Intercourse Education for Women: A Comprehensive Guide to Sexual Health, Consent, Intimacy, Safe Sex and Healthy Married Relationships

Understanding Female Sexual Response, Comfortable Intercourse, Pregnancy Prevention, STI Protection, Communication, Counselling and the Integrative Unani Perspective

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Updated with scientific and clinical information available through September 2026

Introduction

In my clinical practice, I have observed that many women enter marriage or an intimate relationship with very little reliable information about their own sexual health. They may know about menstruation and pregnancy, yet know very little about female sexual anatomy, arousal, lubrication, contraception, sexually transmitted infections, consent, orgasm, painful intercourse or how to communicate comfortably with a partner.

This lack of education can create unnecessary fear.

A woman may wonder:

“Will intercourse always hurt?”

“Do I have to bleed the first time?”

“Can I become pregnant the first time?”

“How do I tell my husband that something is painful?”

“Is it normal if I need more time to become aroused?”

“What if my sexual desire is different from my partner's?”

“Is something wrong with me if I do not reach orgasm every time?”

These are legitimate health questions, not reasons for embarrassment.

The World Health Organization describes sexual health much more broadly than simply the absence of disease. It includes physical, emotional, mental and social well-being related to sexuality and emphasizes respectful, safe and pleasurable sexual experiences that are free from coercion, discrimination and violence.

The WHO's **March 2026 comprehensive sexuality education guidance** similarly emphasizes scientifically accurate information about relationships, consent, communication, anatomy, menstruation, fertility, contraception, pregnancy prevention, sexually transmitted infections and help-seeking skills. Importantly, evidence reviewed by WHO shows that good sexuality education does **not** encourage earlier or riskier sexual behaviour; instead, it supports healthier and more informed decisions.

Although this article appears in a disease/health-information section, **intercourse education itself is not a disease**. It is preventive sexual and reproductive healthcare.

My aim in this article is therefore to discuss sexual intercourse from the perspective of **health, dignity, comfort, mutual respect, communication and responsible medical knowledge**, while also explaining how appropriate principles of Unani medicine can complement this approach.

Why Intercourse Education Is Important for Women

Intercourse education is not simply an explanation of how sexual intercourse occurs.

A complete education should help a woman understand:

her own body, sexual response, menstrual and reproductive physiology, pregnancy risk, contraception, STI prevention, consent, personal boundaries, sexual pain, lubrication, communication, emotional intimacy and when medical help is required.

WHO's current comprehensive sexuality education framework specifically includes relationships, communication, bodily autonomy, consent, reproductive anatomy, pregnancy prevention, contraception and sexually transmitted infections as interconnected areas rather than treating sexual activity as an isolated physical event.

I believe this is particularly important in communities where women may receive most of their information from friends, social media, pornography or frightening cultural myths rather than qualified healthcare professionals.

Incorrect information can create fear before intimacy has even begun.

Correct information creates confidence.

Sexual Health Begins With Understanding the Female Body

Many women are never properly taught the difference between the vulva and the vagina.

The **vulva** refers to the external female genital structures.

The **vagina** is an internal muscular canal leading toward the cervix.

The clitoris is an important organ of sexual sensation. Only a portion of it is externally visible; much of its structure extends internally.

The vagina is not simply a passive passage. Its walls are muscular and capable of adapting, while the pelvic floor also contributes to sexual comfort and function.

Understanding these structures can reduce fear and help women communicate much more accurately when something is uncomfortable.

The Clitoris and Female Sexual Pleasure

Female sexual satisfaction should not be reduced to vaginal penetration.

The clitoris contains extensive sensory innervation and is central to sexual pleasure for many women.

Some women can reach orgasm with penetration, while many require additional clitoral stimulation.

Neither pattern represents abnormality.

This is why intercourse education should teach couples that female sexual satisfaction is not measured by penetration alone.

A healthy sexual relationship should be based on mutual understanding of what feels pleasurable, comfortable and appropriate to each individual rather than assumptions based on films, pornography or hearsay.

The Hymen: One of the Most Important Myths to Correct

Women and families frequently misunderstand the hymen.

The hymen is a thin membrane of variable shape and appearance located near the vaginal opening. ACOG explains that it may stretch or tear during sexual activity, but it may also change because of tampon use, sports or medical procedures. Most importantly, **the presence or absence of hymenal tissue does not establish whether a woman has previously had sexual intercourse.**

WHO, UN Women and the UN Human Rights Office have stated clearly that no genital examination can scientifically prove whether a woman or girl has previously had vaginal intercourse and that so-called “virginity testing” has no scientific or clinical basis.

