

Navigating Menopause-Related Sexual Changes

Understanding Desire, Vaginal Dryness, Painful Sex, Arousal, Orgasm and Intimacy During Perimenopause and After Menopause

By Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

BUMS – Hamdard University, Delhi

MD, CGO

Certificate in Infertility – MGBIMS, Delhi

Certificate in Urology – London, UK

Masters in Male Infertility – MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health – ISRH, UNFPA

Introduction

Many women reach their forties or fifties and begin noticing changes that they did not expect.

Periods become irregular. Sleep becomes disturbed. Hot flushes appear. Mood may feel different. The vagina may become dry. Sexual intercourse, which was previously comfortable, may suddenly begin to burn or hurt. Sexual desire may decrease, or it may take longer to become aroused.

Some women tell me:

“Doctor, I still love my husband, but I no longer feel the same sexual desire.”

Another woman says:

“I want intimacy, but intercourse has become painful.”

Another may ask:

“Why does my body not respond as quickly as it used to?”

And sometimes the woman's partner begins wondering:

“Has she lost interest in me?”

These are important sexual-health concerns, and they deserve proper medical discussion rather than embarrassment.

Menopause is a natural biological transition, not a disease. The World Health Organization defines natural menopause as the permanent end of menstrual periods



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due to loss of ovarian follicular function, usually recognised after **12 consecutive months without menstruation when there is no other physiological or pathological explanation**. Most women experience natural menopause between approximately 45 and 55 years of age.

However, although menopause itself is natural, symptoms associated with falling estrogen and other midlife changes can significantly affect comfort, relationships and quality of life.

WHO specifically recognises vaginal dryness, pain during sexual intercourse, urinary symptoms, sleep disturbances and mood changes among common menopause-associated concerns. WHO has also highlighted that the sexual wellbeing of menopausal women is frequently overlooked in healthcare.

As a physician whose focused practice includes **sexual disorders and infertility**, I consider this subject extremely important.

A woman should never be made to feel that sexual discomfort after menopause is something she simply has to accept because she is getting older.

At the same time, menopause should not automatically be blamed for every sexual problem.

Sexual health is influenced by hormones, physical health, medications, sleep, emotional wellbeing, relationship circumstances, pelvic-floor health and previous sexual experiences.

The correct approach is therefore:

understand what has changed, identify why it has changed, and treat the individual woman rather than treating the word “menopause.”

Menopause Is a Transition, Not the End of Sexuality

One of the most damaging cultural ideas about menopause is that a woman's sexual life should naturally finish when menstruation stops.

Medically, this is incorrect.

Menopause marks the end of natural reproductive cycling. It does **not** automatically mean the end of:

sexual desire,

sexual pleasure,

orgasm,



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romantic relationships,
or satisfying intimacy.

The Menopause Society emphasises that there is no single “normal” level of sexual activity or desire at midlife. Some women notice reduced interest, some notice little change, and others experience increased sexual interest. What matters clinically is whether the woman's sexual experience is comfortable and satisfactory to her.

This is an important distinction.

A woman who has less interest in sex but is completely comfortable with that change does not automatically have a disorder.

Another woman who experiences a major decline in desire and feels distressed by it may need evaluation and treatment.

Medicine should not impose a sexual standard.

It should help the patient achieve the sexual wellbeing that is appropriate and satisfactory for her.

Perimenopause, Menopause and Postmenopause

These terms are often confused.

Perimenopause is the transition leading up to menopause. During this period, ovarian hormone production fluctuates and menstrual cycles often become irregular.

A woman may experience:

hot flushes,
sleep disturbance,
mood changes,
changes in sexual desire,
vaginal symptoms,
and unpredictable periods.

Perimenopause may continue for several years.

Menopause is technically the point reached after 12 consecutive months without a menstrual period for reasons related to natural ovarian ageing.

Postmenopause refers to the years following menopause.

WHO notes that symptoms associated with the menopausal transition vary greatly between individuals. Some women experience relatively few problems, while others have symptoms that significantly affect work, relationships, sleep and quality of life.

Why Does Menopause Affect Sexual Health?

The ovaries gradually produce less estrogen during the menopausal transition.

Estrogen influences many tissues, including:

the vagina,

vulva,

urethra,

bladder,

pelvic tissues,

brain,

bones,

blood vessels.

When estrogen levels fall, genital tissues may become thinner, drier and less elastic.

Blood flow and lubrication may change.

At the same time, menopause often occurs during a stage of life when other issues may be present.

A woman may also be dealing with diabetes, hypertension, weight changes, chronic illness, caregiving responsibilities, work pressure, ageing parents, children leaving home, sleep disturbance or changes in her relationship.

A 2025 review of sexual function across menopause emphasised that menopausal sexual changes are **multifactorial**, involving biological, hormonal, psychological, relationship and social factors rather than hormones alone.

That is how I prefer to approach the subject clinically.

Sexual Function Has Several Different Components

When a woman says:

“My sexual life has changed,”



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we need to understand exactly what she means.

Sexual function includes several related but distinct areas.

