

Returning to Intimacy After Childbirth

A Complete Guide to Sexual Recovery, Comfort, Desire, Pelvic-Floor Health and Emotional Connection After Having a Baby

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Introduction

After childbirth, families naturally give most of their attention to the newborn baby.

Feeding schedules, sleepless nights, vaccinations, crying, recovery from delivery and adjusting to a completely new routine can occupy almost every hour of the day.

But sooner or later, many couples quietly begin wondering:

“When can we become intimate again?”

The mother may be thinking:

“Will intercourse hurt?”

“Have my stitches healed?”

“Why is my vagina so dry?”

“Why do I have no sexual desire?”

“Will my body ever feel normal again?”

The partner may be thinking:

“Should I initiate intimacy, or will that put pressure on her?”

“Could sex damage her stitches?”

“Does she no longer find me attractive?”

These questions are extremely common.



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Yet many couples do not discuss them because sexual health after childbirth is still treated as an embarrassing subject.

In my clinical work in **sexual disorders and infertility**, I believe postpartum intimacy deserves the same professional attention as fertility, menstruation, erections, ejaculation or any other area of reproductive health.

Childbirth creates major physical, hormonal, emotional and relationship changes.

The World Health Organization considers the first six weeks after childbirth a particularly important period for the mother's physical and psychological recovery, but recovery does not suddenly finish at six weeks. For many women, healing and adjustment continue for months.

My first message to couples is therefore:

There is no competition to restart sexual intercourse after childbirth.

The goal is not to return to sex as quickly as possible.

The goal is to return to **comfortable, consensual and satisfying intimacy when the mother's body and both partners are ready.**

There Is No Single “Normal” Time to Restart Sex

One of the most common questions I hear is:

“Doctor, exactly how many days after delivery can we have intercourse?”

There is no single number that is correct for every woman.

Some women recover quickly after an uncomplicated vaginal birth.

Another woman may have had an episiotomy.

Another may have experienced a third- or fourth-degree tear.

Another may be recovering from a Caesarean section.

Another may have persistent postpartum bleeding.

Another may be physically healed but emotionally unready.

Mayo Clinic notes that there is no mandatory waiting period that applies to everyone, although patients are commonly advised to allow time for healing and often to wait until they have been medically reviewed after childbirth. Vaginal tears should be healed before penetrative sex is resumed.



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The NHS similarly states that there are **no fixed rules about when sexual activity must restart**. A woman can resume when she feels physically and emotionally ready, but she should not feel pressured to rush.

In practice, many clinicians use the approximately **six-week postpartum period** as a useful checkpoint because much of the initial healing has occurred by then.

But six weeks is not a deadline.

A woman is not medically or emotionally “late” because she does not want intercourse at six weeks.

What Happens to the Body After Childbirth?

The postpartum period—traditionally called the puerperium—begins after delivery of the placenta and involves substantial physiological changes as the body gradually moves toward its non-pregnant state.

During this period, the uterus contracts toward its previous size.

Vaginal bleeding and discharge, known as lochia, gradually reduce.

Hormone concentrations change dramatically.

Pelvic-floor tissues recover from pregnancy and delivery.

Abdominal muscles begin recovering.

Breastfeeding may influence estrogen and prolactin levels.

Sleep patterns are disrupted.

The body is also recovering from blood loss, labour, surgery, tearing or episiotomy where applicable.

Sexual recovery therefore involves much more than waiting for one wound to close.

Recovery After Vaginal Birth

Pregnancy itself places pressure on the pelvic floor, and vaginal birth may stretch muscles, nerves and connective tissues further.

After delivery, the vaginal area can feel:

sore,

swollen,



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bruised,

different in sensation,

or temporarily less controlled.

This does not necessarily mean permanent damage.

Pelvic tissues often improve considerably during the weeks and months after childbirth.

RCOG explains that pelvic-floor strength may initially be reduced after birth and sensation may also feel different, but function commonly improves over time.

Perineal Tears Are Common

The **perineum** is the area between the vaginal opening and anus.

During vaginal delivery, this tissue may stretch or tear.

RCOG reports that some degree of tear, graze or episiotomy occurs in as many as **9 in 10 first-time mothers having a vaginal birth**, although most injuries are minor and heal quickly.

A first-degree tear affects mainly the skin.

A second-degree tear extends into perineal muscle.

Third- and fourth-degree injuries involve the anal sphincter and require more extensive repair and follow-up.

It is therefore inappropriate to give exactly the same advice about sexual intercourse to every woman after vaginal delivery.

What If I Had Stitches or an Episiotomy?

An episiotomy is a surgical incision made in the perineum during some vaginal births.

