

Submission

Senate Inquiry into Issues related to menopause and perimenopause

Thank you for inviting the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG, the College) to make a submission to the Community Affairs References Committee on the Issues related to menopause and perimenopause.

RANZCOG is the lead standards body in women's health in Australia and New Zealand, with responsibility for postgraduate education, accreditation, recertification, and the continuing professional development of practitioners in women's health, including both specialist obstetricians and gynaecologists, and GP obstetricians. Perimenopause and menopause are included in the core curriculum for both specialist training and the Certificate of Women's Health, a training program for other medical practitioners seeking to increase their knowledge of women's health.

Background

The National Women's Health Strategy (2020-30)¹ signals awareness that economic participation is central to the continued wellbeing of women and to our economy. This is consistent with the United Nations (UN)² and World Health Organization's (WHO) position. Australia has been slow to recognise how menopause may fit into these strategies, but this is now changing.

There is a wide variation in the symptoms reported by individuals experiencing menopause. However, there is a lack of consensus regarding what symptoms are in fact caused by menopause. All women should have easily accessible, up-to-date, evidence-based information about the normal process of menopause including the associated changes and potential symptoms. Those with troublesome symptoms should have access to an individualised discussion regarding treatment options. Moreover, those who receive treatment should have access to regular review to ensure individualised and up to date care.

Recommendations

- a. Challenge the negative culture around ageing in women by:
 - i. Focusing on the strengths and achievements of older women (e.g. as essential workers and leaders)
 - ii. Directly challenging gender-based ageism
 - iii. Avoid pathologizing menopause which is a normal stage in women's lives.
- b. Provide realistic and calm advice for women approaching menopause about what they might expect and where to go for help if needed.
- c. Undertake high quality research on how perimenopause impacts women and how problematic symptoms can best be managed.
- d. Educate health care providers and society about what symptoms menopause may cause and the effective treatments available.
- e. Educate healthcare providers and women about common midlife symptoms that are not due to menopause (such as depression) and indicate where to get help.
- f. Provide clear, evidence-based unbiased information about how these symptoms can be effectively treated.
- g. Ensure that menopause experts who are funded by pharmaceutical organisations are open and transparent about their conflict of interests and do not use their privilege to promote products for money.
- h. Encourage women aged 50 and over to engage with evidence-based cancer screening.

- i. Undertake high quality research to establish how best to support women experiencing troublesome menopausal symptoms in the workplace, including consultation across a range of working environments.
- j. Consider how existing policies can be better utilised to protect and support women experiencing work difficulties due to menopause.
- k. Take an intersectional approach. For example, consider the needs of women with low job security working shifts in hot environments and/or wearing uniforms.

Specific Feedback – Terms of Reference

Terms of Reference item A: The economic consequences of menopause and perimenopause, including but not limited to, reduced workforce participation, productivity, and retirement planning.

On average, the menopause transition (perimenopause) starts at around 47 years of age with the final menstrual period occurring at around 51 years of age. Typical symptoms such as hot flushes and night sweats start during the menopause transition and last around seven years on average³. The proportion of women working through and beyond menopause is increasing, and midlife women are one of the fastest growing sectors of the workforce⁴. Evidence presented at the UK Faculty of Occupational Medicine indicates that eight out of ten menopausal women are in paid employment⁵.

The Australian workforce is critically dependent on older workers, particularly women. The COVID-19 pandemic revealed that most essential workers in health, childcare and education are women, often older women. Australia has a shortage of skilled workers, particularly in healthcare and we need strategies to attract and retain skilled older workers.

It is uncertain whether menopause leads to reduced workforce participation in Australia.

Media coverage in the UK and Australia about women quitting their jobs because of menopausal symptoms is not supported by robust evidence. For example, the market research survey that reported 'nearly one million' women quit their jobs is based on scaled up figures from a smaller market research survey and includes those leaving work for a range of reasons, not limited to menopause⁶. Similarly, economic modelling from the US is based on scaled up market-research. Systematic bias means that those most bothered by menopause are most likely to answer these convenience surveys, meaning that the impact of menopause on leaving work is likely to be over-estimated.

