

IMAP Statement on Menopause

Introduction

Menopause is a retrospective diagnosis: it is defined after a woman or person who can menstruate is amenorrheic for 12 months. (1) At this time, estrogen levels are diminished, the ovaries no longer ovulate and spontaneous conception is no longer possible. The average age of the final menstrual period (FMP) is between 46-52 years of age globally. (2) Early menopause occurs between the ages of 40-45 and premature ovarian insufficiency refers to

menopause occurring spontaneously before 40 years of age.

Of note, although most professional societies define menopause occurring following 12 months of amenorrhea, the United Kingdom Faculty of Sexual and Reproductive Health defines it as 12 months in people over the age of 50 years of age and 24 months in those between 40-50 years of age. (3) See Table 1 for a glossary of terms.

Table 1: Glossary of Terms

Term	Definition
Menopause	Cessation of menstrual cycles. The final menstrual cycle (FMP) is diagnosed after a full 12 months of no bleeding*
Surgical Menopause	Menopause induced by the removal of both ovaries
Induced Menopause	Cessation of menstrual cycles due to other causes such as chemotherapy
Early Menopause	Cessation of menses between ages 40-45 not due to other causes of secondary amenorrhea
Premature ovarian insufficiency	Cessation of menses prior to age 40

Term	Definition
Menopause Transition	The start of menopausal symptoms and/or irregular bleeding until the FMP
Perimenopause	The phase including the menopause transition until 12 months after the FMP

The Faculty of Sexual and Reproductive Health defines as 12 months in patients over the age of 50 years of age, and 24 months in patients between 40-50 years of age.

The menopause transition is the start of menopausal symptoms and/or menstrual irregularities until the FMP. Perimenopause includes the menopause transition, during which time contraception may continue to be needed, and one year after the FMP, when menopause is officially diagnosed. (4) Both menopause and perimenopause are a time of great transition. Perimenopause is associated with significant hormonal fluctuations with an eventual reduction in ovarian estrogen production. In the initial years after the FMP, estrogen levels may still fluctuate but, over time, will diminish to a persistent low estrogen state. These hormonal changes can have significant physical, emotional, and mental effects.

Menopause occurs naturally but other types exist. Surgical menopause occurs when both ovaries are surgically removed. Menopause can also be induced after medical treatments, such as with chemotherapy, that result in cessation of ovarian function which may be permanent or reversible.

Globally, life expectancy is increasing, albeit varying by geographical location. Some people may spend decades in perimenopause and menopause. Often the needs of those in perimenopause/menopause are unmet; recognizing and addressing these needs are essential to ensure the health and wellness of this often-overlooked population.

Purpose of the Statement

The purpose of this statement is to define the health impact of perimenopause and menopause

and review therapeutic options to address the healthcare needs of this population.

Intended audience and stakeholders

This statement is aimed primarily at IPPF Member Associations to define the issues of perimenopause and menopause and guide the health care they provide. It may also be useful for primary care physicians and providers who are interested in or care for perimenopausal or menopausal patients. Other sexual reproductive health organizations, policy makers, researchers or activists may also benefit from the guidance.

Defining the problem

Perimenopausal and menopausal symptoms

Perimenopause can precede the cessation of menstrual cycles by months or years. Hormonal fluctuations beyond those of the normal menstrual cycle occur with greater rises and falls in hormonal levels such as estradiol. These changes may trigger a variety of symptoms while some have minimal or no impact.

Bleeding:

The most common symptom during perimenopause is irregular bleeding. Menstrual cycles may initially be regular and predictable but eventually become irregular in timing, duration and quantity. Menstrual cycles may be shorter in length, further apart or a combination of both, leading to unpredictable bleeding patterns. This unpredictable bleeding can be problematic for some. The amount of bleeding may also change.

Some experience heavier flow than their baseline, while others may notice lighter flow. [\(1\)](#)

Although irregular bleeding is common in perimenopause, bleeding that is more frequent, heavier or prolonged and/or interspaced between periods requires further evaluation to rule out precancerous (endometrial hyperplasia) or cancerous conditions, as well as structural issues like endometrial polyps. Evaluation may consist of imaging, endometrial biopsy or referral for further evaluation. After menopause, any vaginal bleeding is abnormal and must be evaluated. People younger than age 45 should be evaluated for other causes of amenorrhea.