Whether stitches result from an episiotomy or natural tear, the tissues need time to heal.

RCOG notes that superficial healing commonly occurs over the first several weeks and tenderness should gradually improve.

When sexual activity resumes, scar tissue may initially feel:

tight,

sensitive,



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tender,

or less flexible.

The first few attempts at intercourse may therefore feel different.

But significant persistent pain should not simply be tolerated.

If the scar remains very painful, feels excessively tight or causes repeated difficulty with penetration, medical review and sometimes pelvic-health physiotherapy can help.

Recovery After a Third- or Fourth-Degree Tear

Women who experience a deeper obstetric anal sphincter injury often require more time and more careful follow-up.

RCOG advises that intercourse can generally be considered once stitches have healed, postpartum bleeding has stopped and the woman feels ready. Persistent pain, bowel-control symptoms or other problems require further evaluation.

Recent evidence reinforces the importance of taking these injuries seriously.

A systematic review published in 2024 found substantial rates of dyspareunia and sexual dysfunction during the first postpartum year among women who had sustained obstetric anal sphincter injuries.

Therefore, a woman recovering from a major tear should not compare her recovery timeline with that of someone who had an uncomplicated birth.

Returning to Intimacy After a Caesarean Section

Some people assume:

“Because the baby did not pass through the vagina, sex should be easy after a C-section.”

This is not necessarily true.

A Caesarean section is major abdominal surgery.

Although there may be less perineal trauma, the uterus, abdominal wall and deeper tissues still require healing.

Postpartum bleeding also occurs after C-section because the uterine lining still has to recover from pregnancy.



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ACOG notes that the abdominal incision remains sore during early recovery and advises allowing several weeks for healing before vaginal intercourse or placing anything in the vagina.

The NHS notes that many women do not feel comfortable resuming activities such as sexual intercourse until approximately six weeks after a Caesarean, although individual recovery differs.

The important principle is:

A C-section does not remove the need for postpartum recovery.

Why Does Sex Sometimes Hurt After Childbirth?

Pain during intercourse after delivery is called **postpartum dyspareunia**.

It is relatively common, particularly during the early months after childbirth.

A 2025 systematic review found that postpartum sexual difficulties during the first year are strongly associated with factors such as perineal trauma, early postpartum pain, assisted vaginal delivery and breastfeeding-related changes.

Pain can arise for several different reasons.

The tissues may still be healing.

A scar may remain sensitive.

Lubrication may be reduced.

The pelvic-floor muscles may be too tense.

There may be fear of penetration.

Occasionally infection, granulation tissue or another pelvic condition may be present.

Therefore:

Postpartum pain should be investigated according to its cause rather than dismissed as something every mother must tolerate.

Breastfeeding Can Cause Vaginal Dryness

This is an important subject because many women are surprised by it.

Breastfeeding influences reproductive hormones.



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Prolactin is elevated and estrogen levels may remain lower, particularly during frequent breastfeeding.

Lower estrogen can make vaginal tissues:

drier,

less lubricated,

more sensitive,

and sometimes uncomfortable during intercourse.

Mayo Clinic's 2026 guidance specifically identifies both **childbirth and breastfeeding** as causes of lower-estrogen vaginal dryness.

ACOG similarly recognises childbirth and breastfeeding as situations in which lower estrogen may cause vaginal dryness.

A 2025 systematic review of postpartum and lactation-related genitourinary symptoms also found clinically important rates of vaginal dryness, dyspareunia and sexual-function problems among breastfeeding individuals.

This does **not** mean breastfeeding is unhealthy or should be stopped because of sexual symptoms.

It means that the symptoms should be recognised and managed appropriately.

Lubrication Can Make a Major Difference

A woman who never required lubricant before pregnancy may temporarily need it after childbirth.

There is nothing abnormal or embarrassing about this.

A suitable personal lubricant reduces friction and may make penetration substantially more comfortable when dryness is an important factor.

Both Mayo Clinic and NHS postpartum guidance specifically recommend considering lubricant when vaginal dryness is making intercourse uncomfortable.

If condoms are being used, choose a lubricant that is compatible with the condom material.

If dryness or pain remains significant despite lubrication, medical assessment is appropriate rather than repeatedly forcing intercourse.



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“I Have No Desire for Sex After Having My Baby”

This is another very common concern.

Low desire after childbirth does not automatically indicate a sexual disorder.

Consider what the mother may be experiencing:

She may be sleeping in short intervals.

She may be breastfeeding several times each night.

She may still have pelvic or abdominal pain.

She may be worried about the baby.

She may feel uncomfortable about changes in her body.

She may be afraid intercourse will hurt.

