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TRAINING MANUAL

The Menopause *Doula*

TRAINING COURSE

Joining the dots from periods to perimenopause, and beyond

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The Menopause Doula Training Course Manual
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TRAINING MANUAL

The 1st Rule of Menopause School
"We don't talk about Menopause, unless we talk about Menstrual Health first"

Contents

The Menopause Doula Training Course Manual
by Fiona Catchpowle, Menopause Doula & Educator, Creator & Founder of The Menopause School.

Introduction

"The story of menopause starts with the story of menstruation.
We don't talk about menopause because we don't talk about menstruation.
We don't talk about menstruation, because no one taught us how to. "

In this manual we methodically cover the fundamentals in human biology that collectively play a huge role in the journey along the Hormone Highway, focusing on the time frame from puberty to postmenopause.
Menstruation and menopause are often explained as isolated aspects of physiology. However, if viewed from an integrated perspective you can easily see the close relationship menstruation has with overall health and the connection between perimenopause, menopause, and postmenopause.

The Challenge

Managing the misconceptions of what the typical menopause is, and isn't, is probably the hardest task that lies ahead. Menopause is not a standalone time in a person's life.
Menopause is not a condition or process that sits in its own physiological bubble that may only affect a few. Menopause is not optional.
Menstruation starts. Menstruation stops. Typically, over a 40-year time span.
In that respect, menopause is not complicated. However, the bigger picture of this well-known fact of our human biology is yet to be given the full consideration it deserves.

In addition, whilst the mechanics of menopause have not changed, the life we live has. How we facilitate the learning of its physiology to take into account life in the 21st century and the mechanism for delivering appropriate menopause care, needs to evolve.
The following modules and lessons have been designed to simply and effectively layer the knowledge, in such a way as to join the dots between menstruation and menopause. Our innovative approach to telling the story of menopause provides a relevant and meaningful approach to The Modern Menopause.

Module 1 - Exploring Menstrual Health with a lifetime lens

Introduction
In this module, we will begin with some background biology that will create a framework for later sections of the course.

There are 3 Lessons in this Module
Lesson 1 - Hormone Basics
Lesson 2 - Menstruation
Lesson 3 - The Hormone Collective

Aim:
This module provides foundation knowledge on hormone basics, menstruation, and the hormone collective. We introduce the concept of the Menstrual Health Timeline as the framework from which we will then explore both hormonal aging and reproductive aging in relevant and meaningful terms to The Modern Menopause.

Your objective is to:

- Understand the menstrual cycle in terms of overall health, beyond the role of reproduction.
- Understand and be able to explain the relevance of menstrual health, in terms of ovarian activity over age
- Explore the impact of the hormone collective and co-factors that contribute to the unique menopause experience

Module 1 - Exploring Menstrual Health with a lifetime lens

Lesson 1 - Hormone Basics

Lesson summary

An introduction to the endocrine system, hormones in general, and those in particular associated with menstruation and menopause transition.

Key points:

- The mechanics of menstruation to menopause include the endocrine system as a collective of both glands and hormones.
- The physiological process of reproductive aging is driven by ovarian activity and the hormone family of oestrogens.
- Menopause transition can be viewed in terms of ovarian aging
- The hormone collective has a lifetime aging blueprint
- The relative levels of the hormone collective affect every system of the body, every day.
- Levels can be influenced by internal and external cofactors.

Footnote: throughout we will use the UK spelling Oestrogen to represent the family name of hormones and the accepted format of estrone (E1), estradiol (E2), estriol (E3), and estetrol (E4).

Keywords:

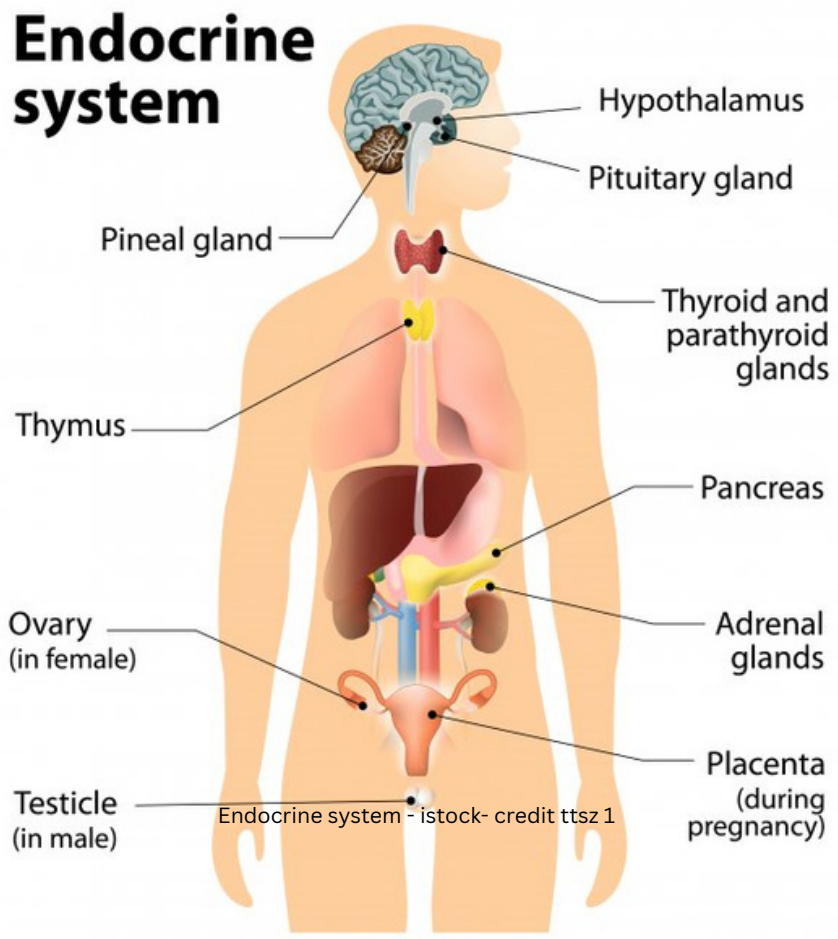
The endocrine system, Hormone Highway*, menstrual health timeline, hormone collective, hormone shift, puberty, periods, perimenopause, postmenopause, and external co-factors.

*The Hormone Highway is a visual learning aid and phrase created by Fiona. It is not a standard term found in regular reference books, other than this one. We have used the phrase to represent the biological time frame and typical pathway from menstruation to menopause.

The Endocrine System

Definition: glands which secrete chemicals called hormones directly into the bloodstream. The blood carries the hormone from one organ to a target organ where it produces an effect.

Major endocrine glands are ovaries, testes, adrenals, pituitary, hypothalamus, pineal, thymus, thyroid, parathyroid, pancreas, placenta (during pregnancy)



Endocrine system - istock- credit ttsz 1

Hormones

Definition: A hormone is a chemical produced by an endocrine gland which is released into the bloodstream to act upon an end organ

Hormones are potent chemical messengers that are regulated and released by the endocrine system - glands and organs that use hormones to control and coordinate metabolism, energy level, reproduction, growth and development, response to injury, stress, and mood.

NB. The hormones created by the ovaries are circulated throughout the entire body and **do not circulate between the ovaries and the uterus only.**

Hormones are incredibly powerful components of human existence. They are equally as important as the air we breathe. There are over 200 different hormones and hormone-like substances that help us function.
Here are some examples of hormones in the hormone collective:

Hormone	Gland	Function/Response
Serotonin	Brain	mood booster, happy hormone
Dopamine	Hypothalamus	stabilizes mood, feelings of well-being, happy hormone
Oxytocin	Pituitary	the 'love' hormone, human behaviours, happy hormone
Oestrogen	ovaries, testes (also synthesised in the adrenal, liver, fat cells, brain, skin and bone)	happy hormone, growth, energy, metabolism ... (see next table)
Progesterone	ovaries (adrenal, nervous tissue, brain, fat cells)	happy hormone, stress buffer ... (see next table)
Testosterone	Ovaries, testes, adrenals	growth, metabolism, mood ... (see next table)
Insulin	Pancreas	regulates blood sugar levels
Cortisol	Adrenal	metabolism, stress, immunity
Thyroxine	Thyroid	regulates metabolism and temperature
Melatonin	Pineal	control of the sleep–wake cycle.
Endorphins	Pituitary	inhibits response to pain

The 3 steroid hormones, derived from cholesterol and a key focus in the full understanding of menstruation and menopause are:

- oestrogens (a family of major and minor hormones)
- progesterone
- Testosterone

SEX HORMONES

Hormone	Gland	Regulate key features of
Oestrogens Major: Estrone (E1) Estradiol (E2) Estriol (E3) Estetrol (E4) – only during pregnancy Minor: 27-hydroxycholesterol, dehydroepiandrosterone (DHEA), 7-oxo-DHEA, 7α-hydroxy-DHEA, 16α-hydroxy-DHEA, 7β-hydroxyepiandrosterone, androstenedione (A4), androstenediol (A5), 3α-androstanediol, and 3β-androstanediol.	ovaries, adrenal glands, brain, liver, fat cells, placenta (during pregnancy) the skin and bone.	speed of muscle regeneration and muscle mass, protection against muscle damage, skeletal system and bone density, collagen synthesis, skin maintenance, cardiovascular system protection, anti-inflammatory properties, metabolism, energy expenditure, body weight, fat storage, endometrial growth, uterine growth, vaginal lubrication, brain activity - dna repair, cognition, verbal memory, mental health, sex drive, secondary sexual characteristics
Progesterone (P4)	ovaries, corpus luteum, placenta, testes, adrenal glands	menstrual cycle (controls endometrial lining thickness), pregnancy, skin elasticity, bone strength, respiration, nerve tissue, anti-inflammatory, immune response, insulin signaling, brain function. Also a crucial metabolic intermediate in the production of other endogenous steroids, including sex hormones and corticosteroids.
Testosterone	ovaries, testes, adrenal glands	muscle mass, bone health, mood, behaviour, immunity, anti-inflammatory, sex drive, brain - neuroprotectant and transmitter.

Over the last few decades, the extensive role that sex hormones play in all bodies has been shown in multiple research papers. However, the textbooks used for studying at GCSE, A Level, and beyond, rarely go further than defining their role in developing secondary sexual characteristics.

A female focus on Oestrogens

During the reproductive years, from puberty onwards until menopause day, the ovaries are the primary source of the most potent of the oestrogens called estradiol (E2), which circulates from the point of creation in the ovaries to our entire bodies.
NB. Reproductive years refers to the time frame when the reproductive organs – ovaries and uterus - are biologically active, NOT whether the individual has reproduced, plans to, or is unable to.

Oestrogens are also made in non-ovarian locations such as the adrenal glands, liver, fat cells, brain, bone and skin.
Whilst both testosterone and progesterone also contribute to optimum health, the reason the menstruation & menopause story is led by oestrogens is because of the variety of changing types/levels of oestrogens throughout the reproductive years.

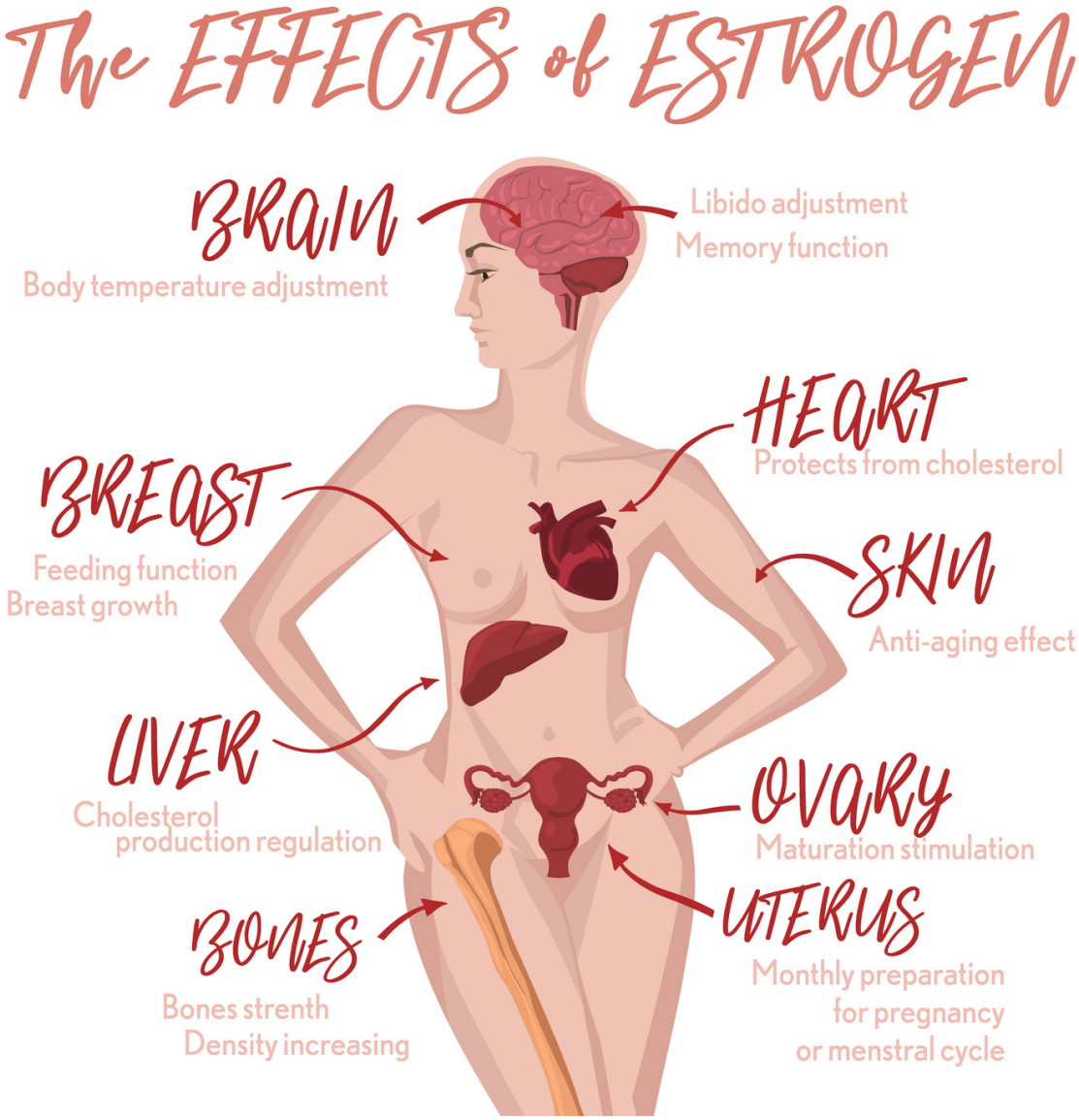
- Ovarian estradiol fluctuates during the menstrual cycle
- Ovarian oestrogens change over age from estradiol (E2) to estrone (E1) a weaker oestrogen.
- Non-ovarian oestrogen levels lower over age.
- Levels of oestrogens, ovarian and non-ovarian, cannot be directly controlled but can be influenced by the hormone collective and how they work as a whole.