Vasomotor symptoms:

Other symptoms of perimenopause and menopause include vasomotor symptoms (VMS) such as hot flashes and night sweats. Hot sweats are characterized by a sudden, intense feeling of warmth that often starts in the chest and spreads to the neck and head and may be accompanied by sweating. The frequency and severity may vary throughout perimenopause and may worsen or lessen once menopausal. Although VMS are a classic feature of perimenopause and menopause, they may not be the most bothersome symptom. Asking about other symptoms beyond just VMS is important to determine if the person is suffering from other less-recognized manifestations of this hormonal transition. [\(1\)](#)

Genitourinary symptoms:

Lower estrogen levels lead to tissue changes in the vulva and vagina consisting of a decrease in collagen, elastin and blood vessel formation; the tissues become thinner, less lubricated and less pliable; there are modifications of the vaginal environment and the normal vaginal flora. In general, lactobacillous populations decrease, leading to elevated pH and potentially an increased risk of vaginal infections, such as bacterial vaginosis (BV). Diagnosing BV in menopausal people is difficult as the diagnostic criteria were developed for premenopausal

people and the natural changes due to reduction in estrogen levels may mimic the signs and symptoms of BV. [\(5,6\)](#) All of the above changes cause vaginal dryness, irritation, burning, and pain with vaginal penetration. Stress urinary incontinence, urinary tract and vaginal infections may also become more common. [\(6\)](#) The combination of these tissue changes and symptoms make up the Genitourinary Syndrome of Menopause (GSM).

Mood, cognitive and behavioral changes:

Mood changes are also common during perimenopause. Irritability, anxiety and depression may start or worsen in those with a prior history. The symptoms may become debilitating and require prompt therapy to minimize impact on wellbeing. Cognitive behavioral therapy, psychiatric medications and/or hormonal therapy may be appropriate. As the fluctuations in hormones are often the trigger for mood disruption, these symptoms may improve once through perimenopause, when a stable hypoestrogenic state is established. [\(1\)](#) Sleep quality may become impaired, with difficulty falling or staying asleep. Middle-of-the-night awakening with the inability to fall back asleep is a frequent complaint of perimenopausal patients. Sleep may also be disrupted due to night sweats, some of which are so severe people need to change their bedclothes. [\(1\)](#)

Cognitive changes are also reported. Many perimenopausal people experience “brain fog” that is difficulty concentrating, changes in both short and long-term memory, word-finding issues and feeling not as cognitively “sharp” as they once were. These symptoms can be severe enough to impact day-to-day functioning, both at work and at home. These cognitive changes can cause additional significant distress as individuals may worry the symptoms indicate the start of dementia or significant, permanent cognitive decline. Fortunately, brain fog will often improve or stabilize with time and is not associated with a future risk of dementia. [\(7\)](#)

A lower sex drive, or libido, is common during perimenopause and menopause. Libido is multifaceted and may be impacted by hormonal fluctuations, life stressors, physical changes, including GSM, relationship factors and mental health, to name a few. Given the complex etiology of low libido during this time, a multiprong approach to care is often needed, including referral to a specialist or with expertise managing these issues. [\(8\)](#)

Other changes:

Other changes that may be noticeable during perimenopause and menopause include an increased prevalence and/or severity in metabolic syndrome, abdominal fat, cholesterol and atherosclerosis. These changes are associated with an increased risk of cardiovascular disease (CVD). The type of menopause also increases CVD, with early and surgical menopause carrying a higher risk than natural menopause. [\(9\)](#)

Skin changes due to a loss of collagen and loss of muscle definition also occur. There is an approximately 30% loss of skeletal muscle and skin collagen during this transition. [\(7\)](#) An increase in strength and resistance training may help mitigate muscle mass loss and improve physical abilities.

The musculoskeletal system presents other changes, including an increase in joint pain and an increase in bone catabolism, which can lead to low bone mass and osteoporosis. Estrogen therapy can decrease bone resorption, prevent osteoporosis and bone fractures. [\(10,11\)](#)

People may experience a wide range of symptoms during perimenopause, and their presence and intensity may vary throughout the menopause transition. For example, mood symptoms and sleep changes may be more prevalent during perimenopause, with vasomotor symptoms being more prominent after menopause. Each person has a unique journey; there is no predictable pattern or course.

