Resources
Transcript

The Impact of Menopause on Women: Considerations for Health Care and the Workplace June 4, 2024, 2:00 – 3:00 pm EST
Resources

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- HRSA/OWH General Email, HRSAOWH@hrsa.gov
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Resources Shared by the US Department of Labor's Women's Bureau (WB)

- NIH: What is Menopause?
- Office on Women's Health: Menopause symptoms and relief
- National Institute on Aging Menopause Page
- OASH Office on Women's Health Menopause Page
- Equal Employment Opportunity Commission (EEOC)
- Wage and Hour Division
- Occupational Safety and Health Administration
- WB Webinar: The Menopause Transition and Work
- WB Website
- WB Newsletter
- WB X: @WB_DOL
- WB LinkedIn

Resources Shared by the Mayo Clinic

- The North American Menopause Society
- Find a Menopause Practitioner

Resources Shared by Coastal CARE Clinics

- **Early menopause in acquired immunodeficiency syndrome.** Mohamed Hassan Ahmed, Sophie Bondje, Riyah Jiwan, Fathima Rawther, Adelaide Duku, Nazik Elmalaika Husain, Clare Woodward, and Dushyant Mital J Res Med Sci. 2021; 26: 122. Published online 2021 Dec 22. doi: 10.4103/jrms.JRMS_691_19
- **Gynecologic issues in the HIV-infected woman.** Helen E. Cejtin, M.D. Infect Dis Clin North Am. Author manuscript; available in PMC 2009 Dec 1. Published in final edited form as: Infect Dis Clin North Am. 2008 Dec; 22(4): 709–vii. doi: 10.1016/j.idc.2008.05.006 PMCID: PMC2649024 NIHMSID: NIHMS79157 PMID: 18954760
- **Menopause and HIV**. www.thewellproject.org. Last updated February 5, 2024.

The Impact of Menopause on Women: Considerations for Health Care and the Workplace June 4, 2024, 2:00 – 3:00 pm EST
Transcript

Helenka Ostrum: Welcome everyone. Thank you for joining today's webinar, “The Impact of Menopause on Women: Considerations for Health Care and the Workplace.”

Helenka Ostrum: My name is Helenka Ostrum, and I am a Public Health Analyst with the Health Resources and Services Administration, or HRSA, in the Office of Women's Health.

Helenka Ostrum: Please introduce yourselves in the chat with your name and organization. I will now turn it over to Bethany Applebaum, the Acting Director of the HRSA Office of Women's Health.

Bethany Applebaum: Good afternoon, everyone and welcome to today's event, “The Impact of Menopause on Women: Considerations for Health Care and the Workplace.”

Bethany Applebaum: My name is Bethany Applebaum and I'm the Acting Director of the HRSA Office of Women's Health.

Bethany Applebaum: This webinar was developed in collaboration with our colleagues at the Department of Labor's Women's Bureau and as part of the Office of Women's Health’s Leadership Series, which features public health experts including HRSA grantees and stakeholders, spotlighting emerging issues and innovations in women's health across the lifespan.

Bethany Applebaum: Before we get started with today's speakers, I want to briefly share a bit about my agency for those of you who might be unfamiliar with our work.

Bethany Applebaum: The Health Resources and Services Administration, or HRSA, is a component of the US Department of Health and Human Services.

Bethany Applebaum: We support a broad range of programs to provide healthcare to people who are geographically isolated and economically or medically vulnerable.

Bethany Applebaum: Every year, HRSA programs support tens of millions of people. Including those with low incomes, people with HIV, pregnant people, children, parents, rural communities, transplant patients, and other communities in need.

Bethany Applebaum: As well as the health workforce, health systems and facilities that care for them.

Bethany Applebaum: Within HRSA, my office, HRSA OWH, leads and promotes innovative sex and gender-responsive public health approaches.

Bethany Applebaum: We are part of a network of women's health offices throughout the Department of Health and Human Services.

Bethany Applebaum: And we work together with our colleagues to improve the health, wellness, and safety of women across the lifespan.

Bethany Applebaum: Today's webinar will focus on menopause, which is currently a popular topic in women's health.

Bethany Applebaum: All women will experience menopause, but there's still a lot of stigma around discussing symptoms, impacts on day-to-day life, and treatment options.

Bethany Applebaum: Our goal with today's webinar is to raise awareness of these issues.

Bethany Applebaum: Menopause is a normal part of a woman's life. It does not happen all at once and the transition to menopause, known as perimenopause, usually starts in a woman's mid-to-late 40s.

Bethany Applebaum: On average, women are in perimenopause for about four years before their periods stop.

Bethany Applebaum: And the average age for menopause in the United States is 52. The hormone fluctuations during this time can cause a variety of symptoms.

Bethany Applebaum: Including sleep issues, hot flashes, irregular cycles, and more, that greatly impact the quality of life for women.

Bethany Applebaum: Changes in the body in the years around menopause may also increase the risk for certain health problems.

Bethany Applebaum: So, for example, low levels of estrogen and other changes related to aging can raise, excuse me, the risk of heart disease, stroke, and osteoporosis.

Bethany Applebaum: For today's program, we'll start from hearing from the US Department of Labor's Women's Bureau, our wonderful partners in organizing this webinar, about worker rights and workplace accommodations for women experiencing menopause.

Bethany Applebaum: Then we'll hear from two physicians about treating women who are going through menopause.

Bethany Applebaum: And we've set aside a few minutes for questions at the end. So please use the Q&A box to raise any questions throughout today's presentation.

Bethany Applebaum: The presentation and transcript will be made available on the OWH website after today's event. Thank you again for joining us today and I will now turn it back to Helenka, who will introduce our next speaker.

Helenka Ostrum: Thank you Bethany. It's my pleasure to introduce our next speaker. Tiffany Boiman has been with the Women's Bureau since 2014 and currently serves as Deputy Director.

Helenka Ostrum: She brings experience working in the area of gender and working women's issues and a background in research and evaluation, policy analysis, and strategic planning.

Helenka Ostrum: Prior to joining the Women's Bureau, she held positions with the Institute for Women's Policy Research, WomenWork, the National Governors Association Center for Best Practices, and the US Government Accountability Office.

Helenka Ostrum: She holds a Master of Public Policy from the Harvard Kennedy School.

Tiffany Boiman: Thanks so much, Helenka. I'm so thrilled to be joining this panel today with a distinguished group of speakers on a really important topic.