Oestrogen receptors are found in almost every cell, of every system, from head to toe. They are a group of proteins found inside cells that are activated by the hormone oestrogen. The circulating oestrogens attach to these receptors and form an integral part of important bodily functions.
Including:

- Cardiovascular - heart, veins, arteries, temperature
- Digestive and excretory - mouth, stomach, intestines
- Endocrine system - influence other hormones
- Exocrine - skin, hair, nails, sweat
- Immune and lymphatic system - defence against disease
- Muscular system - movement and metabolism
- Nervous system - sense and the brain
- Renal and urinary system - kidneys
- Reproductive system - periods and pregnancy
- Respiratory system - breathing capacity
- Skeletal system - bones formation, tendon and ligament flexibility

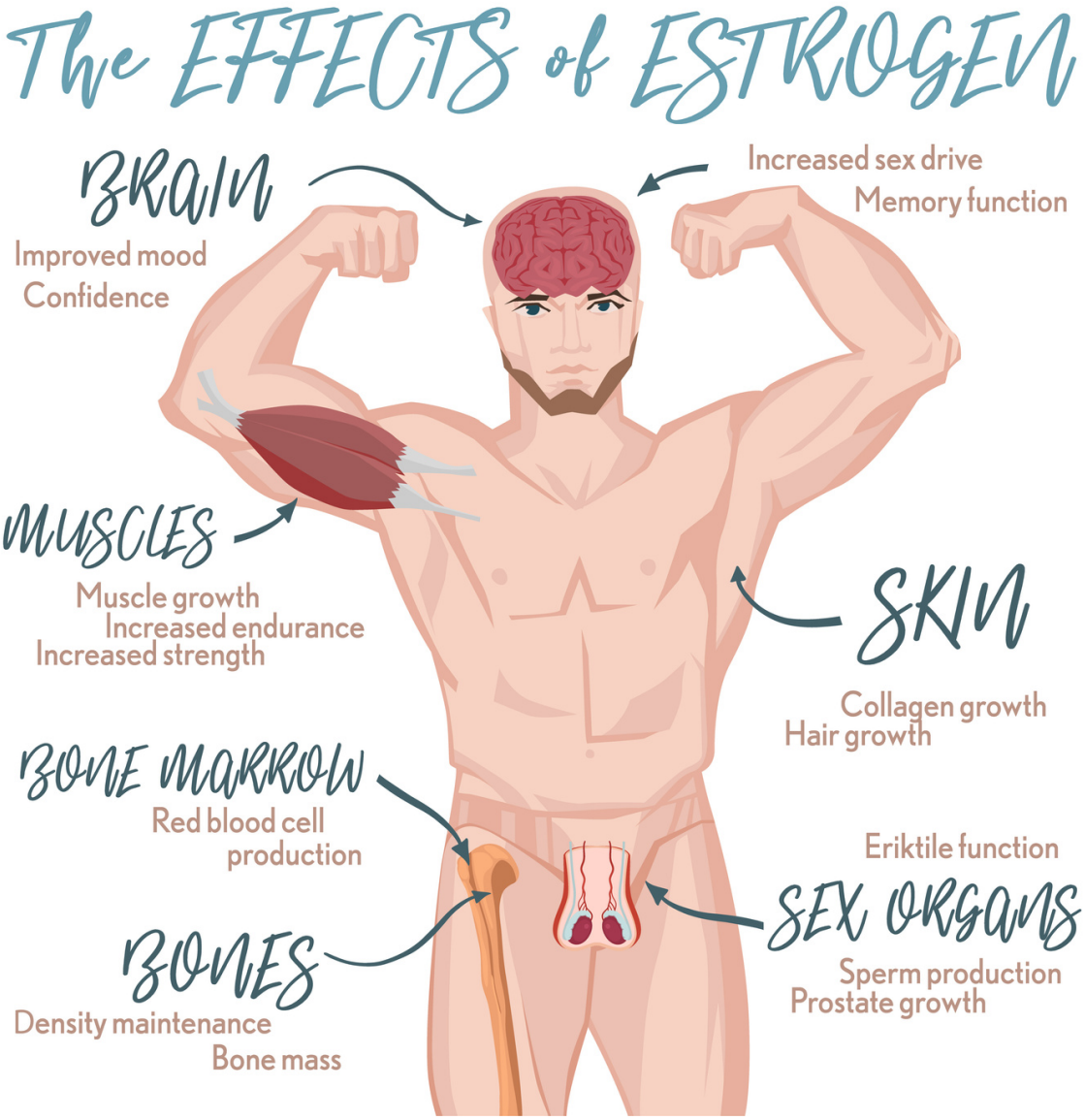
A female focus on Oestrogens

The following images are artistic representations of how oestrogens work within the 11 systems of the body, in both menstruators and co-menstruators. However, I am aware they represent a huge gender bias being pink and blue, but I have kept them here to show specifically the way in which male and female characteristics are described and perpetuate the myths.



An artistic impressions of Oestrogen receptors throughout the body and their roles in females

An artistic impressions of Oestrogen receptors throughout the body and their roles in males



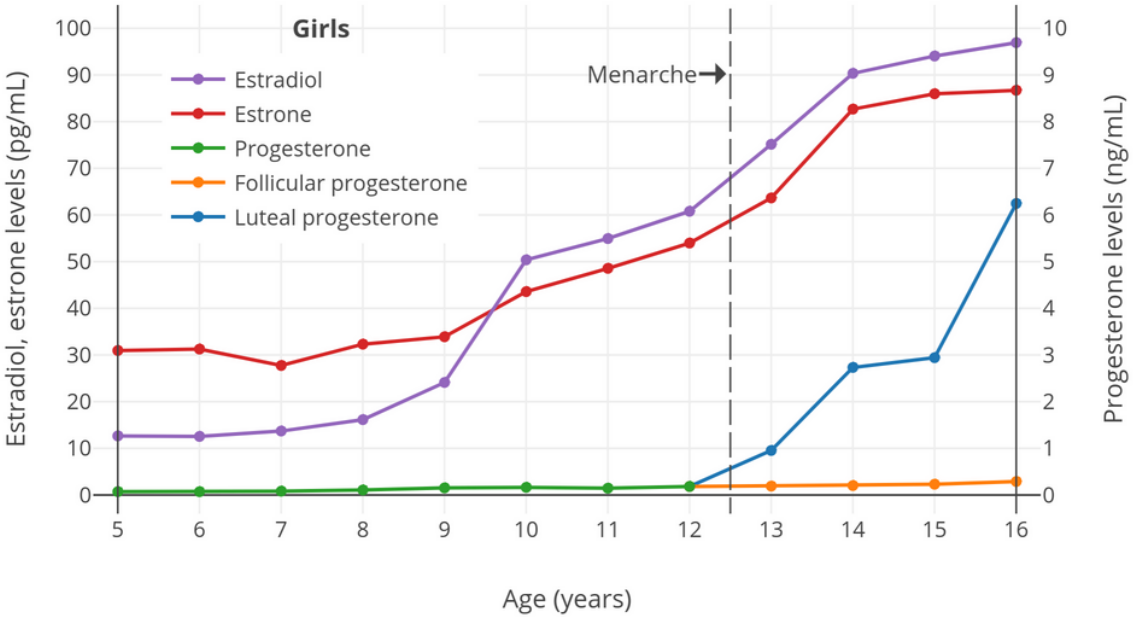
There are **4 key sex hormone level changes** along the menstrual health timeline, associated with ovarian aging. Because there is no exact timestamp when they occur, I will call them *shifts* in the continuum:

- Puberty
- Periods
- Perimenopause
- Postmenopause

[pregnancy represents a large shift in hormones but is not part of all menstrual health timelines]

The **first** large-scale hormone shift in total circulating levels of the Oestrogen family starts at puberty aged 8-10, prior to periods (menarche), when the ovaries begin to produce the oestrogens estrone (E1) and estradiol (E2).

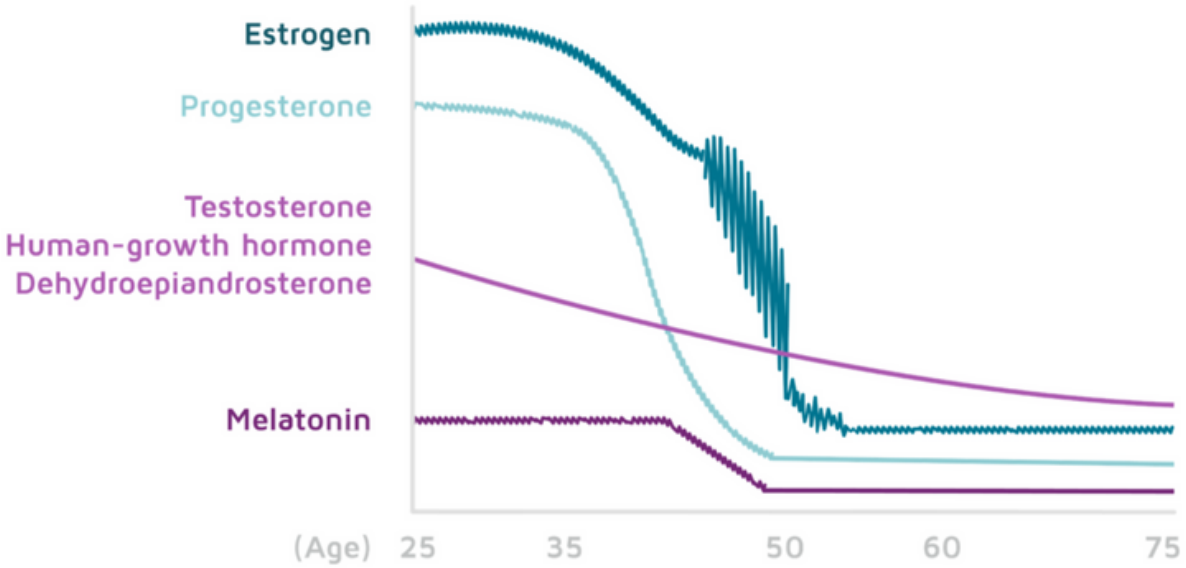
Once the menstrual cycle begins (menarche), a couple of years later, the **second** hormone shift continues along the hormone highway. The pattern of periods then becomes regular, and total levels continue to rise but less sharply.



Estrogen and progesterone levels by age (Source: Creative Commons)

Levels plateau around the late 20s and remain this way until hormonal aging begins in the late 30s.

The **third** hormone shift that occurs during the later reproductive years, called perimenopause, (subdivided into early and late) also has a typical pattern, which shows marked fluctuations, often triggered by irregular periods, as a direct result of irregular ovarian activity and decline in total oestrogen production from the ovaries.



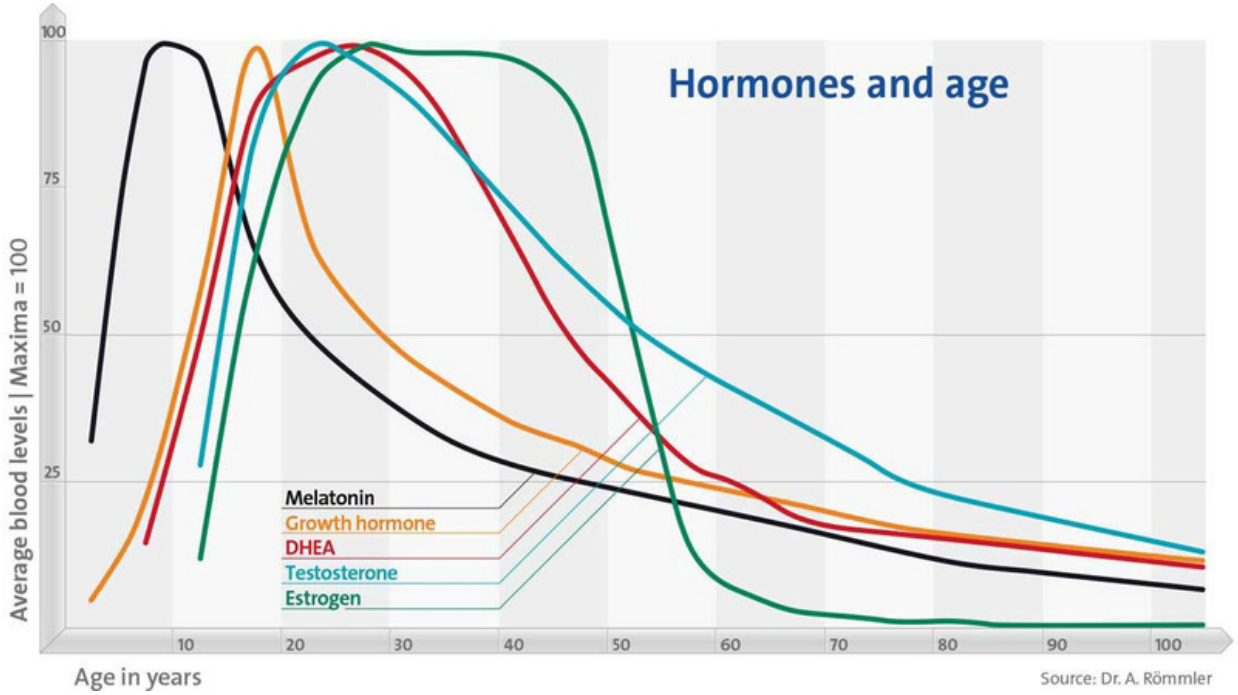
- The changing levels over time, and the ratio of O:P:T, result in physical and psychological changes in the body and mind, based on the hormone functions. The changes are called signs & symptoms.
- The process is considered to be an evolutionary adaption and is termed reproductive aging.
- The sharp changes in levels of oestrogens, as shown in the diagram, can often trigger larger-scale changes in the body and mind, these signs & symptoms can create additional physical and psychological changes that impact upon health and well-being over time, called risks & consequences.
- Postmenopause marks the **fourth** and final shift which is the permanent state when menstruation has ceased.

Levels of the hormone collective

Hormone levels are not static. As a matter of course they change individually, depending on the system they relate to, and as a collective.

- Second by second
- Day by day
- Month by month
- Year by year

In addition, the hormone collective has levels that change overage



Specific levels of hormones, from the point of creation and circulation, are influenced by co-factors. Some we can make conscious decisions over, some we cannot.

- Ageing
- Genetics
- Disease and conditions
- Environment
- Stress
- Nutrition
- Movement
- Respiration
- Sleep
- Lifestyle – smoking, alcohol, social factors

Further reading:
The structural biology of oestrogen metabolism

Oestrogen synthesis

Extra-gonadal sites of oestrogen biosyntheis and function

Physiology of Progesterone

Module 1 - Exploring Menstrual Health with a lifetime lens

Lesson 2 - Menstruation

Lesson summary

In this lesson we will cover the hormones involved in menstruation, the cycle stages, how to encourage menstrual health awareness, and the support choices for each phase.

At the end of this lesson, you will be able to join the dots between knowledge and understanding of menopause with previously held beliefs around menstruation. **Menstruation is the menopause memo!**

Tuning in to the menstrual cycle and listening to the changes, both physical and emotional, provides really solid data on health and well-being. If this was introduced as a mainstream principle for everyone who menstruates alongside any holistic health care practice, the cycle average/normal/natural would become relevant and meaningful to the individual.

Menstrual well-being markers provide such a huge insight into overall health, it would be more than reasonable to consider Menstruation as the 5th Vital sign. **The impact of menstruation goes beyond the bleed.**

Key points:

- Each menstruator is advised to record their menstrual cycle pattern and become body literate, using accurate words to describe their anatomy in particular.
- 2 of the key hormones in menstruation affect energy levels and metabolism, growth, structure digestion, breathing, and immunity, plus other bodily systems
- How menstrual health is viewed by the individual from a physical, emotional, and social perspective will influence how perimenopause and beyond are approached.
- The day-to-day changes are a conversation between the brain and the ovaries.
- Testosterone is made in the ovaries but is not a part of the menstrual cycle.
- The menstruation timeline, aka reproductive aging, is represented in the chart called STRAW+10 (Stages of Reproductive Aging Workshop 2001/2011)

Footnote: we are referring to menstrual cycles not masked by hormonal contraception.

Overview of Menstruation Awareness

The signs & symptoms, risk & consequences of the shifts along the Hormone Highway, from a point of regular periods, irregular periods, and then no periods, will be unique for each person. When change happens, it is not always obvious, but if there is information to compare it with, you can identify small variations a lot quicker.
The patterns observed are like the 5th vital sign.

Menstrual cycle ovarian hormones influence physical and emotional characteristics, which affect in particular energy levels and metabolism, growth, digestion, breathing and immunity, and all bodily systems. Menstrual cycle hormone levels change every single day to form a repeat pattern so tracking responses is a very valid healthcare guideline to know about, and should be used outside the framework of fertility, simply to learn about the mind and body effectively.
The value of this simple recording technique cannot be underestimated. I urge anyone who works with menstruators on an emotional and physical level to encourage them to track menstruation patterns to become truly aware of what the mind and body are saying to each other.

The day-to-day changes are a conversation between the brain and the ovaries, *"The ovaries speak to the brain, and the brain speaks back to the ovaries, every single day." - Dr Lisa Mosconi, Neuroscientist and Author of The XX Brain.*

The process of menstruation

There are 4 key hormones that ebb and flow throughout the cycle, which on average is 28 days in length. They work in synchrony and each one affects the level of the next during the cycle. The biological mechanism is called a negative feedback loop.
The 4 hormones:
Oestrogen (Estradiol*), Progesterone – from the ovaries/corpus luteum
Follicle Stimulating Hormone (FSH), Lutenizing Hormone (LH) – pituitary gland (brain)
*Estradiol is the potent oestrogen released in the menstrual cycle and will be the word used in the following lessons when referring to menstruation.

