FAMILY PLANNING
ALLIANCE AUSTRALIA

GPO Box 1317
Canberra ACT 2601

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100, Parliament House
Canberra ACT 2600

14 March 2024

To Whom It May Concern,

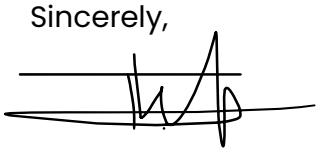
**RE: FPAA submission to Senate Standing Committees on Community Affairs in response to inquiry on issues related to menopause and perimenopause**

FPAA is a long-standing alliance of the key sexual and reproductive health organisations from each of the Australian states and territories and is their national policy and advocacy voice. We advocate primarily at the national level to uphold, strengthen, and advance sexual and reproductive health and rights, so that all people have freedom and autonomy over all matters related to sexuality, reproduction, gender and wellbeing. FPAA is the Australian International Planned Parenthood Federation (IPPF) country member.

FPAA supports the Senate inquiry on issues related to menopause and perimenopause and appreciates the opportunity to respond. Our submission has been prepared by Sexual Health Victoria (SHV) with 16 Recommendations made by the FPAA in consultation with our Primary Members. We consent to this submission being published on the inquiry website and shared publicly online.

If you wish to discuss this submission, please contact me at 0434 937 or tracey.hutt@familyplanningallianceaustralia.org.au. Thank you for your consideration of this submission.

Sincerely,



**Tracey Hutt, she/her**
CEO, FPAA

FAMILY PLANNING
ALLIANCE AUSTRALIA

# Submission to the senate inquiry on issues related to menopause and perimenopause

## Preface

FPAA regard menopause as a gender and age-equality issue in need of urgent address by the federal government. FPAA view this inquiry as an important opportunity to learn more about people's diverse experiences during perimenopause and menopause, and systemic changes needed to enable equity. It is heartening to see the Government focus on women and women's health as a primary concern and this should be the priority in a system with finite dollar. However, we also support an inclusive approach to identifying and addressing issues; recognising that not all people who experience perimenopause and menopause identify as women; trans men, non-binary and gender diverse people also experience perimenopause and menopause, facing both similar and distinct challenges to cis-gendered women. People with innate variations in sex characteristics (intersex) may or may not experience menopause differently, and it may be influenced by their medical treatments.

## Terms of Reference

Issues related to menopause and perimenopause, with particular reference to:

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

The economic impacts of menopause and perimenopause are a common concern expressed by clients seeking care at our clinics. Based on clinician observations and evidence in the literature,[1-3] perimenopause and menopause frequently affect people in the following ways:

- Difficulties in functioning effectively and comfortably within the workplace and/or coping with usual workload and responsibilities
- Concerns about using sick leave and/or not having enough sick leave for other health and well-being issues
- Concerns about obtaining medical certificates to take time off work
- Reduction in work hours or cessation of work earlier than intended, resulting in loss of income and status
- Reduction of work role/responsibilities, or deferring career opportunities; impacting career trajectory and earning capacity

- Significant stress relating to the impacts on finances, independence and mental health

**Recommendations:**

(1) Access to additional paid leave for menopause and perimenopause symptoms
(2) Access to sick certificates from the community pharmacies.

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

Whilst many people regard vasomotor symptoms as the main physical symptoms, musculoskeletal and skin symptoms can also impact on physical health and well-being. Fatigue as a specific symptom, but also as a side effect of poor sleep and nocturnal vasomotor symptoms, can impact physical health. It can lead to decreasing exercise and increasing weight which in turn worsens metabolic disease. Menopause also occurs at a time of mid-life health which includes increasing risk of metabolic diseases including diabetes and cardiovascular disease, breast and bowel cancer and osteoporosis.

Provision of high quality, evidence-based, holistic menopause care requires longer GP appointment times to assess the multiple health impacts of menopausal symptoms and to consider preventative care and risk screening.

