

## Sexual Health During Breastfeeding

**Understanding Desire, Vaginal Dryness, Painful Intercourse, Hormonal Changes, Intimacy, Fertility and Sexual Recovery During Lactation**

**By Dr. Nizamuddin Qasmi**

**Founder & Chief Physician, Saira Health Care**

**Focused Practice in Sexual Disorders & Infertility**

Breastfeeding is an important and natural stage of motherhood, but it is also a period of major hormonal, physical, emotional and relationship changes.

Many women are prepared for changes in their breasts, sleep and menstrual cycle after childbirth, yet very few are told that breastfeeding can also influence their **sexual desire, vaginal lubrication, comfort during intercourse, orgasm, body image and overall interest in intimacy.**

A breastfeeding mother may ask me:

“Doctor, before pregnancy my sexual desire was normal. Why do I have almost no interest now?”

Another may say:

“I want to be close to my husband, but intercourse feels dry and painful.”

Some women notice that their breasts leak milk during sexual arousal. Others worry that having sex may reduce their breast milk, harm their baby or cause another pregnancy even though their menstrual periods have not returned.

These concerns are common and deserve proper medical explanation.

My first message to breastfeeding women is therefore:

**Changes in sexual function during breastfeeding are common, usually understandable from the hormonal and postpartum changes taking place in the body, and in many cases are temporary. However, persistent pain, severe dryness, loss of sexual function or significant emotional distress should not simply be dismissed as “normal motherhood.”**

A major systematic review published in 2025 found substantial levels of vaginal dryness, vulvovaginal atrophy, painful intercourse and sexual dysfunction among lactating postpartum women. A newer systematic review published in 2026 similarly concluded that sexual function during breastfeeding is influenced by a combination of hormonal, physical, psychological, social and relationship factors.

At **Saira Health Care**, I therefore consider sexual health an important part of postpartum and reproductive healthcare rather than an embarrassing subject that women are expected to manage silently.

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### **Breastfeeding and Sexual Health: An Important Distinction**

Breastfeeding is **not a sexual disorder**.

Likewise, reduced desire, vaginal dryness or temporary changes in sexual activity during lactation do not automatically mean that a woman has developed a disease.

Breastfeeding produces a unique hormonal environment designed primarily to support milk production and care of the newborn. These same hormonal changes can temporarily affect the reproductive and sexual systems.

At the same time, childbirth itself may have involved an episiotomy, perineal tear, caesarean section, pelvic-floor injury, blood loss, sleep deprivation or emotional stress.

A woman's postpartum sexual health therefore reflects much more than breastfeeding alone.

This is why I prefer to examine the complete picture.

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### **What Happens to Hormones During Breastfeeding?**

To understand sexual changes during breastfeeding, we first need to understand two important hormones: **prolactin and estrogen**.

Prolactin rises to support breast-milk production. Frequent suckling helps maintain prolactin secretion.

At the same time, breastfeeding can suppress normal hypothalamic-pituitary-ovarian activity. Ovulation may be delayed, menstrual periods may temporarily stop and estrogen levels can remain relatively low, particularly during intensive breastfeeding and lactational amenorrhea.

Recent reviews describe this as a state of **physiological hypoestrogenism**—a normal temporary reduction in estrogen related to lactation.

Low estrogen can affect the vagina and vulva in several ways.

The tissues may become relatively thinner and less lubricated. Natural vaginal moisture may decrease. Some women notice burning, sensitivity or discomfort during penetration.

Prolactin and other hormonal changes may also influence sexual desire.



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These hormonal effects are one important reason sexual function during breastfeeding can feel very different from sexual function before pregnancy.

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### **The Emerging Concept of Genitourinary Syndrome of Lactation**

An important recent development in sexual medicine is the proposed term **Genitourinary Syndrome of Lactation, or GSL**.

Researchers proposed this term to describe the group of genital, urinary and sexual symptoms that may occur in breastfeeding women partly because of lactation-related low estrogen and androgen activity.

Symptoms may include vaginal dryness, vulval irritation, burning, discomfort during intercourse, urinary symptoms and changes in sexual function.

The concept was first developed in recent sexual-medicine literature, and a new 2026 review has emphasized that GSL is often under-recognized in postpartum care.

I would emphasize that **GSL is still an emerging clinical concept rather than a universally standardized diagnosis**.

Not every sexual or vaginal symptom occurring during breastfeeding is caused by low estrogen.

A woman may instead have an episiotomy scar, pelvic-floor dysfunction, infection, vulval skin disease, endometriosis, urinary disease, psychological distress or another condition.

Therefore, the term should help us recognize symptoms—not encourage us to attribute every postpartum complaint to breastfeeding.

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### **How Common Are Sexual Problems During Breastfeeding?**

They are considerably more common than many patients realize.

A 2025 systematic review examining postpartum lactation-related genitourinary symptoms estimated vaginal dryness in approximately **54%** and findings consistent with vaginal atrophy in approximately **64%** of lactating postpartum women included in the studies.

The same review estimated painful intercourse, or dyspareunia, in approximately **60% at three months postpartum, 40% at six months and 29% at twelve months**. These are pooled research estimates rather than predictions for an individual woman, and populations differed across studies.

