

Postpartum Painful Intercourse

Understanding Dyspareunia After Childbirth: Causes, Assessment, Treatment and an Integrative Unani Approach

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Pain during sexual intercourse after childbirth is much more common than many women expect.

A woman may tell me:

“Doctor, my delivery was several months ago, but intercourse still hurts.”

Another may say:

“I feel completely healed, but penetration causes burning.”

Some women experience pain precisely over an episiotomy or tear scar. Others describe vaginal dryness, tightening at the vaginal entrance, deep pelvic pain or fear that intercourse will reopen their stitches.

Many remain silent because they assume that pain is a normal price of childbirth.

My first message to such patients is very important:

Painful intercourse after childbirth is common, but persistent pain should not simply be accepted or silently tolerated.

The medical term for painful sexual intercourse is **dyspareunia**. When it develops or persists after childbirth, it is generally called **postpartum dyspareunia**.

The World Health Organization has highlighted the substantial long-term burden of postpartum health problems. Its review of global evidence reported pain during sexual intercourse in approximately **35% of postpartum women**, although frequency varies considerably according to timing after delivery, breastfeeding status, perineal injury, study population and how pain is measured.

More recent research has reinforced how common this problem can be. A 2025 systematic review focusing on lactating postpartum women estimated dyspareunia prevalence at approximately **60% at three months, 40% at six months and 29% at twelve months postpartum** in the studies analyzed. These figures should not be interpreted as applying to every woman, but they demonstrate that postpartum sexual pain deserves much more clinical attention than it traditionally receives.



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At **Saira Health Care**, I consider postpartum painful intercourse as part of the woman's broader **sexual, pelvic and reproductive health**, rather than simply telling her to “wait a little longer.”

The correct question is:

Why is intercourse painful in this particular woman?

Once we understand the cause, treatment becomes much more rational.

What Is Postpartum Dyspareunia?

Postpartum dyspareunia means persistent or recurrent pain before, during or after sexual intercourse following childbirth.

The pain may occur:

- at the vaginal entrance,
- over an episiotomy scar,
- around a repaired tear,
- inside the vagina,
- deep within the pelvis,
- around the vulva,
- in the perineum,
- after intercourse has finished.

The discomfort may feel like:

- burning,
- stinging,
- stretching,
- tearing,
- tightness,
- pressure,
- soreness,
- sharp pain,
- deep aching,



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- throbbing after intercourse.

The pattern of pain provides important diagnostic information.

Superficial and Deep Dyspareunia

Clinically, it is useful to distinguish **superficial pain** from **deep pain**.

Superficial or Entry Pain

Pain occurs around the vulva, vaginal opening or perineal area as penetration begins.

Common causes include:

- vaginal dryness,
- episiotomy scar,
- scar tenderness,
- repaired perineal tear,
- granulation tissue,
- pelvic-floor muscle tightening,
- vulval irritation,
- infection,
- fear-related involuntary muscle contraction.

Deep Dyspareunia

Pain is felt deeper in the vagina or pelvis during deeper penetration.

Potential causes include:

- pelvic-floor muscle dysfunction,
- pelvic inflammation,
- endometriosis,
- ovarian or uterine disorders,
- pelvic infection,
- pelvic organ prolapse,
- musculoskeletal pain,
- other gynecological conditions.



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The distinction is important because an external scar problem and deep pelvic pain require very different management.

Is Painful Intercourse Normal After Delivery?

Some tenderness during the early postpartum period is expected.

The tissues need time to heal after pregnancy and childbirth.

However, persistent or severe pain should not automatically be considered “normal.”

WHO specifically recommends that health professionals ask postpartum women about perineal pain, wound healing and dyspareunia and assess the perineum when concerns exist.

ACOG likewise recognizes sexuality and the management of dyspareunia as important components of comprehensive postpartum care.

So if sexual intercourse remains painful, the correct approach is not embarrassment or endurance.

It is assessment.

When Can Sexual Intercourse Be Resumed After Childbirth?

There is no single compulsory date that applies to every woman.

ACOG notes that there is no fixed time when every couple must resume sex, although many obstetricians traditionally recommend waiting approximately six weeks after childbirth.

The more practical rule is that a woman should be:

- physically healing appropriately,
- no longer experiencing significant postpartum bleeding,
- free from wound infection,
- emotionally ready,
- comfortable with the idea of intercourse.

A woman with a major perineal tear, difficult episiotomy repair, caesarean complications or persistent pain may need longer.

There should never be pressure to restart penetrative intercourse simply because six weeks have passed.



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The NHS similarly advises that there is no universal rule and that intercourse should not be rushed if it is painful.

