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Submission to the Australian Senate Inquiry into Perimenopause and Menopause

This submission is from the Monash University Women's Health Research Program (WHRP).

The WHRP has reported some of the largest, most comprehensive Australian studies of premenopausal, perimenopausal and postmenopausal women, including menopause in women after breast cancer, and published internationally endorsed guidelines for the care of perimenopausal and postmenopausal women. The Practitioner Toolkit for Managing Menopause was updated and re-endorsed in 2023.

This submission makes the following key points:

- *Menopause is not an isolated life event* and must be seen in context of other health and socioeconomic challenges women encounter.

- Information about menopause, notably associations with/impact on work, must be evidence-based. Presently there is insufficient research in this space *and more quality research is essential to inform the community and workplace policy.*

- *Poor midlife health should not be 'blamed' on menopause* and further stigmatise menopausal women. Structural social and financial inequality and the societal demands are the broader determinative landscape and should not be ignored. All women need flexibility and good health at all stages of life for broader reasons than menopause.

- *Workforce training (including nurses and allied healthcare providers) is inadequate, hence the management and appropriate treatment of menopause is poor and inconsistent*, and many treatments are not available on the PBS. Misinformation and the profits made on products that don't work has taken root in the vacuum.

- *Community understanding of menopause is poor and menopausal myths are widespread.*

- *The greatest risks to midlife and menopausal women are cardiovascular disease, diabetes, bone loss and fracture and exacerbation of pre-existing poor mental health.* Abstracting menopause from these realities risks obscuring the urgency of preventing, diagnosing and treating these in context. The prevalence of these diseases amongst women also contribute to poor economic and social outcomes for women.

- The *strongest predictor of menopause-related depression is premenopausal depression*. The investment that must be made to deliver better mental health outcomes for midlife women is in *arresting the mental health crisis manifest in young Australian women*.

- The *impacts of menopause amongst First Nations women and women from different cultural backgrounds are poorly understood and under researched.* However, the prevalence of cardiovascular disease and diabetes in First Nations communities risks exacerbation in menopause.

- Menopausal care and delivery platforms should be kept in primary care.

- **The tools and expertise to improve perimenopausal/menopausal and overall midlife women's health exist. They are just not widely known by policy makers and too inconsistently applied.**

This submission makes the following key evidence-based recommendations:

- Menopause is perceived differently by different cultures- research findings cannot be extrapolated from one country/population to another.

- Most Australian women (~70%) do not have substantial menopausal symptoms- hence most do not need menopausal hormone therapy.

- Menopause increases the risks of cardiovascular disease (CVD), diabetes, bone loss and fracture for all women. While menopausal hormone therapy should not be prescribed to prevent CVD/diabetes, all women merit a full health assessment in the early postmenopausal period to re-evaluate their health risks.

- In Australia, the prevalence of depressive symptoms in peri and postmenopausal women (~15%) is half that seen in premenopausal women (~30%). Menopausal hormone therapy may improve low mood related to menopause, but it is not a treatment for clinical depression. The mental health crisis in younger women urgently needs to be addressed. This would be a sound investment in reducing the risk of depression at midlife and beyond.

- Misinformation about menopause is widespread - community education is urgently needed to enable women to make informed health choices.

- The management of menopause in Australia is poor- GPs, gynaecologists and pharmacists lack skill and confidence in menopausal care. Upskilling is urgently required.

- **Existing organisations, notably the Australasian Menopause Society and Jean Hailes for Women's Health, supported by research such as that conducted by the Women's Health Research Program, have the capability of instituting major improvements in community knowledge and upskilling the health care workforce if adequately funded.**

Menopause and work engagement

- Overall, the available peer-reviewed literature shows no difference for work outcomes for women according to menopausal stage (ie being premenopausal/perimenopausal/postmenopausal)

- Severe vasomotor symptoms (flushes and sweats), irrespective of stage ie peri/postmenopause, or years postmenopause, have been associated with poorer work indices.

- Major independent determinants of leaving the workforce/poor work indices for midlife women include work stress, feeling unappreciated, low job satisfaction, housing/financial insecurity, poor health, partner's employment status, and job interfering with family life.

- Only focusing on menopause may miss the major drivers of economic disadvantage for midlife women being overlooked, such as prior absences from work in childbearing years, poor career progression, low paid work and so forth.

