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Menopause in Brazil: Lived Experiences, Inequities, and Opportunities for Inclusive Care (MARIE-Brazil WP2a)

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Posted Date: 14 October 2025

doi: 10.20944/preprints202510.1062.v1

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Abstract

Background: Menopause, whether natural, surgical, or medically induced, represents a significant transition in women's health, often accompanied by biological, psychological, and social challenges. Despite its global prevalence, evidence on lived experiences across diverse populations remains limited, particularly setting as Brazil. Addressing these knowledge gaps is essential for designing equitable health interventions and informing policy. Methods: The MARIE-Brazil chapter conducted a qualitative study as part of work-package 2a to explore menopausal experiences. A topics guide was used to conduct interviews of participants that were purposively sampled aged 18–99 years that

 doi:10.20944/preprints202510.1062.v1

self-identified as experiencing perimenopause, menopause, or post-menopause. Sampling captured heterogeneity across age, menopausal stage, socio-economic position, ethnicity, and healthcare access. Data were transcribed verbatim, anonymised, and analysed thematically using Braun and Clarke's six-phase approach. To enhance rigour, coding was conducted by multiple researchers, guided by the Delanerolle and Phiri framework, and reporting followed COREQ guidelines. Results: The findings indicate intersecting biological, psychological, socio-cultural, and health system determinants shaping experiences. Participants reported vasomotor symptoms, sleep disturbance, cognitive difficulties, and urogenital changes that influenced quality of life and occupational participation. Barriers to care included limited clinical knowledge, fragmented pathways, and financial inaccessibility of treatments. Cultural stigma, gender norms, and workplace discrimination further exacerbated inequities, particularly among women with multimorbidities or marginalised identities. Conversely, peer networks, supportive clinicians, and targeted interventions improved coping and health outcomes. Conclusion: Menopause is not solely a biological milestone but a multifaceted transition shaped by structural and cultural determinants. Findings highlight urgent needs for inclusive healthcare training, workplace policy reform, and accessible treatment pathways. Incorporating lived experiences into service design and policy frameworks is critical to promoting equity in menopause care across diverse global settings.

Keywords: menopause; brazil; experiences; inequities; opportunities; inclusive care

Background

Menopause in Brazil represents a complex intersection of biological processes, cultural perceptions, and systemic health challenges [1,2]. It is commonly defined as the permanent cessation of menstruation following 12 consecutive months without a menstrual period, and is preceded by the perimenopausal phase characterised by irregular cycles and a wide spectrum of symptoms such as vasomotor instability, sleep disturbances, mood changes, and genitourinary difficulties [3]. While the majority of Brazilian women experience natural menopause around the median age of 49–51 years, the lived experience is highly variable depending on genetics, comorbidities, socioeconomic status, and access to healthcare [4–7]. Surgical menopause, often the result of hysterectomy and bilateral oophorectomy, is also prevalent in Brazil, reflecting both the historically high rates of gynaecological surgery [8]. In addition, medical menopause induced by chemotherapy, radiotherapy, or endocrine therapies in women with cancer or other conditions introduces an abrupt and often more severe transition, with profound psychosocial consequences [9]. Together, these pathways underscore the importance of recognising not only the biological dimensions of menopause but also its broader implications across perimenopause, menopause, and post-menopause in diverse Brazilian contexts.

The epidemiological significance of menopause in Brazil is magnified by demographic transitions [10,11]. Brazil, like much of Latin America, has undergone rapid population ageing, with women constituting a majority in older age groups. Life expectancy for Brazilian women is currently above 78 years [12,13], meaning that a substantial proportion will live more than one third of their lives in post-menopause. This demographic shift carries profound implications for public health planning and national infrastructure. Women over 50 represent a growing share of the Brazilian workforce, particularly in healthcare, education, and informal caregiving sectors, and their productivity is directly influenced by menopausal wellbeing [14]. Poorly managed symptoms may contribute to absenteeism, reduced efficiency, and premature exit from employment, thereby affecting economic growth. At the same time, the burden on healthcare services is amplified, as postmenopausal women face elevated risks of osteoporosis, cardiovascular disease, diabetes, and mental health conditions. Thus, the menopause transition is not only an individual health milestone but also a pressing public health issue with wide-ranging social and economic consequences for Brazil [15,16].

 doi:10.20944/preprints202510.1062.v1

Despite its epidemiological weight, the menopausal landscape in Brazil remains underdeveloped, characterised by fragmented provision, clinical guidelines not incorporated into health care, and sociocultural barriers to care. Awareness of menopause as a health issue is uneven across regions, with urban women generally reporting greater knowledge and healthcare access compared to their rural counterparts [3]. Primary care services within the Unified Health System (Sistema Único de Saúde, SUS) are not consistently equipped to address menopausal health, with significant variation in clinician training and confidence. Hormone replacement therapy (HRT) is available, but access is shaped by socioeconomic disparities, with those in the private system often benefiting from specialist care while those reliant on SUS face limited options, long waiting times, and scarce counselling about risks and benefits. Non-hormonal interventions and mental health support are even less developed, leaving many women to rely on informal coping mechanisms or complementary practices without professional oversight. Stigma and cultural silence surrounding menopause compound these systemic weaknesses, discouraging open dialogue and reinforcing inequities [17,18]. The evidence base on Brazilian menopausal experiences is sparse, with existing research concentrated in specific urban centres and predominantly quantitative, thereby missing the nuanced sociocultural and experiential dimensions of the transition.

