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Perceptions and experiences of receptive anal intercourse among women: a systematic review and thematic analysis

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ABSTRACT

Introduction Receptive anal intercourse (RAI) is an increasingly reported sexual practice across diverse populations and carries a higher risk of certain health consequences, including HIV and other sexually transmitted infections, anal trauma and anorectal disorders, compared with vaginal intercourse. Despite these risks, research exploring women's experiences, motivations and perceptions of RAI remains limited. Much of the existing literature has focused on gay and bisexual men, leaving women's perspectives comparatively underexamined and their ability to make fully informed sexual-health decisions constrained by this evidence gap.

Objectives This qualitative systematic review and thematic synthesis aimed to explore women's perceptions, motivations and experiences of RAI, including how societal attitudes and gender dynamics shape these experiences.

Methods A qualitative systematic review and thematic analysis was conducted following Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines. Searches of PubMed, PsycINFO, CINAHL and Embase identified peer-reviewed qualitative studies published between January 2010 and June 2025 that examined women's views and experiences of RAI. The Sample, Phenomenon of Interest, Design, Evaluation, Research type framework guided study selection, and data extraction captured study characteristics and verbatim qualitative findings for synthesis.

Results 22 studies encompassing 593 women across 12 countries were included. Participants represented diverse ages (14–84 years) and socioeconomic backgrounds. Three overarching themes emerged: (1) motivations for engaging in RAI, often linked to partner expectations, intimacy or curiosity; (2) experiences, spanning pain, discomfort and coercion, but also instances of pleasure and agency and (3) societal views, which reflected both normalisation and enduring stigma. Women's accounts revealed that RAI is negotiated within relational and cultural constraints, where agency and coercion, pleasure and pain, frequently coexist rather than oppose one another.

Conclusions Women's experiences of RAI reveal a complex interplay between sexual agency, bodily autonomy and social meaning. Recognising that pleasure and discomfort can coexist and that decisions are often shaped by relational and cultural dynamics highlights the need for open, non-judgemental discussion of RAI within sexual-health education and clinical practice. Addressing stigma and providing evidence-based guidance can support informed, consensual and safe sexual decision-making for women.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Receptive anal intercourse (RAI) has increasingly been reported among women. Despite this, research and clinical discussion on RAI have largely focused on men and overlooked women's perspectives. It is therefore imperative that healthcare professionals engage with this topic, collect objective data on outcomes and ensure that women have access to accurate, evidence-based information to make informed sexual-health decisions.

WHAT THIS STUDY ADDS

⇒ This review synthesises qualitative evidence on women's perceptions and experiences of RAI. Women described engaging in RAI through a complex interplay of curiosity, coercion, relationship maintenance and pleasure. Their narratives reveal that agency and constraint coexist, shaped by social norms, partner expectations and substance use.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Findings highlight the need for inclusive, non-judgemental sexual-health education and clinical practice that explicitly address RAI. Healthcare providers should be trained to initiate open, sensitive discussions about RAI, acknowledging both its potential risks and its relevance to women's sexual well-being. Future research should examine cultural, age-related and socioeconomic variations in women's experiences to inform equitable and evidence-based sexual-health policy.

INTRODUCTION

Receptive anal intercourse (RAI) among women has been increasingly reported in population-based sexual behaviour surveys, with lifetime prevalence in the USA and Europe ranging from 28.5% to 44%.[1–4] Once regarded as an extreme or taboo topic,

RAI is now more commonly discussed and depicted in mainstream media, where film and television not only portray it as part of contemporary sexual repertoires but also serve as sources of influence.[5 6] Despite its visibility, there is a paucity of targeted public health education addressing RAI among women.[7] RAI has been reported to carry a higher risk of sexually transmitted infections (STIs), anal malignancy and anorectal disorders.[8–11] Elevated anal cancer risk among individuals exposed to human papillomavirus (HPV) during RAI reflects HPV's broader oncogenic potential, which is also implicated in cervical, vaginal, vulvar, penile and oropharyngeal cancers associated with penile–vaginal and other forms of sexual contact.[12] The absence of cervicovaginal secretions and susceptibility to traumatic abrasions are some of the factors considered to increase these risks in RAI.[13] Compounding this risk is the behavioural factor of lower documented rates of condom use during anal sex.[14 15]

Beyond infectious risks, RAI is linked to a spectrum of anorectal disorders, including anal fissures, bleeding, incontinence and anal sphincter injury.[8 16] Women are particularly vulnerable to these conditions owing to anatomical differences, specifically, a shorter and less robust anal sphincter compared with men's.[17–19] These differences may be further compounded by hormonal changes, pregnancy and ageing, all of which can weaken sphincter function and increase the likelihood of anorectal complications. National surveys have identified higher rates of faecal incontinence among women engaging in RAI compared with those who do not,[9 20] and several studies indicate that anal sex is associated with an increased prevalence of pain and tears, with trauma recognised as an aetiological factor for chronic fissures.[21–23]

Anorectal disorders are stigmatising,[24 25] and women may lack adequate information about both the risks and the contexts in which RAI occurs, limiting their ability to make fully informed sexual-health choices. Equally, the healthcare community requires a deeper understanding of women's motivations and the social, relational and cultural factors shaping their decisions. Previous reviews have largely examined RAI in relation to sexual risk or HIV prevention rather than as an aspect of women's sexual experience. Consequently, women's perspectives and the meanings they attach to RAI have been underrepresented in sexual health research.

This systematic review therefore synthesises qualitative studies exploring women's perceptions and experiences of RAI with male partners, aiming to illuminate the motivations, meanings and social contexts that underpin this practice and to situate these within the broader discourse on sexual health, stigma and gendered norms.

METHODS

This review followed Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines and was prospectively registered in PROSPERO (CRD42023390284). A qualitative systematic review and thematic synthesis were conducted to identify, appraise and integrate studies on women's perceptions and experiences of RAI with male partners.