Tiffany Boiman: Next slide, please.

Tiffany Boiman: So, I thought I would start out by just giving folks a brief overview of kind of who we are and what we do here at the Women's Bureau because many people are not already familiar with us.

Tiffany Boiman: Essentially, we champion policies and standards that safeguard the interests of working women. We advocate for equality and economic security of women and their families and promote quality work environments.

Tiffany Boiman: And we were established on June 5, 1920, so our 104th birthday is tomorrow. And we are the only federal agency mandated to represent the needs of wage-earning women.

Tiffany Boiman: We accomplish our mission a couple of ways. Through a variety of research and policy analysis, grant making, and education and outreach.

Tiffany Boiman: And our focus areas at this point in time include eliminating the persistent gender wage gap, reducing caregiving penalties for women and low-paid workers, and eliminating gender-based violence and harassment and discrimination in the world of work.

Tiffany Boiman: Next slide, please.

Tiffany Boiman: So, Bethany has already given us a brief overview of menopause and what it is, but I want to highlight a few key points that I think have particular relevance for working women.

Tiffany Boiman: As we heard, for most people the menopause transition happens sometime in their 40s and this is a time when women are statistically likely to be employed.

Tiffany Boiman: To put this in context, there are about 15.5 million women between the ages of 45 and 54 in the labor force which is about 9.2% of the total labor force.

Tiffany Boiman: And that of course does not include all the menstruators outside this group who can experience the menopause transition and related symptoms.

Tiffany Boiman: We know that menopause can come with a variety of different symptoms. And I want to mention a few that can impact people at work in particular.

Tiffany Boiman: Things like changes to periods, including irregular or heavy bleeding, hot flashes, bladder control issues, physical changes.

Tiffany Boiman: Sleep disruptions that have impacts during the day, mood changes, anxiety and depression, and brain fog and memory problems.

Tiffany Boiman: And it's important, I think, to note that while every individual's experience is different, research suggests that black women are more likely than white women to go through early menopause and report greater vasomotor symptoms, like hot flashes and night sweats.

Tiffany Boiman: So not everybody experiences this transition in the same way. Next slide, please.

Tiffany Boiman: So, I already talked briefly about some statistics about women in the labor force, but I want to look at some trends that I think will be important context setters for the rest of this discussion.

Tiffany Boiman: Since the US first began analyzing women's employment trends in the late 1940s, women's share of the labor force has grown materially from 28.6% to nearly half at 46.8% today and you can see that in the chart here. Next slide, please.

Tiffany Boiman: And older women workers are really important component of that. Not only are they a growing share of the workforce, but increasingly women are staying in the workforce longer.

Tiffany Boiman: The number of women 55 and older in the US workforce has almost tripled in the last 40 years, from about 6 million in 1980 to 18 million in 2021.

Tiffany Boiman: So now more than one in 10 US workers are women ages 55 and older. And this means the menopause transition is not stopping the majority of women from participating in the workforce, but rather that policymakers and employers should understand that women are a critical group of workers who are consistently participating in the workforce as they age.

Tiffany Boiman: And so, these quality-of-life issues during their workday are important ones that we need to consider. We should be providing supports to ensure that they can fully participate while maintaining the dignity that all workers deserve.

Tiffany Boiman: Next slide, please.

Tiffany Boiman: And while I think we would all like to live in a world where employers and policymakers provide support because it's the right thing to do, sometimes we need to make the business case for why these supports are needed.

Tiffany Boiman: The first argument we would make is that policymakers and employers have taken steps to address how some life events that women commonly experience like pregnancy, childbirth, and related medical conditions may affect their work life.

Tiffany Boiman: Some examples of this include mandating employers to provide rooms to pump breastmilk, providing paid maternity leave, and allowing flexible work arrangements during pregnancy or to accommodate caregiving.

Tiffany Boiman: The next argument is that some people experiencing menopause symptoms, particularly if they're severe, may have to make difficult decisions about work such as cutting back hours, leaving jobs or even retiring early.

Tiffany Boiman: While again the data shows us that most women are not leaving their jobs because of perimenopause or menopause, women are still a critical facet of our economy who are concentrated in some of our most essential sectors, like healthcare and care work.

Tiffany Boiman: And losing women or having women not be able to fully participate will weaken the economy and employers in the long run.

Tiffany Boiman: The evidence base on the impact of the menopause transition on the economy is still growing, including a recent Mayo clinic study that I know Dr. Faubion will discuss.

Tiffany Boiman: There's evidence that symptoms of menopause are causing women to miss work, some women, and that has a cost to employers and the broader economy.

Tiffany Boiman: Finally, providing more support is popular among employers and employees alike. And we see this born out in representative survey data.

Tiffany Boiman: A recent AARP study of employers and women ages 35 and older found that 73% of employers and 54% of female employees agree that employers should be doing more to support women going through menopause.

Tiffany Boiman: In another recent study that came out in the Journal of the Menopause Society found that a high percentage of women workers, over 60%, would like workplace measures related to menopause but very few had seen those implemented in their workplaces, less than 7%.

Tiffany Boiman: And yet menopause is still not being discussed enough. In that same AARP study that I mentioned a minute ago, 31% of employers and 38% of employees say that menopause is not discussed at work.

Tiffany Boiman: Next slide, please.

Tiffany Boiman: So, I've talked about the business case for supporting workers through menopause, which is largely reliant on voluntary employer practice.

Tiffany Boiman: But before we talk more about things that employers can do voluntarily to provide support, I also want to lay out the legal framework that already exists.

Tiffany Boiman: This information comes from our colleagues at the Equal Employment Opportunity Commission and the Department of Labor's Wage and Hour Division, and Occupational and Safety and Health Administration who enforced the laws that I'm going to talk about.

Tiffany Boiman: And if you have more questions, I urge you to reach out to them and there are links to some resources at the end of my slides.

Tiffany Boiman: Though US federal law currently does not explicitly protect against discrimination based on menopause, in certain cases, employees may be protected under laws and regulations that prohibit employment discrimination, including harassment on the basis of age, sex, disability, or a combination of these characteristics.

Tiffany Boiman: So, while menopause is not a disability per se under federal disability discrimination laws, medical conditions related to menopause may be disabilities under these laws if they meet the legal definition.