Rationale

The Brazilian chapter of MARIE-WP2a was designed to explore gaps, recognising that menopause in Brazil is insufficiently studied through the lens of lived experience and intersectional inequality. While epidemiological surveys and clinical audits provide some insights into symptom prevalence and HRT usage, they fail to capture the everyday realities of women navigating biological, psychological, social, and systemic challenges during midlife. Qualitative exploration remains limited in Brazil, particularly across diverse regions, socioeconomic groups, and healthcare pathways. MARIE Brazil WP2a therefore seeks to fill this critical void by examining how women articulate their menopausal journeys, the barriers they encounter within the healthcare system, and the strategies they employ to cope with symptoms. By foregrounding voices that are often excluded from mainstream research including women with multimorbidities, and those dependent on public services, this study adds essential depth to the evidence base. Such insights are indispensable for shaping responsive policies, strengthening clinical training, and developing equitable interventions that can support women across all stages of menopause. In doing so, MARIE Brazil WP2a contributes both to national health priorities and to the global imperative of advancing gender-sensitive health systems.

Methods

Study Design

This qualitative study formed part of the MARIE-Brazil chapter as part of work-package (WP)2-a to investigate perimenopausal, menopausal and post-menopausal experiences. The Brazilian chapter sought to explore lived experiences of menopause, with a focus on symptom trajectories, coping practices, and health system engagement. A qualitative design was chosen to capture the depth, nuance, and contextual variation in participants' narratives that cannot be adequately addressed through quantitative surveys alone. The study followed COREQ guidelines to ensure transparency and rigour.

Research Team and Reflexivity

The study was conducted by a multidisciplinary team with expertise in women's health, public health, qualitative research, and clinical practice. Interviews were conducted in Portuguese by trained interviewers experienced in sensitive health topics. Researchers maintained reflexive journals

 doi:10.20944/preprints202510.1062.v1

to document assumptions, positionality, and evolving interpretations. Reflexivity discussions were held during team meetings to mitigate bias and enhance interpretative depth.

Participant Selection and Recruitment

Participants were purposively recruited to capture variation across age, menopausal stage (peri-, natural post-, and surgical menopause), socioeconomic position, and healthcare access (public vs private). Recruitment strategies included outreach through community networks, women's health organisations, and healthcare clinics. Eligibility criteria included: (i) self-identification as experiencing perimenopause, menopause, or post-menopause; (ii) age between 40 and 65 years; and (iii) residence in Brazil for ≥12 months. Exclusion criteria were inability to provide informed consent or language barriers precluding participation.

Setting and Data Collection

Interviews were conducted between October 2024 and December 2024 in urban and peri-urban settings across Brazil. Most interviews took place in private rooms within community centres or healthcare facilities, while some were conducted online using secure video platforms due to participant preference. Only the participant and interviewer were present. Interviews followed a semi-structured guide covering symptom experiences, coping strategies, healthcare encounters, workplace implications, and sociocultural meanings. Interviews were audio-recorded with consent and transcribed verbatim in Portuguese, with identifying information removed.

Translation and Transcription

Portuguese transcripts were first checked for accuracy by researchers. Transcripts were then translated into English for cross-site analysis, ensuring preservation of colloquial terms (e.g., *calorão*, *pavio curto*), which were documented in a bilingual glossary. Back-translation was applied to a subset of transcripts to confirm semantic fidelity. Where culturally specific terms lacked direct English equivalents, explanatory notes were added.

Data Analysis

Analysis followed Braun and Clarke's six-phase thematic analysis, complemented by contextual analysis to situate experiences within biological, psychological, sociocultural, and health system dimensions. Coding was inductive and iterative, conducted using NVivo software. A codebook was developed collaboratively and refined across transcripts to ensure consistency. Themes were reviewed and defined through team consensus, with discrepancies resolved via discussion. Constant comparison across participants enabled identification of commonalities and divergences. Reflexivity notes were incorporated to maintain analytic transparency.

Trustworthiness and Rigour

Rigour was ensured through multiple strategies:

- Credibility: Triangulation across researchers and iterative coding discussions.
- Dependability: Maintenance of an audit trail including coding decisions, codebook (Table 1) evolution, and reflexivity logs.
- Confirmability: Peer debriefing within the research team to minimise individual bias.
- Transferability: Detailed description of participants, settings, and contexts to enable applicability to other health systems.

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Table 1. Codebook developed for the purpose of the analysis. This codebook was developed inductively from qualitative interviews with participants in the MARIE Brazil study (PID1–20). It catalogues the main codes identified, with accompanying definitions, determinants, illustrative quotes, and thematic allocation. Codes reflect multiple levels of influence, including biological (e.g., vasomotor episodes, GSM, sleep disruption), psychological (e.g., irritability, anxiety, low mood), socio-cultural (e.g., faith-based coping, cultural silence, colloquial idioms), and health system determinants (e.g., private vs SUS reliance, clinician reluctance, misinformation). The structure demonstrates how symptom experiences were situated within broader contexts of comorbidity, healthcare access, and inequity. This framework provides transparency to the analytic process, ensures reproducibility, and facilitates transferability of findings across settings.

Code	Definition	Determinant(s)	Example Quote (PID)	Theme
Hot flushes / calorão	Sudden intense heat, often with sweating	Hormonal decline	*"The hot flushes… my God! Horrible."* (PID7)	Symptom burden – vasomotor
Night sweats	Nocturnal sweating disrupting sleep	Vasomotor instability	*"I woke up drenched, bed wet."*(PID4)	Symptom burden – vasomotor
Insomnia	Difficulty initiating/maintaining sleep	Vasomotor symptoms, anxiety	*"I couldn't sleep… I rolled in bed."*(PID16)	Symptom burden – sleep
Fragmented sleep	Multiple awakenings, unrefreshing sleep	Anxiety, night sweats	*"I woke up and couldn't sleep again."* (PID20)	Symptom burden – sleep
Vaginal dryness / secura	Reduced lubrication, painful sex	Oestrogen decline, hysterectomy	*"Dryness in the vagina, pain in sex, libido zero."* (PID20)	Symptom burden – GSM
Painful sex / dor na relação	Dyspareunia linked to dryness	GSM	*"Very dry… pain during sex."*(PID18)	Symptom burden – GSM
Recurrent UTIs	Frequent urinary infections	Oestrogen deficiency, GSM	*"I get infections almost every month."* (PID8)	Symptom burden – GSM
Libido loss / libido zero	Diminished sexual desire	GSM, mood changes	*"No desire for sex, libido gone."*(PID7, PID5)	Symptom burden – GSM
Memory lapses	Forgetting tasks, poor recall	Menopause, sleep loss	*"I forgot many things."* (PID11)	Symptom burden – cognitive
Concentration difficulties	Reduced focus, task repetition	Fatigue, insomnia	*"I had to redo tasks 3–4 times."*(PID20)	Symptom burden – cognitive