Search strategy

Comprehensive searches were conducted in PubMed, EMBASE, PsycINFO and CINAHL for studies published between January 2010 and June 2025. Search terms combined controlled vocabulary and free-text keywords relating to women, RAI, sexual behaviour and qualitative methods. Full search strings are provided in online supplemental table 1. The SPIDER framework informed inclusion parameters, described below:

Sample (**S**): Women across various settings and socioeconomic groups

Phenomenon of Interest (**PI**): RAI with a male partner

Design (**D**): Systematic review and thematic synthesis

Evaluation (**E**): Experiences, perceptions, motivations and meanings associated with RAI

Research Type (**R**): Qualitative research, including the qualitative findings of mixed-methods studies.

Eligibility criteria

Eligible studies: (1) used qualitative or mixed-methods designs with extractable qualitative data; (2) examined women's experiences or perceptions of RAI with male partners and (3) were published in English in peer-reviewed journals (2010–2025). Exclusions included quantitative-only studies, opinion pieces and research focusing exclusively on men or transgender populations.

Study selection and quality appraisal

Two reviewers (TG and NH) independently screened titles and abstracts; disagreements were resolved through discussion. Full texts meeting criteria were appraised using the Critical Appraisal Skills Programme (CASP) qualitative checklist[26] (TG and VD). No studies were excluded based solely on quality, but appraisal informed interpretation.

Data extraction and synthesis

Data were extracted using a structured Excel template capturing study, participant and design characteristics. Qualitative data from Results/Findings sections were imported verbatim into NVivo V.14 for coding. Only content relating to women's perceptions, motivations and experiences of RAI was included.

Thematic synthesis followed Thomas and Harden's[27] process: (1) line-by-line coding, (2) development of descriptive themes and (3) generation of analytical themes. Initial coding by TG was independently reviewed by NH, with discrepancies resolved through discussion and iterative refinement.

Patient and public involvement

This study is a systematic review of published qualitative evidence; therefore, patients and members of the public were not involved in the design or conduct of the

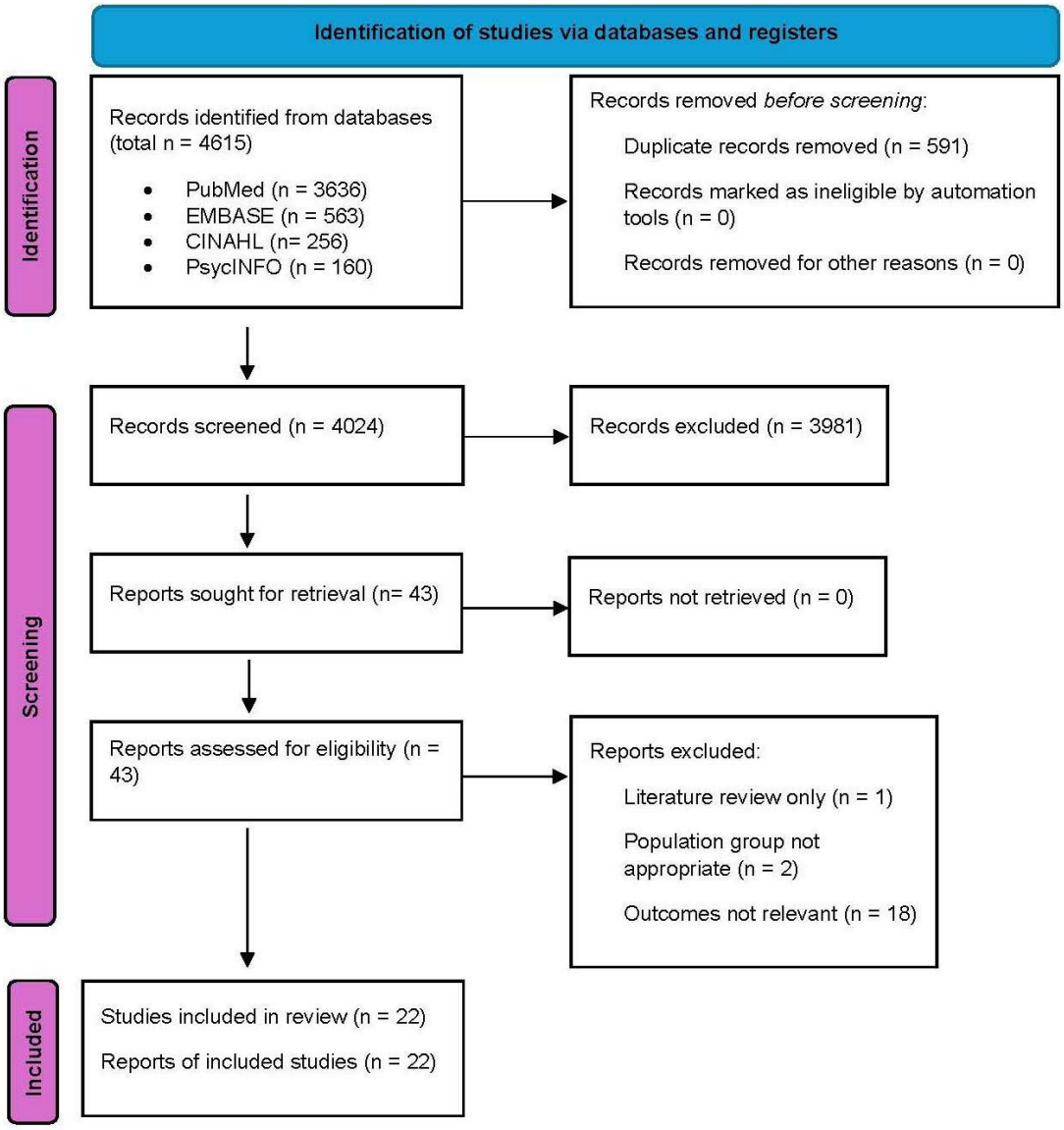

Figure 1 PRISMA flow diagram illustrating study selection. Records identified through database searching (n=4615), with 591 duplicates removed. After screening 4024 records, 43 full-text articles were assessed for eligibility. 21 reports were excluded (literature review only n=1; inappropriate population n=2; irrelevant outcomes n=18). 22 studies were included in the final review. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

research. Public involvement may be valuable in future work to guide research priorities and ensure findings are interpreted and communicated in ways that are meaningful to women with lived experience.