- Workplace flexibility is important to support women with menstrual issues at any age, women experiencing fertility treatment and an array of other health issues- it does not need to be menopause-focused.

- There is currently no evidence-based workplace intervention that improves outcomes for working women or for employers. Commercial groups offering "workplace menopause-friendly accreditation" need to be independently evaluated.

Evidence to support key recommendations

The menopause experience:

The menopause, by definition, is the final menstrual period in a previously regularly (naturally) menstruating woman[1] It is identified after 12 months of no further bleeding. The perimenopause commences when menstrual cycles start to vary in length by 7 or more days and ends 12 months after the final menstrual period. The perimenopause and menopause are less easily identified in women who do not have regular menstrual cycles before the onset.

Our systematic review of international guidelines[2] reaffirms that the recognised symptoms of the perimenopause are hot flushes and night sweats (prevalence in Australian women~ premenopausal 38%, perimenopausal 67%, early postmenopausal 74%[3]), lowered mood, but not clinical depression, sleep disturbance, diminished sexual interest, and vaginal estrogen-deficiency symptoms. The prevalence of psychological symptoms differs much less between premenopausal, perimenopausal and postmenopausal women (83%, 93% and 90%, respectively) as do physical symptoms (96%, 91% and 97%, respectively)[3].

The majority of Australian women (~83% perimenopausal, 60-70% of postmenopausal)[4,5] do not experience moderately to severely bothersome menopausal symptoms. For many women the menopause is a relief from menstrual symptoms (bleeding, migraine, mood swings) and concern about contraception.

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

Key messages

Available data has shown that majority of women at in employment at midlife (~80%) rate their work ability as good to excellent; only 3-6.5% rate their work ability as poor[6,7].
Our systematic review of peer reviewed studies has revealed that:

- Menopause stage (ie being pre/peri/postmenopausal) is not independently associated with *work productivity[5,8,9], change working hours[10] or exiting the workforce[10].*
- *Severe hot flushes and night sweats have been associated with lower work productivity but the associations vary substantially between studies and countries (findings from a non-Australian study cannot be generalized to Australia), and when observed the association is not strong*
- *There are substantial differences as to how the impact of menopause is seen by women between countries[11], such that great caution is advised in extrapolating findings from one country to other countries.*

- Few studies have taken into account critical sociodemographic factors that affect women at midlife (caring for children and parents, general health and mental health, work satisfaction, autonomy and pre-existing financial security).
  - *Important independent determinants of work productivity include work environment, job stress[9,12], perceived health, depressed mood [7,8], feeling unappreciated, and low job satisfaction[13], housing insecurity and overweight, obesity[6], but not physical demands[13]. Factors independently associated with exiting work include partner's employment status and housing security[10].*

Many figures quoted are from marketing studies that are limited by inclusion of selected samples of women (eg highly symptomatic women which biases recruitment), having not accurately defined menopause or used validated questions, and not including a control group eg premenopausal women or women not suffering bothersome symptoms.

- In addition to collecting data regarding the associations between menopause symptoms and work *it is vital to determine how women perceive their menopause experience in the context of their work and workplace, and how women across the full spectrum of symptoms wish menopause to be considered in the workplace.*
- Only focusing on menopause may miss the major drivers of economic disadvantage for midlife women being overlooked such as prior absences from work in childbearing years, poor career progression, low paid work and so forth.
- Large research studies of unselected women, women representative of the Australian population, are needed to determine the impact of menopause on employment, including paid work, volunteer work self-employment and women who are carers for other people.

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

Key messages

- Overly focusing on menopausal symptoms could lead to most women (the 70% without bothersome symptoms) missing out on a menopause-associated health review and their changed health risks may go undetected. All women should merit a full health assessment in the early postmenopausal period to re-evaluate their cardiovascular disease and diabetes risks, and risk of osteoporosis and fracture.
- Menorrhagia is not a perimenopause-specific condition. Heavy and/or painful menstruation may affect women at all reproductive ages (22% of Australian women aged 18-39 years)[14]. In Australia, heavy/ painful periods are associated with greater absenteeism in premenopausal women[14]. Access to health care for women with menorrhagia should be available for women at all ages.