Based on the UK market research survey in October 2022, the Australian Institute of Superannuation Trustees (AIST) estimated that menopause costs women more than \$17 billion in lost earnings and superannuation, based on an estimate of 25 per cent of menopausal women experiencing 'debilitating symptoms leading to long-term absences from work or forcing them into early retirement'⁷. However, the evidence does not show that 25 per cent of women experience debilitating symptoms⁸. Also, the nature and severity of menopausal symptoms varies considerably by factors such as race and geographical location.

Australian Data

Australian data does not suggest that women have reduced productivity or plan to leave their jobs because of menopause. A 2017 survey of around 1000 female healthcare workers in Victoria found no association between menopause and work engagement, organizational commitment, job satisfaction or work limitations. Two-thirds reported that menopause did 'not at all' affect their work performance, six per cent that menopause 'very much' affected work performance and six per cent that menopause 'somewhat' affected their work performance⁹.

Together, this suggests that a small but important minority of women experience menopausal symptoms that impact on work.

An Australian survey of around 1200 women in paid employment in 2016 reported that women with vasomotor symptoms had a reduced self-reported work ability. 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 more than 3000 women by Jean Hailes reported that less than one in ten missed work due to symptoms that they attributed to menopause, and seven per cent reported a negative impact of these symptoms on their daily activities including work¹⁰. This is very consistent with the six per cent reported from female healthcare workers¹¹. Overall, only 3.8 per cent of those who experienced bothersome symptoms missed days of work or study due to these symptoms. However, almost half (47 per cent) of midlife women experienced bothersome symptoms they attributed to menopause but remained at work. Another 36 per cent did not have bothersome symptoms.

Managing at work is a common reason why women take Menopausal Hormone Therapy (MHT)¹². Around 14 per cent of Australian women take MHT¹³. Whilst MHT is an effective treatment for troublesome vasomotor symptoms, it is not 100 per cent effective and carries small but significant health risks such as breast cancer¹⁴.

MHT is effective, but should not be the default prescription

Retirement Planning

On average, women spend less time in the workforce than men, largely because of absence due to parenting responsibilities and earlier age at retirement. In Australia, women earn 21.7 per cent less than men on average¹⁵, almost triple the gender pay gap in the UK (7.7 per cent¹⁶) and retire with \$136,000 (37 per cent) less superannuation¹⁷. Together, these contribute to poverty in older age. The gender pay gap and less time in paid employment mean that retired women are 80 per cent more likely to live in poverty than retired men.

It is uncertain whether women retire earlier because of menopause. Reasons such as male partners retiring may be of more importance. However, the Australian Human Rights Commission confirm that caring duties lead to time out of paid work and poverty in older age for women¹⁸. 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. Whether women leave their jobs may depend on the nature of the work. For example, a British Medical Association survey in 2020 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 hospitals¹⁹.

Terms of Reference item B: The physical health impacts, including menopausal and perimenopausal symptoms, associated medical conditions such as menorrhagia, and access to healthcare services.

The experience of the menopause varies considerably between women and within the same woman over time. Around one in four have no symptoms and most have mild or moderate symptoms²⁰. A smaller percentage (around 20 per cent) have severe and/or prolonged symptoms.

During the early menopause transition (perimenopause), heavy, irregular, or prolonged menstrual bleeding affects more than 90 per cent of women at least once and nearly 80 per cent at least three times²¹. Hence, abnormal bleeding may impact on work, the workplace environment, and factors such as lack of access to toilets and breaks may cause difficulties. This is also when vasomotor symptoms are most likely to occur, peaking in the year around the final menstrual period²². Many women experience more than one symptom at once. For

example, hot flushes, sleep disturbance and fatigue commonly co-occur²³. Social factors also play a role. The most symptomatic women are likely to also have financial difficulties, obesity and be smokers²⁴. This is relevant for the working population, since intersectional factors are likely to modify how menopause affects work.

Vasomotor symptoms at work may cause embarrassment, affect confidence and lead to stress²⁵. Aspects of work management and physical environment that may exacerbate the burden of symptoms include overheated workplaces, shiftwork and uniforms or personal protective equipment (PPE) made with synthetic materials²⁶.

