Submission from The Royal Women's Hospital, Melbourne
Issues related to menopause and perimenopause

1. Introduction

Menopause is usually a natural and healthy part of ageing. However, the experience varies from one person to another, and while most report symptoms that are mild or moderate, a smaller proportion experience severe symptoms that can impact their quality of life.

This submission promotes the normalisation of menopause. It provides an overview of our current knowledge (as well as the knowledge gaps and inconsistencies) and outlines some important areas for consideration. It suggests some recommendations to challenge stigma and ageism, to improve knowledge and understanding, and to develop supportive strategies for women as they transition through the menopause.

2. About the Women's

Established over 165 years ago, the Women's is one of Australia's leading hospitals dedicated to improving and advocating for the health and wellbeing of women and newborns. Offering care to women through all stages of life, the Women's provides a range of services including maternity, gynaecology, sexual and reproductive health, cancer care, women's mental health and neonatal care. The hospital offers a range of state-wide specialist services and is a major research and teaching hospital. It plays a unique role in Australia's healthcare system by advancing research and evidence-based practice and providing clinical training, leadership and advocacy.

Under the leadership of Professor Martha Hickey, the Women's established the multi-disciplinary Menopausal Symptoms After Cancer Service in 2010 specifically to care for women struggling with menopausal symptoms, mood, sleep and sexual difficulties after cancer. The service also cares for women at high inherited risk of cancer. It is the largest public menopause clinic in Australia and takes a patient-focused approach to managing all common symptoms in women cancer patients in one place. The clinic provides advice on the full range of pharmacological and non-pharmacological evidence-based therapies for menopausal symptoms, information on lifestyle factors, such as exercise and nutrition, sexual counselling, and fertility. The service offers expert information specific to women's unique health needs on mental health, heart and bone health.

About Professor Martha Hickey

Professor Hickey is Professor of Obstetrics and Gynaecology at the University of Melbourne and Adjunct Professor of Obstetrics, Gynaecology and Reproductive Sciences at Yale University, Connecticut. She leads menopause services at the Royal Women's Hospital, including Complex Menopause and Menopausal Symptoms After Cancer Services. She also leads the hospital's Gynaecology Research Centre, which includes over 50 researchers across a range of specialties focusing on women's health.

Professor Hickey is an Editor for the Cochrane Collaboration (evidence-based medicine) and her research has driven evidence-based care in menopause internationally, including new discoveries, treatments, models of care, evidence synthesis and clinical guidelines. Recognised as a global expert, she is also the Clinician expert for the UK National Institute for Health and Care Excellence (NICE) guidelines on Menopause Committee, due to report in May 2024. Professor Hickey was invited by The Lancet to lead their first Clinical Series on Menopause (in press, March 2024) and in 2023, was the first gynaecologist to be elected to the prestigious Australian Academy of Health and Medical Sciences.

Professor Hickey holds an NHMRC Investigator Grant in menopause research and is currently leading the Menopause Priority Setting Partnership. This global initiative involving over 40 countries is designed to consult women with lived experience, and their healthcare providers, to better understand the gaps in menopause research, and identify the 'unanswered questions' people with lived experience believe are important.

3. Addressing the committee's terms of reference

(a) The economic consequences of menopause and perimenopause, including but not limited to, reduced workforce participation, productivity and retirement planning

In 2020, the Australian Government launched its National Women's Health Strategy 2020–2030, followed in 2021 by The Scottish Women's Health Plan and The Women's Health Strategy for England. Each of these policy positions and intentions signal increasing awareness that economic participation is central to both the continued well-being of women and gender equality, as articulated by the United Nations (Sustainable Development Goal 5: Gender Equality) and World Health Organization. Australia has been slow to recognise how menopause may fit into these strategies, but this is now changing.

Women[1] in midlife make a vital contribution to the Australian economy and paid employment provides women with many benefits. In addition to income, work can provide fulfilment and social connection, and improve self-esteem, confidence and identity. Organisations also benefit from employing skilled and experienced older workers who often fulfill formal and informal roles as leaders, mentors and educators.