Why Does Intercourse Hurt After Childbirth?

Postpartum dyspareunia usually results from one or more of several interacting factors.

These include:

1. perineal tears,
2. episiotomy,
3. scar tenderness,
4. vaginal dryness,
5. breastfeeding-related low estrogen,
6. granulation tissue,
7. pelvic-floor muscle dysfunction,
8. birth-related pelvic injury,
9. infection or impaired wound healing,
10. psychological fear or birth trauma,
11. vulvovaginal disease,
12. underlying pelvic disorders.

Very often, more than one factor is present.

1. Perineal Tears

During vaginal childbirth, the tissues between the vaginal opening and anus—the **perineum**—must stretch substantially.

Some women develop a spontaneous tear.

Tears are generally classified according to depth.

Minor tears involve superficial tissues.

More severe tears may extend into deeper perineal muscles or the anal sphincter.

Even after the tear has technically healed, the tissue may remain:

- sensitive,



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- stiff,
- tight,
- tender,
- painful when stretched.

This can make penetration uncomfortable.

A 2026 systematic review of women who experienced obstetric anal sphincter injury found increased rates of postpartum dyspareunia compared with women without this degree of birth trauma, although the researchers emphasized that the certainty of evidence remains limited because the available studies are heterogeneous.

2. Episiotomy

An **episiotomy** is a surgical incision made in the perineum during certain vaginal deliveries.

After repair, scar tissue develops as part of normal healing.

For most women the scar gradually becomes flexible and relatively painless.

In some, however, scar tissue remains:

- thick,
- rigid,
- hypersensitive,
- tight,
- painful during stretching.

ACOG specifically recognizes that women who have had episiotomy or perineal tears may experience painful intercourse for several months and may benefit from treatments such as physical therapy or other targeted interventions.

A clinical study examining women with postpartum dyspareunia also identified episiotomy as an important risk factor for scar tenderness.

3. Painful Scar Tissue

Scar tissue is not identical to the original flexible vaginal or perineal tissue.

During intercourse, the scar is stretched.



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If the scar is:

- contracted,
- poorly aligned,
- adherent,
- highly sensitive,
- associated with local nerve irritation,

penetration may feel as though the area is “tearing again.”

Some women can identify one exact painful point at the vaginal opening.

A focused examination is very useful because this type of pain may be treatable.

4. Postpartum Granulation Tissue

Sometimes healing tissue continues to remain red, fragile and sensitive after a tear or episiotomy.

This is called **postpartum granulation tissue**.

It can cause:

- persistent local pain,
- spotting,
- bleeding after intercourse,
- discharge,
- pain on penetration.

A 2025 study of postpartum granulation tissue found that the condition often presented after the routine six-week postpartum period and could require conservative treatment, silver nitrate or excision depending on severity. Importantly, some women continued experiencing pain even after visible granulation tissue had resolved, showing that more than one pain mechanism may coexist.

If a woman has one very sensitive or easily bleeding area around an episiotomy scar, granulation tissue should be considered.

5. Breastfeeding and Low Estrogen



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One of the most important and frequently overlooked causes of postpartum painful intercourse is **breastfeeding-related hormonal change**.

During breastfeeding, prolactin levels remain elevated.

This suppresses ovarian activity in many women and can reduce estrogen levels.

Lower estrogen may lead to:

- decreased vaginal lubrication,
- thinner vaginal tissues,
- dryness,
- irritation,
- burning,
- discomfort during penetration.

ACOG specifically notes that vaginal dryness is common after pregnancy, particularly during breastfeeding, and states that lubricants and local estrogen therapy can be used when appropriate.

Genitourinary Syndrome of Lactation

The effect of lactation on the vagina and urinary tract has received increasing scientific attention.

A 2025 systematic review examined what researchers have termed **genitourinary syndrome of lactation**.

Among postpartum breastfeeding women included in the studies, vaginal dryness was estimated in approximately **54%** and vaginal atrophy-related findings in approximately **64%**.

The same review found high rates of dyspareunia and sexual dysfunction during lactation.

These results help explain why a woman whose delivery wound has healed perfectly can still experience significant painful intercourse while breastfeeding.

It is not necessarily a scar problem.

Sometimes the vaginal tissue itself has temporarily become dry and less elastic because of hormonal changes.



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6. Inadequate Lubrication

Natural vaginal lubrication depends on several factors:

- estrogen,
- sexual arousal,
- emotional relaxation,
- adequate stimulation,
- absence of pain and anxiety.

After childbirth, several of these factors can change simultaneously.

A woman may be:

- breastfeeding,
- sleep deprived,
- anxious about pain,
- caring for a newborn,
- experiencing reduced desire,
- rushing intercourse because of limited privacy.