She may be touched constantly throughout the day while feeding and caring for the baby.

She may simply be exhausted.

Under these circumstances, it is understandable that sexual desire may temporarily be reduced.

Hormonal changes can also contribute.

Postpartum sexuality should therefore never be judged purely by comparing libido with the woman's pre-pregnancy level during the first few weeks or months.

The Partner Should Not Interpret Low Desire as Rejection

This is where communication becomes extremely important.

A partner may think:

“She loved intimacy before the baby. Now she never initiates it. Maybe she has lost attraction to me.”

The mother may actually be thinking:

“I love my partner, but I am exhausted, dry and frightened that penetration will hurt.”

If these thoughts are never spoken aloud, emotional distance can develop.

A helpful conversation might be:



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“I still care about our intimate relationship, but my body is recovering and my desire is different right now. I need us to return gradually without pressure.”

That statement allows the partner to understand that recovery is occurring—not rejection.

The Importance of Partner Support

Postpartum sexual recovery does not take place in isolation.

Recent evidence suggests that higher levels of partner and family support are associated with better sexual-function outcomes during the postpartum year.

Support is not only saying:

“Tell me when you’re ready.”

It can also mean helping with:

night-time baby care,

household work,

meals,

appointments,

older children,

and giving the mother opportunities to sleep and recover.

If a mother is physically exhausted every day, sexual desire cannot reasonably be treated as though it exists separately from the rest of her life.

Body Image After Childbirth

A woman's body may change dramatically after pregnancy.

She may notice:

abdominal changes,

stretch marks,

breast changes,

weight changes,

a Caesarean scar,



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perineal scarring,

or changes in pelvic-floor sensation.

Some women adapt comfortably.

Others struggle with confidence.

A recent systematic review found that more positive postpartum body image was associated with better sexual-function outcomes.

The partner can help considerably by avoiding criticism and reassuring the mother without putting pressure on her to “return” immediately to her pre-pregnancy appearance.

Pregnancy changes the body because the body has completed an enormous biological task.

Recovery deserves time.

Pelvic-Floor Recovery Matters

The pelvic floor supports the:

bladder,

uterus,

rectum,

and other pelvic structures.

Pregnancy places increasing pressure on these muscles for months.

Vaginal delivery may further stretch or injure them.

Women may therefore experience:

urine leakage,

difficulty controlling wind,

a sensation of vaginal heaviness,

reduced pelvic sensation,

or changes during sexual activity.

RCOG encourages pelvic-floor rehabilitation following childbirth and recommends specialist physiotherapy when significant bladder, bowel, pain or pelvic-floor dysfunction persists.



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Evidence suggests postpartum pelvic-floor muscle training can improve some pelvic-floor outcomes, although protocols and study quality vary.

Not Every Pelvic Floor Needs Only “More Strengthening”

This is an important clinical point.

Some postpartum women have a **weak** pelvic floor.

Others develop muscles that are painful or excessively tight.

A woman with pain during penetration may therefore not benefit from simply doing hundreds of contractions without proper assessment.

Pelvic-health physiotherapy can evaluate:

strength,

relaxation,

coordination,

scar sensitivity,

pain,

bladder function,

and bowel symptoms.

A good pelvic-floor programme should be individualized.

Urinary Leakage During Intimacy

Some women notice urine leakage during coughing, exercise or sexual activity after childbirth.

This can be embarrassing and may lead them to avoid intimacy.

Please do not hide it.

Postpartum urinary leakage is common, and pelvic-floor rehabilitation can help many patients.

A 2025 systematic review found that physiotherapy-based interventions, particularly pelvic-floor muscle exercise programmes, may reduce postpartum urinary-incontinence symptoms, although further high-quality research remains necessary.



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Persistent leakage deserves assessment rather than being accepted as an unavoidable lifelong consequence of motherhood.

Fear Can Make Pain Worse

Suppose the first attempt at intercourse after childbirth hurts.

The woman remembers the pain.

Before the second attempt, she becomes anxious.

Her pelvic-floor muscles tighten.

Arousal and lubrication reduce.

Penetration becomes more difficult.

The second experience hurts again.

Now she begins thinking:

“Sex is going to hurt every time.”

This can create a cycle:

pain → fear → muscle tension → reduced arousal → more pain → greater fear

At this stage, the original physical injury may already be healing, but the protective response remains.

This is where pelvic-floor therapy, gradual reintroduction of intimacy and sometimes psychological or psychosexual support can be extremely useful.

Do Not Force Penetration to “Make the Body Normal Again”

This is very important.

If intercourse is painful, repeated forceful penetration is not rehabilitation.

It can make the problem worse.

It may irritate healing tissues.