The Australian workforce is critically dependent on older workers, particularly women. As we know, most essential workers in health, childcare and education are women, often older women, and Australia has a shortage of skilled workers, particularly in healthcare. For example, the average age at menopause in Australia is 51 years and, according to government figures almost half (46%) of Australia's nurses are aged 45 or older. The situation is similar in the education sector where the majority of teachers are female and their average age is 44 years [1]. Women comprise 57% of the higher education sector and 78% of the health and social care sector, meaning that supporting women's health across the life course is central to our economy.

Reduced workforce participation and productivity

The proportion of women working through and beyond menopause is increasing, making this the fastest growing working population group [2,3]. Evidence presented at the UK Faculty of Occupational Medicine of the Royal College of Physicians indicates that 8 out of 10 menopausal women are in paid employment and the figures are likely to be similar in Australia.

But evidence supporting claims that menopause leads to reduced workforce participation is harder to come by. Sensationalist media coverage in the UK about women quitting their jobs because of menopausal symptoms has not been well substantiated. For example, a market research survey (Menopause and the Workplace) that reported 'nearly one million' women quit their jobs, is based on scaled up figures from a smaller survey and includes those leaving work for a range of reasons, not limited to menopause. Similarly, economic modelling from the US is based on similar scaled up market research.

In October 2022, the Australian Institute of Superannuation Trustees (AIST) used the UK's Menopause and the Workplace market research survey to estimate that menopause costs women a collective loss of $13.2 million in lost earnings and superannuation. This figure was based on an estimate of 25% of menopausal women experiencing 'debilitating symptoms leading to long-term absences from work or forcing them into early retirement'. But while the AIST methodology may be flawed, it does highlight the AIST report's own

[1] All people with functioning female gonads who do not take cross gender hormones will experience menopause at some point. This includes most individuals assigned female at birth, even if their gender identity does not align with that assignment. We use the terms 'women' and 'women's health' in this document to encompass all these individuals.

recommendation that government itself should "…measure and report on the extent to which menopausal symptoms impact women's employment and retirement decisions, and how these impact their super balances and retirement incomes". Without truly, and independently, understanding the scale of the problem and its social and economic consequences, it's difficult for government to identify and implement effective policy solutions.

Australian data

Australian data do not suggest that women have reduced productivity or plan to leave their jobs because of menopause. A survey in 2017 of around 1,000 female healthcare workers [2] in Victoria found no association between menopause and work engagement, organisational commitment, job satisfaction or work limitations. Two-thirds reported that menopause did 'not at all' affect their work performance, 6% that menopause 'very much' affected work performance and 6% that menopause 'somewhat' affected their work performance [2]. Together, this suggests that a small but important minority of women experience menopausal symptoms that impact on work.

Another Australian survey of around 1,200 women in paid employment in 2016 reported that women with vasomotor symptoms (hot flushes/night sweats) had a reduced self-reported work ability [3]. However, factors independent of menopause such as obesity, partnership status, housing and financial security were more strongly related to work ability than menopausal symptoms.

A 2023 Australian survey of >3000 women by the Australasian Menopause Society, Monash University and Jean Hailes for Women's Health reported that less than one in ten missed work due to symptoms they attributed to menopause, and 7% reported a negative impact of these symptoms on their daily activities including work. Overall, only 3.8% of those who experienced bothersome symptoms missed days of work or study due to these symptoms. Almost half (47%) of midlife women experienced bothersome symptoms they attributed to menopause but remained at work. Another 36% did not have bothersome symptoms.

Retirement planning

On average, women spend less time in the workforce than men, largely because of absences due to parenting responsibilities and earlier age at retirement. According to the Australian Government's Status of Women Report Card (2023), Australian women are less likely to participate in the workforce (62%) than men (71%) and more likely to work part-time (43%) than men (19%). The gender pay gap in Australia is 29% in terms of total annual taxable income, with women approaching retirement having 23% less superannuation than men of the same age. Together, these contribute to significant disadvantage for women, including poverty in older age.