RESULTS

22 studies, published between 2010 and 2025, met the inclusion criteria and spanned 12 countries across North America, Europe, sub-Saharan Africa and Asia.[28–49] The details of the selection process are shown in the PRISMA flow chart in figure 1. The descriptive variables of the included studies are summarised in online supplemental table 2.

Across all studies, 593 female participants were represented, with age groups ranging from 14 to 84 years. Data were collected primarily through interviews or focus groups. Thematic analysis and grounded theory analysis were the most commonly used analytical approaches. All the included studies were of a satisfactory quality and provided value to this systematic review. A quality appraisal summary is given in online supplemental table 3.

Our analysis identified three categories of analytical themes. It is important to note that the themes highlighted overlap and are interconnected. For example, the experience that women who have engaged in RAI have plays a role in their reasons for engaging in AI.

Motivations for engaging in RAI

Relationship maintenance

Relationship maintenance was a dominant subtheme in 15 articles,[28–32 35 37 39–44 46 47] highlighting the role of RAI

in preserving relationships. Many women engaged in anal intercourse primarily to satisfy their male partners and maintain their interest, believing it ensured relationship security and reduced the risk of infidelity.

Some women described anal intercourse as a 'sacrifice'[28] or a way to demonstrate devotion, while others saw it as a reward for their partners. Some men felt entitled to it, and women, despite previous negative experiences, offered it as a gesture of intimacy. For instance:

> My partner really wanted it, so it's good to experiment and explore. I think if you're in a solid trusting relationship, then it's okay… It's really painful for me… I still try for him. (female participant, USA)[31]

Cultural perspectives further reinforced this dynamic. Some African women believed anal intercourse was more pleasurable for men, especially postpartum, and offered it to maintain their partner's satisfaction.[30] Some women also engage in anal intercourse to maintain vaginal elasticity for future penile-vaginal encounters to come.[30]

Others engaged in anal intercourse during menstruation to avoid losing their partner, despite discomfort.[43 46] In several cases, women hesitated but ultimately yielded to their partner's desires, prioritising their partner's pleasure over their own discomfort:

> I don't like anal sex. It's not pleasurable for me. Sometimes I cry… Usually, I do it if I'm on my period and he wants to be pleased… He'll ask and ask, and it's like, okay, okay. (female participant, USA)[31]

For some, the act was not a choice but an unspoken obligation—a duty to fulfil their partner's needs[31 32 46]: *"it was really a favour I was doing him as a present or a sacrifice that I was making for him," (female participant, New Zealand)*[32]

Taken together, the accounts highlight a pattern of Women engaged in RAI not because they desired it, but because they valued their relationships and feared the consequences of refusal. Whether through subtle expectation or explicit pressure, RAI was frequently positioned as something women 'do for him', reflecting gendered norms around obligation, sacrifice and maintaining male satisfaction within intimate relationships.

Coercion, fear and substance use

Across 15 studies, women described experiences of RAI that occurred through varying degrees of coercion, persuasion and intoxication.[28 30–36 39 40 42–44 46 48] Although a few women framed these encounters as consensual, many accounts reflected constrained or ambiguous consent. The tactics employed by men ranged from persistent verbal pressure to physical force and exploitation of intoxicated states.

Verbal coercion and emotional pressure

Many participants portrayed RAI as the outcome of relentless requests, 'nagging' or manipulation. Partners' persistence eroded initial resistance, often resulting in resigned acquiescence:

> Because he was like, "Can we do it, can we do it, can we do it?" (childish voice) And eventually you're like, fuck, like, okay. It's like a child nagging their mum for a chocolate bar or something, like, like just fuck off, we'll do it so that you can stop nagging me. (female participant, New Zealand)[32]

A number of women reflected on how partners interpreted their passivity as consent. A young female participant recounted how her boyfriend became "*annoyed*" or "*angry*" when she refused RAI and later blamed herself for not being physically forceful enough. *"I know that no means no … but if I'm not pushing him off me then it must mean, to him, I still want it to happen."*[33]

Several women said they complied to avoid conflict or abandonment: *"You can't refuse if you love him … you agree to everything." (female participant, South Africa).*[30] Others equated acquiescence with duty: *"It's something that's for him. It's something that I'm kind of sacrificing for him."(female participant, USA)*[28]

Fear, threat and physical coercion.

Fear of violence, rejection or accusations of infidelity frequently motivated participation.

> Women are afraid to speak for themselves … afraid that a man might beat them and accuse them of cheating if they refuse. (female participant, South Africa)[30]

Some accounts described explicit force: *"He grabbed a hold of me and did it … It was very painful." (female participant, South Africa*).[30] In other cases, women recounted what they perceived as "*accidental*" penetration—partners "*slipping in*". In Marston and Lewis,[33] participants noted that men presented such acts as mistakes and that women "*pretended to believe it*", illustrating how coercion can be masked by pretence and silence. Although a few women described these acts as "*consensual*", this labelling reflected internalised norms that reinterpret unwanted physical manipulation as compliance rather than assault.

Substance use as facilitator or coercive context.

