International Journal of Transdisciplinary Research and Perspectives
Volume 2, Issue 5, May 2026
www.ijtrp.com | E-ISSN: 3107-7935 | RESAIM Publishing | www.resaim.com

Cultural and Socioeconomic Determinants of Sexual Dysfunction in South India: A Structured Narrative Review

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***Abstract*: Sexual dysfunction is one of the most common yet highly neglected health concerns in South India, affecting not only physical health but also emotional well-being, relationships, and quality of life. In the South Indian context, sexual dysfunction is often viewed through the lens of shame, morality, cultural silence, and gender expectations rather than as a medical or psychological concern. This review aims to examine the sociocultural and socioeconomic determinants associated with sexual dysfunction in South India and to understand how these factors influence access to professional sex therapy. A structured review of literature was conducted using databases such as PubMed, Google Scholar, PsycINFO, IndMED, and Shodhganga, along with Indian psychiatric and psychological journals. The findings from the reviewed studies indicate that stigma, lack of sexual awareness, rigid gender norms, myths such as Dhat syndrome, poverty, low educational status, caste-based inequalities, and the rural–urban divide significantly contribute to the persistence of sexual dysfunction and delay help-seeking behaviour. The review also highlights the severe shortage of trained sex therapists and the large treatment gap, particularly in rural South Indian communities. Concluding these findings, there is a strong need for culturally sensitive interventions, improved sexual health education, professional training, and public health policies that address sexual dysfunction through a biopsychosocial and sociocultural approach rather than a purely biomedical perspective.**

***Keywords*: Sexual dysfunction, Sociocultural factors, Sex therapy, Gender norms, Dhat syndrome, South India.**

1. Introduction

Sexual dysfunction in South India cannot be understood solely as a clinical or diagnostic issue. It is closely tied to social expectations, cultural norms, gender roles, and patterns of silence surrounding sexuality. In many communities, conversations about sex remain highly restricted within both family and educational settings. As a result, individuals experiencing sexual difficulties often lack not only access to professional care, but also the vocabulary and social permission necessary to describe their experiences openly.

Conventional biomedical models of sexual dysfunction are clinically important, but they do not fully account for the sociocultural conditions within which sexual concerns develop and persist. For example, a young man from rural Tamil Nadu who experiences anxiety related to nocturnal emissions may interpret his symptoms through traditional beliefs regarding semen loss and bodily depletion rather than through psychiatric or physiological frameworks (Grover et al., 2020; Murthy & Chand, 2021). Similarly, women who report little or no sexual pleasure within marriage may not conceptualize this as dysfunction at all, particularly in settings where female sexuality has historically been associated more with marital obligation than with personal desire or well-being (Sharma et al., 2023; Grover et al., 2021).

According to the DSM-5 (American Psychiatric Association, 2013), sexual dysfunction refers to clinically significant disturbances in sexual response, desire, arousal, orgasm, or pain associated with sexual activity. Diagnostic categories include erectile disorder, premature ejaculation, delayed ejaculation, male hypoactive sexual desire disorder, female sexual interest/arousal disorder, female orgasmic disorder, and genito-pelvic pain or penetration disorder. Existing research demonstrates that these conditions are influenced by multiple interacting factors, including biological vulnerability, psychological distress, relational dynamics, and sociocultural environment. Within South India, sociocultural influences appear particularly significant in shaping both symptom expression and treatment-seeking behaviour.

The World Health Organization (2022) defines sexual health as a state of physical, emotional, mental, and social well-being in relation to sexuality. This definition is especially relevant in contexts where sexuality is heavily regulated by social norms and moral expectations. Limited sexuality education, stigma surrounding sexual discussion, restricted autonomy for women, and inadequate access to trained professionals all contribute to broader deficits in sexual health awareness and care.

South India, comprising Tamil Nadu, Karnataka, Kerala, Andhra Pradesh, and Telangana, represents a region of considerable linguistic, religious, and cultural diversity. Despite these differences, many communities across the region continue to maintain relatively conservative attitudes toward sexuality. Religious institutions, caste structures, patriarchal family systems, and expectations surrounding marriage all influence how sexual behaviour is understood and discussed.

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Community-based studies from Tamil Nadu report erectile dysfunction prevalence estimates ranging from 21% to 34% (Chandra et al., 2021; Sundararajan & Krishnan, 2023), while clinical studies from Karnataka and Andhra Pradesh indicate high rates of premature ejaculation among married men attending outpatient services (Rao et al., 2020). Data from the National Family Health Survey (NFHS-5, 2021) additionally point to substantial gaps in sexual and reproductive health literacy, particularly among women in rural populations.

Sex therapy has an established evidence base internationally and commonly incorporates psychoeducation, communication training, behavioural interventions, and cognitive approaches. However, the availability of trained professionals in South India remains limited. Most specialized services are concentrated in private urban clinics and are inaccessible to large segments of the population due to cost, distance, or stigma associated with seeking treatment (Shidhaye & Muke, 2021; Pratisandhi, 2021). In many districts, professional sexual healthcare services are effectively absent.

This review addresses the limited availability of region-specific synthesis on the sociocultural and socioeconomic determinants of sexual dysfunction in South India. Although existing studies have explored individual dimensions of stigma, gender, cultural beliefs, and healthcare access, fewer attempts have been made to examine how these factors interact within the broader social context of the region. By organizing findings thematically, the present review aims to contribute to current discussions in counselling psychology, sexual health, and public mental health, while also identifying implications for clinical practice, policy development, and future research.