A woman may have reduced **desire**, meaning less interest in sexual activity.

She may have difficulty with **arousal**, meaning that mentally or physically she does not become sexually responsive as easily.

She may experience reduced **lubrication**.

She may have difficulty reaching **orgasm**.

She may experience **pain**.

Or she may experience normal physical sexual response but reduced **satisfaction** because of relationship or emotional factors.

A modern 2025 review specifically evaluates menopausal sexual health through these major domains—desire, arousal/lubrication, orgasm, satisfaction and pain.

This is why one medicine cannot be appropriate for every woman.

What Is Genitourinary Syndrome of Menopause?

One of the most important conditions for patients to understand is:

Genitourinary Syndrome of Menopause, or GSM

GSM refers to a group of genital, sexual and urinary symptoms related to the lower-estrogen state of menopause.

It may include:

vaginal dryness,

burning,

irritation,

pain during intercourse,

vulvar discomfort,

urinary urgency,

pain or burning with urination,

and recurrent urinary symptoms.



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NICE specifically defines menopause-related genitourinary symptoms as including vulvovaginal dryness, pain during sex, vulvovaginal irritation or discomfort and painful urination.

The 2025 international sexual-medicine recommendations describe GSM as a common, chronic condition that can affect quality of life and intimate relationships.

GSM Is Different From Hot Flashes

This distinction is extremely important.

Hot flashes often eventually improve.

Genital and urinary symptoms may behave differently.

GSM can persist or become more troublesome if the underlying tissue changes are not addressed.

This is one reason a woman should not simply wait for years thinking:

“Eventually the vaginal dryness will disappear when menopause is over.”

Appropriate treatment can substantially improve symptoms for many women.

Vaginal Dryness

Vaginal dryness is one of the most common menopause-related sexual complaints.

A woman may notice that she requires much more time to become lubricated.

Another may remain dry even when she feels mentally aroused.

Some describe intercourse as:

burning,

scratching,

tight,

or uncomfortable.

This can be confusing because the woman may still feel attracted to her partner.

She may think:

“If I love him and I am mentally interested, why is my body not responding?”

The reason may be physiological.



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Reduced estrogen can affect the vaginal tissues and lubrication.

That does not mean the woman has emotionally rejected her partner.

Pain During Intercourse

Painful intercourse is called **dyspareunia**.

During menopause, pain is commonly associated with dryness and tissue changes, but these are not the only causes.

Pain may also arise from:

pelvic-floor muscle problems,

vulvar skin disease,

infection,

endometriosis or previous pelvic disease,

pelvic surgery,

scar tissue,

nerve pain,

or another gynaecological condition.

Therefore, persistent pain should not automatically be labelled “menopause.”

The correct diagnosis matters.

The 2025 international GSM recommendations identify vaginal dryness and dyspareunia among the most common GSM symptoms.

The Pain–Avoidance Cycle

Once sex becomes painful, another problem can develop.

The woman remembers the pain.

Before the next sexual encounter, she becomes anxious.

Her pelvic-floor muscles tighten.

Arousal may reduce.

Lubrication may reduce further.

Penetration becomes even more uncomfortable.



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The next painful experience reinforces the fear.

Eventually the woman begins avoiding intimacy entirely.

The partner may interpret avoidance as loss of attraction.

Now a biological menopausal symptom has created:

fear,

sexual avoidance,

performance pressure,

and relationship misunderstanding.

Treatment therefore needs to address both the tissue problem and any secondary psychological or relationship consequences.

Lower Sexual Desire

Reduced sexual desire is another common concern, but it is much more complicated than simply saying:

“Your hormones are low.”

Desire can be influenced by:

vaginal pain,

hot flushes,

poor sleep,

fatigue,

depression,

anxiety,

medications,

body-image concerns,

relationship problems,

chronic disease,

and hormonal changes.

NICE explicitly lists **low sexual desire** among sexual difficulties that can occur around menopause.



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The Menopause Society similarly notes that desire varies considerably among women at midlife.

So before treatment, I want to know:

Does she have desire but avoid sex because it hurts?

That is different from:

She feels physically comfortable but has genuinely lost sexual interest.

And both are different from:

She feels sexual desire when alone but not within her current relationship.

These situations require different approaches.

Sexual Desire Does Not Always Begin Spontaneously

Some couples expect sexual desire to work exactly as it did in their twenties.

They expect spontaneous desire to appear first, followed by sexual activity.

But for many adults—particularly within long-term relationships—desire may sometimes become **responsive**.

This means a woman may not initially think:

“I want sex.”

But when affection, privacy, touching and stimulation begin, sexual interest develops.

Understanding this can reduce unnecessary anxiety.

However, a woman should never feel obligated to begin sexual activity in the hope that desire will eventually appear.

Consent and comfort remain essential.

Changes in Arousal

Some women tell me:

“It takes much longer to become aroused.”

This can happen.

Arousal is affected by:

genital blood flow,



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hormones,
nervous-system function,
psychological attention,
medication,
relationship context,
and stimulation.

A longer arousal period does not mean sexual function has disappeared.