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Brain fog / cabeça lenta	Slowed mental processing	Sleep loss, hormonal changes	*"It seemed like my head was slow."*(PID4)	Symptom burden – cognitive
Back pain	Chronic lumbar pain	Osteoporosis, disability	*"My back always hurts."* (PID3)	Symptom burden – musculoskeletal
Joint pain / knee/spine issues	Musculoskeletal complaints	Chronic illness	*"Many spine problems, knee surgery."* (PID2)	Symptom burden – musculoskeletal
Weight gain	Noticeable post-menopause weight increase	Hormonal, lifestyle	*"I gained a lot of weight after menopause."* (PID1)	Symptom burden – body image
Attributional ambiguity	Difficulty separating menopause from comorbidities	Disability, surgery	*"I don't know if it's menopause or the amputation."* (PID1)	Symptom burden
Irritability / pavio curto	Short temper, easy frustration	Hormonal, sleep loss	*"Short-fused… everything irritates me."* (PID12)	Psychological impact
Anxiety / nervosismo	Heightened worry, nervousness	Pre-existing or menopause-triggered	*"I didn't know I was so anxious until menopause."* (PID2)	Psychological impact
Low mood / sadness	Emotional downturn, crying, demotivation	Hormonal, occupational stress	*"I became more sad, cried easily."*(PID15)	Psychological impact
Accelerated ageing	Feeling older, diminished identity	Cultural scripts	*"I felt I was ageing fast."* (PID18)	Psychological impact
Faith-based coping	Reliance on prayer, Bible	Religious orientation	*"I read the Bible and prayed a lot."*(PID5)	Coping
Self-care routines	Exercise, meditation, therapy apps	Individual agency	*"I used meditation apps."* (PID3)	Coping
Psychotropic use	Antidepressants/anxiolytics	Anxiety, depression, pain	*"I take fluoxetine."* (PID20); *"Duloxetine for anxiety and pain."*(PID2)	Coping

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HRT use	Hormone replacement therapy (gel, patch, tablet)	Private access, physician	*"I use oestrogel and Duphaston."*(PID20)	Coping
HRT contraindication	Unable to use HRT	Thrombosis, risk factors	*"I couldn't use hormones because of thrombosis."* (PID1)	Coping
Clinician reluctance	Doctors avoid prescribing	Fear of side effects	*"Doctors are afraid to prescribe."*(PID13)	Healthcare
Complementary therapies	Acupuncture, reiki, homeopathy	Cultural adaptation	*"I tried acupuncture and reiki."*(PID2)	Coping
Private care reliance	Access via insurance/self-pay	Socioeconomic privilege	*"I do everything private."* (PID20)	Healthcare access
SUS reliance	Dependence on public system	Socioeconomic constraint	*"I do everything through SUS."*(PID1)	Healthcare access
Appointment delays	Long waits, quick consults	Under-resourcing	*"It takes long to schedule, consults are quick."* (PID14)	Healthcare access
Doctor turnover	Lack of continuity	Workforce instability	*"Hard to trust; depends on who you get."* (PID17)	Healthcare access
Post-surgical counselling gaps	No menopause briefing post-hysterectomy	Peri-operative care	*"I lacked info when I had my uterus removed."* (PID8)	Healthcare access
Front-desk gatekeeping	Receptionist/nurse ignorance	System literacy gap	*"Receptionist asked odd questions about hormones."* (PID18)	Healthcare access
Misinformation online	Confusion from internet	Information desert	*"On the internet it's worse… everyone says different."* (PID13)	Healthcare access
Education demand	Desire for group sessions/resources	Community-based support	*"Why not a group for menopause?"*(PID13)	Healthcare access
Equity/ability to pay	Paying vs relying on SUS determines care	Structural inequity	*"If you don't have money, it's*	Systemic inequity

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			complicated." (PID9)	
Cultural silence	Generational non-discussion	Social norms	*"In my mother's time nobody spoke."* (PID8)	Systemic inequity
Occupational impact	Errors, fatigue, presenteeism	Sleep/cognition loop	*"I had to redo tasks 3–4 times."*(PID20)	Systemic inequity

Ethical Considerations

Ethical approval was obtained from UNICAMP's Research Ethics Committee under the reference number: CAAE 77391024.3.0000.5404 in Brazil and from the coordinating institution. All participants provided written informed consent prior to participation. Confidentiality was ensured through anonymisation of transcripts. Participants were informed of their right to withdraw at any point without penalty. Sensitive topics were approached with care, and referrals to support services were provided when needed. The study was conducted in accordance with the Declaration of Helsinki.

Results

The analysis generated a series of interrelated themes that captured the breadth of women's menopausal experiences in Brazil. These themes encompassed symptom burdens, psychological impacts, coping strategies, healthcare encounters, and wider systemic inequities, each shaped by biological, sociocultural, and structural determinants. Table 2 presents the thematic framework, illustrating sub-themes, exposures, determinants, and participant quotations that anchor the findings in lived experience.