Impact of symptoms

Symptoms may go beyond affecting the individual to impacting the family, work environment and productivity. Increases in work absenteeism and working whilst not feeling well occur during perimenopausal and menopause, as sleep deprivation, brain fog, anxiety, and depression combined with VMS may cause people to feel unwell. [\(12-14\)](#) People often feel unsupported in their work environment and report a lack of understanding about and education on their symptoms. Counselling and educating people, both employers and employees, on the possible symptoms, potential impact and management options may help alleviate the stress and uncertainty experienced during this time. Addressing and treating symptoms can improve workplace productivity issues.

Fatigue, depression, anxiety and physical changes may negatively influence relationships with family and friends and the home environment. The hormonal changes of menopause often correspond with shifting dynamics at home as people are often sandwiched between caring for children and aging parents. People may also have feelings of sadness and melancholy once adult children have left home. [\(15\)](#) High resilience, the capacity/ability to cope with all of these changes, and strong family support can reduce the psychological toll these changes may have on overall well-being. [\(16\)](#)

Globally, the prevalence of symptoms varies, and studies have inconsistent findings. A recent systematic review found a high degree of variability among studies, but general trends were noted. VMs were higher in black people than in white or people of East Asian descent while sleep disturbances were higher in white women. [\(17\)](#) The highest overall prevalence of VMS was in the Quechua women of Peru. [\(17\)](#) A global cross-sectional survey study of people in Japan, Europe and the United States found the most common symptoms reported were fatigue, joint pain and difficulty sleeping followed by VMS. The most bothersome reported symptom was weight gain.

(18) Environmental and cultural factors also play a role. Asian Indian women living in the UK had a higher prevalence of VMS compared to those living in India. However, Bangladeshi women, regardless of location (UK or Bangladesh), had higher VMS compared to white European women. (19)

Of note is that middle- and low-income countries appear to have an earlier age of onset of menopause and a higher prevalence of early menopause. (20) This is particularly relevant as new data indicates that the earlier age at menopause and the severity and duration of the VMS may correlate with an increase in cardiovascular disease risk in the future. (11,21) Recognizing early onset of menopause will help physicians and other healthcare providers counsel on disease prevention strategies to help improve health and longevity.

Unmet need for Menopausal Hormone Therapy (MHT)

MHT refers to the use of exogenous hormones taken systemically to treat perimenopausal and menopausal symptoms. The general population may not be aware of the signs and symptoms of perimenopause and menopause and may not be aware that therapies, hormonal and non-hormonal, systemic and local, exist that may alleviate symptoms and improve quality of life. This lack of information may prevent people from accessing medical care to discuss and address their perimenopausal and menopausal needs. Not every person may want or need therapy but understanding options helps people make the best healthcare decisions for themselves.

Another barrier to accessing care is the lack of education, training and knowledge in healthcare providers. Although half of the world's population will experience menopause, minimal time is dedicated to it in medical education. In 2002, the Women's Health Initiative (WHI) published a large, randomized control trial on menopausal hormone therapy (MHT) and stated that MHT increased the risk of breast cancer and cardiovascular disease

in users. (22) This study had the long-lasting and far-reaching impact of dramatically reducing the use of MHT globally as the main messaging was that MHT is risky and should be used sparingly, if at all. (23) Two decades later, with additional studies and data, a more nuanced understanding of the risks described in the WHI is apparent. This deeper understanding has led to a more balanced approach to MHT that evenly weighs the risks and benefits of this potentially life-changing therapy.

Globally, there are geographical and ethnic differences in the use of MHT, with white people, Europeans and North Americans reporting a higher use rate than other regions. (17) This may be due to several factors, including access to healthcare providers with knowledge and comfort in menopausal medicine, access to therapeutic options and lack of patient education on menopausal symptoms and treatments. There is clearly a need for more accurate information - for women and health providers - regarding the risks and benefits of the different types of MHT (estrogen alone, estro-progestogen combined, other hormonal compounds) depending on an individual's conditions and needs.

