MENOPAUSE, SEX AND PAIN:

The toll it takes on emotional and mental health

MENOPAUSE RESEARCH AND EDUCATION FUND

ABOUT THE MENOPAUSE RESEARCH & EDUCATION FUND (MREF)

The Menopause Research & Education Fund (MREF) is a registered charity in England & Wales.

Company Snapshot

Established: 2023

Business Type:
Registered Charity
Charity No: 1208828

Location:
London, United Kingdom.

OUR VISION:

A world where menopause is understood by science and managed with confidence by every individual.

OUR MISSION:

To support and fund pioneering research and provide evidence-based education for all, to bridge the menopause knowledge gap, improve health, and the understanding of the impact it can have.

We support everyone going through menopause and those who support them.

WHAT WE DO:

- **Education** - Deliver evidence-based education to healthcare professionals, not just across the UK, but across the globe.
- **Information** - Free downloadable resources for all those who go through menopause, including access to video interviews with world-leading menopause experts.
- **Advocacy** - Support, fund, and lobby for research into menopause and its impact on health.

MREF TRUSTEES

Vikram Talaulikar
Associate Professor Reproductive Health, UCL & BMS accredited menopause trainer

Diane Danzebrink
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Website: mref.uk

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Disclaimer:
This survey is not a peer-reviewed clinical study and is not intended to guide clinical decision-making. It is a snapshot that is intended to inform and perhaps spark interest in further research and discussion.

All those who answered questions about identity identified as female (100%). When we use the word 'women', we recognise that gender is non-binary and is deeply personal. The language used in this report respects the diverse identities of our participants while allowing us to clearly analyse and communicate the aggregated survey trends.

**Where we have used the term 'penetrative sex', we do not mean only sex with men. We mean anything that may penetrate the vagina for the purposes of sexual pleasure, whether you are alone or with a partner of any sex or gender.*

MENOPAUSE, SEX AND PAIN:
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Foreword

Director, Fiona Clark

Welcome to the Menopause Research and Education Fund (MREF) report on menopause and sexual health.

While the phrase Genitourinary Syndrome of Menopause (GSM) is not one that rolls readily off the tongue, it is one of the most common symptoms associated with menopause, affecting up to 87% of women[1]. Its onset is often slow and insidious, starting with a bit of dryness or itching that feels like thrush. There can be more urinary tract infections, tearing and bleeding of the skin on the labia (external genitalia), and sex can become painful. In some cases, the burning, itching, and irritation can be so painful that it's hard to walk, sit, or even sleep. There can be a loss of sensation and shrinkage of the labia and clitoris, reducing sexual pleasure. It is progressive and won't go away without treatment. But it's not just the physical symptoms that matter; these changes can have a significant impact on our emotional and mental health.

I know first-hand how this can impact quality of life and relationships because these were some of my worst menopause symptoms. And even though I studied anatomy and physiology at university and spent 20 years writing and editing in medical publications, I had no idea what menopause had in store for me, let alone what could help treat it and prevent it from getting worse.

This is one of the reasons we conducted the sexual health survey. The other is a comment made in a social media support group that really stuck with me. A woman asked for advice because her husband had threatened to leave her if she didn't have sex with him. He didn't believe that sex was painful for her. No woman should be in this position, but unfortunately, our survey shows she is far from being alone.

It may sometimes be brushed off as 'just a bit of dryness' and the toll it takes on relationships and mental health is rarely discussed. When it is, as our survey shows, it's often dismissed by healthcare professionals, and very few people are given adequate advice or treatment. To put that in perspective, even though up to 87% may have GSM symptoms, just 5% will be prescribed topical oestrogen - a cheap and effective treatment[2].

Why? On the health profession's side, there is a lack of education on how to talk about and treat these symptoms, let alone the impact they can have beyond physical symptoms. For patients, there are cultural taboos, embarrassment, and a sense that this is just what happens and it has to be put up with, as well as a lack of knowledge about available treatment options.

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This needs to change. We need better education for all, including partners where applicable, so people can get the treatment they need.