This is extremely important.

A woman should never be medically judged, shamed or declared “virgin” or “not virgin” based on a hymen examination.

Does a Woman Have to Bleed During First Intercourse?

No.

Bleeding during first intercourse is **not compulsory** and does not prove or disprove previous sexual activity.

Some women may experience a small amount of bleeding because of friction, tissue stretching or inadequate lubrication.

Many do not bleed at all.

Therefore, the culturally common expectation that:

“A newly married woman must bleed on the first night”

has no reliable medical basis.

Persistent, heavy or recurrent bleeding after intercourse should be evaluated rather than assumed to be normal. ACOG considers spotting or bleeding after sex a form of abnormal uterine bleeding that may deserve assessment depending on the circumstances.

First Intercourse Does Not Have to Be Painful

Some discomfort may occur, particularly if a woman is anxious, not fully aroused, insufficiently lubricated or if intercourse is rushed.

But severe pain should never be regarded as an unavoidable part of becoming sexually active.

ACOG notes that painful intercourse is common at some point in women's lives but can result from multiple treatable causes, including inadequate arousal or lubrication, vulvovaginal disorders, pelvic-floor muscle spasm, vaginismus, endometriosis, infections, scars and hormonal changes. Frequent or severe pain should be assessed.

The most useful rule is simple:

Pain is information—not something a woman should be forced to tolerate.

Why Anxiety Can Make Intercourse More Difficult

The mind and body interact closely during sexual activity.

If a woman is frightened, under pressure or anticipating severe pain, pelvic muscles may tighten and arousal may decrease.

Reduced arousal can reduce natural lubrication.

Reduced lubrication increases friction.

The discomfort then confirms the original fear.

A cycle can develop:

fear → muscle tension → less arousal → more discomfort → more fear.

This is one reason why patience, reassurance and emotional safety are medically relevant aspects of sexual intercourse.

Female Sexual Desire Is Not Always Immediate

Many couples wrongly assume:

“If a woman wants intercourse, she should become sexually excited immediately.”

That is not how everyone experiences desire.

Some women experience spontaneous desire before intimate activity.

Others experience **responsive desire**, meaning sexual interest develops after emotional closeness, affectionate touch or pleasurable stimulation begins.

This variation is normal.

A woman should not be declared “cold” or sexually weak simply because she needs more time to become mentally and physically engaged.

Responsive Desire Does Not Mean Consent Can Be Assumed

This distinction is essential.

A woman may freely decide:

“I am not strongly aroused yet, but I feel comfortable beginning affectionate intimacy and seeing how I respond.”

That is very different from being told:

“You will eventually enjoy it, so you must agree.”

Healthy sexual response requires freedom.

Consent must never be replaced by assumptions about desire.

Consent: The Foundation of Healthy Intercourse

Consent means that a person freely agrees to a particular sexual activity.

ACOG emphasizes that both people should feel comfortable with sexual activity and that no one should pressure another person into sex. It also explains that agreeing because someone is afraid of angering or disappointing the partner is not genuine consent.

Marriage does not eliminate this principle.

A healthy married relationship allows each partner to express:

yes, no, not now, slower, stop, or I am uncomfortable

without humiliation or punishment.

Consent is not merely a legal concept.

It is one of the foundations of sexual trust.

Consent Can Change During Intimacy

Agreeing to intimacy at the beginning does not mean that every later activity is automatically acceptable.

A woman may initially feel comfortable and later develop pain or anxiety.

She may change her mind.

A respectful partner responds to that change rather than interpreting it as rejection or disobedience.

The ability to stop is part of what makes genuine intimacy emotionally safe.

Healthy Sexual Intercourse Requires Communication

Communication is not a sign that a relationship has failed.

It is how couples learn about each other.

A large meta-analysis examining **93 studies and 38,499 people in relationships** found that better sexual communication was associated with both greater relationship satisfaction and greater sexual satisfaction. The quality of communication appeared more strongly associated with satisfaction than merely how often couples discussed sex.

In simple language:

How you talk matters more than how much you talk.

How a Woman Can Communicate About Intimacy

A woman should feel able to explain what is:

comfortable, uncomfortable, painful, pleasurable, frightening or emotionally important to her.

Instead of remaining silent and becoming resentful, she may say:

“I need more time to feel relaxed.”

“That is uncomfortable; can we slow down?”

“I would like more affection before intercourse.”

“I feel anxious when sex feels rushed.”

“I don't want intercourse tonight, but I still want emotional closeness.”

These are healthy relationship communications.