A 2026 systematic review of 22 studies also found that breastfeeding women commonly reported reduced libido, vaginal dryness, dyspareunia and reduced sexual satisfaction. Hormonal changes, particularly increased prolactin and reduced estrogen, were important, but psychological, social and relationship factors were also significant.

These findings tell us something important:

**Postpartum sexual difficulties are common enough that clinicians should ask about them routinely rather than waiting for women to overcome embarrassment and raise the subject themselves.**

WHO considers access to sexual and reproductive health information an essential component of good postnatal care.

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### **Reduced Sexual Desire During Breastfeeding**

Reduced libido is one of the most frequent concerns.

A woman may love her partner, feel emotionally connected and still have very little spontaneous sexual desire.

This does not automatically indicate a relationship problem.

Sexual desire after childbirth is influenced by hormones, fatigue, sleep deprivation, breastfeeding frequency, recovery from pregnancy, anxiety about pain or another pregnancy, body-image changes and the enormous mental responsibility of caring for an infant.

Recent systematic reviews confirm that breastfeeding-associated changes in sexual function are multifactorial rather than purely hormonal.

In my consultations I therefore avoid describing every woman with reduced postpartum libido as having “low sexual power.”

That description oversimplifies a complex physiological period.

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### **Prolactin and Sexual Desire**

Prolactin is essential for milk production.

Persistently elevated prolactin during active breastfeeding may contribute to suppression of ovarian hormone activity. This hormonal environment has been associated in the research literature with reduced libido and other changes in sexual function.

However, hormone levels are only part of the explanation.



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A mother who has slept in two-hour intervals for several months, feeds her infant repeatedly during the night and spends much of the day caring for a baby may understandably experience little spontaneous sexual interest.

Sexual function should therefore never be reduced to one laboratory hormone value.

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### **Vaginal Dryness During Breastfeeding**

Vaginal dryness is one of the most characteristic sexual-health changes associated with lactation.

ACOG specifically notes that estrogen levels can fall after childbirth and during breastfeeding and that this can cause vaginal dryness.

A woman may describe:

“I feel interested mentally, but my vagina does not become lubricated.”

This is important because lack of lubrication should not automatically be interpreted as lack of attraction.

Hormonal dryness can occur even when sexual desire and emotional attraction remain intact.

Reduced lubrication increases friction during penetration.

Friction can cause burning.

Burning produces fear of the next sexual encounter.

Fear reduces arousal and increases pelvic muscular tension.

That can create a cycle:

**dryness → painful intercourse → fear of pain → reduced arousal → greater muscular tension → more pain.**

Breaking this cycle early can prevent a relatively simple hormonal symptom from developing into persistent sexual pain.

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### **Vaginal Atrophy During Lactation**

The word **atrophy** can sound frightening, but in this context it generally describes temporary thinning and reduced estrogen stimulation of vulvovaginal tissues.

The 2025 systematic review found signs of vaginal atrophy to be common among the lactating postpartum populations studied.



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Symptoms may include vaginal dryness, burning, tenderness, irritation, discomfort during intercourse and occasionally urinary symptoms.

This does not mean that every breastfeeding woman will develop severe symptoms.

Many have little or no difficulty.

Others are significantly affected.

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### **Painful Intercourse During Breastfeeding**

The medical term for painful intercourse is **dyspareunia**.

Breastfeeding can contribute through hormonal dryness, but postpartum dyspareunia often has more than one cause.

For example, a breastfeeding woman may simultaneously have low-estrogen vaginal dryness and an episiotomy scar.

Another may have dryness plus an overactive pelvic floor.

Another may have pelvic pain that has nothing to do with breastfeeding.

Therefore, painful sex deserves assessment rather than simply being attributed to lactation.

The newest 2026 review on GSL emphasizes exactly this point: clinicians should consider perineal scar pain, pelvic-floor disorders, vulvodynia, infection, vulval disease, urinary conditions and psychological factors rather than automatically attributing all symptoms to low estrogen.

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### **Pelvic-Floor Changes After Childbirth**

Pregnancy and delivery place enormous mechanical demands on the pelvic floor.

Some women develop weakness, which may contribute to urinary leakage or prolapse symptoms.

Others develop the opposite problem: excessive muscular tension or pain.

A tight pelvic floor may produce pain during penetration even when the vaginal tissues themselves appear healthy.

The distinction matters.

A woman with weakness may benefit from carefully prescribed strengthening exercises.



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A woman with painful overactivity may need relaxation, breathing, myofascial treatment and pelvic-floor physiotherapy instead.

This is why I do not recommend repeated Kegel exercises blindly to every woman with postpartum sexual difficulty.

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### **Episiotomy and Perineal Tear Pain**

When painful intercourse follows a vaginal delivery, I always ask about episiotomy and perineal tears.

A healed scar may remain sensitive or less flexible than the surrounding tissue.

A woman may feel pain at exactly one point when penetration begins.

The pain may have little to do with breastfeeding hormones.

A careful examination can distinguish scar tenderness from generalized vaginal dryness and pelvic-floor pain.

