JMM Journal of Menopausal Medicine
pISSN: 2288-6478, eISSN: 2288-6761
https://doi.org/10.6118/jmm.25104
J Menopausal Med 2025;31:3-11
ORIGINAL ARTICLE

Asia-Pacific Menopause Federation Consensus Statement on the Management of Menopause 2024

Seng Bin Ang[1], Stella Rizalina Sasha Sugianto[2], Felicia Clara Jun Hui Tan[3], Sonia Davison[4], Qi Yu[5], Masakazu Terauchi[6], Mee-Ran Kim[7], Jignesh Shah[8], Shaikh Zinnat Ara Nasreen[9], Choon Moy Ho[10], Enkhee Sodnomdorj[11], Muhammad Fidel Ganis Siregar[12], Rubina Hussain[13], Ma Corazon Zaida Noblejas-Gamilla[14], Yang Chua[15], Yung-Chieh Tsai[16], Unnop Jaisamrarn[17]

[1]Family Medicine Service, KK Women's and Children's Hospital, Singapore, [2]Department of Obstetrics and Gynaecology, KK Women's and Children's Hospital, Singapore, [3]Singapore Family Medicine and Continuing Care, Singapore General Hospital, Singapore, [4]Jean Hailes for Women's Health, Melbourne, Australia, [5]Peking Union Medical College Hospital, Beijing, China, [6]Department of Womens Health, Institute of Science Tokyo, Tokyo, Japan, [7]Seoul St. Mary's Hospital, The Catholic University of Korea, Seoul, Korea, [8]Dr Shah Maternity & Nursing Home, Ahmedabad, India, [9]Z H Sikder Women's Medical College & Hospital, Dhaka, Bangladesh, [10]Pantai Hospital Cheras, Kuala Lumpur, Malaysia, [11]Onoshmed Medical Center, GynEndo Unit, Ulaanbaatar, Mongolia, [12]Department of Obstetrics and Gynaecology, General Hospital H. Adam Malik, Medan, Indonesia, [13]Pakistan Menopause Society, Ziauddin University, Karachi, Pakistan, [14]University of Santo Tomas Hospital, Manila, Philippines, [15]A Clinic for Women, Singapore, [16]Department of Obstetrics and Gynaecology, Chi Mei Medical Center, Tainan, Taiwan, [17]Center of Excellence in Menopause and Aging Women Health, Faculty of Medicine, Chulalongkorn University, Bangkok, Thailand

Objectives: This study aimed to achieve expert consensus on menopause management in the Asia-Pacific region, taking into account patient diversity, the latest evidence, and current treatment options.

Methods: A focused literature search was performed to identify clinical practice statements on menopause management. Menopause experts were nominated by members of the Asia-Pacific Menopause Federation (APMF) society. A modified Delphi methodology, involving iterative rounds of anonymous surveys, was employed until consensus was reached for each statement. Consensus was defined as ≥ 70% of experts voting 'agree' or 'strongly agree' for a given clinical practice statement.

Results: A total of 39 participants from 14 different APMF member societies were involved. Eighty-five clinical practice statements reached a consensus. Based on the clinical practice statements, an algorithm was created as a tool to guide clinicians on menopause management. APMF experts agreed that, in addition to vasomotor symptoms, Asian women experiencing somatic or psychological symptoms may also benefit from treatment with menopausal hormone therapy (MHT). MHT should also be considered for the prevention of osteoporosis in asymptomatic peri- and postmenopausal women.

Conclusions: This APMF consensus statement supersedes the previous one published in 2008. It provides guidance to gynecologists, endocrinologists, family physicians, and other healthcare professionals in delivering optimal care to menopausal women in the ethnically and culturally diverse Asia-Pacific region.

Key Words: Asia-Pacific, Menopausal hormone therapy, Menopause, Osteoporosis, Perimenopause

INTRODUCTION

The Asia-Pacific region was home to more than 50% of the world's population in 2024, with five Asia-Pacific countries amongst the top ten most populous countries in the world namely, China, India, Indonesia, Pakistan, and Bangladesh [1]. With increasing life expectancy in most parts of the world, many women are expected to spend more than a third of their lives postmenopausal. Since women make up more than half of the popula-

Received: April 4, 2025 **Revised:** April 15, 2025 **Accepted:** April 17, 2025
Address for Correspondence: Stella Rizalina Sasha Sugianto, Department of Obstetrics & Gynaecology, KK Women's and Children's Hospital, 100 Bukit Timah Road, Singapore 229899, Singapore
Tel: 65-9663-8202, **E-mail:** stella.r.s.sugianto@singhealth.com.sg, **ORCID:** https://orcid.org/0000-0001-7685-4852

tion, optimizing women's health will be imperative in view of the rapidly aging demographics. It was estimated that in the year 2021, more than 400 million women in Asia were in the menopause transition (45–60 years old) [2].

