Resumption of sex after a second birth: An Australian prospective cohort

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Funding Australian National Health and Medical Research Council (NHMRC) (Grant nos. 199222, 433006 and 491205)

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Word count: 3829

Taking longer to resume sex after the second baby is normal.

Resumption of sex after a second birth

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This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as [doi: 10.1111/birt.12363](https://doi.org/10.1111/birt.12363)

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Acknowledgements

We are grateful to members of the Maternal Health Study research team who contributed to recruitment and follow-up of the cohort, in particular Ann Krastev and Susan Perlen. We are also extremely grateful to all of the women taking part in the study.

EM planned and conducted analyses and co-wrote the paper. SB wrote the study protocol, took primary responsibility for the design and conduct of the study, contributed to the analysis plan and interpretation of the data, and contributed to writing the paper. EM and DG were responsible for data management.

DG and HW contributed to interpretation of data and contributed to drafts of the paper. All authors have approved the final draft of the manuscript for publication.

This research was supported by project grants from the Australian National Health and Medical Research Council (NHMRC) (Grant nos. 199222, 433006 and 491205); a Vic-Health Public Health Research Fellowship (2002–2006) (SB), an ARC Future Fellowship (SB), an National Health and Medical Research Council Career Development Fellowship (No. 491205, 2008–2011) (SB), and Senior Research Fellowship (No.1103976 , 2016-2020) (SB); a La Trobe University Postgraduate Scholarship (EM); a grant from the Medical Research and Technology in Victoria Fund (ANZ Trustees) and the Victorian Government's Operational Infrastructure Support Programme.

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Article type : Original Article

Abstract

Background Few longitudinal studies have examined women's experiences of sex after childbirth. Much of the advice given to couples about what to expect in relation to sex after childbirth is based on cross-sectional studies.

Objective To investigate timing of resumption of sex after a second birth and assess associations with obstetric factors (method of birth and perineal trauma) and time interval between first and second births.

Method Prospective cohort of 1507 nulliparous women recruited before 25 weeks' gestation in Melbourne, Australia followed-up at 3, 6, 9 and 12 months after first births, and 6 and 12 months after second births. Measures include: obstetric factors and resumption of vaginal sex after first and second births.

Results By eight weeks after their second birth, 56% of women had resumed vaginal sex, compared with 65% after their first birth. Women were more likely to resume sex later than eight weeks postpartum if they had a spontaneous vaginal birth with episiotomy or sutured perineal tear (aOR: 2.21, 95% CI: 1.5-3.2), operative vaginal birth (aOR: 2.60, 95% CI: 1.3-5.3) or caesarean section (aOR: 2.15, 95% CI: 1.4-3.3) compared to a vaginal birth with minimal or no perineal trauma. There was no association between timing of resumption of sex and the time interval between births.

Conclusion For almost half of the cohort, sex was not resumed until at least eight weeks after the second birth. Timing of resumption of sex was influenced by obstetric factors, but not the time interval between births.

Keywords Method of birth, multiparous, perineal trauma, pregnancy cohort, resumption of sex

Introduction

Having a first baby is a major life transition impacting on women's physical and mental health and intimate partner relationships.(1) There is now a considerable body of research investigating the influence of pregnancy and childbirth on maternal postpartum physical and mental health, (2-10) but comparatively less research examining the impact of childbirth on women's sexual health.(11, 12) Studies that do report on women's postpartum sexual health, frequently lack the study power to assess factors influencing outcomes (13, 14), or have other limitations, such as a high attrition of study participants (15) or samples restricted to primiparae or women having a vaginal birth.(16, 17) As a result, the evidence to inform clinical practice and the information available for women regarding their sexual health after childbirth remains limited.(11, 18)

Pregnancy and childbirth impact on women's postpartum sexual health and relationships in multifaceted ways, (19-22) via relationship transitions, (23) breastfeeding (20, 24, 25) and paternal factors such as fathers' mental health and wellbeing.(26) There are conflicting findings in the literature regarding the contribution of method of birth and other obstetric factors to postpartum sexual health, largely because many studies are too small for meaningful statistical comparisons, (27-29) and because of differing definitions and ways of measuring sexual difficulties and sexual function.(11)

