



# ACKNOWLEDGEMENT OF COUNTRY

The Victorian Women's Health Services acknowledge that we live and work on the unceded sovereign lands of Aboriginal and Torres Strait Islanders – the First Peoples and First Nations of this country.

We pay our respect to elders past and present and acknowledge the care that First Nations Peoples have exercised over this country for thousands of years.

Always was, always will be Aboriginal land.

# WHO ARE THE VICTORIAN WOMEN'S HEALTH SERVICES?

The Victorian Women's Health Services are a network of 12 independent, not-for-profit feminist organisations in Victoria that promote health and wellbeing of all women<sup>1</sup> with an intersectional gender lens. We are centres of excellence in gendered health promotion and prevention, winning awards for innovations and achievements.

## **Victoria's Women's Health Services Network:**

- provides a statewide infrastructure to promote Victorian women's wellbeing
- promotes good health and wellbeing to Victorian women
- applies an expert intersectional gendered lens to health issues and systems to improve outcomes for women and prevent the underlying causes of ill-health and harm for women in Victoria.

Funded by the Victorian Government, we are the State's only primary prevention and health promotion infrastructure that seeks to improve the health and wellbeing of Victorian women and achieve measurable population health outcomes.

Our combined vision is to achieve optimal health and wellbeing for all Victorian women and increase gender equality through addressing the social determinants of health. Our combined purpose is to lead best practice health promotion and primary prevention in women's health, promoting gender equal health and wellbeing outcomes and the prevention of illness and disease in Victorian women.

We comprise:

## **Three state wide organisations**

1. Women's Health Victoria (WHV)
2. Women with Disabilities Victoria (WDV)
3. Multicultural Centre for Women's Health (MCWH)

## **Four metropolitan organisations**

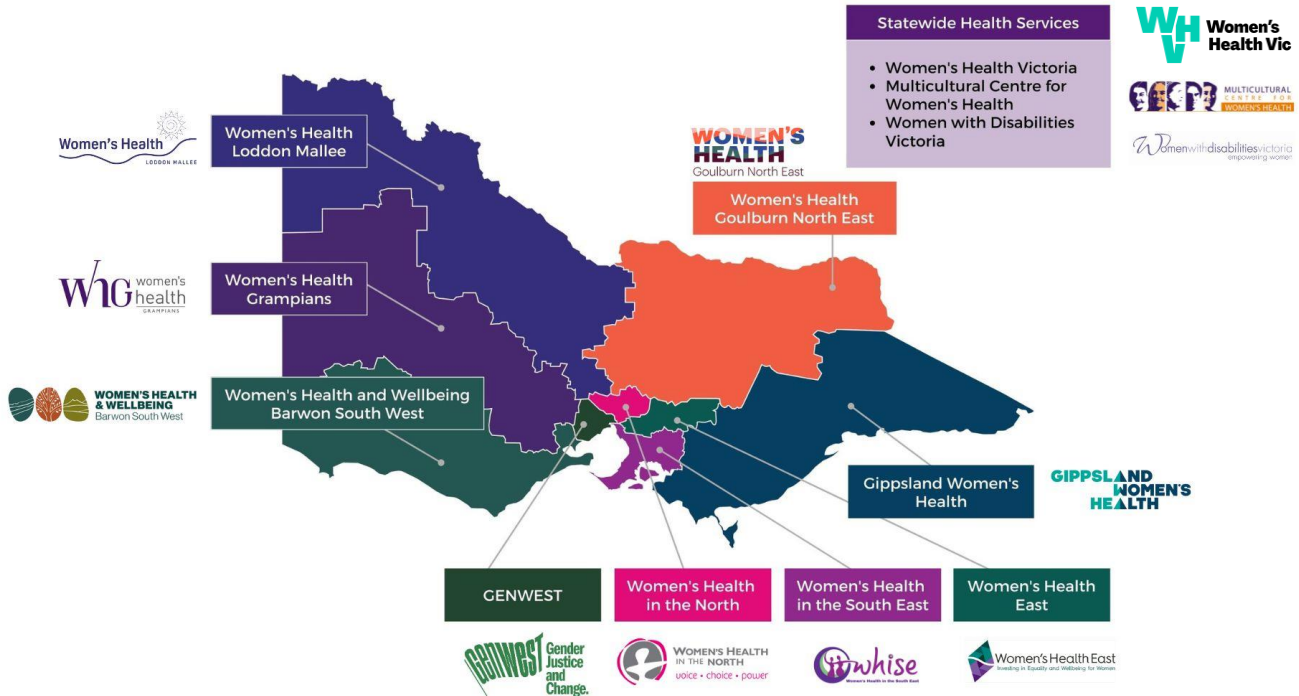
4. Women's Health in the North (WHIN)
5. Women's Health East (WHE)
6. Gen West
7. Women's Health in the South East (WHISE)

## **Five rural organisations**

8. Women's Health Loddon Mallee (WHLM)
9. Women's Health Goulburn North East (WHGNE)
10. Gippsland Women's Health (GWH)
11. Women's Health and Wellbeing Barwon South West (WHWBSW)
12. Women's Health Grampians (WHG)

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<sup>1</sup> Please see Language, page 4.