Menopause is a natural process that all women will go through. While many women breeze through this life stage with little issues, there are a significant number of women who experience distressing symptoms which can impact their personal, social, and professional quality of life. For Asian women, physical symptoms such as body aches and joint pains, as well as mental health symptoms, are recognized to be more prevalent than vasomotor symptoms (VMS) [3,4].

The Asia-Pacific region is made up of ethnically diverse populations with varied cultural, socioeconomic, and educational background. A meta-analysis revealed that Asian women tend to adopt a neutral or positive attitude towards menopause, viewing menopause as a natural transition in a woman's life. This was likely due to cultural and religious influences [5]. Asian women were also less likely to seek medical consultations for menopausal symptoms [5,6].

In two recent studies conducted in Australia and China, it was noted that the awareness of menopause amongst healthcare professionals has increased. The majority of healthcare professionals considered training in menopause management to be important [7,8]. However, there were knowledge gaps identified, which need to be addressed by regular training. Within the Asia-Pacific region, there are large differences in accessibility to information about the menopause, to healthcare services and to professionals with a special interest in menopause.

The aim of this study was to achieve expert consensus on the management of menopause in the Asia-Pacific region, considering patient diversity, current evidence and treatment options. This will provide an update to supersede the previous Asia-Pacific Menopause Federation (APMF) consensus statement, which was published in 2008.

MATERIALS AND METHODS

Expert panel members

Experts on menopause practising in the Asia-Pacific region were nominated by their respective APMF society member to participate in a survey seeking information on their usual practice of managing menopause. E-mail invitations were sent to the nominated members to participate in the survey. Upon acceptance, experts were included in the survey to generate agreement. Surveys were disseminated to the experts using Google Forms (Google). For participants who did not have access to Google Forms (e.g., participants in China), copies of the questionnaires were provided in Microsoft Word (Microsoft) or Portable Document Format (Adobe). The filled questionnaires were returned anonymously.

Delphi process

The overall scope of the project was determined through a search and review of available literature on menopause, focusing particularly on existing clinical guidelines on the management of menopause in the Asia-Pacific region, as well as areas where the committee felt that clear evidence was lacking. The clinical practice statements were presented to experts in the form of a survey questionnaire, which included sections on menopause, principles of prescribing menopausal hormone therapy (MHT), alternative therapies, premature ovarian insufficiency (POI), and menopause-specific issues. The experts responded to several rounds of survey questionnaires by voting to what extent they agree or disagree with a clinical practice statement on a 7-point Likert scale—strongly disagree, disagree, somewhat disagree, neutral, somewhat agree, agree, and strongly agree. Participants were also encouraged to write comments about the clinical practice statements. Consensus was defined as achieved when ≥ 70% of experts voted 'agree' or 'strongly agree' for a given clinical practice statement. Clinical practice statements that did not reach consensus were either rephrased to be re-voted at the next survey or removed if they were unlikely to reach consensus. A summary report was provided to the participants before the next survey.

Ethics approval

The study obtained ethics approval from the Singhealth Centralised Institutional Review Board (202308-00067). The requirement to obtain informed consent from participants of the study was waived. This study is also registered on ClinicalTrials.gov under NCT06048965.