Australian women generally have poor understanding of the potential health consequences of menopause[15]. Postmenopausal women without symptoms may be silently impacted by menopause.

The changes at menopause predispose women to increased cardiovascular disease and diabetes risk[16], central abdominal weight gain (increasing risk of bowel and breast cancer)[16], and accelerated net bone loss (in the order of 5-6% of bone lost[17]). Hence:

- 1 in 3 women aged over 50 years will experience an osteoporotic fracture[18]
- Cardiovascular disease is the leading cause of death in postmenopausal women[19]
- Diabetes is increasing in women and the adverse outcomes conferred by diabetes are considerably greater in women than men[19]

The younger a woman is at menopause the greater the risk of subsequent early cardiovascular disease.[20]

c. the mental and emotional well-being of individuals experiencing menopause and perimenopause, considering issues like mental health, self-esteem, and social support;

Key messages

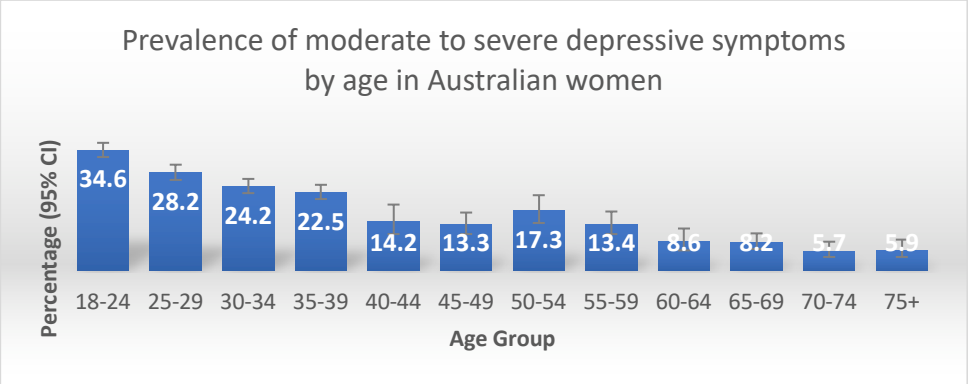
- **Depression:** As premenopausal depression is a major risk factor for perimenopausal depressive symptoms it is important to better understand, prevent and better manage depressive symptoms in premenopausal women.
- **Cognitive function:** Well designed, longitudinal studies to document the type and frequency of any cognitive changes during the perimenopause, predisposing factors to any observed change, and the impact of hormone therapy or ovulation suppression on cognitive performance during the perimenopause are needed.

1. Menopause-associated depressive symptoms

Mental health at menopause is strongly determined by mental health and wellbeing before menopause.

- The prevalence of depressive symptoms in midlife women remains low compared with younger women.

The figures below show the prevalence of moderate to severe depressive symptoms in ~10,500 Australian women aged 18-79 years assessed by the validated Beck Depression scale[21-23].



- There is a small perimenopause-associated increase in moderate-severe depressive symptoms, the prevalence remains substantially lower than for women aged less than 40 years.
- Premenopausal depression increases the likelihood of menopause-associated depressive symptoms.
- Our unpublished analysis of the independent determinants of perimenopausal depressive symptoms indicate factors other than menopausal status make the most significant contribution to the likelihood of depressive symptoms.
- There is an urgent need to address the mental health crisis manifest in young Australian women.

2. Menopause and cognition

Brain fog is a term often used to describe symptoms such as poor memory/ concentration/problem solving etc. These are not menopause-specific or age-specific, symptoms.
The most common causes of "brain fog" are stress and fatigue[24]. Other causes are poor physical and mental health (acute and chronic). While commonly attributed to menopause, brain fog is not a perimenopausal/menopause-specific symptom.
The most comprehensive discussion of this issue is the International Menopause Society White Paper published in 2022[25].
Some studies suggest that some perimenopausal women may experience cognitive symptoms, primarily impaired verbal memory[25], which mostly still remains within the range of normal function. Strategic thinking and planning (executive function) have not been shown to change[25]. When cognitive symptoms occur, they appear to dissipate as women transition through the menopause. Randomised controlled trials have not shown improvement in cognitive performance in postmenopausal women with a variety of MHT regimens[26-29]. Whether MHT would help perimenopausal women with cognitive symptoms is not known.

d. the impact of menopause and perimenopause on care giving responsibilities, family dynamics, and relationships

Key messages:

- The changes that occur at menopause can impact relationships, especially if there are pre-existing relationship issues.
- Greater community awareness of the potential impact of menopause on women could be of benefit in terms of the impact of menopausal symptoms on relationships.
- Evidence as to whether peri/menopause independently impacts care-giving responsibilities is lacking
- Loss of libido is a major cause of relationship discord. While this can emerge as a problem in association with menopause, sexual problems are usually multifactorial, with biological, psychological and sociological components.