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### **Sexual Health After Caesarean Delivery**

Women sometimes assume that sexual problems occur only following vaginal childbirth.

That is incorrect.

Caesarean delivery prevents some forms of perineal trauma, but it does not eliminate postpartum hormonal changes.

A breastfeeding mother following caesarean delivery can still experience vaginal dryness, reduced libido, fatigue, pelvic-floor dysfunction, fear of another pregnancy, body-image concerns and abdominal discomfort.

Sexual recovery is therefore not determined solely by how the baby was delivered.

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### **Breastfeeding and Orgasm**

Breastfeeding changes the hormonal environment surrounding sexual response, but women remain capable of experiencing sexual arousal and orgasm.

Some women notice that orgasm feels different after childbirth.

Others have difficulty reaching orgasm temporarily.

Still others report no change.

Oxytocin plays an important role in breastfeeding because it produces the **milk-ejection or let-down reflex**. A systematic review confirms the rapid release of oxytocin during breastfeeding and its central role in milk ejection.

Because oxytocin also participates in sexual response, some lactating women notice breast-milk leakage during sexual arousal or orgasm.

This can surprise or embarrass couples, but it is a recognized physiological phenomenon.

It does not mean anything is wrong with the breasts or the woman's sexual response.

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### **Breast-Milk Leakage During Sex**

Some women release a small amount of milk during intimacy, breast stimulation or orgasm.

Couples should understand that this is not dangerous.

If leakage is distracting, practical measures can help, such as breastfeeding or expressing milk before intimacy and keeping a towel nearby.

Other couples are completely unbothered by it.

There is no medical requirement to treat normal milk leakage during sexual activity.

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### **Breast Sensitivity and Sexual Touch**

A woman's relationship with her breasts may also change while breastfeeding.

Before pregnancy, breast or nipple stimulation may have been sexually pleasurable.

During lactation, however, the breasts may feel primarily associated with infant feeding.

Some women become uncomfortable with sexual breast stimulation because the nipples are tender or because they feel “touched out” after frequent feeding.

Others continue to find breast stimulation pleasurable.

Neither reaction is abnormal.

Partners should communicate rather than assuming that sexual preferences remain exactly as they were before pregnancy.

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### **Feeling “Touched Out”**



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This term is increasingly used by breastfeeding mothers.

A woman may spend many hours each day with a baby feeding, sleeping against her or being carried.

By the evening, she may have had so much physical contact that additional touch feels overwhelming rather than relaxing.

This does not necessarily mean she has lost attraction to her partner.

Sometimes she simply needs physical space, sleep or emotional support before sexual interest can return.

Understanding this difference can prevent unnecessary relationship conflict.

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### **Postpartum Fatigue and Sexual Desire**

Sleep deprivation has a powerful effect on physical and emotional wellbeing.

A breastfeeding mother may wake several times every night.

She may also be recovering from delivery, managing household responsibilities and adapting psychologically to motherhood.

Under these circumstances, the body's priority may be sleep rather than sex.

Partner support can therefore indirectly improve sexual health.

A 2026 systematic review found that social and relationship factors—including partner support—can meaningfully influence sexual experience during breastfeeding.

Sometimes helping with nighttime care, household work and emotional support is more helpful for intimacy than any sexual medicine.

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### **Body Image After Pregnancy**

Pregnancy, childbirth and breastfeeding alter the body.

Breasts may become larger or change shape.

The abdomen may remain different.

Stretch marks, scars and changes in weight can affect self-confidence.

Some women feel proud of what their body has achieved.

Others struggle with their changed appearance.

Both responses are understandable.



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Recent research identifies body image and psychological wellbeing as important contributors to postpartum sexual function.

Treatment should therefore never focus only on the vagina or hormone levels when the patient is struggling with self-image or confidence.

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### **Postpartum Depression, Anxiety and Sexual Health**

Depression and anxiety can significantly reduce sexual interest and satisfaction.

Postpartum mental-health problems can also affect sleep, self-esteem, relationship communication and perception of physical symptoms.

Conversely, persistent painful intercourse or loss of intimacy may worsen emotional distress.

Mental and sexual health should therefore be considered together.

Seeking psychological support is not an admission that physical symptoms are imaginary.

Physical and emotional problems frequently coexist.

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### **Is Sex Safe During Breastfeeding?**

Breastfeeding itself is **not a reason to avoid sexual activity**.

The important issue is postpartum healing.

There is no single universal date on which every woman should resume intercourse. ACOG notes that many obstetric clinicians recommend waiting approximately six weeks after childbirth, while NHS guidance emphasizes that women can resume sexual activity when they feel physically and emotionally ready.

Women recovering from major tears, episiotomy complications, caesarean complications or infection may need more time.

Intercourse should not be forced simply because six weeks have passed.

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### **Sexual Intimacy Does Not Have to Mean Penetration**

One of the most useful things I tell couples is that intimacy does not need to restart with penetrative intercourse.



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A couple can gradually rebuild closeness through affectionate touch, conversation, kissing, massage and other mutually comfortable forms of intimacy.

If vaginal penetration hurts, continuing despite the pain is usually counterproductive.

Repeated painful intercourse can make the nervous system anticipate pain and cause the pelvic muscles to tighten automatically.

