The Menopausal Transition

Major public health issue
without enough data

THE CENTER FOR COMMUNITY SOLUTIONS

> Perimenopause and menopause are major public health issues that affect women's health, relationships, and the ability to work. These burdens often fall hardest on BIPOC women and women with lower incomes, who are more likely to face severe symptoms, barriers to care, and medical mistrust. Although national research on the menopausal transition is growing, Ohio still lacks enough state and local data.

Key findings

- The menopausal transition impacts many facets of a woman's life from health and relationships to their careers.
- Black, Indigenous, and People of Color (BIPOC) women and women from lower socioeconomic statuses (SES) experience harsher symptom severity of perimenopause and menopause.
- Women often feel that their concerns about perimenopause and menopause are dismissed or overlooked by healthcare providers.
- Supporting more research, legislative bills, and incorporating the menopausal transition into training and educational spaces are critical to improve this public health issue for women.

What is the menopausal transition?

As a woman's hormones decline, a biological transition occurs in three stages. The first phase is perimenopause. Perimenopause starts when a person's body starts transitioning between eight to 10 years leading up to menopause.[1] During perimenopause, the body will produce less estrogen and progesterone hormones which can cause the menstrual cycle to become irregular or less frequent. An individual can start experiencing this transition between their mid-30s or mid-50s.[2]

Once a person has gone without a period for 12 consecutive months, that signals the next phase: menopause.[3] The body does not produce much estrogen during this time. Menopause can occur either naturally, surgically by removing ovaries, or artificially through radiation or chemotherapy.[4] After a person reaches menopause, then they will experience post menopause, the last phase, for the rest of their life.[5] In post menopause, symptoms either get milder or go away. The following are symptoms of both perimenopause and menopause. This is not an exhaustive list.

- Irregular periods

- Hot flashes (aka vasomotor symptoms)
- Insomnia
- Night sweats
- The need to urinate right away
- Changes in mood
- Dry eyes
- Vaginal dryness
- Brain fog[6]
- Hair loss
- Depression

There are similar treatments for both perimenopause and menopause. The following is a list (not exhaustive) of treatments for both conditions (see endnotes 2 and 3):[7]

- **Hormone replacement therapy (HRT)**—A type of therapy that uses either estrogen or estrogen and progesterone to increase hormone levels. This is used when *someone has gone into menopause before age 40*.
- **Hormone therapy**—Similar to HRT, the use of either estrogen or estrogen and progesterone to increase hormones. Physicians use this term when someone is experiencing menopause *at a natural age (after age 45)*.
- **Vaginal estrogen creams**—address dryness, pain, and to decrease urinary tract infections.[8]
- **Antidepressants**—This type of medication is used for hot flashes and mood swings.
- **Gabapentin (Neurontin)**—A medicine that treat seizures which can also relieves hot flashes.

The menopausal spectrum is a complicated biological process that women endure, and those experiences can be magnified while also maintaining their roles as mothers, caregivers to aging parents, spouses, employees, etc. Due to the drastic changes in both perimenopause and menopause, there should be more awareness about this reproductive health issue.

- How does perimenopause and menopause **impact** women across the lifespan?
- How does perimenopause and menopause show up as health **disparities** among racial/ethnic groups and socioeconomic status?
- How does **legislation** vary across the United States, Ohio, and Northeast Ohio?
- How does health **insurance** cover perimenopause and menopause treatment?
- What are the **solutions** to address these issues?

How does perimenopause impact women across the lifespan?

The symptoms of both perimenopause and menopause affect physical and mental health. Additionally, perimenopause can put people at risk for cardiovascular, endocrine, periodontal, and neurodegenerative diseases (see endnote 1).

Perimenopause and menopause can increase a woman's risk for osteoporosis.[9]

Perimenopause and menopause at work

Even though the menopausal transition is not well documented, there is some emerging evidence that it can affect women in their occupations. According to researchers, some perimenopausal women struggled to work due to brain fog.[10] Specifically, one participant explained they could not keep up with work demands and another person stated they were unable to go to work.

A large U.S.-based study found that 13.4% of employed women reported adverse work outcomes (e.g., missing days from work, reduced work hours, and either quit, retired or changed jobs) related to menopause. As a result, 10.8% reported missing work in the past year due to symptoms. Greater symptom severity was strongly linked to higher levels of workplace impairment, with individuals experiencing the most severe symptoms being more than 15 times as likely to face negative work outcomes.[11] Due to the results of their study, researchers estimated that menopause-related missed workdays could result in an annual economic loss of $1.8 billion in the U.S.

