The National Association of NURSE PRACTITIONERS in WOMEN'S HEALTH

POSITION STATEMENT

Health and Healthcare for Midlife Women

The National Association of Nurse Practitioners in Women's Health (NPWH) asserts that women's health nurse practitioners (WHNPs) and other advanced practice registered nurses (APRNs) who provide women's healthcare have a critical role in providing evidence-based care, education, and anticipatory guidance that promotes wellness and quality of life throughout the midlife years and beyond. Midlife is often defined as comprising a specific age range (eg, 35–65 years) or specific reproductive aging parameters (eg, perimenopause, menopause, postmenopause). The *Table* highlights the criteria established for these reproductive aging parameters.[1] In this position statement, the term menopause is used to encompass the menopause transition and postmenopause.

TABLE. REPRODUCTIVE AGING TERMINOLOGY (STRAW CRITERIA AND CHARACTERISTICS)[1]

Terminology	Duration	Menstrual cycles	VMS
Menopause transition (MT) – time before FMP when menstrual cycles become variable and other menopause-related symptoms begin	**Early MT** variable **Late MT** 1–3 years	**Early MT** variable length – persistent > 7-day difference in length of cycles **Late MT** intervals of amenorrhea > 60 days	**Early MT** not likely **Late MT** likely
Menopause – permanent cessation of menses	**Early postmenopause** within 8 years of FMP **Late postmenopause** remaining lifespan	Absent	Most likely in first 2 years after FMP and often extends beyond this time
Perimenopause	Encompasses early and late menopause transition and early postmenopause		

FMP, final menstrual period; STRAW, Stages of Reproductive Aging Workshop; VMS, vasomotor symptoms.

NPWH is committed to raising public and healthcare provider awareness about menopause and its effect on women and their health. Expected changes and health considerations related to menopause often are not discussed within families and communities or addressed by healthcare providers. When women do not have access to accurate, culturally responsive, and linguistically appropriate information, they are left to navigate this transition with inadequate or incorrect information and are not aware of effective and safe treatment options to manage their symptoms, prevent osteoporosis, and potentially preserve cardiovascular function.[2] In fact, inadequate or incorrect information can leave women vulnerable to financial and health harm.[3,4] NPWH promotes a person-centered approach to the care of women at midlife and beyond. This approach to care should be based on current evidence and recognized guidelines on hormone therapy and non-hormonal therapies and with shared decision making about best strategies for individualized symptom management, health promotion, disease prevention, and quality of life. Cultural background, socioeconomic status, health literacy, history of trauma, and overall health must be considered as these factors influence the menopause experience. NPWH is dedicated to providing resources that WHNPs and other APRNs can use to provide evidence-based, person-centered care for midlife women.

NPWH affirms that WHNPs, as leaders in women's healthcare, are supported in their academic and clinical education to obtain the knowledge and competencies needed to provide common and complex menopause healthcare. NPWH's *Women's Health Nurse Practitioner: Guidelines for Practice and Education* specifies curriculum content for WHNPs to prepare them with the competencies to provide advanced assessment, diagnosis, and management with attention to the influence that an individual's menopausal health has on overall wellbeing and the potential effect that other health conditions can have on menopausal health ***(Box 1)***.[5] WHNPs bring expertise to healthcare teams to successfully advocate for patient-centered care that addresses all components of midlife women's health. Social determinants of health (SDOH)-mediated inequities in menopausal care must be addressed through changes in healthcare systems, health professional education, and public health measures. Persons from minority ethnic and racial populations, sexual minority women, transgender and gender-diverse individuals, persons with disabilities, persons with comorbidities, and other underrepresented and marginalized groups must be fully represented in research about menopause, the findings of which constitute the basis for guidelines on best healthcare and best health outcomes.