RESULTS

Table 1 provides the demographic data of the partici-

Table 1. Demographic data of participants

Age	
Median years (interquartile range)	59 (55–62.75)
Sex	
Male	14
Female	25
Specialty	
General obstetrics and gynaecology	10
Reproductive gynaecology	22
Urogynaecology	1
Endocrinology	5
Family medicine	1
Setting of work	
Public patients	14
Private patients	5
Both public and private patients	20
Length of time in clinical practice	
Median years (interquartile range)	31 (25.75–35.25)
Length of practice treating menopausal women	
Median years (interquartile range)	23 (19.25–29.25)
Geographical region of practice	
East Asia (China, Mongolia, Japan, Taiwan, Korea)	20
South Asia (India, Bangladesh, Pakistan)	5
Southeast Asia (Indonesia, Malaysia, the Philippines, Singapore, Thailand)	12
Oceania (Australia)	2

pants and details about their clinical practice. There were a total of 39 participants in this study. The participants came from 14 different Asia-Pacific regions/countries including East Asia (China, Mongolia, Japan, Taiwan, Korea), South Asia (India, Bangladesh, Pakistan), Southeast Asia (Indonesia, Malaysia, the Philippines, Singapore, Thailand), and Oceania (Australia).

Figure 1 shows the flow diagram of the Delphi process. There were 3 survey questionnaire rounds conducted between November 2023 to August 2024. The number of expert participants at each round were 39, 32, and 31, respectively. A total of 85 clinical practice statements reached consensus.

These are the clinical practice statements that reached consensus in our study i.e., at least 70% of experts voted 'agree' or 'strongly agree' to the statement (Supplementary Table 1 [available online] for specific percentage figures). The clinical practice statements address important principles on managing menopause and prescribing MHT.

Lifestyle advice for the midlife woman

Recommended lifestyle advice for peri- and postmenopausal women includes:

1. Regular exercise – at least 150 minutes of moderate-intensity exercise per week.
2. Healthy diet, which includes whole grains, fruits and vegetables, meat and other protein-rich foods, while limiting the intake of total fat and salt.
3. Women should maintain their weight to achieve or maintain a healthy body mass index (BMI) range as per the individual country's national guidelines.

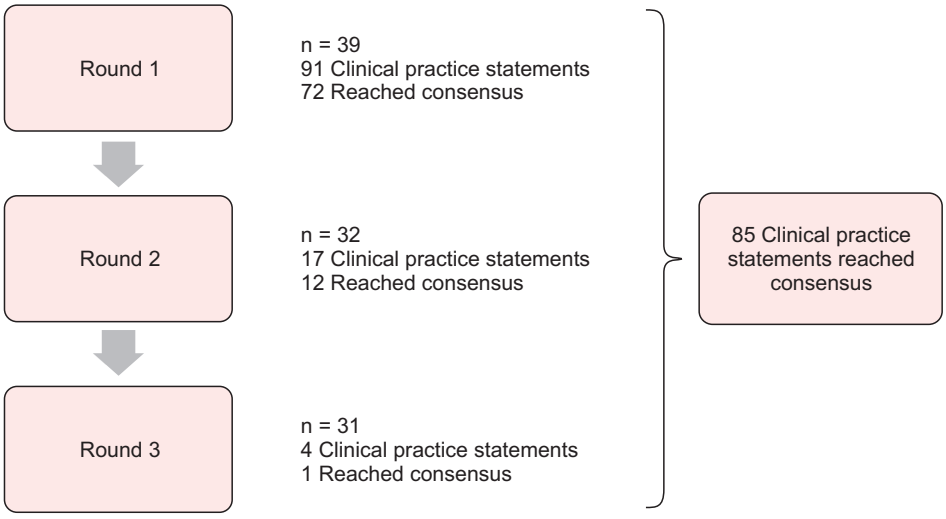

Fig. 1. Flow diagram of the delphi process. n: number of experts.

4. Smoking should be avoided.
5. Alcohol intake should be limited.
6. Regular sleeping hours with at least 7 hours of sleep each night.
7. Staying socially connected to family, friends and the community.
8. Keeping mentally active by reading or learning new things.

Menopausal hormone therapy

9. MHT is the most effective therapy for VMS and urogenital atrophy.
10. Other menopause-related complaints, such as joint and muscle pains, mood swings, sleep disturbances and sexual dysfunction may improve with MHT.
11. MHT may improve affective symptoms for women with depression or depressive disorders that occur during the menopausal transition.
12. MHT should not be recommended without a clear indication for its use.
13. The risk to benefit ratio of MHT is generally favourable when given to women less than 60 years old or within 10 years of menopause.
14. Counselling should convey the benefits and risks of MHT in clear and comprehensible terms.
15. Consideration of MHT should be part of an overall strategy including lifestyle recommendations for maintaining the health of peri- and postmenopausal women.
16. Women taking MHT should have at least an annual consultation, which would include an update of their medical and family history, a physical examination and relevant investigations.
17. There is no mandatory limit for the duration of MHT, provided that it is consistent with treatment goals, and after assessing the individual's benefits and risks.