Women's Health Services Network:

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# EXECUTIVE SUMMARY

The Victorian Women's Health Services Network (WHSN) welcomes the opportunity to make a submission to the *Senate Community Affairs References Committee Inquiry into the issues related to menopause and perimenopause*.

This submission is led by Women's Health Victoria with input and support from WDV, WHIN, WHE, Gen West, WHLM, WHGNE, GWH, WHWBSW and is endorsed by WHG, WHISE and MCWH. As feminist organisations, the members of the Victorian WHSN bring an evidence-based reproductive justice framework to our health policy advocacy, and are dedicated to centring the experiences of women and gender diverse people.

We have a world-leading public health system in Australia. Yet, the health needs of women and gender diverse people over their lifespans – including during the menopause transition – are not consistently met across the country. As the Victorian WHSN argued in its submission to the Senate Inquiry into Universal Access to Reproductive Healthcare in 2022, access to appropriate, evidence-based sexual and reproductive healthcare services – including menopause – often depends on the postcode, income, language spoken, residency status, ability, or gender identity of the person seeking care. To ensure that all people living in Australia can access the menopause and perimenopause services that they need in a timely manner, reform and coordination is needed at a national level.

Through decades of direct work with women and communities at local and state-wide levels, the Victorian Women's Health Services have highly developed understandings of factors affecting sexual and reproductive health and mental health experiences and access to care. In response to the Inquiry's Terms of Reference, we have identified key issues relating to the experiences and impacts of menopause on people around Australia, which are highlighted in this submission:

- Research and funding gaps
- Healthcare workforce capacity and knowledge
- Intersectional, systemic barriers to accessing care
- Poor health literacy among people who will experience menopause
- Inadequate workplace policy
- Cultural and societal factors affecting public attitudes

These are addressed in our six recommendations outlined below, in alignment with the Inquiry *Terms of Reference*.

## Language

Throughout this document we use:

**menopause** to refer to the entire period of transition to, during and post-menopause

**women and gender diverse people.** We understand that people of all genders may go through menopause, and we are committed to including all people's needs in our recommendations to the Senate Inquiry.

**refugees and asylum seekers, migrants, Medicare ineligible people.** We acknowledge that these terms are often inadequate to describe the experiences of people seeking asylum and people from refugee backgrounds, people living in the diaspora, with experiences of migration, displacement and dispossession, and others with backgrounds of cultural, country of birth, and ethnic diversity.

both **Aboriginal and Torres Strait Islander** and **First Nations People**, according to the context of the content being discussed.

**people-first language:** we avoid disempowering language such as 'struggles with' and 'challenged by' and instead offer contexts describing the broader social determinants of health, and the barriers that affect access to appropriate and adequate healthcare and referral pathways.

**underserved communities** to recognise the structural inequities in the Australian health system and services, and in acknowledgement that terms such as 'vulnerable' imply intrinsic problems in or inadequacies of the populations themselves. As the MCWH write in their Building Bridges report (Tran et al. 2023), many communities deemed to be 'marginalised' or 'hard to reach' experience racial and gender discrimination, lack of culturally and linguistically responsive services, lack of accessible information, inadequate in-language and interpreting services, and other barriers that prevent access. These barriers for access and inclusion are also common experiences for women with disabilities across communities, which furthers stigma and can lead to poorer health outcomes and violence.

# RECOMMENDATIONS

## **1. Invest in research informed by an intersectional gendered and social determinants of health perspective to address knowledge gaps in understanding of experiences and treatment of menopause symptoms.**

*Terms of reference alignment: a, b, i*

- 1.1 Invest in research on the impact of gender inequality on experiences of perimenopause and menopause.
- 1.2 Invest in research on links between mental health and perimenopause and menopause.
- 1.3 Ensure gaps in research on underserved communities' menopause experiences and needs are addressed.
- 1.4 Invest in research on the impact of perimenopause and menopause on employment and workplace performance.
- 1.5 Ensure lived and living experience participants are involved at all stages of the research process from design onwards.