BOX 1. WHNP: GUIDELINES FOR PRACTICE AND EDUCATION EXAMPLES OF MENOPAUSE/MIDLIFE- RELATED CONTENT[5]

- **Advanced menopause transition physiology, endocrinology, and body changes**
- **Menopause transition and postmenopausal healthcare**
- **Social/structural determinants and inequities that affect health**
- **Comprehensive and age-appropriate health risk assessment**
- **Age- and risk-based health screening recommendations**
- **Gynecologic, sexual, reproductive, and menopausal healthcare for women who have sex with women or who identify as lesbian or bisexual**
- **Gynecologic, sexual, reproductive, and menopausal healthcare for transgender and gender non-conforming individuals**
- **Nongynecologic conditions that may affect or be affected by gynecologic, sexual, reproductive, and menopausal health**
- **Psychological factors and conditions that may affect or be affected by gynecologic, sexual, reproductive, and menopausal health**
- **Abnormal uterine bleeding**
- **Breast and gynecologic cancers**
- **Pelvic floor disorders**
- **Urinary and fecal incontinence**
- **Vulvovaginal disorders**

BACKGROUND

In the United States, 1.2 million women experience menopause yearly.[6] Worldwide, 70% to 85% of women experience menopausal symptoms.[7] The symptom profile is vast, varied, and can arise within nearly all body systems as female hormones play an important role within and beyond the reproductive system. Most common symptoms include hot flashes, night sweats, sleep disruption, muscle and joint pain, and changes in genitourinary and sexual function, as well as mood changes such as irritability, anxiety, and depression.[1] The type, timing, and severity of symptoms are variable, as are the perspectives of individuals on the significance of these symptoms in their daily lives.

Women who receive education about menopause and its associated symptoms have more positive attitudes about the transition and report less severe symptoms.[3,8] Anticipatory guidance, that is, the education provided before an event, can reduce anxiety and be reassuring and validating when symptoms do occur.[9] However, anticipatory guidance is rarely provided by healthcare providers, and menopause-related symptoms continue to be seen as unimportant, something to be endured, or completely ignored.[3,10,11] Women's knowledge about menopause is often limited, with much information being unreliable, negative, and difficult to navigate.[3,8,11]

Many healthcare providers have misconceptions and knowledge gaps related to menopause.[4,12] Nationally, obstetrics and gynecology, internal medicine, and family medicine residency programs lack adequate menopause curricula.[13,14] Without this education, healthcare providers are more likely to misunderstand, misdiagnose, or dismiss menopausal symptoms, with resulting implications for health and quality of life.[4] Improved menopause-specific curriculum for all healthcare providers who see women in midlife can prepare them to provide anticipatory guidance and individualized, evidence-based symptom management.[4,12]

Midlife and aging-related body changes also occur and often become evident during the menopause transition. Weight gain, body composition changes especially an increase in abdominal visceral fat, increased vascular dysfunction, and dyslipidemia are changes that occur in midlife, all of which can significantly increase the risk for metabolic and cardiovascular disease (CVD).[15,16] Beyond physical health, changes in weight and increased abdominal girth can be psychologically distressing for some women.[7] Bone loss is most marked during the menopause transition and can lead to postmenopausal osteoporosis and potentially life-altering fracture events.[1] Opportunities exist before, during, and after the midlife years to reduce risks for CVD and osteoporosis-related fractures and to promote overall long-term health. The Women's Preventive Services Initiative provides age- and risk-related recommendations for screening, counseling, and anticipatory guidance that can be used at well visits.[17] Recommendations that correlate with the midlife years of age 40 to 64 are noted in ***Box 2***. Other guidelines are available for healthcare providers to use in mitigating risk factors and treating specific conditions that are identified (eg, dyslipidemia, hypertension, osteoporosis, urinary incontinence, depression, anxiety).

BOX 2. WPSI WELLNESS VISIT COMPONENTS FOR WOMEN AGE 40–64[17]

- **Alcohol use screening and counseling**
- **Anxiety screening**
- **Blood pressure screening**
- **Contraceptive counseling (when indicated)**
- **Depression screening**
- **Intimate partner violence screening**
- **Lipid screening**
- **Obesity screening and counseling**
- **Substance use screening and counseling**
- **Tobacco screening and counseling**
- **Urinary incontinence screening**
- **Hepatitis C screening (at least once in adult years)**
- **HIV risk assessment**
- **HIV screening (at least once in adult years)**
- **Immunizations (use ACIP recommendations)**
- **Breast cancer screening (use current age- and risk-related recommendations)**
- **Cervical cancer screening (use current age- and risk-related recommendations)**
- **Risk assessment for *BRCA* 1/2 testing**

ACIP, Advisory Committee on Immunization Practices; *BRCA*, breast cancer susceptibility gene; HIV, human immunodeficiency virus; WPSI, Women's Preventive Services Initiative.