Tiffany Boiman: So, applicants and employers with disabilities have the right to request reasonable accommodations if needed. They're also protected from retaliation for requesting a reasonable accommodation, for filing an employment discrimination complaint, participating in an employment discrimination proceeding such as mediation, investigation, or a lawsuit, or reasonably opposing employment discrimination.

Tiffany Boiman: In some cases, individuals experiencing severe symptoms of the menopause transition may qualify for leave under the Family and Medical Leave Act.

Tiffany Boiman: Employees may also be covered by sick leave requirements for federal contractors. Or paid family and medical leave under state laws that can be used for menstruation or menopause related reasons.

Tiffany Boiman: And lastly, Occupational Safety and Health Administration enforces sanitation standards that require access to water and sanitation facilities.

Tiffany Boiman: Next slide, please.

Tiffany Boiman: So, I want to turn to some kind of common-sense suggestions of workplace flexibilities and accommodations that can be helpful for people going through menopause that employers can implement either to meet their legal requirements that I just outlined or going beyond what is required in terms of voluntary employer practice.

Tiffany Boiman: They include some things like scheduling and work flexibilities such as telework. Flexible work hours or shift accommodations.

Tiffany Boiman: Access to temperature controls or ventilation like fans and windows that can be opened. Uniforms made of breathable fabric with options in dark colors.

Tiffany Boiman: Flexibility with layering different articles of clothing that can be removed or added. Opportunities to change clothes during work hours.

Tiffany Boiman: Access to bathrooms, including at an increased frequency. And sufficient supply of varied period products in bathrooms.

Tiffany Boiman: And you'll notice that many of these things are also helpful for people not going through menopause, highlighting the fact that making workplaces more menopause friendly can be a benefit for everyone.

Tiffany Boiman: Next slide, please.

Tiffany Boiman: There are also some other helpful policies that I want to mention. Things like explicitly citing menstruation and menopause as allowable reasons to take sick leave.

Tiffany Boiman: In other words, just making people explicitly aware of the benefits that they have. Training workers and managers on best practice and policy.

Tiffany Boiman: Including support services for menstruation and menopause in employee assistance programs. And ensuring coverage for menstruation and menopause management and treatments in employer-sponsored health insurance are all things that we can do in workplaces to make that transition a little easier.

Tiffany Boiman: Next slide, please.

Tiffany Boiman: So, like I mentioned, we included some links to some potentially helpful resources here. And I know these slides will also be made available after the fact.

Tiffany Boiman: The Women's Bureau is also getting ready to publish a fact sheet that we're very excited about that includes a lot of the information that I've covered here today.

Tiffany Boiman: And if you're interested, you'll be able to find it on our website soon. And we encourage you to follow our newsletter so that you'll be notified right away when it's published.

Tiffany Boiman: Next slide, please. Again, I want to say thanks for being included in this webinar today and I hope this information was helpful and I'm happy to take any questions today and obviously feel free to email us after the fact if you'd like to discuss this more.

Tiffany Boiman: Thanks so much.

Helenka Ostrum: Thank you so much for that presentation. I'd now like to introduce Dr. Faubion.

Helenka Ostrum: Dr. Faubion is Professor and Chair of the Department of Medicine at the Mayo Clinic in Jacksonville, Florida, Director of the Mayo Clinic Center for Women's Health and the Medical Director of the Menopause Society.

Helenka Ostrum: She is the author of The New Rules of Menopause, a Mayo Clinic Guide to Perimenopause and Beyond.

Helenka Ostrum: She is an innovator in women's health and aims to better serve women in the menopause transition and beyond.

Helenka Ostrum: I'll now turn it over to Dr. Faubion.

Dr. Stephanie Faubion: Hi there. Thanks so much for having me today. Today, as you know, we're talking about menopause and work.

Dr. Stephanie Faubion: And I'm specifically discussing some impact, challenges, and opportunities. Next slide.

Dr. Stephanie Faubion: I have no disclosures, next slide.

Dr. Stephanie Faubion: So, we're going to work on explaining the potential impact of menopause symptoms in the workplace and discuss opportunities for implementation of workplace policies to accommodate women with menopause symptoms.

Dr. Stephanie Faubion: Next slide.

Dr. Stephanie Faubion: The background is, and you've already heard this, menopause is a universal experience for 51% of the world's population.

Dr. Stephanie Faubion: You've also heard that the mean age at menopause is 52 years and is defined by no menstrual cycle for 12 months.

Dr. Stephanie Faubion: But the normal age of menopause is much greater than just that 52 number. It everything after age 45 is considered normal and about 90 or 95% of us have gone through menopause by the age of 55 or so.

Dr. Stephanie Faubion: In addition, women experience these menopause symptoms well before their last menstrual period, even 6 to 10 years before they have their last menstrual period.

Dr. Stephanie Faubion: So, this is not a single day or a single year even. We also know that women drive the global economy and are a vital part of the global workforce as you've already heard.

Dr. Stephanie Faubion: Next slide, please.

Dr. Stephanie Faubion: Menopause symptoms are incredibly common. We know that about 75% of women report hot flashes and night sweats.

Dr. Stephanie Faubion: Again, these can occur even before the last menstrual cycle occurs and even before women start to skip their periods.

Dr. Stephanie Faubion: So even before there's a significant variation in their monthly cycle month to month. There are also racial and ethnic differences with women of color, experiencing more severe symptoms and symptoms that start earlier.

Dr. Stephanie Faubion: So, well before the last menstrual period, the symptoms can also last longer, about 10 years on average for black women.

Dr. Stephanie Faubion: We also know that hormone therapy prescribing rates and hormone therapy is the most effective therapy for menopause symptoms.

Dr. Stephanie Faubion: These rates of prescribing are quite low. They were roughly 40% of women were using hormone therapy before the results of the women's health initiative study were published in 2002 but those have fallen now to 4 to 6%, the last data published on that were in 2012 so we have a gap with regard to current information.

Dr. Stephanie Faubion: Next slide.

Dr. Stephanie Faubion: You've also heard that menopause symptoms can impact women at work and it's not just the hot flashes, it's the fact that women aren't sleeping well.

Dr. Stephanie Faubion: There are also night sweats which are contributing to the sleep disturbance. Mood changes appear to be some of them more bothersome symptoms to women with regard to the workplace.

Dr. Stephanie Faubion: Women also report something called brain fog, this can be difficulty with concentration, memory recall, and genitourinary symptoms.

Dr. Stephanie Faubion: So urinary frequency, urinary urgency, increased risk of urinary tract infections, also vaginal dryness, which is not just applicable during sex, it even impacts women's ability to sit or wipe with toilet paper when going to the bathroom.