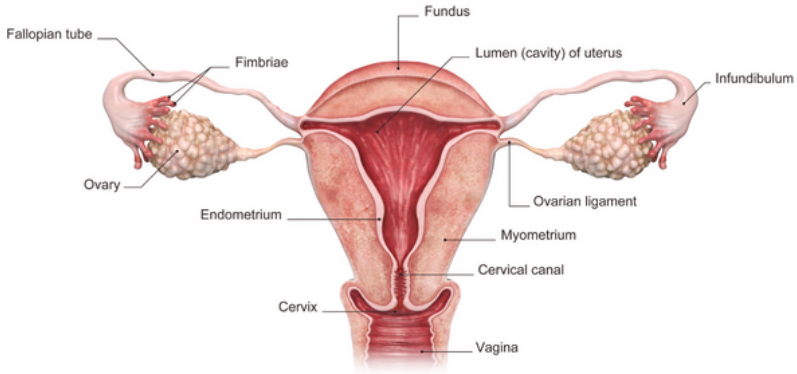
NB. Testosterone is made in the ovaries but is not a part of the menstrual cycle.

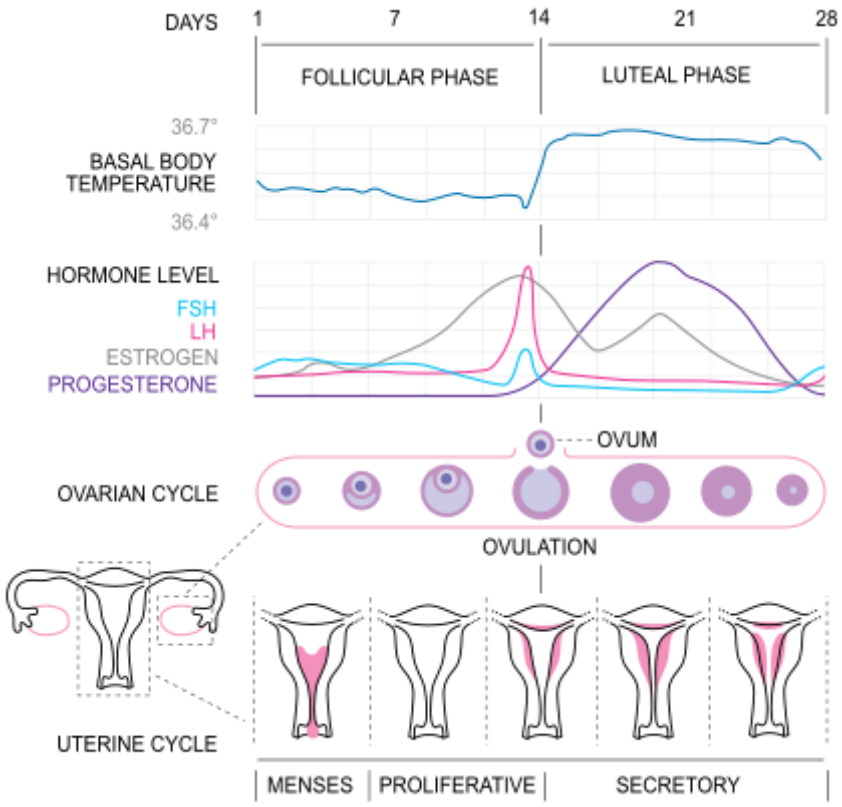
The changes noticed in the mind and body through the pubescent and reproductive years during the menstrual cycle can be explained by the role the hormones play and the changing levels.

The uterus and ovaries

The uterus is a hollow muscular organ located in the female pelvis between the bladder and rectum. The ovaries produce the eggs that travel through the fallopian tubes. Once the egg has left the ovary, termed ovulation, it can be fertilized and implant itself in the lining of the uterus.

The Uterus





Cycle Length

- A menstrual cycle may not be the same length every cycle.
- Cycle length ranges from 21 to 35 days. Some people will have a longer or shorter cycle. This is also 'typical' for them.
- 28 days represents a mean average and each menstruator is advised to record their pattern as a reference point for their cycle and become body literate, using proper names for their anatomy in particular, as opposed to colloquialisms.

Menstruation would typically consist of 2–3 days of heavy blood flow followed by another 2–4 days of lighter flow. The menstrual flow from the vagina is a mixture of blood and tissue from the inner lining of the uterus. Volume varies considerably from 30–50 ml of blood per period, up to 80 ml is still considered 'normal'.

If the menstrual cycle is different from the typical one described, it does not mean that it is abnormal or not natural. Cycles are relative to the individual and therefore tracking is essential for purposes way beyond fertility awareness.

- The follicular phase (1st half of cycle) is the part of the cycle that will most likely vary in length from month to month, and person to person. On average it is 14 days.
- From the point of ovulation (egg release), the luteal phase (2nd half of cycle) will be approximately 14 days and rarely changes.

CLEARLY the range of potential variations means that the hormone levels will vary from cycle to cycle, person to person.
A small variation in reproductive hormone levels has an impact on the hormone collective. The whole person will be affected to a greater or lesser extent. The variation may not be noticed, physically or mentally, but it is still there.

This is why menstruation is the 5th vital sign.

Typical hormone levels as a collective are imbalanced, even at optimal levels.

- They are not all at the same level at any one time.
- There is an imbalanced balance.
- The ratio to each other is what matters
- If the imbalance is offset too much in one direction, health, and well-being will most likely be impacted in a negative way.

[The exception to a huge hormone shift that in general terms would be considered a positive change is pregnancy, for example].

Ovulatory v Anovulatory cycles

Some cycles may result in an egg NOT being released. Each calendar year represents approximately 13 cycles, some of which will be anovulatory, when ovulation does not occur and an egg is not released.

- A typical ovulatory cycle (with egg release) is the most common type of cycle and results in a 'regular' bleed.
- An anovulatory cycle (no egg released) can result in a different kind of bleed

Once the ovum is shed from the follicle after ovulation, the remaining shell is called a corpus luteum. The corpus luteum becomes a mini-endocrine gland, and produces the progesterone you see on the cycle chart. No ovulation, means no corpus luteum, which means no progesterone is created from this* endocrine gland during that cycle. (*Remember that progesterone is also made in the adrenal glands)

The different cycles could be due to a variety of reasons, such as the hormone collective, and the co-factors that influence them e.g. stress, food and drink, lifestyle, sleep, and movement.

CLEARLY this has an impact on the hormone collective, and disrupts the average balance between Progesterone and Estradiol from a total circulation viewpoint.

During perimenopause, periods are often irregular and potentially more likely to be anovulatory, which can trigger a faster and erratic decline in ovarian Progesterone levels, when compared to Estradiol, and therefore the ratio between the two becomes disrupted.
During premenopause a menstruator can expect to have 2-3 anovulatory cycles. During perimenopause, this can double.

A popular term used to describe this is Oestrogen Dominance – this is not a defined medical condition. The Menopause School does not advocate the use of the term. The preferred reference is Oestrogen excess and Progesterone deficiency.

The Menstrual Health Timeline aka The Reproductive years

Birth - ovaries contain all the potential eggs (follicles) available for release during the reproductive years, which become either a pregnancy or a bleed, which we call a period.
(Cf. testes don't start creating sperm until reaching puberty onward, at a constant pace, not in a cycle).

Puberty – ovaries start to release sex hormones, and a couple of years later the menstrual cycle begins. From the age of 12 to 52 there are around 400-450 periods, or fewer if pregnancy occurs, over 40 years approx.

Periods start – each cycle starts with the follicles competing to be 'top egg'. The follicle that reaches its full potential each month travels toward the uterus ready to be fertilised. If the egg is not fertilised the lining of the womb which was thickening in preparation, sheds away and that is called a period.

Premenopause (aged from puberty to late 30s)
Regular periods are typical at this point of the reproductive years. This is very significant and the point at which a menstruator should be recording their own health signs and identifying what is 'regular' for them. Menstrual cycle regularity and the time span is important data to know, and being able to explain to a physician the details, such as bleed amount, duration, and what is regular, is incredibly helpful when discussing hormonal health.

Tapping into the intelligence of the body and responding to its unique needs is a huge act of personal care. How menstrual health is viewed by the individual from a physical, emotional, and social perspective will influence how perimenopause and beyond are approached.

Perimenopause (aged from the late 30s to the year after periods stop)

[the STRAW+10 criteria call this early + late menopausal transition]
Irregular periods are common, but not certain, at this point on the menstrual health timeline but, if periods are irregular, it often indicates the beginning of hormonal decline. *'Irregular'* could be in the length of the cycle, type of bleed, how long, and also whether an egg is released, or not.
The ovaries become erratic in hormone production levels and timing of the cycle. Some months there will be a period and some there will not. When the ovarian aging blueprint reaches this part of the menstrual health timeline and hormone aging lifeline, the only thing we can predict is the unpredictability of the activity of the endocrine system and the hormone collective.

Menopause

Periods stop - 12 consecutive months without a period is menopause, determined retrospectively. The ovaries no longer respond to stimuli to mature and release an egg which creates the menstrual cycle.

Postmenopause

The day after menopause has been noted the STRAW+10 criteria calls this postmenopause. However, because the 12 months mark is with hindsight there is often a 'is it' or 'isn't it' menopause day confusion.
Plus, perimenopause is also termed as the year after menopause day, so there is a 2-3 year window where a time zone is hard to assign. However, it does not change the outcome and the next best steps for maintaining good health.

	Menarche					FMP (0)				
Stage	-5	-4	-3b	-3a	-2	-1	+1 a	+1b	+1c	+2
Terminology	REPRODUCTIVE				MENOPAUSAL TRANSITION		POSTMENOPAUSE			
	Early	Peak	Late		Early	Late	Early			Late
					Perimenopause					
Duration	*variable*				*variable*	1-3 years	2 years (1+1)		3-6 years	*Remaining lifespan*
PRINCIPAL CRITERIA										
Menstrual Cycle	Variable to regular	Regular	Regular	Subtle changes in Flow/ Length	*Variable Length* Persistent ≥7- day difference in length of consecutive cycles	Interval of amenorrhea of >=60 days				
SUPPORTIVE CRITERIA										
Endocrine FSH AMH Inhibin B			Low Low	Variable* Low Low	↑ Variable* Low Low	↑ >25 IU/L** Low Low	↑ Variable Low Low		Stabilizes Very Low Very Low	
Antral Follicle Count			Low	Low	Low	**Low**	Very Low		Very Low	
DESCRIPTIVE CHARACTERISTICS										
Symptoms						Vasomotor symptoms *Likely*	Vasomotor symptoms *Most Likely*			*Increasing* symptoms of urogenital atrophy

* Blood draw on cycle days 2-5 ↑ = elevated
**Approximate expected level based on assays using current international pituitary standard[67-69]

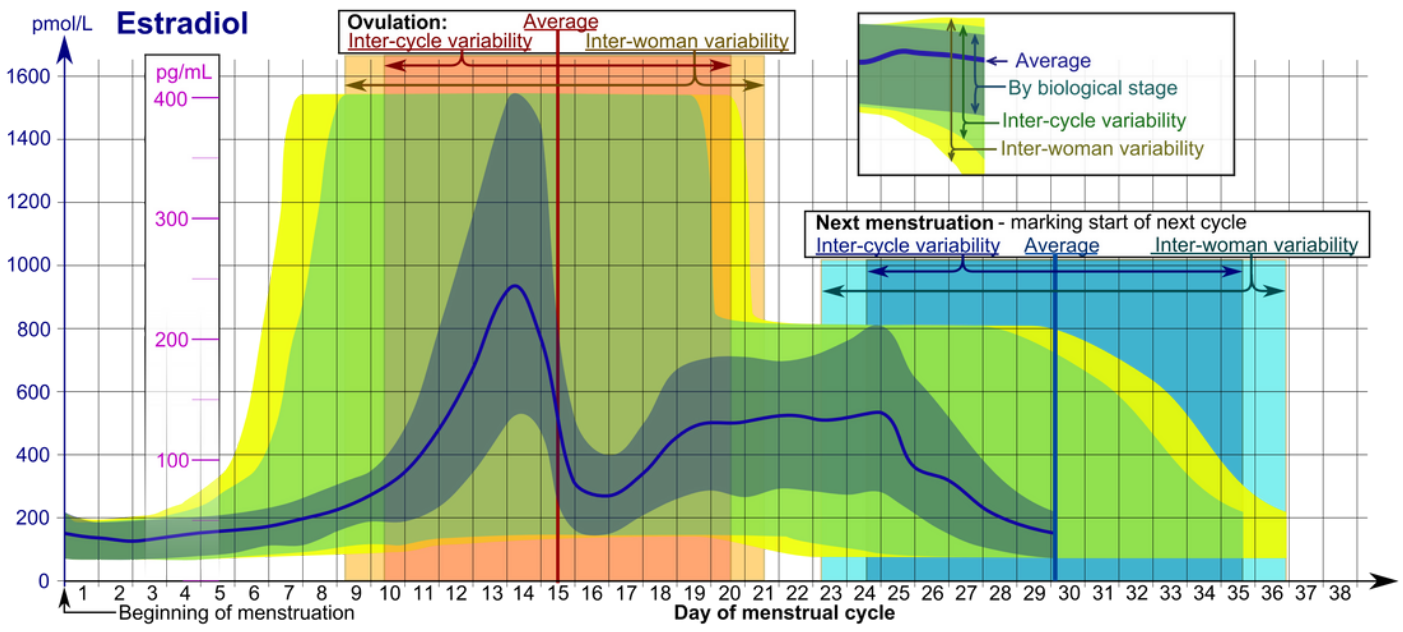
Normal Estradiol Levels

The inter-woman variability in Estradiol levels is vast.
The normal range levels for Estradiol are:
Premenopausal - 30 to 400 pg/mL
Postmenopausal - 0 to 30 pg/mL

All aspects of the different phases of the cycle have inter-cycle and inter-women variables.
This is one of the reasons why blood testing levels is not appropriate to make a *diagnosis of menopause* or classify where you are on the Menstrual Health Timeline, because the levels are relative to the individual.

Tuning in, and tracking personal physiological change, is a much better way of monitoring hormone levels and seeing patterns for the individual, rather than in comparison to another menstruator. Be more #HormoneDetective

[Image shows reference ranges for estradiol, progesterone, luteinizing hormone, and follicle-stimulating hormone during the menstrual cycle]



Module 1 - Exploring Menstrual Health with a lifetime lens

Lesson 3 - The Hormone Collective

Lesson summary

In this lesson, we take a closer look at the hormone collective and the modern menopause.
At the end of this lesson, you will understand the role of hormones as a whole, the cumulative effect they play on symptoms of menopause transition, the health risks of postmenopause in relation to the hormone collective, and an insight into the whole person approach.
When ovarian production of estradiol starts to reduce, symptoms may not be noticed as the total levels of whole-body oestrogens are still high enough for the effective functioning of the main systems.
The purpose of menopausing is to allow the body to adapt to ever-decreasing levels of total oestrogen, in preparation for post-reproductive health. When periods stop and no further ovarian oestrogen is created, the body is then able to effectively manage the hormone collective with the oestrogens produced from the adrenal glands, fat cells, and some tissue-specific sites like the liver, brain, and skin, plus other sex hormones such as testosterone that is still produced in the ovaries for a few years postmenopause.

Key points:

- The mechanics of menopause have not changed but the world around us has.
- Healthy, disability-free life expectancy has dropped 1.1 years in the last 3 years to 61.3 years.
- Ovarian activity leads to changes in oestrogen levels, but the hormone collective jointly contributes to whole-body change that may lead to signs & symptoms, and risks & consequences.

Key words:

Hormone collective, the modern menopause, blueprint, life expectancy, disability-free, whole person, cortisol connection, stressors, insulin connection, menopause tool-kit, disruptions, wear & tear, rest & digest.

The Hormone Collective V The Modern Menopause

The mechanics of menopause has not changed, but the life we lead has.

"Some systems … are very sensitive to their starting conditions, so that a tiny difference in the initial 'push' you give them causes a big difference in where they end up, and there is feedback, so that what a system does affects its own behaviour." – an extract from Deep Simplicity by John Gribbin, British Science Writer

The physical demand on our physiology is incredibly different compared to that of 100 years ago. The psychological stressors we now experience on a daily basis can be so extreme, and we have nothing to compare them with, in the entire history of the world.
The next cohorts of menopausal people are entering unknown territory.