This paper draws on longitudinal data collected in a prospective cohort study designed to investigate the natural history of common maternal health problems after first and subsequent births. We have reported on the resumption of sex after the first birth and associations with method of birth previously.(30) The objectives of the current paper are twofold, first, to investigate the timing of resumption of sex after a second birth; and

second, to investigate whether timing of resumption of sex after a second birth is influenced by: (i) method of birth for the second birth, (ii) the combination of method of birth for the index (first) birth and second birth; or (iii) the interval between births.

Methods

Sample and Participants

A prospective pregnancy cohort of nulliparous women was recruited between 2003 and 2005 at six metropolitan public hospitals in Melbourne, Australia. To be eligible to take part women needed to be ≥ 18 years, English speaking, and ≤ 24 weeks' gestation. In the first phase of the study, women completed self-administered questionnaires and computer-assisted telephone interviews in early and late pregnancy, and at 3, 6, 9, 12 and 18 months postpartum. Women who enrolled in the study and completed at least one follow-up questionnaire or telephone interview in the first phase of the study were eligible to take part in the second phase of follow-up, which involved follow-up four years after the index (first) birth, and six and 12 months after second and subsequent births. Follow-up after second and subsequent births ceased when the index child turned 10 years of age. The period of data collection after the second birth was from 2005 to 2015. Further details regarding the study design, recruitment methods and procedures for follow-up are available in a published study protocol. (31)

All women in the cohort were mailed a formal invitation to take part in phase two of the study. This included a letter inviting them to take part in the next phase of the study, and a plain language statement explaining what would be involved. Women consenting to take part were encouraged to notify the research team (by phone, email or postcard) when they were expecting another baby, and when their baby was born. All participants received a study newsletter twice a year reminding them to let the research team know if they were expecting another baby. In addition, we contacted women every six to 12 months to update their contact details and remind them to let us know when they were pregnant and/or had had another baby. All correspondence from the research team included a copy of a reply paid postcard for women to use to notify the research team when they were pregnant or had recently had another baby.

The questionnaires mailed to women 6 and 12 months after second and subsequent births

were similar in content to questionnaires completed after the index birth. Women were invited to complete the questionnaires and return them to the research team in a reply paid envelope. Women who did not return a completed questionnaire within two weeks were sent a reminder postcard, followed by a phone call two weeks later.

Measures and definitions

Questionnaires completed by mothers in the first and second phases of the study were B5 size booklets, approximately 40 pages in length, and included questions on a range of common maternal health problems, including sexual health issues. Previously validated instruments were used where possible. Questions on sexual health drew on the questions included in the Australian Longitudinal Women's Health Study (32) and a study by Barrett et al.(21) Information was collected that enabled us to categorise method of birth and degree of perineal trauma for the first and second births. Both women's self-report and hospital medical records were used to ascertain labor and birth events. A high level of congruity (98%) was found between medical record data and women's own accounts of method of birth.(33, 34) Data from questionnaires have been used to categorise method of birth and perineal trauma as more complete data were available from study questionnaires for these variables. To ascertain method of birth, women were asked "How was your baby born?" Response categories included: vaginal birth, vaginal breech birth, birth assisted by forceps, vacuum extraction or ventouse, caesarean section after unsuccessful attempt to delivery your baby using forceps or vacuum extraction, caesarean section (no other procedures used first). To ascertain perineal trauma women were asked if they had an episiotomy (surgical cut to your perineum), whether they had a perineal tear, stitches for a tear or episiotomy or a tear that affected their rectum (with additional detail on anal sphincter and rectal lining involvement). Data on method of birth and degree of perineal trauma were combined to provide a single stratified measure for each birth allowing us to assess associations for different combinations, for example vaginal birth with/without perineal trauma. In order to investigate the extent to which the timing of resumption after the second child is influenced by the combination of method of birth for the index pregnancy and the current pregnancy, we created a summary variable that combined data on method of birth and degree of perineal trauma in both pregnancies.