Unmet need for contraception

An important issue for perimenopausal people is the presence of symptoms combined with the ongoing need for contraception. While experiencing traditional menopausal symptoms such as VMS, perimenopausal people may be still ovulating and conception is possible, despite age-related decline in fertility. Up to 75% of pregnancies that occur over the age of 40, however, are unintended. (24) Unplanned pregnancies are high in this population as people and healthcare providers alike often believe the person is no longer fertile or the chances of pregnancy are slim. Multiple medical societies recommend contraception until age 55 or until menopause is confirmed. (1,3,25,26) Contraceptive options need to be reviewed for all perimenopausal people and a risk/benefit approach to method use should be applied. Fortunately, some contraceptive options can

treat menopausal symptoms or be combined with hormonal therapy to help address both contraceptive need and symptom management.

Menopause and Sexually Transmitted Infections (STI)

Condom use decreases with age as people become less concerned about pregnancy prevention. This decrease in use results in an increased risk for and prevalence of STIs. Discussing the continued need for STI protection can promote safer sexual practices at all ages. [\(27\)](#).

Menopause and HIV

People with HIV are living longer and spending more of their lives in perimenopause and menopause. It is unclear if people living with HIV experience menopause earlier than the general population. [\(28\)](#) Diagnosing menopause in this population can be complicated due to symptoms that overlap between HIV and perimenopause/ menopause such as menstrual irregularities and joint pain. An increase in menopausal symptoms may lead to a decrease in adherence to HIV treatment in this population. [\(29\)](#) People living with HIV are at an increased risk for osteoporosis and cardiovascular disease, two conditions that also worsen with menopause. [\(30,31\)](#)

People living with HIV often have a delay in diagnosis of menopause and a decrease in treatment with MHT given concerns about potential drug interactions from their providers. However, MHT is not contraindicated with concurrent HIV medications and may be particularly beneficial for prevention of osteoporosis and cardiovascular disease. [\(29\)](#)

Sexual and Gender Based Violence (SGBV)

Although SGBV is most prevalent in younger populations, perimenopausal and menopausal people are also at risk. People experiencing SGBV have a higher prevalence of menopausal symptoms, including VMS, insomnia and GSM. [\(32\)](#) Screening for current and past SGBV will help

identify people at risk for violence and those at higher risk for bothersome perimenopausal and menopausal symptoms.

Review of the available evidence and guidance for symptomatic people

When considering the best therapeutic approach to symptomatic people, several criteria are important for guidance. First, does the person need contraception? If yes, then a combined hormonal contraception or progestin-only contraceptive combined with estrogen may be the best treatment. These are also appropriate options for a person experiencing bothersome bleeding, such as frequent or heavier menses. If contraception or bleeding therapies are not needed, then traditional MHT with estrogen and progestogen is often the most reasonable first-line therapy. There is no “one size fits all” with perimenopausal and menopausal therapies; the person and their provider together should decide on the best approach, knowing that adjustments may be needed if symptoms are not adequately addressed.

Combined hormonal contraception (CHC)

CHC, including oral, transdermal and vaginal routes, may prevent pregnancy and address several symptoms including irregular bleeding, mood changes and vasomotor symptoms. In appropriate healthy individuals, with no other comorbidities or medical contraindications (per the WHO Medical Eligibility Criteria for Contraceptive Use), CHC could be used until age 55. [\(33,34\)](#)

Contraception combined with estrogen therapy

Another option is progestin-only contraception combined with estrogen therapy. Estrogen therapy, in oral, transdermal or vaginal routes, can be safely combined with progestin contraceptives, either oral pills or intrauterine systems. Estrogen products, particularly in non-oral routes (transdermal or vaginal) have fewer restrictions for use than oral ethinyl estradiol, used in most combined hormonal contraception, and

may better alleviate symptoms. If people have breakthrough perimenopausal symptoms even on CHC, a switch to a CHC with a different estrogen than ethinyl estradiol (such as estetrol or estradiol) or

to a progestin-only option with estrogen therapy may help. See Table 2 for guidance on combining progestin-only options with estrogen therapy. [\(33\)](#)

Table 2: Use of Progestin-only contraceptive methods in combination with estrogen therapy

Method		Recommended Use
POP	Norethindrone	0.35 mg minimum daily dose
	Drospirenone	4 mg daily dose
Etonogestrel Implant		Not approved although data demonstrate endometrial thinning
IUS	52 mg levonorgestrel	Approved in Europe for 5 years of use with estrogen therapy, off label use in US
	19.5 and 13.5 mg levonorgestrel	Off-label use, may not provide adequate protection during entire FDA approved contraceptive timeframe
DMPA		No data, generally not recommended

POP: progestin - only method

IUS: Intrauterine system

DMPA: depot medroxyprogesterone acetate

US: United States

Reprinted with permission from Perimenopausal contraception. Voedisch AJ, Ariel D. *Curr Opin Obstet Gynecol*. 2020 12;32(6):399-407.