It's not just people who'd benefit from this. Vaginal oestrogen can save the health system money, and it can save lives. UTIs cost the UK health system £604 million in 2023-24, and women as they age are 5 times more likely to have them than men[2]. UTIs are a leading cause of sepsis, and the death rate in those aged over 65 can be as high as 50%[3]. Vaginal oestrogen has been shown to reduce the rate of recurrent UTIs by around 50% in postmenopausal women[4]. So, sexual health matters right across the healthcare landscape.

We can't solve all these issues with one survey, but I hope this report will shed some light on just how significant sexual health is for women's emotional and mental health around menopause, so we can kick-start a conversation that will finally see it taken seriously.

Thank you for taking the time to read it. And a special thank you to all those who took part, and my co-authors below.

Kind regards,

Fiona Clark

Fiona Clark
Trustee, Menopause Research and Education Fund & study co-author.

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References

1. Carlson K, Vadakekut ES. Genitourinary Syndrome of Menopause. [Updated 2026 Jun 17]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2026 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK559297/
2. Perelmuter S, Srivastava M, Freedman KP, Hanfling S, Rubin RS. Vaginal Estrogen: Pearls for the Practitioner A Practical Review of Evidence, Guidelines, and Prescribing Strategies for Genitourinary Syndrome of Menopause. Journal of Women's Health. 2026;35(10):900-907. doi:10.1177/15409996261465193
3. https://www.gov.uk/government/news/utis-cost-nhs-hospitals-over-600m-last-year#:~:text=New%20data%20from%20UKHSA%20reveals,million%20in%202023%20to%202024.
4. NHS England Patient Safety Alert https://www.england.nhs.uk/wp-content/uploads/2014/09/psa-sepsis.pdf
5. Tan-Kim J, Shah NM, Do D, Menefee SA. Efficacy of vaginal estrogen for recurrent urinary tract infection prevention in hypoestrogenic women. Am J Obstet Gynecol. 2023 Aug;229(2):143.e1-143.e9. doi: 10.1016/j.ajog.2023.05.002. Epub 2023 May 11. PMID: 37178856.

METHODOLOGY

The survey was run online for three months between September and December 2025 using SurveyMonkey. It was promoted on various social media channels and in the Menopause Research and Education Fund's monthly newsletters.

Responses were anonymous, and no identifying or personal data was collected or held. Some 537 people completed the survey, all of whom identified as female. The results have been analysed and rounded to the nearest percentage point.

As per the disclaimer, we are not presenting this as a definitive peer-reviewed piece of research. It is a survey that we hope will shed light on, inform, and guide discussions on a topic that is rarely spoken about and under-researched, yet has a significant impact on many of those who go through menopause.

KEY FINDINGS

‘I DON’T WANT TO BE A BURDEN’

- Vaginal dryness and pain with penetrative sex (with or without a partner) gets worse as women progress from pre-to-post menopause.
- Painful sex sees women reduce or stop having penetrative sex and has a negative effect on their relationships and emotional health.
- ‘Mate guarding’: Just under half of those who continued to have sex with their partner despite the pain said they feared of losing them or felt guilty if they didn’t have sex.
- Women’s confidence, self-esteem and sense of self-worth are affected. They feel ‘isolated’, ‘depressed’ and ‘less of a woman.’
- Healthcare professionals (HCPs) were often dismissive and access to treatment was a postcode lottery with White women who had higher education or higher socioeconomic status most likely to be offered advice or treatment.

RESULTS AND DISCUSSION

Menopause, pain & Sex: The Emotional Cost

One of the most confronting things about menopause can be the physical changes it causes to our bodies. One of the most common, yet rarely spoken about, is vaginal dryness. This can cause a host of problems from itching, burning, tearing and bleeding on both internal and external tissues. As a result, sex can become very painful and often impossible.

To find out what the effect of this was, the MREF surveyed 537 premenopausal, perimenopausal, and postmenopausal women. The responses paint a picture of painful symptoms, often ignored by healthcare professionals and misunderstood by partners.

The result: a significant toll on the women's emotional and mental health, and their relationships.