The workplace culture is also critical.

It is well established that lack of support and understanding by managers and inflexibility around working hours and conditions contribute significantly to the burden of menopausal symptoms²⁷. These are all modifiable by changing workplace practices and culture.

Managing menopause at work may be particularly difficult for the ten per cent who experience menopause prematurely (younger than 40 years) or early (younger than 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 population²⁸. In a matched study, women with previous breast cancer had menopausal symptoms that were more frequent, severe, prolonged, and distressing²⁹. The Royal Women's Hospital in Victoria provides a clinical service for women struggling with menopausal symptoms after cancer, based on a multidisciplinary model of care^{30,31,32,33}. This service (MSAC, Managing Menopause after Cancer) has been replicated across Australia and in seven countries worldwide. The service has generated evidence-based clinical guidelines for managing menopause after cancer globally^{34,35,36,37,38,39,40,41}, cited as best practice in national and international guidelines.

Access to healthcare services varies by across Australia.

Women should have access to affordable menopause care. Most care is provided by general practitioners (GPs) but many do not feel confident managing menopause⁴². For those requiring more complex care, there are very few public menopause services in Australia. The Royal Women's provides the largest public clinical service with a particular focus on complex care and menopause after cancer.

Women's health hubs are under development but have not yet been evaluated. Menopause does not necessarily require any diagnosis or treatment since it is a normal phase of life. However, clinical input may be needed to provide information and potentially to prescribe pharmaceutical treatments. Menopausal Hormone Therapy (MHT) is currently the most effective treatment for troublesome vasomotor symptoms and is used by around 14 per cent of Australian women⁴³. For those who cannot or do not wish to take MHT, a range of non-pharmaceutical and non-hormonal options are available⁴⁴. However, most women do not wish to take pharmacological therapies unless their symptoms are severe⁴⁵. Unfortunately, most information available online about menopause is generated by commercial entities selling a product or service⁴⁶.

There is an unmet need for high-quality information about management of menopausal symptoms including self-management and drug-free strategies.

Whilst natural menopause at the average age does not cause chronic disease, midlife is an opportunity to optimize health into older age. Population screening for colorectal and breast cancer commences at age 50 years and lifestyle choices at midlife (such as exercise and smoking) may impact on later life health. The opportunities for health education and lifestyle changes at midlife do not require a healthcare professional and could be delivered by anyone who is appropriately trained, with the option of GP referral if needed. Similarly, menopausal symptoms do not necessarily require pharmacological therapies and there is high quality evidence supporting psychological interventions such as cognitive behavioural therapy (CBT) for troublesome hot flushes⁴⁷.

Terms of Reference item C: The mental and emotional well-being of individuals experiencing menopause and perimenopause, considering issues like mental health, self-esteem, and social support.

Menopause may affect mental and emotional wellbeing. Regarding mental health, large prospective Australian studies indicate that around nine per cent experience increasing depressive symptoms over the menopause transition and about the same proportion (8.5 per cent) report decreasing depressive symptoms⁴⁸. However, those with previous clinical depression are at increased risk of relapsed depression and depressive symptoms^{49,50}. Major depression is the leading global disease burden and costly for employers and employees due to decreased work participation, sick leave, and reduced productivity⁵¹.

In addition to the access issues highlighted above, individuals experiencing menopause should have access to up-to-date and evidence-based information regarding mental health in the menopause, including both non-pharmacological and pharmacological treatment options and their efficacy. There should be clear referral pathways, and access to, mental health services to support both patients and clinicians during this time.

Together, this suggests a role for identifying and supporting those at elevated risk of depression over the menopause.

Mental and emotional health of those experiencing menopause can be affected by the work environment, including attitudes of managers and colleagues, workplace cultures and the continuance of gender and age-based stereotypes⁵². Because both menopause and ageing in women are stigmatized, workplaces could address this by directly challenging ageism and sexism in the workplace⁵³. Individuals should be given evidence-based information regarding the actual impact of menopause on their mental health and educated about self-management strategies, lifestyle optimisation, non-pharmacological management, and non-hormonal treatments.⁵⁴

Across our community women are the main providers of care across generations. It is well established that caring responsibilities impact on participation in the paid workforce. Whether menopause further impacts on caregiving, family dynamics and relationships is unknown.