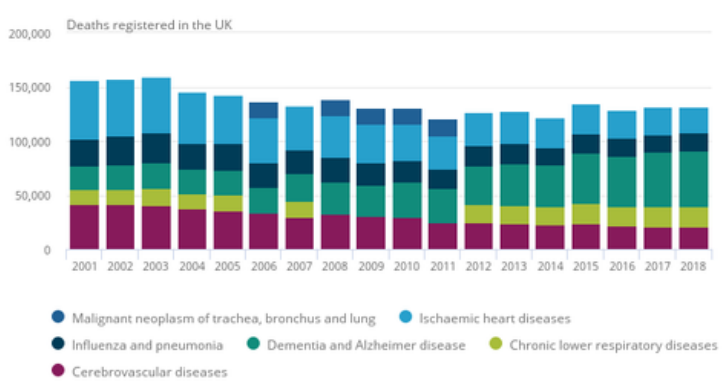
On a global scale, the world population of menopausal and post-menopausal people is projected to be 1.2 billion worldwide by 2025.
That's a lot of people who don't know about their body's potential to change overnight. Then we have to consider the long-term health consequences of personally mismanaging menopause transition, simply because we didn't know how to.

Statistics from Alzheimer's Research UK:

- One million people in the UK will have dementia by 2025 and this will increase to two million by 2050.
- 15% of female deaths in the UK in 2022 were due to Alzheimer's disease and other dementias. It was the leading cause of death for women.
- Women are 2.3 times more likely to provide care for someone with dementia for over 5 years

Figure 2: Dementia and Alzheimer disease has become the leading cause of death for females

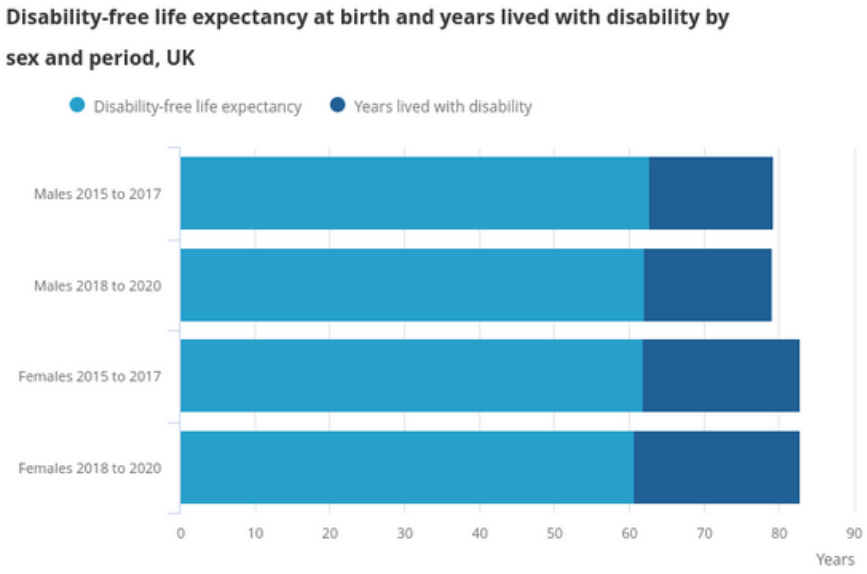
Deaths registered in the UK by leading causes of death, females, all ages, 2001 to 2018



Source: Office for National Statistics – Leading causes of death

"Osteoporosis is becoming an increasing burden to the health service both in financial and human terms with one in three women over 50 years suffering a fragility fracture. One in six women will have a hip fracture and, of these, 20% will die within one month, 30% within one year and over 50% will no longer be able to live independently." **British Menopause Society**.

The Office of National Statistics issued information in 2018 about life expectancy. For females, the age is 83.1 years. However, a healthy, disability-free life expectancy is 61.3 years. In other words, females are only expected to live 76.2% of their lives in good health!



The Cortisol connection with the modern menopause

The term "stress", as it is currently used was coined by Hans Selye in 1936, who defined it as "the non-specific response of the body to any demand for change".
A stress response triggers the release of the hormone cortisol from the adrenal glands and is part of the survival mechanism. The non-specific response can be classed as either positive or negative.

1. Positive stressor e.g. getting out of bed in the morning. If our cortisol didn't rise then we would find it very difficult to get moving. Our survival instinct says move and seek out nutrients. A positive stressor is generally short-acting, aka acute.
2. Negative stressor e.g. a life-threatening environment, traffic jams, work pressure, family difficulties and constantly connected to communication systems. Our survival instinct is easily disrupted as the reason for the 'demand for change' is unclear. A negative stressor is generally long-acting, aka chronic.

The Cortisol connection with the modern menopause (cont)

A short-term negative stressor, when life is threatened, can also be seen as positive because it enables us to survive at that moment in time. Once the stressor is removed the stress response and cortisol levels return to normal. Modern stressors, however (traffic jams, work pressure, family difficulties and constantly connected to communication systems) are mostly negative and never stop. Chronic activation of this survival mechanism affects health & well-being because elevated levels of cortisol for prolonged periods (in the modern world that could be more than 12 hours at a time) impairs the effectiveness of the hormone collective e.g. surges of stress hormones on a constant basis damage blood vessels and even influence the way our body burns carbohydrates and stores fat.

Over time the entire collective of hormones becomes inefficient. The permanent state of anxiety then becomes the norm and the body adapts. In some respects, we can call this resilience, but dependency on becoming even more resilient as the negative stressors continue starts to create a situation of wear and tear that then adds a further harmful layer to overall health & well-being.
There are many texts and conversations to be had about stress in general, but the type most relevant to menstruation and menopause is that **elevated cortisol reduces the effectiveness of Oestrogen, particularly in the brain.** Increased stress, therefore, reduces the ability of oestrogens to work as designed.

At a time when levels are dropping, we should be conserving the power of oestrogens, not reducing them further.
This is why lifestyle choices and environment selected as part of the menopause tool-kit need to consider ways of reducing stress and therefore cortisol levels.

The Insulin Connection with the modern menopause

Clinical trials and animal studies have revealed that a significant reduction, or loss, of circulating oestrogens induces rapid changes in whole-body metabolism, fat distribution, and insulin response action.
When we eat food, glucose is absorbed from our gut into the bloodstream, raising blood glucose levels. This rise in blood glucose triggers insulin to be released from the pancreas so glucose can be moved out of the blood and into the cells and be used, maintaining a steady safe level of blood glucose. **This is the insulin response**.

The Insulin Connection with The Modern Menopause (cont)

As oestrogen levels drop, so does the sensitivity to the insulin response, making it harder to respond effectively to changes in blood glucose levels. Continued stress on the insulin response system, without the protection of oestrogen, can lead to insulin resistance and associated ongoing health risks, such as type 2 diabetes.
Subsequently, postmenopause, when oestrogen levels are incredibly low compared with premenopause levels, this increases the risk of type 2 diabetes. This is why nutritional choices selected as part of the menopause tool-kit need to consider the nature of the nutrient to support reduced insulin sensitivity.

The Serotonin and Oestrogen Relationship

Serotonin is the key hormone that stabilizes mood, feelings of well-being, and happiness. This hormone has an effect on the entire body.

- It enables brain cells and other nervous system cells to communicate with each other. Serotonin also helps with sleeping, eating, and digestion.
- However, if the brain has too little serotonin, it may lead to depression.
- If the brain has too much serotonin, it can lead to excessive nerve cell activity.
- It also helps reduce depression, regulate anxiety, and maintain bone health.

Oestrogen is related to the production of serotonin. Fluctuating oestrogen and progesterone levels, plus other factors, cause serotonin production disruption, which in turn affects all of its functions.
This is why part of the menopause toolkit needs to consider ways of minimising inflammation in the system as a whole, to maintain the effectiveness of each component of the hormone collective as much as possible.

The Thyroxine Environment

Irregular oestrogen levels affect thyroid function and the sensitivity to the production of thyroxine. Thyroxine determines how much energy the body uses, otherwise known as the metabolic rate, and acts upon all systems of the body. When the thyroid gland does not make enough thyroxine many of the body's systems slow down. This is part of the aging process, which then connects with the ovarian aging process.
This is why part of the menopause toolkit needs to be robust and adaptable to the process that continues postmenopause.

The hormone collective in summary

Healthy aging is directly related to healthy menopausing.

- Hormones work in synchrony with each other. When one changes the others do too.
- There is a normal range of fluctuation that keeps us in good health. If we go outside this range, health can be impaired.
- Co-factors can create large-scale change and, if not kept in check, can create large-scale disruption.
- Controllable co-factors are environment, stress, nutrition, movement, respiration, sleep, and lifestyle factors.
- If we choose to manage the controllable co-factors we can choose to manage the change.
- The objective would be to manage the controllable co-factors before the change becomes too large and the disruption is beyond repair.

For example:

- Menstruation represents a regular change in hormone levels, within a set framework, to create a desired effect.
- However, external influences from co-factors can disrupt that framework e.g. prolonged stress, poor nutrition (not real food), no movement, poor sleep etc. because **they** affect the hormone collective, not just the ones involved in menstruation.
- If no change is made to the controllable co-factors this starts to create inflammation which disrupts the framework further.

CLEARLY, the predetermined ovarian aging blueprint is the explanation for *menopause day* and the biological process by which that point is reached, but the impact is felt via the hormone collective.
[The disruption to the framework we call wear & tear.]
In order to ***minimise*** this wear & tear we need to **'rest and digest'** and utilise the controllable co-factors wisely to restore a hormone collective that allows the transition from regular periods to no periods to be as smooth as possible.

Minimal disruption = minimal wear & tear
Minimal wear & tear = more responsive to rest & digest

Prolonged wear & tear is a result of modern-day living and The Modern Menopause therefore needs to be treated from a whole-person perspective to make us more responsive to rest & digest.

Effective rest & digest = reduced risk of disease & conditions = positive health outcomes

Module 2 - The Modern Menopause

Introduction
In this module, we look at menopause in-depth, including what it is (and is not) as well as highlighting commonly held myths and misdirection around menopause.

There are 4 Lessons in this Module
Lesson 1 - Menopause
Lesson 2 - Signs & Symptoms
Lesson 3 - Risks & Consequences
Lesson 4 - Words Matter

Aim:
This module provides foundation knowledge on the process of perimenopause and hormonal decline. We cover the physical, psychological, and physiological signs & symptoms triggered by accelerated ovarian aging and explore how the risks & consequences are related to healthy menopausing.

Your objective is to:

- Understand the process of menopause from the point of menarche to postmenopause.
- Understand and be able to explain the relevance of indicators versus signs & symptoms of perimenopause and accelerated ovarian aging, in terms of hormone shifts and the physical, psychological, and physiological changes that can occur.
- Learn the impact of the co-factors, plus ovarian aging, that contribute to higher risks and consequences to long-term health outcomes of postmenopause

Module 2 - The Modern Menopause

Lesson 1 - Menopause

Lesson summary

The stages of the typical menopause transition and understanding the different stages of reproductive aging. The Hormone Highway stages have a variety of labels. The semantics of this labeling is probably the single biggest confusing aspect of menopause.

Key points:

- The mechanics of menopause and the Hormone Highway are labeled in several ways.
- The word menopause is not a verb, but it should be!
- STRAW+10 is the global naming system for reproductive aging.
- Ovarian activity changes over time and can be compared in terms of the Eggs-factor

Keywords:

Menopause transition, Menopause day, Premenopause, perimenopause, menopause, postmenopause, to menopause, *menopausing**, ovarian activity, the Eggs-factor, hormonal decline.

The Stages of Typical Menopause Tradition

Premenopause - some hormonal changes may be occurring, but there are no noticeable changes in your body.
Perimenopause (around menopause) – the years leading up to Menopause Day, and a year after. Perimenopause is realistically around 10 years in length but may be shorter. Triggered by a drop in ovarian estrogen levels and observed by *signs & symptoms*.
Menopause – tends to be used as an umbrella term, but is in fact 12 consecutive months without a period = *Menopause Day*
Postmenopause – the day after 'menopause day' and the rest of your life.

"The menopause is defined as the cessation of the menstrual cycle. It is caused by ovarian failure. The term is derived from the Greek menos, meaning month, and pausos, meaning an ending. The median age at which the menopause occurs in the UK is approximately 51 years. Women who have been through the menopause are considered to be postmenopausal." Management of the Menopause (sixth edition) – British Menopause Society

- Menopause is in fact one day (or moment in time), reached 12 consecutive months without a period. The next day is classed as postmenopause. This makes it retrospective in its diagnosis. The typical/average age is 51 years of age for white females in the UK.
- Assuming periods started around puberty, periods will inevitably come to an end – in that sense menopause is not optional.
- 85% of this pattern is determined in DNA. The menstrual cycle timeline is expected to last approximately 40 years. In this regard, the blueprint is considered a typical pattern.

Menopause transition is initially classified as either:

- Typical or usual (also called by some as natural/of nature)
- Drug-induced
- Surgical

Menopause day can occur at any age, for one or more of those reasons.
The age at which *menopause day* occurs other than the typical timeline can also be because of:

- Premature ovarian insufficiency (POI) is the occurrence of menopause before the age of 40.
- Early menopause occurs between 40 and 45 years of age.

Menopause the word

The word menopause is defined in grammatical terms as a noun. There does not appear to be a universally accepted position on whether it should have a definite article and called The Menopause or just Menopause.
If it was a verb, *to menopause*, and conjugated as such:

- I menopause
- You menopause
- He/she/it menopauses
- We menopause
- You (plural) menopauses
- They menopause

I feel that would make more sense and incorporates the process as well as the moment in time.

Taken a step further and bending the rules on grammar we could use the word as an independent noun or adjective e.g menopausing:*

- I am menopausing
- You are menopausing
- He/She/It is menopausing
- You (plural) are menopausing
- We are menopausing
- They are menopausing

*Menopausing is a visual learning aid and phrase used by Fiona Catchpowle and is not a biological term found in reference books.

Stages of reproductive ageing
The Stages of Reproductive Aging Workshop (STRAW+10) staging system is generally considered to be the gold standard for labelling reproductive ageing from menstruation (menarche) to menopause (climacteric). STRAW divided the adult female life into three broad phases: reproductive, the menopausal transition, and postmenopause. See diagram.
There are limitations to this chart with regards to surgical and drug-induced menopause, but it provides a standardised classification system to work from.

Stages of Reproductive Aging

The Stages of Reproductive Aging Workshop (STRAW+10) staging system is generally considered to be the gold standard for labeling Reproductive Aging from menstruation (menarche) to menopause (climacteric) and postmenopause.
[I prefer the term **ovarian aging** to reproductive aging, because in talking with many people over the years, those who have not reproduced or who don't wish to, did not engage with the menopause conversation as a result, as they did not realise it applied to them.]

STRAW divided adult female life into three broad phases: reproductive, the menopausal transition, and postmenopause.
There are limitations to this chart with regard to surgical and drug-induced menopause, but it provides a standardised classification system to work from.

	Menarche					FMP (0)				
Stage	-5	-4	-3b	-3a	-2	-1	+1 a	+1b	+1c	+2
Terminology	REPRODUCTIVE				MENOPAUSAL TRANSITION		POSTMENOPAUSE			
	Early	Peak	Late		Early	Late	Early			Late
					Perimenopause					
Duration	*variable*				*variable*	1-3 years	2 years (1+1)		3-6 years	*Remaining lifespan*
PRINCIPAL CRITERIA										
Menstrual Cycle	Variable to regular	Regular	Regular	Subtle changes in Flow/ Length	*Variable Length* Persistent ≥7- day difference in length of consecutive cycles	Interval of amenorrhea of >=60 days				
SUPPORTIVE CRITERIA										
Endocrine FSH AMH Inhibin B			Low Low	Variable* Low Low	↑ Variable* Low Low	↑ >25 IU/L** Low Low	↑ Variable Low Low		Stabilizes Very Low Very Low	
Antral Follicle Count			Low	Low	Low	**Low**	Very Low		Very Low	
DESCRIPTIVE CHARACTERISTICS										
Symptoms						Vasomotor symptoms *Likely*	Vasomotor symptoms *Most Likely*			*Increasing* symptoms of urogenital atrophy

* Blood draw on cycle days 2-5 ↑ = elevated
**Approximate expected level based on assays using current international pituitary standard[67-69]

The Menstrual Health Timeline in Reverse:

Postmenopause - approximately 30 years, from the point of menopause day until we die. Hormone levels are very low. Disability-free life expectancy is 61. Life expectancy is 83.
Menopause day - average age 51 - periods stop permanently and we are said to have reached *menopause* (the pause of our menses). Hormone levels have dramatically declined and now fluctuations are minimal.
Perimenopause - the 10 years prior to menopause day, periods move to an irregular pattern when 'fertility can no longer be predicted'. Hormone levels are fluctuating unpredictably.
Premenopause - periods are *regular* for approx 30 years, and defined as the time when 'fertility can be predicted'. Hormone levels are rising and then plateau prior to the hormonal decline tipping point.
Puberty – ovarian activity aged 8-10 triggers the first menstrual period, on average age 11. Periods become regular, approximately every 28 days, with an estimate of 400-450 periods over 40 years.