The survey highlights the gaps in HCPs' knowledge of vaginal health around menopause and what can help with these GSM symptoms, as well as the lack of acknowledgement of how much of a role sex plays in women's sense of self, self-confidence, and mental health.

WHAT WE FOUND:

The survey found that 50% of postmenopausal women and 38% of those in perimenopause said penetrative sex (in any form*) was painful, but 41% continued to have sex despite the pain.

Those who continued to have sex despite the pain said they did so because they:

- **Feared their partner would leave them or have an affair.**
- **Felt guilty (15%) if they didn't.**
- **Didn't want to be a burden.**

A small group (4%) hadn't told their partners sex was painful.

Those who did said: 'He feels slightly rejected, which makes me think he will have an affair.' Another said it had contributed to her partner's infidelity.

Others said they worried for their relationship and felt 'vulnerable' and 'replaceable'.

One woman stated simply: 'We are divorcing.'

SURVEY OVERVIEW

537
Women participated in the online survey.

POPULATION
Premenopausal, Perimenopausal, and Postmenopausal women.

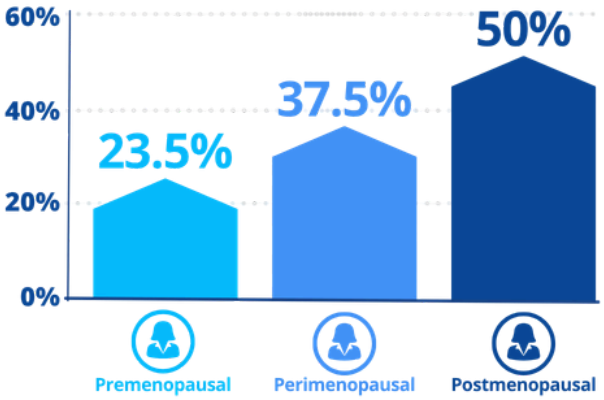
IMPACT ON SEX LIFE

62.7%

Said painful sex had a moderate-to-severe negative impact on their sex life.

PAINFUL PENETRATIVE SEX

% of women who reported painful penetrative sex



Painful penetrative sex becomes increasingly common across the menopausal transition.

Other symptoms:

44%	Had bladder issues (stress incontinence, urgency & waking at night to pee.)
33%	Said the dryness, itching, burning or bladder symptoms disturbed their sleep

CHANGES IN SEXUAL ACTIVITY

PERI- AND POSTMENOPAUSAL WOMEN

24.5%	24%	55.5%
Had stopped having penetrative sex altogether.	Had not had penetrative sex for more than one year.	Reported having penetrative sex less frequently.

41% of women remained sexually active despite pain.

The Impact:
How this made women feel

'Worthless', 'broken', 'guilty', 'sad', 'anxious', and 'lonely' are just some of the words women used to describe the emotional toll of menopausal-related changes on their ability to enjoy sex.

'It's such a shame for any woman to feel like this,' said lead study author, menopause GP and sexologist, Dr Angela Wright. 'We know many women continue to have sex despite pain due to a fear of losing their partner - this can be a form of "mate guarding".'

She adds, 'women often fear for the safety of their relationship if they don't have sex. Many feel ashamed about the changes associated with ageing and often don't disclose what's happening to their partner.'

‘It’s as if I’m a liar’

Almost a quarter of respondents who had partners had not discussed their symptoms with them. Reasons given included being too embarrassed, not knowing what to say, or concern that their partners wouldn’t understand.

Some 40% of respondents who had partners said it was difficult or very difficult to talk to their partners about this. However, when they did discuss it 50% said their partners were supportive and that it had improved their relationship.

Unfortunately, this wasn’t a universal experience. Around 4% said their partners were unsupportive, and 3% said their partners did not believe them when they said sex was painful for them.