It is uncertain whether women retire earlier because of menopause. However, the Australian Human Rights Commission confirms that caring duties lead to time out of paid work and poverty in older age for women. In the UK, a survey by Wellbeing of Women in 2016 reported that one quarter of women had considered quitting work because of the menopause. However, the decision to leave work may depend on the nature of that work. For example, a 2020 survey report by the British Medical Association reported that female doctors experiencing menopause were reducing their hours, moving to lower-paid roles or retiring early from medicine due to sexism and ageism in surgeries and hospitals.

(b) The physical health impacts, including menopausal and perimenopausal symptoms, associated medical conditions such as menorrhagia, and access to healthcare services

The menopause transition (perimenopause) starts at around 47 years, on average, with the final menstrual period at around 51 years. Typical symptoms such as hot flushes and night sweats start during the menopause transition and may last for around 7 years(4).

The experience of menopause varies considerably between women, and for the same woman over time. Around one in four have no symptoms and most have mild or moderate symptoms(5). A smaller but significant percentage (around 10-20%) have severe and/or prolonged vasomotor symptoms.

According to a US longitudinal research program, the Study of Women's Health Across the Nation, during perimenopause, heavy, irregular or prolonged menstrual bleeding affects >90% of women at least once, and nearly 80% of women at least 3 times [6]. Abnormal bleeding may impact women at work and the workplace environment along with factors, such as lack of access to toilets and breaks, may cause difficulties. The menopause transition and early postmenopausal period are also when vasomotor symptoms are most likely to occur(7). Many women experience more than one symptom at once. For example, hot flushes, sleep disturbance and fatigue commonly co-occur(8). Social factors also play a role with the most symptomatic women likely to also have financial difficulties, obesity and be smokers [8].

Research suggests vasomotor symptoms at work may cause embarrassment, affect confidence and lead to stress [9]. Aspects of work management and physical environment that may exacerbate the burden of symptoms include over-heated workplaces, shift-work and non-breathable uniforms / PPE made with synthetic materials [10]. The workplace culture is also critical. Lack of support and understanding by managers and inflexibility around working hours and conditions contribute to the burden of menopausal symptoms [10].

Managing at work is a common reason why women take menopause hormone therapy (MHT) [11]. Whilst MHT is an effective treatment for troublesome vasomotor symptoms, it also carries small but significant health risks such as breast cancer [12]. As an alternative to MHT, small changes and adjustments within workplaces can make an enormous difference in supporting women during menopause and consequently might reduce the need for MHT.

Managing menopause at work may be particularly difficult for the 10% of women who experience menopause prematurely (<40 years) or early (<45 years). Lack of recognition by employers that menopause may affect younger women and lack of peer support can add to the burden.

Similarly, research by our team and others shows that menopausal symptoms after cancer may be more severe than in the non-cancer population [13]. In a matched study, women with previous breast cancer had menopausal symptoms that were more frequent, severe, prolonged and distressing [14]. At the Women's we provide an award-winning clinical service for women struggling with menopausal symptoms after cancer, based on a multidisciplinary model of care [15 – 18]. This service (Managing Menopause after Cancer) has been replicated across Australia and in 7 countries worldwide. The service has generated evidence-based clinical guidelines for managing menopause after cancer globally and is cited as best practice.

Access to healthcare services and information

As menopause and perimenopause are part of the natural ageing process, this period of a woman's life does not necessarily require diagnosis or treatment. Some women may benefit from information and reassurance by a healthcare professional and those with severe symptoms may request treatment.