Dr. Stephanie Faubion: Next slide.

Dr. Stephanie Faubion: We also know that menopause symptoms impact women at work, as you've heard. There have been associations with lower hourly and lower annual productivity.

Dr. Stephanie Faubion: Lower work performance was associated with a greater number of menopause symptoms. Greater rates of presenteeism.

Dr. Stephanie Faubion: That means you show up at work when you probably shouldn't have shown up at work or you're much less productive at work, likelihood of exiting employment.

Dr. Stephanie Faubion: Or reducing your hours at work, increased risk of unemployment, and there was a dollar figure of two billion a year in lost productivity related to new onset sleep symptoms of midlife women.

Dr. Stephanie Faubion: Then a UK study with similar findings also noted that the occupation type and the physical requirement of the job didn't influence the results.

Dr. Stephanie Faubion: So, in other words, it didn't really matter if you were a physical laborer or working in an office, menopause symptoms were equally bothersome.

Dr. Stephanie Faubion: Next slide.

Dr. Stephanie Faubion: It's really interesting to note that this relationship between work and menopause symptoms may be a two-way street.

Dr. Stephanie Faubion: We know there are certain aspects of work that influence the experience of menopause. For example, some of the psychosocial and physical aspects of work and the workplace may influence menopause symptom burden.

Dr. Stephanie Faubion: Next slide.

Dr. Stephanie Faubion: There was a recent systematic review of 12 studies from multiple countries involving over 15,000 women that showed that menopause symptoms and environmental factors predicted poor quality of life in the workplace.

Dr. Stephanie Faubion: And the things that they called out were working in confined crowded spaces, high levels of noise, poor workstation design, unstable work patterns like constant interruptions, and insufficient restroom facilities as the reasons for the poor quality of life at work.

Dr. Stephanie Faubion: Next slide.

Dr. Stephanie Faubion: We also know that there are economic consequences to lost work productivity. Number one, it costs the healthcare system more.

Dr. Stephanie Faubion: A previous study by Phil Sarrel estimated that the direct medical costs are higher in women in menopause.

Dr. Stephanie Faubion: There are more visits, more doctors visits annually. And the rate he quoted, adjusted for inflation, is about $1,350 per year per woman.

Dr. Stephanie Faubion: There are also adverse consequences to employers and company. They're losing valuable workers. The human capital loss during this time is incredible.

Dr. Stephanie Faubion: Women also have lost opportunities for advancement and financial insecurity. And I personally think this is a reason for the leaky leadership pipeline that we see in midlife women.

Dr. Stephanie Faubion: And then to society in general. This is a huge, huge impact across the globe.

Dr. Stephanie Faubion: Next slide.

Dr. Stephanie Faubion: As referred to previously, we did a Mayo Clinic study that was published just last year and looking at over 5,000 employed women.

Dr. Stephanie Faubion: They were reporting that they were actually missing days of work specifically related to menopause symptoms and about a 11% of them were missing days of work.

Dr. Stephanie Faubion: This equates to about 1.8 billion dollars annually in lost revenues. And when you combine that with the estimated medical costs per year per woman that we were talking about the net cost is about 28 billion dollars annually to the US alone.

Dr. Stephanie Faubion: Next slide. Please.

Dr. Stephanie Faubion: So, considerations for workplace policies. Next slide.

Dr. Stephanie Faubion: A Mercer report published just last year was very interesting and the blue line is services or coverage provided by the employer and the blue slash pink one on the bottom is what women felt would be helpful to themselves or their families.

Dr. Stephanie Faubion: You'll see the biggest gap in in what was being provided to them by their employers and what they wanted was in preventive cancer screenings, but you'll also notice that menopause support had quite a large gap with 17% of employers providing something and 42% of women asking for something.

Dr. Stephanie Faubion: We know that roughly 15% of employers with 500 employees or greater either currently have or plan to have in 2024 a menopause work policy that provides some sort of benefits and coverage for menopause services.

Dr. Stephanie Faubion: Next slide, please.

Dr. Stephanie Faubion: So, the Menopause Society, which you've heard, I'm in the medical director for, is also working to publish a menopause in the workplace consensus recommendation.

Dr. Stephanie Faubion: This will be published in August. It will also have a MenoNote associated with it, which is a patient-facing companion piece.

Dr. Stephanie Faubion: That will guide women on recommendations for menopause in the workplace. Next slide.

Dr. Stephanie Faubion: So, some of the things that we have suggested inside this consensus recommendation are things for employers to do. You've already heard some of this today.

Dr. Stephanie Faubion: But we have suggested that employers should evaluate existing workplace policies and health care plans, provide education and training to managers and supervisors on menopause.

Dr. Stephanie Faubion: Ensure that all employees are aware of their workplace policies and offerings and health care coverage that are available to them.

Dr. Stephanie Faubion: And then of course provide access to restrooms with sanitary products. Access to cold water and flexibility in terms of work breaks, scheduling, dress policy, and options for hybrid or remote work.

Dr. Stephanie Faubion: And temperature control. Next slide.

Dr. Stephanie Faubion: What should women employees know or do? They should be able to seek information on menopause to help navigate their menopause experience.

Dr. Stephanie Faubion: They could contact their HR or occupational health departments to identify their workplace policies and resources available for menopause symptoms, understanding that not all of them will be menopause-specific.

Dr. Stephanie Faubion: And this is important. So, it's not that employers need to necessarily recreate the wheel. We don't need a specific mental health menopause policy.

Dr. Stephanie Faubion: But there are usually existing mental health policies that employees have, or employers have. So, I think a lot of this can be a sort of adaptation of existing policies.

Dr. Stephanie Faubion: Women can also consider starting or joining an employee resource group and they need to understand federal and state laws that will provide them rights and protections.

Dr. Stephanie Faubion: Next slide.

Dr. Stephanie Faubion: This is important. What should occupational health professionals know or do? I know that I didn't get any menopause management education when I was a medical school or residency for that matter.

Dr. Stephanie Faubion: And we published the study a couple of years ago in 2019 where we assessed residents graduating from programs in internal medicine, OB/GYN, and family

medicine across the country and the most that was reported in terms of menopause education was one to two hours and most residents didn't get more than that.

Dr. Stephanie Faubion: And the majority of the residents surveyed at all levels of residency felt that they were unprepared to manage menopause symptoms when they got out of training.