## **2. Implement a national workforce and training plan to monitor and increase the capacity of the Australian health workforce to provide evidence-based, best practice menopause-related healthcare provision.**

*Terms of reference alignment: c, f, i*

- 2.1 Invest in training treating healthcare professionals, especially GPs and pharmacists as frontline workers, to increase knowledge of best-practice, evidence-based treatment options.
- 2.2 Work with professional associations and accrediting/registering bodies to implement menopause education guidelines into the accreditation/competency frameworks and continuing professional development requirements.
- 2.3 Ensure medical and allied health education providers include menopause as a core topic in women's health.

## **3. Develop a national, integrated and coordinated healthcare system to ensure that everyone living in Australia can access the menopause healthcare that suits their needs.**

*Terms of reference alignment: b, d, f*

- 3.1 Reform Medicare Benefits Schedule (MBS) patient rebates to incentivise bulk-billed general practice services and facilitate longer appointments to ensure the viability of affordable and accessible menopause-related primary care.
- 3.2 Extend the Pharmaceutical Benefits Scheme (PBS) to cover a wider range of menopause hormone therapies to reduce reliance on a limited number of products (in view of ongoing supply shortages) and increase access to alternatives to patches (e.g., gels and creams) by making them more affordable and ensuring adequate supply for both menopausal people and trans and gender diverse people using these treatments for feminising therapy.
- 3.3 Work with women's and community health services to develop targeted, tailored, in-language resources and programs to equip healthcare professionals to improve community understanding of health issues connected to menopause and post-menopause (e.g. cardiovascular health) and access to relevant care.



**4. Ensure that underserved communities have access to affordable, best practice, evidence-based information and services that are culturally safe, culturally and linguistically appropriate, and disability inclusive.**

*Terms of reference alignment: a, b, e, f, h*

- 4.1 Train healthcare professionals including primary care providers to enable them to offer appropriate, tailored, evidence-based treatment options to trans and gender diverse people and people with innate variations of sex characteristics.
- 4.2 Recruit and train Aboriginal health workers in sexual and reproductive healthcare in line with co-design principles to produce culturally safe and appropriate resources and guidelines.
- 4.3 Extend Medicare to include all migrants and refugees, regardless of visa status or category.
- 4.4 Invest in regional hubs to improve services including telehealth.
- 4.5 Resource primary care providers with evidence-based information about menopause in a range of accessible formats and languages, including simple English.
- 4.6 Fund the recruitment, training and ongoing professional development of an increased workforce of interpreters who are skilled to deliver sexual and reproductive health information to combat long wait times for appointment/interpreter availability.

**5. Create provisions in national legislation via both modern awards and in National Employment Standards that enshrine the right to paid gender-inclusive reproductive leave and to flexible working arrangements.**

*Terms of reference alignment: a, c, g, h*

- 5.1 Create national legislation for gender-inclusive reproductive leave (that includes menopause leave) via both modern awards and in National Employment Standards.
- 5.2 Implement capacity building for employers/management to foster gender-equitable workplace cultures.
- 5.3 Utilise existing gender equality legislation and structures (e.g. Victorian Gender Equality Act) to build norms such as flexible working arrangements and reproductive leave entitlements into gender equality action plans.
- 5.4 Invest in and collaborate with place-based women's and community health services that engage with workplaces and offer training and resources.

**6. Address stigma towards and lack of understanding of menopause in Australian society.**

*Terms of reference alignment: c, e, g*

- 6.1 Integrate education on menopause and perimenopause into expanded sexual and reproductive health education in school settings.
- 6.2 Introduce protocols requiring standard practice engagement between primary healthcare providers and patients on menopause and perimenopause, including available hormonal and non-hormonal treatment options.
- 6.3 Invest in public health promotion and awareness raising campaigns to counteract misinformation.
- 6.4 Encourage discussions of perimenopause and menopause in the workplace as a key site for education as part of wider employee health and wellbeing initiatives.
- 6.5 Equip healthcare providers with tailored resources for partners to encourage discussion and understanding about menopause, its symptoms and treatment options.

Recommendation 1: Invest in research informed by an intersectional gendered and social determinants of health perspective to address knowledge gaps in understanding of experiences and treatment of menopause symptoms.

*Terms of Reference alignment: a, b, i*

### Impact of gender inequality on understanding of experiences and treatment of perimenopause and menopause

There are currently significant gaps in our understanding of the physiology of menopause. Alarming, 99% of preclinical ageing studies ignore menopause (Gilmer et al. 2023). This lack of knowledge is directly related to gendered ageism, common in Western societies such as Australia (Hickey et al. 2022), which influences health and medical research funding and choice of research questions. This gap in research leads to gaps in women's healthcare.