This can reduce lubrication further.

Then friction causes pain.

Pain reduces arousal.

Reduced arousal causes still less lubrication.

A cycle develops.

7. Pelvic-Floor Muscle Overactivity

The pelvic-floor muscles surround and support the vagina, bladder and rectum.

Pregnancy and childbirth can change these muscles substantially.

Many people assume that childbirth only makes the pelvic floor “weak.”

That is incomplete.

Some women develop **excessive pelvic-floor tension or muscle spasm**.

The muscles around the vaginal opening may tighten during attempted penetration.



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This can cause:

- pain at entry,
- deep muscular aching,
- sensation of blockage,
- burning,
- pain after intercourse.

If a woman repeatedly expects intercourse to hurt, the muscles may contract defensively before penetration even begins.

This is a genuine physical response—not something the woman is consciously choosing.

Weak Pelvic Floor Versus Tight Pelvic Floor

These conditions should not be confused.

A weak pelvic floor may contribute to:

- urinary leakage,
- pelvic organ prolapse,
- poor support.

An overactive pelvic floor may contribute to:

- painful intercourse,
- difficulty relaxing during penetration,
- pelvic pain,
- difficulty with bowel movements.

A woman can sometimes have weakness in some muscles and excessive tension in others.

This is why simply advising every postpartum woman with sexual pain to perform more Kegel exercises is not always appropriate.

The muscles first need to be assessed.

8. Obstetric Anal Sphincter Injury



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Third- and fourth-degree tears involve the anal sphincter and represent more substantial perineal trauma.

These injuries can affect:

- pelvic-floor function,
- bowel control,
- body confidence,
- sexual function,
- pain during intercourse.

A 2024 systematic review reported dyspareunia rates of approximately 27–35% during the first year among women studied after obstetric anal sphincter injuries.

Women with these injuries deserve proactive follow-up rather than being expected to mention sexual difficulties themselves.

9. Wound Infection or Delayed Healing

Pain following childbirth can occasionally result from:

- wound infection,
- breakdown of stitches,
- delayed healing,
- abscess,
- abnormal granulation tissue.

Warning signs include:

- increasing pain rather than gradual improvement,
- redness,
- swelling,
- offensive discharge,
- wound opening,
- fever,
- persistent bleeding.



ACOG advises women to contact a healthcare professional when episiotomy or tear pain persists or worsens or when redness or discharge is present.

Infection should be treated before attempting to solve the problem as a sexual dysfunction.

10. Vaginal or Vulval Infection

Sometimes postpartum dyspareunia has nothing directly to do with the birth injury.

Conditions such as:

- candidiasis,
- bacterial vaginosis,
- urinary infection,
- sexually transmitted infection,
- vulvovaginal inflammation

may produce pain or burning during intercourse.

Discharge, itching, odour or urinary symptoms can provide important clues.

Repeated self-treatment should be avoided because vaginal dryness, scar pain and infection can produce overlapping symptoms.

11. Vaginismus and Genito-Pelvic Pain

After one or more painful attempts at intercourse, some women develop a strong protective response.

When penetration is attempted, pelvic muscles tighten automatically.

This may be accompanied by:

- fear,
- anticipation of pain,
- involuntary closing or tightening,
- avoidance of penetration.

ACOG recognizes vaginismus and childbirth-related injury among important causes of painful sex.



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The condition should never be interpreted as a woman “refusing to relax.”

It involves an involuntary interaction between the pelvic muscles and nervous system.

12. Fear After a Difficult Birth

Childbirth can sometimes be physically and emotionally traumatic.

A woman may remember:

- severe labour pain,
- emergency intervention,
- instrumental delivery,
- major tearing,
- emergency caesarean,
- frightening bleeding,
- painful stitching.

Later, attempted intercourse may trigger fear of injury or another pregnancy.

The body may respond with muscle tightening.

This is one reason postpartum sexual care cannot be limited to examining only the vaginal scar.

13. Fatigue, Sleep Deprivation and Reduced Desire

Caring for a newborn can fundamentally change sexual life.

A woman may be:

- physically exhausted,
- breastfeeding during the night,
- recovering from surgery,
- emotionally overwhelmed,
- worried about the baby,
- adapting to major changes in body image.

Reduced sexual desire during this period is common.



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ACOG notes that pregnancy, breastfeeding, inadequate sleep and relationship factors can all influence arousal and sexual function.

If desire and arousal are reduced, vaginal lubrication also tends to decrease, which may contribute to painful intercourse.

14. Postpartum Depression and Anxiety

Mental health and sexual health are closely connected.