They are not signs of sexual failure.

A Husband or Partner Also Needs to Be Heard

Healthy counselling should not assume that only the woman's concerns matter.

A partner may experience:

rejection, confusion, insecurity or frustration.

His feelings deserve respectful discussion too.

The goal is not to decide who is “right.”

It is to create a relationship where both individuals can discuss sexual expectations without pressure.

Avoid Accusatory Sexual Communication

Statements such as:

“You never satisfy me.”

“You don't love me.”

“A normal wife should do this.”

“Other husbands are better than you.”

usually increase shame rather than solve the problem.

It is more constructive to describe one's experience:

“I feel disconnected lately, and I would like us to understand what both of us need.”

This turns conflict into collaboration.

Sexual Communication Should Not Happen Only During an Argument

Couples often wait until one partner refuses sex and then begin discussing the entire relationship.

That is usually the worst time.

A calmer conversation outside the bedroom can be much more productive.

Research examining communication during sexual conflict has found that demand–withdraw patterns—where one partner pushes harder while the other retreats—are important relational processes associated with sexual and relationship distress.

The lesson is practical:

Do not wait until hurt and anger are at their highest before discussing intimacy.

Pregnancy Can Occur the First Time

Another important myth is:

“Pregnancy cannot happen during the first intercourse.”

It can.

If sperm enters the reproductive tract during the fertile window, pregnancy can occur regardless of whether it is the first sexual experience.

ACOG explicitly notes that pregnancy can occur even the first time vaginal intercourse takes place.

Couples who do not currently want pregnancy should therefore discuss contraception **before** intercourse rather than afterward.

Contraception Is Part of Intercourse Education

WHO's July 2025 guidance emphasizes that contraception allows individuals and couples to decide freely and responsibly whether and when to have children and how to space pregnancies. There are many reversible and permanent methods, and the appropriate choice depends on health conditions, preferences and reproductive plans.

Contraceptive choices can include condoms, oral contraceptive pills, injectable contraception, implants, intrauterine devices and permanent methods for people who have completed their family.

No one method is ideal for everyone.

A healthcare professional can help select the safest and most suitable method.

Condoms Have a Special Role

Condoms are different from most other contraceptive methods because they can help reduce both **pregnancy risk and STI transmission**.

WHO states that condoms are the contraceptive method that can provide protection against both pregnancy and sexually transmitted infections including HIV.

CDC similarly states that consistent, correct condom use reduces the risk of HIV and many other STIs, although protection is not absolute and is lower for infections transmitted through uncovered skin-to-skin contact.

Birth-Control Pills Do Not Protect Against STIs

This is another important distinction.

Oral contraceptive pills can be very effective at preventing pregnancy when used correctly, but they do not prevent sexually transmitted infections.

WHO's December 2025 update states that fertility returns quickly after stopping combined or progestin-only pills and that these pills do **not** cause a lasting delay in fertility. It also emphasizes that they do not protect against HIV or other STIs.

This helps correct two common myths at once:

the pill does not provide STI protection, and modern oral contraception does not permanently damage fertility.

Intrauterine Devices

IUDs are among the most effective reversible contraceptive options.

WHO's January 2026 fact sheet states that both copper and hormonal IUDs result in fewer than one pregnancy per 100 users during the first year, depending on correct placement and product, and fertility returns after removal. IUDs do not protect against STIs.

The decision to use an IUD should be individualized with a qualified healthcare professional.

Emergency Contraception

Intercourse education should also include knowledge of what to do if contraception fails.

Emergency contraception may be considered after situations such as:

unprotected intercourse, condom breakage, missed contraceptive use or certain other contraceptive failures.

WHO states that emergency contraception works best as soon as possible and can be used within five days depending on the method. Emergency contraceptive pills prevent or delay ovulation; they do **not** terminate an established pregnancy. A copper IUD can also serve as highly effective emergency contraception in appropriate candidates.

Emergency contraception should not be confused with an abortion medication.

Sexually Transmitted Infections Can Have No Symptoms

Women should understand that an STI does not always cause obvious discharge, itching or pain.

The CDC's March 2026 testing guidance emphasizes that many STIs can be present without symptoms and can still cause health complications and be transmitted to partners. Testing recommendations depend on age, pregnancy, sexual practices, partner history and other risk factors.

This is why:

“My partner looks healthy”

is not the same as:

“There is no possibility of infection.”

STI Testing

Current CDC guidance recommends annual chlamydia and gonorrhoea testing for sexually active women younger than 25 and for some women aged 25 and above with factors such as new or multiple partners or a partner with an STI. Recommendations differ by country and individual risk, so women should discuss testing with a healthcare professional.