Timing of resumption of intimate contact and resumption of vaginal sex was derived

drawing on data collected at 3, 6, 9 and 12 months postpartum for the index (first) birth, and at 6 and 12 months postpartum for second births. Each questionnaire included two questions about timing of resumption of vaginal sex. Women who answered 'yes' to the question "Have you had vaginal intercourse since your baby was born?" were asked "When did you first have vaginal intercourse again (or attempted vaginal intercourse again) after you had your baby?" Priority was given to the first occasion on which women reported having had vaginal sex after their first and second births. Postnatal depressive symptoms were assessed using the Edinburgh Postnatal Depression Scale (EPDS), with a cut off score of ≥ 13 used to identify women likely to be clinically depressed. (35) Exposure to intimate partner violence in the first 12 months postpartum after the second birth was assessed using the Composite Abuse Scale. (36, 37) Assessment of infant feeding included whether the infant had ever been breastfed, the type of feeds the baby was having at six months postpartum, and how old their baby was when they stopped breastfeeding (number of completed weeks). Babies having any breastfeeds were classified as breastfed for the purpose of the analysis. Tiredness was assessed at six months postpartum with the question "Since the birth have you ever experienced extreme tiredness or exhaustion?" with response options of 'never', 'rarely', 'occasionally' or 'often'. Women were classified as experiencing tiredness if they responded 'occasionally' or 'often'.

Data on social characteristics such as maternal age and country of birth were collected in the baseline questionnaire. Other social characteristics, such as maternal education and relationship status were assessed at each follow-up.

Statistical Analysis

Data were analysed using Stata version 14.(38) Factors associated with not having resumed vaginal sex within eight weeks of the second birth were investigated using univariable and multivariable logistic regression. The decision to examine factors associated with not having resumed sex within eight weeks of the second birth was an *a priori* decision based on the common assumption that everything will be 'back to normal' by around six weeks postpartum.(39, 40) Factors included at the univariable level included breastfeeding, extreme tiredness, relationship status, educational qualification, time interval between births, depressive symptoms and intimate partner violence. Multivariable analysis was used to examine (i) associations between method of birth and perineal trauma in the second

birth and non-resumption of sex, and (ii) the extent to which the timing of resumption of sex after a second child is influenced by the method of birth and perineal trauma for the first and second births taking into account potential confounders. Maternal age was included in the multivariable models for *a priori* reasons based on evidence of associations between maternal age and sexual function found in other research.(41) Other variables were included in multivariable models based on observed associations in univariable analyses applying the following criteria: 95% confidence interval not crossing one and a significance level of <0.01. Data are presented as crude or adjusted odds ratios (ORs) with 95% confidence intervals (95% CI).

Ethics approval was granted by La Trobe University (2002/38), Royal Women's Hospital (2002/23), Southern Health (2002-099B), Angliss Hospital and The Royal Children's Hospital (27056A).

Results

Participants

A total of 1507 eligible women enrolled in the study. The mean gestation at enrolment was 15.0 weeks (range 6 to 24 weeks). At the time of giving birth to their first baby, participants ranged in age from 18.9 - 49.9 years (mean 31.0) The majority were Australian born (74.0%), married (60.7%) or living with a partner (34.6%) and had post-secondary qualifications (72.1%). Comparison of study participant characteristics with routinely collected Victorian Perinatal Data for nulliparous women giving birth as public patients during the period of recruitment showed that participants were representative in terms of method of birth and infant birthweight for the index birth, but younger women (18-24 years, 15.5% versus 29.9%) and women born overseas of non-English speaking background (16.2% versus 21.0%) were under-represented.