Postpartum depression or anxiety can affect:

- sexual desire,
- arousal,
- body confidence,
- relationship intimacy,
- pain perception.

Conversely, chronic painful intercourse may itself produce frustration, guilt, sadness and relationship difficulty.

The condition should therefore be approached sensitively from both physical and emotional perspectives.

15. Caesarean Delivery Does Not Completely Prevent Dyspareunia

Some women believe:

“I had a caesarean section, so childbirth cannot be responsible for painful intercourse.”

This is not always correct.

A caesarean delivery avoids some forms of perineal injury, but pregnancy itself still affects:

- pelvic-floor muscles,
- hormones,
- abdominal muscles,
- pelvic tissues.

Breastfeeding can still cause vaginal dryness.

Pain, fatigue, fear, low desire and hormonal changes can occur regardless of the route of delivery.

Persistent deep pain after caesarean delivery also requires assessment for other pelvic or abdominal causes.

16. Endometriosis and Other Pelvic Disorders

Not every episode of postpartum dyspareunia is directly caused by childbirth.

Other possible causes of deep painful intercourse include:

- endometriosis,
- ovarian cysts,
- pelvic inflammatory disease,
- uterine disorders,
- bladder pain syndrome,
- pelvic adhesions,
- pelvic organ prolapse.

If pain is deep, severe or associated with other pelvic symptoms, these possibilities may require investigation.

The Importance of Pain Location

When I assess a patient, I frequently ask:

“Can you point with one finger to where it hurts?”

This simple question can be surprisingly useful.

Pain exactly on an episiotomy scar suggests one group of causes.

Burning around the entire vaginal entrance suggests another.

Deep pelvic pain during thrusting suggests another.

Pain only after intercourse suggests yet another mechanism.

The more accurately the pain is described, the more targeted the treatment can become.



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Risk Factors for Postpartum Dyspareunia

Research indicates that important risk signals include:

- perineal trauma,
- episiotomy,
- severe tear,
- significant early postpartum pain,
- breastfeeding-related hormonal changes,
- vaginal dryness,
- pelvic-floor dysfunction,
- wound complications.

A 2025 systematic review examining postpartum sexual dysfunction found **perineal trauma and early pain** to be among the most consistent risk factors, while breastfeeding-related symptoms and psychosocial factors also influenced postpartum sexual recovery.

How I Assess Postpartum Painful Intercourse

The first step is not to prescribe a painkiller.

The first step is to understand **why intercourse hurts**.

I usually begin with a detailed history.

Questions About Delivery

I ask:

- Was delivery vaginal or caesarean?
- Was vacuum or forceps assistance used?
- Was an episiotomy performed?
- Was there a tear?
- What degree was the tear?
- Were stitches required?
- Was there wound infection?



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- Did the wound reopen?
- Was healing prolonged?

These details provide important clues.

Questions About the Pain

I ask:

- Is pain at the entrance or deep inside?
 - Is there burning?
 - Does the scar hurt?
 - Does pain begin immediately on penetration?
 - Does it worsen with deeper penetration?
 - Does pain continue afterward?
 - Is there bleeding afterward?
 - Is there one specific tender spot?
-

Breastfeeding History

Because breastfeeding may lower estrogen, I ask:

- Is the mother exclusively breastfeeding?
- Have periods returned?
- Is there vaginal dryness?
- Does the vagina feel dry even outside intercourse?
- Has lubrication decreased compared with before pregnancy?

These questions can identify an important hormonal component.

Sexual Function Before Pregnancy

It is useful to know whether intercourse was painful before pregnancy.

If dyspareunia was present before childbirth, conditions such as:

- endometriosis,



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- vaginismus,
- pelvic-floor dysfunction,
- vulvodynia

may already have existed.

Childbirth may have changed rather than created the problem.

Physical Examination

A careful examination may assess:

- vulval skin,
- vaginal entrance,
- perineum,
- episiotomy scar,
- repaired tears,
- granulation tissue,
- infection,
- pelvic-floor muscle tenderness,
- vaginal dryness,
- pelvic organ support.

The examination should be gentle and should stop if the woman is significantly uncomfortable.

No patient with sexual pain should feel forced through a painful examination.

Scar Assessment

I look for:

- scar tenderness,
- tissue tightness,
- abnormal alignment,
- granulation tissue,



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- persistent inflammation,
- wound separation.

A scar problem can often be distinguished from generalized pelvic-floor pain.

Pelvic-Floor Assessment

Where appropriate, pelvic-floor assessment helps determine whether the muscles are:

- weak,
- excessively tense,
- tender,
- poorly coordinated.

This information is important because treatment differs substantially.