Comfort should come before performance.

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### **Lubricants During Breastfeeding**

For mild vaginal dryness, a suitable personal lubricant can make a substantial difference.

ACOG recommends lubricants as one option for vaginal dryness after pregnancy and during breastfeeding.

Water-based or silicone-based lubricants are commonly used.

Women using latex condoms should avoid products that damage latex, including certain oil-based lubricants.

A lubricant should reduce friction rather than produce burning or irritation.

If a product causes discomfort, it should be stopped.

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### **Vaginal Moisturizers**

A lubricant is mainly used around sexual activity.

A vaginal moisturizer is different: it may be used regularly to help maintain moisture between sexual encounters.

For women with persistent lactation-related dryness, a non-hormonal moisturizer may be considered before hormonal treatment.

The recently published 2026 GSL review recommends a stepped approach beginning with education, gentle vulval care, lubricants and vaginal moisturizers before proceeding to more specialized therapy when necessary.

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### **Local Vaginal Estrogen During Breastfeeding**

Persistent moderate-to-severe dryness sometimes leads to consideration of low-dose vaginal estrogen.



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This requires individualized medical assessment.

The subject deserves careful explanation because patients often hear contradictory statements.

The latest LactMed update from September 2026 notes that estradiol transfer into breast milk depends on the route of administration. Vaginal estradiol can produce measurable milk concentrations, and estrogens can reduce milk supply, particularly when introduced before lactation is well established. A small study using low-dose vaginal estradiol twice weekly did not find interference with milk production, but the overall evidence remains limited.

The newest 2026 review on Genitourinary Syndrome of Lactation considers low-dose vaginal estrogen a reasonable option for persistent moderate-to-severe symptoms after individualized shared decision-making, particularly after lactation is established.

Therefore, I would not advise a breastfeeding woman to start estrogen on her own.

The clinician should consider the severity of symptoms, age of the infant, establishment of milk supply, breastfeeding pattern, maternal medical history and available non-hormonal alternatives.

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### What About Vaginal DHEA or Prasterone?

This is another example where newer treatments used in menopausal women should not automatically be transferred to breastfeeding patients.

The 2026 GSL review specifically notes that **vaginal prasterone currently lacks sufficient lactation-specific safety and effectiveness evidence and cannot be routinely recommended during breastfeeding.**

This is why treatment should be based on evidence rather than online recommendations intended for postmenopausal women.

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### Pelvic-Floor Physiotherapy

Pelvic-floor physiotherapy can be extremely useful when sexual discomfort is related to muscular dysfunction, childbirth injury or scar-related guarding.

A trained therapist may assess muscle strength, resting tension, scar mobility, coordination and pain.

Treatment may involve relaxation exercises, breathing, manual therapy, scar mobilization, gradual desensitization or strengthening depending upon the findings.



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There is no single pelvic-floor exercise suitable for every postpartum woman.

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### When Vaginal Dryness Is Not Caused by Breastfeeding

A woman who is breastfeeding can still develop an unrelated condition.

Possible alternatives include vaginal candidiasis, bacterial vaginosis, vulval dermatitis, lichen sclerosus, urinary infection, sexually transmitted infection, vulvodynia or another inflammatory disorder.

This is particularly important when dryness is accompanied by marked itching, abnormal discharge, unpleasant odour, ulcers, significant bleeding or persistent urinary symptoms.

The latest GSL literature emphasizes ruling out these conditions rather than attributing every problem to lactational hypoestrogenism.

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### Does Breastfeeding Prevent Pregnancy?

Not automatically.

This is one of the most important misconceptions surrounding postpartum sexual health.

Ovulation occurs **before** menstruation.

Therefore, a woman can become fertile before she sees her first postpartum period.

NHS guidance states that pregnancy can occur from approximately **three weeks after childbirth**, including in breastfeeding women whose menstrual periods have not yet returned.

Breastfeeding can suppress ovulation, but it should only be relied upon as contraception when strict criteria are met.

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### Lactational Amenorrhea Method — LAM

Breastfeeding can function as temporary contraception through the **Lactational Amenorrhea Method**, but only under specific circumstances.

In practical terms, LAM requires that the infant is younger than six months, menstrual periods have not returned, and breastfeeding is exclusive or nearly exclusive and frequent, including at night. ACOG describes intervals of no more than roughly four to six hours between feeds as part of the conditions under which pregnancy is unlikely.



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Once feeding becomes less frequent, formula or solids are introduced, night feeds stop, menstruation returns or the baby passes six months of age, another contraceptive method becomes important.

Breastfeeding should never be assumed to provide indefinite contraceptive protection.

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### Contraception During Breastfeeding

A variety of contraceptive methods can be used during lactation.

These include barrier methods, progestin-only methods, implants and intrauterine contraception, depending upon the patient's medical circumstances and postpartum timing.

The 2024 U.S. CDC recommendations permit progestin-only methods and implants during breastfeeding according to postpartum eligibility criteria. Combined estrogen-containing contraception is restricted during the early postpartum period because of blood-clot risk and possible concerns regarding milk supply.