Dr. Stephanie Faubion: I don't think that's changed significantly so we have a serious gap in terms of education of medical professionals.

Dr. Stephanie Faubion: And this has led to a lack of management of menopause symptoms in general. So occupational health professionals should routinely ask about menopause symptoms and assess the effect on quality of life and work performance.

Dr. Stephanie Faubion: They should have a working knowledge of menopause, the effects of menopause on work. And of the workplace on menopause symptoms and well-being, as well as the therapeutic options available for management of symptoms related to menopause.

Dr. Stephanie Faubion: And they should know where to refer women for specialized menopause care. There is a website, our website, Menopause.org has a locate a provider tab.

Dr. Stephanie Faubion: So, that medical professionals and women can identify those who have a certification in menopause specifically.

Dr. Stephanie Faubion: Next slide.

Dr. Stephanie Faubion: So, we are starting a workplace certification program that will launch this fall, which will consist of a free employee toolkit with resources, FAQs, conversation guides.

Dr. Stephanie Faubion: Suggestions for examining policies and adaptation, expansion, or creation of new policies, a checklist of workplace conditions, and examples of flexible work agreements.

Dr. Stephanie Faubion: And a recognition seal of approval, there will probably be a tiered approach to this as well and we hope to get this together and up and running by about October.

Dr. Stephanie Faubion: Next slide.

Dr. Stephanie Faubion: So, conclusions, menopause symptoms can adversely impact women in the workplace. We know women are a vital part of the global workforce and economy.

Dr. Stephanie Faubion: The cost to women, the healthcare system, employers and society in general are quite staggering. And there's a critical need to improve the medical treatment provided to women with menopause symptoms and an opportunity to make the workplace environment more supportive.

Dr. Stephanie Faubion: For women going through this universal life stage. Next slide.

Dr. Stephanie Faubion: Thank you very much and I look forward to questions at the end.

Helenka Ostrum: Thank you so much for that presentation, Dr. Faubion. It's my pleasure now to introduce Dr. Hagins.

Helenka Ostrum: Dr. Hagins is an in-the-trenches frontline physician who has dedicated the entirety of her thirty-plus year medical career to serving and caring for some of our nation's most vulnerable persons, especially persons living with HIV.

Helenka Ostrum: Dr. Hagins, I'll turn it over to you.

Dr. Debbie Hagins: Thank you so much. I am still excited about this presentation. And again, welcome to everyone. I have no disclosures. I didn't put that slide in.

Dr. Debbie Hagins: So, the topic is menopause in the cisgender HIV positive woman, the journey continues.

Dr. Debbie Hagins: And I was pleased as I looked at the number of participants that there were a number of males on this call, and I don't know how many of you all treat women living with HIV.

Dr. Debbie Hagins: But I have been an educator for more than 30, 30+ years.

Dr. Debbie Hagins: And I use the word cis gender because these are women who were assigned female at birth and then self-identify as female.

Dr. Debbie Hagins: And there isn't much information on transgender men who are still physiologically and biologically women who have ovaries and uterus. So, I wanted to focus on those women that we would consider assigned sex at birth as women and then identify.

Dr. Debbie Hagins: So, the journey does continue and as it has already been stated, every female who makes it into adulthood who does not have a surgical intervention will experience menopause. And menopause is a journey, it doesn't just happen overnight. Next slide.

Dr. Debbie Hagins: So, we already had discussed about the perimenopausal period which can occur several years before the actual complete cessation of menses.

Dr. Debbie Hagins: But in the HIV positive women, they will frequently report that they are noticing changes in their menstrual cycle prior to the onset of menopause.

Dr. Debbie Hagins: So, in this unique population of individuals, menstrual dysfunction, which can mean irregular menses, menorrhagia, menometrorrhagia, or extended periods of amenorrhea occur.

Dr. Debbie Hagins: Some of these symptoms are associated directly with HIV, but many of them are not. I put this picture in here to talk about the importance of lifestyle choices.

Dr. Debbie Hagins: And a woman living with HIV is first still a woman. And we should view them in that way and not focus so much on the disease itself.

Dr. Debbie Hagins: And while these women are also dealing with the diagnosis of HIV, as they age, they tend to have other comorbidities associated with other chronic illnesses, such as you know hypertension, diabetes, dyslipidemia but smoking, exercise, family history, the use of

illicit or recreational drugs also contribute to perimenopausal symptoms before the actual onset of menopause.

Dr. Debbie Hagins: Next slide.

Dr. Debbie Hagins: So early menopause is associated with women living with HIV. And early menopause, though not well understood, can sometimes be defined as having the complete cessation of menses prior to the age of 40.

Dr. Debbie Hagins: But some people use the change, the term interchangeably just to occur between 40 and 45.

Dr. Debbie Hagins: But there were many, many studies that I came across as I was researching this very, very interesting topic.

Dr. Debbie Hagins: That menopause does tend to occur about five years earlier in women living with HIV compared to their HIV negative counterparts.

Dr. Debbie Hagins: And one of the questions that was raised, when we are evaluating people living with HIV. Should there be a different criteria in establishing the definition?

Dr. Debbie Hagins: In HIV positive women it has been observed that when they have not had a period for as much as 12 months and then you measure hormone levels, particularly FSH.

Dr. Debbie Hagins: Those levels may still be normal. Which is inconsistent sometimes, of course, with a diagnosis of menopause.

Dr. Debbie Hagins: And then, so we have to at least then make a more educated decision about how we're going to approach this woman.

Dr. Debbie Hagins: It is estimated that early menopause occurs at a prevalence of 8 to 12%. I'm sorry that incidence is 8 to 12% in women living with HIV each year and a prevalence as high as 27% when you just look at a cross-sectional view.

Dr. Debbie Hagins: Now, we don't look at the anti-Mullerian hormone. This is a term that I came across doing my research and it is a test that I do not order.

Dr. Debbie Hagins: But I found out that it is sometime identified as the biomarker of gonadal aging and ovarian reserve.

Dr. Debbie Hagins: Now, AMH is sometimes used, you know, when a woman presents for a fertility workup. It also is used sometimes when there is an ovarian mass or tumor and there is measuring in response to treatment.

Dr. Debbie Hagins: Well, in women living with HIV, in who were being studied for menopause and early menopause onset, these levels were obtained.

Dr. Debbie Hagins: And they were found to be lower in women who have HIV. And when you have lower AMH levels, you also have higher levels of inhibition.