Substance use appeared in two distinct ways.

a. Voluntary intoxication to endure pain or inhibition. Several women reported deliberately drinking or using drugs to numb discomfort or shame:

> A lot of women have got to get drunk to do anal. Women that do anal, they still have to get drunk to do anal because it, I guess, makes it easier…the effect that alcohol has on you, you get lightheaded and you're more go with the flow… Girl, I had to get wasted you know. (female participant, USA)[45]

b. Non-consensual or opportunistic acts during intoxication. Others described men initiating penetration while they were too drunk or high to refuse:

> Some people may not want that to happen but if you drunk and the guy already in there, he might just go ahead and put it in there. You probably don't even know the difference anyway and they ain't going to stop because you're under the heat of the moment… (female participant, USA)[45]

No study reported women being deliberately drugged by partners, but several described partners exploiting existing intoxication. Substance use thus functioned both as self-administered coping and as a condition enabling coercion. In Hutton *et al*[36], women linked alcohol expectancies to the belief that intoxication was necessary to 'handle the pain and humiliation'.[44] Reynolds *et al* likewise found that RAI was 'more likely to occur under the influence', revealing how intoxication both facilitates and conceals coercive dynamics.[43]

Spectrum of constrained consent.

Women's narratives reveal a continuum—from reluctant acquiescence after badgering, through fearful submission, to acts under intoxication or force. Even when labelled 'consensual', many accounts involved pressure, obligation or impaired capacity to refuse. As one participant summarised, *"I just did it to make him happy." (female participant, US)*[29]

A young female participant described her experience as *"consented, but in a qualified and constrained kind of way"*, later clarifying that it was *"slightly reluctant consent … which isn't really explicit consent in that same way"*.[45] Similarly, one woman explained that she *"let [her] boyfriend do those things"* despite not wanting them, because she felt she should be grateful that *"someone wants to be with me.*[45]

Others described surprise or submission rather than proactive choice. Another recalled a painful experience where she remained silent because there were *"other people in the house"* and later reflected, *"I wish there were more words for what it, like, the consent and not consent … I didn't even know myself which is tricky."* For her, and for many others, consent existed in a grey area, neither active refusal nor freely given agreement.

Coercive tactics surrounding RAI rarely involved a single mechanism; rather, they intertwined emotional dependence, fear and intoxication. 'Nagging' and 'slipping in' illustrate how women's resistance was gradually eroded, while substance use acted as both an enabler and a mask for non-consent. These findings underscore that consent under pressure or impairment is qualitatively different from free agreement and demonstrate how gendered power and social norms sustain coercive sexual practices.

Sexual pleasure

Pleasure from RAI was described by participants in twelve studies.[28–31 35 37 39 40 43 44 46 47] While the accounts were fewer than those describing pain or coercion, they represent an important dimension of women's experiences and motivations. Women who expressed pleasure did so for diverse reasons; physical sensation, emotional connection, partner satisfaction, or the appeal of experimentation.

Some participants reported direct bodily enjoyment or orgasmic response, eg, *"It's like a totally different sensation and a pretty strong orgasm too. Yeah, I really enjoy it."*[28] and *"It can be enjoyable for a lot of people. Point blank, that's why people do it."*[35] These women often emphasised comfort, lubrication and mutual attentiveness as prerequisites for pleasure, noting that RAI *"felt good … when we took our time."*[43]

Women enjoyed anal intercourse either because it gave them pleasure, or because they found the associated pain pleasurable, or because it made them feel adventurous. The unconventionality of AI was what appealed to some women, participating in something "*new and taboo*" was what they found intriguing.[40] Rather than contradicting RAI's increasing social visibility, these women's descriptions reflect how personal novelty, doing something different or "*forbidden*", enhanced arousal. Another important factor in deriving pleasure from AI for some was the opportunity to give their partners pleasure, "*they liked it, because he liked it*".[31]

The description of sexual pleasure is one of the few positive associations some women have with anal intercourse, and this was seen more commonly in women who had agency, were in long-term established relationships, had significant experience and those who considered pain to be part of pleasure, eg,

> I'm actually a big pain person so I like the pain, just how it felt. It hit certain different points and stuff and it was something different to try. I liked it a lot. (female participant, USA)[31]

Across studies, pleasure from RAI was associated with agency, communication and contextual factors such as trust, preparation and emotional connection. Women who exercised greater control over when and how RAI occurred, or who felt safe with their partners, were more likely to report enjoyment. In contrast, where coercion or uncertainty predominated, pleasure was absent or ambivalent.

To fit in

Nine studies portrayed RAI as an increasingly visible and socially normalised practice among women.[28 31 32 35 37 39–41 48] Participants described experiencing both internal and external pressures to engage in RAI, shaped by evolving sexual norms and media representations. Internal pressures arose from women's perception that RAI had shifted from being taboo to being expected.

> When I look back on my first sexual experiences… it was considered still maybe a bit of a taboo… But then as I've noticed going through all my partners, yeah…… it's very, very normalized to the point where I'm, I'm weird not to. (female participant, New Zealand)[32]

Curiosity and peer discussions also contributed to this internal pressure. Some women reported feeling drawn to the idea after hearing others describe it as exciting, fashionable or a marker of sexual openness: *"It just seemed like the thing people were doing, like, kind of 'hip' and 'in'." (female participant, USA).*[31]

External pressures emerged from partners, peers, pornography and broader media imagery, all of which reinforced the notion that RAI was a routine element of heterosexual sex. Several women said that these

portrayals influenced their partners' expectations and their own sense of what counted as normal:

> …without that constant reinforcement of pornography, the normalizing of anal sex and all those other things, I don't think that, I don't think that guys would be so insistent nowadays to do that.[32]

Collectively, these accounts illustrate how RAI has been absorbed into contemporary heterosexual sexual scripts, not solely as an act of curiosity or experimentation, but increasingly as a socially reinforced expectation. For many women, the pressure to participate reflected both the internalisation of new sexual norms and the external influence of cultural and media narratives that portray RAI as typical, desirable and even obligatory within heterosexual intimacy.