ACOG similarly recommends individualized postpartum contraception counselling rather than assuming that breastfeeding alone will prevent another pregnancy.

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### Breastfeeding, Return of Periods and Fertility

There is tremendous individual variation in when menstruation resumes.

One breastfeeding woman may menstruate after a few months.

Another may remain amenorrhoeic for considerably longer.

Neither pattern by itself proves whether ovulation has or has not occurred.

For women who do not currently want another pregnancy, contraception should therefore be planned.

For women trying to conceive again, the return of ovulation depends partly upon breastfeeding intensity and individual hormonal recovery.

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### Does Breastfeeding Cause Infertility?

No.

Breastfeeding causes **temporary physiological suppression of fertility** in many women; it does not ordinarily cause permanent infertility.

Once breastfeeding becomes less intensive and normal ovarian activity returns, fertility generally returns as well.

If menstrual cycles fail to recover long after breastfeeding has substantially reduced or stopped, or if a couple subsequently experiences infertility, other causes should be investigated.

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### **Sexual Health and Birth Spacing**

Sexual-health counselling during breastfeeding should also include discussion of future pregnancy planning.

The postpartum period is not only about avoiding pregnancy; it is also an opportunity to consider when another pregnancy would be physically and emotionally appropriate.

ACOG recommends discussing reproductive plans, contraception and birth spacing as part of comprehensive postpartum care.

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### **Breastfeeding and Sexually Transmitted Infections**

Breastfeeding does not protect a woman from sexually transmitted infections.

Condoms remain important where STI prevention is required.

Women experiencing new vaginal discharge, genital ulcers, pelvic pain, painful urination or symptoms following a new or potentially risky sexual exposure should receive appropriate testing.

These symptoms should not simply be attributed to breastfeeding hormones.

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### **When Should Sexual Symptoms Be Investigated?**

A temporary change in desire during the first months of motherhood may not require medical treatment.

However, persistent symptoms deserve evaluation when they cause significant distress or interfere with intimacy and quality of life.

A woman should seek appropriate assessment especially if she has severe or persistent pain during intercourse, penetration that has become impossible, recurrent bleeding after intercourse, significant pelvic pain, unusual discharge or odour, genital ulcers, severe dryness despite simple measures, urinary symptoms, a painful episiotomy scar, symptoms of prolapse, significant depression or anxiety, or sexual symptoms that continue well after breastfeeding decreases.

These symptoms may indicate something more than uncomplicated lactation-related hormonal change.

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### **How I Assess Sexual Health During Breastfeeding**

When a breastfeeding woman comes to me with a sexual-health concern, I do not begin by asking only whether she wants a sexual medicine.

I first try to understand what has changed.

I ask about pregnancy and delivery, whether there was an episiotomy or perineal tear, breastfeeding frequency, return of menstruation, vaginal dryness, sexual desire, arousal, pain, orgasm, contraception, urinary symptoms, vaginal symptoms, pelvic-floor complaints, medications, emotional health and relationship factors.

I also ask what sexual function was like before pregnancy.

This distinction is important.

A woman who always had painful intercourse before pregnancy has a different problem from a woman who had completely comfortable intercourse until she started breastfeeding.

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### **Examination and Investigations**

Not every patient requires laboratory testing.

When symptoms are mainly hormonal dryness and the history is typical, assessment may be straightforward.

When there is persistent pain, abnormal discharge, bleeding or another concerning symptom, examination may be necessary.

Depending upon the problem, this can include assessment of the vulva, vaginal tissues, episiotomy scar, pelvic floor and cervix.

Testing for vaginal infection, urinary infection or STI may be required in appropriate situations.

If symptoms suggest an endocrine or other medical disorder, laboratory investigation can be selected accordingly.

The objective is not to order every test.

The objective is to identify the cause.

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## The Emotional and Relationship Side of Breastfeeding Sexuality

Sexual health during lactation cannot be fully understood through hormone measurements.

A woman's life has changed.

She may be adjusting to her identity as a mother.

Her partner may also be adapting to new responsibilities.

Privacy may have disappeared.

Sleep may be fragmented.

The baby may wake exactly when the couple finds time together.

Breastfeeding can sometimes create a very close physical relationship between mother and baby, while the partner may temporarily feel excluded.

None of these issues means the relationship is failing.

Open communication can make a major difference.

Current systematic-review evidence confirms that partner support and relationship circumstances influence sexual wellbeing during breastfeeding.

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## Sexual Desire Does Not Have to Be Spontaneous

Many couples expect desire to appear spontaneously as it may have before pregnancy.

Postpartum sexuality can work differently.

A woman may not initially think about sex but may gradually become interested after relaxation, affectionate touch and emotional connection.

This is sometimes described as **responsive desire**.

It can be entirely normal.

The important distinction is whether the woman feels comfortable and capable of experiencing desire when intimacy develops, or whether she feels persistent distress, pain or complete loss of sexual response that requires assessment.

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## Pressure Makes Sexual Recovery More Difficult

No woman should feel obligated to restart intercourse because a particular number of weeks has passed.



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Likewise, a partner should not interpret temporary reduced desire as rejection without considering postpartum physiology.

Pressure can increase anxiety and pelvic muscular guarding.