Terms of Reference item D: The impact of menopause and perimenopause on caregiving responsibilities, family dynamics, and relationships.

In Australia, most paid and unpaid carers are women. However, whether menopause impacts family dynamics and relationships is unknown⁵⁵. There is some evidence that premature or early menopause may impact relationships⁵⁶. It is estimated at least half of postmenopausal individuals will experience at least some genitourinary symptoms of menopause.⁵⁷ These symptoms may have a significant impact on wellbeing and quality of life, particularly intimate relationships where such symptoms result in painful intercourse and or reduced libido.^{58,59} Vaginal dryness affects around one third after the menopause and may impact relationships by affecting sexual function⁶⁰. Further research should focus on whether, and how, menopause distinctly may influence social relationships and, as a result what support structures may be useful in aiding this transition.

Terms of Reference item 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.

The experience of menopause, perceptions and attitudes vary substantially by race, ethnicity and geographical location and there is no universal “menopause syndrome”⁶¹. 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 community⁶². This is in direct contrast with the wider community where both ageing and menopause are highly stigmatized. A 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 women⁶³. Small studies of Arabic⁶⁴ women in Sydney showed similar symptoms to white women but found that Indian⁶⁵ and Chinese women⁶⁶ experienced fewer menopausal symptoms.

There is a need for more research on the cultural and societal factors affecting the experience of menopause amongst culturally and linguistically diverse, First Nations communities and other minority groups.

Women, particularly women of colour, are further subjected to the intersecting prejudices of age, ethnicity, and gender bias. Older women may face ageism in the workplace and struggle to find work and for equal pay. Ageism persistently impedes women's chances of full-time work⁶⁷. This impacts directly on “essential workers”. For example, female nurses paid less than male nurses. There is extensive variation globally and within Australia about the cultural meaning and experience of menopause. Clinicians should be aware of this and practice in a culturally safe manner.

When considering menopause in the workplace, policy makers should consider that the gender pay gap impacts working women across all ages.

Terms of Reference item 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 increasingly covered in the teaching of health care professionals including doctors and in the UK is now covered in the high school curriculum. However, lack of awareness about menopause and its symptoms persists.

This may reflect the lack of consensus amongst clinicians and researchers about what symptoms can be attributed to menopause.

Confusion and lack of consensus about what symptoms menopause causes is a barrier to the provision of evidence-based care. In 2005 a systematic review and expert consensus by the National Institutes of Health in the USA concluded that “many women have few or no symptoms” and only hot flushes, night sweats and vaginal dryness were clearly attributable to menopause⁶⁸. Subsequently, prospective studies have measured on mood, sleep, memory, and sexual function over the menopause transition demonstrating small changes in some women. However, social media and some professional organisations cite long lists of menopausal symptoms (e.g. depression, brain fog, anxiety, or even suicidal ideation) to menopause. This runs the risk of misdiagnosis and inappropriate or ineffective treatment.

A range of other symptoms are commonly attributed to menopause including brain fog, fatigue, anxiety, loss of concentration and weight gain in a non-exhaustive list. This results in patients seeking menopausal hormone therapy to aid in symptom relief for which there is an insufficient evidence base to demonstrate efficacy. As with all treatments and interventions, menopausal hormone therapy is not without risk, which must be balanced against treatment efficacy. Consequently, people experiencing troublesome menopausal symptoms should receive accurate, up-to-date evidence-based information regarding treatment options.

Consensus based on prospective evidence about what symptoms menopause causes would greatly help with education, decision making about treatment and clinical care. Please note that menopause does not make women “patients”, and most do not choose to take medical therapies.

More evidence is required to better inform consensus about menopause symptoms.

