though the region contains unimportant excess tissue.

Its anatomy is neurovascularly complex.

The Urethra Is Not the Vagina

The **urethra** is the short tube through which urine leaves the bladder.

Its opening lies within the vulvar vestibule, above the vaginal entrance.

Women sometimes mistakenly assume they urinate through the vagina.

They do not.

Understanding this distinction is useful when evaluating:

urinary burning,

urethral pain,

recurrent urinary symptoms,

and sexual discomfort.

Skene or Paraurethral Glands

Small glands and ducts are located around the urethral region and are commonly called **Skene glands or paraurethral glands**.

Their precise contribution to female sexual physiology continues to be researched.

These structures should not be oversimplified into claims that every woman possesses one identical “pleasure organ” in the anterior vaginal wall.

Female genital anatomy varies.

Bartholin Glands

The **Bartholin glands**, also called the greater vestibular glands, lie near the posterior portion of the vaginal opening.

Their ducts open into the vestibule.

They have traditionally been considered contributors to local secretions, although current research indicates that the precise physiology of vestibular glands and their contribution to lubrication and sexual function remain incompletely understood.

If a Bartholin duct becomes blocked, a cyst or abscess can develop.

This is a medical condition and should not be confused with normal anatomy.

What About the "G-Spot"?

Few topics in female anatomy create as much confusion as the so-called **G-spot**.

Patients are often led to believe that there is a distinct small organ hidden in one precise location and that failure to find it indicates sexual dysfunction.

Current scientific understanding is more complicated.

The Fifth International Consultation on Sexual Medicine discusses an interacting region involving **clitoral, urethral and vaginal structures**, sometimes described as the **clitoral-urethral-vaginal complex**, in relation to some forms of sexual sensation.

However, anatomical terminology remains debated, and the medical literature has not established one universally agreed separate organ corresponding to the popular concept of a G-spot. Recent work is still attempting to standardize terminology for clitoral and neighboring erectile anatomy.

My advice to patients is therefore:

Do not turn sexual intimacy into a search for one magical anatomical point.

Different women experience sensation differently.

The Vagina

The **vagina** is an elastic muscular canal connecting the vaginal opening to the cervix.

It has several functions.

It:

allows menstrual flow to leave the body,

receives penetration during vaginal intercourse,

forms part of the birth canal,

and provides access to the cervix during gynecological examination.

It is not simply a “pleasure tube,” nor is it the only female sexual organ.

The vagina works together with the vulva, pelvic floor, nervous system and brain.

Vaginal Lubrication

During sexual arousal, vaginal and vulvar tissues undergo vascular changes.

Lubrication arises through several mechanisms, including fluid movement through vaginal tissues and secretions from surrounding glands.

It is therefore incorrect to assume that one gland alone produces all lubrication.

The 2025 review of vestibular glands concluded that these glands are believed to assist lubrication but emphasized that important gaps remain in understanding their detailed function.

This is an important example of why medical education should distinguish established facts from assumptions.

Lubrication Does Not Perfectly Measure Desire

A woman can feel mentally interested but have limited lubrication because of:

menopause,

breastfeeding,

medication,

hormonal changes,

illness,

or insufficient time for arousal.

Conversely, a physical genital response does not automatically prove emotional desire or consent.

Modern sexual medicine recognizes that **cognitive arousal and genital arousal are related but distinct components** of sexual response. The 2026 ICSM consensus defines female genital and cognitive arousal difficulties separately.

Therefore:

Physical response is not a complete measurement of what a person feels or wants.

The Pelvic Floor: The Muscular Foundation

Below and around the pelvic organs lies the **pelvic floor**.

These muscles help support:

the bladder,

uterus,

vagina,

rectum,

and surrounding pelvic structures.

They also participate in sexual response and orgasmic contractions.

Healthy pelvic-floor function requires more than strength.

Muscles must be capable of:

contracting,

relaxing,

and coordinating appropriately.

A pelvic floor that is excessively tight may contribute to:

painful penetration,

pelvic pain,

vulvar pain,

or difficulty relaxing during sexual activity.

A weak or poorly coordinated pelvic floor may contribute to:

urinary leakage,

pelvic support problems,

or changes in sexual sensation.

This is why indiscriminately prescribing Kegel exercises to every woman is inappropriate.

