Female Sex Education

A Complete Guide to Female Sexual Health, Reproductive Health, Relationships, Fertility and the Unani Perspective

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Updated: September 2026

Introduction

Female sexual health is an important part of a woman's overall physical, emotional and reproductive health, yet it remains one of the subjects most surrounded by hesitation, myths and incomplete information.

In my clinical practice, I regularly meet women who are highly educated in other areas of life but were never properly taught how their own reproductive system works. Some do not know what type of vaginal discharge is normal. Some believe that menstruation is an illness or impurity. Others assume that intercourse is supposed to be painful, that sexual desire should be identical in every woman, that contraception causes infertility, or that problems such as vaginal dryness, vaginismus, loss of sexual desire and difficulty reaching orgasm must simply be tolerated.

Many women reach marriage without receiving reliable information about their bodies and then try to learn everything from friends, social media or anonymous websites.

This is exactly why **female sex education should be treated as a health subject—not as something shameful or inappropriate**.

The World Health Organization describes sexual health as involving **physical, emotional, mental and social well-being related to sexuality**, rather than merely the absence of disease. WHO also emphasizes respect, safety and freedom from coercion, discrimination and violence.

Female sex education therefore means much more than explaining sexual intercourse. It includes understanding:

- The female body and reproductive organs.
- Puberty and menstruation.
- Vaginal and vulval health.
- Sexual desire and arousal.
- Consent and personal boundaries.
- Healthy relationships.
- Contraception and family planning.
- Sexually transmitted infections.
- Fertility and infertility.
- Pregnancy and reproductive planning.
- Sexual pain and dysfunction.
- Menopause and age-related changes.
- Emotional and psychological sexual health.
- When professional medical care is necessary.

The purpose of education is not to encourage sexual activity. The purpose is to give women **accurate information so they can make informed, responsible and healthy decisions**.

UNESCO's February 2026 review of comprehensive sexuality education reports that good-quality education improves knowledge and healthier attitudes, and is associated with delaying sexual debut, greater contraceptive and condom use among sexually active young people, and less unprotected sexual activity. Programmes based only on abstinence have not shown the same effectiveness.

As a physician working in sexual disorders and infertility, I consider sexual education an important form of **preventive medicine**.

Female Sex Education Is a Health Subject, Not a Disease

Before going further, I want to make one important distinction.

Female sex education itself is not a disease and does not require medicine.

A woman does not need a sexual tonic, hormonal medicine or herbal formulation simply because she wants to understand her body better.

Medicines become relevant only when a genuine medical condition is identified—for example:

- PCOS/PMOS.
- Abnormal vaginal discharge.
- Vaginal infection.
- Painful intercourse.
- Vaginismus.
- Vaginal dryness.
- Menstrual disorders.
- Low sexual desire causing distress.
- Infertility.
- Endometriosis.
- Hormonal disorders.
- Menopausal symptoms.

This distinction is particularly important in Unani practice.

The role of Unani medicine in female sexual health is not simply to prescribe aphrodisiacs. Its more valuable role includes **health education, prevention, individualized assessment, dietary and lifestyle regulation and appropriate treatment of diagnosed disorders**.

What Should Good Female Sex Education Achieve?

In my opinion, good sexual-health education should leave a woman with confidence rather than fear.

After receiving appropriate education, she should understand what is normal for her body, what symptoms need attention, how pregnancy occurs, how pregnancy can be prevented when desired, how sexually transmitted infections are reduced, and when fertility evaluation is appropriate.

She should also understand that sexual health involves dignity and choice.

WHO's framework specifically emphasizes that sexual health is relevant throughout life and is influenced not only by biological factors but also by psychological, social, cultural and relationship factors.

That holistic concept has considerable compatibility with the Unani emphasis on physical constitution, emotional state, lifestyle, environment, diet and general well-being.

Understanding Female Anatomy

One of the most basic components of female sex education is knowing the correct names and functions of the reproductive organs.

Unfortunately, many women have never been taught even this fundamental information.

The Vulva

The **vulva** is the external female genital region.

It includes structures such as the labia majora, labia minora, clitoris and the openings of the urethra and vagina.

People often incorrectly use the word “vagina” to describe the entire external genital area.

The external part is the vulva.

The Vagina

The **vagina** is an elastic muscular canal extending from the vaginal opening toward the cervix.

It allows menstrual blood to leave the body, receives penetration during vaginal intercourse and forms part of the birth canal during childbirth.

The Clitoris

The clitoris is an important organ of female sexual sensation.

It contains a high concentration of sensory nerves and has a larger internal structure than the small external portion that can be seen.

Understanding female anatomy helps correct another common misunderstanding: sexual pleasure in women does not depend solely upon vaginal penetration.

Different women respond to different forms of stimulation, and sexual response naturally varies from person to person.

The Cervix

The **cervix** is the lower part of the uterus that opens into the vagina.

It plays important roles in menstruation, fertility and pregnancy and is also the site from which most cervical cancers develop.

The Uterus

The **uterus**, or womb, is the muscular organ in which a pregnancy develops.

Its inner lining is called the endometrium.

During most reproductive cycles, this lining thickens. If pregnancy does not occur, much of it is shed during menstruation.

The Ovaries

The ovaries contain follicles from which eggs can develop.

They also produce reproductive hormones including estrogen and progesterone and smaller amounts of androgens.

The Fallopian Tubes

The fallopian tubes connect the region around the ovaries with the uterus.

Fertilization commonly occurs within a fallopian tube before the developing embryo travels toward the uterus.

A basic understanding of these structures makes subjects such as menstruation, contraception, infertility and pregnancy much easier to understand.

Puberty: The Beginning of Reproductive Maturation

Female sexual and reproductive health education should ideally begin **before puberty**, not after a young girl has already experienced frightening or confusing physical changes.