Pregnancy also creates specific screening needs.

Individual counselling is preferable to fear-based testing.

Before Marriage or a New Sexual Relationship

Where culturally and personally acceptable, couples can consider discussing:

previous relevant health conditions, contraception plans, pregnancy intentions, STI risk, fertility expectations and sexual concerns.

This is not about interrogating or humiliating one another.

It is about creating responsible health communication.

A relationship based on secrecy and fear rarely becomes safer simply because the subject is uncomfortable.

Sexual Arousal and Lubrication

Lubrication helps reduce friction and discomfort.

A woman's natural lubrication may vary according to:

arousal, age, menopause, breastfeeding, medications and other physical factors.

A woman who experiences dryness should not automatically be told:

“You are not attracted to your partner.”

Physical and psychological arousal are related but are not identical.

When lubrication is insufficient, an appropriate lubricant may improve comfort.

Persistent dryness deserves medical assessment, particularly around menopause or when associated with pain or irritation.

Lubricants Can Be Useful

ACOG recommends lubricants as one strategy for reducing discomfort during sexual activity. Water-soluble lubricants can be useful for women prone to irritation, and silicone-based products tend to last longer. Oil-based products can damage latex condoms and should not be used with them.

Using lubricant is not evidence of female sexual failure.

Sometimes it is simply good healthcare.

When Pain During Intercourse Needs Medical Evaluation

Pain during intercourse is called **dyspareunia**.

Pain may be felt:

at the vulva, vaginal opening, inside the vagina, pelvis, lower abdomen or deeper during penetration.

ACOG notes potential causes including vulvodynia, vaginitis, vaginismus, hormonal changes, pelvic inflammatory disease, endometriosis, childbirth injuries and inadequate arousal.

A woman should seek evaluation when pain is recurrent, severe or causing avoidance of intimacy.

Vaginismus and Pelvic-Floor Tightening

Some women experience involuntary tightening around the vaginal opening when penetration is attempted.

This may produce:

fear, burning, tightness or inability to tolerate penetration.

It is not something a woman can simply overcome by being told:

“Relax and tolerate it.”

Treatment may involve pelvic-floor physiotherapy, gradual therapeutic techniques, counselling and treatment of associated fear or pain depending on the individual situation.

Do Not Force Intercourse Through Pain

Trying repeatedly to “break through” pain can worsen fear and muscle tension.

A respectful response to pain is to stop, understand the cause and choose a more comfortable approach.

If pain continues, seek clinical assessment.

This protects both physical and emotional health.

Menopause and Intercourse

Around and after menopause, lower estrogen levels can lead to vaginal dryness, thinning and reduced elasticity.

These changes may make intercourse uncomfortable.

ACOG notes that local vaginal estrogen can improve vulvovaginal dryness and pain for appropriate patients.

Treatment should be individualized, especially in women with significant medical histories.

Menopause should not be interpreted as the end of sexual life.

It is a physiological stage that may require adaptation and, sometimes, medical treatment.

Pregnancy and Postpartum Sexuality

Sexual desire and comfort can change during pregnancy and after childbirth.

Women may experience:

fatigue, body-image changes, fear, vaginal dryness, perineal discomfort, pelvic-floor changes or reduced interest.

After childbirth, particularly if tears or an episiotomy occurred, pain can persist for a period and may benefit from appropriate medical or physiotherapy assessment. ACOG recognizes childbirth-related trauma as one cause of painful intercourse.

A woman should not be pressured to resume intercourse before she feels physically and emotionally ready.

Sexual Pleasure Is Not a Luxury

Sexual health education has historically focused heavily on:

pregnancy, infection and danger.

These areas are essential, but sexual health also includes comfort, intimacy and pleasure.

WHO's definition explicitly includes the possibility of safe and pleasurable sexual experiences within sexual well-being.

A woman should therefore be able to learn about her own body without shame.

Pleasure does not remove the need for responsibility.

Responsibility does not require eliminating pleasure.

Orgasm: No Woman Should Be Judged by a Performance Standard

Some women reach orgasm easily.

Others require more time or different types of stimulation.

Some enjoy sexual activity even when orgasm does not occur every time.

Difficulty reaching orgasm becomes clinically relevant particularly when it causes personal distress.

ACOG notes that orgasm difficulties are common and may be affected by physical health, mental health, relationships, surgery or other factors.

Sex should not become another examination that a woman feels she has failed.