The Cervix

The **cervix** is the lower portion of the uterus and projects into the upper vagina.

It has an opening through which:

menstrual blood passes,

sperm can enter the uterus,

and the cervix changes significantly during pregnancy and childbirth.

Some women report cervical or deep pelvic sensations during intercourse, while others find deep contact uncomfortable.

Individual sensation varies.

The cervix should primarily be understood as an important reproductive structure rather than being marketed as a universal sexual pleasure point.

The Uterus and Fallopian Tubes

The **uterus** is the muscular organ in which pregnancy develops.

The **fallopian tubes** transport the egg from the ovarian region toward the uterus and are normally where fertilization occurs.

These structures are essential to reproductive health but should not be confused with the external sensory anatomy of sexual pleasure.

A woman can have completely normal external sexual sensation yet experience fertility difficulties involving ovulation or the fallopian tubes.

Likewise, she can have normal fertility while experiencing significant sexual dysfunction.

Sexual health and fertility overlap, but they are not the same thing.

The Ovaries

The ovaries release eggs and produce important reproductive hormones including estrogen and progesterone, along with androgens.

Hormones influence:

menstrual cycles,

vulvovaginal tissues,

sexual desire,

arousal,

and general reproductive physiology.

However, female sexuality should never be reduced to hormone levels alone.

The brain, relationship, nervous system, pelvic anatomy and general health all matter.

The Hymen and the Myth of "Virginity Testing"

The **hymen** is a variable rim or fold of tissue around part of the vaginal opening.

Its shape and appearance differ considerably between individuals.

It can stretch or change because of:

normal growth,

physical activity,

tampon use,

medical procedures,

or sexual activity.

Importantly, ACOG states that the presence or absence of a hymen **does not indicate whether a person has previously had intercourse**.

Therefore, so-called virginity testing based on the hymen is not scientifically valid.

Female Genital Anatomy Has Enormous Normal Variation

This cannot be emphasized enough.

There is no single normal:

labial length,

labial color,

clitoral-hood size,

vulvar pigmentation,

or degree of asymmetry.

ACOG states clearly that vulvar size, shape and color vary widely between people and can also change during puberty, pregnancy, aging and menopause.

A 2025 study found that nearly half of women attending gynecological care reported some concern about their genital appearance, yet those concerns were not explained by actual labial measurements after adjustment for factors such as age and childbirth history.

This tells us something important:

Anatomical education is also body-image medicine.

Women should not compare themselves with edited photographs, pornography, cosmetic advertising or diagrams showing only one anatomical appearance.

Puberty Changes Female Anatomy

At puberty, rising reproductive hormones change the vulva.

The labia minora grow.

Pigmentation may become darker.

The clitoral hood and genital tissues mature.

Pubic hair develops.

A recent systematic review confirmed considerable variation in normal pubertal vulvar development, including frequent asymmetry.

Variation during puberty should therefore not automatically be pathologized.

Pregnancy Also Changes the Vulva

Pregnancy substantially increases blood flow to the pelvis.

The vulva may become:

more vascular,

darker in color,

or somewhat swollen.

Some women develop vulvar varicosities.

ACOG notes that these changes can be normal consequences of pregnancy and often improve afterward.

Childbirth Can Affect Anatomy and Sexual Function

Vaginal childbirth may stretch or injure:

pelvic-floor muscles,

perineal tissues,

vaginal tissues,

and occasionally sensory nerves.

Women may experience temporary or persistent:

pain,

reduced pelvic-floor strength,

tightness,

scar discomfort,

or altered sexual sensation.

Postpartum sexual concerns should not simply be dismissed as something women must tolerate.

Persistent pain or dysfunction deserves assessment.

Breastfeeding and Postpartum Hormones

During breastfeeding, lower estrogen levels can contribute to:

vaginal dryness,

slower genital arousal,

and uncomfortable intercourse.

A woman may still feel sexual desire yet experience a different physical response.

This again illustrates why sexual desire, genital response and anatomy must be considered separately.

Menopause Changes Vulvar and Vaginal Tissues

Menopause is another important life stage.

The 2026 Fifth International Consultation on Sexual Medicine describes **genitourinary syndrome of menopause (GSM)** as involving changes in structures including the labia,

clitoris, vestibule, vagina, urethra and bladder due largely to the low-estrogen state after menopause.