Amongst medical professionals, menopause has largely been viewed as a “hormone deficiency disease”⁶⁹. This is both inaccurate and potentially harmful since it implies that all women require hormonal treatment⁷⁰. Natural menopause at the average age (45-55 years) is not a health risk⁷¹. Beyond the management of troublesome symptoms and ensuring women are up to date with cancer and other health screening, there is no specific role for medical professionals. Medicalisation and over-attribution of symptoms may also create trepidation and negative expectations for younger women. This has direct consequences since those with negative expectations of menopause are more likely to report problematic symptoms⁷². As such, women and healthcare providers are likely to benefit from reassurance and support, realistic, evidence-based information and access to effective treatments when wanted/needed.

Clinicians can support symptomatic women with information, self-management techniques and evidence-based therapies for those seeking treatment for vasomotor symptoms such as hot flushes and night sweats. MHT should not be offered for symptoms other than vasomotor symptoms since the evidence does not support this. Similarly, it should not be offered for the prevention of chronic disease⁷³.

Conflict of interest is a major issue in menopause care in Australia. Pharmaceutical companies bombard GPs with promotional material claiming that their products are safer/more effective. In addition, numerous clinicians working in menopause and financially involved with pharma and willing to promote these products. This has substantially influenced the amount and type of MHT prescribed in Australia. Specifically, the increased prescribing of micronized progesterone, which is not PBS listed, hence increases costs for patients. However, it remains uncertain whether micronized progesterone has a lower risk of breast cancer, and it does appear to increase abnormal bleeding and endometrial cancer risk⁷⁴. Similarly, vaginal laser has been heavily promoted despite high quality evidence from Australia showing no effect⁷⁵. Australia has a female testosterone product (Androfem). Whilst testosterone has a modest benefit for sexual function in selected women⁷⁶. However, it is aggressively promoted by those with financial interests.

There is a need for greater transparency around financial conflicts of interest by clinicians working in menopause. A discussion is needed about how conflict of interest should be managed when making policy decision.

Most treatments for menopausal symptoms, particularly pharmaceutical treatments carry potential risks as well as benefits. MHT is the most effective treatment for vasomotor symptoms but is unlikely to completely resolve them⁷⁷. Topical estrogen is effective for vaginal dryness⁷⁸. MHT may also improve sleep and potentially mood but has not been shown to improve other symptoms often ascribed to menopause such as exhaustion, sore breasts, brain fog, irregular periods, weight gain, forgetfulness, or mood swings. In the short term, MHT

increases the risk of urinary incontinence⁷⁹. In the longer term, it increases the risk of breast cancer and stroke and may increase dementia risk⁸⁰. MHT prevents bone loss and fracture but only for the duration of use. In addition, vasomotor symptoms commonly rebound on stopping MHT⁸¹. The US Preventive Task Force warns against using MHT for the prevention of chronic disease considering risks and benefits⁸². Other treatments (such as CBT) might be less effective for vasomotor symptoms but are less likely to have serious side effects⁸³. Patients choosing treatment require clear and unbiased information about the options available. New targeted therapies (such as Fezolinetant), not yet available in Australia may have similar efficacy to MHT but are likely to be costly at around \$10,000 pa⁸⁴.

A Decision Aid would support decision making for women seeking treatment for menopause symptoms.

Access to MHT products in Australia is frequently limited by supply issues. These lead some women to discontinue their treatments and many others to approach multiple suppliers. Healthcare provider time is also wasted on this. More clarity and transparency is needed about the reasons for these supply issues. Whilst these are global issues, Australia appears worse affected than other OECD countries.

Historically, almost all studies of interventions for menopausal symptoms were conducted on postmenopausal women. However, vasomotor symptoms commonly start in the perimenopause and are most frequent in the year around the final menstrual period⁸⁵. Consequently, there is a gap in knowledge around optimum management of troublesome symptoms in the perimenopause.

Large prospective studies in the USA demonstrate that race, ethnicity, and socio-economic disadvantage contribute to both the timing of menopause and the nature and burden of symptoms⁸⁶. More disadvantaged women experience earlier menopause with its attendant elevated risks of chronic disease. Minority group women are at greater risk of surgical menopause which may have adverse effects on long-term disease risk⁸⁷. In the USA, black women report more severe and persistent vasomotor symptoms and sleep disturbance compared to white women⁸⁸. Similar studies have not been performed in Australia.