Puberty involves hormonal maturation that leads to breast development, pubic and underarm hair growth, changes in body shape, skin changes and eventually menstruation.

WHO defines comprehensive sexuality education as **scientifically accurate, age-appropriate information** that includes anatomy, puberty, menstruation, relationships, consent, contraception, pregnancy and sexually transmitted infections.

There is nothing inappropriate about teaching a girl that menstruation will occur.

What is harmful is allowing her first period to arrive without understanding what is happening.

Understanding Menstruation Properly

Menstruation is a normal biological process.

It is not a disease.

It is not evidence of bodily impurity.

It does not make a woman physically inferior.

WHO's June 2026 menstrual-health guidance emphasizes that people should receive accurate information about menstruation before their first period and should be able to menstruate without shame or stigma. WHO notes that the menstrual cycle averages approximately **21 to 35 days**, although individual patterns vary.

Some cramping, breast tenderness, bloating or mood change may occur.

However, severe menstrual symptoms should not simply be normalized.

A woman should seek assessment if she experiences:

- Very severe menstrual pain.
- Extremely heavy bleeding.
- Repeated fainting or severe weakness.
- Very irregular menstruation.
- Periods disappearing for months without pregnancy.
- Bleeding between periods.
- Bleeding after sexual intercourse.
- Menstrual symptoms preventing normal daily activities.

WHO's latest guidance emphasizes that very painful, heavy, unpredictable or infrequent menstruation can sometimes indicate conditions such as endometriosis, adenomyosis, fibroids, bleeding disorders or PMOS/PCOS.

I frequently tell young women:

“Do not allow anyone to dismiss severe menstrual suffering simply by saying that periods are supposed to hurt.”

Mild discomfort is common. Disabling pain deserves evaluation.

The Hymen and the Myth of “Virginity Testing”

This is one of the most important areas where medical education can protect women from misinformation.

The hymen is a thin rim or membrane of tissue around the vaginal opening. Its shape and appearance vary considerably between individuals.

It can stretch or change through normal physical activities, tampon use, medical procedures or sexual activity.

Most importantly:

The appearance of the hymen cannot prove whether a woman has had sexual intercourse.

WHO, UN Women and the UN Human Rights Office have concluded that so-called "virginity testing" has **no scientific or clinical basis**, and there is no physical examination that can determine whether a woman or girl has previously had vaginal intercourse.

ACOG similarly states that the presence or absence of hymenal tissue does not indicate virginity.

Therefore, statements such as:

"An intact hymen proves virginity."

or

"A woman must bleed during first intercourse."

are medically incorrect.

Some women bleed during first intercourse.

Many do not.

Neither outcome proves anything about previous sexual activity.

Sexual Desire Is Different in Every Woman

Another important part of sex education is understanding that there is **no single normal level of sexual desire**.

Some women have frequent spontaneous sexual interest.

Others develop desire mainly after emotional or physical intimacy has begun.

Desire may naturally increase or decrease depending upon:

- Age.
- Hormonal changes.
- Pregnancy.
- Breastfeeding.
- Menopause.
- Stress.
- Sleep.

- Mental health.
- Relationship quality.
- Medications.
- Physical illness.
- Previous experiences.

ACOG notes that sexual problems can involve desire, arousal, orgasm, pain or medication-related effects and that these categories often overlap.

A woman should therefore not compare her libido with advertisements, films, social media or another person's experience.

Low desire becomes a medical concern particularly when it is persistent and personally distressing or represents a major change from the woman's previous sexual health.

Female Sexual Arousal

Sexual arousal involves both the mind and body.

Physical changes can include increased genital blood flow and vaginal lubrication, but mental excitement and emotional comfort are equally important.

A woman may mentally want intimacy but have insufficient physical lubrication.

Another woman may experience a physical response while having little emotional interest.

Neither reaction means that she is defective.

Arousal can be affected by anxiety, stress, tiredness, relationship conflict, medications, pregnancy, breastfeeding, menopause and illness.

This is why good sexual medicine does not simply ask:

“Is the vagina lubricated?”

We also ask:

“Does the woman feel safe, comfortable, emotionally connected and interested?”

Female Orgasm and Normal Variation

Orgasm is one component of sexual response, but every sexual encounter does not have to end with an orgasm to be considered healthy.

Some women reach orgasm easily.

Some require more time or particular forms of stimulation.

Some rarely experience it.

Others may lose the ability temporarily because of medication, stress, hormonal change, surgery or relationship circumstances.

ACOG recognizes orgasmic difficulty as a common sexual-health concern and recommends assessment when it becomes personally troubling.

Women should not be pressured to imitate unrealistic sexual responses portrayed in entertainment or pornography.

Sexual health should be based on **comfort, communication, consent and individual satisfaction**, not performance.

Sexual Activity Should Never Be Painful by Default

A widespread misconception is that women must tolerate pain during sexual intercourse.

That is incorrect.

Painful intercourse is medically called **dyspareunia**.

It may result from:

- Vaginal dryness.
- Inadequate lubrication.
- Infection.
- Vaginismus.
- Pelvic-floor muscle spasm.
- Endometriosis.
- Pelvic inflammatory disease.
- Vulvodynia.
- Menopausal changes.
- Childbirth-related injuries.
- Psychological distress or fear.

ACOG notes that pain during intercourse is common but should be medically assessed when it is frequent or severe.

A partner should never continue penetration when the woman is experiencing significant pain.

Pain is a health symptom, not a test of love or marital commitment.

Vaginismus

Vaginismus involves involuntary tightening of muscles around the vaginal entrance when penetration is attempted.

The woman may genuinely wish to have intercourse but find penetration painful or impossible.