A cooperative approach is much more helpful.

The aim should be to rebuild mutually comfortable intimacy rather than to “prove” that sexual function has returned.

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### **Breastfeeding Should Not Have to Compete With Sexual Health**

It is important not to present breastfeeding as the enemy of sexuality.

Breastfeeding has major nutritional and health benefits for infants and important health benefits for mothers.

Recognizing lactation-associated sexual symptoms does not mean discouraging breastfeeding.

The newest 2026 review on Genitourinary Syndrome of Lactation makes exactly this point: recognition of these symptoms is intended to make postpartum care more complete, **not to suggest that breastfeeding is harmful.**

A woman should ideally be supported both in breastfeeding and in maintaining her own comfort, health and sexuality.

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### **The Unani Perspective on Sexual Health During Breastfeeding**

As a physician trained in Unani medicine, I view breastfeeding and the postpartum period as an important stage of maternal recovery.

Classical Unani medicine discusses postnatal care within concepts such as **Tadābīr-e-Wilādat** and **Zamāna-e-Nifās**, with attention to the woman's recovery after childbirth, nutrition, lactation, reproductive health, emotional wellbeing, sleep, digestion and restoration of general strength.

A 2024 review of postnatal care in Unani medicine similarly described the traditional Unani approach as holistic, incorporating maternal hygiene, nutrition, postpartum recovery and management of lactational concerns.

I believe there is value in this whole-patient perspective.

However, traditional concepts must be integrated responsibly with modern medical knowledge.

A woman experiencing vaginal dryness because of lactational hypoestrogenism should have that physiology recognized.

A painful episiotomy scar must be examined.

A vaginal infection should be diagnosed.

Pelvic-floor dysfunction should not simply be labelled as weakness.

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### How Unani Medicine May Be Useful

In appropriately selected women, individualized Unani management can form a supportive part of postpartum and sexual-health care.

The purpose may include supporting general maternal recovery, adequate nutrition, digestive health, sleep and wellbeing; addressing selected postpartum complaints; supporting lactation where a genuine milk-supply problem exists; and approaching associated reproductive-health concerns within the woman's overall constitution and clinical condition.

This is different from claiming that one Unani formulation universally treats low libido or vaginal dryness during breastfeeding.

The patient first needs a correct diagnosis.

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### Unani Medicine and Lactation Research

Unani medicine has a long tradition of discussing insufficient lactation, known as **Qillat-e-Laban**, and maternal postnatal care.

Modern research has begun evaluating some of these traditional approaches.

For example, a recent single-arm interventional study investigated *Foeniculum vulgare* in women with perceived inadequate lactation and reported improvements in measured breastfeeding-related outcomes, although the authors appropriately called for larger randomized trials.

Randomized research has also evaluated traditional Unani galactagogue approaches using herbs such as *Asparagus racemosus* and *Cuminum cyminum* for lactation insufficiency.

There is also clinical research from the National Institute of Unani Medicine examining selected Unani approaches to postpartum perineal wound healing and pain.

These studies demonstrate that postpartum and lactation-related conditions are being scientifically investigated within Unani medicine.



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However, this evidence should not be overstated.

There is currently **insufficient high-quality evidence showing that a particular Unani formulation directly treats breastfeeding-associated female sexual dysfunction or Genitourinary Syndrome of Lactation.**

That is an important distinction.

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### **Herbal Medicines During Breastfeeding Require Special Caution**

Anything taken by a breastfeeding mother deserves additional consideration because some substances can enter breast milk or affect milk production.

The description “natural” does not automatically mean “safe during lactation.”

Herbal medicines may also interact with prescription medicines or be inappropriate for particular medical conditions.

Therefore, Unani or other herbal treatment during breastfeeding should ideally be prescribed after assessment of the mother, the infant's age, breastfeeding pattern, medical history and other medicines being used.

This is particularly important in the early weeks when milk supply is still being established.

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### **My Integrative Approach at Saira Health Care**

At **Saira Health Care**, my approach to sexual-health concerns during breastfeeding begins by identifying the dominant problem rather than assuming every woman needs the same medicine.

One patient may primarily have hormonal vaginal dryness.

Another may have a painful episiotomy scar.

Another may have pelvic-floor overactivity.

Another may have reduced desire related to severe fatigue and postpartum depression.

Another may actually have candidiasis or another vaginal condition.

Another may have no disease at all but needs reassurance that reduced spontaneous libido during intensive breastfeeding is common.

The treatment therefore needs to match the woman.



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Where clinically appropriate, contemporary treatment options such as lubricants, vaginal moisturizers, pelvic-floor physiotherapy, gynecological treatment, contraception counselling or carefully considered local hormonal therapy can be incorporated.

Unani management can then be individualized as supportive care where appropriate.

This is what I consider responsible integrative medicine.

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### **Saira Health Care's Contribution to Sexual and Reproductive Health**

At **Saira Health Care**, our work in the field of **Sexual Disorders & Infertility** includes recognizing that women's sexual health changes across different stages of reproductive life.

Sexual medicine should not begin only when infertility develops or when intercourse becomes impossible.