It may increase pelvic-floor tightening.

And it can create fear associated with intimacy.

The correct approach is:

stop when it hurts, identify the cause, allow healing and return gradually.



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Sexual activity should never be continued because one partner feels obligated.

Intimacy Does Not Have to Mean Penetration

Couples sometimes make the mistake of believing:

“If we cannot have intercourse, we cannot be intimate.”

That is not true.

During recovery, intimacy can include:

affection,

kissing,

cuddling,

massage,

conversation,

non-painful sexual touching,

and other mutually comfortable forms of closeness.

This allows couples to maintain emotional and physical connection without turning penetration into a test of recovery.

Mayo Clinic specifically advises couples experiencing postpartum discomfort to consider forms of sexual connection other than vaginal intercourse while recovery continues.

How to Restart Intimacy Gradually

When both partners feel ready, there should be no pressure to reproduce exactly the kind of intercourse they had before pregnancy.

Start slowly.

Choose a time when the baby is settled and both partners are reasonably rested.

Allow plenty of time for arousal.

Use lubricant if necessary.

The person who recently gave birth should be able to control the pace and depth of penetration.



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If something hurts:

stop.

Changing position may sometimes improve comfort.

The first postpartum sexual experience does not need to be a test of whether everything is “normal.”

“Will My Vagina Be Permanently Loose?”

This concern causes enormous unnecessary anxiety.

Pregnancy and vaginal birth can temporarily change pelvic-floor tone and vaginal sensation.

But the vagina is a highly elastic muscular structure.

Postpartum recovery continues over many months.

Pelvic-floor rehabilitation can improve strength and function when weakness is present.

Persistent significant symptoms such as vaginal heaviness, bulging, major urinary leakage or bowel-control difficulties should be assessed because they may indicate pelvic-floor dysfunction or prolapse.

A woman should not be made to feel defective because her body feels different several weeks after childbirth.

Sexual Function Can Continue Improving for Months

Recovery is not limited to the traditional six-week postpartum visit.

A 2025 systematic review found that sexual-function problems can remain relevant throughout the first postpartum year, with some breastfeeding-related effects becoming less prominent over time.

Other research similarly shows that sexual function may remain altered beyond the early postpartum period, especially after perineal trauma or assisted vaginal birth.

Therefore:

Six weeks is a checkpoint—not the end of recovery.

Contraception Must Be Discussed Before Sex Restarts



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This is critically important.

Some couples assume:

“Periods haven't returned, so pregnancy cannot occur.”

That is incorrect.

Ovulation occurs **before** a menstrual period.

Therefore, the first postpartum ovulation can occur before a woman ever sees her first postpartum period.

NHS guidance warns that pregnancy can occur from approximately **three weeks after childbirth**, even when breastfeeding and before menstruation has resumed.

ACOG likewise notes that fertility can return relatively quickly after childbirth and recommends discussing postpartum contraception before unintended pregnancy occurs.

Does Breastfeeding Prevent Pregnancy?

Breastfeeding can suppress ovulation, but breastfeeding alone is **not automatically reliable contraception**.

The Lactational Amenorrhea Method, or **LAM**, works only under specific conditions.

The mother must remain amenorrhoeic, the baby must be younger than six months, and breastfeeding must be exclusive or nearly exclusive with sufficiently frequent feeding.

WHO advises transitioning to another method when these criteria are no longer fulfilled and by six months postpartum.

If another pregnancy is not currently desired, discuss contraception with a doctor, midwife or appropriate reproductive-health professional.

How Long Should Couples Wait Before Another Pregnancy?

This is different from asking when intercourse can restart.

Intercourse may restart once recovery allows.

But another pregnancy is a separate decision.

WHO public-health guidance advises waiting **at least two years after childbirth before attempting another pregnancy** to reduce risks for mother and baby.



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Other professional guidance, including ACOG, advises avoiding intervals shorter than six months and counselling about the increased risks associated with pregnancy sooner than approximately 18 months after the previous birth.

Individual circumstances matter.

Age, previous infertility, Caesarean delivery, pregnancy complications and reproductive plans can all influence advice.

Returning to Intimacy After a Difficult or Traumatic Birth

Not all birth experiences are emotionally positive.

Some women experience:

emergency surgery,

severe bleeding,

a major tear,

unexpected neonatal complications,

intensive-care treatment,

or a birth that felt frightening or out of control.

The body may heal before the mind has processed the experience.

A woman may become frightened of genital touch.

She may have intrusive memories.

She may avoid hospitals or discussions about the delivery.

Intimacy may bring back memories of examinations or procedures.

RCOG acknowledges that serious perineal injury and complicated childbirth can be emotionally distressing and that some women develop anxiety, low mood or post-traumatic symptoms requiring support.