There is a paucity of public menopause services available in Australia. Moreover, access issues are of particular importance for women in rural and regional areas, where there may be fewer clinicians including those with confidence managing menopausal symptoms as well as potentially longer waiting times to see a clinician. Affordability of services for patients in rural and regional areas may also include travel to, and accommodation in, major centres, particularly if they require specialist care. While the increased utilisation of telehealth services since the Covid-19 pandemic may assist with this,⁸⁹ it does not negate the need for more widespread public menopause services throughout the country.

Terms of Reference item 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.

As above, beyond vasomotor symptoms and vaginal dryness there is uncertainty about what symptoms menopause causes and which may be common at midlife due to other reasons. This likely contributes to reduced awareness and uncertainty around employers and workers.

Workplaces vary in whether they offer supports and what supports this includes. It is not the role of managers or employers to determine what symptoms are due to menopause. This should be a discussion between the employee and their GP. If an employee considers that she may have menopausal symptoms that impact negatively on work, she should discuss with her GP then advise her manager if indicated.

Regarding work, research by our team and others has shown the key issue is lack of awareness around how menopausal symptoms may impact on work⁹⁰. For example, women woken up by night sweats may struggle with early starts and with shift work. Those wearing uniforms made of synthetic material may struggle with hot work environments, such as hospitals and care homes. Women consistently report that they do not discuss 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 impact on 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 women⁹¹.

Terms of Reference item H: Existing Commonwealth, state and territory government policies, programs, and healthcare initiatives addressing menopause and perimenopause.

In the UK more than half of all organisations now have a menopause policy. However, many menopause policies don't specifically include perimenopause, particularly the impact of heavy and irregular menstrual bleeding. In the USA there continues to be stigma and shame around menopause with no legal protection against discrimination. In Australia, the importance of menopause for working women and their employers has only recently been recognized with minimal translation into policy. Australian policies have largely focused on "menopause leave". However, the limited study asking working women what support they need have not indicated that menopause leave is a priority⁹². Menopause leave runs the risk of "box ticking" by not addressing the key issues of workplace culture and support.

There are potential advantages to employers of implementing menopause policies.

Australian workplace law requires that employers manage potential psychosocial hazards that may impact on employee's mental health⁹³. Implementing a menopause policy may potentially protect employees from workplace complaints. In Australia, commercial organisations such as Menopause Friendly Australia have emerged to support employers to develop policies and provide accreditation⁹⁴. However, whether these accreditation services will lead to meaningful change for women at work has not been established.

Not only do midlife women make an important contribution to the Australian economy, but paid employment is also good for women. In addition to salary, work can provide fulfilment, improve self-esteem and identity, and provide social benefits⁹⁵. Organisations also benefit from employing skilled older workers. Many people now expect their employer to demonstrate behaviour consistent with their values. For employers aiming to promote diversity and inclusion, evidence-based and effective policies to support menopausal women may be attractive for employees.

Evidence from Australia

An Australian survey of 1092 female healthcare workers (mainly nurses) over the age of 40 years in 2017 reported that overall 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 organizational support, specifically temperature control, flexible work hours and information about menopause for employees and managers⁹⁶.

The intersectional experiences of menopause at work must also be considered. There is an established literature on intersectional disadvantage in composite with race, sexuality, disability, and class disadvantage in the workplace⁹⁷. Studies of embodiment at work have highlighted how workplace inequality manifests through some bodies being indexed as more or less valuable or capable. Women experiencing menopausal symptoms at work may encounter gendered ageism and stereotypes such as the 'cranky old women'⁹⁸.

Australia has a shortage of skilled workers in sectors such as healthcare and education. Women comprise 57 per cent of the higher education sector and 78 per cent of the health and social care sector, meaning that supporting women's health across through the course of life is central to our economy. For example, the average age at menopause in Australia is 51 years and almost half (46 per cent) of nurses are age 45 or older.⁹⁹

It is essential that those potentially affected by menopause at work are consulted and are part of the solution.

The situation is similar in the education sector where most teachers are female, and their average age is 44 years¹⁰⁰. Work settings may be differently affected by menopause. For example, teachers who cannot leave the classroom to get to the toilet during lessons and nurses required to wear uniforms and PPE. Hence, supporting these women at work may require different solutions for different settings. Women are already concerned about disclosing their menopausal experience at work for fear of stigma and recrimination¹⁰¹. Deeply embedded gendered ageism may contribute to this.