This should not be interpreted as stubbornness or lack of affection.

Treatment may involve:

- Education.
- Pelvic-floor physiotherapy.
- Relaxation techniques.
- Gradual dilator therapy.
- Psychological or sex therapy.
- Management of underlying pain or trauma.

The condition can improve significantly with appropriate care.

Forcing penetration usually worsens fear, muscular contraction and pain.

Vaginal Dryness

Vaginal dryness may occur at almost any age.

Common situations include:

- Inadequate arousal.
- Breastfeeding.
- Perimenopause.
- Menopause.
- Certain medications.
- Some cancer treatments.

- Chronic medical conditions.

Appropriate lubricants and vaginal moisturizers may help, while menopausal women with significant symptoms may sometimes benefit from local hormonal or other prescription treatments after medical evaluation.

Women should not repeatedly apply unverified oils or herbal mixtures inside the vagina.

The vaginal environment is sensitive, and inappropriate preparations can cause irritation or infection.

Understanding Normal Vaginal Discharge

Another subject that unnecessarily frightens many women is vaginal discharge.

A healthy vagina normally produces secretions.

Clear or white discharge without a strong unpleasant smell, severe itching or pain is often normal and may vary through the menstrual cycle.

Not every white discharge is “leucorrhoea disease,” infection or weakness.

Abnormal discharge becomes more concerning when it is accompanied by:

- Strong foul or fishy odor.
- Intense itching.
- Burning.
- Green or markedly yellow colour.
- Genital sores.
- Pelvic pain.
- Pain during urination.
- Bleeding.

The cause then needs to be identified rather than repeatedly taking antibiotics or antifungals without diagnosis.

Vulval and Vaginal Hygiene

Women frequently ask me whether special intimate washes are required.

In most situations, **the inside of the vagina does not need to be washed**.

The vagina maintains its own biological environment.

Repeated douching or use of strongly scented intimate products can irritate tissues and disturb normal vaginal bacteria.

Gentle external hygiene is generally adequate.

A woman should not use an antiseptic, detergent, perfume or harsh soap inside the vagina in the belief that this is necessary for cleanliness.

Consent: An Essential Part of Female Sex Education

Sexual-health education is incomplete if it teaches anatomy and pregnancy but ignores **consent**.

Consent means willingly agreeing to sexual activity.

Healthy sexual activity requires that both partners are comfortable with what is happening.

Pressure, threats, fear, emotional coercion or physical force are not healthy sexual communication.

ACOG states that sexual activity in a healthy relationship should be a choice and that no person should be pressured into sexual activity they do not want.

Consent also remains relevant during an encounter.

Agreeing to one form of intimacy does not mean automatically agreeing to everything else.

A person can change their mind.

Respect for boundaries is part of sexual health.

Sexual Violence Is a Health Issue

Sexual violence can have physical, reproductive and psychological consequences.

WHO's June 2026 update estimates that approximately **one in three women worldwide has experienced physical and/or sexual intimate-partner violence or non-partner sexual violence during her lifetime**.

A woman who has experienced sexual assault deserves respectful, confidential and trauma-informed medical care.

She should never be blamed for what happened.

Medical priorities may include assessment of injuries, pregnancy risk, STI prevention/testing, emergency contraception where appropriate, psychological support and safeguarding.

Healthy Relationships and Communication

A healthy sexual relationship does not depend only on physical function.

Communication matters.

Partners should be able to talk about:

- Comfort.
- Boundaries.
- Contraception.
- Fertility goals.
- STI prevention.
- Sexual difficulties.
- Pain.
- Emotional needs.
- Frequency of intimacy.
- Pregnancy planning.

A disagreement in desire does not mean that one partner is defective.

Some couples may benefit from sexual counselling or relationship therapy when communication difficulties are significantly affecting intimacy.

Safe Sex and Sexually Transmitted Infections

Sexually transmitted infections, or STIs, can be transmitted during sexual contact.

Important examples include:

- Chlamydia.
- Gonorrhoea.
- Syphilis.
- Trichomoniasis.
- HIV.
- Genital herpes.

- Human papillomavirus or HPV.
- Hepatitis B.

A major problem is that **many STIs cause no obvious symptoms**.

CDC's March 2026 guidance emphasizes that STI testing is important because a person can have an infection without knowing it. Testing recommendations depend upon age, exposure, pregnancy status, sexual history and local guidelines.

Women should seek evaluation particularly if they develop:

- Unusual vaginal discharge.
- Genital ulcers or sores.
- Pelvic pain.
- Bleeding after sex.
- Pain during intercourse.
- Burning during urination.
- Known exposure to an STI.

Condoms and STI Prevention

Condoms are particularly important because they provide protection against both unintended pregnancy and many sexually transmitted infections.

WHO notes that among contraceptive methods, condoms are the method that also provides protection against transmission of STIs including HIV.

A woman taking oral contraceptive pills or using an IUD may have excellent pregnancy prevention but still require condoms when STI protection is important.

Pregnancy prevention and infection prevention are related but **not identical goals**.

Understanding Contraception

Contraception allows individuals and couples to decide whether and when they want pregnancy.

Modern contraceptive options include:

- Condoms.
- Oral contraceptive pills.

- Hormonal injections.
- Contraceptive implants.
- Copper or hormonal intrauterine devices.
- Permanent sterilization.
- Fertility-awareness methods.
- Emergency contraception.

The appropriate method depends upon health conditions, preferences, future fertility plans and individual risks.

WHO's 2025 family-planning guidance emphasizes that contraception helps prevent unintended pregnancy and allows people to decide the number and spacing of children. WHO also states that modern contraceptive methods **do not cause infertility**.

This is important because many women unnecessarily avoid reliable contraception because they have been told that using birth-control pills or an IUD will permanently damage fertility.