Participation across waves of follow-up was excellent, with 90% of women completing follow-up 12 months after the index birth (See Figure 1). A total of 1345 women consented to follow-up after second and subsequent births, and three-quarters of these women had a second baby. Of these, 97 notified the research team of their baby's birth after six months

postpartum. Prior to the six-month follow-up five women withdrew (two women were too busy, one woman had a stillbirth, two women did not specify a reason) and 10 were lost to follow-up. Of the remaining 898 women, 94.2% returned a completed six-month follow-up questionnaire. After the six-month follow-up two women withdrew (one woman due to ill-health, one woman was too busy). Fifty women notified the research team of the birth of their second child too late to be included in 12-month follow-up. A total of 943 women were sent the 12-month questionnaire, 89.5% of whom returned a completed questionnaire to the research team.

Compared to women who returned the questionnaire six months after the birth of their second baby, women who did not respond were younger, had lower qualification levels, and were more likely to have a Health Care Card. Women who notified the team too late after the birth of their second child to be sent a six-month postpartum questionnaire did not differ significantly in age, education level or income from women who notified the team in time to be sent a six-month postpartum questionnaire. A significantly higher proportion of women who were born overseas in a non-English speaking country were not sent a six-month postpartum questionnaire due to late notification, than women who were born in Australia, or born overseas in an English speaking country ($X^2 = 11.9, p=0.003$).

The mean number of years between the first and second birth was 2.7 years. The minimum gap between children was 11.1 months, and the maximum gap was 9.7 years. A third of women (34.5%) had a subsequent birth within two years of their first baby, over half between two and four years (53.1%) and just over one in ten women (12.4%) had a gap of more than four years.

Two thirds of women (67.6%) had a spontaneous vaginal birth for their second birth, with just over half of this group sustaining a sutured tear or episiotomy (53.1%). Of the remaining women, 19.5% gave birth by caesarean prior to labor, 7.8% had an emergency caesarean during labor, and 5.1% (n=43) gave birth assisted by forceps (n=20) or vacuum extraction (n=23).

One in ten women resumed vaginal sex within four weeks of having their second baby, one in three within six weeks and just over half by eight weeks after the second birth (Table 1).

Fewer women reported resuming vaginal sex in the first eight weeks after the second birth compared to the first birth. Whereas 65% of women resumed vaginal sex by eight weeks after their first birth, 56% of women resumed sex by eight weeks after the second birth, with confidence intervals indicating that this difference is unlikely to have occurred by chance (Table 1).

Several factors were associated with timing of resumption of sex. Compared to women who had a vaginal birth with minimal or no perineal trauma, women who had a vaginal birth and a sutured tear or episiotomy, and those who had a caesarean section had raised odds of not resuming sex by eight weeks postpartum (Table 2). Older women (≥ 30 years) were also more likely not to have resumed sex by eight weeks postpartum than younger women (< 30 years). Other factors associated with non-resumption of sex by eight weeks after the second birth were: breastfeeding, and extreme tiredness in the first three months after childbirth. There were no differences in timing of resumption of sex after second births related to maternal education, relationship status, maternal depressive symptoms or exposure to intimate partner violence after the first birth. Nor was there any association between timing of resumption of sex after the second birth and the time interval between births. Method of birth remained significantly associated with timing of resumption of sex after adjusting for potential confounders. Even after adjusting for maternal age, breastfeeding and tiredness, the odds of non-resumption of sex by eight weeks postpartum were more than two times higher for women who had an operative vaginal birth, caesarean section or spontaneous vaginal birth accompanied by an episiotomy and/or sutured tear compared with women who had a vaginal birth with minimal or no perineal trauma (see Table 2).

Approximately 12% of women had a vaginal birth with minimal or no perineal trauma for the birth of both their first and second child. A higher proportion - one in three - had a vaginal birth with a sutured tear and/or episiotomy on both occasions. One in five women had a caesarean section for both births, 5% of women had a caesarean section for the first birth and vaginal birth for the second birth, and 5% had a vaginal birth for their first birth and caesarean section for the second (Table 3). One in five women had an operative vaginal birth for their first birth. A much smaller proportion of women had an operative vaginal birth for their second baby (around 5%). In both cases, around half were assisted by forceps and half were assisted by vacuum extraction.