Avoiding pregnancy and preserving vaginal virginity

Less striking and more particular to certain religious, societal and cultural beliefs, maintaining a 'virginity' status and preventing pregnancy were additional reasons women engaged in RAI. The relevant references were from eight articles from the USA,[29 31 44 46] UK,[35] Palestine,[38] New Zealand[32] and Tanzania.[48]

Pregnancy prevention.

Across four studies,[29 31 44 46] women described RAI as a means of maintaining intimacy while avoiding the risk of pregnancy. *"I wanted to take [our relationship] to another level. I wanted to be close to him, I wanted to be intimate with him [without the risk of pregnancy]" (female participant, USA).*[44] Some framed the practice as a pragmatic alternative when contraception was unavailable or distrusted, while others reported that partners promoted it as 'safer' sex. Such reasoning positioned RAI within a utilitarian framework of risk management rather than pleasure or desire.

Virginity maintenance.

In five studies,[31 32 35 38 48] participants explicitly linked RAI to preserving the physical appearance of vaginal virginity. This motivation was particularly salient in societies where female chastity before marriage symbolised moral worth.

> …Arab girls… before marriage have a tendency to practice anal sex so that they may preserve their virginity. Their intention is to be found virgins when they marry, [female participant, FGD, Tanzania].[48]

Even in more liberal contexts, some women viewed their virginity as a "gift" to be saved, equating RAI with technical, rather than moral, virginity loss: *"I performed anal sex when I was younger… it kept my virginity intact." (female participant, USA)*[31]

Pregnancy avoidance and virginity preservation demonstrate how women navigate conflicting pressures of sexual desire, reproductive risk and social respectability. While differing in rationale, both behaviours reflect the influence of gendered moral norms that value fertility control and chastity, shaping how women interpret and manage their sexual agency.

For financial gain

Five studies reported that some women engaged in RAI for financial reasons, most often within populations of female sex workers or women using illicit drugs.[30 39 41 43 48] In these accounts, RAI was described as both a source of higher payment and a survival strategy within contexts of poverty and limited economic opportunity.

> When I engaged in anal intercourse for the first time, I hadn't slept for days… it was a matter of life or survival to engage in anal intercourse. If I did not accept those offers, what other options do I have (Female Sex Worker, Ethiopia)[39]

Mazeingia *et al*[39] found that female sex workers were offered much more money for anal intercourse than vaginal sex which allowed them to have a better income to pay for essentials such as food. They only "accepted *offers for anal intercourse from men….to get money to survive"*. Wamoyi *et al*[48] had similar findings. One woman stated that *"oh, in the anus you get much more money"*, demonstrating a clear reason why these women choose to engage in anal intercourse.

These narratives reveal financial motivation rooted in material necessity rather than preference or pleasure. Women exercised limited agency in choosing RAI as a higher-value service, negotiating payment and risk within constrained circumstances.

At the same time, several accounts showed that economic need often coexisted with coercion. Some participants described feeling unable to refuse clients' requests despite discomfort or pain, and others recounted incidents while intoxicated that blurred the line between consent and exploitation. Economic dependence thus intensified vulnerability; women's decisions were shaped less by desire for profit than by the imperative to survive.

While RAI could represent an income-generating strategy, poverty, gender inequality and substance dependence frequently limited women's ability to decline it. These findings highlight the importance of distinguishing economic choice constrained by circumstance from sexual coercion, even when both arise within the same transactional context.

Out of curiosity

Women also engaged in anal intercourse to fulfil their own curiosity as referenced in three articles from the USA.[31 37 40] Fahs and Gonzalez outlined that some women had an initial interest in anal intercourse and wanted to 'try it' but then found that they did not enjoy it. They highlight the desire to explore and experiment with sexual behaviours in order to discover preferences.

> I've tried anal sex only once and it wasn't for me. I was with my first boyfriend and I was young, so we were all about experimenting and we'd try anything just for the sake of it.

> I just wasn't into it. He didn't seem to care. I wasn't getting aroused by it at all. It was just painful. (female participant, USA)[31]

The disappointment experienced by some may have been as a result of unrealistic expectations and fantasy as a result of external factors such as pornography, but also could have been as a result of a lack of preparedness.

> I had thought it would be this great thing but once we actually tried it I realized how awful it really was! He didn't use enough lube and we were fumbling around trying to make it sexy while I was all tense and embarrassed. He lost his erection in the middle. (female participant, USA)[31]

The experiences of women who engaged in RAI

18 articles described the experiences of women who engaged in RAI.[28–32 34 37 39–44 46–48] Pain was a consistent subtheme in all of these articles. For the vast majority, this was associated with displeasure; however, for some, it was considered pleasurable.

Pain and unpleasantness

18 studies describe RAI as a painful and unpleasant experience for women.[28–34 36 37 39–44 46–48] Verbal and non-verbal coercion played a large part in the pain experienced by women. However, in several cases where RAI did not appear to be coerced, it was still considered painful. It was interesting to find that in this cohort of participants, they persisted in engaging in RAI over time with either the same or a different partner, despite discomfort to themselves.

There are suggestions that the intensity of the pain experienced reduced over time with repeated practice; however, this was not universal. Preparedness and adequate lubrication have been suggested as the key to more tolerable or even enjoyable RAI; however, this does not necessarily eliminate pain and local trauma. An example is seen here.

> Even if he [man] will apply oil, it will help him to enter [his penis] easily but you [woman] will still get bruises and tear your anus, [female participant, FGD, Tanzania].[48]

The physical effect of this pain is described by some participants as tears, bleeding, inability to defecate, being '…turned inside out…',[43] etc. There were also some accounts of failed RAI attempts due to severe pain experienced.