The menopausal transition is not difficult for the majority of women and people with a functioning uterus and ovaries, however, a significant minority – up to a third – will experience severe or disruptive symptoms (Davis et al. 2023). While there are a range of treatment options available, including hormonal and non-hormonal therapies, the lack of research means we do not yet know the long-term effects of available treatments. In addition, many have been trialled on menopausal women only, so their efficacy and safety on perimenopausal women is unclear (Davis et al. 2023).

Along with further research to improve menopause treatments, regulations guiding policy and clinical practice are also needed to ensure people experiencing bothersome symptoms can access unbiased, accurate information without undue industry influence (Hickey et al. 2024).

### Research into links between perimenopause and menopause and mental health

Little research has been undertaken on the relationship between mental health and menopause. While we need a better understanding of how physical symptoms may contribute to mental ill-health for people experiencing menopause, and of links between perimenopause and first-onset mood disorders (Musial et al. 2021), it is equally important to consider the social determinants of mental health. These include social connectedness, socio-economic status, freedom from discrimination and violence, and economic participation (Rychetnik & Todd 2004) as well as drivers of mental ill-health commonly associated with women's experiences at midlife, including increased caregiving and financial responsibilities (Barr et al. 2023), all of which are influenced by the broader environmental context of gender inequality. This includes, for example, research to better understand how gender inequality can intersect with menopausal symptoms to negatively impact work performance, family relationships, or social connectedness. Attributing mental ill-health solely to the biology of the menopausal transition renders this social context irrelevant, and risks further entrenching the views of women's unsuitability for the workforce or lack of resilience due to 'biological needs' (Kirkman & Fisher 2021).

## Research into the menopause experiences and needs of underserved communities

Much of the existing research on menopause is on white, middle-class, urban and generally healthy women (Verdonk, Bendien & Appelman 2022). Research is urgently needed to address the menopause experiences and needs of women and gender diverse people from migrant and refugee backgrounds, First Nations women, women with disabilities, those living in regional and remote communities and from low-socio-economic backgrounds (Schoenaker et al. 2014). For example, previous literature has found that women with lower socioeconomic status and/or low educational attainment are more likely to have a higher rate of symptom reporting. Socioeconomic position is also associated with age at natural menopause, with lower income women more likely to experience menopause at an earlier age (Schoenaker et al. 2014). The perspectives of women with disabilities on the transition to menopause is also largely missing from research (Moore, Reidy & Foran 2023).

There is a critical lack of research on experiences of ageing and menopause for trans men, non-binary and gender diverse people, and people with innate variations of sex characteristics who also have a functioning uterus and ovaries (Cheung, Nolan & Zwickl 2023). These communities can experience menstruation, menopause and perimenopause in a variety of ways. However, available information, resources and support from health professionals are tailored to the experiences of cisgender women which can be unaffirming and distressing for people seeking advice and support (Napier 2024).

In particular, there is extremely limited research on First Nations women's experiences of menopause. What research exists, some of which is a decade old, suggests that some First Nations women fear menopause symptoms or are uncertain about their origins, due in part to a lack of culturally responsive health promotion (Jurgenson et al. 2014). It is vital that research on First Nations women's experiences of menopause adheres to the Inala Manifesto, which foregrounds Indigenous intellectual sovereignty (Watego 2021).

Approximately 12% of women experience early menopause (menopause between 40-44 years) and/or premature ovarian insufficiency (before age 40), either spontaneously or as a result of medical treatment, predominantly for cancer or gynaecological conditions. Experiences of diagnosis, symptoms, longer-term impacts and treatment for people with early menopause or premature ovarian insufficiency (EM/POI) are different (and typically more challenging) from those undergoing menopause at the usual age, and different again depending on cause of EM/POI and age at diagnosis (Johnston-Ataata, Flore & Kokanović 2020; Mishra et al. 2024).

Key research gaps in this area are:

- poor understanding of the causes of idiopathic spontaneous EM/POI;
- lack of understanding of EM/POI among healthcare professionals;
- inadequate understanding of the long-term impacts of oestrogen deficiency commencing before age 45; and
- lack of effective treatments for menopausal symptoms for women with iatrogenic EM/POI as a result of treatment for hormone-related cancer. This group is unable to take menopause hormone therapy (MHT), however non-hormone-based therapies are less effective for symptom relief.

## Research into the impact of perimenopause and menopause on employment and workplace performance

As stated in the report *The impact of symptoms attributed to menopause by Australian women* (Australasian Menopause Society et al. 2023), further research is needed to differentiate between 'the true impact of perimenopause and menopause from other causes of midlife stressors on women in the workplace'. There have been only two rigorous Australian studies evaluating the relationship between perimenopause (moderate to severe vasomotor symptoms) and work ability, neither of which assessed workplace absences (Hickey et al. 2017; Gartoulla et al. 2016). While both studies found only a minority reported menopause symptoms negatively impacting their work ability, in one study work ability was also independently associated with other variables, such as health, partnership status, housing and financial security (Gartoulla et al. 2016).