Women who gave birth to their second child vaginally and sustained perineal trauma had five-fold higher odds of not resuming vaginal sex by eight weeks postpartum compared to women who had a vaginal birth for both their first and second births with minimal or no perineal trauma. Women who gave birth to both their first and second child by caesarean section had two-fold higher odds of not resuming sex by eight weeks, compared to women who had two vaginal births with minimal or no perineal trauma (Table 3). Similarly, women who had a vaginal birth with a sutured tear and/or an episiotomy for both births also had two-fold higher odds of not resuming sex by eight weeks postpartum, compared to women who had two vaginal births with minimal or no perineal trauma.

Discussion

In this prospective cohort of Australian mothers followed up for ten years after their first birth, around one in ten women that had a second birth in the study period had a spontaneous vaginal birth with an intact perineum for both births. More than one in five had a caesarean section for both births, and one in three had a vaginal birth with an episiotomy and/or sutured tear. Our findings demonstrate the extent to which obstetric intervention during childbirth has become normative for Australian women.

Just over half of women had resumed sex by eight weeks postpartum after their second birth. Women who had an operative vaginal birth, caesarean section or vaginal birth with an episiotomy or sutured tear resumed sex later than women who had a vaginal birth with an intact perineum. There was no evidence to suggest that having a caesarean section resulted in earlier resumption of vaginal sex, compared with vaginal birth. In fact, patterns of resumption of sex were strikingly similar for women who had an operative vaginal birth, spontaneous vaginal birth with an episiotomy or perineal tear and those having a caesarean section. Even after taking into account potential confounders, the odds of not having resumed sex by eight weeks postpartum were two times higher for women who any of these experiences compared to women who had a spontaneous vaginal birth with an intact perineum.

Whilst a number of studies of postnatal sexual health include multiparous women (13, 28, 42-47), to our knowledge no other studies have undertaken prospective follow-up of a nulliparous cohort after first and subsequent births. The ability to follow up women after

their first and subsequent births enabled consideration of the extent to which the time interval between births, and method of birth for the first and second birth, influence timing of resumption of sex. Our findings suggest that the time interval between first and second births has little bearing on timing of resumption of sex after the second of birth. On the other hand, the study provides evidence that method of birth in the first birth does have a bearing on timing of resumption of sex after the second birth. Women who had a caesarean section for their first birth had three-fold higher odds of resuming sex later than eight weeks postpartum even when they have a spontaneous vaginal birth with no perineal trauma in the second birth. It is possible that this reflects a legacy effect whereby timing of resumption of sex after the first birth influences couples' decisions about resumption of sex after a second birth. The group with the highest odds of not resuming vaginal sex by eight weeks postpartum were women who had vaginal birth with no perineal trauma for their first birth, and then had a vaginal birth with an episiotomy and/or sutured tear for their second birth. This may reflect a response to a more difficult second birth, although results must be interpreted with caution due to the wide confidence interval reflecting the small number of women experiencing this particular combination. Prior research has shown timing of resumption is associated with operative vaginal births, episiotomy and more severe perineal trauma.(16, 45, 46, 50) Other factors salient to timing of resumption of sex after a second birth are fatigue and breastfeeding, both of which are associated with later resumption of sex. These data lend support to prior findings. (42, 47, 51) Previous longitudinal research found the impact of fatigue on a couple's sexual relationship an increasing problem over time (4 years compared to 6 months after an index birth) but unrelated to the number of subsequent children.(52) Counter-intuitively, neither depressive symptoms nor intimate partner violence appeared to have a marked effect on timing of resumption of sex after second births, although odds were raised in both cases. Similar findings have been reported in another large cross-sectional study. (47)