Studies examining how SDOH affect the menopause experience indicate that attitudes toward menopause are influenced both positively and negatively by cultural and ethnic factors and that lower education level and socioeconomic status are associated with more severe menopausal symptoms.[18,19] Studies of the menopause experience have revealed disparities between Black and White women. Black women are more likely to experience earlier menopause, have more severe and longer lasting vasomotor symptoms, and are less likely to receive treatment for symptoms.[20,21] More research is needed to understand the factors that drive recognized inequities in menopause, including racism, discrimination, and lack of access to healthcare.[22,23]

The effects of menopause extend to a reduction in workforce productivity. In the US, it is estimated that $1.8 billion is lost annually due to lost days of work related to menopausal symptoms. This does not account for unpaid work done by women or the costs associated with reduced work hours, switching to lower-paying jobs, not taking a promotion, or retiring early. Black and Hispanic women report worse

work-related outcomes due to their menopausal symptoms.[23,24] The Employee Perspectives and Challenges Concerning the Transition of Menopause (EMPACT Menopause) study found that 1 in 3 women experiencing menopausal symptoms considered reducing or reduced their workload. As well, 2 out of 5 women considered finding a new job, over one-third of respondents experienced presenteeism or working while feeling unwell, and less than half felt comfortable talking about their symptoms and experience of menopause at work.[25]

IMPLICATIONS FOR PRACTICE

Women's health nurse practitioners and other APRNs who provide women's healthcare are well positioned to support a paradigm shift that promotes wellness during midlife and menopause as more than the absence of disease.[26] They play a key role in improving the quality of healthcare and health outcomes for women during midlife, menopause, and beyond. Anticipatory guidance is relevant for all life transitions, including menopause and midlife. Promoting health behaviors such as nutrition, physical activity, weight management, stress management, and avoiding substance misuse before and during menopause can potentially lessen symptom severity and have positive long-term health effects.[1,27]

Person-centered evidence-based care and shared decision making are essential to managing menopausal symptoms effectively and promoting current and future health. A collaborative, team-based approach with other primary care providers, social workers, mental and behavioral health professionals, other specialists, and healthcare administrators is critical to overcoming SDOH-meditated inequities in menopause and midlife health. Within this team-based approach, WHNPs and other APRNs have an important leadership role in the development, implementation, and outcome evaluation of initiatives for improving the quality of menopause and midlife care.

NPWH LEADERSHIP

NPWH will provide leadership to ensure:

- Continuing education programs and resources are available to support WHNPs and other APRNs who provide women's healthcare in evidence-based, person-centered menopause and midlife care.
- WHNP educational programs have access to evidence-based information on person-centered menopause and midlife healthcare that can be incorporated into curricula.
- Collaborative engagement takes place with other organizations that support campaigns to increase public awareness about menopause and midlife health.
- Advocacy for health policies addresses SDOH influencing women's experience of menopause and their health at midlife and beyond.
- Menopause research and quality improvement initiatives progress and include attention to diversity, equity, and inclusion.

REFERENCES

1. Crandall CJ, Bachman GA, Faubion SS, et al, eds. *Menopause Practice: A Clinician's Guide*, 6th ed. The North American Menopause Society; 2019.
2. Levy B, Simon JA. A contemporary view of menopausal hormone therapy. *Obstet Gynecol.* 2024;144(1):12-23.
3. Munn C, Vaughan L, Talaulikar V, et al. Menopause knowledge and education in women under 40: results from an online survey. *Womens Health* (Lond). 2022;18:17455057221139660.
4. Aninye IO, Laitner MH, Chinnappan S; Society for Women's Health Research Menopause Working Group. Menopause preparedness: perspectives for patient, provider, and policymaker consideration. *Menopause.* 2021;28(10):1186-1191.
5. National Association of Nurse Practitioners in Women's Health. *Women's Health Nurse Practitioner: Guidelines for Practice and Education,* 8th ed. Washington, DC: National Association of Nurse Practitioners in Women's Health; 2020.
6. Peacock K, Carlson K, Ketvertis KM. Menopause. Updated December 21, 2023. In: StatPearls. Treasure Island, FL: StatPearls Publishing; 2024 Jan-. https://www.ncbi.nlm.nih.gov/books/NBK507826/
7. Geraghty P, ed. Each Woman's Menopause: *An Evidence Based Resource: For Nurse Practitioners, Advanced Practice Nurses and Allied Health Professionals.* Springer; 2022.