Such patients should not be told simply to “relax.”

Trauma-informed psychological treatment may be appropriate.

Postpartum Depression, Anxiety and Sexual Desire

Mental health is another important part of postpartum sexuality.



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Some mood fluctuation in the first few days can represent the commonly described **baby blues**.

ACOG notes that baby-blues symptoms generally improve within days to one or two weeks.

Postpartum depression is different.

It can involve persistent sadness, anxiety, hopelessness, loss of interest, difficulty functioning and sometimes thoughts of harming oneself or the baby.

WHO emphasises that postpartum depression and anxiety are common and treatable and that postnatal care should address physical, psychological and social wellbeing together.

A person experiencing significant depression understandably may have little interest in sexual activity.

The priority in such a situation is not to pressure sexual performance.

It is to treat the mental-health condition.

Postpartum Psychosis Is an Emergency

Postpartum psychosis is uncommon but extremely serious.

Symptoms may include:

hallucinations,
delusional beliefs,
severe confusion,
rapidly changing mood,
or behaviour indicating loss of contact with reality.

WHO identifies postpartum psychosis as a medical emergency requiring urgent treatment.

Likewise, thoughts of suicide, serious self-harm or harming the baby require immediate professional or emergency assistance.

These symptoms should never be dismissed as tiredness.

The Partner Can Also Struggle Emotionally

The person who gave birth is not the only one adjusting.

Partners may experience:

sleep deprivation,
anxiety,
financial pressure,
fear about the baby's health,
changes in relationship roles,
and feelings of being excluded.

ACOG notes that depression and anxiety after a baby's birth can also occur in partners and encourages professional help when symptoms appear.

A healthy postpartum relationship therefore requires communication in both directions.

What If the Partner Wants Sex Before the Mother Is Ready?

The answer is straightforward:

She should not be pressured.

Giving birth does not create an obligation to resume intercourse on a particular schedule.

The partner can communicate desire without demanding sexual activity.

A respectful statement might be:

"I miss being close to you, but I want you to tell me when you feel physically and emotionally comfortable."

That preserves both honesty and consent.

A damaging approach would involve:

guilt,
threats,
comparison,
repeated pressure,
or treating intercourse as a marital duty regardless of pain.

Healthy intimacy requires mutual willingness.



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How the Mother Can Explain Her Needs

Many women avoid discussing the issue because they do not want their partner to feel rejected.

A simple conversation can help:

“I still love being close to you, but my body is recovering from childbirth. I am tired and sometimes worried that intercourse will hurt. I want us to return to intimacy gradually rather than rushing.”

If dryness is the problem, say so.

If the scar hurts, say so.

If desire is absent, say so.

If you are afraid, say so.

Partners cannot understand symptoms that remain completely hidden.

When Should Persistent Pain Be Investigated?

Some mild discomfort during the first attempt after childbirth can occur.

Persistent pain deserves evaluation.

Speak with an appropriate healthcare professional if:

pain is moderate or severe,

pain happens repeatedly,

penetration remains impossible,

the episiotomy or tear scar feels very painful,

bleeding occurs repeatedly after intercourse,

there is abnormal or foul-smelling discharge,

there is persistent urinary or bowel leakage,

there is vaginal pressure or bulging,

or pain is not gradually improving.



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ACOG recommends postpartum care that specifically addresses sexuality, dyspareunia, contraception and physical recovery rather than treating the postpartum visit merely as a quick routine examination.

Important Postpartum Warning Signs

Sexual-health concerns sometimes occur alongside more serious postpartum complications.

Seek urgent medical assessment for symptoms such as:

very heavy bleeding,
high fever,
severe or worsening lower-abdominal pain,
severe persistent headache or visual symptoms,
chest pain,
significant breathlessness,
seizures,
or painful swelling in one leg.

Thoughts of harming yourself or the baby also require urgent help.

ACOG lists these among important postpartum warning symptoms that should receive prompt medical attention.

Sex should obviously be postponed while a significant postpartum complication is being evaluated or treated.

The Unani Perspective on Postpartum Recovery

In Unani medicine, the postpartum period is traditionally recognised as a distinct stage of maternal recovery, commonly associated with the concept of **Nifas** and the puerperal period.

This broader approach is important because the woman is not considered simply as someone whose delivery has finished.

She is a patient recovering from pregnancy and childbirth whose:
strength,

nutrition,
sleep,
physical condition,
emotional state,
reproductive system,
and general wellbeing
all require attention.

The Central Council for Research in Unani Medicine has historically included professional discussion specifically on **puerperium and prevention of puerperal diseases**, reflecting the recognised place of postpartum care within Unani obstetrics and gynaecology.