In some cases, RAI went beyond unpleasantness; some women reported feeling powerless, used and humiliated during RAI. The pain described transcended the physical aspect; emotionally, they were distressed. There was a sense they were subjected to masculine entitled dominance and had no choice in the matter. In some of these cases, coercive tactics were used. Intoxication with alcohol was sometimes required for the pain,

> That is the worst thing ever to do and—I can't do it unless I have like a whole lot to drink, because it hurts. (female participant, USA)[36]

Pain and pleasure

Eleven studies explored women's experiences of RAI through the intertwined dynamics of pain, pleasure and control.[28–31 37 39 40 43 44 46 47] Across these accounts, the boundary between discomfort and desire was often blurred. For many participants, pain was initially dominant, yet over time some reported that pain became tolerable, even erotic, when associated with trust, emotional closeness or a sense of agency.

Several women described a trajectory from pain to pleasure, noting that repeated experience or greater comfort with a partner reduced discomfort and increased arousal:

> When you start doing it, it is painful, but once you get used to it, it feels good… It is better than vaginal sex. (female participant, South Africa)[30]

Pain and pleasure coexisted, sometimes described as inseparable sensations rather than opposites. For a small group of women, discomfort intensified excitement: *"Pain is part of the pleasure. The culmination is anal orgasm." (female participant, Croatia)*[47] and *"It hit certain different points… I'm a big pain person, so I liked the pain, just how it felt." (female participant, USA)*[31]

These accounts illustrate how physical sensations of tension, pain and release could be reinterpreted as components of pleasure, shaped by individual disposition and relational context. A recurring feature among women who reported positive or mixed experiences was the presence of trust and emotional safety. Feeling able to stop the act or direct its pace was central to enjoyment:

> He would be like, 'Is this okay? Do you want to stop?'… I always felt like I was in charge of what was happening. (female participant, USA)[28]

These narratives emphasise relational agency; pleasure was possible when women felt safe, respected and emotionally connected. Conversely, lack of trust or unwanted pressure transformed pain into distress rather than stimulation. While some women sought repeated RAI due to sexual curiosity, intimacy or the pleasurable mixture of pain and satisfaction, others viewed it as a one-time experience marked by discomfort: *"I've tried it, and I'm just like—no, thank you." (female participant, USA).*[40]

This diversity underscores that women's interpretations of pain and pleasure were not fixed but context-dependent—shaped by partner dynamics, consent and meaning attributed to the act.

Societal views and stigma

Women across studies described mixed societal views of RAI, characterised by growing visibility alongside persistent stigma.

RAI as a social norm

Nine studies[28 31 32 35 37 39–41 48] noted that RAI is increasingly portrayed as a mainstream heterosexual practice. Across diverse cultural settings, participants described a shifting landscape in which RAI has become increasingly visible, discussed and expected, though not always accepted. In

this context, 'norm' denotes a practice that is common and widely represented, even when ambivalently viewed or morally contested. Women's narratives revealed that RAI's normalisation was driven by intersecting influences. Many women described a generational change in which RAI transitioned from secrecy to mainstream visibility. Participants linked this shift to global media and digital culture: *"celebrities are talking about it and music is talking about it, so now it's becoming a little bit opener" (female participant, USA)*[40]

> "Having it through the back is the trend currently… at the front they say oldies." (female participant, FGD, Tanzania)[48]

In these accounts, RAI is not necessarily endorsed as desirable but is viewed as part of modern or fashionable sexual repertoires. This marks a shift from earlier perceptions of anal sex as deviant or taboo toward a performative sign of openness and sexual experience.

Exposure to pornography was repeatedly cited as a major force behind RAI's normalisation, shaping both men's expectations and women's sense of sexual adequacy:

> it's the thing to do now… I think it's from watching porn and stuff. They feel the need to compete with the porn stars. (female participant, USA)[31]

Peer discussions reinforced this impression, leaving some women feeling prudish or excluded for not participating:

> Everyone's having anal sex… even if you want to say no when someone asks you… you're probably going to give in very easily. (female participant, New Zealand)

The normalisation of RAI as part of the sexual repertoire appears to create a narrative that leaves women feeling left out for not being a part of it and men feeling entitled to access to RAI with their female partners.

RAI as stigmatised

RAI was described as stigmatised in thirteen studies. Despite increasing visibility, RAI continues to be perceived as an unacceptable or deviant sexual act for women. Stigma arose from intersecting religious, cultural and gendered beliefs, often portraying RAI as 'unnatural', 'dirty' or morally inappropriate.

In some African and Middle Eastern studies, participants described RAI as against nature or against God's will, associating it with homosexuality and moral corruption.

> God created us to have sex through the vagina… the anus is for passing faeces. (female participant, Uganda)[30]

> …a man should not fantasise having anal sex. … If you have anal, it means you are doing it with other men. (female participant, Zimbabwean)[30]

Such narratives illustrate a moral framework where RAI transgresses divine or cultural order. In these settings, stigma manifests not only as disapproval but also as secrecy, women concealing participation to avoid judgement, exclusion or even legal risk.

In Western contexts, participants echoed similar sentiments of disgust and social censure, describing RAI as 'gross', 'trashy' or something 'only porn stars or prostitutes do'.[28] : *"I think people don't want to admit if they've had anal sex… because you'd get judged." (female participant, USA)*[40]

While religious condemnation was less prominent in these accounts, moral disgust and purity discourses persisted, often reinforcing boundaries of 'respectable' femininity. Participants linked RAI stigma to pornography, describing how the act's association with sexual objectification positioned women who engaged in it as 'less respectable' or 'unfeminine'.