Studies have also found that a range of factors can impact on perceived severity of symptoms, and ability to work, for people experiencing menopause, including job stress, lower health status, work type (including both non-traditional and care work), physical working conditions (such as office temperature and ventilation, job physicality and uniforms), management support, and levels of responsibility (Mishra & Kuh 2006; Ayers, Forshaw & Hunter 2010; Verdonk, Bendien & Appelman 2022). This demonstrates the need for more research into the optimal psychosocial working conditions 'in order to provide women with the opportunities to live up to their potential'.

Finally, evidence on the unique impacts of EM/POI and work is also limited (Vincent et al. 2024).

## Addressing research gaps must be in line with lived experience co-design principles

Failure to listen to people with lived experience and to incorporate and understand lived realities has led to poorer research, policy gaps and inequitable and inappropriate treatment. Authentic co-design that leads to genuine system change is about placing those most impacted at the centre, preferencing their voices and being guided by them (CMHL Victoria 2022; McKercher 2020).

Sub-recommendations
1.1 Invest in research on the impact of gender inequality on understanding of experiences and treatment of perimenopause and menopause.
1.2 Invest in research on links between mental health and perimenopause and menopause.
1.3 Ensure gaps in research on underserved communities' menopause experiences and needs are addressed.
1.4 Invest in research on the impact of perimenopause and menopause on employment and workplace performance.
1.5 Ensure lived and living experience participants are involved at all stages of the research process from design onwards.

## Recommendation 2: Implement a national workforce and training plan to monitor and increase the capacity of the Australian health workforce to provide evidence-based, best practice menopause-related healthcare provision.

### *Terms of Reference alignment: c, f, i*

Research has found that while Australian health professionals are knowledgeable about menopause, they are uncertain about its management (Davis et al. 2021), as evidenced by GPs and pharmacists continuing to either recommend or not discourage unproven or ineffective treatments (including complementary and alternative medicines) and expressing reticence about prescribing MHT (Davis & McGraith 2023). Contributing factors include the exclusion of menopause from most medical and allied health education at the undergraduate and post graduate level (McPherson & Quinton 2022), conflicting information about treatment for menopausal symptoms in the wake of the 2002 Women's Health Initiative Study findings, and clinical management guidelines that have not kept pace with the latest international evidence. Areas where health practitioner knowledge is particularly lacking include diagnosis and treatment of early menopause and premature ovarian insufficiency, and the links between menopause and both the biological and social determinants of mental ill-health at midlife.

The Royal Australian College of Obstetricians and Gynaecologists (RANZCOG) was due to update its 2020 menopause management clinical guidelines in 2023 but to our knowledge the revised version is yet to be published (RANZCOG 2020). This needs to be given priority; in the meantime, existing resources such as the *Practitioner's Toolkit for the Management of Menopause* (Monash University Women's Health Research Program 2023), and the comprehensive array of guidance on the Australasian Menopause Society website should be promoted more widely among health practitioners, particularly primary care clinicians and pharmacists but also others specialists and allied health professionals working with women and gender diverse people with menopause including gynaecologists, endocrinologists, and physiotherapists.

The relevant federal and state government authorities are also urged to work with other professional associations (e.g., the Australasian Menopause Society) and accrediting and registering bodies to implement menopause education guidelines into their accreditation and competency frameworks and continuing professional development requirements.

Finally, medical and allied health education providers need, as a matter of urgency, to redress the inexcusable absence of menopause as a core topic in women's health.

Sub-recommendations
2.1 Invest in training treating healthcare professionals, especially GPs and pharmacists as frontline workers, to increase knowledge of best-practice, evidence-based treatment options.
2.2 Work with professional associations and accrediting/registering bodies to implement menopause education guidelines into the accreditation/competency frameworks and continuing professional development requirements.
2.3 Ensure medical and allied health education providers include menopause as a core topic in women's health.

Recommendation 3: Develop a national, integrated and coordinated healthcare system to ensure that everyone living in Australia can access the menopause healthcare that suits their needs.

***Terms of Reference alignment: b, d, f***

Good quality menopause care is holistic and individually tailored, addresses physical and mental health impacts as well as underlying associated health risks and any other relevant health concerns, and is underpinned by affordable access to a variety of evidence-based treatments.

Currently menopause care is not provided to a consistent standard in Australia, nor is it tailored to the needs of women from different communities or backgrounds. Part of the reason for such variation in care is lack of adequate menopause education and updated menopause management guidelines, as discussed under Recommendation 2 above.