Why the Unani Approach Can Be Valuable

One of the useful features of responsible Unani practice is its emphasis on the whole patient rather than one isolated symptom.

After childbirth, I do not believe treatment should begin with the question:

“Which sexual medicine should we give?”

Instead, we should ask:

Is the mother physically healed?

Is she breastfeeding?

Is she excessively weak or fatigued?

Is there anaemia?

Is she sleeping at all?

Is there constipation?

Is there pelvic pain?

Is there vaginal dryness?

Are the pelvic-floor muscles functioning well?

Was there a tear or episiotomy?

Has the Caesarean wound healed?



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Is there fear of intercourse?

Is there depression or anxiety?

Does she wish to become pregnant again soon?

Only when these questions are answered can supportive treatment become rational.

Unani Lifestyle Principles During Postpartum Recovery

The broader Unani health framework gives considerable importance to diet, sleep, rest and activity, psychological state and bodily functions.

In modern clinical practice, these principles can be translated into practical attention to:

adequate nutrition,

appropriate hydration,

rest and sleep wherever possible,

gradual physical recovery,

bowel health,

emotional wellbeing,

and individualized postpartum care.

These principles can complement modern postnatal recommendations.

WHO likewise emphasises that postnatal care should support the mother's overall physical and mental recovery rather than focusing exclusively on the newborn.

What Is the Role of Unani Medicine in Postpartum Sexual Problems?

In appropriately selected women, individualized Unani care may have a **supportive role** in postpartum recovery.

Depending on the clinical situation, the focus may include:

general recovery after childbirth,

nutrition,

digestive health,

sleep,



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fatigue,

emotional wellbeing,

menstrual and reproductive health,

and associated sexual-health complaints.

However, it is extremely important to understand the limits of treatment.

A herbal formulation cannot repair an unhealed third-degree tear.

It cannot replace treatment of postpartum infection.

It cannot substitute for pelvic-floor rehabilitation when significant muscular injury is present.

It cannot safely replace treatment for postpartum depression or psychosis.

And it cannot replace obstetric or gynaecological assessment for unexplained bleeding or severe pelvic pain.

This is where responsible integration becomes important.

What Does Modern Research Say About Unani Postpartum Sexual Care?

At present, high-quality modern clinical research specifically testing Unani treatment for **postpartum sexual dysfunction or postpartum dyspareunia** is limited.

This should be stated honestly.

Unani medicine has an established traditional framework relating to puerperium and women's health, but many traditional postpartum interventions still require well-designed clinical trials before specific claims about sexual-function outcomes can be made.

A recent 2026 case report involving a postpartum patient treated through an integrated regimen that included Unani care also illustrates continuing academic interest in multidisciplinary postpartum treatment, but a single case report cannot establish effectiveness for unrelated postpartum sexual problems.

Therefore, at Saira Health Care, my approach is:

respect traditional Unani principles, use them responsibly, and combine them with appropriate modern diagnosis.

Herbal Medicines During Breastfeeding Require Extra Care



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Another important point is breastfeeding.

A medicine taken by the mother may sometimes reach breast milk.

The safety of many traditional herbs during lactation has not been studied to the same extent as commonly used modern medicines.

Therefore:

“Natural” does not automatically mean “safe during breastfeeding.”

Before prescribing or taking a Unani or herbal formulation, the doctor should know that the patient is breastfeeding.

The infant's age, the ingredients, dose, duration and available safety information should all be considered.

Unknown over-the-counter herbal mixtures should be avoided.

My Approach at Saira Health Care

At **Saira Health Care**, I consider returning to intimacy after childbirth to be a sexual and reproductive-health issue that deserves confidential, individualized assessment.

My approach begins with understanding the birth itself.

Was it a spontaneous vaginal birth?

Was forceps or vacuum assistance used?

Was there an episiotomy?

Was there a significant tear?

Was the birth by Caesarean?

Is the patient breastfeeding?

Has bleeding stopped?

Is penetration painful?

Is vaginal dryness present?

Is there urinary leakage?

Is there bowel dysfunction?

Is there a sensation of pelvic heaviness?

Has sexual desire changed?



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Is there fear after the birth experience?

Is the relationship being affected?

Is the couple planning another pregnancy?

The answer may then involve reassurance, sexual-health counselling, individualized supportive Unani management or referral for appropriate specialist treatment.

Why Collaboration Is Important

Postpartum sexual problems sometimes require more than one professional.

A woman with an unhealed perineal injury may need an obstetrician or gynaecologist.

A woman with significant pelvic-floor dysfunction may need a pelvic-health physiotherapist.