2. Research Question

The present review is guided by the following central research question:

What sociocultural factors contribute to sexual dysfunction in South India, and how do these factors influence access to sex therapy and related professional services?

To examine this question in greater depth, the review addresses five related sub-questions:

- How do stigma, sexual silence, and religious or moral belief systems influence the experience and disclosure of sexual dysfunction in South India?
- In what ways do gender expectations, marital roles, and relationship dynamics contribute to sexual difficulties among men and women in South Indian communities?
- How do cultural myths, Dhat syndrome, and pornography-related misconceptions shape sexual attitudes and patterns of help-seeking?
- What role do socioeconomic factors such as income, education, caste, and rural–urban disparities play in determining access to sexual health knowledge and services?
- What barriers limit access to trained sex therapists in South India, and what alternative sources of help are commonly used in their place?

3. Methodology

A. Study Design

This study employs a structured narrative review design to examine the sociocultural and socioeconomic determinants of sexual dysfunction in South India. A narrative synthesis approach was selected because the review focuses on understanding how cultural beliefs, gender norms, economic conditions, and healthcare barriers interact within a specific social context. Given the interpretive nature of the research question, a purely quantitative synthesis or meta-analysis was not considered appropriate.

At the same time, the review follows a systematic process for identifying, selecting, and organizing literature. Search procedures, inclusion criteria, data extraction methods, and thematic analysis procedures were defined in advance in order to improve transparency and consistency. The five major thematic domains were established prior to analysis on the basis of the research objectives and existing literature, while additional sub-themes were allowed to emerge during the review process. This approach aligns with established guidance for narrative synthesis in health research (Braun & Clarke, 2006; Popay et al., 2006)

B. Search Strategy

Relevant literature was identified through searches conducted in PubMed/MEDLINE, Google Scholar, PsycINFO, JSTOR, the Cochrane Library, IndMED, and Shodhganga. Additional material was obtained from official publications including the National Family Health Survey (NFHS-5, 2021) and reports published by the World Health Organization (2022). Manual searches were also conducted in journals frequently publishing work related to sexuality and mental health in India, including the *Indian Journal of Psychiatry*, *Indian Journal of Psychological Medicine*, *Journal of Sexual Medicine*, *Journal of Psychosexual Health*, and *Asian Journal of Psychiatry*.

Search terms were grouped according to the five thematic domains of the review. Examples included:

- “sexual stigma South India”
- “sexual taboo South India”
- “male performance anxiety in South India”
- “marital sexual communication South India”
- “Dhat syndrome South India”
- “socioeconomic barriers sexual health South India”

Boolean operators such as AND and OR were used to refine search combinations. Searches were limited to publications released between January 2020 and March 2026. Following screening and relevance assessment, 50 sources were included in the final review.

C. Inclusion Criteria

Studies were included if they met the following criteria:

- Peer-reviewed journal articles, institutional reports, or government publications published between January 2020 and March 2026.
- Research focused on South Indian populations or studies with substantial relevance to South Indian

contexts.

- Studies examining sexual dysfunction, sociocultural influences, help-seeking behaviour, gender norms, cultural syndromes, or barriers to sexual and mental healthcare access.
- Quantitative, qualitative, mixed-methods, and review-based research designs.
- Research involving adult participants aged 18 years and above.
- English-language publications.

D. Exclusion Criteria

The following categories of literature were excluded from the review:

- Studies focused exclusively on non-South Indian populations.
- Publications released prior to January 2020.
- Primarily pharmacological or surgical studies without discussion of sociocultural or psychological factors.
- Opinion articles, editorials, or publications lacking empirical or analytical grounding.
- Studies involving participants below 18 years of age.
- Non-English publications and unverifiable grey literature.

E. Justification for Population:

A structured narrative review was chosen for this study because the available literature on sexual dysfunction in South India is too methodologically diverse to be meaningfully collapsed into a meta-analysis. The existing research spans community surveys, clinical case studies, qualitative interviews, ethnographic accounts, and national health data each contributing a different but equally important layer of understanding. Forcing these into a single statistical framework would flatten nuances that are, in this context, clinically and culturally essential. Beyond methodology, the thematic scope of this review cuts across cultural psychology, gender studies, medical anthropology, and clinical practice and a narrative approach is simply better equipped to hold that breadth together. Studies were included if they were empirically grounded, relevant to South Indian or directly applicable pan-Indian populations, focused on adults aged 18 and above, and published between 2020 and 2026. Studies were excluded if they lacked empirical data, addressed purely pharmacological or surgical outcomes without any sociocultural framing, or focused on populations with no South Indian relevance. These criteria were not applied mechanically, they were shaped by the central question of this review, which is not simply what exists in the literature, but what genuinely helps us understand the lived experience of sexual dysfunction in South India.

F. Data Extraction

Data from the selected studies were extracted using a standardized framework. Information recorded from each source included bibliographic details, geographic setting, study design, participant characteristics, sample size, major variables examined, and key findings relevant to the thematic domains of the review. Where applicable, clinical implications and recommendations proposed by study authors were also documented.

The extracted data were subsequently organized into a thematic matrix to facilitate comparison across studies. Some studies contributed to multiple thematic categories and were therefore cross-referenced during analysis.

G. Data Analysis: Thematic Analysis

Thematic analysis was conducted using the six-stage framework proposed by Braun and Clarke (2006), including familiarization with the data, initial coding, theme development, theme review, theme definition, and final reporting.