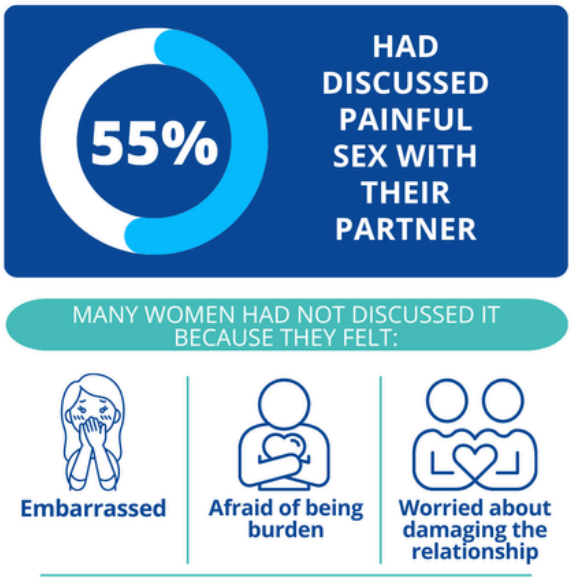
‘It’s as if I’m a liar,’ one said, while another stated, ‘it’s like my symptoms were more of an excuse.’

Many described feeling ‘low’, like a ‘failure’, ‘isolated’, ‘not good enough’, with ‘low self-confidence’, and ‘body image problems’ were frequently mentioned.

Some 43% of respondents said this had negatively affected their relationship, but 8.5% said it had had a positive effect. For the remainder, there was no significant change or it was not applicable.

‘Made me feel like I was making it up’

COMMUNICATION WITH PARTNERS



EMOTIONAL WELL-BEING

What women said about the way they felt:

EXPERIENCES WITH HEALTHCARE PROFESSIONALS

Sex, Pain and the Lack of Management

The MREF survey also found that just 5% of respondents reported a 'positive' experience when discussing sexual pain with their doctor. In contrast, 42% described the experience as 'neutral' and 39% as 'negative'.

Some women said they were told to 'just relax', 'fake it', 'have a glass of wine' or 'drink some herbal tea'. One was told 'use it or lose it'. These comments left women feeling rejected, unheard and unsupported. Very few were offered advice or a treatment option.

Just 15.5% of perimenopausal respondents were prescribed topical vaginal oestrogen while 56% of postmenopausal women received one.

Some were told they couldn't use both systemic and topical oestrogen together (which, in most cases, is not correct). Others said they had to supply letters from specialists, or were told by the doctor that they simply would not prescribe it.

Dr Wright warns this is yet another example of the healthcare system failing women, echoing findings in the Renewed Women's Health Strategy, which found that too often women aren't listened to and their symptoms are dismissed, with paternalism and misogyny still endemic. Better education for doctors on how to talk to patients about their sexual health would help, she said.

Some respondents took matters into their own hands and bought topical oestrogen online or over-the-counter at a pharmacy.

THE ETHNICITY AND ECONOMIC DIVIDE

Those who were offered a prescription for topical vaginal oestrogen, the gold standard treatment for GSM symptoms, tended to be white, middle or upper class, and well educated.

A breakdown by socioeconomic and ethnic background reveals stark differences. Those who came from lower socio-economic backgrounds or who were Black or East Asian were less likely to receive a prescription. Just 4.5% of lower socioeconomic respondents were prescribed topical oestrogen, compared to 46.5% of those who said they were from a middle socioeconomic background.

Only 16% of Black women and 10% of East Asian women received topical oestrogen prescriptions, compared to 41% of White women and 38% of Indian women.

This must change, according to Dr Wright. It should not be a postcode lottery and a greater emphasis should be placed on healthcare providers to ensure they are equipped to better support women who are experiencing these symptoms.

OTHER CHANGES:

Libido and loss of sensation

Loss of libido was a commonly reported symptom. It is associated with social, psychological, and physical changes, and it affected 71.5% of respondents.

A host of physical changes were also noted, including clitoral shrinkage (20%) and loss of volume of the labia, or 'lips' around the vulva (28%). Difficulty climaxing vaginally was reported by 35% of respondents, and difficulty climaxing with clitoral stimulation was a concern for 27%.

A small number, however, said sex was more enjoyable (3.5%), and around one-fifth of women said maintaining a sexual relationship had benefits for them and their partner (if applicable) and that it was important for them.