Possible symptoms include:

dryness,

burning,

irritation,

pain during intercourse,

urinary symptoms,

and altered genital sensitivity.

These are genuine physiological changes, not simply psychological aging.

Appropriate treatment can significantly improve quality of life.

The Brain Is Also Part of Female Sexual Anatomy—Functionally

Anatomically, of course, the brain is not part of the vulva.

Functionally, however, sexual sensation is impossible to understand without it.

Sensory signals must be interpreted by the brain.

Sexual pleasure can be influenced by:

attention,

emotional safety,

memory,

expectation,

relationship quality,

stress,

anxiety,

fear,

and cultural beliefs.

The 2025 ICSM basic-science consensus emphasizes that female sexual function involves interacting neurological, endocrine and psychosocial systems, and that orgasm involves both incoming sensory information and higher brain processing.

This helps explain why identical touch can feel pleasurable on one occasion and neutral or uncomfortable on another.

Understanding Arousal

Sexual arousal involves several processes occurring simultaneously.

Blood flow increases in genital erectile tissues.

The clitoris becomes engorged.

Vulvar tissues may swell.

Lubrication may increase.

Heart rate and respiration may change.

Sensory attention may intensify.

The pelvic floor participates.

But none of these responses has to occur in exactly the same order in every woman.

ACOG's current guidance recognizes a **circular rather than strictly linear female sexual-response model**, in which desire may sometimes appear only after arousal begins.

This is closely related to the concept of **responsive desire**.

Understanding Orgasm

An orgasm is not simply a vaginal event.

It involves sensory input, brain processing and characteristic neuromuscular responses.

The 2025 ICSM basic-science consensus describes female orgasm as involving clitoral stimulation prominently for many women, while other genital and non-genital pathways can contribute in some individuals.

The latest 2026 ICSM definitions also emphasize that women vary widely in how much and what type of stimulation they require. Importantly, a woman should **not** be diagnosed with Female Orgasmic Disorder simply because she can orgasm with clitoral stimulation but not vaginal penetration.

This is one of the most important sexual-health facts couples can learn.

Clitoral Stimulation Is Normal Female Anatomy, Not a Defect

A woman requiring external clitoral stimulation for orgasm is not sexually abnormal.

The clitoris is a principal sensory organ involved in female sexual pleasure.

If penetration alone is not sufficient for a particular woman, the proper conclusion is not:

“Her body is defective.”

The more accurate conclusion may simply be:

“Her anatomy responds more reliably to another form of stimulation.”

Modern sexual medicine recognizes this as normal variation.

Is One Kind of Orgasm “Better” Than Another?

No medical evidence supports ranking women according to whether orgasm is experienced mainly through clitoral, vaginal or combined stimulation.

The relevant outcome is whether the experience is:

wanted,

comfortable,

pleasurable,

and personally satisfying.

Sexual medicine should help patients understand their anatomy—not create another standard they feel pressured to meet.

Physical Arousal Is Not Consent

This deserves its own section.

Genital swelling, lubrication or another automatic physical response does not prove:

desire,

enjoyment,

or consent.

Consent is a voluntary decision.

WHO's sexual-health framework emphasizes pleasurable and safe sexual experiences that are free from coercion, discrimination and violence.

No anatomical response overrides a person's right to say no or stop.

Disorders That Can Affect the Clitoral and Vulvar Region

Knowledge of normal anatomy helps us recognize abnormal conditions.

Symptoms around the clitoris or vulva can result from conditions such as:

vulvodynia,

vestibulodynia,

pelvic-floor dysfunction,

lichen sclerosus,

dermatitis,

infection,

genitourinary syndrome of menopause,

clitoral adhesions,

neurological disorders,

trauma,

or—in uncommon cases—precancerous or malignant disease.

ACOG recommends professional assessment for persistent vulvar burning, itching, pain, new lumps or skin changes.

Education should therefore produce awareness, not self-diagnosis.

When Clitoral Sensation Becomes Reduced

Some patients report:

“Doctor, my clitoris feels numb.”

Possible explanations can include:

neurological disease,

diabetes-related neuropathy,

pelvic surgery,

nerve injury,

menopausal tissue changes,

medication effects,

clitoral adhesions,

or altered arousal.