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;

Key messages:

- Menopause is perceived differently by different cultures. In western/European cultures it is associated with loss of fertility and ageing and the predominant symptoms are flushes and sweats. In other populations, attitudes towards menopause vary substantially, ranging from positive attitudes and increased social status with ageing, through to negative attitudes. Fairly consistently, the predominant physical symptoms in Asian populations are musculoskeletal (back ache, joint aches etc), not flushes and sweats[30,31].
- Multicultural research into the experience of menopause in Australia is inadequate. Partly this is because studies to date have had insufficient statistical power to examined specific cultural/ethnic groups and partly because so many Australians have multicultural/multi-ethnic backgrounds.

Research in **First Nations Communities** is limited. Our small study of women in the Kimberly and west Victoria[32] conducted 20 years ago revealed that

- menopausal symptoms were common amongst First Nations Australian women, and mostly untreated
- the cause of the menopausal symptoms (flushes and sweats) was poorly understood
- although used for other ailments, traditional approaches such as "bush medicine" (healing plants gathered from the bush) for dealing with menopausal symptoms were lacking, possibly because they were never developed as in the past most women may have not lived until menopause.

A contemporary understanding of how First Nations women perceive, and experience menopause is needed to inform appropriate health care delivery.
Noteworthy is that a high proportion of First Nations women will have diabetes and cardiovascular disease by the age of menopause and menopause may exacerbate these conditions.

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 of treatments;

Key Messages:

- The management of menopause in Australia is poor. Women are consuming vast quantities of complementary therapies and supplements known to be ineffective for symptoms[2], which are being promoted as effective through social media and various websites.[33]
- M**enopausal hormone therapy (MHT) is not being consistently and appropriately prescribed**. While some women are being inappropriately denied therapy, others are being treated with excessive doses that lack established safety, or compounded hormones that are not TGA-approved and for which evidence of appropriate dosing, absorption, and safety are completely lacking. Compounded hormone therapy is often falsely promoted as safer than TGA-approved hormone therapy and treated women often undergo repeated, costly hormone testing.
- There is widespread misunderstanding of the symptoms of menopause in the community:
  - The only menopause-specific symptom is permanent loss of menstruation in a previously regularly ovulating women.
  - While new onset hot flushes/night sweats are highly suggestive of menopause, these occur in ~32% of premenopausal women[4]. The other symptoms attributable to menopausal estrogen insufficiency include low mood, disturbed sleep, low desire and vaginal symptoms (dryness, irritation etc).
  - A variety of symptoms are being attributed to perimenopause and menopause that are either seen with similar frequency in premenopausal women[4] or are symptoms of other common conditions (eg fatigue due to low iron, anxiety due to thyroid disease).
  - There is substantial confusion as to what symptoms are likely to be due to menopause and those likely to improve with hormone therapy. This puts women at risk of delayed/missed diagnosis of other important medical conditions or hormone therapy for symptoms unlikely to improve with hormones.
- GPs and gynaecologists generally lack confidence in the management of menopause[34].
  - Pharmacists and GPs often recommend complementary therapies known to be ineffective before prescribing menopausal hormone therapy
  - Prescribing skills and understanding of benefits and risk of menopausal hormone therapy is poor
  - Over 50% of postmenopausal women experience symptomatic vaginal estrogen deficiency symptoms but less that 10% of postmenopausal women aged less than 65 years are prescribed vaginal estrogen[35].
  - Many treatment options are not available on the PBS, including estradiol-containing contraceptives which are preferred for perimenopausal women. This has resulted in substantial inequity in health care options for Australian women.
- **Community education is urgently needed to enable women to make informed health choices**
- **Upskilling of the health care workforce in menopause-related care is urgently required.**
- Nurses can be upskilled to provide advice on lifestyle management, and to increase access to evidence-based information for menopause management and post-menopausal health.