The 4 female-specific hormone shifts:

- Puberty
- Periods
- Perimenopause
- Postmenopause

[Pregnancy is also a huge hormone shift that is selected and not 'naturally' a part of the blueprint]

Ovarian activity over time

At no point in time can the ovaries be strictly controlled by any action, neither general function nor the level of hormone output. They can be *influenced* via the controllable co-factors, but not controlled.
Fertility is a complex subject and is outside the scope of this manual.

The Eggs Factor* in a *regular* cycle

- A surge in Estradiol (days 1-14) from the ovaries comes from a small group of maturing eggs competing in the *Eggs Factor* for the 'top egg' competition.
- There are approx 15-20 potential eggs in each competition during premenopause and therefore the surge in levels is approximately the same each cycle.

The Eggs Factor* during perimenopause

- Over time during perimenopause, the number of competing eggs in each cycle gradually reduces and over time the Estradiol surges decline.
- Occasionally the number of competing eggs in a cycle increases and creates an unexpected surge in Estradiol levels
- Some months the ovaries don't have an eggs-factor at all.
- The eggs factor stops for several months at a time ...
- But can come back at any time without notice

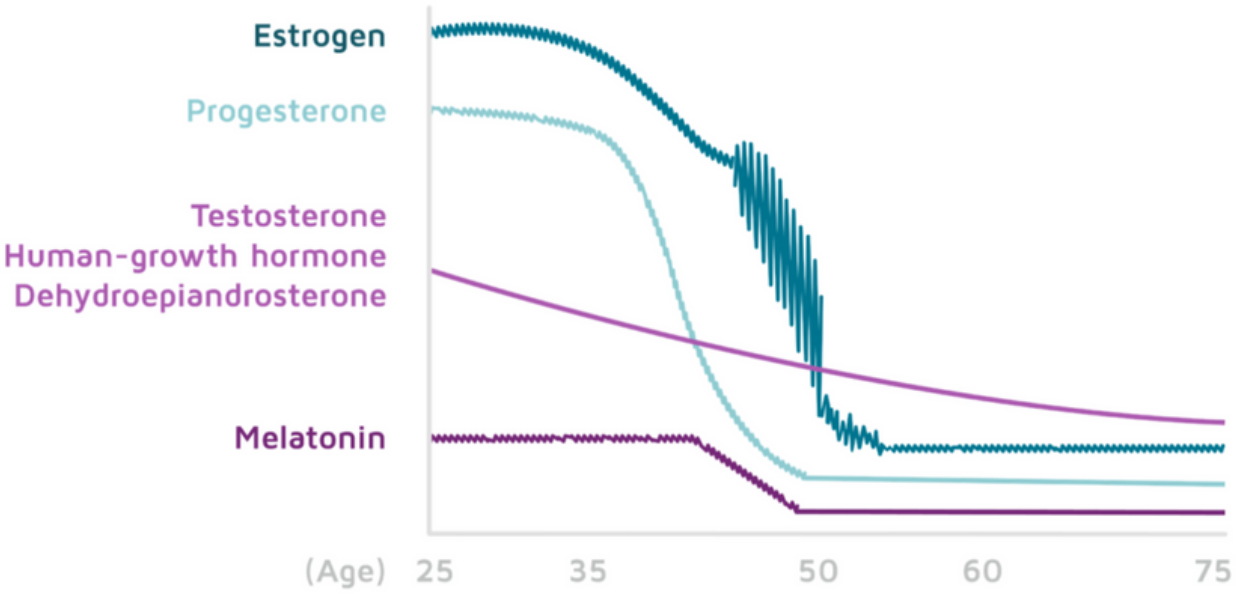
*The *Eggs Factor* is a visual learning aid and phrase created by Fiona Catchpowle and is not a biological term found in reference books.

Hormonal decline

The ovarian output is changing, but not smoothly. The decline is erratic and creates sharp changes in hormone levels, which can be observed most often during the mid to late perimenopause phase. The rate at which levels of oestrogens and progesterone change in proportion to each other also has a huge knock-on effect on the entire process.

It is these unpredictable changes that create unpredictable triggers for menopausal symptoms. In the symptoms module we will address this further.

- Hormone levels decline over time as a matter of course in both male and female bodies. This is called hormonal aging, as opposed to chronological aging
- Ovarian aging aka reproductive aging, may or may not fall in line with hormonal aging. The key challenge for females is that ovarian aging is erratic.
- Males do not experience the same unpredictable changes in hormone levels.



Module 2 - The Modern Menopause

Lesson 2 - Signs & Symptoms

Lesson summary

The grouping of symptoms as physical and psychological, predicted patterns can be observed, and why treating symptoms is better with a whole-person approach.
At the end of this lesson, you will understand the biological mechanism of symptoms, their impact on an individual level, and the connection between hormonal decline.
"Menopausal symptoms can begin months or even years before your periods stop and last around 4 years after your last period, although some women experience them for much longer". NHS

With age, the declining amounts of oestrogens in general, are massively influenced by the irregular ovarian output of estradiol.

- Signs & symptoms may or may not be observed.
- Risks & consequences will be present in either the short or long term, due to both hormonal and reproductive aging, with or without signs and symptoms.

There are risks & consequences to health and well-being as part of the aging process. How we age both hormonally and reproductively will contribute toward the level of risk of future 'disease' and the consequences of hormonal decline, on both mind and body.

Key points:

- The signs & symptoms do not appear in a pre-determined order.
- How we age both hormonally and reproductively will contribute toward the level of risk of future 'disease'.
- The defined symptoms of hormonal decline, each connected to a key bodily system, are relative to the individual.

Keywords:

Signs & symptoms, Risk & consequences, ovarian output, the menopause experience, Modify, mend, manage, menopause tool-kit, infradian rhythm, circadian rhythm, inflammation.

The Symptom Paradox

The signs & symptoms of menopause transition do not appear in a pre-determined order. However, very often the psychological ones occur first during early perimenopause but are rarely noted or connected to the beginning of hormonal decline.

The hormone collective creates a unique, whole-person, menopausal experience for each individual. There may be no apparent signs & symptoms at all, but it does not mean that hormonal or ovarian aging has not started.
In addition, there are no specific signs & symptoms indicators to pinpoint where on the Menstrual Health timeline the individual is at any one time.

There are other health challenges that share similar signs & symptoms of the menopause experience. However to say a symptom is or is not 'down to menopause' is misleading, as ovarian aging is happening whether noted or not.
[Remember the time frame is 85% DNA related. Periods start and eventually stop.]

It is probably more accurate to assume, in the case of the typical blueprint, that a diagnosed health challenge is occurring 'as well as' the menopause experience rather than 'instead of.'

The typical Menopause Day can happen at any age, therefore perimenopause can happen at any age, and it may be a short or long transition, and a few or a lot of signs & symptoms.
The defined signs & symptoms of hormonal decline, each connected to a key bodily system, are relative to the individual. Perception of physical discomfort and psychological differences on a daily basis is only comparable to previous experience.
Menstrual cycle tracking and data collection give us some degree of correlation on a *before and after* basis, but the individual recipe for what is brain fog, a hot flush, and night sweats is personal.

This poses a huge challenge on various levels, throughout the hormone highway journey.

The Symptom Paradox (cont)

If knowing and understanding what is happening to the mind and body as a whole is based on a comparison to the individual, it's a very hard concept to learn and ultimately accept. What we have is a chicken and egg situation, where 'we don't know what we don't know'.

Even when we have awareness of the process and its effects, we cannot predict whether a new sign & symptom is directly related to menopause transition or if it is a secondary situation as a result of menopause transition e.g. we change our behaviour according to how we feel.

The symptom catalogue

The following list of known signs & symptoms is fairly comprehensive but not final.

- Depression/anxiety
- Palpitations, panic attacks, loss of confidence
- Mood changes/irritability/rage
- Loss of sex drive
- Brain fog/difficulty concentrating
- Period changes, irregular, painful & heavy
- Hot flushes, Night sweats
- Changes in your skin - dry/itchy
- Vaginal dryness
- Allergies Brittle nails
- Breast tenderness
- Joint aches & pains
- Headaches/Migraines
- Burning tongue, electric shocks, tingling extremities
- Digestive issues/Bloating
- Gum problems
- Muscle tension/weakness
- Sleep problems/insomnia
- Fatigue and tiredness
- Hair loss/thinning hair
- Dizziness
- Bladder irritation/incontinence
- Tinnitus
- Unexplained /sudden weight gain
- Change in body odour

The Symptom Influences

The frequency, severity, and time span of symptoms are directly linked to every system in the body that oestrogens, testosterone and progesterone play a role.

As a reminder, those systems are:

- Cardiovascular - heart, veins, arteries, temperature
- Digestive and excretory - mouth, stomach, intestines
- Endocrine system - influences other hormones
- Exocrine - skin, hair, nails, sweat
- Immune and lymphatic system - defense against disease
- Muscular system - movement and metabolism
- Nervous system - sense and the brain
- Renal and urinary system - kidneys
- Reproductive system - periods and pregnancy
- Respiratory system - breathing capacity
- Skeletal system - bones formation, tendon, and ligament flexibility

Once we pass the tipping point of regular ovarian activity the pattern that then unfolds is **unique** to each person (and hence the symptoms).
That's the aspect we can predict. The rest is unpredictable.

- The ovaries cannot be controlled.
- The ovarian frequency of hormone creation and level of output cannot be controlled.
- Not even by HRT. That is not how it works.
-

Are you aware of anyone who has ever been able to control their periods to the day? They may have thought they were in control of the flow, and discomfort, which is true to some extent, but 'control' is not really the right word.

Please be mindful when using words like hormone balance and hormone reset in relation to ovarian activity for this very reason.

The Symptom Influences (cont)

The effectiveness of the hormones created by the ovaries can be influenced by supporting the hormone collective. e.g. When we eat a carbohydrate we know with absolute certainty that insulin will be released and the level will change from pre, during and post-carbohydrate ingestion.

Oestrogen levels do not respond in the same way to a relaxing massage, a bowl of chick peas or a yoga class. BUT as a hormone collective the effectiveness and ability of oestrogens to work well can be influenced by the hormone collective.
When we talk about managing symptoms, and applying principles and practice, to support the mind and body we are exerting an **influence** on the hormone collective, **not specific levels** of hormones and certainly not ovarian functionality. Fertility is a complex subject.

Hormone patterns

There are daily patterns that form a hormonal aging blueprint, from birth to death. This follows a similar timeline to ovarian aging and a similar shape. Each hormone has a slightly different lifetime pattern and in isolation, we don't really notice it specifically, but what we do notice is a cumulative effect.

Daily changes in hormone levels (circadian rhythm)

Stress (real or perceived) sleep, movement and the foods we choose to eat/drink have a direct impact on hormone levels like cortisol and insulin. They in turn have a direct impact on the effectiveness of the sex hormones.

Monthly changes in hormone levels (infradian rhythm)

The changes in levels of hormones during the menstrual cycle trigger the physical and emotional changes that we notice. Combined with daily changes and what influences those, will affect the total cycle on a minute-by-minute basis.

Hormone patterns (cont)

The collective response

The symptoms we notice are a cumulative effect, initially triggered by a change in oestrogen levels, both ovarian and non-ovarian. The effect may not be noticed for several years, or it can be noticed within days. The way the ensemble works together to support, or impair each other is similar, but individual.

- 25% of menstruators will find their body adjusts to the typical declining levels of, ovarian and non-ovarian-related, hormones **with very few symptoms.**
- 50% of menstruators will find their mind & body adjusts to the typical declining levels of, ovarian and non-ovarian-related hormones, **with many symptoms**, some of which can have a **negative** impact on their quality of life.
- 25% of menstruators will find their mind & body adjusts to the typical declining levels of, ovarian and non-ovarian-related hormones, **with many serious symptoms**, some of which can have a **huge negative** impact on their quality of life.

The whole-person approach

When approaching symptom management, it is much more effective to tackle them as a whole, rather than isolated. *Mend, modify and manage the different components that we know we can influence and this will subsequently support the whole system.*
Understanding the cause and effect is probably one of the hardest concepts with regard to menopause. Why a certain symptom suddenly gets worse, or a different one pops up does not, at face value, have a reason or explanation but if we look at each hormone change pattern – daily, monthly, age, plus the collective as a whole you can start to join the dots.

Let's take a point in the menstrual cycle, written from the perspective of a menstruator, and cover it in different ways using the cortisol connection and how high cortisol impairs the effectiveness of estradiol:

Example 1

The scene - cortisol was high because the cat was sick, the kids are screaming, and the computer crashed.
Day 1 of your cycle - when Estradiol is low, and you just started a crime scene style heavy period.

Estradiol's normal anti-inflammatory job is being trodden on from a great height by the cortisol and the fact it's low in levels anyway at this point in the month. It would be fair to say at this precise moment in time your stress management potential is highly nobbled.
What happens next if the kettle breaks? It's not a life or death situation at the end of the day, but does it become a 'straw that broke the camel's back' moment?

Example 2

The scene - cortisol was high because the cat was sick, the kids are screaming, and the computer crashed.
Day 14 of your cycle, - when Estradiol is high (with a small amount of progesterone), not only would the kettle breaking not bother you, but you'd easily prepare a 3-course meal for a group of work colleagues at the drop of a hat 'Ready, Steady Cook' style, and probably have enough energy left over the next day to complete the year 6 Egyptian Mummy project.

Now let's throw in perimenopause ...

Example 3

The scene - cortisol was high because the cat was sick, the kids are screaming, and the computer crashed.
Day 'absolutely no idea' of your cycle - and no idea how you are likely to respond to a stressful situation and you have no idea where you are on your menstrual cycle because periods are irregular and estradiol is up and down like a yo-yo!

Modify & Mend

The effectiveness of estradiol is a key priority. If we modify stress/cortisol levels we can mend the response and manage the effectiveness of estradiol. By supporting the effectiveness of estradiol we are thereby having an effect on other oestrogen-deficient symptoms.

How can stress (cortisol) levels be modified?

Lifestyle.
We generally seek out solutions that try to fix too many variables at the same time. Start with one. Stress (cortisol) is a key variable that can be modified simply and effectively. e.g breathing, mindfulness, doing nothing for 5 minutes.

The direct response will be felt very quickly by the hormone collective when cortisol is modified. Apply the practice more than once and the effect will be increased.
We are not fixing menopausing per se. We are not repairing the symptom; we are simply managing our response to the symptom.

Stress levels will be one of the single biggest co-factors that influences how and when symptoms manifest.
This is one of the aspects of The Modern Menopause that makes it different from previous generations.

Inflammation adds to symptoms in a negative way. The primary objective therefore is to find ways to *calm and soothe all systems*. Nutrition choices are fundamental in that support process. The fluctuations of ovarian hormones, colliding with other co-factors triggers a domino effect that, at times, can feel fairly draining and deflating.

Another of oestrogen's many talents is in **appetite and eating behaviour, fat metabolism and energy expenditure** (1). We also know that oestrogenic actions in the brain **prevent obesity** (2). Clinical trials and animal studies have revealed that loss of circulating oestrogen induces rapid changes in **whole body metabolism, fat distribution, and insulin action** (3).

Modify & Mend (cont)

References:

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3866684/
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6066788/
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4391691/

Time-restricted eating can help with reducing inflammation. When food consumption is limited to smaller windows it gives the body more time to repair. A lower carbohydrate (ones with a low glycaemic index) way of eating and higher protein ratio has shown to be very beneficial as it maintains insulin levels to a more manageable level, in relation to oestrogen.

In addition, food sensitivities and tolerances appear at this time of hormonal decline because of the same reason and the difficulty the body has in responding to the consumption of foods, previously, we didn't think twice about eating.

In summary

The body has a survival mechanism and will focus on preventing death before anything else. While it's busy metabolising alcohol, stopping your blood sugar from rising to uncontrollable levels, or preventing cortisol from causing a heart attack, the ovarian aging spikes are left unattended causing their own havoc.

Help the body heal itself.

Module 2 - The Modern Menopause

Lesson 3 - Risks & Consequences

Lesson summary

The long-term impact of hormonal decline, possible health outcomes, and data-driven risk factors.

At the end of this lesson, you will understand why decisions made during the reproductive years affect the health and outcomes of postmenopause.