Table 2. Themes, sub-themes, determinants, exposures and example quotes of the sample.

Theme	Sub-theme	Determinants	Exposures (what happened)	Example quote (PID)
Symptom burden	Vasomotor intensity & cyclicity	Oestrogen decline	Hot flushes, night sweats, daytime sweating cycles	*"The hot flushes… my God! Horrible."* (PID7)
	Sleep fragmentation & non-restorative sleep	Vasomotor activation; anxiety	Difficulty initiating sleep, multiple awakenings, unrefreshing sleep	*"I couldn't sleep… I rolled in bed."* (PID16)
	Genitourinary syndrome of menopause (GSM)	Oestrogen depletion; surgical menopause	Vaginal dryness, burning, dyspareunia, urinary discomfort/UTIs	*"Very dry… pain during sex."* (PID18); *"Frequent infections, almost every month."* (PID8)

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	Sexual function & desire	GSM; mood; relationship context	Low libido, avoidance of sex, partner misunderstanding	*"Libido zero."* (PID20); *"My ex-husband didn't understand."* (PID5)
	Cognitive efficiency	Menopausal transition; sleep loss	Forgetfulness; slowed processing; reduced concentration; task repetition	*"I had to redo tasks 3–4 times."* (PID20); *"I forgot many things."* (PID11)
	Musculoskeletal pain & fatigue	Osteoporosis; disability; comorbid pain	Back pain; joint pain; daytime fatigue	*"My back always hurts."*(PID3)
	Weight & body image	Hormonal milieu; mood; activity	Weight gain; altered self-image	*"I gained a lot of weight after menopause."* (PID1)
	Attributional ambiguity	Multimorbidity; surgical history	Difficulty separating effects of disability/surgery vs menopause	*"I don't know if it's menopause or the amputation."* (PID1)
Psychological impacts	Irritability & "short fuse"	Hormonal shifts; poor sleep	Lower tolerance, proneness to anger	*"Short-fused… everything irritates me."* (PID12)
	Anxiety amplification	Pre-existing anxiety; transition stressors	Persistent nervousness, hyper-arousal	*"I didn't know I was so anxious until menopause."*(PID2)
	Low mood & demotivation	Chronic symptoms; role strain	Sadness, crying, loss of drive	*"I became more sad, cried easily."* (PID15)
	Identity/ageing sense-making	Social narratives of ageing	Feeling "old", accelerated ageing	*"I felt I was ageing fast."*(PID18)

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Coping & management	Faith-based coping	Religious orientation; community	Prayer, Bible reading, meaning-making	*"I read the Bible and prayed a lot."* (PID5)
	Self-care routines	Individual agency; digital access	Exercise, meditation, therapy apps; vitamins	*"I used meditation apps and therapy."* (PID3)
	Psychotropics	Access; comorbidity	Antidepressants/anxiolytics for mood, sleep, pain	*"I take fluoxetine."* (PID20); *"Duloxetine for anxiety and pain."* (PID2)
	HRT access & effects	Private vs SUS; safety perceptions	Patches/gels/tablets; vaginal oestrogens; symptom relief	*"Oestrogel and Duphaston helped."* (PID20)
	HRT constraints/contraindications	Thrombosis history; risk perceptions	Non-use despite need; under-prescribing	*"I couldn't use hormones because of thrombosis."*(PID1); *"Doctors are afraid to prescribe."* (PID13)
	Complementary therapies	Cultural acceptability	Acupuncture, homeopathy, reiki	*"I tried acupuncture and reiki."* (PID2)
	Workplace self-adaptation	Role autonomy; support	Task pacing, error checking, breaks	*"I had to redo tasks several times."* (PID20)
Healthcare access & communication	Private care reliance	Socioeconomic privilege	Direct gynaecology access; steady HRT	*"I do everything private."*(PID20)
	SUS reliance (UBS) pathways	Socioeconomic constraint	Family doctor triage; variable follow-up	*"I do everything through SUS."* (PID1)
	Appointment logistics & time	Under-resourcing	Delays, rushed consults, scheduling difficulty	*"It takes long to schedule…*

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				consults are quick." (PID14)
	Continuity/turnover ("doctor shopping")	Staffing; contracts	Repeating history, inconsistent advice	*"It's hard to trust; depends on who you get."* (PID17)
	Post-surgical counselling gaps	Peri-operative education	Hysterectomy without menopause briefing	*"I lacked info when I had my uterus removed."* (PID8)
	Gatekeeping & staff literacy	Non-clinical staff; stigma	Receptionist/nurse questioning, embarrassment	*"Receptionist asked odd questions about hormones."*(PID 18)
	Misinformation & info deserts	Internet noise; absent materials	Conflicting guidance; fear of hormones	*"On the internet it's worse… everyone says different."*(PID1 3)
	Demand for education & groups	Community models	Desire for group classes/resources	*"Why not a group for menopause?"* (PID13)
Systemic inequities	Ability to pay = quality of care	Income; insurance	Private/HRT vs public/limited options	*"If you don't have money, it's complicated."* (PID9)
	Cultural silence & stigma	Norms; generational gaps	Menopause invisible in families/work	*"In my mother's time nobody spoke."* (PID8)
	Occupational consequences	Sleep/cognition; supports	Errors, fatigue, presenteeism	*"I had to redo tasks 3–4 times."* (PID20)

Thematic Analysis

Symptom Burden is Multidimensional and Mutually Reinforcing

Women described a *clustered* experience wherein vasomotor surges triggered night sweats and sleep fragmentation, which then intensified irritability, cognitive lapses, and daytime fatigue (Figure 1). GSM (vaginal dryness, burning and dyspareunia) was both highly prevalent and under-treated, with clear implications for intimacy and self-esteem. Cognitive symptoms *slowed thinking,*

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forgetfulness, task repetition were particularly salient for those in paid work, while musculoskeletal pain magnified the energy cost of daily functioning. Some women struggled to disentangle menopause from comorbid disability or surgical histories (attributional ambiguity).