But before deciding on care and treatment options, many women simply need high-quality, evidence-based information about menopause, potential symptoms and their management – from a trusted and independent source. This includes information normalising menopause and suggesting effective self-management and drug-free strategies. For example, CBT may be effective for vasomotor symptoms [19] and non-hormonal treatments may also be helpful [20]. However, while there are a few good sources of quality, independent information available online, it is not always easy to find them and Google algorithms are often biased towards information about menopause that is alarmist and/or generated by commercial entities selling products or services.

It should be noted that for some women who do need access to a GP or nurse practitioner, there are significant physical, social and cost barriers to accessing healthcare. This includes women living in rural, regional and outer-urban areas; women experiencing economic stress; women from culturally and linguistically diverse backgrounds; and some within the LGBTQI+ community.

(c) The mental and emotional well-being of individuals experiencing menopause and perimenopause, considering issues like mental health, self-esteem, and social support

Menopause does not necessarily affect mental or emotional wellbeing. Large prospective Australian studies indicate that around 9% of women experience increasing depressive symptoms over the menopause transition and about the same proportion (8.5%) report decreasing depressive symptoms [21]. However, research indicates that menopausal women with previous clinical depression are at increased risk of relapsed depression and depressive symptoms over the menopause transition and shortly after [22,23]. Major depression is the leading global disease burden and costly for employers and employees due to decreased work participation, sick leave and reduced productivity [24]. Together, this suggests a potential role for the workplace in identifying and supporting those at elevated risk of depression during menopause.

More generally, there is extensive evidence that the mental and emotional health of those experiencing menopause can be affected by the work environment, including the attitudes of managers and colleagues, workplace cultures, and the continuance of gender and age-based stereotypes. Both menopause and ageing in women are stigmatised and another recent study suggests workplaces could address this by directly challenging ageism and sexism in the workplace [25]. Local governments, communities and the arts can also play a role by celebrating older women and challenging gender and social stereotypes.

(d) The impact of menopause and perimenopause on caregiving responsibilities, family dynamics, and relationships

Across our community, most paid and unpaid carers are women and, it is well established that caring responsibilities impact a woman's participation in the paid workforce. However, the impacts of menopause on caregiving, family dynamics and relationships are not well understood and independent research and investment in this area is limited.

One Australian study suggests that premature or early menopause may impact relationships(26) with some women's accounts suggesting they felt they had 'changed' after premature or early menopause, meanwhile others portrayed the experience as not particularly disruptive. The US Women's Health Across the Nation longitudinal study reports vaginal dryness affects around one third of women after the menopause and may impact relationships by affecting sexual function [27].

Anecdotally, there are indications that menopause and perimenopause may impact this realm of women's lives, however we would welcome further research and investment in this area.

(e) The cultural and societal factors influencing perceptions and attitudes toward menopause and perimenopause, including specifically considering culturally and linguistically diverse communities and women's business in First Nations communities

We know the experience, as well as the perceptions and attitudes of menopause, vary substantially by race/ethnicity and geographical location, and that there is no universal "menopause syndrome" [28]. However, while there are some studies looking at Canadian First Nations women and menopause, relatively little is known about the experience of menopause amongst different racial and ethnic groups in Australia.

A small study (n=25) of First Nations women in Western Australia reported that the "change of life" led to greater respect from their community [29]. This is in direct contrast with the wider community where both ageing and menopause are often seen as shameful or negative experiences. A small cross-cultural study between Australian and Laotian women (total n=108) reported more psychological symptoms, sexual dysfunction and vasomotor symptoms in Australian compared to Laotian women [30]. Meanwhile small studies of Arabic [31] women in Sydney showed similar symptoms to white women, but found that Indian [32] and Chinese women [33] reported experiencing fewer menopausal symptoms.

Large prospective studies in the US demonstrate that race, ethnicity and socio-economic disadvantage contribute to both the timing of menopause and the nature and burden of symptoms [34]. More disadvantaged women experience earlier menopause, with its attendant elevated risks of chronic disease. Minority group women in the US are at greater risk of surgical menopause, which may have adverse effects on long-term disease risk [35]. In the USA, Black women report more severe and persistent vasomotor symptoms and sleep disturbance compared to white women [36].