Contraindications to menopausal hormone therapy include women with:

18. Undiagnosed vaginal bleeding.
19. Hormone-dependent cancers e.g., breast cancer.
20. High risk of venous thromboembolism (VTE).
21. High risk of ischaemic heart disease or cerebrovascular disease.
22. Active liver disease.

Menopausal hormone therapy use should be individualised, taking into account:

23. The woman's symptoms and their effects on her quality of life.
24. Her personal health risks and her need for preventive health.
25. Her age and/or time since menopause.
26. Her preferences and expectations.

Oestrogen therapy

Systemic oestrogen

27. The dosage of systemic oestrogen should be titrated to the lowest effective dose for symptom control.

Vaginal oestrogen

28. For women with moderate to severe genitourinary syndrome of menopause (GSM), vaginal oestrogen therapy is a safe and effective treatment.
29. Vaginal oestrogen therapy has minimal systemic absorption. It has not been shown to increase the risk of cardiovascular disease (CVD) or breast and endometrial cancer.
30. Low-dose vaginal oestrogen therapy for GSM can be continued for as long as needed to relieve symptoms.
31. Use of a progestogen or routine endometrial surveillance is not recommended with low-dose vaginal oestrogen therapy.

Progestogen therapy

32. Women on systemic oestrogen therapy with an intact uterus require progestogen therapy for endometrial protection.
33. Progestogen can be given as a sequential therapy (12–14 days of the cycle) for perimenopausal women or a continuous therapy for women who are one year from their last period.
34. Continuous combined MHT provides more effective endometrial protection than sequential MHT.
35. The dosage of oral micronized progesterone for adequate endometrial protections is 200 mg/day for 12–14 days a month in sequential therapy or 100 mg/day for continuous therapy where the oestradiol dose is 2 mg/50 μg or less.
36. Women who require high-dose oestrogen should consider having their progestogen dose increased to ensure adequate endometrial protection.
37. The 52 mg levonorgestrel-releasing intrauterine system can be used for endometrial protection for

women on MHT.

38. Women who continue to have unscheduled bleeding beyond 4–6 months of taking MHT, should be assessed to exclude endometrial pathology.

Testosterone therapy

39. The only evidence-based indication for testosterone therapy for women is for the treatment of hypoactive sexual desire disorder.

40. Before testosterone therapy can be considered, women should be fully assessed for other treatable causes of their sexual dysfunction, and these should be addressed.

41. The long-term safety of testosterone therapy has not been adequately studied.

Tibolone

42. Tibolone is an alternative to MHT for the treatment of menopausal symptoms in post-menopausal women.

43. Tibolone may be useful for women with reduced libido due to its androgenic effects.

44. Tibolone at a dose of 1.25 mg per day improves bone mineral density (BMD) and reduces the risk of fractures in postmenopausal women.

45. Tibolone is not advisable in breast cancer survivors as it may increase the risk of breast cancer recurrence.

46. Initiating tibolone in women above 60 years old may be associated with an increased risk of stroke.

Non–hormonal treatment

47. Women who wish to avoid MHT, or in whom MHT is contraindicated, may choose non-hormonal therapy to relieve their menopausal symptoms; these include selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, clonidine and gabapentin.

48. Non-hormonal medications are generally less efficacious than MHT, and may have more side-effects.

49. Women choosing to use complementary or alternative medicines (e.g., traditional medications, acupuncture) to relieve menopausal symptoms should be made aware that the efficacy is less than that of MHT, and that the quality control is questionable.

50. Compounded bioidentical MHT products are unregulated and not recommended because they are not evidence-based for effectiveness and safety.

51. Vaginal moisturisers, and lubricants for sexual activity, can be used to treat women with GSM.

52. Vaginal laser therapy is not routinely recommended for the treatment of GSM as there are insufficient studies on its long-term safety and efficacy.

Newer therapies

53. The combination medication of conjugated oestrogens and bazedoxifene is a tissue-selective oestrogen complex that provides relief of VMS and improves BMD.

54. The combination medication of conjugated oestrogens and bazedoxifene is a progestogen-free alternative to MHT for women with a uterus because the selective oestrogen receptor modulator prevents oestrogen therapy-associated endometrial hyperplasia.