The five primary themes of the review were identified prior to analysis based on the research objectives. However, several secondary themes emerged inductively during repeated engagement with the literature. For example, the concept of medical pluralism appeared across multiple studies examining informal treatment pathways and alternative healing practices.

To maintain consistency, all included studies were reviewed more than once during the coding and synthesis process. Divergent findings were retained and discussed where relevant rather than excluded from interpretation.

4. Results and Findings

The 50 studies included in this review collectively indicate that sexual dysfunction in South India is shaped by a combination of cultural norms, gender expectations, economic inequality, and limited access to appropriate healthcare services. Although the studies differ in methodology, setting, and disciplinary orientation, several recurring patterns appear consistently across the literature. These include high levels of stigma surrounding sexual discussion, delayed help-seeking, inadequate sexual health literacy, and reliance on informal or non-professional sources of treatment. Together, the findings suggest that sexual dysfunction in South India cannot be examined independently of the broader social and institutional environment within which it occurs.

Theme 1: Cultural Determinants: Stigma, Silence, and Religious Morality

One of the most consistent findings across the reviewed literature is the role of stigma and social silence in shaping experiences of sexual dysfunction. In many South Indian communities, sexuality continues to be treated as a private or morally sensitive subject, limiting opportunities for open discussion within families, educational institutions, and healthcare settings. Several studies suggest that this silence contributes directly to delayed disclosure, misinformation, and avoidance of professional treatment.

Chandra et al. (2021), in a community survey conducted across rural districts of Tamil Nadu and Karnataka, reported that 81% of participants who had experienced sexual difficulties had never discussed these concerns with anyone, including partners or healthcare professionals. Participants commonly identified shame, embarrassment, and uncertainty regarding where to seek help as major reasons for

nondisclosure. These findings indicate that many individuals experience sexual problems in relative isolation, often without access to reliable information or support.

Religious and moral interpretations of sexuality also appear to influence how sexual dysfunction is understood. Singh et al. (2022), based on qualitative interviews with married adults in Andhra Pradesh, found that many participants interpreted sexual concerns through moral or spiritual frameworks rather than medical ones. Sexual difficulties were frequently associated with guilt, moral failing, or perceived spiritual imbalance. The term *paapam* was repeatedly used by participants when describing distress related to sexuality, reflecting the moral language through which these experiences are often framed.

Related patterns were observed in Das et al.'s (2022) Kerala-based qualitative study, where several participants reported initially consulting religious authorities or faith healers before approaching medical or mental health professionals. For some individuals, sexual dysfunction was interpreted primarily as a spiritual issue requiring ritual or religious intervention. Although culturally meaningful, these pathways often delayed access to evidence-based treatment.

Stigma additionally affects interactions with formal healthcare systems. Joseph et al. (2024), studying adults with sexual concerns in Chennai and Coimbatore, found that many participants avoided in-person consultations because of fear of being recognized at sexual health or psychiatric clinics. Online consultations and anonymous digital platforms were therefore perceived as more socially acceptable alternatives. Similar findings have been reported in broader Indian mental health research, where anticipated social judgment frequently acts as a barrier to treatment-seeking (Shidhaye & Muke, 2021).

Several studies also emphasize the relationship between caste, social hierarchy, and sexual health access. Nair and George (2022) identified notable differences in sexual health awareness and help-seeking behaviour across caste groups in rural Kerala. Participants from Scheduled Caste and Scheduled Tribe communities reported greater shame associated with discussing sexual concerns and lower engagement with formal healthcare systems. These disparities appear to reflect wider inequalities in educational access, healthcare familiarity, and social mobility.

The debate surrounding Comprehensive Sexuality Education (CSE) further illustrates the contested nature of sexual discourse in South India. ARROW (2020) documented resistance to sexuality education initiatives in Tamil Nadu and Karnataka, particularly from religious and conservative groups concerned that such curricula would undermine traditional values. In practical terms, limited sexuality education has contributed to significant gaps in sexual health literacy. Sudha and Ramesh (2023), in a Mysuru hospital-based study, found that a majority of participants had never received structured sexual health education and relied instead on peers, media, or informal community knowledge.

The WHO South-East Asia Regional Office (2022) similarly identifies South Asia as a region where sexual health remains poorly integrated into public healthcare and educational systems. Several authors argue that future interventions will need to engage not only healthcare providers but also religious leaders, educators, and community institutions if destigmatization efforts are to be effective within local cultural contexts.

Overall, the literature suggests that stigma and silence function not simply as background cultural conditions but as active determinants of sexual health outcomes. They shape disclosure patterns, influence explanatory beliefs, and significantly affect access to professional care.

Theme 2: Gender and Relational Norms: Masculinity, Sexual Obligation, and Communication Barriers

The reviewed literature consistently demonstrates that sexual dysfunction in South India is strongly shaped by gendered social expectations. Although both men and women experience sexual difficulties, the social meanings attached to those difficulties differ considerably across genders.

Among men, sexual performance is frequently linked to ideas of masculinity, marital competence, and social status. Rao et al. (2020), in a multicentre outpatient study conducted in Hyderabad and Bengaluru, found that many male participants described erectile dysfunction in terms associated with inadequacy, humiliation, or loss of masculine identity. In several cases, participants also reported pressure from extended family members regarding expectations of sexual performance and marital fulfilment.

Performance anxiety emerged repeatedly as a major psychological contributor to male sexual dysfunction. Grover et al. (2021) identified performance-related anxiety as one of the most commonly reported risk factors for erectile dysfunction and premature ejaculation among Indian men. In many cases, anxiety appeared to intensify existing physiological vulnerabilities rather than operate independently of them.