However, research indicates that lack of access to longer and/or bulk-billed GP appointments, limited availability of treatment options, particularly subsidised therapies available via the Pharmaceutical Benefits Scheme (PBS), and frequent supply shortages of PBS-listed therapies are also contributing factors (Davis & McGraith 2023; Cheung 2024; RACGP 2024). Lack of culturally safe and tailored care for people from marginalised communities (particularly trans and gender diverse people with a functioning uterus and ovaries, women from migrant and refugee communities, First Nations women, women with disabilities, low-income women, and women living regionally and rurally) is also a significant barrier.

## Sub-recommendations

- 3.1 Reform Medicare Benefits Schedule (MBS) patient rebates to incentivise bulk-billed general practice services and facilitate longer appointments to ensure the viability of affordable and accessible menopause-related primary care.
- 3.2 Extend the Pharmaceutical Benefits Scheme (PBS) to cover a wider range of evidence-based menopause hormone therapies to reduce reliance on a limited number of products (in view of ongoing supply shortages) and increase access to alternatives to patches (e.g., gels and creams) by making them more affordable and ensuring adequate supply for both menopausal people and trans and gender diverse people using these treatments for feminising therapy.
- 3.3 Work with women's and community health services to develop targeted, tailored, in-language resources and programs to equip healthcare professionals to improve community understanding of health issues connected to menopause and post-menopause (e.g. cardiovascular health) and access to relevant care.

Recommendation 4: Ensure that underserved communities have access to affordable, best practice, evidence-based information and services that are culturally safe, culturally and linguistically appropriate and disability inclusive.

**Terms of Reference alignment: a, b, e, f, h**

### Trans and gender diverse people, and people with innate variations in sex characteristics

There is a lack of gender-affirming information and services available and appropriate to support trans and gender diverse people who also experience perimenopause and menopause. Similarly, the side effects of long-term use of gender-affirming hormone therapy are under-researched, and healthcare providers' knowledge is low. The health impacts of this are compounded by the systemic inequalities and discrimination trans and gender diverse people and people with innate variations in sex characteristics face throughout their lives, including from healthcare providers. Poorer treatment and fear of mistreatment mean that trans and gender diverse people experience poorer physical and mental health outcomes in general (Cheung, Nolan & Zwickl 2023).

Some people with innate variations in sex characteristics will also experience perimenopause and menopause, however there is very little information available that speaks to experiences beyond those of cisgender women.

## Aboriginal and Torres Strait Islander women

There is a dearth of published research on the menopause experiences of Aboriginal and Torres Strait women; however existing research highlights that Aboriginal health workers are under-resourced and under-trained on how to discuss menopause or give appropriate, culturally safe advice on menopause symptoms and treatment options (Jurgenson et al. 2014).

## Migrant and refugee women

Migrant and refugee women and trans and gender diverse people experience a range of systemic barriers to accessing treatment for perimenopause and menopause symptoms. For example, temporary visa holders who do not have access to Medicare are subject to restrictive waiting periods, as well as high upfront costs (Shannon 2021). Barriers to developing health literacy and digital literacy, such as lack of in-language, culturally appropriate resources or unavailability of interpreters trained in sexual and reproductive healthcare, can also exacerbate difficulty accessing timely, appropriate healthcare advice. Interpreters and bilingual workers need to be recognised as an important part of the provision of health information. They should be supported, resourced and offered ongoing professional development to deliver sexual and reproductive health information with professionalism and sensitivity.

## Women living in rural and remote areas

In regional/rural locations access to best practice, evidence based menopause-related healthcare is not always available or affordable. Given long travel times, clinics that only operate on limited hours are not appropriate for many people living rurally. While telehealth has been proposed as a key strategy for improving access to healthcare and overcoming staff shortages in rural and remote areas, there are some implications for its use which need to be considered. Telehealth is not an option in many rural areas where connectivity to the internet is an issue. There are also workforce considerations such as ensuring healthcare professionals have the appropriate skills to utilise telehealth effectively. Telehealth services complemented with adequate face-to-face services have the potential to improve access to healthcare in rural and remote areas (Bradford, Caffery & Smith 2016; Mathew et al. 2023; Fraser et al. 2017; Gippsland PHN 2022).

## Women with disabilities

For women with disabilities, ableism and gender discrimination intersect, leading to multiple forms of disadvantage at the same time (Women with Disabilities Victoria 2022). Only 24% of people with disabilities in Australia describe their health as very good, compared with 65% of Australians without disability (AIHW 2022). Women with disabilities are less likely to receive appropriate sexual and reproductive health care support than women without disabilities, due to negative attitudes towards disability from healthcare providers, inaccessible information and communication and physical barriers to services (Groce et al. 2009). Women with physical disabilities experience the same symptoms at menopause as women in the general population. However there can be an increased risk of secondary complications, such as osteoporosis, cardiovascular disease and thrombosis. Research suggests these increased risks could be related to physical conditions, earlier menopause,



surgically induced menopause and interactions between medications used to manage some disabilities (Dormire, Becker & Lin 2006).