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;

Placing major emphasis on menopause may be distracting from the core issues for midlife women in employment: less career progression than male counterparts due to time out for children, job dissatisfaction etc, combining child care/family caring and trying to perform well at work, shift work, financial stress/insecurity, poor general health, and onset of other medical issues. Menopause occurs at an age for women where work, personal health, and carer responsibilities "collide". It is not all about the biology of menopause.
Menopause leave: an Australian survey of working women has not shown that women in general want menopause leave{Hickey, 2017 #7208}. As menopause leave may have the unintended consequence of stigmatising women in the workforce further research is needed before it is considered further.

Key messages:

- Workplace policies should be based on evidence and presently evidence to inform menopause workplace policies is sorely lacking.
- Workplace flexibility is important in general to support women with menstrual issues at any age, women experiencing fertility treatment and an array of other health issues- it does not need to be menopause-focused.

- There is currently no evidence-based workplace intervention that improves outcomes for working women or for employers- commercial groups offering "workplace menopause-friendly accreditation" need to be independently evaluated.

h. existing Commonwealth, state and territory government policies, programs, and healthcare initiatives addressing menopause and perimenopause;

1. Menopause should be mostly managed in primary care. Menopause does not occur in isolation, such that centres focussed only on menopause may not have the capacity to address the common health issues that may complicate care- weight management, blood pressure control, musculoskeletal disease, CVD prevention, menopause unrelated mental health issues and other concurrent health concerns, leading to fragmented care.

2. The Practitioner Toolkit for Managing Menopause 2023 has been published with free access and care algorithms available at
https://www.monash.edu/__data/assets/pdf_file/0011/3476072/a-practitioners-toolkit-for-managing-menopause.pdf
Developed by the Women's Health Research Program in the Monash University School of Public Health and Preventive Medicine, 2023 the Toolkit is endorsed by the International, Australasian and British Menopause Societies, the Endocrine Society of Australia, RANZCOG and Jean Hailes.

The Toolkit meets the needs of women and their clinicians by providing clear, evidence-based advice as to how to address and manage symptoms of, or concerns about menopause during clinical consultations. It includes pragmatic algorithms to assess menopausal status, including that of women with a past hysterectomy or endometrial ablation, and users of hormonal contraception, along with treatment options and symptom management algorithms.

3. MenoPROMPT: a co-designed, comprehensive, evidence-based program to improve the care of women at and after menopause an NHMRC Partnership project grant
Menopause health prompts are being embedded in GP software and a co-designed a simple pre-consultation menopause-health assessment for women to complete to inform their doctor is under development.

4. Monash University has made a midlife/menopause module compulsory for all medical students

3. The **Australian Women's Middle Year's (AMY) Study is currently recruiting. This large, comprehensive, national study** will generate contemporary data on the impact of menopause on women's physical, psychological and socioeconomic wellbeing, and thus inform health care and policy for midlife women.

i. how other jurisdictions support individuals experiencing menopause and perimenopause from a health and workplace policy perspective; and any other related matter.

Other jurisdictions:
The NHS UK has funded a National Menopause Improvement Program with 4 main streams:
(https://www.sfh-tr.nhs.uk/media/14541/2pdf-suzanne-banks-menopause-presentation-sfh-sb.pdf)

- Optimal treatment pathways for patients, to ensure best practice is received as standard
- Workforce Support for NHS employees experiencing the Menopause.
- Menopausal training practices for Clinicians.
- Awareness for Population to capitalise on the growing awareness and attention given to the menopause in the public sphere.

Other related matter- potential conflict of interest

Menopause is a natural life phase that is unique to every woman. Most women will transit their perimenopause and early postmenopausal years without the need for medical therapy.

Consideration of conflicts of interest pertaining to menopause are mostly focused on pharmaceutical entities. Other commercial and non-commercial entities have high potential conflicts of interest including producers/providers of complementary therapies (medications and physical treatments) and supplements, people offering workplace training for menopause or other commercial interests who are seeking to shape discourse and policy responses. Potential conflict of interest also extends to health care providers and researchers whose careers are built on their menopause expertise.

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