Reduced sensation should be evaluated particularly when the change is new, significant or accompanied by other neurological symptoms.

Clitoral anatomy is sufficiently complex that persistent sensory loss should not automatically be treated with an aphrodisiac.

When the Clitoris Becomes Painful

Pain involving the clitoris is sometimes described as **clitorodynia**.

Possible contributors include:

infection or inflammation,

adhesions,

vulvar dermatological disease,

nerve-related pain,

pelvic-floor dysfunction,

or broader vulvodynia.

Clitoral adhesions can be associated with pain, hypersensitivity or reduced sensation, but the condition should be confirmed before treatment.

Why Female Genital Cosmetic Surgery Requires Caution

Another reason anatomy education matters is the increasing popularity of cosmetic genital procedures.

Most vulvas do not look identical.

ACOG emphasizes that there is no single correct vulvar appearance and that variation in labial size and asymmetry is normal.

The clitoral and vulvar region also contains important neurovascular structures.

Any surgical procedure performed near these tissues should therefore respect sensory anatomy and be based on an appropriate indication and informed discussion of benefits and risks.

Women should not undergo surgery simply because normal anatomical variation has been presented to them as a defect.

Anatomy Education and Painful Intercourse

A woman experiencing painful intercourse should not simply be told:

“Relax.”

Pain may originate from:

vulvar tissue,

the vestibule,

pelvic-floor muscles,

vaginal dryness,

endometriosis,

infection,

hormonal changes,

or other conditions.

Anatomical localization helps determine where the pain arises.

This is one reason precise knowledge of female anatomy is essential in treating dyspareunia, vaginismus, vulvodynia and other sexual-pain disorders.

Female Anatomy and Infertility

Another important distinction is between **sexual anatomy** and **reproductive anatomy**.

The clitoris is critically important for sexual sensation but is not required for fertilization.

The ovaries, fallopian tubes, uterus, cervix and reproductive hormones are more directly involved in conception.

Therefore, a woman may have:

normal sexual pleasure but infertility,

or

normal fertility but significant sexual dysfunction.

At Saira Health Care, where my work focuses on both **sexual disorders and infertility**, I frequently have to explain this difference.

Treating fertility without considering sexual comfort can also create problems.

Repeated timed intercourse may become stressful or painful.

Conversely, severe vaginismus or vulvodynia may indirectly interfere with conception because intercourse becomes difficult even when the reproductive organs are otherwise healthy.

Anatomy Education Can Improve Couple Communication

Sometimes couples do not have a disease.

They simply lack accurate information.

A husband may assume penetration should automatically cause orgasm.

A wife may feel embarrassed to explain that she needs different stimulation.

Both become disappointed.

The woman may think:

“Something is wrong with me.”

The man may think:

“I am failing.”

Neither conclusion is necessarily correct.

Accurate anatomical education replaces blame with understanding.

The Role of Unani Medicine in Female Sexual-Health Education

As a Unani physician, I consider **whole-person understanding** one of the strengths of the Unani system.

However, anatomy requires scientific precision.

The clitoris does not change its anatomical structure because of a particular Unani medicine, and there is no high-quality evidence showing that an herbal preparation can create new clitoral nerves, enlarge normal sensory anatomy or guarantee orgasm.

Responsible Unani medicine should therefore **complement accurate anatomical knowledge rather than replace it**.

The greatest usefulness of Unani principles in this area lies in supporting the broader conditions necessary for sexual and reproductive well-being.

Asbab Sitta Daruriyya: A Whole-Person Framework

Classical Unani medicine describes **Asbab Sitta Daruriyya**, the six essential factors on which health depends.

CCRUM identifies them as:

air and environment; foods and drinks; physical movement and rest; mental activity and peace; retention and evacuation; and sleep and wakefulness.

These principles are highly relevant to sexual health even though they do not alter anatomy.

For example, a woman experiencing:

severe sleep deprivation,

chronic stress,

poor general health,

metabolic disease,

constipation,

or persistent fatigue

may have more difficulty experiencing comfortable sexual arousal.

Correcting those factors supports the whole person.

Ilaj-bil-Ghiza — Dietotherapy

Unani medicine emphasizes appropriate nutrition.