The Importance of Female Counselling in Married Life

Female counselling is particularly valuable when it provides a confidential place to discuss subjects a woman may feel unable to discuss elsewhere.

Good counselling can help a woman understand:

her body, sexual expectations, boundaries, fear of intercourse, desire, relationship conflict, contraception, fertility, pain and emotional needs.

It should not teach a woman merely how to “keep her husband happy.”

A healthy counselling model supports **both the woman's well-being and the couple's relationship**.

Communication Is the Foundation of a Strong Marriage

A healthy marriage requires communication about far more than sex.

Couples need to discuss:

expectations, finances, family responsibilities, children, emotional needs, privacy and future goals.

Sexual communication becomes easier when the relationship already allows safe disagreement.

Research consistently links communication quality with both relationship and sexual satisfaction. In the major meta-analysis of 38,499 individuals, sexual communication showed meaningful positive associations with both outcomes.

This is why I often say:

A good intimate relationship begins long before intercourse begins.

Active Listening

Communication does not mean waiting for your turn to speak.

It means trying to understand what your partner is actually saying.

For example, when a woman says:

“I don't feel ready tonight,”

the message may mean fatigue, anxiety, pain, resentment or simply lack of desire.

Immediately interpreting it as:

“You don't love me”

may create a conflict that did not need to exist.

Similarly, a husband's desire for intimacy should not automatically be interpreted as selfishness.

Listening allows meaning to be clarified.

Trust and Emotional Intimacy

Sexual intimacy tends to become healthier when each partner believes:

“I can be honest and still be respected.”

Trust grows through:

reliability, confidentiality, kindness and respecting boundaries.

It can be damaged by ridicule, threats, infidelity, coercion or repeated dismissal of the partner's feelings.

Where trust has been significantly damaged, professional couple counselling may be valuable.

Handling Conflict Without Damaging Intimacy

Conflict is normal.

Contempt is destructive.

Couples can disagree without humiliating one another.

Arguments are healthier when partners discuss a specific behaviour rather than attacking character.

For example:

“I felt hurt when we stopped talking after the disagreement.”

is much more constructive than:

“You are a terrible spouse.”

A systematic review of marital communication and sexual-skills interventions found that communication training and related couple-focused interventions can improve marital and sexual satisfaction and reduce conflict, although individual study quality varies.

Sexual Counselling Can Help

Sexual counselling is not only for severe dysfunction.

It can help couples with:

mismatched desire, pain, performance anxiety, communication difficulty, fear of intercourse and adjustment to medical or reproductive changes.

A systematic review and meta-analysis of PLISSIT and EX-PLISSIT counselling approaches found improvements in sexual-function outcomes and some communication-related sexual quality measures across the included studies.

The important point is that counselling can be a legitimate part of healthcare—not an admission that the relationship has failed.

Self-Care and Personal Growth

A healthy marriage does not require a woman to erase her individuality.

Adequate sleep, exercise, friendships, personal interests, emotional health and time for oneself can support relationship functioning.

A person who is physically and emotionally exhausted may have little capacity for intimacy.

Self-care is therefore not selfish.

It helps sustain the person who participates in the relationship.

Healthy Boundaries Strengthen Relationships

Boundaries communicate:

“This is comfortable for me.”

“This is not comfortable.”

“I need more time.”

“I need privacy.”

“I don't want this particular activity.”

Respecting boundaries does not weaken intimacy.

It makes intimacy safer.

ACOG explicitly describes consent and boundaries as central elements of healthy relationships.

Digital Boundaries Matter Too

Sexual-health education today must also consider digital communication.

No woman should be pressured to send intimate photographs, videos or sexual messages.

ACOG notes that intimate digital content can be saved, copied or shared even when an application appears to promise deletion.

A healthy partner respects digital privacy just as they respect physical boundaries.

When Relationship Problems Require More Than Communication Advice

Some situations require professional intervention.

These include:

persistent sexual coercion, violence, threats, severe emotional abuse, untreated psychiatric illness, addiction, repeated infidelity-related trauma or situations in which one partner does not feel physically safe.

These should not be reframed as simply:

“Improve your communication.”

Safety comes first.

The Unani Perspective on Sexual and Marital Well-Being

As a physician trained in Unani medicine, I believe its greatest contribution to this subject comes from its traditionally **holistic view of health**.

Unani medicine developed from the Greco-Arabic medical tradition and considers physical health, temperament, diet, environment, psychological state, sleep, movement and other aspects of life as interconnected.

Official Ministry of Ayush guidance describes the importance of **Asbab-e-Sitta Zarooriyah**, the six essential factors that Unani medicine considers important in maintaining health.