Similar cross-cultural studies have not been undertaken in Australia. Clearly, there is a significant need for more research on the menopause experience and needs of First Nations women, and the cultural and societal factors affecting menopausal women in other minority groups in Australia.

f) The level of awareness amongst medical professionals and patients of the symptoms of menopause and perimenopause and the treatments, including the affordability and availability

Menopause is covered during the training of health care professionals, including doctors in Australia, and in England, it is now included in the high school curriculum. However, many women report dissatisfaction with their medical care and a lack of awareness about symptoms and treatments persists among health professionals and the general community.

A contributing factor is the lack of consensus about what symptoms menopause causes. Whilst symptoms such as brain fog, mood swings, anxiety and weight gain may be common, they have not been shown to be attributable to menopause. Stigma around ageing in women and a research focus on pharmacological treatments means that evidence is limited. Addressing this would help women and health professionals to better understand this life stage and aid decision-making about self-management, treatment and clinical care.

It should be noted that referring to menopausal women as ‘patients’ assumes a medicalised approach to what is usually a natural stage of life. Natural menopause at the average age (45-55 years) is not a health risk [34] and need not be treated as a ‘disease’. Unfortunately, amongst many medical professionals, menopause has largely been pathologised and viewed as a “hormone deficiency”. This is both inaccurate and potentially harmful and can lead to over-diagnosis and over-treatment [37]. It can also create negative expectations, and those with negative expectations are more likely to report problematic symptoms [39].

Menopause hormone therapy

MHT is the most effective treatment for vasomotor symptoms but is unlikely to completely resolve them [41] and as previously stated, does present some health risks. MHT may also improve sleep and potentially mood, but it has not been shown to improve other symptoms often ascribed to menopause, such as exhaustion, sore breasts, brain fog, irregular periods, weight gain, forgetfulness, mood swings etc. In the short term, MHT increases the risk of urinary incontinence [42] and in the longer term, increases the risk of breast cancer and stroke and may increase dementia risk [43]. MHT does prevent osteoporosis and fracture but only for the duration of use. Since fracture risk is highest in the older population, MHT will not prevent fracture in this group unless it is used into older age. However, as long-term use (and dosage) of MHT increases health risks, the US Preventive Task Force warns against using MHT for the sole purpose of preventing chronic disease [38].

Currently around 22% of Australian women take MHT [44]. For those who cannot or do not wish to take MHT, a range of non-pharmaceutical and non-hormonal options are available [20]. However, some research suggests many women do not wish to take pharmacological therapies unless their symptoms are severe [39].

The cost of MHT can be prohibitive for some people and presents a potential equity issue. In Australia, Pharmaceutical Benefits Scheme (PBS) listed products (such as Estalis Conti) cost around $25 per month but widely prescribed non-PBS items, such as Estrogel Pro, cost over $50 month and have not been shown to be superior in terms of efficacy and safety. Heavy promotion by the pharmaceutical industry plays a significant factor in treatment recommendations and has included paying menopause experts to state that these products are safer and more effective than PBS listed treatments. Similarly, products such as Androfem (testosterone cream) are

only available on private prescriptions (ie. not on the PBS) but are heavily promoted by those with financial interests. Unfortunately, many clinicians working in menopause have financial involvements with pharmaceutical companies (see Medicines Australia transparency reporting) which likely affects their treatment and prescription decisions constituting a clear conflict of interest. It can also be difficult for clinicians and consumers to know whether the content of "educational" webinars, conferences and videos about MHT are sponsored by pharma.