Adjusting to life with a new baby is a critical period in couple relationships.(22, 53) How well couples navigate this period has implications for long-term relationships and the health and well-being of the whole family.(54, 55) It is common for women and men to say that they didn't know what to expect after having a baby (23, 26), and research over the past four decades has called for more assistance for parents in the area of sexual health and postnatal

relationship issues.(21, 26, 42, 56-60) Sex remains a taboo topic that can be difficult for women and men to bring up in consultations unless specifically asked whether they have any questions related to this issue.(19, 61) Clinicians may also be reluctant to raise the topic of sex, although qualitative studies show that women are generally appreciative of the opportunity to ask questions about sex after childbirth and to clarify any concerns.(62)

Strengths and Limitations

Strengths of the study include: (i) prospective data collection after first and second births; (ii) frequent follow-up and low attrition; (iii) excellent retention and participation in follow-up after second births; (iv) detailed measures assessing resumption of sex, method of birth and other obstetric covariates known to influence timing of resumption of sex. Study limitations include: the exclusion of women receiving maternity care in the private sector where rates of obstetric intervention are higher, and inability to consider differences between the experiences of women having different types of operative vaginal birth (i.e. forceps versus vacuum extraction and high versus low forceps). While data were collected on a range of obstetric events, the number of women experiencing each of these interventions was too small for meaningful statistical comparisons. Breastfeeding questions did not distinguish between exclusive, predominant or complementary breastfeeding. In addition, the length of the study questionnaires may have discouraged some women from participating and is a possible reason for the under-representation of younger women in the sample.

Conclusion

Our findings show that many couples do not resume sex after a second birth until at least the third month after childbirth. Both caesarean section and operative vaginal birth were associated with later resumption of sex after second births, compared to spontaneous vaginal birth with minimal perineal trauma. Time interval between births did not appear to influence timing of resumption of sex. Informing women and their partners that it is not unusual for couples to resume sex more than eight weeks after childbirth may be reassuring and reduce the pressure for everything to be 'back to normal' within six weeks of giving birth.

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Table 1. Resumption of vaginal sex after first births (from 2003 to 2006) and second births (from 2005 to 2015) in Melbourne, Australia

	After the first birth (n=1425)			After the second birth (n=895)		
	n (%)	Cum. %	95% CI	n (%)	Cum. %	95% CI
1st 4 weeks	216 (15.2)	15.2	13.3-17.1	98 (11.0)	11.0	9.0-13.2
5-6 weeks	368 (25.8)	41.0	38.4-43.6	205 (22.9)	33.9	30.8-37.1
7-8 weeks	341 (23.9)	64.9	62.4-67.4	198 (22.1)	56.0	52.7-59.3
9-12 weeks	195 (13.7)	78.6	76.4-80.7	179 (20.0)	76.0	73.0-78.7
3-4 months	186 (13.1)	91.7	90.1-93.0	98 (11.0)	87.0	84.5-89.1
5-6 months	50 (3.5)	95.2	93.9-96.2	50 (5.6)	92.5	90.6-94.2

7-9 months	28 (2.0)	97.1	96.1-97.9	27 (3.0)	95.5	94.0-96.8
10-12 months	11 (0.8)	97.9	97.0-98.6	7 (0.8)	96.3	94.9-97.5
Not resumed by 12 months	30 (2.1)	100.0	99.7-100	33 (3.7)	100.0	99.6-100

Table 2. Relationship between method of birth, perineal trauma and non-resumption of vaginal sex by eight weeks after second birth from 2005 to 2015*