Similarly, supportive practices can be made available to the whole workforce, meaning that women do not have to disclose or 'confess' to menopause to access them. This is particularly important since inequality in the workplace may directly impact on uniform requirements, work patterns and autonomy over time and tasks¹⁰². Changes in workplace policy should ensure that menopausal women are supported while not exposing women to further prejudice or inequality¹⁰³.

Terms of Reference item 1: How other jurisdictions support individuals experiencing menopause and perimenopause from a health and workplace policy perspective.

Evidence based on a UK Parliamentary Report recommend that employers introduce a range of "reasonable adjustments"¹⁰⁴. These are usually straightforward and simple to implement. The UK considered and rejected the concept of menopause as a protected characteristic and considered that existing legislation around sex, age and disability would provide protection against unfair treatment. They appointed a Menopause Ambassador to work on behalf of Government to represent the interests of those experiencing menopause. Also, a Menopause Taskforce to identify, share and implement best practice. The Taskforce agreed that work and employment would be a priority theme. This is the first response to the Menopause and the workplace from the House of Commons Women and Equalities Committee¹⁰⁵. The UK Government Equalities Report on Menopause highlights the need for employers to put in place training, processes, and information so all colleagues have a clear understanding of menopause¹⁰⁶. They recommend that any policy or guidance document is clearly visible and well publicised.

A report from the UK Advisory, Conciliation and Arbitration Service states that menopause policies may be financially beneficial to employers¹⁰⁷. The cost to lose and replace an employee is estimated at around \$50,000. Defending an employee complaint costs around \$20,000 not counting fees or awards. Organisations in the UK that have adopted menopause policies report that it benefits employers and employees.

'Henpicked' in the UK has a checklist for employees. In 2021 a Global Consensus on menopause in the workplace by the European Menopause and Andropause Society and including Australian researchers Martha Hickey, Gita Mishra, and Gavin Jack¹⁰⁸ 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, involving, if available, occupational health professionals and human resource managers working together. Women should not be discriminated against, marginalized, or dismissed because of menopausal symptoms. Health and allied health professionals should recognize that, for some women, menopausal

symptoms can adversely affect the ability to work, which can lead to reduction of working hours, underemployment or unemployment, and consequently financial insecurity in later life.

Components of menopause policies in other jurisdictions

The UK Faculty of Occupational Medicine provides some specific recommendations:

- a) Manager training
 - i. Most women are unwilling to disclose menopause-related health problems to line managers, many of whom are men or younger women.
 - ii. Managers do not need extensive training about menopause or its management.
 - iii. Managers should convey that menopause is a natural and temporary stage in women's lives and that whilst most women do not have significant symptoms, some may require additional support at work which they can provide.
 - iv. Managers should facilitate discussion about troublesome symptoms, communicating that these are normal, may impact on work and that adjustments can easily be made.
 - v. Managers should encourage those with health concerns to discuss with their GP.
- b) Workplace culture
 - i. Employees should expect respectful behaviour at work including those related to their gender and age. Infographics may be helpful.
 - ii. For those reluctant to discuss menopause with their manager an occupational health professional can be useful.
- c) Work environment
 - i. Review control of workplace temperature and ventilation and how they might be adapted to suit individual needs. This might include office desktop fans in or locating a workstation near an opening window or away from a heat source.
 - ii. Consider flexible working hours or shift changes. If sleep is disturbed, later start times might be helpful.
 - iii. Provide access to cold drinking water in all situations, including off-site venues.
 - iv. Ensure access to bathroom facilities and toilets, including when travelling or working in temporary locations.
- d) Guidance for affected women at work
 - i. Find out more about menopause from creditable sources.
 - ii. Talk to the GP to see if treatment for troublesome symptoms is needed.
 - iii. Discuss your practical needs with your line manager, HR, or a manager you feel comfortable talking to.
 - iv. Use technology where this is helpful, e.g. for reminders or note taking.
 - v. Discuss possible work adjustments with occupational health.
 - vi. Talk about your symptoms and solutions with colleagues, particularly those who are also experiencing symptoms. Sometimes humor can deflect embarrassment.
 - vii. Work out your preferred coping strategies, support needs and working patterns.
 - viii. Avoid hot flush triggers if these are identified especially before stressful situations.
 - ix. Consider relaxation techniques such as mindfulness and other helpful techniques such as cognitive behavioural therapy, which can reduce the impact of symptoms¹⁰⁹(30).
 - x. Consider lifestyle changes such as weight reduction, smoking cessation, and exercise.