That is not generally true.

Emergency Contraception

Emergency contraception may be used after unprotected intercourse or contraceptive failure to reduce the chance of pregnancy.

Options can include emergency contraceptive pills or a copper IUD depending upon individual circumstances and local availability.

Emergency contraception is not the same thing as routine contraception and should not replace a regular contraceptive plan when ongoing pregnancy prevention is desired.

WHO notes that emergency contraceptive options need to be used within a limited period after unprotected intercourse, generally within five days depending on the method.

HPV, Cervical Cancer and Female Sex Education

A modern sexual-health education programme should also teach women about **human papillomavirus, or HPV**.

Persistent infection with certain high-risk HPV types is the major cause of cervical cancer.

The good news is that cervical cancer is now considered largely preventable through **HPV vaccination and appropriate cervical screening**.

WHO's July 2026 cervical-cancer update states that prevention through vaccination and screening, followed by treatment of precancerous lesions where necessary, is central to global cervical-cancer elimination efforts.

Women and parents should therefore discuss HPV vaccination and cervical screening with an appropriate healthcare professional according to national guidelines.

Receiving an HPV vaccine is a preventive health decision.

It should not be interpreted as a statement about someone's character or sexual behaviour.

Fertility Education Is Part of Sex Education

Sex education should teach not only how to prevent pregnancy but also how fertility works.

Ovulation is the release of an egg from an ovary.

Pregnancy becomes possible when sperm reaches an egg during the fertile part of the menstrual cycle.

However, fertility is not unlimited throughout life.

Female fertility gradually declines with age, particularly from the mid-30s onward.

This is not intended to frighten women or pressure them into pregnancy.

It is simply information that allows better reproductive planning.

When Is Infertility Evaluation Appropriate?

WHO defines infertility clinically as failure to achieve pregnancy after **12 months or more of regular unprotected sexual intercourse**. Approximately one in six people experiences infertility during their lifetime. Importantly, infertility can result from male factors, female factors, both partners or unexplained causes.

ACOG recommends evaluation after approximately:

- **12 months** of trying for women younger than 35.
- **6 months** for women older than 35.
- Earlier evaluation when age is over 40 or when there is a known fertility problem.

Conditions such as very irregular menstruation, endometriosis, previous pelvic infection or known reproductive disease may justify earlier assessment.

One of the messages I strongly emphasize at Saira Health Care is:

Infertility is not automatically the woman's fault.

Male-factor infertility is common and the couple should generally be considered together.

Menstrual Apps and Fertile-Window Calculations

Tracking periods can help women understand cycle patterns.

However, mobile applications are not perfect predictors of ovulation.

Women with irregular menstrual cycles, particularly those with PMOS/PCOS, may find predicted fertile dates unreliable.

Apps can be useful tools, but they should not replace clinical fertility assessment when a couple is experiencing difficulty conceiving.

Pregnancy Education

Women should understand the basic signs of possible pregnancy and the importance of timely antenatal care.

When pregnancy is desired, preconception care can include:

- Folic acid.
- Medication review.
- Control of diabetes or thyroid disease.
- Vaccination review.
- Avoidance of tobacco and recreational drugs.
- Appropriate nutrition.
- Management of chronic illnesses.

Pregnancy should not be treated merely as a positive test result.

Maternal health before conception can influence pregnancy outcomes.

Sexual Health During Pregnancy

Sexual desire can increase, decrease or fluctuate during pregnancy.

This variation is normal.

Hormonal changes, breast tenderness, nausea, fatigue, body-image changes and concern about pregnancy may affect intimacy.

In an uncomplicated pregnancy, sexual activity is often medically permissible, but specific pregnancy complications can require restrictions.

Women with bleeding, significant pain, leaking fluid, threatened preterm labour or other obstetric complications should follow their obstetric clinician's advice.

Sexual Health After Childbirth

The postpartum period can be physically and emotionally demanding.

Women may experience:

- Vaginal soreness.
- Breastfeeding-related vaginal dryness.
- Reduced libido.
- Fear of pain.
- Pelvic-floor weakness.
- Episiotomy or tear discomfort.
- Fatigue.
- Postpartum mood changes.
- Changes in body image.

Sexual activity should resume when the woman feels physically and emotionally ready and medical recovery is adequate.

A woman should not be pressured into painful intercourse simply because a certain number of weeks has passed since delivery.

Menopause and Sexual Health

Female sex education should continue beyond the reproductive years.

Menopause is not the end of sexual health.

Declining estrogen can lead to:

- Vaginal dryness.

- Reduced tissue elasticity.
- Painful intercourse.
- Urinary symptoms.
- Changes in sexual desire.

These symptoms may be part of **Genitourinary Syndrome of Menopause** and can often be effectively managed with lubricants, vaginal moisturizers and, in selected women, prescription treatments such as local vaginal estrogen.

Women should not assume that painful intercourse is an unavoidable consequence of ageing.

Common Female Sexual Health Problems

During my clinical practice, female sexual concerns generally fall into several overlapping groups.

Reduced Sexual Desire

Low libido may be related to stress, fatigue, relationship problems, depression, medication, menopause, breastfeeding, illness or hormonal factors.

Treatment depends upon the cause.

Reduced Sexual Arousal

A woman may have interest but experience limited physical or emotional excitement.

Again, stress, medications, hormonal changes and relationship factors may contribute.

Orgasm Difficulty

Some women require more time or stimulation, while others experience difficulty because of medications, anxiety, illness, previous experiences or relationship factors.

Painful Intercourse

Dyspareunia may result from dryness, infection, pelvic-floor dysfunction, endometriosis, menopause or other causes.

Vaginismus

Pelvic-floor muscle tightening may make penetration painful or impossible.