Vaginal and Cervical Tests

When symptoms suggest infection, investigations may include:

- vaginal swab,
- fungal testing,
- bacterial testing,
- STI testing.

This prevents unnecessary treatment when the actual problem is hormonal dryness or scar tenderness.

Pelvic Ultrasound

Ultrasound is not required in every woman with postpartum painful intercourse.

It may become useful when there is:

- persistent deep pelvic pain,
- abnormal bleeding,
- suspected ovarian pathology,
- uterine abnormality,



- other concerning findings.

Investigation should be guided by clinical findings rather than ordered automatically.

Treatment Must Be Based on the Cause

There is no one treatment for postpartum dyspareunia.

The best treatment for vaginal dryness will not correct a painful scar.

Pelvic-floor physiotherapy will not eliminate infected granulation tissue.

Surgery is unnecessary for a woman whose principal problem is breastfeeding-related dryness.

For this reason, a **targeted approach** is essential.

A clinical study specifically examining postpartum dyspareunia found significant improvement when women were classified according to the likely cause and treated accordingly.

Lubricants

For dryness or mild friction-related discomfort, lubricant is often one of the simplest interventions.

A good lubricant can reduce friction and improve comfort.

ACOG recommends lubricants as an option for postpartum vaginal dryness.

Women should select products that do not cause irritation and should stop using any lubricant that produces burning or allergy.

Vaginal Moisturizers

Moisturizers differ from lubricants.

Lubricants are mainly used around sexual activity.

Vaginal moisturizers may be used more regularly to improve ongoing dryness in selected women.

The appropriate product depends on the woman's symptoms and sensitivity.

Local Vaginal Estrogen



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When breastfeeding-related low estrogen causes significant vaginal dryness or atrophy, local vaginal estrogen may sometimes be considered.

ACOG includes local estrogen among treatment options for postpartum vaginal dryness.

However, especially during breastfeeding, the decision should be individualized with the woman's obstetrician or gynecologist after considering:

- symptom severity,
- breastfeeding,
- medical history,
- contraindications,
- alternative treatments.

Women should not start hormonal treatment on their own.

Pelvic-Floor Physiotherapy

Pelvic-floor physiotherapy can be extremely valuable when muscle dysfunction contributes to pain.

Treatment may include:

- muscle relaxation,
- breathing exercises,
- manual therapy,
- myofascial release,
- scar mobilization,
- gradual desensitization,
- pelvic coordination exercises,
- appropriate strengthening where weakness is present.

The treatment should be individualized.

Again, **more Kegel exercises are not automatically the answer.**

If the muscles are already overactive, relaxation may be more important than strengthening.



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Scar Mobilization

Once the wound has fully healed and a clinician confirms that it is safe, gentle scar mobilization or perineal massage may help selected women with stiff scar tissue.

The goal is gradually to improve:

- scar flexibility,
- tissue mobility,
- sensitivity,
- comfort during stretching.

This should not be performed over:

- an open wound,
 - active infection,
 - active bleeding,
 - unresolved granulation tissue.
-

Treatment of Granulation Tissue

Persistent granulation tissue should be examined by an appropriate clinician.

Depending on its size, location and symptoms, treatment may involve:

- observation,
- local treatment such as silver nitrate,
- surgical excision in selected cases.

The 2025 study on postpartum granulation tissue demonstrates that treatment may need to be individualized and that persistent pain deserves additional assessment even after visible tissue has resolved.

Pain Medication

Analgesic or anti-inflammatory medication may be appropriate in some situations, particularly in the earlier postpartum period.

ACOG notes that ibuprofen and acetaminophen are commonly compatible with breastfeeding when appropriately used.

However, chronic dyspareunia should not simply be managed by taking painkillers before intercourse.

The cause should be identified.

Gradual Return to Sexual Activity

Intercourse should not become an examination that a woman must “pass.”

A gradual approach may include:

- affectionate touch,
- non-penetrative intimacy,
- relaxation,
- adequate sexual stimulation,
- external touch,
- gentle self-exploration,
- eventual gradual penetration when comfortable.

Pain should not be pushed through.

Repeated painful intercourse can teach the nervous system to expect pain and may worsen pelvic-floor guarding.

Sexual Positions

Some positions allow the woman greater control over:

- depth,
- speed,
- angle of penetration.

This may improve comfort when intercourse is resumed.

The best position is simply the one that does not provoke pain.

There is no medically superior sexual position for every postpartum woman.



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Psychological and Sex Therapy

When fear of pain, traumatic birth memories or relationship stress become part of the problem, psychological or psychosexual therapy may be beneficial.

This should not be interpreted as saying that pain is “all in the mind.”