This framework is particularly useful when sexual health is being affected by:

stress, poor sleep, poor nutrition, chronic illness, physical exhaustion or emotional disturbance.

Mizaj: The Principle of Individuality

Unani medicine places importance on **Mizaj**, or individual temperament.

In practical contemporary healthcare, one valuable lesson from this idea is that people are different.

Not every woman experiences:

the same level of desire, the same response to touch, the same sleep requirement or the same emotional needs.

A good physician should therefore avoid giving every woman the same sexual-health advice.

Individualization is one of the strongest principles we can preserve from Unani clinical thinking.

Harkat wa Sukoon Nafsani: Psychological Activity and Repose

One of the traditional Unani lifestyle factors concerns psychological activity and rest.

This has clear relevance to sexual wellbeing.

A woman living with chronic:

anxiety, relationship tension, family pressure or exhaustion

may experience reduced sexual interest even when there is no genital disease.

A holistic programme should therefore consider the emotional environment rather than prescribing an aphrodisiac automatically.

Sleep and Sexual Health

Traditional Unani medicine also emphasizes balance between sleep and wakefulness.

Modern sexual-health practice similarly recognizes that poor sleep and fatigue can affect sexual desire and arousal.

A newly married couple who are anxious, exhausted and under family or social pressure may need:

rest, privacy and reassurance

more than medicine.

Ilaj bil Ghiza: Dietotherapy

Good nutrition contributes to overall reproductive and sexual health.

However, I do not believe women should be encouraged to consume large quantities of sweet tonics, honey or calorie-dense “strengthening foods” simply because they are beginning married life.

The dietary plan should reflect the woman's actual health.

A woman with diabetes, obesity or PCOS may require very different dietary advice from a woman who is underweight or anaemic.

Unani dietotherapy is most useful when it is **individualized rather than ceremonial**.

Ilaj bit Tadbir: Regimenal and Lifestyle Care

Regimenal care can support:

appropriate physical activity, relaxation, sleep, daily routine and stress management.

These may help women whose sexual difficulties are being worsened by fatigue or emotional stress.

They should complement—not replace—medical treatment of genuine disease.

Psychological Factors in Unani Sexual Medicine

The CCRUM's official Unani guideline on sexual debility includes **Umūr Wahmiyya**, or psychological factors, among contributors to sexual difficulty and includes treatment of psychological factors within its principles of management.

Although that particular traditional guideline is oriented largely toward male sexual debility, the broader principle is important:

sexual function cannot be separated completely from psychological health.

That principle applies equally to responsible counselling of women.

The Role of Unani Pharmacotherapy

Unani pharmacotherapy has a place when a qualified practitioner identifies a specific medical indication.

But intercourse education is **not itself an indication for medicine**.

A woman who needs information about consent, contraception or sexual communication does not need an herbal tonic.

A woman with recurrent genital pain needs diagnosis.

A woman with infection needs appropriate treatment.

A woman with vaginal dryness related to menopause may require evidence-based local therapy.

A woman experiencing depression may require psychological or psychiatric care.

Traditional medicine should support responsible healthcare rather than hide a treatable condition.

Unani Medicine Does Not Replace Contraception

This point is essential.

No Unani herb, diet or lifestyle regimen should be promoted as a reliable replacement for established contraception unless it has been specifically validated and approved as such—which traditional sexual tonics have not.

Couples who wish to prevent pregnancy should use established contraceptive methods. WHO provides evidence-based options ranging from condoms and pills to implants and IUDs.

Unani Medicine Does Not Protect Against STIs

Likewise, traditional medicines cannot replace condoms, testing or appropriate antimicrobial treatment for sexually transmitted infections.

STIs can sometimes remain asymptomatic and still have health consequences.

Good integrative medicine recognizes where modern preventive medicine is essential.

Unani Treatment Should Not Override Consent

No traditional concept of marital duty, temperament or sexual vitality should be used to pressure a woman into unwanted intercourse.

WHO's sexual-health framework clearly places safety, dignity and freedom from coercion at the centre of sexual wellbeing.

A truly holistic approach must respect the mind, body and autonomy of the patient.

My Specialized Approach at Saira Health Care

At **Saira Health Care**, when a woman or couple seeks counselling regarding intercourse, married life or sexual difficulties, I prefer to begin with education and assessment rather than medication.

My clinical questions may include:

whether intercourse has begun, whether there is fear, whether penetration is painful, whether lubrication is sufficient, whether the woman feels safe, whether she understands contraception, whether pregnancy is desired, whether either partner has symptoms suggesting an STI, whether desire is mismatched, whether there is erectile dysfunction or premature ejaculation in the partner, whether fertility is a concern and whether relationship conflict is contributing.