The couple may simply need to adapt.

Rushing penetration may be particularly uncomfortable in a woman with GSM.

More time for comfortable stimulation can improve arousal and help natural lubrication where sufficient estrogenic tissue response remains.

Changes in Orgasm

Some women notice that orgasm feels:

less intense,
slower to develop,
or more difficult to reach.

Others experience little or no change.

Again, there is enormous individual variation.

Difficulty with orgasm may arise from:

reduced genital sensitivity,
inadequate stimulation,
medication,
depression,
pelvic-floor factors,
relationship difficulties,
or sexual pain.

A woman who spends an entire sexual encounter worrying about pain is understandably less likely to reach orgasm.



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Treating pain may therefore improve orgasm without any separate “orgasm medicine.”

Sleep Matters More Than Many Couples Realise

Night sweats and insomnia can have an indirect but powerful effect on sexual health.

Imagine a woman who wakes repeatedly each night because of hot flushes.

She has been tired for months.

Her concentration is poor.

Her mood is irritable.

Then her partner asks:

“Why don't you want sex anymore?”

The answer may be partly:

“Because I am exhausted.”

The Menopause Society specifically notes that hot flushes, night sweats and inadequate sleep may contribute to reduced sexual interest.

Sexual health therefore cannot be separated from menopause symptom control.

Mood, Anxiety and Sexual Health

Menopause can coincide with mood changes, anxiety and depressive symptoms in some women.

WHO recognises mood changes, depression and anxiety among symptoms that may occur during the menopausal transition.

NICE advises that menopausal symptoms should be assessed and treated individually and that hormone therapy may be considered for certain depressive symptoms arising around the same time as other menopause symptoms, although a clinical depressive disorder requires appropriate mental-health assessment and treatment.

Persistent depression is not simply “normal menopause.”

A woman who experiences sustained hopelessness, severe anxiety or significant impairment in daily functioning should seek professional help.

Body Image and Midlife



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Weight and body composition may change during midlife.

Breasts may look different.

Skin may change.

A woman may feel that society no longer views her as sexually attractive.

These beliefs can influence sexual confidence.

But sexuality does not disappear because a person becomes older.

One of the important tasks during this stage of life is sometimes to separate:

actual sexual dysfunction

from:

negative cultural messages about ageing and female sexuality.

The patient deserves medical treatment when a physiological problem exists and psychological support when negative beliefs are damaging her confidence.

Relationship Changes Matter

Menopause occurs within relationships, not in isolation.

One partner may have a higher sexual desire than the other.

The woman's partner may also be ageing and experiencing erectile difficulty, diabetes, prostate disease or reduced libido.

Therefore, a couple may mistakenly believe:

“Menopause ruined our sex life,”

when in reality both partners have health issues that need attention.

A 2025 study of GSM and coupled relationships found that menopausal genital symptoms were associated with lower sexual function and could negatively affect the couple's desire and sexual satisfaction.

This is why partner education can be extremely useful.

How Should a Woman Explain Menopause-Related Sexual Changes to Her Partner?

You do not need complicated medical language.

You might say:



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“I am still attracted to you, but menopause has made my vaginal tissues drier and intercourse is sometimes uncomfortable. I want us to continue being intimate, but I need more time, lubrication and treatment so that sex is comfortable again.”

If desire is the concern:

“My sexual interest has changed recently. I don't think this means I love you less. I would like us to understand what is changing instead of putting pressure on each other.”

These conversations can prevent months of misunderstanding.

What Should the Partner Understand?

A partner should understand that menopause-related dryness is not a sign that the woman is sexually uninterested.

Pain is not rejection.

Slower arousal is not rejection.

Lower desire is not automatically loss of love.

A supportive partner can help by allowing more time, listening to what feels comfortable and avoiding pressure.

A damaging response is:

“You used to enjoy this.”

or:

“You just need to try harder.”

or:

“You are getting old.”

Sexual wellbeing improves through cooperation, not humiliation.

Lubricants: A Simple but Important Treatment

Lubricants are used during sexual activity to reduce friction.

They can be particularly useful for mild vaginal dryness or discomfort.

Water-based or silicone-based products are common options.

For some women, lubricant alone makes a major difference.



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The Menopause Society notes that water-, silicone- or oil-based lubricants can help reduce dryness and discomfort during sexual activity, although compatibility with condoms or other products must be considered.

Lubricant is used **during sexual activity**.

That is different from a vaginal moisturizer.

Vaginal Moisturizers

Vaginal moisturizers are typically used regularly rather than only at the time of intercourse.

Their purpose is to help maintain vaginal moisture and comfort.

NICE recommends non-hormonal vaginal moisturizers or lubricants when vaginal estrogen is contraindicated or when a patient prefers not to use it.

A major 2024 systematic review found that vaginal moisturizers may improve some GSM symptoms, although the strength of evidence varies by product and outcome.

These can be particularly useful for women who wish to begin with non-hormonal treatment.

Vaginal Estrogen

For many women with significant GSM, **low-dose vaginal estrogen** is one of the most effective evidence-based treatments.