Dr. Debbie Hagins: I'm sorry, of inhibin. Which also contributes to lower levels of estrogen being produced, of course then which contributes itself more to the onset of the vasomotor symptoms that we so commonly have experienced and listen to in women living with HIV.

Dr. Debbie Hagins: So, while one study, this suggested HIV positivity is linked to premature ovarian insufficiency, the data is inconclusive across multiple studies.

Dr. Debbie Hagins: Next slide. So, I think about this slide. And as I was thinking about this slide this morning about why do women living with HIV experience the earlier onset of menopause than their HIV negative counterparts.

Dr. Debbie Hagins: I thought about how myself, okay, would drive a car.

Dr. Debbie Hagins: I know how to crank it, but I've shifted gears, but I don't always know what's going on underneath the hood.

Dr. Debbie Hagins: And why am I hearing a funny noise? Or why won't my car start? Is it the battery?

Dr. Debbie Hagins: Is it the alternator? I don't know what it is, you know. So, we try to at least understand what are some of the factors that may be contributing to early menopause in women living with HIV.

Dr. Debbie Hagins: So that we can either reduce or delay the onset of menopause and the consequences that come with it.

Dr. Debbie Hagins: Now I heard in our previous presentations that, you know, the symptoms of associated with menopause can certainly be mild and very tolerable.

Dr. Debbie Hagins: But for some women, they can be severe. And I was very impressed with the information shared on lost productivity.

Dr. Debbie Hagins: The impact that women experienced who were not able to go to work because of the menopause symptoms.

Dr. Debbie Hagins: And of course, in my mind, I can think of some very, very extreme cases of women experiencing menopause with symptoms who just simply could not function, do their day-to-day work.

Dr. Debbie Hagins: They couldn't pay their bills. They could not manage their businesses. And I remember one of my colleagues talking about having brain fog and that she was going to have to do something to get her through this process.

Dr. Debbie Hagins: So, we've already heard about the differences by race and why we heard that the average age of menopause in America or in North America is 52. It is 52 in white women.

Dr. Debbie Hagins: In African American women it may be two years earlier and Asian women and Latina women, it can also differ.

Dr. Debbie Hagins: I even read that in women who live in rural communities sometimes have the onset of menopause earlier than women living in urban settings and women who live at higher altitudes.

Dr. Debbie Hagins: Their menstrual cycles as well as the onset of menopause can be influenced by where they live.

Dr. Debbie Hagins: It is not just one particular thing. In the woman living with HIV, the stage of her disease also can influence or contribute to not only early menopause but also menstrual irregularities.

Dr. Debbie Hagins: Not only does a T-cell count less than 200, which of course defines them as AIDS, but women who have more advanced disease have T-cell counts less than 50.

Dr. Debbie Hagins: And typically, when we meet in or encounter women who have low T-cell count, they also have wasting, low BMIs.

Dr. Debbie Hagins: They have low muscle mass. And even the women who were HIV negative, we know that women who have eating disorders, who are underweight, also can experience menstrual irregularities or amenorrhea.

Dr. Debbie Hagins: Having been a co-infecting with Hepatitis B and C, which we would not typically associate with early onset of menopause but in women who have HIV they already have one chronic viral infection.

Dr. Debbie Hagins: Now if they're dealing with Hep B or Hep C, they now have two or three and those individuals who have what we call the trifecta.

Dr. Debbie Hagins: That are also having an influence on hormone axes in the woman's body. Now, treatment, the drug that we use can be a contributing factor to the onset of early menopause in women living with HIV. But as we have made significant advances in antiretroviral therapy.

Dr. Debbie Hagins: We see less of an impact on drug-drug interaction with some of these medications. Now we do have some case studies.

Dr. Debbie Hagins: That show certain classes of medicines have had an impact on the menstrual irregularities in women living with HIV, especially in our adolescence.

Dr. Debbie Hagins: And we have to at least look at the risk and benefits. That if we do nothing to treat the underlying illness of HIV, which we know we need to treat.

Dr. Debbie Hagins: Then we have to be prepared to at least recognize that medications that are used to treat HIV may have some contributing factor to onset of early menopause.

Dr. Debbie Hagins: I've already talked about low BMI and that's not just for women living with HIV.

Dr. Debbie Hagins: That's in any woman. And I think about women who are very athletic, who certainly have greater muscle mass, how they also experience muscle.

Dr. Debbie Hagins: They also experience a menstrual irregularity. That when we talk about women who are living with HIV, remember what I said that these are still women.

Dr. Debbie Hagins: They are women first. And many women who are living with HIV, unfortunately because of the disproportionate impact HIV has in our country and abroad, socioeconomic status.

Dr. Debbie Hagins: So, they have found that women who experienced earlier menopause do tend to be poorer, have less education, and therefore have poor nutrition, and have lifestyle behaviors that are not consistent with what we consider healthy.

Dr. Debbie Hagins: More of them smoke, some of them are on illicit drugs, but many of them sometimes have psychiatric illnesses, whether it is depression.

Dr. Debbie Hagins: Or they have bipolar disorders. Or other mental illness that do require the prescription of psychotherapeutic drugs or psychotropic drugs. And psychotropic drugs can also influence early onset of menopause and menopausal symptoms.

Dr. Debbie Hagins: And you see I have here our antiepileptic drugs as well as chemotherapy and radiation for women who are advanced in age and who've also undergone treatment.

Dr. Debbie Hagins: Either while they have HIV or prior to the diagnosis and of course the infection with HIV.

Dr. Debbie Hagins: So, we have to look at other endocrine disorders, because you know menstruation is influenced of course by hormones.

Dr. Debbie Hagins: And we have these axes that come from the ovaries and the adrenal gland and the pituitary.

Dr. Debbie Hagins: So, there are other endocrine disorders that can have a negative impact on menstrual symptoms in women, but in women with HIV as well.

Dr. Debbie Hagins: And I put these on here because we don't always want to just zero in on HIV and we blame everything on HIV and medication, but to do our due diligence as providers.

Dr. Debbie Hagins: So, all immune disorders such as lupus and Sjogren's, rheumatoid arthritis, Cushing's disease, we see these things in women living with HIV.

Dr. Debbie Hagins: And sometimes they have these diagnosis prior to the infection and sometimes they are diagnosed after they acquire HIV because we know that women who present with advanced HIV disease

Dr. Debbie Hagins: Can have what is called an immune reconstitution reaction or have a delay in the manifestation of an autoimmune disorder.