As with other sexual activities, a double standard sometimes exists, particularly concerning heterosexual dynamics. Men engaging in RAI may be praised for their perceived conquests, while women face social stigma, often referred to as 'slut-shaming'. This dichotomy is powerfully summarised by one respondent:

> If a guy speaks about anal sex, everyone is, like, 'Oh man, it's so great.' Whereas if a girl says, 'Oh I've had anal sex' and is proud about it, she gets labelled a slut. (female participant, USA)[40]

Across contexts, stigma constrained women's willingness to disclose or discuss RAI. Even those who participated described doing so privately or euphemistically:

> This practice is confidential. It is not as public as HIV, so people do not talk about it openly. (female participant, FGD, Tanzania)[48]

> It is just something like a secret. This is my little secret. (female participant, USA; McBride)[40]

Although stigma rarely prevented participation outright, it shaped the conditions under which RAI was practised—hidden, unspoken and emotionally fraught.

> I think a lot of people claim that they don't do it [referring to PAI] or don't like it, but they really do, because it's still like a taboo. (female participant, USA)[40]

Although stigma rarely prevented participation, it shaped how RAI was practised—privately, cautiously and with emotional ambivalence. Women navigated a paradox where RAI is normalised in cultural discourse yet remains socially marginalised in practice, reinforcing the tension between emerging sexual norms and enduring moral boundaries.

DISCUSSION

This systematic review synthesised evidence from 22 qualitative studies across 12 countries to explore women's motivations, experiences and societal perceptions of RAI. The findings demonstrate that engagement in RAI is embedded within complex social, relational and cultural contexts. While some women described curiosity, intimacy or pleasure as motivating factors, RAI was more

commonly associated with pain, coercion, ambivalence and stigma. The intersection of agency and constraint, normalisation and taboo, and pleasure and pain highlights enduring gendered power imbalances within heterosexual relationships and the persistent influence of patriarchal sexual scripts.

Women's motivations for engaging in RAI were predominantly relational rather than individual. Many participants described acquiescing to RAI to maintain relationships, satisfy partners or demonstrate trust and commitment. Women's desire to prioritise their partner's happiness has been noted in other forms of sexual practice, including penile-vaginal intercourse.[50] Despite consistent reports of pain and unpleasantness, many continued to engage in RAI to preserve emotional connection and intimacy, an important component of their relationships, even when the act itself was not pleasurable.[51] This behaviour reflects entrenched heterosexual norms in which men are positioned as initiators and women as accommodators, consistent with sexual scripting theory,[52 53] the effects of which are seen not only in penile-vaginal intercourse, but also in RAI. Women often described adopting a more submissive role, agreeing to RAI for the benefit of their male partners while disregarding their own discomfort or consequences.[54] Recent insights into sexual scripting remain concordant with traditional scripts. Women seek commitment and monogamy in their relationships;[55] therefore, the possibility of securing this by satisfying their partners' anal sex requests may outweigh their own sexual desires. Popular culture and pornography increasingly frame RAI as an expected or 'modern' sexual practice, contributing to perceptions that women who decline it are 'not normal' or 'weird not to' engage, reinforcing sexual conservatism as undesirable. Such sociocultural pressures often consolidate internalised motivations to please male partners, demonstrating how women's sexual agency is negotiated within patriarchal boundaries.

Coercion was another salient factor. Verbal coercion from male partners often came in the form of repeated requests; however, physical coercion was also common, for example, male partners inserting their penis into the anus without prior discussion or consent. Although many of the participants did not describe their unwanted encounters as non-consensual, they clearly reflected violations of consent. These dynamics exemplify manifestations of male sexual entitlement. Marston and Lewis report on how their 16–18-year-old British male participants considered coercion to be a part of RAI, and their expectation that women eventually accept this coerced RAI for varying reasons, including the assumption that they secretly want it despite their reluctance.[37] They describe a sense of masculine sexual entitlement other authors have similarly described. Jozkowski and Peterson provide a different perspective, some of their male participants used coercive tactics because they knew women hated RAI and coercion insured against refusal.[56]

Substance use also emerged as a gateway to RAI. Although some data came from studies focused on women with a history of drug use,[43] others recruiting from general populations found similar patterns.[32 44 46] Prior research has established associations between substance use and risky sexual behaviours.[57–59] Lowered inhibitions and impaired judgement can increase susceptibility to pressure or exploitation. For some women, substance use appeared intentional to facilitate relaxation and acceptance of RAI, but for others, it served as a context for coercive or unwanted encounters.

A minority of women reported engaging in RAI for personal reasons; curiosity, physical pleasure or practical considerations such as pregnancy prevention or preservation of 'technical virginity'. Pleasure was most often reported in contexts of trust and perceived control, highlighting the importance of agency in shaping sexual experience. However, only 43 of 546 participant quotations in the included studies referenced sexual pleasure, suggesting either that positive experiences are rare or that research disproportionately focuses on negative or health-related outcomes.[31] These accounts were outweighed by broader narratives of compliance and constraint, particularly in contexts where female chastity or submission remains culturally valued. Across social and economic settings, women's participation in RAI was seldom fully autonomous but shaped by intersecting factors including gender norms, financial dependency and social expectations.

Pain was the most consistent experience reported across studies, in both consensual and coercive contexts. Many women described tearing, bleeding and prolonged discomfort; Stulhofer and Ajdukovic[47] found that 73.4% of their participants experienced pain during RAI. Hensel and colleagues reported that although 35% of women had experienced pleasure from anal stimulation, it was generally limited to shallow penetration (ie, not beyond the depth of a fingertip/knuckle).[60] Pain likely reflects local trauma to the anal canal, increasing the risk of STIs and anorectal disorders.[45]

Although some authors attribute pain to insufficient preparation whether psychological or physical (including lubrication), accounts from experienced women indicate that pain can persist even when adequately prepared.[47 48] It is therefore important that women are aware that pain may occur regardless of preparation and that repeated trauma may have long-term implications. The medical risks, alongside instances of coercion and violence, underscore the power imbalances many women navigate in their relationships. A significant proportion of young women reported feeling pressured into RAI, often experiencing subsequent regret, shame or lowered self-esteem. Some women rationalised pain as evidence of intimacy or devotion, reflecting internalised norms that prioritise male pleasure and endurance over female comfort. As Marston observed, discomfort was often interpreted as personal inadequacy ("*if only I could be more relaxed*") rather than a result of partner behaviour or insufficient care.[37]

Across diverse settings, RAI occupies a paradoxical position, simultaneously normalised and stigmatised.[5 61] In Western and high-income contexts, it is increasingly depicted as fashionable or routine, yet moral judgement and silence persist. In more conservative societies, particularly in parts of Africa and the Middle East, RAI is sometimes framed as a means of preserving vaginal virginity or avoiding pregnancy, reflecting cultural imperatives around chastity and fertility. For women engaged in sex work or living in economic precarity, RAI can function as a survival strategy, exchanged for higher payment, illustrating how structural inequities constrain sexual autonomy.