In female sexual health, the sensible goal of dietotherapy is not to claim that a particular food directly stimulates the clitoris.

Instead, good nutrition can support:

cardiovascular health,

diabetes control,

healthy weight,

energy,

general hormonal health,

and overall well-being.

These factors can indirectly influence sexual function.

There is no scientifically established **“clitoris food”** or guaranteed orgasm-enhancing diet.

Ilaj-bil-Tadbir — Regimental and Lifestyle Care

CCRUM recognizes **Ilaj-bil-Tadbir** as one of the principal therapeutic modes of Unani medicine, together with dietotherapy, pharmacotherapy and surgery.

In sexual-health care, appropriate lifestyle support may include:

adequate physical activity,

rest,

healthy sleep,

stress reduction,

weight management,

and correction of bowel or general-health problems.

These interventions may improve general well-being and the environment in which healthy sexuality occurs.

Mental and Emotional Balance in Unani Medicine

The Unani concept of **Harakat-o-Sukun Nafsani**, broadly referring to mental activity and peace, is especially relevant to sexuality.

CCRUM's standardized terminology recognizes mental activity and psychological peace as an essential health factor.

Modern sexual medicine reaches a similar practical conclusion:

anxiety,

fear,

relationship conflict,

performance pressure,

and shame

can strongly influence sexual experience.

In suitable patients, sexual education, counseling or psychosexual therapy may therefore be more important than medication.

Ilaj Nafsani and Psychological Support

CCRUM teaching material also recognizes **Ilaj Nafsani**, or psychological therapy, within broader Unani therapeutic approaches.

This is particularly useful when anatomical misconceptions have produced:

body shame,

sexual guilt,

performance anxiety,

fear of intercourse,

or relationship misunderstandings.

Accurate information can itself be therapeutic.

Unani Medicines: A Supportive, Not Anatomical, Role

Unani pharmacotherapy may be considered for appropriately diagnosed associated conditions.

However, a herbal preparation should never be used as a substitute for evaluation of:

vulvar pain,

genital numbness,

pelvic-floor dysfunction,

infection,

clitoral adhesions,

menopausal symptoms,

or another medical condition.

Similarly, patients should avoid applying concentrated oils, perfumes, powders, herbal pastes or irritating home remedies directly to delicate vulvar or clitoral tissue without professional guidance.

“Natural” does not automatically mean safe for genital skin.

Dr. Nizamuddin Qasmi's Specialized Educational and Clinical Approach

At **Saira Health Care**, I prefer an anatomy-first approach when patients present with female sexual concerns.

I begin by clarifying **where the symptom actually occurs**.

Is it the clitoris?

Vulva?

Vestibule?

Vaginal entrance?

Pelvic floor?

Deep vagina?

Urethra?

Or pelvic reproductive organs?

Then I determine what type of problem is present.

Is the concern about:

appearance,

desire,

arousal,

lubrication,

sensation,

orgasm,

pain,

penetration,

or fertility?

These are different clinical questions.

My Approach When a Woman Reports Reduced Pleasure

When a patient tells me:

“I don't feel pleasure properly,”

I do not immediately prescribe a sexual tonic.

I ask whether she has ever experienced normal sensation.

I consider:

whether clitoral sensation is intact,

whether stimulation is adequate,

whether pain is present,

whether the pelvic floor is overactive,

whether menopause or breastfeeding has produced dryness,

whether diabetes or medication might affect nerves,

whether antidepressants are involved,

whether relationship anxiety is contributing,

and whether expectations about intercourse are realistic.

Only then can treatment be individualized.

My Approach When a Woman Cannot Reach Orgasm

If the woman can achieve orgasm through clitoral stimulation but not penetration alone, current international sexual-medicine guidance tells us not to automatically diagnose Female Orgasmic Disorder.

If orgasm is absent in every circumstance and the patient is distressed, then a more detailed evaluation may be appropriate.

This can involve:

sexual education,

psychological or psychosexual support,

medication review,

pelvic-floor assessment,

gynecological evaluation,

or other treatment depending on the cause.

My Approach When Anatomy Is Painful

Pain changes the entire clinical pathway.

Persistent vulvar, clitoral or penetration-related pain deserves diagnosis.