Perimenopause and menopause research at national, state, and local levels

Research has shown that the biological changes women experience during perimenopause and menopause affect their physical/mental wellbeing and overall quality of life. One of the leading national research sources on this topic is the Study of Women's Health Across the Nation (SWAN).[12] SWAN is a longitudinal, multi-site, and epidemiologic study that observes women's health during their midlife years. The SWAN study investigates the psychological, physical, biological, and social changes during this period.

- The likelihood of experiencing high anxiety symptoms was significantly higher during early perimenopause, late perimenopause, with the highest levels observed in late perimenopause.[13]
- Up to 80% of women in the SWAN study reported hot flashes or night sweats in the past two weeks at some point during the menopausal transition, with the highest rates occurring as they moved from early to late perimenopause.[14]



- From over nine years of the SWAN study, 68 percent of women (1550) reported seeking treatment for urinary incontinence (UI). Women had higher odds of seeking treatment if IU was more frequent in the previous year.[15]

Researchers from different studies identified other national statistics. In the U.S., 1.3 million women enter menopause every year.[16] U.S. women experience menopause at 52 years of age, but natural menopause can happen between 45 to 55 years of age or older.[17]

Research about how the menopausal transition affects Ohioans, and in particular those in northeast Ohio, is limited. A nonprofit, nonpartisan research organization called RAND examined the state-by-state economic costs of menopausal symptoms among employed women in the U.S.[18] In 2023, the economic cost of the menopause transition for in Ohio was $176.1 million. That value means the amount of lost productivity due to women missing work, presenteeism (employees are physically present at their jobs, but they do not perform at their full potential), and healthcare utilization.

In a 2002 study about low-income perimenopausal women in Cleveland, forty low-income women (ages 39-55) were interviewed to explain their experiences and views about menopause. Most participants did not perceive menopause as a medical condition (see endnote 4). Instead, they described that their symptoms were manageable and often less noticeable than other everyday health issues like aches or shortness of breath.

Only a few participants sought medical treatment—many were unfamiliar with hormone therapy, and only a small number utilized it. They relied on reading materials and personal research for information but talked with health care providers less often. This was partly due to their mistrust of the medical system, especially with male doctors as some women felt that their concerns were dismissed.

Estrogen therapy is usually initiated during menopause, but a recent study conducted at Case Western Reserve University (CWRU) determined if starting estrogen therapy earlier during perimenopause could positively impact longer term health outcomes (breast cancer, heart attack, and stroke).[19] The researchers compared two groups: those who started estrogen therapy during perimenopause, people who started the therapy after menopause, or did not use the therapy at all.

After examining over 120 million patient records, they determined that earlier initiation of estrogen therapy during perimenopause showed no significantly higher rates of heart attack, stroke, and breast cancer, compared to the other groups.

Overall, the research shows that women deal with many health challenges as they go through the menopausal transition even though society sometimes fails to acknowledge

this health issue. The next section takes a deep dive as to how menopausal transition produces health disparities, and which societal systems contribute toward them.

Health disparities within the menopausal transition

BIPOC women experience perimenopause and menopause differently from white individuals. On average, Black women reach menopause earlier than white women by 8.5 months, "with some entering perimenopause as early as their late 30s or early 40s."[20]

As they experience menopause, Black women endure this phase for 10 years compared to 6.5 years among white women (see endnote 20). Also, Black women are twice as likely to have surgical menopause (removal of ovaries and/or uterus) than other racial groups.[21]

BIPOC women suffer from greater severity of menopausal symptoms compared to white women. In a study of 68,864 in the U.S. women, Black women had the highest odds of severe vasomotor symptoms (hot flashes), night sweats, sleep disturbances, and more facial hair/acne more than white women.[22] Indigenous/First Nations participants endured the most severe symptoms of depression/anxiety, joint/muscular discomfort, and painful sex.

Moreover, Middle Eastern and Indigenous/First Nations women dealt with a high severity of brain fog and fatigue/low energy. Hispanic women experience more severe symptoms compared to white women. For Hispanic women, this includes all menopausal symptoms mentioned in the study. According to the researchers from this study, access to care and increased discrimination contributed toward the severity of symptoms among BIPOC women.

Differences in the severity of menopausal symptoms are also linked to socioeconomic status. Studies described that people of lower SES undergo menopause earlier and have more frequent hot flashes and sleep disturbances.[23] However, researchers from another study explained even when they incorporated SES with race to determine symptom severity, they found out that Hispanic and Black women still reported worse menopausal symptoms than non-Hispanic white women (see endnote 22).

Researchers in another study indicated that both homeless women and uninsured women living in Arizona (locations based on different SES resources) had a higher menopausal symptom burden (i.e., psychological and somatic symptoms) than their insured counterparts living in areas of high neighborhood advantage.[24]



What contributes to menopausal health disparities?