Economic pressures also intersected with these concerns. Thangadurai et al. (2020), studying men from rural Tamil Nadu, found that financial stress, unstable employment, and perceived inability to fulfil breadwinner expectations were strongly associated with premature ejaculation. Similar findings were reported by Subramanian and Krishnamurthy (2022), who identified financial debt as a significant predictor of sexual distress among male agricultural workers.

For women, the literature highlights a different set of pressures rooted in sexual silence, relational obligation, and limited recognition of female sexual autonomy. Sharma et al. (2023), in qualitative interviews with married women in Karnataka, found that many participants described sexual activity primarily in terms of marital duty rather than desire or mutual pleasure. Several participants reported never experiencing orgasm but did not initially interpret this as a health concern. These findings suggest that female sexual dissatisfaction may remain underrecognized partly because women are often socialized not to prioritize or articulate sexual needs.

The underreporting of female sexual dysfunction is discussed across multiple studies. Nair and George (2022) observed that women experiencing pain, low desire, or arousal difficulties rarely sought care specifically for sexual concerns. Instead,

many presented indirectly through general medical or gynecological complaints. This pattern complicates prevalence estimation and may contribute to the limited visibility of female sexual dysfunction within clinical settings.

Communication within marriages also emerged as an important factor. Kumar and Murthy (2022), in a study involving couples in Chennai, found that open communication regarding sexuality was relatively uncommon despite its strong association with relationship satisfaction. Many couples reported discomfort discussing sexual expectations, dissatisfaction, or difficulties, particularly within arranged marriage contexts where emotional intimacy may initially be limited.

Sathyanarayana Rao and Banerjee (2022) note that arranged marriages can create additional pressures surrounding first sexual experiences. Limited premarital interaction, combined with high social expectations regarding consummation and fertility, may contribute to anxiety, miscommunication, and avoidance during early marital sexual adjustment.

The literature additionally identifies marital sexual coercion as an under-addressed issue affecting women's sexual health. NFHS-5 (2021) data indicate that significant numbers of women across South Indian states report experiences consistent with sexual coercion within marriage. Bhattacharya et al. (2021) discuss the psychological consequences of such experiences, including low desire, sexual avoidance, and pain-related disorders. However, these concerns remain insufficiently addressed within many clinical and social settings.

Finally, Verma et al. (2021) found that attitudes toward women's sexual autonomy remained conservative across many participant groups in Karnataka, despite modest generational shifts among younger urban men. Expectations regarding marital sexual availability continued to influence perceptions of gender roles and sexual entitlement within relationships.

Taken together, the findings indicate that gender norms influence not only the experience of sexual dysfunction but also its interpretation, disclosure, and management. Sexual concerns are therefore embedded within broader systems of masculinity, marital expectation, communication patterns, and gendered power relations.

Theme 3: Myths, Cultural Syndromes, and Sexual Belief Systems

The literature reviewed in this section indicates that sexual dysfunction in South India is influenced not only by structural and relational factors, but also by culturally embedded belief systems that shape how sexuality is interpreted and managed. Several studies emphasize that these beliefs function as socially reinforced explanatory frameworks rather than simply as isolated misconceptions. As a result, they often influence symptom interpretation, emotional distress, and treatment-seeking behaviour in clinically significant ways.

Dhat syndrome remains one of the most widely discussed culturally specific presentations within the South Asian sexual health literature. Recognized in the DSM-5 as a cultural concept of distress, Dhat syndrome is characterized by anxiety and somatic complaints associated with perceived semen loss. Commonly reported symptoms include weakness, fatigue, low mood, palpitations, and sleep disturbance attributed to nocturnal emissions, masturbation, or semen leakage. Existing literature links these beliefs to traditional Ayurvedic concepts that position semen as a highly valuable bodily substance associated with vitality and masculine strength.

Grover et al. (2020), reviewing data from multiple clinical centres across India, reported that Dhat syndrome continues to account for a notable proportion of outpatient psychiatric consultations, particularly among young unmarried men. The condition was most frequently observed among men between 18 and 25 years of age. Several studies suggest that distress related to semen loss is reinforced through peer conversations, family narratives, local media, and online content that pathologizes otherwise normal physiological experiences.

Kar et al. (2023), based on interviews with patients attending a tertiary care hospital in Bengaluru, found that many participants had first encountered Dhat-related beliefs through older male relatives or regional-language media sources. Importantly, increased internet access did not necessarily reduce exposure to misinformation. In some cases, online forums and commercial websites appeared to reinforce anxieties surrounding masturbation, semen loss, and masculinity.

Help-seeking patterns associated with Dhat syndrome often differ from those observed in other forms of psychological distress. Because symptoms are interpreted as evidence of physical depletion, individuals commonly seek treatment from traditional healers, herbal practitioners, or unqualified providers before consulting mental health professionals. Sudha and Ramesh (2023) found that many patients experienced prolonged delays before accessing evidence-based care. Sarkar and Gupta (2021) report preliminary support for culturally adapted cognitive-behavioural approaches that address anxiety while remaining sensitive to patients' explanatory beliefs and cultural background.

The reviewed studies also highlight the continuing influence of virginity-related myths on women's sexual health. In several South Indian communities, virginity remains strongly associated with expectations surrounding marriage, morality, and family honour. Nair and George (2022) documented cases in Kerala where women underwent hymenoplasty due to fear of social consequences associated with not bleeding during first intercourse after marriage. These concerns were linked not only to misinformation regarding female anatomy, but also to broader social expectations regarding female sexual purity.