8. Ropponen RBW. Evaluation of consumer-oriented websites that provide menopause education. *Womens Healthcare.* 2024;12(1):35-40.
9. Richardson MK, Coslov N, Woods NF. Seeking health care for perimenopausal symptoms: observations from the Women Living Better Survey. *J Womens Health* (Larchmt). 2023;32(4):434-444.
10. Harper JC, Phillips S, Biswakarma R, et al. An online survey of perimenopausal women to determine their attitudes and knowledge of the menopause. *Womens Health* (Lond). 2022;18:17455057221106890.
11. O'Reilly K, McDermid F, McInnes S, Peters K. An exploration of women's knowledge and experience of perimenopause and menopause: an integrative literature review. *J Clin Nurs.* 2023;32(15-16):4528-4540.
12. Macpherson BE, Quinton ND. Menopause and healthcare professional education: a scoping review. *Maturitas.* 2022;166:89-95.
13. Allen JT, Laks S, Zahler-Miller C, et al. Needs assessment of menopause education in United States obstetrics and gynecology residency training programs. *Menopause.* 2023;30(10):1002-1005.
14. Kling JM, MacLaughlin KL, Schnatz PF, et al. Menopause management knowledge in postgraduate family medicine, internal medicine, and obstetrics and gynecology residents: a cross-sectional survey. *Mayo Clin Proc.* 2019;94(2):242-253.
15. Marlatt KL, Pitynski-Miller DR, Gavin KM, et al. Body composition and cardiometabolic health across the menopause transition. *Obesity* (Silver Spring). 2022;30(1):14-27.
16. Nappi RE, Simoncini T. Menopause transition: a golden age to prevent cardiovascular disease. *Lancet Diabetes Endocrinol.* 2021;9(3):135-137.
17. Women's Preventive Services Initiative. Well-Woman Chart. Recommendations for Well-Woman Care. 2024. https://www.womenspreventivehealth.org/wellwomanchart
18. Dashti S, Bahri N, Fathi Najafi T, et al. Influencing factors on women's attitudes toward menopause: a systematic review. *Menopause.* 2021;28(10):1192-1200.
19. Namazi M, Sadeghi R, Behboodi Moghadam Z. Social determinants of health in menopause: an integrative review. *Int J Womens Health.* 2019;11:637-647.
20. Blanken A, Gibson CJ, Li Y, et al. Racial/ethnic disparities in the diagnosis and management of menopause symptoms among midlife women veterans. *Menopause.* 2022;29(7):877-882.
21. Harlow SD, Burnett-Bowie SM, Greendale GA, et al. Disparities in reproductive aging and midlife health between Black and White women: The Study of Women's Health Across the Nation (SWAN). *Womens Midlife Health.* 2022;8(1):3.
22. Cortés YI, Marginean V. Key factors in menopause health disparities and inequities: beyond race and ethnicity. *Curr Opin Endocrine Metabolic Res.* 2022;26(9):100389.
23. Evandro M, Falkingham J, Qin M, Vlachantoni A. Menopausal transition and change in employment: evidence from the National Child Development Study. *Maturitas.* 2021;143:96-104.
24. Faubion SS, Enders F, Hedges MS, et al. Impact of menopause symptoms on women in the workplace. *Mayo Clin Proc.* 2023;98(6):833-845.
25. Society for Women's Health Research. Employee Perspectives and Challenges Concerning the Transition of Menopause (EMPACT Menopause) study. January 2024. https://swhr.org/wp-content/uploads/2024/02/FINAL-Menopause-Workplace-Fact-Sheet-02012024.pdf
26. Geller DE, Swan BA. Recent evidence of nurse practitioner outcomes in a variety of care settings. *J Am Assoc Nurse Pract.* 2021;33(10):771-775.
27. Davis SR, Taylor S, Hemachandra C, et al. The 2023 practitioner's toolkit for managing menopause. *Climacteric.* 2023;26(6):517-536.

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