Unlike systemic hormone therapy, local vaginal estrogen is intended mainly to act on vaginal and vulvar tissues.

NICE's updated guidance recommends offering vaginal estrogen for menopause-related genitourinary symptoms in appropriate patients, including women who are already using systemic hormone therapy.

NICE also explains that systemic absorption from vaginal estrogen is minimal compared with systemic hormone therapy and that serious adverse effects are very rare in the general population, although individual medical history must still be considered.

The 2025 AUA/SUFU/AUGS guideline similarly concludes that low-dose local vaginal estrogen has the **most robust evidence base** among treatments evaluated for GSM.

How Long Can Vaginal Estrogen Be Used?



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This is a common question.

GSM can be chronic, and symptoms often return when treatment stops.

ACOG's November 2025 patient guidance states that topical estrogen for vulvar or vaginal dryness and painful sex often begins improving symptoms within weeks and can be continued long-term when appropriate.

NICE similarly advises patients that symptoms may return after vaginal estrogen is stopped and treatment may then be restarted when appropriate.

Treatment should still be reviewed periodically rather than continued without any clinical follow-up.

Vaginal Estrogen and Previous Breast Cancer

This requires particular care.

Women with a personal history of estrogen-dependent breast cancer should not make decisions about hormonal treatment based on internet advice.

NICE recommends starting with non-hormonal moisturizers or lubricants. If symptoms continue, vaginal estrogen may be considered in selected patients after weighing individual recurrence risk, and patients receiving aromatase inhibitors should have treatment decisions coordinated with their breast-cancer specialist.

ACOG similarly supports shared decision-making with the patient's gynaecologist and oncology team in appropriate cases.

This is a perfect example of why menopause care must be individualized.

Vaginal Prasterone

Another treatment option is **vaginal prasterone**, also known as vaginal DHEA.

NICE recommends considering vaginal prasterone when vaginal estrogen or non-hormonal moisturizers and lubricants have been ineffective or cannot be tolerated.

The Menopause Society also describes intravaginal DHEA as beneficial for sexual pain related to menopausal vulvovaginal changes.

It is not automatically the first treatment every woman needs.

Selection should depend upon symptoms, medical history and availability.



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Ospemifene

Ospemifene is an oral selective estrogen-receptor modulator.

It can be used for selected women with menopause-related vaginal symptoms and painful intercourse.

NICE recommends considering ospemifene when locally applied treatments are impractical.

The Menopause Society also identifies it as a treatment that can alleviate GSM-related vaginal dryness and pain.

Because it is a systemic oral medicine, it should not be confused with a simple lubricant or local vaginal treatment.

Individual risks and contraindications need consideration.

Systemic Hormone Replacement Therapy

Hormone replacement therapy, or HRT, can be effective for broader menopausal symptoms such as:

hot flushes,

night sweats,

and some genitourinary symptoms.

However, whether systemic HRT is appropriate depends upon the woman's:

age,

time since menopause,

medical history,

risk factors,

symptoms,

and treatment preferences.

Hormone therapy should therefore be an individualized decision rather than being treated as either:

“dangerous for everyone”

or:

“something every menopausal woman needs.”



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The Menopause Society's current position emphasises individualized assessment of medical conditions, personal and family history, symptoms and preferences when considering systemic hormone therapy.

Vaginal Estrogen and Systemic HRT Are Not the Same Thing

This distinction prevents considerable confusion.

Systemic HRT circulates throughout the body and is used for symptoms such as significant hot flushes or night sweats in appropriate patients.

Low-dose vaginal estrogen acts mainly on local genital and urinary tissues.

A woman may therefore require local vaginal estrogen even when systemic HRT is not indicated.

Conversely, a woman using systemic HRT may still require additional local treatment if GSM remains troublesome.

NICE specifically allows vaginal estrogen to be used alongside systemic HRT when needed.

What About Testosterone for Low Sexual Desire?

Testosterone sometimes becomes part of discussions about postmenopausal sexual desire.

But it should not be used casually.

NICE recommends considering testosterone supplementation for **low sexual desire associated with menopause when HRT alone has not been effective**, with treatment selected and monitored appropriately.

The Menopause Society likewise notes evidence that testosterone may improve low sexual desire in some perimenopausal and postmenopausal women.

This does not mean:

“Every woman with low libido should take testosterone.”

First ask whether low desire is actually caused by:

pain,

poor sleep,

relationship difficulties,



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depression,

medication,

or another condition.

Testosterone treatment requires medical supervision and should not be obtained from gyms, beauty clinics or unregulated online sellers.

Do Not Use Testosterone Simply to “Reverse Ageing”

This is important.

Menopause treatment should address defined symptoms and health needs.

Hormones should not be prescribed simply because someone wants to “stay young.”

Excess androgen exposure can produce unwanted effects, and long-term safety considerations matter.

Treatment should have:

a clear indication,

appropriate dosing,

clinical review,

and monitoring.

Pelvic-Floor Health and Menopause

Reduced estrogen, childbirth history, ageing and changes in connective tissues can contribute to pelvic-floor symptoms.