The etonogestrel contraceptive implant and injectable depot medroxyprogesterone in combination with estrogen therapy have not been extensively studied for endometrial protection in symptomatic perimenopausal people and are not routinely used in this context. However, both products are known to cause endometrial thinning and may be reasonable to consider, provided endometrial status can be periodically evaluated.

An important question is how to determine when contraception is no longer needed, as using a hormonal contraceptive may mask menses as a marker for menopause. For those without symptoms who are medically eligible to continue their hormonal method, continuing therapy until age 55 is reasonable. It is also possible to evaluate menopausal status while on contraceptives. See Table 3 for guidelines on assessing menopausal status in contraceptive users. [\(33\)](#)

Table 3: Assessing menopausal status by contraceptive method

Clinical Evaluation		Laboratory Evaluation*
Non-hormonal	Amenorrhea for 12 months	
CHC		Stop method for 6 weeks and if no menses check FSH twice 1-2 months apart; if elevated > 30 IU/L both times contraception can be discontinued OR FSH > 30 IU/L on two occasions 6-8 weeks apart after 7-14 hormone free days starting at age 50 years old
DMPA		FSH > 30 IU/L on two occasions 90 days apart (first day of injection) method can be stopped
Implant, IUS, POP		FSH > 30 IU/L on one occasion, then continue method for one more year
Other	Age 55 years old can stop all methods without laboratory evaluation	

*Laboratory evaluation should be limited to women 50 years of age or older.

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Menopausal Hormone Therapy

MHT uses exogenous hormones, in different forms of estrogen and progestogen, to treat perimenopausal and menopausal symptoms. Estrogen therapy is available in oral, transdermal, and vaginal routes. The most common formulations are estradiol and conjugated equine estrogens. Progestogens are available in oral and intrauterine routes as well as in combination transdermal products with estrogen. Oral progestogens include micronized progesterone and synthetic progestins in the form of medroxyprogesterone, norethindrone and drospirinone.

The goal of MHT is to improve quality of life through decreasing problematic bleeding, sleep disturbances, VMS, GSM, mood disturbances, and decreasing the risk of bone loss and osteoporosis. Although MHT may be beneficial for CVD and brain fog, it is not recommended for the *prevention* of CVD or dementia.

For symptomatic people who do not need contraception, either because they are 55 years of age or have gone more than 12 months with no menses, they may benefit from menopausal hormonal therapy (MHT). As with all medications, there are risks associated with MHT, but these risks depend mainly on the timing of initiation of the therapy ([Table 4](#)).

Table 4: Risks of Menopausal Hormone Therapy (MHT)

Initiated within 10 years of menopause and < 60 years old	Increased Risk	Decreased Risk	No Change
	VTE ^b (11 cases/10,000 per women per year)	CHD	Stroke ^c
	Breast Cancer ^d (<1/1000 per women per year in EPT)	All-cause mortality (approx. 30%)	Dementia ^e
	Gallbladder disease ^b (47/10,000 EPT and 58/10,000 ERT per women per year)	Osteoporosis, bone loss and fractures CRC (6/10,000 person years)	
Initiated more than 10 years after FMP and/or > 60 years of age	Increased Risk	Decreased Risk	No Change
	VTE ^{a,f}	Osteoporosis and fractures	All-cause mortality
	Breast Cancer (<1/1000 per women per year in EPT)	CRC (6/10,000 person-years)	
	Stroke		
	CDH		
	Dementia		

^a Risk estimate changes are provided when data is available

^b Especially with oral routes

^c Data is mixed. There may be a small absolute increase risk of 1.5/10,000 women per year

^d Increased risk in estrogen and progestin combination users only and risk increase is less than other lifestyle factors

^e Observational studies show decreased risk of Alzheimer

^f Higher than risk when initiated within 10 years of FMP

Abbreviations: FMP final menstrual period, VTE venous thromboembolism, CHD coronary heart disease, CRC colorectal cancer.