There are a wide range of effective non-hormonal and non-pharmacological treatments for vasomotor symptoms [20]. To date, these do not appear equivalent to MHT in efficacy but new targeted therapies (such as Fezolinetant) are not yet available in Australia may have similar efficacy to MHT [45]. Access to treatments in Australia is frequently limited by supply issues for MHT products (for example, Climara shortages). Greater clarity and transparency are needed about the reasons behind these supply issues and effective approaches to preventing them.

g) The level of awareness amongst employers and workers of the symptoms of menopause and perimenopause, and the awareness, availability and usage of workplace supports

For some women, menopausal symptoms can adversely affect their ability to work, which can lead to reduced working hours, underemployment or unemployment, and consequently financial insecurity in later life.

At present, the management of sex-specific health issues other than pregnancy are rarely discussed in the workplace. This is changing with greater recognition that factors such as heavy menstrual bleeding, pain and menopausal symptoms might impact work. Employers have legal responsibilities for the health and safety of all their employees, as well as for the creation of a fair and discrimination-free workplace, but there are also clear business reasons for proactively supporting an age-diverse workforce.

Workplaces vary in terms of whether they offer supports, and what these supports are. Experts say a key issue is a lack of employer and employee awareness around how menopausal symptoms may impact work [46]. Women consistently report that they do not raise these issues with their managers because of a perceived (and probably accurate) lack of understanding. There is evidence from qualitative and quantitative studies that modifiable factors in the workplace can impact the experience of menopause at work. For example, compulsory uniforms, shift work, stigma and lack of support from managers are modifiable factors that may worsen the experience for working women [47].

But in acknowledging menopause in the workplace and making simple modifications to accommodate women, it is also important that we do not characterise menopause as a debilitating illness. Research confirms women are concerned about disclosing their menopausal experience at work for fear of stigma and recrimination [1]. Australian women experiencing menopause rate their work performance as high and do not feel that symptoms impair their work ability [2]. A study led by Professor Hickey in 2017 of 1,092 female healthcare workers (mainly nurses) age 40+ years reported that overall, menopausal women rated their work performance as high and did not feel that menopausal symptoms impaired their work ability. Specifically, they did not wish to be considered as a "problem group" in the workplace. However, most would appreciate greater organisational support, specifically temperature control, flexible work hours and education about menopause for employees and managers [2].

Australian workplace law requires that employers manage potential psychosocial hazards that may impact employees' mental health. Implementing a menopause policy makes good business sense and forms part of an employer's duty of care to its workforce. In Australia, commercial organisations such as Menopause Friendly Australia, can support employers to develop policies and provide accreditation.

We suggest supportive practices in the workplace can be made available to the whole workforce so that women do not have to disclose or 'confess' to experiencing menopause to access them. Changes in workplace policy could also ensure that menopausal women are supported while not exposing women to further prejudice or inequality [1].

Some Australian organisations have introduced menopause policies, mainly focusing on menopause leave (ABC news), sometimes combined with other sex-specific leave purposes, such as menstrual leave. Unfortunately, there is relatively little evidence showing that these workplace adjustments actually result in improved physical or mental health for employees or improved workplace outcomes such as productivity, absenteeism or presenteeism [47] and this lack of evidence is proving to be a hindrance to progress.

In 2021, a Global Consensus on Menopause in the Workplace: A European Menopause and Andropause Society position statement (coauthored by a number of experts including Australian researchers Professor Martha Hickey, Professor Gita Mishra and Professor Gavin Jack [46] recommended that workplace health and wellbeing frameworks and policies should incorporate menopausal health as part of the wider context of gender and age equality and reproductive and post-reproductive health. Workplaces should create an open, inclusive and supportive culture regarding menopause that involves occupational health professionals and human resource managers working together. This approach reduces the risk of discrimination and marginalisation of women experiencing menopausal symptoms.

Intersectional experiences of menopause at work

Intersectionality recognises that individuals experience overlapping and interconnected forms of discrimination or bias, based on various categories, such as race, sex, gender, class, sexual orientation, disability, and more. Intersectionality is another important factor when considering experiences of menopause at work. It provides a useful framework to help us understand the experiences and needs of a broad range of menopausal and perimenopausal people within the workplace, and to develop effective policies, practices, and cultural shifts that acknowledge and address the unique challenges faced by menopausal people in different contexts.