A woman can simultaneously have:

- a physical injury,
- pelvic-floor tension,
- fear of reinjury.

Treating all components is often more successful than treating only one.

When Surgery May Be Necessary

Surgery is rarely the first treatment for postpartum dyspareunia.

However, a minority of women develop significant anatomical distortion or severe scar problems following perineal repair.

Specialist assessment may sometimes lead to consideration of scar revision or perineoplasty.

The decision requires careful examination because many women can improve without another operation.

Should a Woman Force Herself to Have Intercourse?

No.

A postpartum woman should never feel that she must tolerate painful penetration because her partner expects intercourse or because a certain number of weeks has passed.

Pain is information from the body.

It should be understood, not ignored.

Non-penetrative intimacy can continue while treatment and healing take place.

Does Painful Intercourse Mean the Stitches Will Open?



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Once a tear or episiotomy has fully healed, normal intercourse should not ordinarily reopen a properly healed wound.

However, if there is:

- wound breakdown,
- active infection,
- unhealed tissue,
- granulation tissue,

intercourse may be painful and should generally be postponed until the area has been assessed.

Fear of stitches opening is very common and should be discussed openly with the clinician.

Is Postpartum Painful Intercourse Permanent?

Usually not.

For many women, symptoms improve gradually as:

- tissues heal,
- estrogen levels change,
- breastfeeding frequency decreases,
- sleep improves,
- pelvic-floor function recovers,
- scar tissue becomes more flexible.

However, persistent symptoms deserve treatment rather than waiting indefinitely.

The 2025 lactation review found that dyspareunia generally declined with increasing time postpartum, although a substantial group still reported pain at 12 months.

Postpartum Dyspareunia and Fertility

Pain during intercourse does not usually mean that a woman has become infertile.

However, severe dyspareunia can make intercourse difficult or impossible and can therefore indirectly affect the couple's ability to conceive.



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If deep pelvic pain is caused by another disorder such as endometriosis or pelvic inflammatory disease, that underlying condition may have separate fertility implications.

Evaluation is therefore appropriate when painful intercourse occurs together with infertility.

Pregnancy Can Occur Before Periods Return

A very important postpartum point is that absence of menstruation does not always mean pregnancy is impossible.

The NHS notes that pregnancy can occur as early as approximately three weeks after childbirth, even before the first menstrual period and even during breastfeeding.

Contraception should therefore be discussed whenever sexual intercourse is resumed and another pregnancy is not currently desired.

A Unani Perspective on Postpartum Painful Intercourse

As a physician trained in Unani medicine, I consider postpartum recovery as a period in which the woman's body is undergoing major physical, hormonal and functional changes.

Traditional Unani medicine gives importance to:

- restoration after childbirth,
- reproductive-organ health,
- pelvic and uterine wellbeing,
- inflammatory conditions,
- general strength,
- nutrition,
- sleep,
- digestive function,
- emotional wellbeing,
- constitutional balance.

This whole-person approach can be valuable during postpartum recovery.



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However, modern diagnosis remains essential.

A painful episiotomy scar should be identified.

Granulation tissue should be examined.

Infection should be treated.

Pelvic-floor dysfunction should be recognized.

Severe vaginal dryness during lactation should not simply be described as “general weakness.”

How Unani Medicine May Support Postpartum Recovery

After appropriate medical assessment, individualized Unani management may have a supportive role in:

- improving general postpartum wellbeing,
- supporting recovery after childbirth,
- addressing associated digestive disturbances,
- supporting sleep and nutritional recovery,
- managing selected inflammatory complaints,
- improving overall reproductive health,
- assisting with associated sexual-health concerns.

At Saira Health Care, I prefer to integrate these principles with appropriate contemporary evaluation rather than using one standard herbal medicine for every woman with dyspareunia.

What Does Research Say About Unani Treatment for Postpartum Dyspareunia?

It is important to be scientifically transparent.

At present, high-quality controlled clinical research specifically evaluating **Unani treatment for postpartum dyspareunia** is very limited.

There is clinical research within Unani gynecology in areas such as vaginal disorders, menstrual pain, urinary symptoms and other women's health conditions, demonstrating growing scientific evaluation of traditional interventions. For example, randomized Unani studies have been published in conditions such as vulvovaginal candidiasis and female pelvic/urinary disorders.

However, these studies should **not** be interpreted as direct proof that the same approaches treat postpartum dyspareunia.

The most responsible approach is therefore:

diagnose the cause using appropriate modern clinical assessment, then integrate Unani supportive care where suitable.

This protects the patient from both undertreatment and unnecessary treatment.