Reprinted with permission from Voedisch et al, Menopause: A Global Perspective and Clinical Guide for Practice. Clinical Obstetrics and Gynecology. Vol 64, No 3, 528-554

If MHT is started in symptomatic people within 10 years of their FMP or before the age of 60, the benefits of MHT usually outweigh the risks. The main risk is a small increase in development of blood clots which can be minimized by using non-oral routes of estrogen. Oral routes are safe and should be utilized in people desiring therapy if non-oral routes are limited or the person prefers oral therapy. (11) Estrogen stimulates the lining of the uterus, and adequate progestogen

therapy is needed to counterbalance and inhibit development of endometrial hyperplasia or endometrial cancer. The overall risk of precancer or cancer of endometrium with the appropriate use of progestogen therapy is very low. People who have had a hysterectomy do not need to use progestogen therapy. See Table 5 for progestogen dosing needed for endometrial protection when using estrogen therapy. (11)

Table 5: Progestogen Dosing Needed to Protect from Endometrial Hyperplasia

	Continuous EPT (daily dosing)	Cyclic EPT (progestogen 12-14 days/month)
Oral		
Micronized progesterone	100 mg	200 mg
Norethindrone acetate	0.5-1 mg	2.5 mg
Norethindrone	0.35 mg	0.35-0.7 mg
Medroxyprogesterone acetate	2.5 mg	5 mg
Vaginal		
Progesterone gel ^a	45 mg	45 mg
Intrauterine system		
Levonorgestrel ^a	6-20 µg/day	N/A

The dosing of progestogen needed to protect from endometrial hyperplasia while using estrogen therapy when not using prepackaged combined products. Continuous use of progestogen involves daily dosing of progestogen; cyclic dosing involves taking progestogen 12-14 days per month.

Adapted with permission from Menopause Practice: A Clinician's Guide (6th Edition) by The North American Menopause Society. Abbreviations: EPT (estrogen progestogen therapy)

^a Not FDA approved for use with hormone replacement therapy

The risk of MHT that has received the most publicity is the risk of breast cancer, which is seen in estrogen-progestogen users only; there is no increased risk with estrogen-only use. People are often mistakenly deemed inappropriate candidates for MHT based on a *family history of breast cancer* and have therefore suffered needlessly from

symptoms that could have been treated. People removed to reduce their future risk of ovarian cancer. Although there is an increased risk of breast cancer in estrogen and progestogen users, the absolute increased risk is small (approximately 1 case per 1000 person-years), and should not prevent people who are otherwise candidates

from being offered potentially life changing therapy. (11) People with a *personal history of breast cancer*, however, should not use MHT.

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Starting hormone therapy after the age of 60 or more than 10 years from the FMP presents a different risk profile and is not recommended. Increased risk of dementia, stroke, thromboembolism and myocardial infarctions have been reported in this population. Of note, this increased risk is for people who *initiate* MHT in this age group but this does not apply to those who initiated MHT earlier and *continue* past the age of 60 or more than 10 years from their FMP. MHT can be continued for people after the age of 60 with persistent symptoms and/or in the setting of osteoporosis prevention if they do not otherwise have a contraindication. Age itself is not a contraindication to the *continuation* of MHT. (11, 35) However, longer duration of therapy should be for documented indications, with a shared decision-making and periodic revaluation of the benefits and risks. (11) Contraindications for MHT are listed in Table 6.

Table 6: Contraindications to MHT

unexplained vaginal bleeding
history of estrogen sensitive cancer
coronary heart disease
liver disease
stroke
myocardial infarction
venous thromboembolism
history or high risk of thromboembolic disease

Abbreviations: MHT hormone replacement therapy

Reprinted with permission from Voedisch AJ. Counseling on hormone replacement therapy: the real risks and benefits. *Curr Opin Obstet Gynecol.* 2023 04 01;35(2):154-159.

Non-hormonal prescription therapies

A new medication, fezolinetant, specifically targeting VMS has recently been released in the last year with more targeted therapies expected in the near future. (36) Fezolinetant is currently available only in the United States, Canada, Europe and Australia and it is expensive, furthering limiting accessibility. Data on use of the drug are currently limited with more studies expected in the future.