A patient with urinary or bowel incontinence may require urogynecological or colorectal assessment.

Persistent severe pain may require specialist pelvic-pain evaluation.

Postpartum depression may require mental-health treatment.

A traumatic birth may require psychological support.

Responsible sexual medicine means recognising when another specialist's expertise is necessary.

Saira Health Care's Contribution to Sexual Disorders and Infertility

Through **Saira Health Care**, my work focuses particularly on sexual disorders, infertility and reproductive health—areas in which physical symptoms and relationship concerns frequently overlap.

Returning to intimacy after childbirth is a good example.

The woman's issue may appear to be:

“Sex hurts.”

But underneath that symptom may be:

breastfeeding-related dryness,

a painful episiotomy scar,

pelvic-floor dysfunction,



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fear,

low desire,

sleep deprivation,

postpartum depression,

or concern about another pregnancy.

The partner may simultaneously develop:

sexual frustration,

fear of causing pain,

performance anxiety,

or confusion about how to restart intimacy.

The objective should therefore not simply be:

“Resume intercourse.”

It should be:

restore comfortable, respectful sexual wellbeing.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

Founder & Chief Physician – Saira Health Care

Focused Practice in Sexual Disorders & Infertility

My stated professional qualifications 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

My focused clinical practice involves sexual disorders, infertility and reproductive-health concerns, where sexual function often intersects with hormonal health, fertility, emotional wellbeing, partner relationships and chronic medical conditions.



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At Saira Health Care, my objective is to provide patients and couples with an environment in which sexual concerns can be discussed without shame and managed according to their individual circumstances.

Frequently Asked Questions

When can we have sex after childbirth?

There is no single date that applies to everyone.

The mother should be physically healed, significant bleeding should have resolved, wounds or tears should be appropriately healed and she should feel emotionally comfortable.

Many clinicians use approximately six weeks as an important recovery checkpoint, but some women require longer.

Is sex safe before six weeks?

Some women may feel physically well earlier, but the early postpartum period involves uterine, vaginal or surgical healing and a greater risk of complications.

It is sensible to follow the advice of the obstetric team who knows the details of the delivery rather than treating six weeks as either an absolute prohibition or an automatic clearance.

How long after a C-section should we wait?

Recovery varies, but abdominal and internal tissues require several weeks to heal.

Many women do not feel ready until approximately six weeks or later. Sex should not be painful or place strain on an incompletely healed wound.

Why is my vagina dry after childbirth?

Estrogen may fall after childbirth and remain relatively low during breastfeeding.

This can reduce natural vaginal moisture and make intercourse uncomfortable.

Is lubricant safe to use?



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Appropriate personal lubricant is commonly recommended when postpartum dryness is causing friction or discomfort.

If pain persists despite lubricant, obtain medical evaluation rather than continuing painful intercourse.

Why do I have no interest in sex?

Low desire can result from hormonal changes, breastfeeding, exhaustion, sleep deprivation, pain, fear of pregnancy, body-image concerns, depression, anxiety and the demands of caring for a newborn.

There is no requirement for libido to return on a particular timetable.

Does breastfeeding reduce libido?

It can in some women.

Breastfeeding-related hormonal changes, vaginal dryness, fatigue and frequent physical contact with the baby may all influence sexual desire and comfort.

Recent research shows breastfeeding is often associated with lower early postpartum sexual-function scores and increased dyspareunia, although these effects tend to lessen over time.

Can I become pregnant before my first postpartum period?

Yes.

Ovulation occurs before menstruation, so pregnancy can occur before the first period.

NHS guidance advises that conception can occur as early as approximately three weeks after birth.

Is breastfeeding enough contraception?

Only when all requirements for the Lactational Amenorrhea Method are met: the baby is younger than six months, menstruation has not returned and breastfeeding is exclusive or nearly exclusive with sufficiently frequent feeds.

Otherwise another method should be used if pregnancy is not desired.



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Why does my episiotomy scar hurt during sex?

Scar tissue can initially be tender or tight.

This commonly improves as healing continues, but persistent pain may require examination, scar management or pelvic-floor physiotherapy.

Can pelvic-floor therapy help?

Yes, especially when there is urinary leakage, muscle dysfunction, pain, pelvic heaviness or difficulty coordinating the pelvic floor.

RCOG supports specialist women's-health physiotherapy when postpartum pelvic-floor problems persist.

Is urine leakage after childbirth permanent?

Not necessarily.

Many women improve as tissues recover and pelvic-floor strength returns.

Persistent symptoms should be assessed rather than accepted as inevitable.

Can postpartum depression reduce sexual desire?

Yes.