Virginity myths additionally appear to contribute to anxiety-related sexual pain conditions. Joseph and Kurian (2022), in a retrospective analysis of patients attending a Chennai sexual health clinic, reported that vaginismus was frequently associated with fear surrounding first sexual intercourse rather than identifiable organic pathology. Anticipatory anxiety, fear of pain, and pressure associated with marital expectations were commonly described by participants.

Another recurring theme across the literature is the growing influence of pornography on sexual expectations among younger men. Subramanian et al. (2022), studying male college

students in Tamil Nadu, found high rates of regular pornography consumption, with a subset of participants reporting distress related to compulsive use or difficulty maintaining arousal during partnered sexual activity. Several authors discuss these findings in relation to pornography-induced erectile difficulties, although the evidence base remains debated and requires further longitudinal research.

Mishra and Mehrotra (2021) similarly found that pornography served as a primary source of sexual information for many young male participants in Hyderabad. Participants exposed primarily to pornography-based sexual learning were more likely to report unrealistic expectations regarding sexual performance, partner behaviour, and relationship dynamics. Some studies additionally noted associations between pornography-related beliefs and interpersonal dissatisfaction within relationships.

Traditional and faith-based healing systems remain influential across many rural communities. Thomas et al. (2021), examining treatment practices in rural Tamil Nadu, documented widespread use of herbal remedies, ritual interventions, and spiritually oriented healing practices for sexual concerns. Although some individuals reported subjective psychological reassurance from these approaches, the studies reviewed generally found limited evidence supporting their effectiveness in treating clinically significant sexual dysfunction.

Overall, the findings suggest that culturally embedded myths and explanatory systems continue to shape sexual attitudes and help-seeking patterns across South India. These beliefs influence how symptoms are interpreted, whether professional care is pursued, and what forms of intervention individuals consider acceptable. Effective clinical responses may therefore require not only symptom management, but also culturally informed psychoeducation and communication strategies.

Theme 4: Socioeconomic Determinants — Income, Education, and Rural–Urban Inequality

The literature reviewed consistently demonstrates that socioeconomic factors significantly influence sexual health awareness, access to treatment, and patterns of help-seeking in South India. While stigma surrounding sexuality affects individuals across social groups, economic inequality, educational access, caste position, and geographic location shape the extent to which individuals are able to recognize sexual concerns and obtain professional care.

One of the clearest patterns identified across studies is the rural–urban disparity in sexual healthcare access. Patel et al. (2021), drawing on NFHS-5 data across South Indian states, reported lower levels of sexual health literacy and lower rates of professional help-seeking in rural populations compared with urban populations. Community awareness regarding sexual dysfunction as a treatable condition was also substantially lower in rural settings.

Sundararajan and Krishnan (2023), focusing specifically on Tamil Nadu, found higher reported prevalence rates of erectile dysfunction in rural communities than in urban populations. The authors associate these differences with multiple overlapping factors, including untreated chronic medical conditions, occupational stress related to agricultural work, financial insecurity, and limited access to specialized healthcare services.

Financial cost remains a major barrier to treatment. Specialized sexual health services in South India are concentrated largely within private urban clinics, making them difficult to access for lower-income populations. Kar et al. (2022), in a needs assessment conducted in Andhra Pradesh, found that treatment costs were one of the most commonly cited reasons for avoiding professional care. Similar income-related disparities in service utilization were reported by Krishnan and Raj (2024) across multiple South Indian cities.

Educational attainment also influences sexual health outcomes in several ways. Studies consistently report that individuals with higher levels of formal education demonstrate greater awareness of sexual dysfunction, stronger familiarity with available healthcare options, and lower endorsement of misinformation related to sexuality. Mukherjee et al. (2022), studying participants in Bengaluru, found that misconceptions regarding masturbation, semen loss, and sexual performance were especially common among individuals with limited formal education.

Gowda et al. (2020) further observed that participants from lower educational backgrounds often presented for treatment only after prolonged delays and with more severe secondary psychological consequences. Limited familiarity with mental healthcare systems and uncertainty regarding where to seek support appeared to contribute to these delays.

Caste and class inequalities were also discussed in several studies. Bhattacharya et al. (2021), in an ethnographic study conducted in peri-urban Karnataka, found that participants from marginalized caste communities frequently described healthcare institutions as socially intimidating or culturally unwelcoming. These experiences affected willingness to engage with formal services even when treatment was technically available. The authors argue that social exclusion operates not only through economic deprivation, but also through institutional environments that may reproduce broader social hierarchies.

Digital access has altered patterns of sexual health information-seeking, particularly among younger populations. Mehrotra and Srinivasan (2022) found that many individuals searched online for information regarding sexual concerns before consulting healthcare professionals. However, participants frequently encountered commercially driven websites promoting unverified treatments, herbal supplements, or misleading health claims. Several studies caution that online accessibility does not necessarily translate into improved sexual health literacy when evidence-based information remains difficult to distinguish from misinformation.

The gendered dimension of socioeconomic inequality is particularly important. Women in economically disadvantaged communities often face additional barriers related to financial dependence, restricted mobility, and limited autonomy in healthcare decision-making. Sharma et al. (2023) observed that women in rural Karnataka frequently required permission or support from husbands or family members before seeking

treatment for sexual or reproductive health concerns. Arora et al. (2022) additionally note that many women rely primarily on informal networks of female relatives or peers when discussing sexual issues, rather than formal healthcare systems.