"The hot flushes… my God! Horrible." (PID7)

"I couldn't sleep… I rolled in bed." (PID16)

"Dryness in the vagina, pain in sex, libido zero." (PID20)

"I had to redo tasks 3–4 times." (PID20)

"I don't know if it's menopause or the amputation." (PID1)

Psychological Impacts Pivot Around Irritability, Anxiety, and Lowered Mood

Irritability ("short fuse"), pervasive anxiety, and intermittent low mood were frequently reported even when vasomotor symptoms were modest often framed as loss of tolerance and emotional volatility. A distinct sub-theme concerned identity and ageing, with participants articulating a felt acceleration of ageing and diminished self-image that compounded demotivation.

"Short-fused… everything irritates me." (PID12)

"I didn't know I was so anxious until menopause." (PID2)

"I felt I was ageing fast." (PID18)

"I became more sad, cried easily." (PID15)

Coping is Diverse: from Faith and Self-Care to Pharmacology and HRT Constrained by Access and Risk

Coping repertoires were broad. Faith-based practices and self-management such as exercise, meditation and therapy apps were common. This was often co-existing with psychotropic medications such as fluoxetine and duloxetine for mood, sleep or pain. HRT patches, gels, tablets, or vaginal preparations was effective where used, but contraindications such as thrombosis and fear of hormones, which were at times clinician-driven limited uptake. Several women pursued complementary therapies such as acupuncture and reiki with variable benefit.

"I read the Bible and prayed a lot." (PID5)

"I used meditation apps and therapy." (PID3)

"I use oestrogel and Duphaston." (PID20)

"I couldn't use hormones because of thrombosis." (PID1)

"Doctors… are afraid to prescribe." (PID13)

Care Pathways Bifurcate by Ability to Pay; Communication Quality is a Decisive Determinant of Outcomes

A stark private–public split emerged. Those with insurance or means secured specialist input and timely HRT, whereas SUS-reliant women faced delays, rushed consults, inconsistent clinicians, and little counselling. Communication gaps were acute after hysterectomy, where many received no anticipatory guidance on surgical menopause. Front-desk and nursing literacy also mattered; gatekeeping interactions could stigmatise hormone users. In the information vacuum, internet misinformation flourished, while several women explicitly requested group education and practical materials.

"I do everything private." (PID20)

"It takes long to schedule… consults are quick." (PID14)

"I lacked info when I had my uterus removed." (PID8)"Receptionist asked odd questions about hormones." (PID18)

"Why not a group for menopause?" (PID13)

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Inequities are Structural, not Incidental

Participants repeatedly linked suffering to structural conditions such as resource constraints in primary care, time barriers, and the cultural invisibility of menopause at home, in clinics, and at work. Several acknowledged personal privilege, contrasting their outcomes with women who cannot pay for private care. For those in demanding jobs, the sleep–cognition–work loop produced errors, presenteeism and exhaustion, seldom buffered by formal workplace adaptations.

"If you don't have money, it's complicated." (PID9)

"In my mother's time nobody spoke [about menopause]." (PID8)

"I had to redo tasks 3–4 times." (PID20)