This duality highlights a transitional sexual culture: while pornography and media portray RAI as a marker of sexual liberation, religious and moral codes continue to frame it as deviant. Consequently, many women practise RAI privately but avoid discussing it publicly, maintaining a culture of silence even as prevalence persists. Reluctance to discuss RAI openly may come from the fear of being judged[28 62] which hinders open dialogue and honest disclosure. This issue extends into establishments responsible for sexual health education and for managing sexual health and the consequences of poor sexual health. Given its prevalence, the paucity of public health information and professional discomfort in addressing RAI represent significant public health concerns.[8] Stigma does not deter women from engaging in RAI; rather, it discourages open communication and informed practice. Benson *et al* describe how this stigma also discourages discussion with healthcare providers.[28] This forms the basis for a wider discussion given the negative physical and mental effects RAI has on some women. Coercion is a form of intimate partner violence and has been highlighted as a factor in RAI for some women. Health services should ideally provide a safe space for addressing intimate partner violence.[63] However, practitioners cannot meet their duty of care when patients feel unable to speak openly about these experiences.

The synthesis suggests a cyclical framework in which societal norms, relational motivations and individual experiences are closely interconnected. Societal norms and media representations promote RAI as a normal or desirable aspect of sexual behaviour, shaping expectations within relationships. These relational dynamics, centred on maintaining intimacy, satisfying partners or conforming to perceived sexual standards, mediate women's willingness to engage. The resulting experiences, encompassing pain, pleasure, coercion or ambivalence, subsequently influence women's future behaviours and internalised understandings of the practice. Meanwhile, persistent stigma and silence sustain a disconnect between the growing public visibility of RAI and women's private discomfort. This cyclical process illustrates how opposing forces, normalisation and taboo, can coexist within the same cultural and interpersonal contexts, and even within individual experiences.

Implications for Clinical Practice and Sexual Health Education

Given the prevalence of RAI and the frequency of pain, coercion and silence, sexual health professionals must adopt inclusive, trauma-informed and gender-sensitive approaches. Clinicians should routinely and non-judgmentally include questions about RAI in sexual histories (for example: "*Many people engage in different types of sex, including anal sex. Is this something you would like to discuss in relation to comfort, safety or pleasure?*"). Educational interventions should provide clear information about infection prevention and anal health, while dispelling myths shaped by pornography and social narratives.

Screening for intimate partner violence should be integrated into routine sexual health assessments using universal, sensitive questioning (eg, "*Has anyone ever pressured you into sexual activity you did not want?*"). Creating confidential and non-judgemental clinical spaces enables women to disclose discomfort, fear or injury without shame. Professional training should address how gendered power dynamics and structural inequities shape women's sexual agency and consent.

Limitations and future direction

This review has several limitations. Qualitative studies may overrepresent women who feel able to discuss RAI, while those who are younger, more conservative or have experienced trauma may be underrepresented. Publication and language bias may have excluded non-English or unpublished work, limiting cultural and geographical diversity. As with all qualitative syntheses, removing quotations from their original contexts may reduce nuance.

The included studies span more than a decade, during which sexual norms and digital cultures have shifted, meaning some differences may reflect temporal rather than cultural change. In addition, gender identity was not specified in the majority of included studies. We therefore assumed that participants described as women were cisgender, reflecting reporting practices at the time of publication, and this should be considered when interpreting the findings. Finally, thematic synthesis identifies patterns but cannot quantify prevalence; the prominence of themes may reflect research emphasis rather than actual frequency.

Future research should broaden representation and methodology, using mixed-methods and longitudinal designs to track how motivations and meanings shift over time. Comparative studies examining both men's and women's perspectives could illuminate relational dynamics and consent. Intersectional approaches considering class, race, religion and sexuality would further strengthen understanding.

Practically, sexual health education and clinical training should address RAI within a non-judgemental, evidence-based framework. Integrating discussion of RAI into routine care and public-health messaging may

reduce stigma and support informed, equitable sexual well-being.

CONCLUSIONS

This systematic review clarifies that women's engagement in RAI is a multidimensional practice shaped by gendered power, cultural expectations and embodied experience. Women's participation reflects an ongoing negotiation between curiosity and coercion, pleasure and pain, and agency and constraint.

The findings show that RAI is not simply a matter of personal preference but a behaviour embedded within structural and relational pressures. Women's narratives illustrate how agency is exercised within limits, as intimacy, trust and male desire intersect with social stigma and gender norms.

Stigma remains a significant barrier to open discussion of RAI. While it does not deter participation, it restricts access to accurate information and care, contributing to avoidable harms such as STIs and anal trauma. As RAI becomes more visible within contemporary heterosexual sexual practices, sexual health education and clinical care must facilitate non-judgmental, evidence-based dialogue.

Recognising these dynamics is essential for trauma-informed, gender-equitable sexual healthcare and more inclusive public discourse. By situating RAI within broader patterns of gender, intimacy and power, this review provides a critical framework to guide future research, clinical training and policy.

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