Health disparities are present in the menopausal transition due to systemic factors. Medical education institutions rarely teach students about the menopausal transition.[25] For instance in one survey, 58 percent of medical students only attained one lecture on menopause and 20 percent never received any training on the topic.[26]

Doctors also dismissed patients concerns about perimenopausal and menopausal symptoms. This appeared in both the *NY Times* article about BIPOC experiences with menopause and CWRU's study about low-income women perceptions toward menopause (see endnote 4). This leads to mistrust in the medical community. Moreover, as BIPOC individuals experience discrimination regularly, that contributes towards worsening health disparities in the menopausal transition, such as a higher prevalence in vasomotor and mental health symptoms (see endnotes 22 and 25).[27]

Health insurance and legislation go hand in hand

Perimenopause and menopause treatments are usually covered by insurance, but it depends on the type of insurance a person has. For example, many health insurance plans can cover hormone replacement therapy for menopause, but copays, deductibles, and plans' formularies vary.[28] This means that patients might pay out of pocket for part of the services. Another example is some insurances cover Midi virtual appointments for prescriptions (Aetna, Cigna, Blue Cross Blue Shield, etc.).[29] Across the U.S., states—including Ohio— have recently enacted laws or are considering bills aimed at making perimenopausal and menopausal related-services more affordable.

In Louisiana, Medicaid and private health insurance plans cover perimenopausal and menopausal treatments without prior authorization.[30]-[31] The medical assistance program—Illinois's Medicaid program—covers hormonal therapy to treat menopause.[32] Ohio State Representatives Ashley Bryant Bailey (D-Cincinnati) and Anita Somani (D-Dublin) introduced the Ohio Menopause, Perimenopause, and Hormone Therapy Coverage Act (House Bill 767) in March 2026.

If enacted, the bill would require Ohio Medicaid and private health insurance plans to cover the diagnosis and treatment of perimenopause, menopause, and their related symptoms.[33] Some of the clinical services that could be covered are provider visits, lab tests, and diagnostic services. Hormonal therapy and non-hormonal treatments could also be covered. Overall, the bill would enable more Ohioans to gain access to affordable perimenopausal and menopausal care. House Bill 767 is currently in the House Insurance

Committee. There is no current legislation about either perimenopause or menopause across northeast Ohio.

At the federal level, U.S. Senator Patty Murray (D-WA) introduced Senate Bill 4246, also known as the Advancing Menopause Care and Mid-Life Women's Health Act. The intent of the bill is to:

- Invest in menopause-related research.
- Improve provider training.
- Establish a national public health awareness, education, and outreach program.

Although this bill was introduced in 2024, U.S. Senator Murray and U.S. Senator Lisa Murkowski (R-AK) recently reintroduced the act in April 2026.[34]

Solutions to help improve health in perimenopause

Invest in and support more research—from the federal to local levels—about the menopausal transition.

For many years, the SWAN study was the main research study people referred to when trying to understand the menopausal transition Yet this significant health issue poses endless opportunities to promote research and treatment. Besides the CWRU study about initiating estrogen hormone therapy during perimenopause, there is currently a research proposal called the *Age of Renewal*, an eight-week occupational therapy workshop that supports perimenopausal women (see endnote 1). The sessions will focus on nutrition, education, stress management, peer support and more.

Additionally, there should be an updated research project on the perceptions of low-income women in Cleveland about menopause because people can access more information about the topic online through social media compared to print materials in the original study. This research would give new perspectives to advance public health efforts in the menopausal transition. Research should also focus on people from underserved communities such as BIPOC individuals and people living with disabilities.[35]

Support the advancement of federal and state bills promoting access to treatment across the menopausal transition.

Individuals should provide testimonies on the current bills mentioned previously and/or talk to their legislators about the importance of advancing the policies. The Center Community Solutions provides steps on how to write an effective testimony.[36]

Provide educational and training opportunities about the menopausal transition for healthcare providers.

There is little medical education about menopausal transition, even for OB/GYNS, as described earlier (see endnotes 25 and 26). Some researchers suggested that healthcare providers, like counselors, should take continuing education credit (CEUs) training about the menopausal transition.

Additionally, some scholars suggested web-based learning, formal lectures, case presentations, and a two-year menopause instruction program for OB/GYN residents (see endnote 35).

Conclusion

Moving forward, stronger research, better provider training, and policies that expand affordable, equitable care are essential to improving support for women across the menopause transition. Doing so will give more attention to this issue, and more people will be able to understand how women has been suffering from the menopausal transition in silence while trying to stay resilient as productive members of society.

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June 2026