Women may experience:

urinary leakage,

urgency,

pelvic heaviness,

prolapse symptoms,

or pain.

WHO notes that menopause can contribute to weakening of pelvic support structures and increase the risk of pelvic-organ prolapse.



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Some women with pain during sex also have pelvic-floor muscles that remain excessively tight.

Others have weakness.

Treatment therefore needs to match the problem.

Pelvic-floor physiotherapy may be appropriate for selected patients.

Recurrent Urinary Symptoms

GSM is not only about the vagina.

The urethra and bladder are also influenced by the menopausal hormonal environment.

Some women experience:

urinary urgency,

burning,

recurrent urinary tract infections,

or discomfort.

NICE includes recommendations regarding vaginal estrogen for postmenopausal women with recurrent urinary symptoms and UTIs within the relevant clinical pathways.

If urinary burning occurs, infection still needs to be considered.

Not every urinary symptom should automatically be labelled GSM.

Bleeding After Menopause Is Not a Normal Sexual Symptom

This point deserves special emphasis.

Once a woman has truly reached menopause, vaginal bleeding should not simply be assumed to result from dryness or intercourse.

Light spotting can sometimes come from fragile vaginal tissue, but **postmenopausal bleeding requires medical evaluation** to exclude important causes.

Do not repeatedly treat unexplained bleeding with lubricants or herbal remedies without examination.

Sexual-health treatment should never delay investigation of a potentially significant gynaecological symptom.



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When Should You Seek Medical Assessment?

You should seek professional evaluation when vaginal dryness, burning, pain, reduced desire or other sexual symptoms are persistent or troublesome.

Evaluation is particularly important when there is:

bleeding after menopause,

significant genital pain,

new vulvar lesions,

abnormal discharge,

recurrent urinary infections,

pelvic pressure or bulging,

unexplained weight loss,

or symptoms beginning after cancer treatment or pelvic surgery.

Sexual difficulties also deserve evaluation when they are causing significant emotional or relationship distress.

What Happens During a Sexual-Health Assessment?

A good consultation should not simply ask:

“Are you sexually active—yes or no?”

I prefer to understand the symptom clearly.

I may ask:

Has sexual desire changed?

Is penetration painful?

Is the pain at the vaginal opening or deeper inside?

Is vaginal dryness present outside sexual activity?

Does urination burn?

Are urinary infections recurring?

Can you reach orgasm?

Has there been previous pelvic surgery?

Are you taking antidepressants or other medicines?



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Are hot flushes interfering with sleep?

Is there anxiety or depression?

How is the relationship?

Has menstruation definitely stopped for 12 months?

Is there any postmenopausal bleeding?

Has there been breast or gynaecological cancer?

These questions determine what type of treatment is appropriate.

Menopause and Sexually Transmitted Infections

Menopause does not protect against sexually transmitted infections.

WHO specifically reminds patients and clinicians that STIs, including HIV, can still be transmitted after menopause. Thinner vaginal tissue may also be more easily injured during intercourse when dryness is present.

Therefore, condoms and STI testing remain relevant in new or non-monogamous relationships.

Pregnancy risk may end after menopause.

STI risk does not.

Pregnancy Is Still Possible During Perimenopause

Irregular periods do not automatically mean fertility has ended.

During perimenopause, ovulation may still occur.

WHO therefore recommends continuing contraception until menopause has been appropriately established.

This distinction is particularly important for women who assume that several months without menstruation means pregnancy is impossible.

What About Vaginal Laser or “Rejuvenation” Treatments?

Patients increasingly see advertisements for:

vaginal laser,



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vaginal rejuvenation,
energy-based tightening,
or anti-ageing genital procedures.

These advertisements can sound extremely convincing.

However, evidence must be separated from marketing.

NICE currently states that **vaginal laser treatment should not be offered for genitourinary symptoms of menopause except as part of a randomized controlled trial.**

A major AHRQ systematic review also concluded that evidence does not demonstrate established effectiveness for energy-based therapies across GSM outcomes.

Some newer studies of radiofrequency or laser remain under investigation, but long-term effectiveness and safety are still areas of active research.

My advice is therefore:

Do not choose an expensive procedure simply because it is marketed as modern or “non-hormonal.”

Ask what high-quality evidence supports it.

Sexual Therapy and Counselling

Not every menopause-related sexual problem can be solved with hormones.

A woman may have received appropriate treatment for dryness but still avoid intercourse because she expects pain.

Another may have no physical pain but significant relationship conflict.

Another may have developed severe body-image anxiety.

Another couple may simply have stopped communicating about intimacy.

Psychosexual therapy or counselling can be very helpful in these situations.

A modern review of postmenopausal sexual dysfunction recommends a multidimensional approach that addresses physical, mental and psychosocial contributors rather than relying upon one intervention alone.

Menopause After Cancer Treatment

Menopause may occur earlier because of:

chemotherapy,

radiation,

surgical removal of the ovaries,

or endocrine cancer treatments.

This may produce a more sudden change than natural menopause.