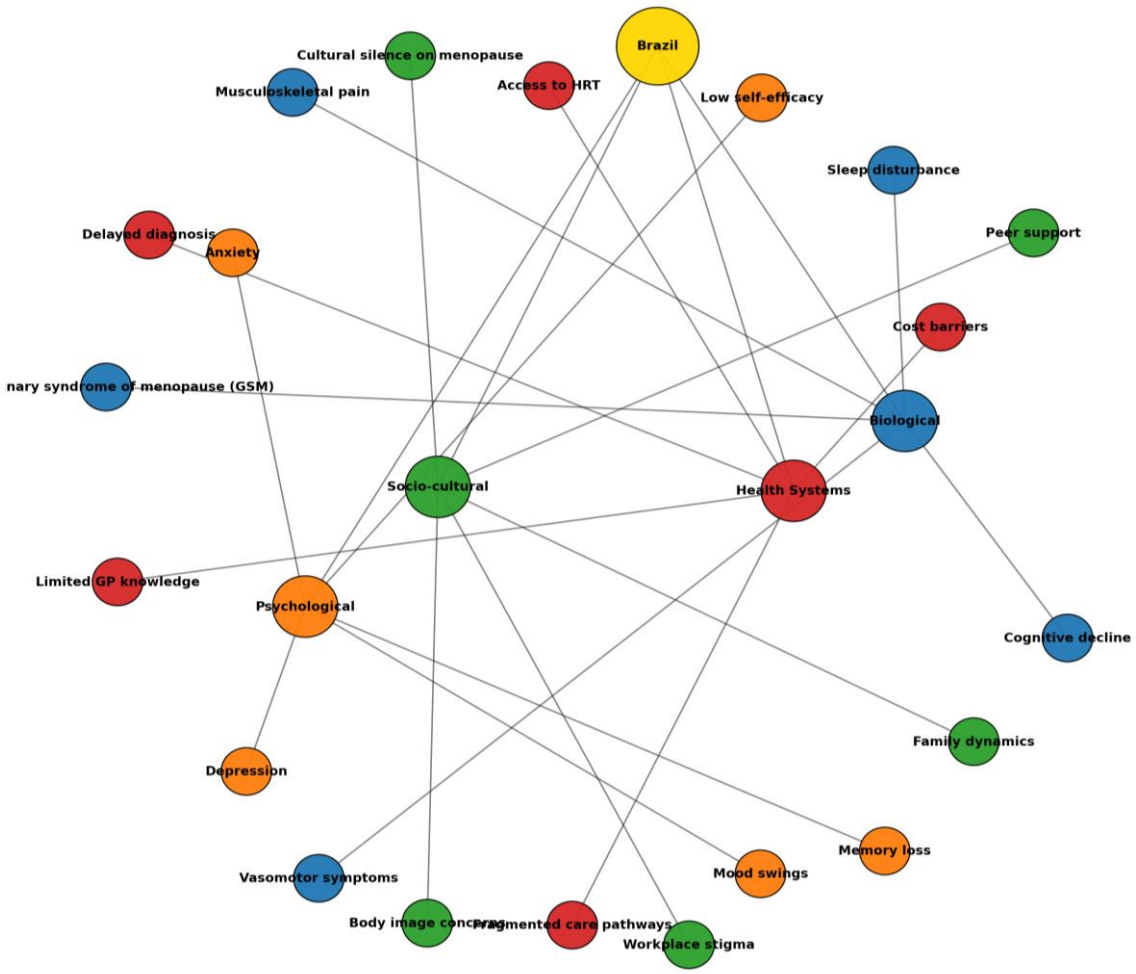

Figure 1. Thematic bubble map based on identified themes and sub-themes identified from the sample.

Contextual Analysis

The Brazilian narratives reveal menopause as a *constellation of interlocking disruptions*, where vasomotor episodes, genitourinary syndrome of menopause (GSM), sleep disturbance, cognitive lapses and musculoskeletal pain converged to erode daily functioning. These symptoms did not act in isolation as night sweats fractured sleep, fragmented sleep fuelled irritability, and cumulative fatigue undermined concentration and mood, producing a cycle of depletion. Surgical menopause compounded this burden, with hysterectomised women reporting particularly severe GSM, while the presence of multimorbidity osteoporosis, diabetes, thromboembolism and disability magnified vulnerability and complexity.

 doi:10.20944/preprints202510.1062.v1

Psychological strain was equally pervasive. Irritability and anxiety were intensified by disrupted sleep and workplace pressures, while demotivation and the pervasive sense of "accelerated ageing" undermined self-efficacy. Psychotropic prescriptions were common, but often addressed chronic anxiety and insomnia rather than menopause-specific drivers such as duloxetine for anxiety and pain reflecting a system that managed symptoms without recognising their hormonal origins.

Against this backdrop, *cultural scripts of silence and shame* restricted open discussion, curtailing help-seeking and perpetuating stigma. Faith-based coping was an important resource for some, yet sexual wellbeing was often compromised by dryness, pain, and loss of desire with misunderstandings from partners compounding distress (PID5). Women's idiomatic language—*"inferno"*, *"calorão"*, *"pavio curto"*—conveyed the visceral intensity of symptoms and the subjective toll of a largely invisible condition.

The health system context further entrenched inequities. The ability to pay dictated access to specialists and HRT, leaving those reliant on SUS facing time constraints, clinician uncertainty, front-desk gatekeeping, and a conspicuous absence of post-surgical counselling. In response, participants articulated pragmatic solutions, calling for group education and genuinely multidisciplinary care models incorporating nursing, physiotherapy and mental health expertise.

The *sleep–cognition–performance cascade* emerged as a defining occupational hazard: women described forgetting tasks, repeating work, and struggling to maintain accuracy under fatigue. Yet formal workplace adjustments were almost entirely absent. Instead, women absorbed the burden themselves through pacing, repetition, and improvised breaks, a tacit expectation that menopause should be endured rather than supported.

Colloquial Terms Table (English- Portuguese, as Used by Participants)

Colloquial terms foreground intensity and lived salience is an important aspect to consider as indicated in Table-3: *calorão* and *inferno* convey not just heat but suffering. Emotional states are socialised through idioms—*pavio curto* and *ficar brava por qualquer coisa*—that map irritability onto everyday interactions. Sexual health language—*secura*, *ardência*, *libido zero*—is direct yet stigmatised, underscoring the need for sensitive counselling. Health-system slang—*postinho*, *SUS*, *convênio*—encodes structural pathways and classed access. Incorporating these terms into educational materials can validate experience, reduce shame, and improve message uptake.

Table 3. Colloquialisms capture intensity, nuance and cultural meaning beyond literal translation. Below are near-equivalents used to interpret participants' narratives and to inform culturally attuned communication materials.

English	Portuguese (colloquial)
Hot flush / heat wave	Calorão / onda de calor
Night sweats	Suor noturno
Vaginal dryness	Secura (na vagina) / ressecamento
Burning (vaginal)	Ardência
Painful sex	Dor na relação / doía para ter relação
No libido	Libido zero / sem vontade
Short fuse / easily irritated	Pavio curto
Angry at anything	Ficar brava por qualquer coisa

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Brain fog / slow thinking	Cabeça lenta
Forgetful	Memória falha / esquecida
Tiredness / fatigue	Canseira / cansaço
Feeling old	Me sentindo velha / envelhecendo rápido
Hellish experience	Inferno
Primary care clinic	Postinho / UBS
Public system	SUS
Private insurance	Convênio
Reception/front-desk	Recepção
Compounded cream	Remédio manipulado
Testosterone gel	Gel de testosterona
Combined pill (brand)	Ceci
HRT patch/gel	Adesivo/gel de hormônio

Discussion

This study highlights that menopause in Brazil is experienced as a multifactorial transition shaped by intersecting biological, psychological, socio-cultural, and systemic determinants. Women reported the well-documented burden of vasomotor symptoms, urogenital atrophy, musculoskeletal pain, cognitive decline, and mood changes, yet these manifestations were intensified by broader inequities. Fragmented care pathways, limited health professional knowledge, and financial inaccessibility of HRT or alternatives exacerbated distress. The findings also illuminate how stigma, cultural silence around reproductive ageing, and gendered workplace dynamics contribute to concealment of symptoms and social isolation. Importantly, participants' narratives suggest that resilience was often derived from informal networks, such as family and peer support, rather than from formal healthcare services. Collectively, the study underscores that menopause in Brazil cannot be understood through a purely biomedical lens; it is shaped by socio-economic stratification, cultural expectations, and health system limitations.