There is an established literature on intersectional disadvantage as it relates to race, sexuality, disability and class disadvantage in the workplace(1). Studies have highlighted how workplace inequality manifests through particular body types being perceived as being ‘more’ or ‘less’ valuable or capable. Other research discusses how women experiencing menopausal symptoms at work may encounter gendered ageism and stereotypes such as the ‘cranky old woman’(1).

(h) Existing Commonwealth, state and territory government policies, programs, and healthcare initiatives addressing menopause and perimenopause

As previously stated, women, including women in mid and later life, play a critical role as contributors to Australian society and the economy. The existing and potential value of women as workers, mentors, leaders and carers is enormous, and the contribution women make to our social, economic and cultural capital is invaluable. It is therefore incumbent on governments to develop policies, create structures and invest in research and initiatives that support Australian women to live healthy, productive and fulfilling lives.

Currently, there is very little direct government investment in initiatives that support women to live and age well into their later years. Most of the work currently underway in menopause and perimenopause in Australia is through clinical research, corporate/pharmaceutical marketing, and awareness raising by the not-for-profit sector – all of which have their limitations or concerns.

There are specific menopause actions outlined in the Commonwealth Government’s National Women’s Health Strategy 2020–2030 (all of which we believe should be implemented) and we note the NSW Government’s Agency for Clinical Innovation has established a Menopause Taskforce and committed funding over four years (2022-23 to 2025-26) to establish services for people experiencing severe symptoms of menopause.

We welcome the Commonwealth Government’s recent announcement of National Health and Medical Research Council funding for Monash University, the Australasian Menopause Society, Jean Hailes for Women’s Health and the Royal Australian College of General Practitioners to conduct joint research to improve the delivery of health care for women experiencing menopause.

As described elsewhere in this submission, the Women's runs a multidisciplinary clinic for females experiencing menopause after cancer, and a few other health services in other states operate smaller clinics, although these are few and far between and largely adopt medicalised models. We note the NSW Government's Perimenopause and Menopause Toolkit which offers a symptom checker, podcast and links to further information and services available to women across NSW (although services appear to be limited). The NSW Government also offers some information for employers and employees and a link to the Menopause Information Pack for Organizations. Developed by an Australian/UK team comprising a menopause expert (Professor Hickey) and researchers in gender workplace issues, this info pack provides open access to evidence-based strategies and actions for employers wishing to support their employees.

Jean Hailes for Women, primarily funded by the Commonwealth Government, provides in language information and facts sheets, as well as education for consumers and health professionals on menopause symptoms and their management. It also offers a fee-for-service GP clinic for women and conducts research into women's health areas, including the recently released report The impacts of symptoms attributed to menopause by Australian women.

(i) How other jurisdictions support individuals experiencing menopause and perimenopause from a health and workplace policy perspective

In 2022, the UK held a parliamentary inquiry into menopause. The resulting report, Menopause and the workplace, concluded that:

- Menopause still carries significant social and cultural stigma, particularly for certain groups, including LGBTQI+ people and young and ethnic minority women.
- GPs need to be knowledgeable about perimenopause and menopause and this should be given more priority in both the initial training and continuing professional development of GPs.
- It is unacceptable that there are parts of the country where women cannot access specialist menopause services they need.
- There has been a lack of progress to address MRT supply issues.
- There is a legal, economic, and social imperative to address the needs of menopausal employees.
- Government has a key strategic role in helping businesses and should lead the way in developing and disseminating good practice.
- Menopause symptoms can have a significant and sometimes debilitating impact on women at work.
- Legislation was required to make the right to request flexible working a day-one right for all employees.
- Relevant industry and employment authorities did not provide any advice on menopause on their website and that they should publish guidance on the legal considerations when supporting employees experiencing menopause.
- Whilst the law rightly protects women from pregnancy and maternity discrimination, it does not serve or protect menopausal women and that the government should undertake consultation on how to amend the Equality Act to introduce a new protected characteristic of menopause, including a duty to provide reasonable adjustments for menopausal employees.