Sexual symptoms can therefore appear rapidly.

Women with a history of breast or gynaecological cancer require individualized treatment because some hormonal therapies may need additional specialist discussion.

This is another situation where collaboration between sexual-health, gynaecology and oncology teams is important.

Premature Ovarian Insufficiency and Early Menopause

Menopause before the usual age range is medically different from natural menopause in the early fifties.

Premature ovarian insufficiency or premature menopause can have implications for:

fertility,

bone health,

cardiovascular health,

sexual function,

and emotional wellbeing.

WHO notes that premature menopause may occur because of genetic, autoimmune or other causes.

A younger woman experiencing loss of periods and menopausal symptoms should therefore receive medical evaluation rather than assuming she has simply entered normal menopause early.

The Unani Perspective on Menopause



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The Unani system of medicine has traditionally regarded ageing and reproductive transitions within a broader understanding of the woman's temperament, constitution and overall health.

In contemporary academic writing on Unani medicine, menopause has been discussed in relation to concepts such as **Sinn al-Yās** and the age-related transition associated with **Ihtibās al-Tamth**, or cessation of menstruation.

Traditional Unani thinking does not consider this transition solely as the disappearance of menstruation.

Attention may also be given to:

Mizaj or temperament,

sleep,

nutrition,

digestion,

psychological wellbeing,

physical activity,

general strength,

and symptoms affecting different organ systems.

A 2025 review involving researchers from the National Institute of Unani Medicine discusses menopause within this broader traditional framework and describes lifestyle regulation, dietary approaches, regimental therapy and herbal pharmacotherapy as components historically used in Unani care.

Why I Consider the Unani Approach Valuable

As a physician trained in Unani medicine, I believe one important strength of the system is its emphasis on **individualization**.

Two menopausal women may both complain of reduced intimacy but have completely different problems.

One has severe vaginal dryness.

Another has recurrent urinary discomfort.

Another has no physical symptoms but severe insomnia.

Another has low sexual desire associated with depression.



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Another has painful pelvic-floor muscle spasm.

Another has relationship difficulties.

Another has diabetes and peripheral neuropathy.

They should not all receive the same “women's tonic.”

The treatment should be built around the actual clinical picture.

How Unani Care May Support Menopause-Related Sexual Health

In appropriately selected patients, individualized Unani treatment may be used as a **supportive component of menopause care**.

Depending upon the patient, the Unani-oriented plan may give particular attention to:

sleep and rest,

balanced nutrition,

digestive health,

appropriate physical activity,

psychological wellbeing,

general vitality,

weight and metabolic health,

and associated reproductive or sexual symptoms.

Traditional pharmacotherapy may also be considered where appropriate and where the ingredients are compatible with the patient's medical history and other treatments.

But the word **supportive** is important.

A woman with postmenopausal bleeding needs gynaecological investigation.

A woman with severe GSM may benefit from established local therapy.

A woman with prolapse may need pelvic-floor or specialist treatment.

A woman with major depression needs proper mental-health assessment.

Traditional medicine should complement responsible diagnosis—not replace it.

What Does Scientific Research Say About Unani and Botanical Approaches?

Research in this area is growing but remains uneven.



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A 2025 systematic and scoping review led by researchers including the National Institute of Unani Medicine evaluated botanical interventions for depression, anxiety and stress in menopausal women. The review included 16 randomized trials involving more than 1,100 participants and found encouraging effects for several botanical compounds, while also concluding that additional robust clinical trials and mechanistic studies are needed.

This is encouraging for integrative menopause research.

However, it is important not to overinterpret the findings.

Evidence that a botanical intervention may help a psychological menopause symptom does not prove that the same intervention treats:

vaginal atrophy,

GSM,

dyspareunia,

urinary symptoms,

or low sexual desire.

Different symptoms require different evidence.

At Saira Health Care, I therefore believe that traditional knowledge should be respected while modern research continues to test specific therapies properly.

Herbal Does Not Automatically Mean Hormone-Free or Risk-Free

This is particularly important in menopause.

Many products are marketed as:

“natural estrogen,”

“herbal hormone replacement,”

“menopause balance,”

or “female rejuvenation.”

Some plants contain compounds capable of interacting with biological hormone pathways.

Other herbs may interact with:

anticoagulants,



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diabetes medicines,
blood-pressure medicines,
sedatives,
or other treatment.

Therefore, the fact that something is herbal does not mean:

“Every woman can safely take it.”

Women with a history of hormone-sensitive cancer require particular caution.

Tell your doctor about every herbal preparation and supplement you use.

My Approach at Saira Health Care

When a woman consults me about menopause-related sexual changes, I do not want the consultation to end with:

“This is normal for your age.”

That answer is not enough.

I want to know what has actually changed.

Is the primary concern dryness?

Pain?

Reduced desire?

Reduced arousal?

Orgasm difficulty?

Urinary symptoms?

Sleep problems?

Mood?

Relationship stress?

Pelvic-floor symptoms?

Medication?

Cancer treatment?

Only after identifying the main mechanism can we discuss treatment.