This allows us to identify whether the primary need is:

education, counselling, medical treatment, pelvic-floor therapy, gynaecological evaluation, reproductive assessment or another form of care.

The Professional Focus of Dr. Nizamuddin Qasmi

My professional profile includes:

Dr. Nizamuddin Qasmi
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My objective in sexual-health counselling is not simply to tell couples how to "perform intercourse."

It is to help them understand the complete sexual and reproductive context:

health, comfort, consent, fertility, contraception, communication, psychological wellbeing and relationship quality.

Saira Health Care's Contribution to Sexual Disorders and Infertility

Sexual-health misinformation causes enormous unnecessary suffering.

Women may believe that:

first intercourse must bleed;

severe pain is compulsory;

pregnancy cannot occur the first time;

contraception causes permanent infertility;

a wife cannot decline sex;

orgasm should occur automatically;

or every sexual problem requires a tonic.

These ideas can create physical and emotional harm.

At Saira Health Care, an important part of our contribution is therefore **patient education**.

We aim to help people understand sexual and reproductive health in simple, respectful language while identifying when actual disease requires investigation.

Intercourse Education and Infertility

Intercourse education also matters in couples trying to conceive.

Some couples with infertility discover that intercourse itself is:

too infrequent, painful, associated with erectile dysfunction or difficult because of severe performance anxiety.

Others become so focused on the fertile window that intimacy begins to feel like medical work rather than a relationship.

Infertility counselling should therefore consider both reproductive biology and the couple's sexual relationship.

WHO's family-planning guidance defines infertility as failure to achieve pregnancy after 12 months of regular unprotected intercourse and emphasizes that infertility can involve male, female or combined factors.

A woman should not carry all the blame when pregnancy is delayed.

Common Myths About Intercourse

There are several myths I particularly want women and couples to avoid:

1. **“Every woman must bleed during first intercourse.”** This is incorrect; hymenal appearance cannot establish sexual history.
2. **“First intercourse cannot cause pregnancy.”** Pregnancy is possible from the first vaginal intercourse.
3. **“Pain is compulsory the first few times.”** Mild temporary discomfort may occur, but severe or persistent pain requires attention.
4. **“A wife must agree every time.”** Healthy sexual relationships require consent and respect for boundaries.
5. **“Birth-control pills permanently cause infertility.”** WHO states that fertility returns rapidly after stopping oral contraceptives.

6. **“If there are no STI symptoms, there is no infection.”** Many STIs can be asymptomatic.
7. **“A woman who needs lubricant is not attracted to her partner.”** Dryness has many physical and psychological causes and can be managed appropriately.
8. **“Intercourse education encourages sexual activity.”** WHO's 2026 evidence review states that comprehensive sexuality education does not increase sexual activity and instead supports safer decision-making.

Frequently Asked Questions

Is intercourse supposed to hurt the first time?

Not necessarily.

Mild discomfort is possible, but severe pain is not something a woman should simply tolerate.

Adequate arousal, relaxation, communication and lubrication can help.

Persistent pain should be medically assessed.

Must a woman bleed on the wedding night?

No.

Many women do not bleed.

Bleeding cannot be used as proof of virginity, and hymenal appearance does not reliably indicate previous intercourse.

Can pregnancy occur during first intercourse?

Yes.

If intercourse takes place around a fertile time and sperm enters the reproductive tract, pregnancy is possible.

Does contraception cause infertility later?

Modern contraceptive methods generally do not cause permanent infertility.

For example, WHO states that fertility returns quickly after stopping oral contraceptive pills and after removal of an IUD.

Which contraceptive method is best?

There is no single method best for everyone.

The decision depends on health history, pregnancy plans, convenience, effectiveness, side-effect preferences and other considerations.

A healthcare professional can help choose appropriately.

Do birth-control pills protect against infection?

No.

Oral contraceptives protect against pregnancy but not against HIV or other STIs.

Are condoms 100% protective?

No method provides absolute protection, but correct and consistent condom use substantially reduces risk of pregnancy and many STIs. Protection is lower for infections spread primarily by skin-to-skin contact outside the covered area.

What should I do if a condom breaks?

Emergency contraception may be appropriate when pregnancy is not desired, and STI assessment may be relevant depending on the situation.

Emergency contraception is most effective when used promptly and may be used within five days depending on the method.

Does emergency contraception cause abortion?

No.