Dr. Debbie Hagins: That may have been present at the time, but because of suppressed immune function, the symptoms didn't manifest themselves.

Dr. Debbie Hagins: And then we have to at least be mindful, even though it is not frequent, a genetic cause involving X chromosomes, such as Turner syndrome or Fragile X.

Dr. Debbie Hagins: Next slide.

Dr. Debbie Hagins: So, once we have at least done our due diligence to evaluate a woman living with HIV as she is journeying through the different stages of life.

Dr. Debbie Hagins: And certainly, I've heard the phrases of you know change of life and things like that.

Dr. Debbie Hagins: We have already heard about the impact on cognitive function. Brain fog. I don't remember.

Dr. Debbie Hagins: They can't concentrate. Sleep disturbances. Either they don't sleep enough, or they just feel tired and want to sleep too much.

Dr. Debbie Hagins: But in addition to those things, we talk about decreased reaction speed, psychomotor speed.

Dr. Debbie Hagins: And I think that all of us are concerned about the menopausal woman who is at increased risk of osteopenia and osteoporosis, which then increases the risk of bone fractures.

Dr. Debbie Hagins: And a woman who sustains a bone fracture like any other individual, male or female, especially a hip fracture, has a decreased quality of life.

Dr. Debbie Hagins: Now, when they talk about endothelial function, we're talking about cardiovascular risk assessment, which I've heard in the very first presentation.

Dr. Debbie Hagins: And these of course can be just a comorbidity, such as having cardiovascular disease.

Dr. Debbie Hagins: They have angina, they have PAD, which is peripheral artery disease or stroke, or it can lead to something that has been more fatal.

Dr. Debbie Hagins: And then this third bullet point here about increased rates of mental health concerns. Depression sometimes can be mild to the point that these individuals would just benefit from a counseling session.

Dr. Debbie Hagins: I am not quick to write prescriptions. If we can intervene in a nonpharmacologic fashion because I already have these individuals on antiretroviral therapy.

Dr. Debbie Hagins: And antiretroviral drugs are going to be involving at least two classes of medications with two different mechanisms and sometimes three classes.

Dr. Debbie Hagins: So, I have to be very mindful of that. And because some of our women okay are having issues with the, you know, obesity and hypertension.

Dr. Debbie Hagins: Then we are really dealing sometimes with polypharmacy.

Dr. Debbie Hagins: So, if there is a way, to address some of the symptoms, and we'll talk about that in a later slide, without having to go directly to a prescription then I will have a conversation with that individual.

Dr. Debbie Hagins: And we would have a shared decision making.

Dr. Debbie Hagins: Next slide.

Dr. Debbie Hagins: So, what are the treatment options for women living with HIV who are going through menopause? First, confirm that it is menopause.

Dr. Debbie Hagins: Rule out pregnancy, do the appropriate workup with the appropriate test and then put it in the context of that women's history.

Dr. Debbie Hagins: She had decision making that I've already said you talk to them about the pros and the cons and while hormone replacement therapy is certainly beneficial.

Dr. Debbie Hagins: You know, many women who sometimes get diagnosed with HIV are already in their fifties and sixties, they've already gone through menopause.

Dr. Debbie Hagins: And we can talk about short-term benefits. We can talk about this is an option for you because you know of your heavy smoking history, you've had cancer in the past you know you're a breast cancer survivor, or you've already had a history of a DVT, well we're going to have to find another way.

Dr. Debbie Hagins: And if we do decide to go with hormone replacement therapy, we talk about the route of administration, whether it's going to be a pill, a patch or cream or something like that.

Dr. Debbie Hagins: And sometimes we might offer just a vaginal estrogen cream for women experiencing vaginal dryness in parts and experiencing urinary symptoms related to menopause.

Dr. Debbie Hagins: And then we're talking about non-pharmacologic alternatives.

Dr. Debbie Hagins: Of course, I'm talking about alternative and complementary approaches. And some of those may just be mindfulness, meditation, biofeedback.

Dr. Debbie Hagins: And some of them also include nonprescriptive estrogen, such as plant-based.

Dr. Debbie Hagins: And I have talked to women about their symptoms, first in my women who smoke and have other risk factors where I am not inclined to go with the hormone replacement therapy.

Dr. Debbie Hagins: But we have to do a drug-drug interaction to make certain because some of these herbal compounds can interfere with antiretroviral therapy, thereby lowering their levels in the blood and then contributing to loss of HIV control.

Dr. Debbie Hagins: And in a case like this, I think that an individual should confer with someone who has expertise and is skilled in alternative options.

Dr. Debbie Hagins: I've even read that some women try acupuncture as a way to address some of their symptoms.

Dr. Debbie Hagins: Next slide. So, what are the takeaways? Women with HIV are living longer. So that's the good news.

Dr. Debbie Hagins: And they are living more productive lives and joyful lives. It's even more good news. And even though this is now a chronic condition because of the longevity and the treatment options that we have, the comorbidities are also present in which we did not use to be concerned about because people typically did not live long enough to enter into menopause if they were diagnosed in their twenties.

Dr. Debbie Hagins: But now that the average age of you know the life is expectancy is 50 years and beyond, and for somebody diagnosed in their fifties we want to stress the importance of good lifestyle choices. If you smoke, quit or cut back.

Dr. Debbie Hagins: Get some exercise, be in healthy relationships. But we as providers, we as clinicians need to be more aware that women living with HIV can have early onset of these menopausal symptoms.

Dr. Debbie Hagins: And we certainly need to be able to provide for them additional support, whether it is just emotional support or women support group, just to go talk to a counselor, and I tell my patients that talk therapy sometimes some of the best therapy you can have.

Dr. Debbie Hagins: To go in a place where you were safe to unload because of the stigma that women live with living with HIV.

Dr. Debbie Hagins: The next slide I think is that was the end. Thank you so, so much for this amazing opportunity.

Dr. Debbie Hagins: I've learned a lot and I have aged along with many of the women in this cohort.

Dr. Debbie Hagins: And I think that when we are women, of course, caring for women and we can share in the journey with them through motherhood, you know, menopause, grandmother's working in the workplace, it certainly makes a difference.

Dr. Debbie Hagins: So again, I'm so appreciative of some of the men who have joined this conversation and have joined this dialogue.

Dr. Debbie Hagins: So that concludes my part.