Taken together, the findings suggest that socioeconomic disadvantage intensifies existing cultural barriers surrounding sexuality. Financial limitations, educational inequality, caste-related exclusion, and geographic disparities collectively shape who is able to access information, recognize dysfunction, and receive appropriate care. These structural inequalities remain central to understanding patterns of sexual health and treatment access across South India.

Theme 5: Access to Sex Therapy: Professional Scarcity, Informal Care, and Treatment Gaps

The literature reviewed in this section indicates that access to professional sexual healthcare in South India remains severely limited. Although awareness of sexual health concerns appears to be increasing in some urban settings, the availability of trained professionals, affordable services, and culturally sensitive care continues to lag substantially behind population needs. In many cases, individuals who seek help encounter long delays, inadequate professional support, or reliance on informal systems of care.

One of the most frequently cited concerns across the literature is the shortage of trained sex therapists and clinicians with formal expertise in sexual dysfunction. Shidhaye and Muke (2021) note that the number of professionals qualified to provide specialized sex therapy services in India remains extremely small relative to the size of the population. Existing services are concentrated largely within major metropolitan centres, creating substantial geographic disparities in access. For individuals living in rural districts or smaller cities, specialized sexual healthcare may be practically unavailable.

The shortage is closely linked to limitations within professional training programs. Pratisandhi (2021), in a national review of postgraduate training curricula in psychology, counselling, and psychiatry, found that sexual dysfunction received limited structured coverage in many programs. Where training was included, it often focused primarily on diagnostic categories rather than therapeutic assessment, communication skills, or intervention strategies. Sathyanarayana Rao et al. (2022) similarly argue that inadequate professional training remains a major obstacle to improving sexual healthcare delivery in India.

Even when services are technically available, stigma continues to affect treatment-seeking behaviour. Kar et al. (2022) found that some individuals who had identified qualified therapists and possessed the financial means to seek care still discontinued the process before attending consultations. Fear of embarrassment, anticipated judgment, and discomfort discussing sexual concerns with professionals were commonly reported barriers. Vijaykumar and Sharma (2023), in their Bengaluru-based pilot study of culturally adapted cognitive-behavioural interventions, observed that establishing trust and reducing shame often constituted a substantial portion of the therapeutic process itself.

Digital platforms have increasingly become alternative spaces for sexual health discussion and support, particularly among younger populations seeking anonymity. Hamirani et al. (2025), analysing Indian online discussion forums, identified large numbers of posts related to erectile dysfunction, premature ejaculation, vaginismus, Dhat syndrome, and relationship concerns. Online anonymity appeared to reduce disclosure-related anxiety for many users. At the same time, several studies caution that these platforms frequently contain misinformation, unverified treatment recommendations, and commercially motivated advice.

Narayanan and Gopalan (2024) examined experiences with online therapy services for sexual concerns in South India and found mixed outcomes. Participants generally valued the privacy and accessibility offered by telehealth platforms, particularly in socially conservative settings. However, concerns were raised regarding inconsistent therapist training and variable quality of care.

The literature also highlights the widespread presence of unqualified or informal treatment providers. Menon et al. (2022), studying peri-urban regions in South India, describe an extensive commercial ecosystem offering “sexual weakness” treatments through roadside advertising, local clinics, social media promotion, and word-of-mouth referral networks. Common interventions included herbal formulations, injectable substances, topical products, and unregulated “performance enhancement” medications. Although some treatments were relatively harmless, others reportedly contained undisclosed pharmaceutical ingredients or delayed access to appropriate medical and psychological care.

Several studies emphasize that the popularity of such providers reflects unmet healthcare demand rather than simple lack of awareness. Individuals often turn to informal practitioners because they are perceived as more accessible, less judgmental, more culturally familiar, or financially attainable than formal healthcare systems.

Access concerns are particularly pronounced for LGBTQ+ individuals. Vaid and Sharma (2020) document the continuing presence of conversion-oriented practices in parts of South India despite growing legal recognition of LGBTQ+ rights. Such practices are associated with significant psychological harm, including anxiety, depression, shame, and sexual distress. The literature suggests that affirming and competent mental healthcare services for LGBTQ+ populations remain highly limited in many regions.

George et al. (2022), in a community survey conducted across rural districts in Kerala, reported that only a small minority of individuals experiencing sexual concerns had ever sought professional assistance. These findings align with broader evidence suggesting a substantial treatment gap across South Indian states.

To address these limitations, several authors recommend a multi-level approach involving expansion of postgraduate training, integration of sexual health assessment into primary healthcare systems, increased public awareness initiatives, and development of culturally sensitive telehealth services. Sathyanarayana Rao et al. (2022) argue that long-term improvements in sexual healthcare access will require both

institutional investment and broader social normalization of sexual health discussions.

5. Discussion

The findings across all five thematic domains suggest that sexual dysfunction in South India is best understood as the outcome of multiple interacting social, cultural, economic, and institutional influences rather than as an isolated clinical phenomenon. Stigma, gender expectations, misinformation, economic inequality, and limited healthcare access do not operate independently. Instead, they reinforce one another in ways that shape how sexual concerns are experienced, interpreted, and managed.