Emergency contraceptive pills work primarily by delaying or preventing ovulation and do not terminate an established pregnancy.

Is vaginal dryness normal?

It can occur occasionally and may relate to arousal, medications, breastfeeding, menopause or other factors.

Persistent dryness or pain should be evaluated.

What if I cannot tolerate penetration?

Do not force it.

Pain, pelvic-floor spasm, vaginismus, anxiety and other conditions can make penetration difficult.

Appropriate gynaecological or pelvic-floor assessment may be necessary.

Is it normal if I do not reach orgasm during intercourse?

Yes, many women do not reliably reach orgasm through penetration alone.

The situation becomes a medical concern mainly when it causes personal distress or represents a significant change.

Should a woman discuss sexual problems with a doctor?

Yes.

ACOG specifically encourages women to discuss sexual-health concerns with their healthcare professional and emphasizes that sexual health deserves the same attention as other aspects of health.

Can counselling improve married life?

It can help many couples.

Evidence from communication and sexual-counselling studies suggests that structured counselling can improve aspects of sexual function, communication and marital or sexual satisfaction.

Can Unani medicine help sexual wellbeing?

Unani medicine can contribute through an individualized holistic approach involving **diet, physical activity, sleep, psychological balance and appropriately selected treatment**.

Its preventive framework of Asbab-e-Sitta Zarooriyah is especially relevant to overall health.

However, Unani medicine should not replace contraception, STI prevention, treatment of infection, gynaecological care or relationship counselling when those are needed.

When a Woman Should Seek Medical Help

Professional consultation is particularly important when intercourse causes frequent or severe pain, there is recurrent bleeding after sex, unusual discharge or strong genital irritation, genital sores, persistent vaginal dryness, inability to tolerate penetration, significant loss of sexual desire causing distress, suspected pregnancy, concern about an STI, infertility or significant psychological distress related to intimacy.

Urgent help is appropriate when there is sexual violence, severe genital injury, severe acute pelvic pain, heavy bleeding, fainting or another medical emergency.

A woman who feels unsafe or coerced should also seek appropriate confidential professional and social support.

A Message From Dr. Nizamuddin Qasmi

When a woman comes to me before or after marriage and says:

“Doctor, nobody ever explained these things to me,”

I consider that a healthcare issue—not something to be ashamed of.

Women deserve accurate information about their bodies.

They deserve to understand what normal sexual response looks like.

They deserve to know that first intercourse does not have to be frightening.

They deserve to know that bleeding is not proof of virginity.

They deserve to understand pregnancy prevention.

They deserve information about sexually transmitted infections.

They deserve to say when something hurts.

And they deserve to participate in intimate relationships with dignity, safety and mutual respect.

At the same time, I also encourage couples to remember that healthy married life is not created through anatomy alone.

Trust matters.

Communication matters.

Kindness matters.

Privacy matters.

Sexual compatibility matters.

And the ability to talk through differences matters.

As a physician trained in Unani medicine, I find the holistic philosophy of the system especially valuable in reminding us that sexual health does not exist separately from **sleep, diet, physical health, psychological balance and overall lifestyle**.

But responsible integrative medicine also means recognizing the limits of every system.

Contraception requires reliable contraceptive methods.

STIs require appropriate testing and treatment.

Persistent sexual pain needs medical assessment.

Relationship conflict may need counselling.

Infertility requires evaluation of both partners.

And consent can never be replaced by medicine or tradition.

At **Saira Health Care**, my aim is therefore not merely to teach "how to have intercourse."

My objective is to help women and couples understand **how to build a safer, healthier, more informed and more respectful sexual and reproductive life.**

About the Author

Dr. Nizamuddin Qasmi

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

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

At **Saira Health Care**, the clinical focus includes confidential and individualized counselling and assessment for sexual-health concerns, intercourse-related problems, erectile and ejaculatory disorders, female sexual difficulties and infertility, with an integrative approach that combines responsible Unani principles with appropriate contemporary medical evaluation.

Medical Disclaimer

This article is intended for **sexual-health education and public awareness**. Intercourse education is not itself a disease, and this article does not replace an individual consultation, examination, diagnosis or treatment plan.

Women experiencing persistent pain, bleeding, discharge, genital lesions, severe dryness, fertility problems or other symptoms should seek appropriate professional evaluation.

Contraceptive choice should be individualized according to medical history and reproductive plans. Condoms reduce the risk of many STIs but do not eliminate all risk. Traditional or Unani medicines should not be used as substitutes for reliable contraception, STI prevention or established treatment of infections or gynaecological disease.