Vaginal Dryness

Hormonal change, breastfeeding, menopause, medication or insufficient arousal may contribute.

Sexual Problems Related to Medicines

Certain antidepressants, blood-pressure medicines and other medications may affect libido or orgasm.

Prescription medicines should not be stopped suddenly. The prescribing clinician should review the problem.

ACOG notes that sexual problems are common and estimates that around **4 in 10 women experience a sexual problem at some point during life**.

Sexual Health and Mental Health

Sexuality cannot be separated completely from mental health.

Anxiety can interfere with arousal.

Depression can reduce sexual interest.

Chronic stress can reduce energy and intimacy.

Previous sexual trauma can contribute to pain, fear or avoidance.

Relationship conflict can reduce desire.

Conversely, untreated sexual difficulties may themselves create frustration, anxiety and relationship strain.

Sometimes the most appropriate treatment is not another medicine.

It may be counselling, pelvic-floor treatment, medication adjustment, couples therapy or management of an underlying psychological condition.

Body Image and Sexual Confidence

Women are exposed to enormous pressure regarding body shape, breast size, skin colour, genital appearance, weight and ageing.

Many develop anxiety because they believe their bodies are somehow abnormal.

There is a wide range of normal genital anatomy.

Labia vary in shape, size, symmetry and colour.

The vulva naturally changes through puberty, pregnancy and ageing. ACOG notes that vulval appearance varies substantially between individuals.

A woman should not assume that digitally altered images, pornography or cosmetic advertisements represent normal anatomy.

Myths About Female Sexual Health

“Women should not need sex education.”

Incorrect. Accurate sexual and reproductive health information is preventive healthcare.

“Sex education encourages young people to have sex.”

High-quality evidence does not support this. Comprehensive education is associated with safer decision-making and may delay sexual debut.

“A woman must bleed during first intercourse.”

Incorrect. Many women do not bleed.

“A doctor can examine the hymen and tell whether a woman is a virgin.”

Incorrect. There is no scientifically valid virginity test.

“Every white vaginal discharge is a disease.”

Incorrect. Some vaginal discharge is normal.

“Pain during intercourse is normal for women.”

Persistent or severe pain deserves medical evaluation.

“A woman who does not experience orgasm is automatically ill.”

No. Sexual response varies. It becomes a medical concern primarily when it is persistent and troubling the individual.

“Contraceptive pills permanently cause infertility.”

Modern contraceptive methods do not generally cause permanent infertility.

“Infertility is mainly a woman's problem.”

Incorrect. Infertility may arise from male factors, female factors, combined factors or remain unexplained.

“Sexual desire should remain the same throughout life.”

Incorrect. Desire can change with age, hormones, pregnancy, breastfeeding, menopause, health and relationships.

Female Sex Education According to the Unani System of Medicine

The Unani system has a long-established branch concerned with female reproductive health.

In formal Unani education, **Amraz-e-Niswan** refers to gynecology, while **Ilmul Qabalat** refers to obstetrics.

The contemporary BUMS curriculum in India includes the anatomy and physiology of the female genital tract, puberty, adolescence, menstruation, menstrual disorders, menopause, vulval disease and other gynecological conditions.

Jamia Hamdard's Department of **Amraz-e-Niswan wa Qabalat** similarly describes the discipline as dealing with women's reproductive health, gynecology and obstetric care.

Therefore, it would be incorrect to portray Unani medicine as being concerned only with herbal remedies.

Education in female anatomy, physiology, menstruation, pregnancy and reproductive disease is formally part of Unani medical training.

The Traditional Unani Understanding of Female Health

Unani medicine developed from the Greco-Arabic medical tradition and was subsequently expanded by physicians across Arab, Persian and South Asian medical scholarship.

Its traditional framework considers concepts such as:

Mizaj — temperament
Akhlat — humours
A'za — organs
Quwa — faculties
Af'al — functions

Classical Unani theory identifies four principal humours:

Dam — blood
Balgham — phlegm
Safra — yellow bile
Sauda — black bile

The Ministry of AYUSH describes balance of the humours and temperament as fundamental traditional concepts within the Unani system.

These are traditional explanatory concepts.

They should not be presented as scientifically identical to modern hormones such as estrogen, progesterone, testosterone or prolactin.

Modern endocrinology and classical Unani humoral theory are different frameworks.

Asbab-e-Sitta Zarooriya and Female Sexual Health

One of the principles of Unani medicine that I find particularly valuable for health education is the **Asbab-e-Sitta Zarooriya**, or six essential factors of life.

These traditionally include:

1. Air and environment.
2. Food and drink.
3. Physical activity and rest.
4. Mental or psychological activity and rest.
5. Sleep and wakefulness.
6. Appropriate retention and elimination.

The Ministry of AYUSH identifies these six essential factors as central to Unani health promotion and disease prevention.

Consider how relevant these principles remain today.

Sleep influences hormonal and mental health.

Nutrition influences menstruation, fertility and pregnancy.

Physical activity influences metabolic health.

Mental stress influences sexual desire and pain.

Smoking and environmental exposures influence reproductive health.

Digestive and general health can influence quality of life.

This does not mean that every sexual disorder can be cured by lifestyle alone.

It means that sexual health is connected to the health of the complete individual.

Mizaj and Individualized Female Care

Mizaj, or temperament, is another important Unani concept.

Traditionally, patients differ in constitutional tendencies related to qualities such as heat, coldness, moisture and dryness.

A Unani physician therefore does not ideally prescribe one medicine simply because two patients have the same symptom.

From a modern clinical perspective, individualized treatment is equally important.

Two women may both complain of reduced libido, but one may have depression, another menopause, another relationship difficulty and another medication-related sexual dysfunction.

Two women may both have painful intercourse, but one may have vaginal dryness while another has endometriosis.