Depending on symptoms, I may consider or recommend evaluation for:

vulvodynia,

vestibulodynia,

pelvic-floor dysfunction,

infection,

dermatological disease,

menopause-related tissue changes,

adhesions,

or neurological pain.

Treatment should follow the actual diagnosis.

My Approach to Female Anatomy and Infertility

When a couple is trying for pregnancy, I also assess whether sexual-health problems are making intercourse difficult.

A woman may have perfectly normal reproductive organs but severe vaginismus.

Another may have normal sexual comfort but blocked fallopian tubes.

A man may have normal fertility but erectile anxiety during timed intercourse.

These are fundamentally different problems.

Because my focused practice includes **both Sexual Disorders and Infertility**, I believe fertility treatment should consider the couple's sexual well-being rather than treating intercourse purely as a reproductive procedure.

Contribution of Saira Health Care to Sexual Disorders & Infertility

At **Saira Health Care**, sexual-health education is an important part of our work.

Many conditions improve when patients finally understand what is happening in their bodies.

Our clinical focus includes concerns such as:

low sexual desire, arousal difficulties, female orgasmic difficulty, painful intercourse, pelvic-floor dysfunction, vulvodynia, vaginismus, male sexual dysfunction, infertility and the sexual impact of chronic medical conditions.

The aim is not to label every difference as disease.

It is to distinguish:

normal anatomy from abnormal anatomy, normal variation from dysfunction, and myths from medically supported information.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi
Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Professional qualifications and training include:

BUMS – Hamdard University, Delhi
MD
CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

My approach brings together a background in **Unani medicine** with contemporary sexual and reproductive-health education.

In a field filled with myths, exaggerated claims and embarrassment, accurate anatomy is one of the most valuable tools a clinician can offer.

Common Myths About the Clitoris and Female Anatomy

“The visible tip is the complete clitoris.”

Incorrect.

The visible glans is only one part. The clitoris also includes a body and paired crura extending more deeply.

“The vestibular bulbs are simply part of the clitoris.”

They are closely related functional neighbors but are anatomically distinct erectile structures.

“Every normal woman should orgasm from penetration.”

Incorrect.

The 2026 ICSM consensus states that women vary greatly in stimulation requirements and that many require clitoral stimulation.

“The clitoris has exactly 8,000 nerve endings.”

That popular claim is oversimplified. Modern human anatomical studies show very rich innervation, including one study estimating about 10,280 myelinated axons from the bilateral dorsal clitoral nerves, but exact numbers depend on the method and what nerve fibers are counted.

“A G-spot is a separate organ that every woman must have.”

Current research supports complex relationships among clitoral, urethral and vaginal structures, but one universally agreed discrete “G-spot organ” has not been established. Terminology remains an area of ongoing research.

“Unequal labia are abnormal.”

No. Asymmetry and considerable differences in labial size are normal.

“The hymen proves whether a woman has had sex.”

No. ACOG specifically states that hymenal appearance does not establish “virginity.”

“Vaginal lubrication proves that a woman wants sex.”

No. Genital response and conscious desire are not identical. Consent remains a conscious and voluntary decision.

Frequently Asked Questions

Is the clitoris larger than what we can see?

Yes.

The glans is the externally visible portion, but the organ also includes a body and deeper paired crura.

Is the clitoris mainly for pleasure?

It is a highly innervated erectile and sensory structure with a major role in female sexual sensation and orgasm. Modern reviews identify it as one of the most important structures in female sexual response.

Do all women need the same type of stimulation?

No.

The latest ICSM consensus emphasizes substantial variation in the type and intensity of stimulation women need to reach orgasm.

Is vaginal intercourse necessary for female sexual satisfaction?

No.

Women may experience satisfying sexuality through different combinations of affection, genital stimulation and intercourse. There is no medical requirement that one activity define every woman's sexual satisfaction.

Is it abnormal to need clitoral stimulation during intimacy?

No.

For many women this is a normal part of sexual response, and needing it should not by itself be diagnosed as sexual dysfunction.

Can the clitoris become numb?

Yes, reduced genital sensation can occur in association with neurological problems, diabetes, surgery, some medications, tissue disease or other conditions. Persistent new numbness deserves medical assessment.

Can the clitoris become painful?

Yes. Clitoral pain may occur with vulvar pain disorders, adhesions, inflammation, dermatological conditions, nerve-related pain or pelvic-floor problems.