Population Science

The insights generated from this study hold profound implications for population health in Brazil. The country faces an epidemiological transition with rapid population ageing: by 2030, one in four Brazilian women will be over 50. The scale of menopause-related needs therefore intersects with the broader pressures on Brazil's Unified Health System (SUS), including the rising prevalence of non-communicable diseases (NCDs) such as diabetes and cardiovascular disease. These conditions are clinically intertwined with menopausal biology and symptom burden. The qualitative evidence demonstrates that marginalised women, particularly those in low-income, rural, or racially minoritised groups experience disproportionately greater barriers to care. This reflects broader structural inequities, including regional disparities in healthcare infrastructure, limited access to gynaecological specialists outside major urban centres, and inconsistent dissemination of public health information. Stigma and cultural silence exacerbate under-recognition of symptoms,

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perpetuating the invisibility of menopause within population health policy. From a population science perspective, menopause must therefore be reframed as a public health priority: an issue that intersects with women's labour force participation, mental health, and quality of life across decades. Without systemic recognition, the cumulative social and economic burden of untreated menopausal symptoms may be substantial, undermining Brazil's progress towards gender equity and sustainable development goals.

Clinical Implications

From a clinical standpoint, the study exposes critical gaps in menopause care within Brazil, while also identifying opportunities for practice reform. Current approaches remain fragmented: while some tertiary centres and private clinics offer specialist menopause services, access is uneven and largely dependent on financial capacity. In contrast, the majority of women in the public system rely on general practitioners or gynaecologists who may lack specific training in menopausal care. This aligns with prior evidence demonstrating that SUS lacks consistent protocols for screening, counselling, and treatment of menopause, and that HRT prescribing is hindered by misconceptions about safety, inconsistent availability, and clinician hesitancy. For example, studies in São Paulo and Rio de Janeiro, report low prescription rates of HRT, often restricted to urban middle-class populations with private insurance, while women in rural North and Northeast regions face limited options altogether [19–22].

International guidelines including those from the North American Menopause Society (NAMS) and the International Menopause Society (IMS) recommend a personalised, evidence-based approach to HRT, considering risk factors, comorbidities, and patient preferences [23,24]. In Brazil, however, clinical practice often defaults to symptomatic management such as analgesics or antidepressants or fragmented gynaecological follow-up, which may not adequately address the multidimensional impact of menopause. The study's findings demonstrate the psychological and occupational toll of untreated symptoms, pointing to the need for multidisciplinary models of care that integrate mental health, primary care, and specialist input. The socio-cultural dimension, particularly stigma and silence demands greater clinical sensitivity and training in communication, enabling clinicians to ask about symptoms proactively.

Evidence from other middle-income contexts suggests that task-shifting strategies, such as equipping community health workers to deliver basic counselling, could help bridge gaps in access [25]. Brazil's extensive Family Health Strategy network offers a potential platform to embed menopause education, screening, and referral pathways at the community level [26]. However, such integration requires investment in training, alongside public health campaigns to normalise menopause as a legitimate health concern. Pharmacological options must also be expanded: equitable access to safe, affordable HRT through SUS is critical, alongside non-hormonal alternatives for women with contraindications.

Critically, the study illustrates that informal coping mechanisms peer networks, family support, and digital communities are compensating for formal system shortcomings. Clinical practice in Brazil must evolve to recognise and build upon these strengths, for example, by facilitating group consultations, peer support programmes, or digital health tools co-designed with women themselves. Without such reforms, the clinical management of menopause risks perpetuating inequities and failing to meet the needs of a growing segment of Brazil's population. Based on the insights gathered, we propose the following recommendations;

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Domain	Policy Recommendations
Health system strengthening	• Integrate menopause into Brazil's Unified Health System (SUS) through standardised screening, counselling, and management protocols.• Establish multidisciplinary menopause clinics in specialized public care centers and leverage the Family Health Strategy for community support.
Equitable access to treatment	• Guarantee the availability of affordable hormone replacement therapy (HRT) and non-hormonal alternatives through SUS, reducing urban–rural and public–private disparities.• Implement bulk procurement and subsidy mechanisms to ensure cost-effectiveness and sustainability.
Clinical training and education	• Introduce mandatory menopause education in medical and nursing curricula, with ongoing continuing professional development for general practitioners and gynaecologists.• Equip community health workers with training to deliver basic counselling, early recognition, and referral.
Public health communication	• Launch culturally tailored campaigns to reduce stigma and normalise open discussion of menopause.• Use different tools, including non-digital ones when necessary to facilitate accessibility.
Workplace and societal policy	• Promote workplace protections through national labour regulations, ensuring flexibility, reasonable adjustments, and anti-discrimination safeguards.• Incorporate menopause into gender equity and aging strategies to align with Brazil's commitments to the Sustainable Development Goals, facilitating a more prolonged incorporation of women into the labor market

Conclusion

Menopause in Brazil is shaped by complex intersections of biology, culture, socio-economic position, and health system capacity. Women's experiences highlight persistent inequities in recognition, access, and management, with informal networks often compensating for gaps in formal care. Addressing these challenges requires health system strengthening, clinician training, equitable access to therapies, and culturally sensitive public health communication. Embedding menopause

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within Brazil's broader population health and policy agendas is essential to advance equity and improve quality of life for millions of women.