Depression and anxiety can substantially affect interest, energy, confidence and emotional connection.

Postpartum depression is treatable and should be discussed with a healthcare professional rather than hidden.

Should I continue intercourse if it hurts?

No.

Stop or change the activity.

Repeatedly forcing painful penetration can worsen physical irritation and create a stronger pain–fear cycle.

Persistent pain should be evaluated.



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Can Unani medicine help postpartum recovery?

Individualized Unani care may be useful as supportive management for general recovery, nutrition, sleep, digestive wellbeing, lifestyle, emotional balance and selected reproductive-health complaints.

However, evidence specifically proving Unani treatment for postpartum sexual dysfunction remains limited.

Necessary obstetric, gynaecological, pelvic-floor or mental-health treatment should not be delayed.

Can I take Unani medicines while breastfeeding?

Only after appropriate assessment.

Breastfeeding should always be disclosed because medicines and herbal ingredients need to be selected with maternal and infant safety in mind.

Do not assume every natural product is automatically safe during lactation.

My Message to New Mothers

If you have recently had a baby and do not feel ready for intercourse, please understand:

You are not failing your partner.

Your body has undergone pregnancy and childbirth.

It may be healing from stitches.

It may be healing from major abdominal surgery.

You may be breastfeeding.

Your hormones are changing.

You may be waking several times every night.

Your pelvic floor may still be recovering.

Your body may feel unfamiliar.

Give yourself permission to recover.

And when you do return to intimacy, do it because you feel ready—not because a calendar says six weeks have passed.



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My Message to Partners

If your partner has recently given birth, one of the most valuable things you can provide is patience.

Do not measure the strength of your relationship according to how quickly intercourse resumes.

Help with the baby.

Help her sleep.

Help with the house.

Listen when she tells you something hurts.

Do not interpret every temporary lack of sexual interest as rejection.

Postpartum recovery is a biological process, not a test of affection.

The intimacy you protect during recovery often creates a stronger foundation for sexual closeness later.

Final Words From Dr. Nizamuddin Qasmi

When couples ask me about returning to intimacy after childbirth, I do not want them to think only about:

“How many weeks?”

The better questions are:

Has the body healed?

Is intercourse comfortable?

Has bleeding stopped appropriately?

Is there dryness?

Are the pelvic-floor muscles recovering?

Is the mother emotionally ready?

Are both partners communicating?

Has contraception been discussed?

Are there symptoms that require treatment?



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These questions are far more important than selecting one date on a calendar.

Modern obstetrics teaches us about tissue healing, postpartum complications, breastfeeding-related hormonal changes, contraception and pelvic-floor rehabilitation.

Modern psychological care helps us understand postpartum depression, anxiety, trauma and relationship adjustment.

The Unani system contributes a longstanding whole-person perspective that recognises the postpartum period as an important stage of recovery in which rest, nutrition, lifestyle, general health and psychological balance deserve attention.

At **Saira Health Care**, my objective is to approach sexual and reproductive health with this broader understanding.

Traditional medicine should not be exaggerated.

Modern medicine should not ignore the patient's emotional or sexual quality of life.

The patient needs both scientific responsibility and compassionate care.

So my final message to couples is simple:

Do not rush.

Do not compare your recovery with another couple.

Do not continue intimacy that hurts.

Do not be ashamed to talk about dryness, pain, desire or fear.

Use contraception if another pregnancy is not currently planned.

Seek medical help when symptoms persist.

And remember:

Returning to intimacy after childbirth is not about returning to the past as quickly as possible. It is about discovering a comfortable, respectful and healthy way of being close again after one of the biggest physical and emotional changes a couple can experience.

Important Medical Disclaimer

This article is intended for general patient education and health awareness. It does not replace individual postpartum, obstetric, gynaecological, psychiatric or pelvic-floor assessment.



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Recovery after childbirth varies according to the mode of birth, perineal injuries, Caesarean healing, breastfeeding, medical complications and the mother's individual health.

Persistent painful intercourse, significant bleeding, abnormal discharge, wound problems, urinary or bowel dysfunction or serious pelvic pain should receive professional evaluation.

Urgent medical assessment is required for severe bleeding, chest pain, difficulty breathing, seizures, severe headache with neurological or visual symptoms, significant leg swelling or pain, severe abdominal pain, high fever, or other concerning postpartum symptoms. Thoughts of harming oneself or the baby require immediate mental-health or emergency assistance.

Unani and herbal medicines should be used under appropriately qualified professional supervision, particularly during breastfeeding. Unani supportive care should not replace medically necessary treatment of postpartum haemorrhage, infection, significant birth injury, pelvic-floor dysfunction, depression, psychosis or other postpartum complications.



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