55. Fezolinetant, a neurokinin 3 receptor antagonist, can be used for the treatment of moderate to severe VMS.

56. Prescribing fezolinetant requires monitoring of women's liver function due to the risk of drug-induced hepatotoxicity.

57. Oral ospemifene is a selective oestrogen receptor modulator that can be considered for the treatment of moderate to severe GSM, especially in those who cannot or prefer not to use a vaginal product.

58. Vaginal dehydroepiandrosterone can be considered for the treatment of moderate to severe GSM in women who are not contraindicated for hormone therapy.

Premature ovarian insufficiency

59. POI is diagnosed in a woman younger than 40 years, who has amenorrhoea or oligomenorrhoea and two elevated follicle-stimulating hormone (FSH) tests > 40 IU/L, 4–6 weeks apart.

60. Women with POI before the age of 40 years or early menopause before the age of 45 years are at higher risk for CVD and osteoporosis, and may be at increased risk of dementia.

61. MHT is the mainstay treatment for women with POI and should be continued at least until the average age of menopause.

62. The recommended dose of oestrogen for women with POI are oral oestradiol 2–4 mg/day or transdermal oestradiol 50–100 μg/day.

63. Combined oral contraceptives can be used as hormone replacement if contraception is required.

64. MHT containing oestradiol may be more beneficial in improving cardiovascular and bone health com-

pared to combined oral contraceptives that contains ethinyl oestradiol.

65. Women with POI may require additional counselling to help them cope with their diagnosis and its effect on their fertility, sexual and medical health.

66. Whenever possible, the ovaries should be conserved in premenopausal women having hysterectomy for benign disease.

Menopause related or menopause treatment related conditions

Osteoporosis

67. MHT is effective in preventing menopause-associated bone loss and decreasing the incidence of all osteoporosis-related fractures, even in women at low-risk for fractures.

68. MHT can be considered for the treatment of osteoporosis in post-menopausal women before 60 years of age or within 10 years after menopause, after considering the benefits and risks of MHT and other available drugs for osteoporosis.

69. Lower dose MHT, compared to standard dose (e.g., oestradiol oral 1 mg/day or transdermal 50 μg/day), has been shown to be effective in preventing postmenopausal bone loss.

70. The protective effect of MHT on BMD declines after cessation of therapy. Women at risk of fracture should receive additional bone protective agents.

Cardiovascular disease

71. MHT is not recommended exclusively for primary or secondary prevention of CVD.

72. MHT is cardioprotective for women when initiated before the age of 60 years old and within 10 years of menopause.

73. Young, healthy postmenopausal women should be started on MHT if clinically indicated without fear of increased CVD risk.

Dementia

74. MHT should not be used exclusively for the prevention or treatment of cognitive impairment or dementia.

75. MHT should not be recommended to prevent or treat declining cognition/dementia in women who enter menopause at a usual age.

Breast cancer

76. Women should be assessed for their risk of breast cancer before prescribing MHT.

77. The risk of breast cancer attributable to MHT is comparable to other lifestyle risk factors such as obesity or alcohol.

78. Oestrogen-only MHT is associated with no or little change in the risk of breast cancer.

79. Combined MHT is associated with a small increased risk of breast cancer, which is duration-dependent.

80. In combined MHT, micronized progesterone and dydrogesterone may be associated with a lower risk of breast cancer, compared to other synthetic progestogen e.g., medroxyprogesterone acetate.

81. Women taking MHT should undergo breast cancer screening (e.g., mammogram) as per their national screening guidelines.

Venous thromboembolism

82. A careful assessment of VTE risk (age > 60 years, obesity, personal or family history of VTE, thrombophilia) is essential before prescribing hormone therapy.

83. Oral MHT should not be prescribed to women with a personal history of VTE.

84. Women who are at higher risk of VTE, including those with a BMI > 30 kg/m^2, are advised to use transdermal oestrogen.

85. In combined MHT, micronised progesterone and dydrogesterone may be associated with a lower risk of VTE, compared to other synthetic progestogen e.g., medroxyprogesterone acetate.

Figure 2 is an algorithm for the management of perimenopausal and menopausal women that summarises the main points of the clinical practice statements. It is a useful tool for clinicians to decide what treatment is suitable for women who present with either menopausal symptoms or concerns relating to menopausal osteoporosis.