Author Contributions: GD developed the ELEMI program and the MARIE project. This was furthered by GD and PP. CBP submitted and secured the ethics approval for the study in Brazil. CBP, RMN and DAY collected data. GD and JQS conducted the data analysis. GD wrote the first draft and was furthered CPB and by all other authors. All authors critically appraised, reviewed and commented on all versions of the manuscript. All authors read and approved the final manuscript.

Funding: No funding.

Availability of data and material: The PIs and the study sponsor may consider sharing anonymous data upon reasonable a request.

Code availability: Not applicable.

Ethics approval: This research was approved by the institution's Research Ethics Committee under the number: CAAE 77391024.3.0000.5404.

Consent to participate: Obtained.

Consent for publication: All authors consented to publish this manuscript.

Acknowledgments: MARIE Consortium: Donatella Fontana, Aini Hanan binti Azmi, Alyani binti Mohamad Mohsin, Arinze Anthony Onwuegbuna, Artini binti Abidin, Ayyuba Rabiu, Chijioke Chimbo, Chinedu Onwuka Ndukwe, Choon-Moy Ho, Chinyere Ukamaka Onubogu, Diana Chin-Lau Suk, Divinefavour Echezona Malachy, Emmanuel Chukwubuikem Egwuatu, Eunice Yien-Mei Sim, Farhawa binti Zamri, Fatin Imtithal binti Adnan, Geok-Sim Lim, Halima Bashir Muhammad, Ifeoma Bessie Enweani-Nwokelo, Ikechukwu Innocent Mbachu, Jinn-Yinn Phang, John Yen-Sing Lee, Joseph Ifeanyichukwu Ikechebelu, Juhaida binti Jaafar, Karen Christelle, Kathryn Elliot, Kim-Yen Lee, Kingsley Chidiebere Nwaogu, Lee-Leong Wong, Lydia Ijeoma Eleje, Min-Huang Ngu, Noorhazliza binti Abdul Patah, Nor Fareshah binti Mohd Nasir, Norhazura binti Hamdan, Nnanyelugo Chima Ezeora, Nnaedozie Paul Obiegbu, Nurfauzani binti Ibrahim, Nurul Amalina Jaafar, Odigonma Zinobia Ikpeze, Obinna Kenneth Nnabuchi, Pooja Lama, Puong-Rui Lau, Rakshya Parajuli, Rakesh Swarnakar, Raphael Ugochukwu Chikezie, Rosdina Abd Kahar, Safilah Binti Dahian, Sapana Amatya, Sing-Yew Ting, Siti Nurul Aiman, Sunday Onyemaechi Oriji, Susan Chen-Ling Lo, Sylvester Onuegbunam Nweze, Damayanthi Dassanayake, Nimesha Wijayamuni, Prasanna Herath, Thamudi Sundarapperuma, Vaitheswariy Rao, Xin-Sheng Wong, Xiu-Sing Wong, Yee-Theng Lau, Heitor Cavalini, Jean Pierre Gafaranga, Emmanuel Habimana, Chigozie Geoffrey Okafor, Assumpta Chiemeka Osunkwo, Gabriel Chidera Edeh, Esther Ogechi John, Kenechukwu Ezekwesili Obi, Oludolamu Oluyemesi Adedayo, Odili Aloysius Okoye, Chukwuemeka Chukwubuikem Okoro, Ugoy Sonia Ogbonna, Chinelo Onuegbuna Okoye, Babatunde Rufus Kumuyi, Onyebuchi Lynda Ngozi, Nnenna Josephine Egbonnaji, Oluwasegun Ajala Akanni, Perpetua Kelechi Enyinna, Yusuf Alfa, Theresa Nneoma Otis, Catherine Larko Narh Menka, Kwasi Eba Polley, Isaac Lartey Narh, Bernard B. Borteih, Andy Fairclough, Kingsley Emeka Ekwuazi, Michael Nnaa Otis, Jeremy Van Vlymen, Chidiebere Agbo, Francis Chibuike Anigwe, Kingsley Chukwuebuka Agu, Chiamaka Perpetua Chidozie, Chidimma Judith Anyaeche, Clementine Kanazayire, Jean Damascene Hanyurwimfura, Nwankwo Helen Chinwe, Stella Matutina Isingizwe, Jean Marie Vianney Kabutare, Dorcas Uwimpuhwe, Melanie Maombi, Ange Kantarama, Uchechukwu Kevin Nwanna, Benedict Erhite Amalimeh, Theodomir Sebazungu, Elius Tuyisenge, Yvonne Delphine Nsaba Uwera, Emmanuel Habimana, Nasiru Sani, Amarachi Pearl Nkemdirim, Rukshini Puvanendram, Manisha Mathur, Rajeswari Kathirvel, Farah Safdar, Raksha Aiyappan, Jean Pierre Gafaranga, Bertin Ngororano, Victor Archibon, Ibe Michael Usman, Baraka Godfrey Mwahi, Filbert Francis Ilaza, Zepherine Pembe, Clement Mwabenga, Mpoki Kaminyoghe, Brenda Mdoligo, Thomas Alone Saida, Nicodemus E. Mwampashi, Olisaemeka Nnaedozie Okonkwo, Bethel Chinonso Okemeziem, Bethel Nnaemeka Uwakwe, Goodnews Ozioma Igboabuchi, Ifeoma Francisca Ndubuisi.

 doi:10.20944/preprints202510.1062.v1

Conflicts of interest: All authors report no conflict of interest. The views expressed are those of the authors and not necessarily those of the NHS, the National Institute for Health Research, the Department of Health and Social Care or the Academic institutions.

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