My Approach at Saira Health Care

At **Saira Health Care**, I do not consider postpartum painful intercourse to be simply a matter of “sexual weakness.”

My assessment considers the complete clinical picture.

Depending on the patient, I evaluate:

- childbirth history,
- episiotomy and tear history,
- scar tenderness,
- wound healing,
- breastfeeding,
- vaginal dryness,
- pelvic-floor function,
- vulvovaginal symptoms,
- deep pelvic pain,
- libido and arousal,
- emotional health,
- fear of penetration,
- fertility concerns,
- relationship factors.

Where required, I advise appropriate gynecological examination, investigation, pelvic-floor physiotherapy or referral.



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Unani management can then be individualized as one component of broader care when clinically appropriate.

Saira Health Care's Contribution to Sexual and Reproductive Health

Postpartum sexual health remains an area where many women suffer silently.

During pregnancy, clinical attention is naturally concentrated on the mother and developing baby.

During labour, attention focuses on safe delivery.

After delivery, much of the attention shifts toward the newborn.

The woman's sexual recovery can therefore be overlooked.

At Saira Health Care, our work in **Sexual Disorders & Infertility** recognizes that postpartum recovery includes more than the absence of a medical emergency.

A woman should also be able to discuss:

- sexual pain,
- vaginal dryness,
- reduced desire,
- fear of intimacy,
- difficulty resuming intercourse,
- fertility concerns,
- contraception,
- relationship changes.

WHO similarly emphasizes that quality postnatal care should include access to sexual and reproductive health information and support.

When Should a Woman Seek Medical Help?

Professional evaluation is advisable if:

- intercourse remains repeatedly painful,
- pain is severe,
- pain is becoming worse,



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- penetration is impossible,
- the episiotomy scar is very tender,
- bleeding repeatedly occurs after intercourse,
- there is persistent vaginal dryness,
- there is abnormal vaginal discharge,
- there is unpleasant odour,
- there is pelvic or abdominal pain,
- the woman suspects pelvic-floor dysfunction,
- symptoms continue for several months.

You do not need to wait until the problem becomes unbearable.

Warning Signs Requiring Prompt Assessment

Seek prompt medical attention if postpartum pain is accompanied by:

- fever or chills,
- worsening severe pelvic or perineal pain,
- foul-smelling vaginal discharge,
- heavy bleeding,
- wound separation,
- pus or increasing redness around stitches,
- severe lower abdominal pain,
- urinary retention,
- significant new swelling.

These symptoms may indicate infection or another postpartum complication rather than uncomplicated dyspareunia.

Frequently Asked Questions

Is painful sex normal after childbirth?

It is common during postpartum recovery, particularly in the first few months, but persistent or severe pain deserves assessment.



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How common is postpartum dyspareunia?

It is very common.

WHO has cited estimates suggesting dyspareunia affects approximately 35% of postpartum women overall. A 2025 systematic review specifically among lactating postpartum women estimated prevalence at around 60% at three months, 40% at six months and 29% at twelve months, although results vary substantially among populations.

Why is sex painful after an episiotomy?

The scar may remain tender, stiff or less flexible than surrounding tissue.

Granulation tissue or pelvic-floor muscle tension may also contribute.

Can breastfeeding make sex painful?

Yes.

Breastfeeding can lower estrogen, contributing to vaginal dryness and reduced tissue elasticity.

Why am I dry even though I feel sexually attracted to my partner?

Postpartum vaginal dryness is not always related to attraction.

Hormonal changes during breastfeeding can significantly reduce natural lubrication.

Can lubricant help?

Yes.

Lubricants can reduce friction and are commonly recommended as an initial treatment for postpartum vaginal dryness.

Can estrogen cream be used after childbirth?

Local vaginal estrogen may sometimes be considered for significant postpartum dryness, including in breastfeeding women, but this should be individualized and



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discussed with the treating gynecologist rather than self-prescribed. ACOG recognizes local estrogen as a treatment option for postpartum vaginal dryness.

Should I do Kegel exercises for painful intercourse?

Not automatically.

If your pelvic floor is overactive or tight, more strengthening may worsen symptoms.

Pelvic-floor assessment can determine whether relaxation, coordination or strengthening is appropriate.

Can pelvic-floor physiotherapy help?

Yes, particularly when muscle tension, pelvic-floor dysfunction, scar restriction or pain-related guarding is involved.

Can scar tissue be treated?

Often yes.

Depending upon the cause, treatment may include scar mobilization, pelvic-floor therapy, treatment of granulation tissue or, rarely, surgical scar revision.

Why do I bleed slightly after intercourse?

Possible explanations include:

- fragile postpartum tissue,
- granulation tissue,
- scar irritation,
- vaginal dryness,
- cervical causes.