DISCUSSION

This consensus statement was commissioned by the APMF council in 2023 to update the previous one developed by representatives from the 14 member societies and published in 2008.

It has been observed that Asian women experience menopausal symptoms differing from those of Caucasian women. Hence, a culturally and ethnically ap-

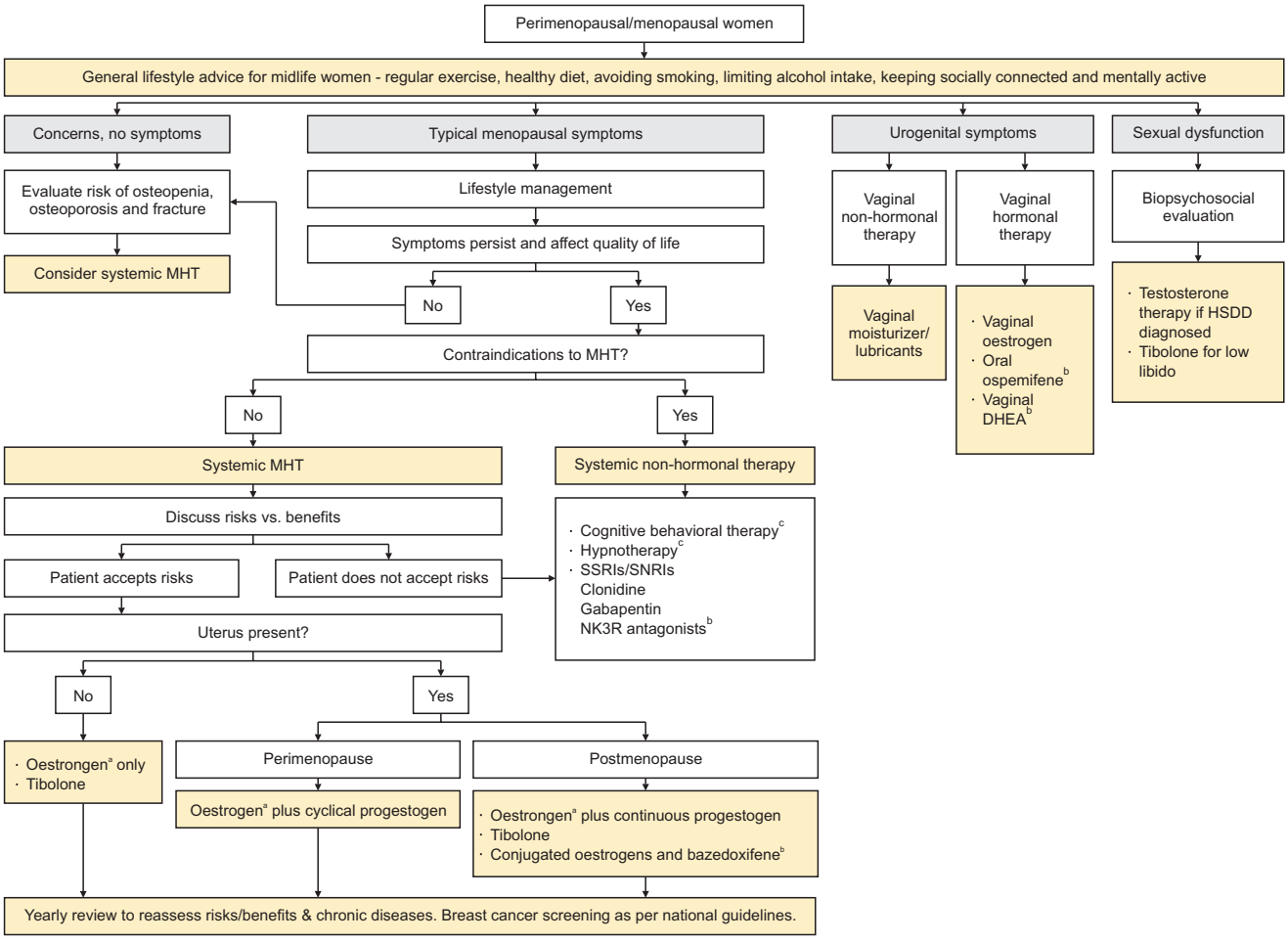

Fig. 2. Algorithm for the management of perimenopausal and menopausal women. MHT: menopausal hormone therapy, SSRI: selective serotonin reuptake inhibitor, SNRI: serotonin-norepinephrine reuptake inhibitor, NK3R: neurokinin 3 receptor, DHEA: dehydroepiandrosterone, HSDD: hypoactive sexual desire disorder. [a]Consider transdermal oestrogen in women with high-risk of venous thromboembolism or a body mass index ≥ 30 kg/m^2; [b]Newer therapies that may not be available in some countries; [c]Not in the consensus but mentioned in the International Menopausal Society White Paper [9].