The **cause matters more than the symptom label**.

Ilaj-bil-Ghiza — Dietotherapy

Unani medicine traditionally uses **Ilaj-bil-Ghiza**, or dietary treatment.

In female reproductive health, diet should support:

- Adequate nutrition.
- Healthy weight.
- Iron status.
- Metabolic health.
- Pregnancy preparation.
- Menstrual health.
- General physical well-being.

However, I do not believe in telling every woman with a sexual or reproductive problem to eat one particular herb or avoid an unnecessarily long list of foods.

Dietary advice should be individualized.

For example, a woman with PMOS, diabetes and obesity requires a different nutritional plan from an underweight woman with iron-deficiency anemia.

Ilaj-bil-Tadbir — Lifestyle and Regimental Management

Ilaj-bil-Tadbir refers broadly to regimenal and lifestyle-based therapeutic measures.

Its modern practical application in female sexual health may involve appropriate attention to:

- Physical activity.
- Sleep.
- Stress.
- Weight management.
- Daily routine.
- Pelvic health.
- Emotional well-being.

Again, the correct regimen depends upon the diagnosis.

A woman with vaginismus may require pelvic-floor physiotherapy.

A menopausal woman with vaginal dryness may require local treatment.

A woman with infertility may require ovulation or tubal evaluation.

Lifestyle management should support—not replace—appropriate diagnosis.

Ilaj-bil-Dawa — Medicines

Unani medicine also uses **Ilaj-bil-Dawa**, or pharmacotherapy.

Traditional single and compound medicines may be considered for specific diagnosed disorders according to Mizaj and clinical condition.

But I want to be very clear:

Female sex education itself does not require a medicine.

I would not advise a woman to take a so-called libido booster simply because she wants better sexual health.

Likewise, formulations marketed as “sexual power medicines” should not automatically be prescribed to women.

The exact cause must first be established.

Some compounds traditionally associated with reproductive vitality have far stronger historical usage than modern clinical evidence. Therefore, traditional use should be distinguished from scientifically established effectiveness.

Why I Do Not Recommend One "Female Sex Tonic"

This is an important principle in my practice.

Imagine four women.

One has loss of libido because she is severely depressed.

The second has painful intercourse because of vaginal dryness after menopause.

The third has vaginismus.

The fourth has normal sexual function but is anxious because she incorrectly believes she should experience orgasm during every intercourse.

Giving all four women the same herbal aphrodisiac would not be rational medicine.

The first may need mental-health treatment.

The second may require management of vaginal dryness.

The third may benefit from pelvic-floor therapy and counselling.

The fourth may primarily need education and reassurance.

Good sexual medicine begins with diagnosis and understanding.

What Is the Scientific Role of Unani Medicine in Female Sexual Health?

Unani medicine has an established academic discipline in gynecology and obstetrics and an important traditional emphasis on preventive healthcare and individualized care.

Current Unani institutions also continue research into women's health.

For example, the Central Council for Research in Unani Medicine currently lists **gynecological disorders, sexual disorders and endocrine disorders** among priority areas for collaborative scientific research.

Aligarh Muslim University's Unani women's-health department also describes family planning, preventive healthcare and reproductive-health services as important areas of its current clinical work.

These developments are encouraging.

At the same time, scientific evidence for specific Unani medicines varies greatly according to the disorder.

Some traditional preparations have small clinical studies.

Others mainly have historical use.

Therefore, I do not believe it is appropriate to claim a universal success rate for “female sexual problems.”

The responsible approach is to use traditional treatment where appropriate while continuing to investigate safety and effectiveness through good-quality clinical research.

Female Sex Education and Cultural Sensitivity

Sexual-health education must be scientifically accurate but also communicated respectfully.

Different families and communities have different religious, cultural and moral values.

Good healthcare does not require mocking those values.

At the same time, culture should not be used to justify medically incorrect information or prevent women from seeking necessary healthcare.

We can respect modesty while teaching anatomy.

We can respect personal values while explaining contraception.

We can respect marriage while discussing consent and painful intercourse.

We can respect tradition while explaining that virginity testing has no medical validity.

This balanced approach helps women receive information without feeling that their identity or beliefs are being attacked.

Digital Sex Education: Useful but Risky

Young people increasingly obtain sexual-health information from social media, short videos, online forums and artificial intelligence.

This creates opportunities but also major problems.

Incorrect information spreads rapidly.

Examples include claims that:

- Normal vaginal discharge causes weakness.
- Masturbation permanently damages fertility.
- Contraception causes infertility.
- A particular herb permanently tightens the vagina.
- One capsule can permanently increase female desire.

- The hymen can prove sexual history.
- Sexual pain is always psychological.

These statements can cause anxiety and inappropriate self-treatment.

Reliable health education should come from qualified healthcare professionals and recognized medical sources.

Pornography Is Not Sex Education

Pornography and entertainment are designed for visual stimulation, not medical accuracy.

They may create unrealistic expectations about:

- Body appearance.
- Duration of sexual activity.
- Frequency of intercourse.
- Genital appearance.
- Sexual responses.
- Orgasm.
- Consent.
- Communication between partners.

A woman should never judge her sexual health by comparing herself with scripted entertainment.

Healthy sexuality is based on real people, real communication, consent and comfort.

Female Sexual Health Across the Lifespan

One of the most important modern developments is recognition that sexual health continues throughout life.

WHO explicitly states that sexual health is relevant from adolescence through older age, rather than only during the reproductive years.

At different stages, education should therefore change.

Adolescence

Focus on puberty, menstruation, anatomy, boundaries, safety, consent and prevention of abuse.

Early Adulthood

Include relationships, contraception, STI prevention, sexual function and reproductive planning.