## Intersectional experiences

People who experience perimenopause and menopause from the above underserved communities may also belong to other communities that experience structural barriers to equitable healthcare, including trans, non-binary and gender diverse people, people with disabilities, people from migrant and refugee communities, and First Nations peoples, and these barriers compound disadvantage and can lead to poorer health. For example, for migrant and refugee women and gender diverse people living in regional and remote areas, transport difficulties and lack of infrastructure such as interpreters and culturally appropriate, in-language information, exacerbate other barriers such as restrictions to accessing Medicare. An intersectional lens on menopause care is critical to illuminate the way in which different forms of disadvantage can compound one another and impact on people's health needs and access to care.

Sub-recommendations
4.1 Train healthcare professionals including primary care providers to enable them to offer appropriate, tailored, evidence-based treatment options to trans and gender diverse people and people with innate variations of sex characteristics.
4.2 Recruit and train Aboriginal health workers in sexual and reproductive healthcare in line with co-design principles to produce culturally safe and appropriate resources and guidelines.
4.3 Extend Medicare to include all migrants and refugees, regardless of visa status or category.
4.4 Invest in regional hubs to improve services including telehealth.
4.5 Resource primary care providers with evidence-based information about menopause in a range of accessible formats and languages, including simple English.
4.6 Fund the recruitment, training and ongoing professional development of an increased workforce of interpreters who are skilled to deliver sexual and reproductive health information to combat long wait times for appointment/interpreter availability.

## Recommendation 5: Create provisions in national legislation via both modern awards and in National Employment Standards that enshrine the right to paid gender-inclusive reproductive leave and to flexible working arrangements.

### *Terms of Reference alignment: a, c, g, h*

As the federal government prolongs Australians' years of workforce participation by increasing the age of eligibility for the Age Pension, it has an attendant responsibility to ensure that workplaces and industrial laws accommodate age-related transitions such as menopause. Workplaces also have a responsibility to better accommodate workers experiencing bothersome menopause symptoms.

Gendered ageism, sexism and ableism, which are embedded in many Australian workplaces, mean that women are unlikely to disclose or seek alternative adjustments for bothersome menopausal symptoms at work (Riach & Jack 2021). A 2021 survey of 700 people who were experiencing or had experienced menopause found that while 83% were affected at work, only 70% would feel comfortable speaking about it with their manager (Circle In 2021).

This lack of support has real and significant impacts on lives, including loss of income and superannuation due to women reducing their working hours, taking early retirement and taking lower-paid roles. The Australian Treasury recently estimated in its Pre-Budget Submission for 2023-24 that menopause 'could currently be costing Australian women a collective loss of \$15.2 billion in foregone income and super for every year of early retirement' (AIST 2023).

Research from the UK shows that women want their employers to have more knowledge and awareness about menopause, develop supportive policies and agree to appropriate work adjustments (Hardy, Griffiths & Hunter 2017). Other studies have found that women prefer not to have a stand-alone workplace policy for menopause, instead preferring menopause support to be embedded into policy in ways that do not necessitate public disclosure as a condition of access (Jean Hailes 2023). While there are risks that failing to openly acknowledge bothersome menopause symptoms perpetuates lack of understanding and feelings of shame and stigma, recognising the impact of existing intersectional barriers to equitable working conditions is key to tackling embedded inequalities that affect women's experiences of menopause in the workplace differently (Riach & Jack 2021).

Taking this approach means integrating menopause support across several policies including flexible working conditions - which also allows for acknowledgement of cultural differences in the perception of menopause. Therefore, we endorse the Equality Rights Alliance's recommendation in their submission to this inquiry that the federal government consider how best to support perimenopausal and menopausal workers who may feel especially reluctant to name menopause as their reason for leave. This may, for instance, include the creation of national legislation for wider reproductive leave (that includes menopause leave) via both modern awards and in National Employment Standards, that enshrine the right to paid gender-inclusive reproductive leave in addition to regular personal and annual leave. We also recommend that flexible working arrangements are enshrined in National Employment Standards.

The Impact of menopause on people's work is directly linked to systemic gender inequality within Australian workplaces. Evidence shows that the best way to achieve lasting and widespread change is through a whole-of-organisation approach to gender equality (Victoria. CGEPS 2021). This includes creating a supportive workplace culture, building staff capacity to support gender equality, and embedding gender equality into organisational policies, systems and processes (O'Shea et al. 2024). Existing legislation that focuses on workplace inequality, such as the Victorian Gender Equality Act, provide examples of how Australian states can build norms such as flexible working arrangements and reproductive leave entitlements into their Gender Equality Action Plans.