"Levels of hormones postmenopause places women at higher risk than men of developing the following conditions - Dementia, type 2 diabetes, bowel cancer, heart disease, and osteoporosis." – NICE Guidelines

Key points:

- The total menopause experience brings about change from which we evolve. There is no going back.
- Prolonged inflammation (aka wear and tear) during the menopause experience may contribute further to ongoing health risks & consequences.
- "Levels of hormones postmenopause places women at higher risk than men of developing the following conditions - Dementia, type 2 diabetes, bowel cancer, heart disease and osteoporosis." – NICE Guidelines
- Knowledge is power, but you can't manage what you don't understand.
- Based on average age markers a menopausing person is destined to spend 32 years in a postmenopausal body.

Keywords:

Risk & consequences, inflammation, Dementia, type 2 diabetes, bowel cancer, heart disease, osteoporosis

Introduction

When we pass the tipping point of hormone decline the typical pattern suggests that the symptoms come and go, become severe, then subside, then reduce significantly and even stop.
Phrases such as 'return to normal after menopause' are used to explain this.

With the benefit of recent Covid19 terminology, we can probably use a slightly more tangible phrase under the circumstance as 'the new normal'. It is this back-to-normal concept that brings up the issue of 'getting through it' and a 'normal thing that has to happen'.
NB. The total menopause experience brings about change from which we evolve. There is no going back.

Postmenopause health

Research shows that it is the transition timeframe and erratic levels of estradiol that trigger the variety of changes, not so much the levels of hormones themselves directly because they are relative to the individual.
Data has shown that the signs & symptoms situation has a lot of temporary features. Once the adaption to new super low hormone levels at postmenopause is stabilised many of the symptoms appear to disappear, or minimise significantly, BUT that doesn't mean the risks & consequences have disappeared too.

However, this does not take away from the fact that the presence of symptoms during transition can be extremely debilitating physically and emotionally. In addition, the prolonged inflammation (aka wear and tear) during the menopause experience may contribute further to ongoing health risks & consequences. In other words, doing nothing or making do, and putting up with symptoms is increasing your risk of long-term health consequences more so, than managing them effectively.

Modify, mend, and manage your menopause tool kit for healthy menopausing and healthy aging.

Postmenopause health (cont)

Each of the 11 systems is affected before, during and after menopause day. For ~ 50 years a rich supply of essential hormones has fed every part of the body, to then reach a point of significantly low hormonal levels postmenopause.
The process of periods to no periods is not optional. It is what human bodies with a uterus are designed to do. Yet menstruators rarely have personal knowledge of what these hormone shifts are going to feel like, nor the physical and mental changes that will occur.
Under the age of 35 menstruators don't give this hormone shift a second thought. Past this point, they are not prepared for the move from periods to no periods.
Levels of hormones postmenopause places women at higher risk than men, of the same age, of developing the following conditions - Dementia, type 2 diabetes, bowel cancer, heart disease, and osteoporosis.

Statistics from Alzheimer's Research UK:

- One million people in the UK will have dementia by 2025 and this will increase to two million by 2050.
- 15.9% of women died due to Alzheimer's disease and other dementias in 2019 in the UK. It was the leading cause of death for women.
- Women are 2.3 times more likely to provide care for someone with dementia for over 5 years.

"Osteoporosis is becoming an increasing burden to the health service both in financial and human terms with one in three women over 50 years suffering a fragility fracture. One in six women will have a hip fracture and, of these, 20% will die within one month, 30% within one year and over 50% will no longer be able to live independently." **British Menopause Society.**

The Office of National Statistics issued information in 2018 about life expectancy. For females, the age is 83.1 years. However, a healthy, disability-free life expectancy is 61.3 years. In other words, females are only expected to live 76.2% of their lives in good health.
The hormone deficiency risk factors can be exacerbated if the perimenopause wear & tear and lack of appropriate menopausing management collide.

Knowledge is power, but you can't manage what you don't understand.

Secondary side-effects

How people feel in themselves (sad, happy, pain, anxious) dictates their behaviour and response.
As a side effect of the physical and psychological symptoms, the decisions people make and how they modify subsequent behaviour, contribute to the overall menopausal experience.

Hormones affect the probability of behaviour, they do not cause behaviour.

Things that can be affected by the secondary side-effects are:

- Self-esteem and emotional well-being
- Confidence in skills, memory, tasks
- Feelings of isolation
- Friendships & Relationships
- Environment & lifestyle choices
- Food & movement choices

Secondary situations can develop as a result of a challenging transition, such as:

- Ability to work
- Current and future finances
- No longer disability-free
- Housing options
- Lifestyle options
- Long-term relationships
- Opportunities that are no longer possible

The Joy of Menopause

Finding the joy of menopause is possible and the section we overlook when educating on the topic, because there is just so much to share about the mechanics of menopause first, to enable people to make an informed choice. We seem to run out of time to talk about the good stuff and I long for the day when we can start with the best bits because everyone knows and everyone cares, and 'how's your menopause going?' is a perfectly acceptable thing to say.

The Joy of Menopause (cont)

Based on average age markers menstruators are destined to spend 32 years in a postmenopausal body, which acts and feels quite different to the premenopausal one, and adjustments will most likely need to be made. Many of the emotional and social changes can actually be energising.

Mindset and how these changes are framed by the individual will be fundamental in how the bigger picture is approached postmenopause. Beyond periods stopping and the drama that goes with each month, PMS subsiding, or meno-rage moments disappearing, minimal to no headaches triggered by hormones, and sex without pregnancy possibilities, there are other things that change when menopausing.

- Age and what the future holds – the realisation that you probably have less time on the planet than you've already lived is quite daunting.
- The relationship with yourself – who are you and what do you want out of life?
- Values and beliefs – navigating a minefield of physical and psychological challenges, with no manual or previous knowledge, does things to your understanding of the world.

Many people decide to take a fresh look at their relationships, their professions, the ways they're caring for their own health, and the ways they want to expend their energy.
I'm not sure the 'you'll get through' or 'you go back to normal after', is a helpful tone and I know that I much prefer the new version of me to the premenopausal one.

In my opinion, there is certainly, and from my own experience, an element of reinvention that needs to be discussed in the menopause story. The hormonal rollercoaster allows us to open our minds, quite literally, due to energy changes in the brain.

Module 2 - The Modern Menopause

Lesson 4 - Words Matter

- See live coaching for the full content applicable to this lesson

Lesson summary

The words we choose matter when explaining the menopause experience are powerful and need to be considered carefully.

Key points:

- The preferred terms are 'a typical menopause' (over natural or normal), understanding that not every woman menstruates and not every menstruator is a woman
- Avoiding misdirection and using correct physiological terms, minimise misunderstanding by being factual and clear.
- We explain why The Menopause School words of choice are menstruator and co-menstruator.
- Use sensitive and ethical terminology that does not favour one way of menopausing over another.

Words Matter

The lack of Menstrual Health literacy is a huge part of the gender education gap.
There are hundreds of synonyms to describe periods alone, ALL negative.
When talking about anatomy we rarely use the correct terminology. So it's hardly surprising we don't talk about menstruation when we don't even know how to describe the process in a confident way with words that were actually created to explain it.
Describing menopause comes with its own set of challenges, but in fact, if it was more uniform it would clear up a lot of confusion. Words matter when describing menopause, and here is why.
Here are my top 6 words/phrases **NOT** to use when talking about menstrual and menopause health

Natural or normal – as humans, we are ***'of nature'*** and our operating systems are natural also. However, the word **natural** is now used as a marketing term to suggest things are simple, pure, or organic and therefore better than non-natural products.
The beginning and ending of regular menstrual cycles can both be natural events, that are neither a medical condition nor a disease. Just because they are classed as natural in terms 'of nature' it does not mean that the physiological results of the shifts are to be accepted without question. Stinging nettles are natural, but touching them can have painful consequences.
When something like mineral water is labelled as ***naturally sourced*** the implication is that it is healthier than other water and **natural** is the preferred choice. Periods starting and periods stopping over age is guaranteed and **natural**, but it does not necessarily mean this timeline is a nice experience.
The preferred phrase is **typical or usual** menopause over natural or normal.
Women go through Menopause – kind of but it is not accurate. Menopause is one moment in time when periods have stopped permanently. Menopause is not a process. Menopause is a word used by a French Doctor 200 years ago to mark the cut-off point where periods stop, long before death. Talking about being 'in' menopause or 'going through it' can be better explained if we turn the word menopause from a noun to a verb and say ***menopausing***. Better still we use the word perimenopause to talk about the time frame before menopause (moment/day).

Words Matter (cont)

All 'women' have a similar menopause experience – this is separate from menopause symptoms. In 6 years of being in, on, and around the conversation I have listened to many discussions that instantly describe women as the 'sandwich generation', with a husband, and children, worrying about their weight, and experiencing low libido.

I have then on the other hand spoken with many different groups of women who instantly assumed that if they were not in a relationship with a man, had children and parents they were looking after, and had a high sex drive, menopause did not apply to them.

One lady said she was overweight and thought her symptoms were due to her weight and not menopause, simply because she didn't like sex, and never had, which meant she had no libido to lose in the first place, plus she didn't have kids and never planned on having them.

Others thought it was only white women who had periods and then menopause.

Not all women experience sudden weight gain or ongoing weight gain with menopause transition.

Not every woman experiences irregular periods as part of menopause transition

The list of variables could go on and on and on.

Be mindful of how society places *women* in different boxes based on sexual identity, race, ethnicity, lifestyle, culture, and religion, and use inclusive terminology and examples when trying to add context to the menopause experience.

Words Matter (cont)

Oestrogen is made primarily in the ovaries – not exactly, but this one takes some explaining, and as you work through the different lessons you will understand more.
Estradiol, is just one of the many oestrogens, and is made primarily in the ovaries, during the years a female is menstruating.
Different Oestrogens are made in various places throughout the lifetime of a menstruator and it is important to use the name of the specific oestrogen.
For example it is not just oestrogen in HRT, it is Estradiol.

Menopause is caused by a hormone imbalance – The typical menopause is caused by genetics and time. Hormones do not become imbalanced and then menopausing starts. Menopausing, aka ovarian aging, reaches a tipping point around the age of 38, at which point due to changes in ovarian activity and the amount of sex hormones they produce moving forward, a change in ratio occurs of sex hormones to other hormones.

ALL women experience menopause – all human females will, but not all women. Please remember the world we live in right now is different from previous generations. 'Not everyone woman menstruates and not every menstruator is a woman.'
We need to consider the audience we are talking to when we use words relating to gender.
Of course, the medical profession and government still refer to Women's Healthcare and the Women's Health Strategy. We are not removing women from history nor dismissing the historical role of patriarchy in the gender health gap, but moving forward we must be mindful of who you may exclude from the conversation depending on the words you choose.

Module 3 - Joining the Dots

Introduction

In this module, we discuss the different approaches to managing menopause transition. We explore how Hormone Replacement Therapy (HRT) can be beneficial to symptom relief and long-term health outcomes. We also present the benefits of a whole-person approach to the menopause experience.

There are 2 Lessons in this Module
Lesson 1 - Prescribed Hormone based therapies
Lesson 2 - Complementary & Lifestyle choices

Aim:

This module provides information on medical and complementary & lifestyle treatment options such as nutrition, movement, sleeping well and stress management. We discuss the importance of a varied and robust Menopause tool-kit to be adaptable along the timeframe of the menstrual health timeline.

Your objective is to:

- Understand the different options to support the process of perimenopause
- Understand and be able to explain the different HRT types.
- Learn how signs & symptoms are supported by taking a holistic view of perimenopause in terms of the 11 systems of the body, the role of the sex hormones and the impact of the co-factors.

Module 3 - Joining the dots

Lesson 1 - Prescribed Hormone based therapies

- See live coaching video for additional content

Lesson summary

There are a variety of options for treatments medically prescribed to support menopause symptoms. We discuss the types, application/use.
It is important for a Menopause Doula to be aware of the choices, but to also remember that prescribing is the remit of a healthcare professional.
Dr Nadira will be present for Q&As at different LIVE sessions

Key points:

- The misleading report on the WHI study
- The benefit: risk ratio of taking HRT
- Body identical, Bioidentical and non-identical (synthetic) hormones
- How to support an informed choice
- Guidelines on healthcare-led conversations and shared decision-making for patients

Keywords:

Hormone replacement therapy, HRT, Benefits & Risks, Women's Health Initiative (WHI),

Introduction

9th July 2002 was possibly the most damaging day for women's health in modern times, with the 'half finished' publication of the findings from the Women's Health Initiative (WHI) trial. HRT became available in the 1960's. Over the next 20 years it became apparent that as well as creating immense symptom relief, women who were using it appeared to have fewer heart attacks, fewer fractures, and less cognitive decline. So a study was started in 1993 by the WHI in the USA to assess these findings.
The study stopped prematurely and some preliminary findings were published in 2002. Women across the world had no idea at that point in time that no one in authority in that study, or any expert outside of it, had seen the results before the media.
Headlines were unexpectedly published the next day, such as:

- HRT study cancelled over cancer and stroke fears
- The HRT scare - backlash to recent findings on Hormone Replacement Therapy.
- Hormone Replacement Study A Shock to the Medical System

It turns out those terrifying headlines were wrong. In 2004 experts finished analysing the results and issued an about-turn on the initial statement of their findings. By then the damage was done, and due to previous interest by the media and inaccurate reporting, we are still recovering from that confusion 19 years on.
There have been huge gains made in recent years, in publicly taking to task the misinformation that has infiltrated healthcare systems worldwide, but we still have a long way to go.
Collectively the Women's Wellness industry and women themselves, need to drive forward from all directions to ensure women are able to make informed choices about their hormonal health.

The link to the lecture below covers the sequence of events in great detail and sets out the clear facts and data that was ultimately revealed from the study.

Choosing HRT

Supplementing the declining oestrogens provides huge benefits and supports sign & symptom relief and reduces the risk & consequences. HRT is just one part of the menopause tool-kit and needs to be considered as an 'as well as' not 'instead of' component of managing menopause.
At times home-grown hormones can create physical and emotional challenges. It should come as no surprise therefore that when replacing them from an outside source, they can also create a situation that can feel unusual to our physiology. As such introducing HRT must be monitored by a health care professional.
The 2 main hormones used in HRT are:
Oestrogen – types used include estradiol, estrone and estriol
Progestogen – either a synthetic version of the hormone progesterone (such as dydrogesterone, medroxyprogesterone, norethisterone and levonorgestrel), or a version called micronised progesterone (sometimes called body identical, or natural) that is chemically identical to the human hormone

HRT involves either taking both of these hormones (combined HRT) or just taking oestrogen (oestrogen-only HRT).
Oestrogen-only HRT is usually only recommended if you have had your womb removed during a hysterectomy.

Ways of taking HRT
HRT comes in several different forms.
Tablets -
Tablets are 1 of the most common forms of HRT. They are usually taken once a day.
Both oestrogen-only and combined HRT are available as tablets. For some this may be the simplest way of having treatment. However, it's important to be aware that some of the risks of HRT, such as blood clots, are higher with tablets than with other forms of HRT (although the overall risk is still small).

Choosing HRT (cont)

Skin patches

Skin patches are also a common way of taking HRT. They stick to the skin and can be replaced every few days. Oestrogen-only and combined HRT patches are available.

Skin patches may be a better option than tablets if the person finds it inconvenient to take a tablet every day. Using patches can also help avoid some side effects of HRT, such as indigestion, and unlike tablets, they do not increase the risk of blood clots.

Oestrogen gel

Oestrogen gel is an increasingly popular form of HRT. It's smoothed onto the skin once a day. Like skin patches, gel can be a convenient way of taking HRT and does not increase the risk of blood clots. But if the person still has your womb, they'll need to take some form of progestogen separately too, to reduce the risk of womb cancer.

Implants

HRT also comes as small pellet-like implants that are inserted under the skin (usually in the tummy area) after the skin has been numbed with local anaesthetic. The implant releases oestrogen gradually and lasts for several months before needing to be replaced. This may be a convenient option if the individual does not want to worry about taking the treatment every day or every few days. But if they still have a womb, they'll need to take progestogen separately too.

When taking a different form of oestrogen and progestogen is needed alongside it, another implant option is the intrauterine system (IUS). An IUS releases a progestogen hormone into the womb. It can stay in place for 3 to 5 years and also acts as a contraceptive.

Choosing HRT (cont)

Vaginal oestrogen

Oestrogen is also available as a cream, pessary or ring that is placed inside the vagina. This can help relieve vaginal dryness, but will not help with other symptoms such as hot flushes.
It does not carry the usual risks of HRT and does not increase the risk of breast cancer, so can used without taking progestogen, even if the individual still has a womb.