Pregnancy and Postpartum

Discuss changing desire, safe intimacy, childbirth recovery, breastfeeding and contraception.

Midlife

Include fertility decline, perimenopause, menopause, vaginal dryness and metabolic health.

Older Age

Address sexual well-being, vaginal health, chronic illness, medication effects and relationship changes.

There is no age at which women become undeserving of sexual-health information.

Cervical-Cancer Prevention Should Be Part of Sex Education

Because HPV is transmitted primarily through intimate sexual contact, cervical-cancer prevention belongs naturally within sexual-health education.

WHO's 2026 cervical-cancer guidance emphasizes two major preventive strategies:

HPV vaccination and cervical screening.

Women should follow the recommended national screening programme according to age and medical history.

Screening should not be avoided because of embarrassment.

Early abnormalities can often be treated before they progress to cancer.

When Should a Woman Seek Medical Advice?

Please seek professional evaluation when there is:

- Persistent loss of sexual desire causing distress.
- Pain during intercourse.
- Inability to tolerate penetration.

- Persistent vaginal dryness.
- Unusual or foul-smelling vaginal discharge.
- Severe genital itching or burning.
- Genital sores or ulcers.
- Repeated urinary infections.
- Very irregular periods.
- Periods absent for several months without pregnancy.
- Very heavy menstrual bleeding.
- Severe menstrual pain.
- Bleeding after intercourse.
- Postmenopausal bleeding.
- Significant pelvic pain.
- Suspected sexually transmitted infection.
- Difficulty becoming pregnant.
- Sexual problems beginning after a medication change.
- Significant anxiety or depression affecting intimacy.

Women should not wait until symptoms become severe simply because they feel embarrassed discussing sexual health.

My Approach to Female Sexual Health at Saira Health Care

When a woman consults me about a sexual-health concern, my first priority is to understand what she actually means.

If she tells me:

“Doctor, I have a sexual problem,”

I do not assume that she needs a sex medicine.

I want to know:

Is the problem desire?

Is it arousal?

Is intercourse painful?

Is penetration difficult?

Is there vaginal dryness?

Is she concerned about orgasm?

Is there abnormal discharge?

Are periods irregular?

Is pregnancy not occurring?

Is menopause contributing?

Is she taking a medicine that may affect sexual function?

Is the main issue stress, anxiety or relationship difficulty?

This detailed conversation is essential.

Saira Health Care publicly describes its clinical focus as involving male and female sexual disorders and infertility and emphasizes detailed history-taking, individualized treatment planning and Mizaj assessment.

The Specialized Approach of Dr. Nizamuddin Qasmi

I am **Dr. Nizamuddin Qasmi, Founder and Chief Physician of Saira Health Care**, with a focused clinical practice in **Sexual Disorders & Infertility**.

My professional education and training include:

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

Saira Health Care's current public professional profile describes my practice as focused on sexual disorders and infertility and lists BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK; the clinic's current published professional material also includes the Masters in Male Infertility and Integrated Sexual and Reproductive Health training.

My clinical philosophy is that sexual-health treatment should remain **confidential, individualized and diagnosis-based**.

A woman should not feel ashamed to describe intimate symptoms to her physician.

A good sexual-health consultation should be a medical conversation, not an interrogation or moral judgment.

How Saira Health Care Contributes to Female Sexual and Reproductive Health

At **Saira Health Care**, our work in sexual disorders and infertility includes more than prescribing medicines.

An important part of our contribution is **patient education**.

Our objective is to help patients understand conditions such as:

- Female low sexual desire.
- Loss of sexual arousal.
- Painful intercourse.
- Vaginismus.
- Vaginal dryness.
- Abnormal vaginal discharge.
- Menstrual disorders.
- PCOS/PMOS.
- Female infertility.
- Male-factor infertility.
- Sexual dysfunction affecting couples.

Saira Health Care's own published description emphasizes a confidential, patient-centred environment and individualized treatment rather than treating only a disease label.

For me, the educational role is particularly important.

A woman who understands her body is less likely to be frightened by normal changes and more likely to seek treatment when something genuinely abnormal occurs.

Integrating Unani Medicine With Modern Sexual-Health Knowledge

I do not believe patients benefit when modern medicine and traditional Unani medicine are presented as enemies.

They answer some questions in different ways.

Modern medicine provides increasingly precise understanding of:

- Hormones.
- Infection.
- Fertility.
- Pelvic anatomy.
- Contraception.
- Cancer prevention.
- Endometriosis.
- Sexual dysfunction.
- Menopause.

Unani medicine contributes a long tradition of individualized assessment emphasizing:

- Mizaj.
- Diet.
- Digestion.
- Sleep.
- Physical activity.
- Psychological condition.
- Environmental influences.
- General vitality.
- Preventive healthcare.

The most responsible clinical approach is to understand where each can contribute.

If a woman has chlamydia, she requires appropriate antimicrobial treatment.

If she has an ectopic pregnancy, she requires urgent modern medical care.

If she has significant menopausal vaginal atrophy, evidence-based local therapy may be appropriate.

If she has infertility, both partners may require investigations.

And where an individualized Unani medicine or lifestyle intervention is appropriate and safe, it can be incorporated responsibly.

Traditional medicine should never become an excuse for delaying urgent diagnosis.

Future of Female Sexual Health Education

Female sexual-health education is changing rapidly.

Several developments are particularly encouraging.

Modern comprehensive sexuality education increasingly includes **healthy relationships, communication, gender, consent and emotional well-being**, rather than focusing only on pregnancy prevention. UNESCO's July 2026 research specifically highlights the role of school-based sexuality education in improving knowledge and relationship skills.

Menstrual health is also increasingly recognized as a major public-health issue. WHO published an extensive new menstrual-health fact sheet in June 2026 and is developing additional guideline work in this area.