Are all large or protruding labia abnormal?

No.

There is wide normal anatomical variation and no universally correct labial size.

Does sexual anatomy change after menopause?

Yes.

Menopause can affect the labia, clitoris, vestibule, vagina, urethra and bladder as part of genitourinary syndrome of menopause.

Does female orgasm improve fertility?

Female orgasm is not required for fertilization. Sexual pleasure and reproductive capacity are related aspects of health but are not the same physiological process.

Can Unani medicine improve female sexual health?

Unani medicine can contribute a useful holistic framework through attention to diet, activity, sleep, psychological balance and general health. CCRUM formally recognizes these domains within *Asbab Sitta Daruriyya* and therapeutic approaches such as *Ilaj-bil-Tadbir* and *Ilaj-bil-Ghiza*. However, no Unani medicine should be claimed to change normal female genital anatomy or guarantee sexual pleasure or orgasm.

When Should a Woman Seek Professional Medical Assessment?

Anatomical variation is usually normal, but symptoms deserve assessment when there is persistent pain or burning, new genital numbness, a lump or ulcer, persistent itching, unexplained bleeding, severe vaginal dryness, inability to tolerate penetration, sudden loss of sexual sensation, major changes after surgery, difficulty with orgasm that is persistent and distressing, or a clitoral or vulvar change that is new and unexplained.

ACOG advises medical evaluation for persistent vulvar pain, burning, itching, swelling or skin changes because infection, inflammatory disease and other disorders can sometimes produce similar symptoms.

Women should not feel embarrassed about seeking care.

Female sexual anatomy is part of normal human anatomy and deserves the same professional attention as any other body system.

My Final Message to Women and Couples

I often tell my patients that one of the most effective ways to reduce sexual anxiety is simply to **understand the body correctly**.

The vulva is not the vagina.

The clitoris is not merely the tiny portion you can see.

The vestibular bulbs are not identical to the clitoris, although they are closely related structures.

The labia do not need to be symmetrical.

There is no single correct vulvar appearance.

The vagina is an important reproductive and sexual structure, but it is not the only structure involved in female pleasure.

The pelvic floor matters.

The nervous system matters.

The brain matters.

Hormones matter.

Relationship context matters.

And different women naturally experience sexual stimulation differently.

Modern research published through 2025 and 2026 continues to demonstrate how much there is still to learn about female genital anatomy. Researchers are actively standardizing terminology, studying clitoral innervation and clarifying the relationships among the clitoris, vestibular bulbs, urethra, vulva and vagina.

That is why I discourage simplistic claims such as:

“Every woman should respond in exactly the same way.”

She should not.

At **Saira Health Care**, my goal is to combine accurate contemporary sexual and reproductive-health knowledge with the whole-person perspective of Unani medicine.

When a woman has a genuine disorder, we identify and treat it appropriately.

When she has a normal anatomical variation, we reassure rather than medicalize it.

When misinformation is producing anxiety, we educate.

When pain is present, we investigate rather than telling her to tolerate it.

When infertility and sexual difficulties overlap, we consider both together.

And when specialist gynecological, pelvic-floor, neurological, endocrine or psychological care is necessary, it should not be delayed.

The most important message is simple:

Female sexual anatomy should be understood with knowledge, dignity and scientific accuracy—not embarrassment, mythology or unrealistic expectations.

Better knowledge of the clitoris, vulva, vagina, pelvic floor and reproductive anatomy does more than teach anatomy.

It can improve body confidence, make medical communication clearer, reduce unnecessary fear, help couples understand sexual response and allow genuine sexual-health problems to be recognized earlier.

That is why anatomical education is an important part of responsible sexual and reproductive healthcare.

Medical Disclaimer

This article is intended for general educational purposes and does not replace individual medical, gynecological, urological or sexual-health assessment. Normal genital appearance varies greatly between individuals. Persistent vulvar or clitoral pain, numbness, skin changes, unexplained bleeding, severe dryness, painful penetration, new genital lesions or significant changes in sexual function should be evaluated by an appropriately qualified healthcare professional. Unani medicines or herbal products should not be used to alter normal genital anatomy, and unverified oils, pastes or other products should not be applied to sensitive vulvar or vaginal tissue without appropriate professional advice.