Working with and investing in place-based women's and community health services is integral to assisting workplaces to adopt more menopause-friendly policies. This settings-based health promotion approach to menopause provides a holistic and socioecological approach, allowing for actions at the individual and organisational level. Successful examples of this approach include the Victorian women's health service Women's Health East, which offers online training on "How to become a menopause friendly workplace" and free menopause literacy workshops for workplaces.

Finally, it is also important to emphasise to employers that menopause is a transition and that any changes to work ability are temporary and not an indication of long-term performance, and to not expose women to further prejudice or inequality in the workplace (Riach & Jack 2021).

Sub-recommendations
5.1 Create national legislation for gender-inclusive reproductive leave (that includes menopause leave) via both modern awards and in National Employment Standards.
5.2 Implement capacity building for employers/management to foster gender-equitable workplace cultures.
5.3 Utilise existing gender equality legislation and structures (e.g. Victorian Gender Equality Act) to build norms such as flexible working arrangements and reproductive leave entitlements into gender equality action plans.
5.4 Invest in and collaborate with place-based women's and community health services that engage with workplaces and offer training and resources.

## Recommendation 6: Address stigma towards and lack of understanding of menopause in Australian society.

### *Terms of Reference alignment: c, d, e, g*

Australian women's experiences of menopause and menopause care are significantly influenced by both stigma and lack of understanding of menopause among the broader community, with each reinforcing the other.

Research demonstrates that experiences of menopause are 'strongly influenced by social values around reproduction and ageing, with positive or negative ramifications' (Hickey et al. 2022). In countries where women's value is predicated on youth and reproductive capacity, and where ageing is portrayed as decline, representations and experiences of menopause tend to be more negative (Hickey et al. 2022).

In the Australian context, systemic gendered ageism combined with a widespread lack of understanding of menopause as a normal part of healthy ageing is driving negative perceptions of menopause and menopausal women (Hardy, Griffiths & Hunter 2017). Commercial interests exacerbate and capitalise on these negative perceptions and lack of understanding through disseminating 'catastrophising' narratives about menopause to sell products and services (Australasian Menopause Society et al. 2023). The creation, production, and distribution of unreliable, non-evidence-based information online, particularly via social media where health-related misinformation has been found to be often more popular than accurate information (Swire-Thompson & Lazer 2020; Wang et al. 2019), further compounds fear and misunderstanding of menopause.

Misinformation and lack of health literacy has a negative impact on understanding of available treatment options: Australian women tend to view menopause hormone therapy (MHT) negatively, 'with shared perceptions of cancer risk and over-prescription' (Herbert et al. 2020). Similarly, there is a lack of understanding of long-term impacts of menopause, such as loss of bone density (beyond ageing-related loss), and the role of treatment options in prevention (Herbert et al. 2020). This can have significant consequences for people's quality of life and risk of mortality.

Publicly funded health literacy initiatives on menopause are needed to counter the spread of misinformation and improve community understanding of menopause as a normal stage of life for more than 50 percent of the population (Australasian Menopause Society et al. 2023). These campaigns must be designed in consultation with people with lived and living experience from all communities, including First Nations peoples, people with disabilities, people from migrant and refugee backgrounds, trans and gender diverse people and people with innate variations in sex characteristics.

Education campaigns must be aimed at fostering more widespread understanding of the full diversity of experiences of menopause, such as for people without regular periods before menopause, for people who use long-acting reversible contraception like IUDs, or people who have had hysterectomies. This could be assisted by adopting a new definition for menopause as 'final cessation of ovarian function', rather than the traditional focus on menstruation (Monash University 2023).

Public health promotion and education campaigns focusing on workplaces, young people in education settings (as part of wider sexual and reproductive health education), and people who will not experience menopause (such as partners) are also needed to help demystify menopause as a normal life event and to counteract misinformation, including stigmatising messaging.

### Sub-recommendations

6.1 Integrate education on menopause and perimenopause into expanded sexual and reproductive health education in school settings.

6.2 Introduce protocols requiring standard practice engagement between primary healthcare providers and patients on menopause and perimenopause, including available hormonal and non-hormonal treatment options.

6.3 Invest in public health promotion and awareness raising campaigns to counteract misinformation.

6.3 Encourage discussions of perimenopause and menopause in the workplace as a key site for education as part of wider employee health and wellbeing initiatives.

6.4 Equip healthcare providers with tailored resources for partners to encourage discussion and understanding about menopause, its symptoms and treatment options.

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