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Saira Health Care's Contribution to Sexual Disorders and Infertility

At **Saira Health Care**, our focused work in sexual disorders and infertility has shown us repeatedly that intimate health problems rarely exist in isolation.

A woman's menopause-related sexual difficulty may affect her partner.

Her partner's erectile dysfunction may affect her own sexual response.

Pain may reduce intercourse frequency.

Reduced intimacy may affect the relationship.

Relationship conflict may further reduce desire.

Therefore, a sexual-health consultation should not simply produce a prescription.

It should create understanding.

Where appropriate, the treatment plan may involve:

medical management,

responsible Unani supportive care,

pelvic-floor therapy,

gynaecological referral,

menopause-specialist assessment,

psychological treatment,

or couple-based sexual counselling.

A Special Note About Fertility

Natural fertility declines considerably before menopause and natural pregnancy is no longer expected after established menopause.

However, sexual health and fertility are not the same thing.

A woman can no longer be naturally fertile and still have an active, satisfying sexual life.

This distinction is important in a clinic such as ours where both **infertility and sexual disorders** are treated.

Reproductive capacity may end.

Sexual wellbeing does not have to end with it.



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Frequently Asked Questions

Is low sexual desire normal during menopause?

It can occur, but it is not universal.

Some women experience reduced desire, some notice no significant change and others experience increased interest.

If reduced desire causes personal or relationship distress, evaluation is appropriate.

Does menopause always cause vaginal dryness?

No.

Not every woman experiences the same symptoms.

However, vaginal dryness is a common effect of the reduced-estrogen environment and is an important component of GSM.

Why does intercourse hurt after menopause?

Common causes include vaginal dryness, thinner tissues and GSM, but pelvic-floor problems, vulvar disease and other gynaecological conditions can also cause pain.

Persistent pain should be evaluated rather than automatically attributed to ageing.

Can lubricant solve the problem?

For mild dryness, lubricant can be very helpful.

But persistent GSM may require regular vaginal moisturizer or prescription treatment such as local estrogen or another appropriate therapy.

What is the difference between lubricant and moisturizer?

Lubricant is usually applied around sexual activity to reduce friction.

A vaginal moisturizer is generally used regularly to improve baseline vaginal moisture and comfort.



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Is vaginal estrogen effective?

Yes.

Current major guidelines support low-dose vaginal estrogen as one of the most effective treatments for appropriate women with GSM. The 2025 AUA/SUFU/AUGS guideline states that it has the most robust evidence base among GSM treatments.

Is vaginal estrogen the same as taking systemic HRT?

No.

Low-dose vaginal estrogen mainly targets local genital and urinary tissues and has much lower systemic exposure than systemic HRT.

Can vaginal estrogen be used for a long time?

In appropriate patients, yes.

GSM may be chronic, and symptoms can return after treatment stops. ACOG's current patient guidance supports long-term topical estrogen use when clinically appropriate.

What if I have previously had breast cancer?

Do not make the decision alone.

Non-hormonal moisturizers and lubricants are generally considered first. Persistent symptoms may sometimes justify carefully selected vaginal estrogen after shared decision-making, with oncology involvement particularly for women using aromatase inhibitors.

Can testosterone help libido after menopause?

It can help selected women with distressing low sexual desire.

NICE recommends considering testosterone when menopause-related low desire remains despite HRT, but treatment requires appropriate selection and medical monitoring.

Does menopause make orgasm impossible?

No.



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Many women continue to experience orgasm after menopause.

Some may notice slower or less intense orgasm because of hormonal, physical, medication-related or psychological changes.

When orgasm difficulties are troublesome, the underlying contributors should be assessed.

Can menopause cause urinary problems?

Yes.

GSM can include urinary urgency, discomfort with urination and recurrent urinary symptoms.

Can sex itself help vaginal health?

Comfortable sexual stimulation may support genital blood flow and tissue function.

The Menopause Society notes that regular painless sexual stimulation, alone or with a partner, can help maintain vaginal function.

The word **painless** is important.

A woman should never repeatedly force painful intercourse because she believes sex itself is a treatment.

Is vaginal laser better than estrogen?

Current evidence is not strong enough to make that conclusion.

NICE advises against offering vaginal laser for menopausal genitourinary symptoms outside randomized clinical trials.

Can pelvic-floor therapy help?

Yes, when pelvic-floor dysfunction contributes to pain, urinary symptoms or other pelvic complaints.

Not every woman needs pelvic-floor therapy, and treatment should depend on examination and symptoms.



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Does menopause cause depression?

Menopause does not automatically cause clinical depression.

However, depressive symptoms, mood changes and anxiety can occur during the transition, and severe or persistent symptoms require appropriate evaluation.

Can Unani medicine help menopause-related sexual changes?

Individualized Unani care may provide useful supportive management for lifestyle, sleep, psychological wellbeing, general vitality, nutrition and selected menopause-associated complaints.

Modern research into botanical approaches during menopause is developing and some findings are encouraging. However, current evidence does not justify claiming that one Unani formulation can universally reverse GSM, restore hormones or cure every menopause-related sexual problem.