One of the clearest patterns emerging from the literature is the central role of stigma in limiting disclosure and delaying treatment-seeking. Across studies, shame and fear of judgment repeatedly appear as barriers affecting whether individuals discuss sexual concerns with partners, family members, or healthcare providers. In this sense, stigma influences not only social attitudes but also practical healthcare behaviour. Similar observations have been reported in other areas of public health in India, including mental health and HIV-related care, where service expansion alone has not always translated into increased utilization in the absence of broader destigmatization efforts (Shidhaye & Muke, 2021).

The reviewed literature also demonstrates that gender significantly shapes the experience of sexual dysfunction, although the mechanisms involved differ between men and women. For many men, sexual dysfunction is closely linked to concerns regarding masculinity, performance, and social identity. For women, sexual distress often appears within contexts characterized by limited sexual autonomy, restricted communication, and social expectations surrounding marital obligation. These differences suggest that interventions may need to be tailored according to gender-specific experiences and patterns of socialization.

The findings related to Dhat syndrome illustrate the importance of culturally informed clinical practice. The studies reviewed indicate that psychological distress is frequently interpreted through culturally available explanatory models. In the case of Dhat syndrome, anxieties surrounding masculinity, health, and sexuality become organized around beliefs regarding semen loss and bodily depletion. Several authors therefore argue that effective intervention requires engagement with patients' cultural frameworks rather than simple dismissal of their beliefs (Sarkar & Gupta, 2021; Prakash & Bharat, 2022).

The evidence regarding socioeconomic inequality further suggests that access to sexual healthcare is unevenly distributed across regions and social groups. Rural populations, lower-income communities, and individuals with limited formal education consistently face greater barriers in accessing information and professional support. If specialized sexual healthcare remains concentrated within private urban settings, existing inequalities are likely to persist.

The widespread use of informal or unqualified treatment providers also reflects broader structural limitations within the healthcare system. The literature suggests that individuals often seek such services because formal alternatives are inaccessible, unaffordable, or socially intimidating. Addressing this issue therefore requires not only regulatory oversight, but also expansion of affordable and culturally acceptable professional services.

Overall, the reviewed evidence supports the need for a broader biopsychosocial approach to sexual healthcare in South India. Effective intervention is unlikely to emerge from medical treatment alone without simultaneous attention to stigma reduction, gender norms, public education, and healthcare accessibility.

6. Implications

A. Clinical Implications

The findings of this review have several implications for counsellors, psychologists, psychiatrists, and other mental health professionals working in South India. One of the most important is the need for greater cultural competence in relation to sexuality and sexual health. Clinicians working in this context are likely to encounter concerns shaped by culturally specific beliefs, gender norms, and stigma-related barriers. Familiarity with issues such as Dhat syndrome, virginity-related anxiety, marital communication difficulties, and gendered patterns of sexual socialization is therefore clinically relevant rather than optional. A limited understanding of these dynamics may reduce therapeutic effectiveness and contribute unintentionally to patient discomfort or shame.

The literature also supports incorporating routine screening for sexual concerns into standard mental health and medical assessments. Avasthi et al. (2020) recommend that clinicians normalize discussion of sexual health through brief and nonjudgmental intake questions rather than relying on spontaneous disclosure. Given the high levels of silence and underreporting documented across studies, proactive screening may improve identification of clinically significant concerns that would otherwise remain unaddressed.

Several studies additionally point to the importance of couple-based approaches in the treatment of sexual dysfunction. Research by Kumar and Murthy (2022), Sathyanarayana Rao and Banerjee (2022), and Verma et al. (2021) suggests that sexual difficulties frequently emerge within broader relational contexts involving communication barriers, marital expectations, and gendered power dynamics. Interventions focused on communication skills, psychoeducation, and relational adjustment may therefore be particularly useful in South Indian settings, especially among couples in arranged marriages or highly conservative family structures.

Psychoeducation itself appears to function as a meaningful therapeutic component in many cases. Due to limited access to formal sexuality education, many individuals enter therapy with significant misinformation regarding sexual functioning, masturbation, arousal, semen loss, or female sexuality. Providing accurate and culturally sensitive information may reduce anxiety, normalize sexual concerns, and improve

treatment engagement. Sarkar et al. (2021), for example, describe improvements among individuals with Dhat-related anxiety following structured psychoeducational interventions.

B. Policy Implications

The findings of this review also suggest the need for broader institutional and policy-level responses to sexual health concerns in South India.

At the national level, several authors advocate for the development of a more comprehensive sexual health framework within public healthcare policy. Such a framework could support integration of sexual health into primary healthcare systems, establish minimum training standards for healthcare professionals, and improve coordination between mental health, reproductive health, and general medical services. At present, responsibility for sexual health concerns often remains fragmented across sectors, resulting in inconsistent service delivery.

At the state level, improved access to district-level sexual health services may help reduce current rural–urban disparities in care. This would likely require expansion of professional training opportunities, incorporation of basic sexual health assessment into existing healthcare services, and development of referral pathways linking primary care providers with specialized professionals. Rao et al. (2023) additionally discuss the potential utility of telehealth models for extending services into underserved regions.

The literature also highlights the importance of Comprehensive Sexuality Education (CSE). Several studies suggest that the absence of structured sexuality education contributes to widespread misinformation regarding sexual functioning, consent, reproductive health, and help-seeking. While political and religious resistance to CSE remains a challenge in parts of South India, some authors argue that culturally contextualized and health-oriented educational approaches may improve public acceptability.