In the aftermath of this work, the UK Government released its Response to the Committee's First Report implementing some of the recommendations and rejecting others. For example, the concept of menopause as a protected characteristic within a legislative framework was rejected with the reasoning that existing legislation around sex, age and disability discrimination was adequate. A Menopause Ambassador, Helen Tomlinson, was appointed in March 2023, and the UK Menopause Taskforce, with a focus on work and employment, has been established to identify, share and implement best practice.

In June 2022, the UK appointed its first Women's Health Ambassador for England. The announcement was received with much fanfare and the role was described as having the aim of closing the gender health gap and addressing a lack of support, awareness and understanding of health conditions specific to women, particularly in the context of the wellbeing of women and the economy. However, we have been unable to find any progress report or information on how this work is being resourced.

We suggest the Committee reviews the UK parliament's Menopause and the workplace report, as well as the UK Government's response and subsequent initiatives, as many are very relevant to the Australian context.

(j) any other related matter

Supporting women experiencing menopausal symptoms at work should be considered within the broader framework of gendered ageism that is a social determinant of health and highly prevalent in our society and workplaces [25].

We believe that to avoid creating additional stigma, changes to policy and/or legislation should not be punitive but rather framed as promoting inclusion and diversity and creating fair and equitable workplaces. Menopause should not be considered a 'condition' or 'disability' and initiatives that provide frameworks for cultural and attitudinal change are preferrable and are likely to benefit older women both within and without the paid workforce.

4. Recommendations

That government:

- Implements all actions relating to menopause in the National Women's Health Strategy 2020–2030 and invests in research and initiatives that support women to live and age well into their later years.
- Considers the potential economic and productivity losses and gains in relation to working women experiencing menopause and perimenopause and how existing or new policies can be utilised to protect and support mid-life women in the workforce.
- Measures and reports on the extent to which menopausal symptoms impact women's employment and retirement decisions, and how these impact their super balances and retirement incomes.
- Considers government initiatives and strategies that help to normalise menopause and create greater awareness, understanding and acceptance of early menopause and menopause symptoms and their management. These might include:
    - The creation and adequate resourcing of a Women's Health Ambassador – an individual who can work with government and others to provide input into key policies and initiatives related to women's health, and communicate and advocate for greater research investment and system reform;
    - A national public information and awareness campaign that promotes independent and evidence-based information about the common symptoms associated with menopause including the risks and benefits of treatments, and the opportunity it provides for healthy female ageing.
- Consults with a diverse range of people with experience of menopause and perimenopause (including First Nations, culturally and linguistically diverse, and LGBTQI+ communities) in the development of these initiatives and strategies.

- Invests in research grants to address the knowledge gaps and encourage Australian research into menopause and perimenopause, in particular, in terms of the experiences of First Nations women, women from culturally and linguistically diverse communities, and the LGBTQI+ community, and policies and strategies that will help to address inequities.
- Utilise policy and regulatory frameworks to promote an equity and inclusion approach to supporting women in the workplace through the development of industry and employment plans, initiatives and processes that support them to thrive in the workforce.
- Considers the affordability options for low-income people in terms of accessing different menopause hormone therapy (MHT) and other restricted medications and treatments and expands those that are subsidised through the Pharmaceutical Benefits Scheme.

The healthcare system:

- Avoids pathologising menopause and recognises it as a normal stage in women's lives rather than an illness or disability requiring treatment or cure.
- Ensures healthcare professionals are appropriately trained and kept up to date on contemporary, practices, approaches and issues related to troublesome menopause symptoms.
- Applies a holistic view of menopause and female ageing that goes beyond the clinical response to include women's long term physical and mental health and well-being.

5. References

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