Other beneficial prescription therapies include the use of gabapentin, a neuropathic agent, that has shown some benefit in reducing VMS and sleep disturbances. Some serotonin selective reuptake inhibitors and serotonin-norepinephrine reuptake inhibitors have also shown benefit in reducing VMS and addressing mood issues. Oxybutynin has been shown to be efficacious in reducing VMS but may cause cognitive decline in older populations, so should be monitored. (37)

Non-prescription therapies

Non-prescription therapies may also reduce symptoms. Cognitive behavioral therapy and clinical hypnosis have both been shown to reduce VMS. (37) Obesity increases the frequency and severity of VMS and weight loss has shown to reduce VMS. (37) Exercise, over-the-counter supplements, acupuncture, and mindfulness may have other health benefits but have not been shown to reduce VMS. Cooling measures such as fans, bed cooling systems, dressing in layers and cooling bedclothes and sheets may provide temporary relief during VMS but do not reduce the frequency or severity of episodes. (37) Cognitive behavioral therapy for insomnia effectively addresses the common sleep disturbances such as sleep-induced insomnia or middle-of-the-night awakenings. (38) Melatonin may also be helpful. (39)

Herbal remedies, such as black cohosh and phytoestrogens, are often used to mitigate menopausal symptoms because they are easily available; however, controlled studies have not shown herbal supplements to reduce menopausal symptoms and their use may delay accessing therapeutic care. (37)

Genitourinary Syndrome of Menopause (GSM)

There are several options available to treat GSM. In people with GSM who do not have other systemic symptoms, local estrogen therapy may adequately treat their symptoms. MHT with estrogens and CHC may successfully address GSM in people with other perimenopausal and menopausal symptoms, but additional local therapies may be needed if symptoms worsen or do not improve.

Vaginal moisturizers are accessible over the counter and can be used 2-3 times per week at bedtime to alleviate dryness, irritation, burning and dyspareunia. Lubricants, different than moisturizers, should be used liberally with sexual activity and silicone-based products may be the

most effective in relieving discomfort during vaginal penetration. (6)

Prescription therapies include vaginal estrogen, vaginal dehydroepiandrosterone (DHEA) and oral ospemifene. Vaginal estrogen has few contraindications and can be used alone or in conjunction with MHT or combined with other contraceptives. Use should be avoided where there is undiagnosed gynecological bleeding and cautioned in those with estrogen-dependent cancers. Vaginal estrogens are available in cream, ring and suppository forms. (6)

DHEA, or prasterone, is used as a daily vaginal insert and is not contraindicated in those with a history of breast cancer, although use is cautioned. It can be combined with MHT or other contraceptives. Ospemifene is an oral selective estrogen receptor modulator that can improve the signs and symptoms of GSM. It is not recommended for people with a history of breast cancer due to a lack of data. (6)

Recommendations for IPPF MAs on delivering rights-base care for people experiencing menopausal symptoms:

Member Associations' providers should:

- Undergo training to understand and recognize the main symptoms of perimenopause and menopause. They should be comfortable discussing and counselling on perimenopausal and menopausal changes and potential symptoms. Providers should also be comfortable discussing prescription and non-prescription therapies, and these commodities should be sufficiently included in medicine procurement.
- Ensure clinics are welcoming spaces for perimenopausal and menopausal people and work to increase awareness and education surrounding perimenopausal and menopausal healthcare.
- Recognize the need for contraception among those not seeking pregnancy until age 55

or until menopause is confirmed. Member Associations should be familiar with the contraceptive options and medical eligibility for their use.

- Recognize the need for continued counselling on how to maintain a satisfying, pleasurable sexual life with aging, which may include the use of vaginal moisturizers and lubricants and STI prevention strategies.
- Offer shared decision- making with clients, ensuring they understand the risks and benefits of MHT treatment for bothersome menopausal symptoms. If Member Associations do not have access to MHT, appropriate referrals should be provided.
- Clients' life expectancies are increasing as is global demand for services. Member Associations should further develop expertise and capacity to meet the increasing demand for menopausal healthcare.
- Establish a formal referral mechanism for people with complex symptoms, who fail to respond to treatment or those whose needs cannot be met in the local healthcare setting.

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Who we are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals

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