Another area requiring policy attention involves regulation of unqualified sexual health practitioners and misleading online treatment markets. Menon et al. (2022) note that many individuals seeking treatment encounter commercially driven providers offering unverified remedies and misinformation. However, the literature also suggests that regulation alone is unlikely to be effective without parallel expansion of affordable and accessible professional services.

C. Research Implications

The review identifies several important gaps within the current research literature on sexual dysfunction in South India.

First, epidemiological evidence remains limited, particularly regarding female sexual dysfunction. Existing prevalence estimates are often derived from clinical samples or studies with limited geographic representation. Large-scale community-based studies using culturally adapted assessment tools would provide a more accurate understanding of sexual health patterns across different South Indian populations.

Second, there remains relatively little intervention-based research within the region. Although many sociocultural determinants of sexual dysfunction have been described, fewer studies have examined the effectiveness of culturally adapted therapeutic approaches, community education programs, or stigma-reduction interventions. Future research evaluating these interventions could help guide clinical practice and public policy.

Third, several authors emphasize the need for more qualitative research focused on women's lived experiences of sexuality and sexual distress. Much of the existing literature relies on quantitative symptom measures without examining how women interpret, negotiate, or communicate sexual concerns within their social environments. Greater qualitative depth may therefore improve understanding of barriers to disclosure and treatment engagement.

Finally, longitudinal research remains limited. Most available studies use cross-sectional designs, making it difficult to examine how sexual attitudes, relationship dynamics, stigma, and dysfunction evolve over time. Longitudinal studies following participants across adolescence, marriage, and adulthood may provide clearer insight into developmental pathways, protective factors, and long-term treatment outcomes.

7. Limitations

Several limitations of this review should be acknowledged when interpreting the findings. First, the study adopts a structured narrative review design rather than a formal systematic review or meta-analysis. While this approach allows for greater interpretive depth and contextual analysis, it does not permit statistical synthesis of findings or quantitative comparison of effect sizes across studies. Consequently, the conclusions presented here should be understood as thematic interpretations of the available literature rather than definitive causal claims (Braun & Clarke, 2006).

A further limitation relates to language inclusion criteria. Only English-language publications were included in the review. Given the linguistic diversity of South India, this likely excluded a substantial body of relevant literature published in Tamil, Telugu, Kannada, and Malayalam. The exclusion of regional-language sources may have introduced bias toward studies involving urban, educated, and institutionally connected populations. Future reviews would benefit from multilingual search strategies and inclusion of regional academic databases where possible.

The review also treats South India as a broad regional category despite substantial differences between states. Tamil Nadu, Karnataka, Kerala, Andhra Pradesh, and Telangana differ considerably in terms of literacy rates, public health infrastructure, caste dynamics, urbanization, and sociocultural norms related to sexuality and gender. Although common themes emerged across the literature, findings from one state cannot automatically be generalized to all South Indian populations without caution.

Publication bias may additionally affect the available evidence base. Studies reporting strong associations between sociocultural factors and sexual dysfunction are generally more likely to be published than studies reporting weak or

nonsignificant findings. As a result, the literature may overrepresent the consistency or strength of some observed relationships.

Finally, the review period from 2020 to 2026 overlaps substantially with the COVID-19 pandemic and its aftermath. The pandemic influenced mental health, healthcare access, relationship dynamics, economic stress, and telehealth utilization across India. Some findings included in the reviewed studies may therefore reflect pandemic-related conditions rather than longer-term patterns that would remain stable over time.

8. Conclusion

The findings of this review indicate that sexual dysfunction in South India cannot be understood solely through a biomedical framework. Across the literature, sexual difficulties are consistently shaped by broader sociocultural influences including stigma, gender expectations, misinformation, economic inequality, and limited access to professional care. These factors influence not only the prevalence and expression of sexual dysfunction, but also whether individuals recognize symptoms, seek help, or receive appropriate treatment.

The evidence reviewed suggests that cultural silence surrounding sexuality remains one of the most significant barriers to effective intervention. In many settings, sexual concerns continue to be associated with shame, moral judgment, or social risk, limiting opportunities for open discussion within families, educational institutions, healthcare systems, and intimate relationships. These dynamics contribute to delayed treatment-seeking, reliance on misinformation, and continued dependence on informal or unqualified sources of care.

The review also highlights the importance of adopting a biopsychosocial and sociocultural approach to sexual healthcare in South India. Although biological factors remain clinically important, the literature demonstrates that sexual dysfunction frequently develops within wider contexts involving relational stress, gendered expectations, economic insecurity, and culturally specific explanatory beliefs. Interventions that focus exclusively on symptom reduction without addressing these contextual influences are therefore likely to have limited effectiveness (Sarkar et al., 2021; Sathyanarayana Rao & Banerjee, 2022).

Several practical priorities emerge from the findings. These include improving professional training in sexual health, expanding access to affordable services beyond major urban centres, integrating sexual health discussions into routine healthcare practice, and strengthening sexuality education initiatives. Greater investment in culturally sensitive public education and community-based destigmatization efforts may also improve awareness and early help-seeking.

At the same time, important gaps remain within the current evidence base, particularly regarding women's experiences, rural populations, intervention outcomes, and longitudinal patterns of sexual health across the lifespan. Future research addressing these areas may help support more effective clinical and policy responses.

Overall, the reviewed evidence suggests that improving sexual healthcare access in South India will require coordinated efforts across healthcare, education, research, and public policy sectors. Addressing sexual dysfunction in the region is therefore not only a clinical issue, but also a broader public health and social challenge shaped by the interaction between individual experiences and the cultural environments in which those experiences occur.

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