		No vaginal sex by eight weeks postpartum			
	Cohort	n	%	Unadjusted Odds Ratio** (95% CI)	Adjusted Odds Ratio (95% CI)
Method of birth and perineal trauma					
Spontaneous vaginal – minimal or no perineal trauma	264 (32.6)	66	25.0	Reference	Reference
Spontaneous vaginal – sutured tear/episiotomy	286 (35.3)	129	45.1	2.47 (1.7-3.6)	2.21 (1.5-3.2)
Caesarean birth	219 (27.0)	94	42.9	2.26 (1.5-3.3)	2.15 (1.4-3.3)
Forceps/vacuum extraction	41 (5.1)	20	48.8	2.86 (1.4-5.7)	2.60 (1.3-5.3)
Maternal age at second birth (years)					
18-29	158 (19.5)	35	22.2	Reference	Reference
30-34	343 (42.3)	126	36.7	2.04 (1.3-3.1)	1.74 (1.1-2.8)
35+	310 (38.2)	149	48.1	3.25 (2.1-5.1)	2.76 (1.7-4.4)
Any breastfeeding at 8 weeks’ postpartum after second birth					
No	108 (14.2)	27	25.0	Reference	Reference
Yes	653 (85.8)	265	40.6	2.05 (1.3-3.3)	2.12 (1.3-3.5)
Extreme tiredness in first 3 months after second birth					
No	195 (24.2)	63	32.3	Reference	Reference
Yes	611 (75.8)	244	39.9	1.39 (1.0-2.0)	1.04 (0.7-1.5)

* By the time of their second birth 49 women had moved interstate, and 26 women had moved overseas. The remainder of the cohort gave birth in Victoria, Australia

491 ** Data relating to the associations between resumption of vaginal sex at eight weeks postpartum
 492 and relationship status, highest educational qualification level, time interval between births,
 493 depressive symptoms, as measured by the Edinburgh Postnatal Depression Scale (EPDS) and
 494 intimate partner violence, as measured by the Composite Abuse Scale (CAS), were not included due
 495 to lack of significance at the univariable level.

Table 3. Relationship between method of birth for first and second birth and non-resumption of vaginal sex by eight weeks after second birth from 2005 to 2015*

Index birth**	Second birth	TOTAL [‡]	No vaginal sex by eight weeks postpartum	
		N (%)	n (%)	Adjusted Odds Ratio*** (95% CI)
Vaginal birth with minimal or no perineal trauma	Vaginal birth with minimal or no perineal trauma	98 (12.3)	25 (25.5)	Reference
Vaginal birth with minimal or no perineal trauma	Vaginal birth with sutured tear or episiotomy	19 (2.4)	12 (63.2)	5.05 (1.7-15.3)
Vaginal birth with sutured tear or episiotomy	Vaginal birth with minimal or no perineal trauma	156 (19.7)	37 (23.7)	1.06 (0.6-2.0)
Vaginal birth with sutured tear or episiotomy	Vaginal birth with sutured tear or episiotomy	262 (33.0)	115 (43.9)	2.26 (1.3-3.9)
Vaginal birth – any	Caesarean Section	39 (4.9)	17 (43.6)	1.98 (0.8-4.7)
Caesarean Section	Vaginal birth - any	45 (5.7)	23 (51.1)	3.15 (1.4-6.9)
Caesarean Section	Caesarean Section	175 (22.0)	75 (42.9)	2.40 (1.3-4.4)
		794 (100.0)	304 (38.3)	

* By the time of their second birth 49 women had moved interstate, and 26 women had moved overseas. The remainder of the cohort gave birth in Victoria, Australia

** Other combinations were not considered due to small n's. These include first and second vaginal births assisted by forceps or vacuum extraction. These data were collapsed into vaginal birth with sutured tear or episiotomy. In addition vaginal first births followed by a caesarean section were collapsed into one group due to low numbers.

*** Adjusted for time interval between 1st and 2nd births, maternal age, tiredness (3 months postpartum) and breastfeeding (8 weeks postpartum)

¥ Method of second birth detail was available for 845 women. For this group of women method of first birth detail was available for 829 women. 16 had missing data. Of the 829 women for whom first and second birth detail was available 35 women had missing data for the timing of resumption of vaginal sex.

Figure 1. Flowchart of participation

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Title:

Resumption of sex after a second birth: An Australian prospective cohort

Date:

2019-03-01

Citation:

McDonald, E. A., Gartland, D., Woolhouse, H. & Brown, S. J. (2019). Resumption of sex after a second birth: An Australian prospective cohort. BIRTH-ISSUES IN PERINATAL CARE, 46 (1), pp.173-181. <https://doi.org/10.1111/birt.12363>.

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