Persistent or recurrent postcoital bleeding should be medically assessed.

Is postpartum painful intercourse psychological?

Not simply.



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It can have physical causes such as scar tissue, hormonal dryness or pelvic-floor dysfunction.

Psychological fear, trauma and anxiety may then interact with these physical factors and intensify pain.

Is it safe to have intercourse six weeks after delivery?

Six weeks is a commonly discussed timeframe, but there is no universal date.

Intercourse should resume when healing is satisfactory and the woman feels physically and emotionally ready.

Does a caesarean delivery prevent painful intercourse?

No.

Women who deliver by caesarean can still develop breastfeeding-related dryness, pelvic-floor dysfunction, reduced desire and other causes of postpartum dyspareunia.

Can painful intercourse cause infertility?

Dyspareunia itself does not usually damage fertility.

However, severe pain may make intercourse difficult, and certain underlying pelvic diseases may separately affect fertility.

Will postpartum painful intercourse eventually disappear?

Many women improve as healing progresses and hormones normalize.

However, persistent pain should not be left untreated in the expectation that it must eventually disappear on its own.

A Message From Dr. Nizamuddin Qasmi

When a woman tells me:

“Doctor, intercourse was normal before pregnancy, but now it hurts,”

I do not consider this a minor complaint.

Sexual health is part of health.



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Pain after childbirth can affect:

- self-confidence,
- marriage,
- intimacy,
- desire,
- emotional wellbeing,
- plans for another pregnancy.

The most important mistake is to tell every woman:

“Your delivery was recent; just tolerate it.”

Sometimes she only needs more healing time.

Sometimes she needs treatment for vaginal dryness.

Sometimes the episiotomy scar is the problem.

Sometimes pelvic-floor muscles have become excessively tight.

Sometimes granulation tissue is present.

Sometimes infection must be treated.

And sometimes fear from a traumatic birth has become part of the pain cycle.

These are different problems.

They deserve different treatments.

Conclusion

Postpartum painful intercourse—or postpartum dyspareunia—is common, but it should not be dismissed.

The most important causes include:

- perineal tears,
- episiotomy,
- painful scar tissue,
- granulation tissue,
- breastfeeding-related low estrogen,



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- vaginal dryness,
- pelvic-floor muscle dysfunction,
- wound complications,
- vaginal or vulval disorders,
- deep pelvic conditions,
- fear and psychological consequences of childbirth.

Modern research increasingly emphasizes how important hormonal changes during breastfeeding are. A major 2025 systematic review found high rates of vaginal dryness, vaginal atrophy and dyspareunia among lactating postpartum women, with symptoms often improving over time but persisting in a meaningful proportion of women at one year.

Perineal trauma is also important. Recent systematic reviews continue to identify significant sexual-health consequences following major birth injuries, particularly obstetric anal sphincter injuries.

Effective management should therefore be **cause-specific**.

Treatment may involve:

- reassurance and healing time,
- appropriate lubricant,
- treatment of vaginal dryness,
- local estrogen in selected patients,
- pelvic-floor physiotherapy,
- scar treatment,
- treatment of granulation tissue,
- management of infection,
- psychosexual support,
- specialist intervention when necessary.

From an Unani perspective, postpartum recovery can be approached holistically, with attention to reproductive health, nutrition, general recovery, inflammatory symptoms, sleep, digestion and overall wellbeing. At present, however, direct clinical evidence for Unani treatment specifically for postpartum dyspareunia remains limited. For this



reason, I prefer an **integrative approach** in which the actual cause of pain is identified first and Unani management is incorporated responsibly where clinically suitable.

At **Saira Health Care**, our aim is not simply to tell a woman that her pain is normal after childbirth.

Our aim is to understand:

Where is the pain? Why is it occurring? What has not yet recovered? And what can be done to restore comfortable sexual and reproductive health?

A woman should not have to choose between motherhood and a comfortable intimate life.

With appropriate diagnosis and individualized treatment, many causes of postpartum painful intercourse can be successfully managed.

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

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 clinical approach emphasizes individualized assessment, responsible integration of Unani medicine with contemporary diagnostic methods, and attention to the physical and emotional dimensions of sexual health.

Medical Disclaimer

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



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Postpartum painful intercourse can result from scar tissue, vaginal dryness, pelvic-floor dysfunction, infection, hormonal changes and other gynecological conditions.

Persistent or severe pain should therefore be professionally evaluated.

Women with fever, foul-smelling discharge, severe or increasing pelvic/perineal pain, heavy bleeding, wound separation or other concerning postpartum symptoms should seek prompt medical care.



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