Pregnancy, childbirth, breastfeeding, postpartum recovery, contraception, menstrual recovery and plans for another pregnancy are all interconnected aspects of reproductive and sexual health.

A breastfeeding woman should be able to discuss reduced desire, vaginal dryness, painful intercourse, orgasmic changes, contraception or fertility without embarrassment.

She should not simply be told:

“You have had a baby; this is normal.”

Some changes are physiological and temporary.

Some require treatment.

The physician's responsibility is to distinguish between them.

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### **Practical Measures That Often Help**

For many breastfeeding women without an underlying disease, sexual comfort can improve considerably with a combination of adequate recovery time, open communication with the partner, longer and unhurried sexual stimulation, a suitable lubricant, vaginal moisturizer when dryness persists, comfortable positions in which the woman controls depth and speed, management of pelvic-floor dysfunction when present, adequate treatment of scar pain or infection, attention to sleep and mental health, and reliable contraception to reduce anxiety about another pregnancy.



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The appropriate combination is different for every woman.

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## **Frequently Asked Questions**

### **Is it normal to have less sexual desire while breastfeeding?**

Yes, reduced sexual desire is common, particularly during intensive breastfeeding and the early postpartum months. Hormonal changes, fatigue, sleep deprivation, body-image changes, pain and relationship circumstances can all contribute.

### **Does low libido mean I no longer love my partner?**

No. Sexual desire and emotional affection are related but not identical. A temporary decrease in libido during postpartum recovery does not necessarily indicate loss of attraction or relationship failure.

### **Why is my vagina dry while breastfeeding?**

Breastfeeding can keep estrogen relatively low, particularly while menstruation remains suppressed. Lower estrogen can reduce vaginal lubrication and contribute to dryness and irritation.

### **How common is vaginal dryness?**

A 2025 systematic review estimated vaginal dryness in approximately 54% of the lactating postpartum women represented in the included studies.

### **Can breastfeeding cause painful intercourse?**

Breastfeeding-related vaginal dryness may contribute to painful intercourse, but childbirth injuries, episiotomy scars, pelvic-floor dysfunction, infection and other conditions can also cause pain.

### **Is intercourse harmful to breast milk?**

Normal consensual sexual activity does not make breast milk harmful or unsuitable for the baby.

### **Why does breast milk leak during sex?**

Oxytocin participates in milk ejection and sexual response. Some breastfeeding women therefore notice temporary milk leakage during sexual arousal or orgasm. This is a recognized physiological response.

### **Do I have to wait six weeks before having sex?**

There is no single compulsory date for every woman. Many clinicians recommend roughly six weeks, but healing and personal readiness are more important. Women with tears, wound complications or significant pain may need longer.

### **Can I become pregnant while breastfeeding?**

Yes. Ovulation may return before the first period, and pregnancy can occur even while breastfeeding.

### **When is breastfeeding reliable contraception?**

LAM is only appropriate when the baby is younger than six months, menstruation has not returned and breastfeeding is exclusive or nearly exclusive and sufficiently frequent. Once these criteria change, another method should be used.

### **Can I use lubricant while breastfeeding?**

Yes. A suitable lubricant is commonly recommended for lactation-related vaginal dryness.

### **Can I use vaginal estrogen?**

Low-dose vaginal estrogen may be considered for persistent significant symptoms after individualized medical discussion. Evidence during breastfeeding remains limited, and estrogen can sometimes influence milk supply, especially when used before lactation is established. It should therefore not be started without professional advice.

### **Will sexual desire return after breastfeeding?**

For many women sexual function gradually improves as postpartum recovery progresses, sleep improves, breastfeeding frequency decreases and ovarian hormones normalize. There is, however, no identical timetable for every woman.

### **Do I need hormone tests for low libido?**

Usually not automatically. The clinical history often explains early postpartum changes. Hormonal or other laboratory testing may be considered when symptoms are unusually severe, persist beyond the expected postpartum period or are accompanied by menstrual, thyroid or other endocrine symptoms.

### **Can Unani medicine help?**

Unani medicine can have a supportive role within individualized postpartum care, particularly through attention to general recovery, nutrition, wellbeing, lactational health and associated reproductive concerns. Direct high-quality evidence for Unani treatment of breastfeeding-associated sexual dysfunction remains limited, so treatment should complement rather than replace appropriate gynecological and sexual-health assessment.

## **A Message From Dr. Nizamuddin Qasmi**

When a breastfeeding woman tells me:

“Doctor, since delivery I am not the same sexually,”

I want her to know that this does not automatically mean that something has permanently gone wrong.

Her body is doing extraordinary biological work.

It has passed through pregnancy and childbirth.

It is producing milk.

Hormonal pathways have changed.

Sleep has changed.

Her relationship with her own body has changed.

The amount of physical contact she experiences every day has changed.

Her responsibilities have changed.

It would actually be surprising if sexuality always remained completely unchanged through all of this.

But I also do not believe every sexual problem should simply be dismissed as “because you are breastfeeding.”

Persistent pain deserves examination.

Severe vaginal dryness deserves treatment.

A painful scar deserves attention.

Pelvic-floor dysfunction deserves therapy.

Depression deserves support.

A woman worried about another pregnancy deserves reliable contraception.