Responsible treatment should combine traditional knowledge with appropriate modern diagnosis.

When You Should Seek Prompt Medical Attention

Menopause-related sexual discomfort usually does not represent an emergency.

However, certain symptoms should never be ignored.

Seek medical assessment for unexplained vaginal bleeding after menopause, persistent or worsening pelvic pain, a new vulvar growth or lesion, significant abnormal discharge, repeated urinary infections, unexplained genital bleeding after intercourse or another new concerning symptom.

Particularly remember:

Postmenopausal bleeding needs evaluation.

Do not assume it is only dryness.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

Founder & Chief Physician – Saira Health Care

Focused Practice in Sexual Disorders & Infertility

My professional qualifications and training include:



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BUMS – Hamdard University, Delhi

MD

CGO

Certificate in Infertility – MGBIMS, Delhi

Certificate in Urology – London, UK

Masters in Male Infertility – MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health – ISRH, UNFPA

My focused clinical practice includes sexual disorders, reproductive-health concerns and infertility, where intimate symptoms frequently involve physical, hormonal, emotional and relationship factors simultaneously.

At Saira Health Care, my objective is to provide patients with a professional environment in which sexual-health concerns can be discussed without shame.

A woman should be able to tell her doctor:

“Sex has become painful.”

“I have lost my desire.”

“I feel dry.”

“I am no longer reaching orgasm.”

without being told simply:

“This happens with age.”

We should investigate why it is happening and explain what can reasonably be done.

My Message to Women Going Through Menopause

Menopause is a major biological transition.

But it is not a declaration that your sexuality has ended.

Your menstrual cycle may finish.

Your fertility may change.

Your hormones may change.

Your body may respond differently.

But you remain a complete person with a right to:

comfort,

sexual health,



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affection,

intimacy,

and appropriate medical care.

If sex hurts, say so.

If your desire has changed and it troubles you, discuss it.

If dryness is affecting your relationship, seek treatment.

If you have urinary symptoms, do not ignore them.

If you are depressed or anxious, ask for help.

And if a clinician dismisses everything by saying:

“You are menopausal; this is normal,”

remember that a change can be associated with menopause and still deserve treatment.

My Message to Partners

If your partner is going through menopause, do not interpret every sexual change personally.

She may still love you and feel attracted to you while simultaneously experiencing:

pain,

dryness,

slower arousal,

sleep deprivation,

hot flushes,

or lower desire.

Ask:

“What would make intimacy more comfortable for you?”

rather than:

“Why aren't you the way you used to be?”

That difference in language matters.



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Sexual recovery and adaptation are easier when couples approach menopause together rather than treating it as one woman's problem.

Final Words From Dr. Nizamuddin Qasmi

In my work with sexual and reproductive-health patients, I believe menopause should be approached neither with fear nor with neglect.

It is natural.

But that does not mean every symptom must be tolerated.

A natural biological transition can still produce real clinical problems.

Vaginal dryness can be treated.

Painful intercourse can be investigated.

GSM can be managed.

Urinary symptoms can be assessed.

Low desire can be explored.

Pelvic-floor problems can be treated.

Mood and relationship difficulties can receive appropriate support.

Modern menopause medicine gives us several evidence-based options, including lubricants, moisturizers, vaginal estrogen, systemic hormone therapy for appropriately selected women, vaginal prasterone, ospemifene and carefully selected testosterone therapy for certain cases of low sexual desire.

At the same time, as a physician trained in the Unani system, I value a broader view of the patient.

Sleep matters.

Nutrition matters.

Physical activity matters.

Psychological wellbeing matters.

General metabolic health matters.

Relationships matter.

And individualized traditional care may provide useful supportive management when applied responsibly.

This does not require choosing between traditional Unani medicine and modern menopause science.

It requires using each responsibly.

At **Saira Health Care**, my aim is to understand the complete patient and help identify which factors are affecting her sexual and reproductive wellbeing.

Because menopause should not be viewed simply as:

“the end of periods.”

It is a transition into another important stage of life.

And with appropriate information, treatment, communication and support, that stage can continue to include **healthy, comfortable and satisfying intimacy**.

Important Medical Disclaimer

This article is intended for general education and patient awareness and does not replace an individual medical consultation, pelvic examination, gynaecological assessment or treatment plan.

Menopause-associated sexual symptoms can arise from hormonal, gynaecological, urinary, pelvic-floor, medication-related, psychological and relationship factors.

Hormone therapy, vaginal estrogen, testosterone, prasterone and other prescription treatments should be used only after appropriate professional assessment of individual risks and benefits.

Women with a history of breast cancer, other hormone-sensitive cancers, unexplained vaginal bleeding, thrombotic disease or other important medical conditions may require specialist advice before some menopause treatments are used.

Unani and herbal medicines should also be disclosed to the treating clinician. “Natural” does not automatically mean appropriate for every patient, free from drug interactions or safe in hormone-sensitive medical conditions.

Any vaginal bleeding after established menopause should be medically evaluated rather than presumed to result from menopause-related dryness.



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