propriate approach in evaluating and managing Asian women who require medical treatment as they transition through the perimenopausal stage is key to providing appropriate care for optimal outcomes [4,9].

Some statements were modified during the consensus development process due to differences in the region. These include statement 3 on BMI. The initial intention was to have a common target BMI. This was eventually modified to allow for country-specific BMI targets due to racial variations amongst Asia-Pacific regions/countries. The threshold for obesity based on BMI differs between the regions/countries in the Asia-Pacific, and this ranges between 23 to 25 kg/m^2 for overweight and 25 to 30 kg/m^2 for obesity [10].

There were differing views about what the standard dose of MHT for Asian women is. Although there is no definite evidence, the consensus was that the standard dose of oestrogen among Asian women should be oestradiol oral 1 mg/day or transdermal 50 μg/day (statement 69), compared to Western guidelines whereby oestradiol oral 2 mg may be considered the standard dose [11]. Experts agree that the dosage of oestrogen should be titrated to the lowest effective dose for symptom control (statement 27). Experts recognized that younger, perimenopausal women may require higher doses of oestrogen than older, postmenopausal women for alleviating menopausal symptoms. Although there is a consensus that lower than standard dose MHT is effective in preventing postmenopausal bone loss (statement 69), further studies in Asia may be required

to determine the optimal dose of oestrogen for preventing osteoporosis. Experts also commented on the paucity of options in oestrogen dosages amongst available MHT preparations in their respective countries or regions.

The consensus achieved for POI differs from those reached by other international guidelines. The latest POI guideline, developed jointly by the American Society for Reproductive Medicine, the European Society of Human Reproduction and Embryology and the International Menopause Society, recommends that the diagnosis of POI be based on disordered menstrual cycles (spontaneous amenorrhea or irregular menstrual cycles) for at least four months, and an elevated FSH concentration > 25 IU/L [12]. The APMF consensus recommends two elevated readings of FSH > 40 IU/L measured 4 to 6 weeks apart. Each country in the Asia-Pacific should, therefore, agree locally on a standard diagnostic threshold to better guide clinicians.

Most of the international guidelines list VMS as the main menopausal symptoms. However, Asian women were found to experience other menopausal symptoms, such as body aches, joint pains, and mental health symptoms, which APMF experts agree would also benefit from treatment with MHT. This finding may empower clinicians from Asia-Pacific regions/countries to prescribe MHT to women experiencing these bothersome symptoms of menopause.

While access to hormonal and non-hormonal therapies to manage the menopausal woman differs greatly across the Asia-Pacific region, most clinicians are aware of the availability of both traditional and newer treatment options that can be used in the management of symptoms.

Limitations

Our study has several limitations. The modified Delphi method is a consensus technique which lends itself to biases despite the panelists' expertise. Responses from the experts could have been influenced by varying linguistic interpretations of the clinical statements.

Non-availability of therapies or dosages of therapies may influence the way clinicians practise in their respective regions. We mitigated these biases by including a larger number of experts from diverse Asia-Pacific regions/countries. All revisions and modifications of clinical practice statements were based strictly on feedback from experts. The anonymity of responses encouraged honest comments, and there were no limit to the number of comments an individual could contribute.

Conclusion

Using the modified Delphi method, consensus was achieved amongst all the expert clinicians from APMF for 85 statements on the management of menopause. Based on the clinical practice statements, a management algorithm was created to summarize the main principles of managing perimenopausal and menopausal women. These statements and management algorithm will provide guidance to gynaecologists, endocrinologists, family physicians, and other healthcare professionals in providing optimal care to menopausal women in the ethnically and culturally diverse Asia-Pacific region.

FUNDING

No funding to declare.