Testosterone

Testosterone is available as a gel that is rubbed onto the skin. It is not currently licensed for use in women, but it can be prescribed after the menopause by a specialist doctor. Testosterone is used alongside other types of HRT.
Possible side effects of using testosterone include acne and unwanted hair growth.

HRT treatment routines

The treatment routine for HRT depends on whether the individual is in the early stages of the menopause or has had menopausal symptoms for some time.
The 2 types of routines are cyclical (or sequential) HRT and continuous combined HRT.

Cyclical HRT

Cyclical HRT, also known as sequential HRT, is often recommended for people taking combined HRT who have menopausal symptoms but still have their periods.
There are 2 types of cyclical HRT:

- monthly HRT – oestrogen every day, and progestogen alongside it for the last 14 days of the menstrual cycle. Monthly HRT is usually recommended for people having regular periods
- 3-monthly HRT – oestrogen every day, and progestogen alongside it for around 14 days every 3 months. 3-monthly HRT is usually recommended for people having irregular periods.

Continuous combined HRT

- Continuous combined HRT is usually recommended for those who are postmenopausal. This is usually when a period has not been experienced for a consecutive time frame of one year.
- Continuous combined HRT involves taking oestrogen and progestogen every day without a break.
- Oestrogen-only HRT is also usually taken every day without a break.

Module 3 - Joining the dots

Lesson 2 - Complementary & lifestyle therapy

Lesson summary

Understanding the importance of nutritional insight, moving through menopause, sleeping hygiene and stress management, a whole person approach, and the benefits of using a wide range of complementary and lifestyle choices when selecting items for The Menopause Tool-kit

Key points:

- The fuelling of a midlife body needs to be approached from a whole-person perspective.
- Focus on nutrient-dense real food
- Reduce inflammation and stress
- Stay hydrated

Keywords:

Whole person approach, *Food & Mood Diary**, reduce inflammation.

*The Food & Mood Diary is an original template created by Fiona Catchpowle

Introduction:

What you put in, on, and around your body matters. For reasons as explained in other modules in relation to the hormone collective a perimenopausal body will respond differently to the same foods when compared to a premenopausal body.
The fuelling of a midlife body needs to be approached from a whole-person perspective. There are specifics to zoom in on, such as spices, herbs, and adaptogens, but if focus is on nutrient-dense real food and making it as tasty as possible with nature's kitchen, it boosts each meal as a matter of course.

There is NOT a single eating system that lasts the whole journey. Menopause is dynamic and the diet will be too.

When oestrogen levels start to drop at a cellular level the gut biome is affected this can contribute to challenges when trying to obtain the nutrients needed to fuel the body optimally, with perimenopause in mind.

Choose Nutrient dense

- Support the body with a rich supply of vitamins and minerals.
- Cover all the bases with a wide variety of real foods. Cut out refined sugar and anything containing it like processed foods.
- Now is not the time for cutting back on calories in the traditional sense, because it generally cuts out nutrients.
- Nature, not number, of the calorie that counts! (Weight management needs to be a secondary consideration in the first instance.)
- A menopausal body needs a regular supply of protein to keep it replenished and optimal. Also from a ratio point of view, higher protein to carb tends to work better as well.

Reduce inflammation

- Foods that soothe and calm, keeping all systems functioning smoothly.
- Now is not the time to be choosing foods that require a lot of digestion, cause insulin spikes or generally leave you feeling in pain.
- Remove food from the diet that triggers inflammation i.e. foods that inflame are ones that leave the body feeling absolutely awful. There are lots of 'programs' out there, but the key to success is compliance and tuning in to what feels best to the individual.

Nutritional insight:

My favourite tool to help identify triggers, find positive patterns, and also support mindset is a **Food & Mood Diary**.* (see the hub for more details and the separate templates)
Aim for foods that have only one ingredient on the pack or no packet at all, such as eggs, avocado, fish, carrot.
My favourite nutritional quote is “eat food made by men in white coats and you’ll end up seeing men in white coats”.

∞ Eat at mealtimes, no grazing, that’s for animals.
∞ Eat the rainbow, but if weight management is also a meno-challenge, focus on the veggie kind first before the fruit kind as they can trigger an unfavourable response in a midlife body.
∞ Fat that comes with food in its natural state is better than added fat, such as from fried food. Foods such as fish, eggs, avocado, nuts (in moderation), and seeds are much better sources of the right kind of fats.
∞ Stay hydrated - Water intake needs to be more than you may think [you will read 2 litres in most places but I’ve yet to master that much myself] – the liver and kidneys are under a lot of pressure during menopause and you need to be as easy on them as possible by reducing consumption of things considered toxic.
Making sure your fluid intake of the non-alcoholic and non-caffeinated type is reduced therefore is an added bonus. It gives your body a better chance of de-cluttering and performing at its best.

Limiting alcohol volume is beneficial for the liver, but due to extra meno-stress we can turn to wine/gin as a means of coping. Working on other lifestyle choices may help and consider mindful-drinking steps if you think you may be overconsuming.
For further support visit joinclubsoda.com or lovesober.com

Moving through menopause

Exercise is an integral part of the 360˚strategy. Keeping moving is essential to ensure muscles and joints are kept strong and supple. The aim should be to maintain or increase muscle strength with regular exercise sessions that accumulate to 2 and half hours a week.

Weight-bearing exercise is important as it encourages bone strength and vital if we are to avoid developing osteoporosis as oestrogen declines.
Strength training is a really good choice such as resistance bands or lifting weights. Unlike aerobic exercise that can be done every day, focused strength training should work each of the various muscle groups just two or three times a week, with at least two days of rest in between.
Avoid intense exercise and hitting the gym as they can have a detrimental effect. Exercises that are gentler and focus on breathing and flexibility, such as yoga and tai chi are great choices as they allow you to connect at a deeper level.
Moving is often the last thing a menopauser wants to do if aches and pains are a symptom, but it's really important to do some kind of movement every day. Even if it's just a short gentle walk each day or your own kitchen disco. Boosting our active blood flow helps our heart and mental health.

Overall, exercising during and beyond menopause is the only noncontroversial and beneficial aspect of lifestyle modification. Everyone agrees it's good for you. Look for the joy in moving and participating in activity, rather than placing exercise in a weight management category. Perceiving exercise as a 'must do' mindset generally results in lower compliance. You'll be more likely to maintain a regular activity schedule if you find the fun.
Any movement is good for you. No matter how long or how huffy-puffy it is. And no movement is certainly bad for you.

Further Complementary & Lifestyle Therapy Tools

Cognitive behavioural therapy (CBT), acupuncture, massage, reflexology and hypnotherapy, will all support cortisol management.
Anything that can reduce stress or tell the mind you are de-stressed will help the adrenal glands, which then has a positive impact on the rest of your health and well-being. Keeping stress levels to a manageable level will help tremendously to smooth the meno-curve.
This is all relates to cortisol levels so do all that you can to manage this particular aspect. Discover what de-stresses you and do more of it.
In a recent survey 95% of women said they would try alternative therapies before HRT because they think they are more natural and because they are worried about the health risks of HRT. NICE guidelines have used carefully weighed evidence-based evaluations of the effectiveness of alternative treatments compared with placebo (no treatment) and also with conventional forms of HRT.

Cognitive Behavioural Therapy (CBT)

Cognitive and behavioural strategies can be used to develop a calmer or accepting view of a situation and therefore to respond (behave) in a helpful way.
CBT is a brief, non-medical approach that can be helpful for a range of health problems, including anxiety and stress, depressed mood, hot flushes and night sweats, sleep problems and fatigue.
CBT helps people to develop practical ways of managing problems and provides new coping skills and useful strategies. For this reason, it can be a helpful approach to try because the skills can be applied to different problems, and can improve wellbeing in general.

Herbal treatments

Guidelines recommend that you look for the THR logo standing for traditional herbal medicines. These products have been approved and you can be sure that the product has the correct dosage, is of high quality and has suitable product information. The NICE guidelines also recommend that many available herbal medicines have unpredictable dose and purity and some herbal medicines have significant drug interactions

Further Complementary & Lifestyle Therapy Tools (cont)

'Breathe and be still'
Self-care starts at a cellular level. Breathing on purpose and with a purpose gives every cell the chance to function optimally. Purposeful breathing acts as a tiny dial down on the cortisol dimmer switch, thereby reducing stress levels.

Sleep – "rest and repair"
Sleep is an essential function that allows the body and mind to recharge, leaving a mind and body refreshed and alert on waking. Healthy sleep also helps the body remain healthy and stave off diseases. Without enough sleep, the brain cannot function properly.
It's a double-edge sword with perimenopause, as often, insomnia is a symptom triggered by the drop in oestrogen, and sleep patterns may be disrupted further by night sweats. Plus a drop in progesterone can affect nighttime breathing, aka snoring. As such a good sleep hygiene routine must be high on the list of priorities, as otherwise a vicious cycle of hormones ensues, affecting sleep, which affects hormones further.
Without good sleep cycles, the cortisol starting point in the morning may already be higher than is helpful long term.

Consider the following:

- Avoid stimulants like caffeine after 12pm.
- Alcohol is not that great either for staying asleep, even though it has the apparent effect of making you drowsy, a few hours later the effect will reverse.
- Establish a realistic bedtime and stick to it every night, even on the weekends.
- Maintain comfortable temperature settings and low light levels in your bedroom.
- Make sure you have a comfortable sleep environment – including your mattress, pillows, and sheets.
- Have spare nightwear within easy reach in case of night sweats, and a temporary bed sheet-towel remedy, to allow you to get back into a dry bed as quickly as possible. Basically be prepared.

Further Complementary & Lifestyle Therapy Tools (cont)

- Clear the route to the bathroom if you need to visit the toilet at night.
- Consider a “screen ban” on televisions, computers and tablets, cell phones, and other electronic devices in your bedroom and the use of blue light glasses.
- A Magnesium supplement in the form of a spray can aid sleep, likewise lavender essential oil.
- Treating poor sleep with HRT is an option and offers relief of other symptoms as well.

Vitamin L aka Laughing

“The greatest sound in the world is someone laughing”

Menopause is not a laughing matter and when in the thick of it there are many aspects that can take your smile away. However, mindset matters and a way of making it positive has to be in the meno-toolkit.
Laughter strengthens the immune system, boosts mood, diminishes pain, and protects you from the damaging effects of stress. Nothing works faster or more dependably to bring the mind and body back into balance than a good laugh.

Proper, out-loud laughing is the best medicine.

Module 4 - The Menopause Tool-kit

Introduction

In this module, we discuss the different approaches to managing menopause transition. We explore how Hormone Replacement Therapy (HRT) can be beneficial to symptom relief and long-term health outcomes. We also present the benefits of a whole-person approach to the menopause experience.

There are 2 Lessons in this Module
Lesson 1 - The Menopause Tool-kit
Lesson 2 - Case Studies

Aim:

This module provides information on medical and complementary & lifestyle treatment options such as nutrition, movement, sleeping well and stress management. We discuss the importance of a varied and robust Menopause tool-kit to be adaptable along the timeframe of the menstrual health timeline.

Your objective is to:

- Understand the different options to support the process of perimenopause
- Understand and be able to explain the different HRT types.
- Learn how signs & symptoms are supported by taking a holistic view of perimenopause in terms of the 11 systems of the body, the role of the sex hormones and the impact of the co-factors.

Module 4 - The Menopause Tool-kit

Lesson 1 - The Menopause Tool-kit

Lesson summary

In this lesson, we discuss the things that can influence decisions around a menopause tool kit and how someone will choose to support the process of menopause transition. We explore how to use the Menopause Support System Questionnaire.

Key points:

- Things that influence choices
- How to use the MSSQ to create the conversation
- Connect the previous lessons with how to guide, nurture and support someone to build a personal Menopause tool-kit
- The role of a Menopause Doula is to create a reassuring environment.
- Use the Menopause Support System Questionnaire (MSSQ) as a prompt to build a picture and enable choices.
- The considerations that influence the decisions

The Menopause Tool-kit

A Menopause Conversation

Making informed choices is not possible until you have the knowledge of the topic and the options available. However, when looking for help on menopausing most people will have gained some knowledge, but are unsure of which steps to take next, due to overwhelming and conflicting statements. Some people may have some information and are already applying complementary & lifestyle solutions but feel they are 'not working'.
The role of a Menopause Doula is to create a reassuring environment and provide additional advice and guidance so the individual is then in a confident position to make an *informed choice*.

How to build a menopause tool-kit with guidance

The Menopause Support System Questionnaire has been designed as a tool for you to enable the *menopauser* to start to build a picture of where they are on the hormone highway and the choices available to them.
Other considerations are:

- Menstruation to Menopause Awareness and current knowledge
- Acceptance and Mindset
- Values & beliefs
- Cultural influences
- Their personal environment
- Family & Friends
- Finances

Completing the questionnaire, food & mood diary, and symptom tracker, before a consultation, provides valuable data points to assist you and the client in understanding their current hormone health position and what options can be considered in the future to build a robust and flexible menopause toolkit.

The Menopause Tool-kit (cont)

A 4-step system

Below you will see an MSSQ template for the client and a version for the Doula, with guidance on how the answers can be used to guide the creation of the client's menopause map and toolkit.

You can use the answers to the 4 steps as a conversation starter. The way the individual answers will demonstrate a current understanding of their own physiology and provide an opportunity to pinpoint daily habits, both physical and emotional.

If the answers provided appear to be based on inaccurate data, now would be a good time to open the conversation and explain in more detail the aspects that need to be clarified before moving forward.

As they progress through the steps the answers will help to design a wider perspective of their current choices and what steps could be taken straight away to support their hormone health. In addition, it will start to become apparent where they are on their hormone highway, based on other information about their menstrual health, age, and family history.

At this point, you can add perspective to what is currently being experienced and, using the Hormone Highway Timeline, explain where they may be with regard to reproductive aging and hormonal decline.

A Menopause Budget

The cost of menopause management can vary depending on the preferred route. It may well be a huge factor for someone in making menopause management decisions.

∞ Nutrition – if their current way of eating includes processed foods choosing to replace them with whole foods may initially create a slight increase in spending, but long term the higher quality way of eating is worth investing in. Nutritional supplements and alternative remedies for symptom relief may add an additional £30-50 a month.

∞ Exercise – walking is free and that's the best place to start.

∞ Lifestyle – deep breathing is again free and alongside walking will help considerably with symptom relief.

∞ Reducing the amount of alcohol purchased will save a few pennies, and likewise giving up smoking, which could then be allocated to other areas of the budget.

The Menopause Tool-kit (cont)

∞ Reducing the amount of alcohol purchased will save a few pennies, and likewise giving up smoking, which could then be allocated to other areas of the budget.
∞ Lotions and potions to help with changing skin demands, most certainly need to be on your financial forecast as well. Not simply for cosmetic purposes but for absolute relief of certain symptoms like itchy-dryness of the skin in general and intimate areas.
∞ Integrated therapy to help with stress levels is another investment.
∞ Alternative clothing for comfort and symptom management is an additional consideration, but well worth it for some.
∞ Hormone replacement therapy – on the NHS you will simply pay the prescription fee.
∞ An unexpected financial consideration could be if symptom challenges lead to time off work or, when symptoms are debilitating, stop work completely.

Even when there is an end-to-end strategy in place there may be days when the individual still has to rest and take a step back. There needs to be a contingency fund and a backup plan if that arises. In the longer term, this could affect a person's pension.

The Choices

A whole-person approach needs a collection of tools to manage symptoms and future risks. They need to be simple, straightforward, and cost-effective. The other modules provide explanations of best-case scenarios to minimise wear & tear. Now we need to present the options and enable the menopauser to utilise them in the best way possible for them.

- Stress reduction
- Nutritional support
- Movement options
- Lifestyle modification
- Hormone replacement therapy

Modify, mend, and manage

Choosing what to place in the toolkit and the considerations that influence those decisions can be used to create a mind map and outline plan. The food and mood diary can be adapted to monitor ongoing results. That way if the tool doesn't modify, mend or manage, there is a way of collecting further data from which to work.

Need help:
Please email support@themenopauseschool.com if you have any questions or technical difficulties.

Module 4 - The Menopause Support System Questionnaire

Client Version

Please answer the questions below as best you can. The questions have been designed to help create a framework from which we can build a menopause toolkit.
We are here to guide, nurture and support you using the information you can share with us during our conversation. This is the time when you get to explore all the options and choose your next best step.