WHO also issued its first global guideline for infertility in late 2025, emphasizing accessible, evidence-based and people-centred fertility care and the need for better fertility education.

At the same time, Unani medicine is increasingly being encouraged to validate traditional experience through modern research, with women's health, endocrine disorders and sexual disorders identified as active areas of research interest.

I consider this a positive direction.

Traditional knowledge becomes stronger—not weaker—when it is studied carefully.

Frequently Asked Questions

Is female sex education medically necessary?

Yes. It helps women understand menstruation, anatomy, contraception, pregnancy, sexually transmitted infections, consent, fertility and sexual-health problems.

Does sex education encourage sexual activity?

Evidence does not show that comprehensive education encourages earlier sexual activity. Good programmes are associated with improved knowledge, safer behaviour and often delayed sexual debut.

Is sexual desire the same in every woman?

No. Desire differs greatly between individuals and can change through different stages of life.

Is it normal for a woman not to experience orgasm every time?

Yes. Sexual response varies considerably. A problem requires clinical attention particularly when it is persistent and personally distressing.

Is pain during intercourse normal?

Occasional minor discomfort can occur, but recurrent or significant pain should be assessed.

Does the hymen prove virginity?

No. No physical examination can scientifically determine whether a woman has previously had sexual intercourse.

Does first intercourse always cause bleeding?

No.

Is vaginal discharge always an infection?

No. Some clear or white discharge is normal. Change in smell, colour or associated itching, burning or pain can indicate disease.

Can contraception cause permanent infertility?

Modern contraceptive methods do not generally cause infertility.

Are condoms still necessary if a woman takes birth-control pills?

They may be, because oral contraception prevents pregnancy but does not provide the same STI protection that condoms do.

Can women with PCOS become pregnant?

Yes. Many women with PCOS/PMOS conceive naturally or with treatment.

Is infertility always a female problem?

No. Male factors are a major cause of infertility and both partners should often be evaluated.

Can stress affect a woman's sexual life?

Yes. Stress can affect desire, arousal, sleep, pelvic-floor tension and relationship satisfaction.

Can menopause cause sexual problems?

It can contribute to vaginal dryness, painful intercourse and changes in desire, but treatment options are available.

Can Unani medicine help with female sexual-health problems?

For selected diagnosed conditions, an individualized Unani approach can be useful as part of comprehensive care, particularly through attention to Mizaj, diet, sleep, stress, lifestyle and

appropriate traditional medicines. The strength of modern scientific evidence varies depending upon the exact condition and formulation.

Does every female sexual problem require herbal medicine?

No.

Some patients primarily require education.

Others need counselling, pelvic-floor physiotherapy, antibiotics, hormonal treatment, fertility evaluation or another condition-specific intervention.

A Personal Message From Dr. Nizamuddin Qasmi

If there is one message I want every woman reading this article to remember, it is this:

Knowing about your body is not something to be ashamed of.

Understanding menstruation does not reduce modesty.

Learning about contraception does not encourage irresponsible behaviour.

Knowing what consent means does not damage relationships.

Learning about fertility does not mean that a woman must become pregnant immediately.

And talking to a doctor about painful intercourse or low sexual desire does not make a woman inappropriate or abnormal.

These are healthcare issues.

In my clinical practice, I have seen how misinformation creates unnecessary fear.

A woman may believe normal vaginal discharge is destroying her health.

Another may tolerate intercourse pain for years.

Another may be convinced that a contraceptive has permanently damaged her fertility.

Another may believe that because she did not bleed during first intercourse, something is wrong with her.

Another may be trying to become pregnant while the real fertility problem is in her partner, yet she alone carries the blame.

Education changes these situations.

The Unani system teaches us to look at the patient as a complete person—her Mizaj, physical health, diet, sleep, mental state and environment.

Modern sexual medicine teaches us to investigate hormones, infection, anatomy, fertility, pelvic-floor function and psychological factors with increasing precision.

I believe women benefit when these strengths are used responsibly together.

Female sexual health should be guided by knowledge, respect, privacy and evidence—not fear, myths or embarrassment.

Conclusion

Female sex education is an essential part of lifelong health.

It should teach women and girls about the female reproductive system, puberty, menstruation, vaginal and vulval health, consent, healthy relationships, contraception, STI prevention, fertility, pregnancy, sexual function and menopause.

WHO's modern concept of sexual health emphasizes that sexual well-being is **physical, emotional, mental and social**, rather than simply freedom from disease.

Current evidence also supports comprehensive, age-appropriate sexual education rather than silence or fear-based teaching. UNESCO's 2026 review shows that high-quality sexuality education improves knowledge and encourages safer and more responsible decision-making.

The Unani system has an established academic tradition in **Amraz-e-Niswan and Ilmul Qabalat**, encompassing female reproductive anatomy, physiology, puberty, menstruation, menopause and gynecological health. Its emphasis on Mizaj, diet, lifestyle and preventive care can contribute meaningfully to individualized women's healthcare.

At **Saira Health Care**, my approach is to combine patient education, confidential consultation, individualized Unani assessment and appropriate contemporary diagnostic knowledge in the management of sexual disorders and infertility.

The goal is not to make unrealistic promises.

The goal is to help women understand what is normal, identify what is abnormal and receive the right treatment when treatment is actually required.

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

Visit Saira Health Care

Medical Disclaimer: This article is intended for education and public awareness. It does not replace individualized medical examination or treatment. Persistent sexual pain, abnormal

bleeding, significant pelvic pain, suspected STI, pregnancy-related concerns, infertility or other sexual and reproductive-health problems should be assessed by an appropriately qualified healthcare professional. Herbal, hormonal, antimicrobial and fertility medicines should not be started solely on the basis of online information.