ACKNOWLEDGMENTS

The authors acknowledge the following clinicians who contributed to this study: Dr. Jie Wu, Dr. Rong Chen, Dr. Yan Wang, Dr. Min Luo, Dr. Chao Chin Hsu, Dr. Ko-En Huang, Dr. Takeshi Iwasa, Dr. Kenjiro Sawada, Dr. Jung-Ho Shin, Dr. Ji Young Lee, Dr. Jaeyan Song, Dr. Sunila Khandelwal, Dr. Atul Munshi, Dr. Sumbul Sohail, Dr. Amanda Vincent, Clin. Assoc. Prof. Rukshini Puvanendran, Assoc. Prof. Yong Tze Tein, Assoc. Prof. Dr. Ng Beng Kwang, Asso. Prof. Dr. Sukanya Chaikittisilpa, Dr. Khunying Kobchitt Limpaphayom, Dr. Maria Jesusa B. Banal-Silao, Dr. Kanadi Sumapradja, Dr. Anditha Namira Rezky Sitompul.

CONFLICT OF INTEREST

Sonia Davison has received honoraria for educational presentations in the area of women's health and menopause from the following entities: Astellas Pharma Australia Pty Ltd., Pfizer Inc., Theramex HQ UK Ltd., Besins Healthcare, Lawley Pharmaceuticals, Jean Hailes for Womens Health, Australasian Menopause Society, HealthEd.

Masakazu Terauchi has received speaker fees and honoraria from: Fuji Pharma Co., Ltd., Otsuka Pharmaceutical Co., Ltd., Astellas Pharma Inc.

Seng Bin Ang has received honoraria and travel grants for educational presentations from the following enti-

ties: Astellas Pharma Inc., Organon Singapore Pte Ltd., Novo Nordisk, Amgen, Pfizer, GSK, Galderma, Roche diagnostics, Actxa Pte Ltd.

The remaining authors declare no potential conflict of interest to this article was reported.

REFERENCES

1. United Nations (UN). World population prospects 2024: summary of results. UN, 2024 [cited 2025 Mar 30]. Available from: https://desapublications.un.org/publications/world-population-prospects-2024-summary-results
2. Kirchengast S. Menopause in a globalized world - a systematic literature review focussing on the challenge of health problems associated with menopausal transition among women with a migration background. Maturitas 2024; 187: 108045.
3. Ang SB, How CH. Menopause: an important milestone in women's health. Singapore Med J 2013; 54: 60-3.
4. Islam MR, Gartoulla P, Bell RJ, Fradkin P, Davis SR. Prevalence of menopausal symptoms in Asian midlife women: a systematic review. Climacteric 2015; 18: 157-76.
5. Shorey S, Ng ED. The experiences and needs of Asian women experiencing menopausal symptoms: a meta-synthesis. Menopause 2019; 26: 557-69.
6. Du L, Xu B, Huang C, Zhu L, He N. Menopausal symptoms and perimenopausal healthcare-seeking behavior in women aged 40-60 years: a community-based cross-sectional survey in Shanghai, China. Int J Environ Res Public Health 2020; 17: 2640.
7. Lin L, Feng P, Yu Q. Attitude and knowledge for menopause management among health professionals in mainland China. Climacteric 2020; 23: 614-21.
8. Davis SR, Herbert D, Reading M, Bell RJ. Health-care providers' views of menopause and its management: a qualitative study. Climacteric 2021; 24: 612-7.
9. Panay N, Ang SB, Cheshire R, Goldstein SR, Maki P, Nappi RE; International Menopause Society Board. Menopause and MHT in 2024: addressing the key controversies - an International Menopause Society White Paper. Climacteric 2024; 27: 441-57.
10. Tham KW, Abdul Ghani R, Cua SC, Deerochanawong C, Fojas M, Hocking S, et al. Obesity in South and Southeast Asia-a new consensus on care and management. Obes Rev 2023; 24: e13520.
11. Birkhäuser MH, Panay N, Archer DF, Barlow D, Burger H, Gambacciani M, et al. Updated practical recommendations for hormone replacement therapy in the peri- and postmenopause. Climacteric 2008; 11: 108-23.
12. ESHRE, ASRM, CREWHIRL and IMS Guideline Group on POI, Panay N, Anderson RA, Bennie A, Cedars M, Davies M, et al. Evidence-based guideline: premature ovarian insufficiency. Climacteric 2024; 27: 510-20.