In Australia

Progress in this field has been slower. Some organisations have introduced menopause policies, mainly focusing on menopause leave, sometimes combined with other gender-specific purposes such as menstrual problems

or miscarriage. However, there is relatively little evidence showing that workplace adjustments actually result in improved physical or mental health for employees or improved workplace outcomes such as productivity, absenteeism or presenteeism¹¹⁰. This is a hindrance to progress. A team including Professor Martha Hickey (O&G) and Professor Gavin Jack (School of Business) have produced a Menopause Information Pack for employers wishing to support their employees¹¹¹. This has been widely used internationally.

A recent survey by [Jean Hailes](#) led to the following recommendations:

- i. Better understanding of symptoms of menopause and additional effective treatments.
- ii. Menopause should be recognized as an opportunity to promote healthy ageing.
- iii. Education of consumers and GPs about premature and early menopause to ensure treatment when indicated.
- iv. Educate GPs to recognize and manage menopausal symptoms and evaluate risk of chronic disease in midlife women.
- v. Public discussion of menopause but avoid catastrophizing as it may stigmatize women and reduce resilience.
- vi. Further studies needed to identify the impact of menopause from other midlife stressors at work.
- vii. More information needed about priority populations such as First Nations people to understand their knowledge and information needs.

Terms of Reference item I: Any other related matter

At present, the management of gender-specific health issues other than pregnancy are rarely discussed in the workplace. This is changing reflecting employer's responsibilities for the health and safety of all their employees. There are also clear business reasons for proactively managing an age-diverse workforce.

Ageist and sexist attitudes are highly prevalent in our society, putting menopausal women at the nexus of "gendered ageism", a social determinant of health¹¹². Hence, initiatives addressing gendered ageism may benefit those within and without the paid workforce. In Australia, these have included the exhibition "Flesh after Fifty" and "In My Prime: Celebrating Older Women"^{113,114}. This inquiry is an opportunity for new initiatives that highlight the value and contribution of older women to our society.

If specific menopause policies are needed, these should be framed as addressing "diversity" rather than "disability". Employers should lead by example and apply the same principals they would use to attract and retain a diverse and inclusive workforce. This starts with creating the environment to talk about menopause openly and without embarrassment.

Whilst this Senate Inquiry is greatly welcomed, the leading priorities of women with lived experience of menopause remain uncertain. The University of Melbourne are leading the first Menopause Priority Setting Partnership (MAPS)¹¹⁵. The University has collected and collated responses across 41 countries from women with lived experience and their healthcare providers asking, "what research questions would you like answered about menopause?". The Priority Setting Partnership expects to report in 2024.

This Priority Setting Partnership will identify the leading research priority for women with lived experience and their healthcare providers to inform a patient-focused research agenda.

The social value of older women likely affects this experience. In societies where women's value is predicated on reproduction, menopause may reduce social status. In contrast, where ageing confers respect, such as Australian First Nations societies, menopause is often considered less problematic¹¹⁶. Growing public discourse

about menopause in some settings (e.g. the UK) is raising awareness and helping change the culture by reducing shame encouraging open discussion and campaigning for greater awareness of women's needs in the workplace. Public initiatives aiming to empower older women by dispelling myths, reducing stigma, share realistic experiences and promote positive images include art projects such as "Flesh after Fifty" and arts and health projects such as "In My Prime".

To this end, RANZCOG supports the Inquiry into Issues related to menopause and perimenopause and looks forward to the report being handed down.

RANZCOG acknowledges with thanks, the contribution of _____ for this submission.

Yours sincerely,

President

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