EXPERIENCES WITH HCPS: ACCESS AND INEQUITY

KEY FINDING

HEALTHCARE INEQUALITY

White women and women from higher socioeconomic backgrounds were more likely to receive vaginal oestrogen treatment than women from other ethnic and socioeconomic groups.

WHO WAS PRESCRIBED VAGINAL OESTROGEN?

44%	White
38%	South Asian
10%	Black
10%	East Asian

WHO WAS PRESCRIBED SYSTEMIC MHT?

44%	White
46%	South Asian
8%	Black
0%	East Asian

WHO WAS PRESECRIBED BOTH?

15%	White
31%	South Asian
8%	Black
0%	East Asian

RESPONDENT DEMOGRAPHICS, FACTS & FIGURES

Sex and identity	100% Identified as female 3% LGBTQAI+, 4% preferred not to say
Menopause status (self reported)	58% postmenopause, 32% perimenopause, 3.4% premenopause, 6.5% unsure
Socio-economic status	12% classed themselves as lower income, 69.5% middle, 18.5% higher income
Education level	70% had an undergraduate or post graduate degree
Information sources	47% websites, 42% social media, 36% HCP, 25% support groups, 18% friends & family
Well informed about menopause?	67% considered themselves well informed

CONCLUSION:
The impact

The survey highlights sexual health's impact on women's mental health and their relationships.

It also shines a glaring light on the taboos in talking about sexual health, how poorly it is rated when it comes to women's physical and mental well-being, and the shocking disparities across ethnic and socioeconomic groups when it comes to accessing appropriate information and treatments.

Co-author and founder of the MREF, Fiona Clark, said there is an urgent need to address these inequities by improving awareness and understanding through education for women, their partners where applicable, and healthcare professionals.

Lead author Dr Wright said sexual health requires a biopsychosocial approach, which the results show is currently lacking. 'The survey sends a clear message to healthcare professionals about the importance of discussing sexual health in a holistic manner.'

'Every healthcare professional should support women not to endure pain,' she says. 'Being expected to put up with painful sex can lead to distress, a loss of bodily autonomy, and can further impact libido.'

The results showed that women who do receive good support from their partners and healthcare professionals found it easier to cope, and some found that it strengthened their relationships and improved their sex lives.

'Better training and support for women, their partners and healthcare professionals on menopause and sexual health is vital, and something we as a charity are committed to improving,' Clark said.

RECOMMENDATIONS

For healthcare professionals

Learn about GSM, the options for treatment, and how to initiate conversations about sexual health and menopause. The MREF runs courses twice a year that cover this, and they can be accessed and downloaded if you can't attend on the day.
Click here or visit mref.uk to register your interest.

For those expereincing painful penetrative sex

Don't let embarrassment stop you from talking to your healthcare professional about the issues - they are real; they affect your health, your physical and emotional well-being, your quality of life, and you deserve the right support.

Ask your doctor about the best options for you, which may include topical vaginal oestrogen for treatment, vaginal moisturisers and/or lube for comfort, pelvic floor physiotherapy or counselling, among other things.

For partners

Speak to your partner and your GP too about the best ways you can help and support your partner. Visit mref.uk to find out more about the Genitourinary Syndrome of Menopause.

For healthcare leaders and policy makers

Mandate training for HCPs on menopause, GSM and sexual health to ensure they understand and can explain the implications of menopause on long-term health and sexual health. Add sexual health and GSM questions to the 40+ health check, fund it, and invite all women over 40, or those with POI or have gone through surgical or medical menopause, to take part.

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LIMITATIONS:

This survey provides a snapshot of women's views on their sexual health and menopause. But even then, it has a number of limitations that need to be taken into account.

1. **Population bias: the audience for our social media is more likely to have symptoms related to menopause, which may cause an overrepresentation of certain symptoms when compared to the general population.**

2. **Demographics: the vast majority (>90%) of respondents were based in the UK, White, and middle class. The smaller sample sizes in ethnically diverse groups mean the results may not be representative of larger populations. Results may vary with a larger sample size.**

The MREF will endeavour to re-run the survey on a larger sample size in the future.

If you would like more information, would like to know more about our courses, or would like to support us, please contact us.

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