What is your aim from our session? What questions do you have about menopausing?
Specifically with regard to menopause, on a *happiness scale** from 1-5, where are you now?
*feeling happy comes in many forms, such as mindset, perception, physical, and emotional.
1 may look like feelings of sadness, despair, or overwhelmed
2 may look like feeling anxious, frustrated, looking for answers
3 make look like feeling confused, apprehensive, and need more guidance before taking action
4 make look like feeling confident, calm, still learning, but overcoming obstacles
5 may look like feeling content, accepting the journey, taking action every day, noting the difficult shifts, and managing well.

Age now: Age you started your periods:

Are you using any prescription medication such as contraception or HRT?

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Module 4 - The Menopause Support System Questionnaire

Client Version

Step 1: It's helpful if we can gain some insight into your menstrual health timeline to date.

1. What have your periods been like over the years? What are they like now? (cycle length, blood flow, discomfort)
2. Do you know much about the menstrual/menopause health of your nearest female relative?
3. Are you able to tune into Yourself as you move through your cycle? Do you notice yourself feeling different each day and if so can you describe how it impacts you?

Step 2: It's helpful if we can understand how you are feeling right now and what you have found that helps.

1. Tell me which menopause symptoms you are experiencing. Can you put them into words?
2. Which would you describe as your top 5?
3. Do you know when they are worse?
4. What do you do currently to help manage your symptoms?
5. How nutrient rich is your diet? (on a scale of 1-5)
6. How much daily stress do you experience? (on a scale of 1-5)

Step 3: Let's look at your current routine and what you may want to do next

1. Which actions currently are working best?
2. Which actions could you upgrade?
3. What happiness factor items can you add to your menopause toolkit?
4. Are any of your choices related to time, cost, or personal beliefs?

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Module 4 - The Menopause Support System Questionnaire

Client Version

To be completed with your Menopause Doula at the end of the session:
Step 4:
1. Have your questions been answered?
2. What do you feel confident to start creating your menopause tool kit?
3. Specifically with regard to menopause, on a happiness scale* from 1-5, where are you now?
Use this space to write your menopause tool-kit action plan:

Need help:
Please email support@themenopauseschool.com if you have any questions or technical difficulties.

Module 4 - The Menopause Support System Questionnaire

Doula Version

Ask your client to write the answers on a piece of paper, or digital version if they prefer.
Alternatively, use the questions as a template for a conversation to build a picture of where they are on their menstrual health journey, the impact it's having, and how to take the next best step forward for them. A template for you to give your clients is also available for download in the Exercise files tab.

Step 1

This is an opportunity to explain the following -

- The genetic connection
- The role of the different hormones in relation to the 11 symptoms
- The changing levels from week 1 to week 4
- The menstrual health timeline

This information promotes intrigue and releases anxiety. The first small step in coming to terms with the journey.

This is an opportunity to learn the following -

- How comfortable they are with menstrual health literacy, which may need you need to adapt your terminology.
- Evidence strongly suggests that those who have experienced menstrual health challenges previously will find the early perimenopause symptoms are more sudden and mimic the severity of previous symptoms.
- Listen for how self-aware they are with regard to changes and guide them to the benefits of journaling to spot patterns in mood/emotions and physical symptoms.

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Module 4 - The Menopause Support System Questionnaire

Doula Version

Step 2
This is an opportunity to explain the following -

- The co-factors that can influence the hormones, with a focus on nutrients and stress.
- How the changing levels of hormones affect the 11 systems
- The support for symptom relief that making small, collective changes can make

This is an opportunity to learn the following -

- The kind of symptoms that are affecting their quality of life most
- What actions do they feel confident with already?
- Listen out for triggers that you can address with the MTK with regard to nutrition (high insulin swings) and reducing stress (micro meno feng shui moments e.g. breathing, move little and often)
- Listen out for whether the symptoms are physical, psychological, physiological or vasomotor.

Building the MTK is easier when you can identify from their own words that a whole-person approach will be more effective longterm
This will help with their mindset and managing expectations moving forward, which has a positive impact on anxiety.

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Module 4 - The Menopause Support System Questionnaire

Doula Version

Step 3
This is an opportunity to explain the following -

- That they are clearly very aware of their own needs, we just need to see what upgrades we can support them with.
- How can they *menopause feng shui or menopause declutter* their nutrition - agree on 2 next steps and focus on how this will make them feel emotionally and physically
- How can they *menopause feng shui or menopause declutter* their stress - agree on 2 next steps and focus on how this will make them feel emotionally and physically
- How can they *menopause feng shui or menopause declutter* their movement - agree on 2 next steps and focus on how this will make them feel emotionally and physically
- Or if neither step is appropriate for this client, how will it make them feel if they were able to do ..... ?
- The value of journaling to monitor their progress and looking at the bigger picture

Uplifting mindset relates to reducing stress, and maintaining social connections but are best if they do not compromise another co-factor. e.g social events with friends that include alcohol will compromise the liver

Need help:
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Module 4 - The Menopause Support System Questionnaire

Doula Version

Step 3 (cont)

This is an opportunity to learn the following -

- How overwhelmed are they and is stress management the priority?
- How you can enable the client to build a robust toolkit that fits with them and include the '*be prepared* principles' if cofactors are compromised by other choices? In the case of social connection v alcohol, how can we mitigate the impact?
- Who needs to be on their *team meno* to support their choices?
- If they are finding it difficult to explain their current steps, then using the tracker and journal will help them see the wood for the trees.
- What is holding them back from taking small steps?
- If they have already taken lots of action but 'nothing is working' are they being consistent?

They need to be congratulated for being proactive, but some people have thrown so much into their existing MTK and maybe need to dial down and step back. Sometimes the mending process feels and is painfully slow, but self-awareness and mindfulness by journaling help them see their journey in a different way.

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Module 4 - The Menopause Support System Questionnaire

Doula Version

Step 4

This is an opportunity to explain the following -

- What you chose today, may not be what you choose tomorrow
- Building an MTK takes time
- This is a self-learning process and the route they take is individual
- Look to the future and set a bigger-picture goal

This is an opportunity to learn the following -

- If their aims have been met
- If they understand the concept of the MTK
- If they feel confident to take their next best step
- How you can support them in the future

Questions to ask yourself

- Did you have any knowledge gaps?
- How did you process the information?
- What would you do differently next time?

Module 4 - The Menopause Tool-kit

Lesson 2 - The Case Studies

- Join the LIVE coaching Call

Lesson summary

In this lesson, we explain how to write your Case Studies, provide examples, talk about the marking scheme, and advice on how to demonstrate best practices.

Key points:

- Use the headings outlined
- Observe the marking scheme

The Case Studies

We would like you to demonstrate, in practical terms, how you have applied the knowledge and principles outlined.

We are looking for you to show that you are confident in having a conversation around menstruation to menopause within the framework we have presented using evidence-based terminology and following NICE Guidelines.

When writing up your case studies please include the following:

- What were the aims and objectives of the client? (1 mark)
- Step 1 - What areas you were able to give them insight into? (3 marks)
- Step 2 - What topics did you cover with regard to nutrition and stress, and what symptoms were they experiencing? (5 marks)
- Step 3 - What MTK items did they choose and why? (5 marks)
- Step 4 - Did you enable them to meet their aims and objectives? (3 marks)
- What highs or lows did you experience and how did you overcome them? (3 marks)

Marks are awarded for the following:

1. Effective use of the questionnaire to learn about the background information on the client's personal menstrual health awareness.
2. The advice you gave was within the scope of practice guidelines.
3. An outline of how you fulfilled the client's objectives, within the scope of practice.
4. An outline of the next best steps for the individual.

How to submit the case studies:

- Send case study 1 clearly labeled with your name, as either an email or a Word doc to fiona@themenopauseschool.com
- Await feedback before submitting the 2nd one.
- Send case studies 2, 3, 4, and 5 in the same way, and await feedback for each before submitting the next.

SCOPE OF PRACTISE

Just as CPR helps you assist an individual having a heart attack, being a Menopause Doula helps you facilitate learning on the topics of menstrual and menopause health, as outlined in the course content.
You will be enabled with the knowledge and skills to guide, nurture, and support a menstruator, and additional nominated individuals, experiencing a menstrual-health-timeline challenge.

Roles & Responsibilities

To follow are the range of allowable practices as a Menopause School, Menopause Doula (MSMD) having successfully completed the Menopause School Menopause Doula Course (MSMDC).

An MSMD has the core skill to do the following within the framework of the MSMDC content:

- Talk to groups or individuals about menstrual and menopause health
- This includes explaining the indicators, signs, and symptoms of perimenopause, menopause, and postmenopause.
- Provide a safe time to listen and talk, without judgment, which allows an informed choice
- Give reassurance and information to build a picture of the menstrual health timeline to enable the person to understand the hormone highway.
- Discuss the non-clinical and clinical menopause support options
- Encourage self-help and support strategies to build a personal menopause tool-kit, using a whole-person approach within the guidelines set.
- Recognise when there are factors and concerns, to be shared with the individual, that requires signposting to other resources or practitioners, beyond complementary and lifestyle options.

The Menopause Doula accreditation is only for 'talking therapy' and not a physical, nutritional, or exercise-related certification. Any direction given to a client that is outside the scope of practice is done so at your own risk and the appropriate insurance must be obtained independently.

Boundaries

An MSMD does not diagnose any menstrual health or menopause condition;
An MSMD does not diagnose disease or plan treatment;
unless you have other qualifications that state otherwise, and if you do so it is at your own risk and is not to be associated with The Menopause School and its content.

Ethical guidelines

The role of an MSMD is both challenging and rewarding. You get to work with all different types of people and help them heal from the challenges and obstacles the menstrual health timeline poses. Due to the emotive and personal nature of the work, it is very important that you remain neutral when using terminology to describe the different support options.

An MSMD does not use misleading or dismissive words to define the different approaches to building a menopause toolkit, specifically, when talking about clinical (HRT and other medications) versus complementary & lifestyle choices (non-clinical alternatives)
We would consider it unethical to use the following words when talking about the support options:
Using a chemical versus a natural approach
Using HRT versus supplements
(or similar phrases)

The Menopause School advocates a whole-person approach, whatever that means to the individual. As we say, *"What you choose today, may not be what you choose tomorrow".*

An MSMD must not recommend/prescribe the following unless you have other qualifications that state otherwise, and if you do so it is at your own risk and is not to be associated with The Menopause School and its content:

- Specific Supplements, other than broad recommendations as outlined in the MSMDC content
- Specific exercise routines other than broad recommendations as outlined in the MSMDC content
- Specific Nutritional programs beyond real food and the broad recommendations as outlined in the MSMDC content
- Specific holistic treatment other than broad recommendations as outlined in the MSMDC content
- Specific medical treatment other than broad recommendations as outlined in the MSMDC content.

MISSION STATEMENT

The global gender health gap is leading to a healthcare crisis.

Hundreds of years of poor quality, misleading information about female health has resulted in menstruators being unable to make simple choices on how to best manage their hormone health from periods to no periods, and beyond.

The Data

In The World Economic Forum, Global Gender Gap Report 2022, based on 146 countries shows, the US ranks 27th, and the UK ranks 22nd in the world overall. In 2022, the global gender gap has been closed by 68.1%. At the current rate of progress, it will take 132 years to reach full parity.

Evidence collected by Nottingham Women's Centre for the Women and Equalities Commission written report, July 2022, found that "many women said they lacked basic knowledge about the menopause, which meant they struggled to identify their own symptoms and reach out for support." and, "Many women reported issues with their GP; they either found that their GP was not sympathetic or understanding, or that they did not spot their menopausal symptoms. GPs do not receive mandatory training in menopause, which is surprising as women are sign-posted to their GPs to get support."

A survey carried out by BUPA shows that 34% of those who consulted a GP said they were unable to help them and a further 30% said the GP didn't know enough about menopause. The data collected by Health&Her showed that 63% of women would rather speak to anyone but their GP/Nurse.

There is clear evidence that menstruators of all ages need someone to turn to for advice and guidance, outside of the current medical healthcare provision, in the UK.

Education is Key

Holistic health advisors and wellness professionals are ideally placed to be a part of the network of support that menstruators need. The Menopause School has the ability and track record to teach them how to.

MISSION STATEMENT

Menstrual Health, a fundamental part of our biology and the mother of all creation (quite literally), continues to be a second-class citizen in the eyes of educational establishments the world over.

The Vision

Our aim is to create a global collective of Menstrual & Menopause Health Confident Educators who will enable and empower others with the relevant and meaningful knowledge needed to make an informed choice on hormone health, from womb to tomb.

People who already have a skill set that supports a menstruator with their physical and mental health, for example, a personal trainer, massage therapist, or life coach, are ideally placed to be a part of the global collective vision.

We pledge to seek ways to close the gender health gap starting with:

- Delivering educational support on menstrual and menopause health to wellness professionals, using a whole-person, evidence-based approach.
- Create a diverse collective of professionals who can create confident conversations and advocate for those who need help with their menstrual and menopause health.
- Teach menstruators the fundamentals of menstrual health with a lifetime lens to enable informed choices and improve health outcomes.

Our mission is for all Wellness Professionals to understand the following framework:

- The Mechanics of Menopause - the back story and the Biology, starting with menstrual health and how menopausing (the transition) happens.
- That menopausing is in fact ovarian aging which, during the typical lifespan has a start date and an end date, and that this timeline is approximately 40 years.

(continued)

- Menopause is defined as the permanent stop of the menstrual cycle, not a collection of symptoms, risks, and consequences.
- Understand that Menopause is not an isolated aspect of female physiology.
- Know that menopause occurs in 100% of females, either as part of ovarian aging, removal of ovaries (surgical menopause), or induced by medication.
- Recognise that menopausing is like a fingerprint. Unique to the individual.
- Understand how menstrual health is an integral part of mental health for a person who menstruates.
- Menstrual health cycle tracking is a valid way of supporting hormone health outside of periods and pregnancy.
- Acknowledge the bigger picture of the role of the hormone collective in every part of female health and well-being
- Know the difference between menopause diagnostic symptoms and long-term menopausing symptoms.
- Observe the science that explains why there are no fixed number of symptoms and the words each person uses is relevant and meaningful to them.
- Symptoms, both diagnostic and long-term, are caused by a change in hormone ratio and overall lifetime levels, triggered by ovarian aging and changes in brain activity.
- There are long-term health consequences of menopausing during the postmenopause lifespan, which can be a third of a menstruators life. The challenge is not only about navigating symptoms but doing it well, so the risk of poor health outcomes is significantly reduced.
- Managing symptoms is based on the 11 bodily systems and how they are affected in the individual. There are no single solutions, short-term fixes, and generic healthy lifestyle mantras. Taking action, building a menopause tool kit, and making changes are essential to positive outcomes.
- We are advocates of an informed choice and recognise the value that hormone replacement plays in the menstrual health lifetime journey, but not at the exclusion of a whole-person approach.
- Being a menstrual health and menopause advocate means you have the ability to guide, nurture and support someone along their hormone highway, and know when and where to signpost them for further advice.

TERMS OF AGREEMENT

The terms of the agreement when purchasing The Menopause School, Menopause Doula Training Course are laid out below.
Included in this agreement are:
The Scope of Practise
Mission Statement

Health Disclaimer

The Menopause School is a team of alternative healthcare tutors and practitioners. We are NOT Medical Doctors, counsellors, psychotherapists or psychiatrists. We make recommendations on diet, supplements, lifestyle, and emotional well-being to create better health. The information presented in this site and in our courses and programs is not intended as medical advice. It is for information purposes only and is not intended to diagnose, prevent, treat or cure any illness.

Refunds

There is a strict no-cancellation/refund policy on online courses where candidates have access to content on purchase. Information on the course is available for every candidate to fully appreciate the course content before purchase. Please contact us if you have any questions. Once purchased and accessed, there are no cancellations/refunds and Candidates are obliged to continue any outstanding installment payments until the balance has cleared. All of the above are at the discretion of The Menopause School. Where we feel there has been foul play or candidates have made unreasonable requests, we reserve the right to deal with every refund and cancellation request on an individual basis.

Payments

We allow people to spread the cost of their study. If you choose to pay via a payment plan, you are entering into a contract with The Menopause School to complete the payment plan in full without exception.
If you default on a payment we will revoke access to your course immediately, and we will email you a link to bring your account up to date. **Defaulted Payments must be settled within 31 days of the original due date**. If they are not settled, we reserve the right to revoke the payment plan entirely and request the balance in full immediately.
Any balance that remains **outstanding for longer than 90 days will be deemed bad debt** and your access to courses will be revoked permanently without refund. We also reserve the right to use a Debt Collection agency for longstanding unpaid accounts.