And a couple struggling with intimacy deserves clear information rather than shame.

My clinical philosophy is therefore:

**Respect breastfeeding, respect postpartum physiology, but also respect the woman's sexual health.**

She should not have to sacrifice one for the other.



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## Latest Medical Understanding

The medical understanding of this subject is evolving rapidly.

In 2024, sexual-medicine researchers proposed the term **Genitourinary Syndrome of Lactation** to draw attention to vulvovaginal, urinary and sexual symptoms associated with the low-estrogen environment of breastfeeding.

A large 2025 systematic review then quantified how frequently dryness, vaginal atrophy and dyspareunia occur among lactating postpartum populations.

A 2026 systematic review further demonstrated that breastfeeding-associated sexual function is influenced not only by hormones but also by psychological wellbeing, body image, partner support and social circumstances.

Most recently, a 2026 clinical review emphasized a stepped approach to possible GSL: education and appropriate vulval care first, followed by lubricants and vaginal moisturizers, pelvic-floor physiotherapy and sexual counselling where indicated, with low-dose vaginal estrogen considered selectively after shared decision-making when more conservative treatment is insufficient.

This increasingly sophisticated understanding moves postpartum sexual health away from the old advice to simply “wait until breastfeeding finishes.”

Women deserve assessment and treatment while they are breastfeeding.

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## Conclusion

**Sexual health during breastfeeding is an important part of postpartum healthcare.**

Breastfeeding can temporarily alter the hormonal environment through increased prolactin and reduced ovarian estrogen activity. These changes can contribute to vaginal dryness, reduced lubrication, decreased sexual desire and painful intercourse.

At the same time, childbirth itself may cause episiotomy or tear pain, pelvic-floor dysfunction, scar tenderness and other physical problems. Sleep deprivation, body-image changes, postpartum depression, anxiety, partner support and the practical demands of caring for an infant further influence sexual function.

Current research shows that these problems are common.

The emerging concept of **Genitourinary Syndrome of Lactation** is helping clinicians recognize the vulvovaginal, urinary and sexual symptoms some breastfeeding women experience. However, GSL should not become an explanation for every postpartum



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symptom; infections, pelvic-floor disorders, scar pain, dermatological disease and other conditions must still be considered.

Treatment should therefore be individualized.

For one woman, reassurance and lubricant may be sufficient.

Another may require pelvic-floor physiotherapy.

Another may need treatment of an episiotomy scar.

Another may benefit from carefully considered low-dose vaginal estrogen after medical assessment.

Another may primarily need treatment for postpartum depression or sexual counselling.

From the Unani perspective, the postpartum and lactation period can be approached holistically, with attention to maternal recovery, nutrition, lactation, reproductive wellbeing, digestion, sleep and general health. Research continues to evaluate traditional Unani interventions for postpartum and lactational conditions, but evidence specifically for breastfeeding-related sexual dysfunction remains limited. Therefore, I consider Unani medicine most responsibly used as part of an **integrative, diagnosis-based treatment plan**.

At **Saira Health Care**, our objective is not simply to restore intercourse as quickly as possible after childbirth.

Our objective is to help the woman regain **comfortable, healthy and confident sexual and reproductive wellbeing while respecting both motherhood and breastfeeding**.

Breastfeeding and a satisfying intimate life are not mutually exclusive.

With understanding, communication, appropriate treatment and time, many women experience substantial improvement as their postpartum recovery progresses.

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## About the Author

**Dr. Nizamuddin Qasmi**

**Founder & Chief Physician, Saira Health Care**  
**Focused Practice in Sexual Disorders & Infertility**

**Qualifications & Professional Training**

**BUMS — Hamdard University, Delhi**

**MD**

**CGO**

**Certificate in Infertility — MGBIMS, Delhi**



**+91-9452580944**



**+91-5248-359480**



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## **Certificate in Urology — London, UK**

### **Masters in Male Infertility — MasterHealthPro (HealthPro)**

### **Integrated Sexual and Reproductive Health (ISRH) — UNFPA**

Dr. Nizamuddin Qasmi's clinical work at **Saira Health Care** focuses on sexual disorders, reproductive-health concerns and infertility. His approach emphasizes detailed assessment of sexual and reproductive symptoms, responsible integration of Unani medicine with contemporary clinical evaluation, and individualized care rather than treating sexual-health concerns with a single standard formula.

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### **Medical Disclaimer**

This article is intended for health education and general public awareness. It does not establish an individual diagnosis and does not replace consultation, examination or treatment by an appropriately qualified healthcare professional.

Sexual-health symptoms during breastfeeding may arise from hormonal changes, childbirth injury, pelvic-floor dysfunction, infection, medications, psychological factors or other gynecological conditions.

Breastfeeding women should consult an appropriately qualified clinician before using hormonal medicines, prescription sexual-health treatments or herbal/Unani preparations because treatment may need to consider both the mother's condition and lactation.

Seek prompt medical care for severe pelvic or abdominal pain, high fever, heavy or unexplained bleeding, foul-smelling discharge, wound infection or breakdown, severe genital swelling, significant urinary difficulty, or other rapidly worsening postpartum symptoms.



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