Helenka Ostrum: Thank you so much, Dr. Hagins. We have some time for questions now. And if you have any questions, please use the Q&A feature to type in your questions.

Helenka Ostrum: I see we do have one that was added to the chat. In addition to menopause, I've been hearing more about PCOS lately. I'm curious how PCOS affects menopause. Does it make symptoms worse for non-HIV positive women?

Helenka Ostrum: Does it have an exponentially deleterious effect on HIV positive women going through menopause?

Helenka Ostrum: I'm wondering if any of our providers want to answer that one.

Dr. Debbie Hagins: I'm just going to chime in. Women with HIV, and I know your question was about non-HIV infected women.

Dr. Debbie Hagins: Women with HIV can have PCOS prior to the onset of being diagnosed with HIV. But the women who did not have PCOS diagnosed as teenagers, once they start antiretroviral therapy and be followed, they can develop PCOS.

Dr. Debbie Hagins: And we don't know if it was the HIV medicine that contributed or maybe this individual was just predisposed to developing PCOS. But in terms of the symptoms, I don't know about those. They have fertility issues for certain.

Dr. Stephanie Faubion: Yeah, hi, I'll take that one. We actually had an abstract on this. A couple of years ago at the Menopause Society meeting and haven't published the paper yet, but the symptoms did not appear to be worse in women with PCOS.

Helenka Ostrum: Thank you both. Some questions from the Q&A. Are menopause symptoms like brain fog temporary or a permanent change?

Dr. Stephanie Faubion: Oh, that's a great question. So far, we think they're temporary. They appeared to be just around the menopause transition and that was in the SWAN study.

Dr. Stephanie Faubion: However, a paper published by Pauline Maki about 2 years ago now, she looked at women with HIV and women with chronic conditions in the same cohort.

Dr. Stephanie Faubion: And some women actually did qualify as actually having cognitive impairment and some of those did not seem to rebound after the menopause transition.

Dr. Stephanie Faubion: So, I think we need a little more work into which women are going to have a problem and which have some trouble rebounding after.

Dr. Stephanie Faubion: But the good news is that in general, brain fog around menopause does not predict future risk of dementia or Alzheimer's disease.

Dr. Debbie Hagins: I firmly agree and women living with HIV who do experience cognitive impairment.

Dr. Debbie Hagins: Cognitive impairment can be a result of the HIV disease itself. And if they present with advanced HIV disease, we do mental health assessments on women who, well all patients who come in.

Dr. Debbie Hagins: Who already have impairment before the onset of menopause. But also, they just have a cognitive impairment because of the disease itself.

Dr. Debbie Hagins: And we do understand that HIV can affect the brain. We try to use drugs that cross the blood brain barrier.

Dr. Debbie Hagins: And even though some of them will rebound fully, some never return to a full level of function. Such that they are not able to go back to their careers, if they had the demanding careers such as accountants and business managers.

Dr. Debbie Hagins: Some of them find that they need to go ahead and retire because they can no longer cope with the stress of a demanding job.

Dr. Debbie Hagins: Some people don't want to learn new things. So, I've had individuals who were in a work environment where they began to switch over to computers to work the register or whatever. They were like, oh my gosh, I can't take on trying to learn this new technology.

Dr. Debbie Hagins: I need to do things the old-fashioned way. And just the frustration from that has led them, of course, to stop working earlier than what they would have.

Dr. Debbie Hagins: So, it recovers for some. And for some they improve and some just never return to their baseline.

Dr. Debbie Hagins: I think for the women living without HIV. You know, yes, I mean, I had brain fog when I went through menopause, but I fully recovered, thank goodness.

Helenka Ostrum: Tiffany, I have a question for you. Many of those watching today's webinar are health care professionals.

Helenka Ostrum: Can you talk a little more about why healthcare practitioners should think about the menopause transition as employers and as workers.

Tiffany Boiman: Yeah, that's a great question. Women represent a majority of workers in private health care and social assistance industries.

Tiffany Boiman: 78.8% as of April 2024 and when you dive deeper into individual occupations those numbers can be even higher and that includes workers in all kinds of settings.

Tiffany Boiman: Doctors offices, outpatient care centers, labs, home health services, all kinds of settings that average people come into contact with every day.

Tiffany Boiman: And we know that these occupations are among the fastest growing according to Bureau of Labor Statistics numbers.

Tiffany Boiman: So, for instance, between 2022 and 2032, BLS expects the number of nurse practitioner jobs to grow by 45%, medical and health services managers to grow by 28% and physicians' assistants by 27%.

Tiffany Boiman: And that's just a few. So, when we think about recruitment and retention for these critical jobs, we should be considering all the barriers that could impede either somebody's entry into that line of work or their retention within it.

Tiffany Boiman: And that can include, you know, disruptive symptoms from perimenopause and the menopause transition.

Tiffany Boiman: So, you know, I've talked and everybody on this session has talked about these flexibilities and policies that you know, we know that not every one will work in every

environment. But many of these things can be adapted to be appropriate for most workplace settings.

Tiffany Boiman: So, you know this difference between improving people's quality of life during the day and not, could be the difference in retaining a critical worker.

Helenka Ostrum: Thank you. Now we have a question in our Q&A that is asking about resources. Is there an app for the recommended clinical treatment guidelines for menopausal or perimenopausal women or are there any other resources that we could point any providers to?

Dr. Stephanie Faubion: For hormone therapy?

Helenka Ostrum: It doesn't specify.

Dr. Stephanie Faubion: So, the Menopause Society has published guidelines for hormone therapy. Our last was published in 2022 and for nonhormonal therapies for menopause symptoms, specifically for vasomotor symptoms, published in 2023.

Dr. Stephanie Faubion: And those are both online.

Dr. Debbie Hagins: Yeah, and for women living with HIV or treaters of people that treat women living with HIV, the wellproject.org is a very good source for, you know, information on that topic.

Helenka Ostrum: Thank you. We are right at time. I want to thank you all so much for your time today.

Helenka Ostrum: The link to the webinar recording and the transcript will be posted on the HRSA Office of Women's Health webinar webpage at www.hrsa.gov/office-womens-health/webinars.

Helenka Ostrum: We encourage you to visit www.hrsa.gov and sign up for the HRSA eNews, a bi-weekly email of comprehensive HRSA news.

Helenka Ostrum: Thank you again to our presenters. Have a nice day.

END OF TRANSCRIPT