Many people do not have access to holistic, comprehensive care required during perimenopause and menopause due to intersecting barriers including the costs and accessibility of health services.

Bone health is also an important consideration, due to the increased risk of osteoporosis associated with menopause. Osteoporosis can cause loss of mobility and quality of life for people, and a significant cost to the health system due to fractures and fragility. The current Medicare rebate for bone density testing cover a number of conditions including premature ovarian insufficiency (very early menopause) minimal trauma fracture or age over 70; excluding many people who are recommended to have the bone density for their long-term health.

The most recent A practitioner's toolkit for the Management of Menopause recommends actively considering bone health and to consider menopausal hormone therapy proactively for those who have osteopenia.[4] Therefore, people who would benefit are

required to pay approximately $150 out of pocket for the scans. Though scans are usually not repeated for another 5 years, it is another economic barrier to quality menopause care.

**Recommendations:**

(3) Increase the number of clinics that are funded to provide free menopause and peri-menopause services.

(4) Increase the investment in clinical training targeting the primary health care sector including GPs, nurse practitioners, sexual and reproductive health nurses and Aboriginal Health Workers.

(5) Improve MBS rates or incentives for menopause and perimenopause-related services so clinicians are able to provide longer consultations.

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

Perimenopause, in particular, is well-recognised as a time of hormonal transition and can cause difficulties with emotional health and well-being, cognition, motivation and concentration. These symptoms can persist beyond menopause.

GPs need appropriate time and funding to provide evidence-based best practice assessment and management of the mental health and well-being of people experiencing perimenopause and menopause. These medical consultations often take long appointment times and GP Clinics need appropriately reimbursed through the MBS. There is also a need for patient and practitioner education regarding the impact, and sensitive management of the impact, on cognition and memory (commonly termed 'brain fog').

Education on the appropriate management options for mental health in primary care during this time is also critical. Access to, and cost for, psychologists and psychiatrists continues to be an ongoing issue for many mental health conditions and it can be challenging to find a mental health practitioner with an interest in menopause and mental health specifically.

**Recommendations:**

(6) Increase the number of clinics that are funded to provide free menopause and peri-menopause services including mental health care

(7) Increase the investment in clinical training targeting the mental health care needs including sexual and reproductive health counselors, mainstream counselors, social workers, mental health nurses, mental health OTs, psychologists and psychiatrists.

(8) Improve MBS rates or incentives for menopause and perimenopause-related services so clinicians are able to provide longer consultations.

**d. the impact of menopause and perimenopause on caregiving responsibilities, family dynamics, and relationships;**

Symptoms of perimenopause and menopause, particularly when not recognised or treated, can lead to relationship difficulties and even breakdown due to impact on physical and mental health. Lack of awareness and understanding among partners and families of menopause and its symptoms can cause significant issues.[4] Whilst online information is readily available, community health promotion is needed to increase awareness about what is normal and what can be helpful. This could be through an advertising campaign or specific educational activities for partners and families.

**Recommendations:**

(9) Increase investment in community health promotion, education and online campaigns to increase awareness and build support from partners and families.

**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;**

There is currently very little research on First Nations people's experiences and perceptions of menopause, nor evidence to guide culturally appropriate and safe best practice menopause clinics and management options. Two small studies have found similarities between Indigenous and non-Indigenous experiences and symptoms of menopause.[5-6] However, the authors found that the current language and health promotion around menopause used within mainstream health settings may not be appropriate for First Nations communities. Further research, consultation and co-design

with First Nations communities is essential to ensure health promotion initiatives are culturally relevant, appropriate and relatable.

Another theme found was that menopause symptoms were often attributed to more serious and common conditions for Aboriginal patients, such as diabetes and heart disease, and that fear of complications and poor outcomes can lead to treatment avoidance. Further research into culturally appropriate best practice menopausal care is required.

For culturally and linguistically diverse (CALD) communities, there is clear lack of easy-English resources. Jean Hailes is looking to develop such resources with input from Sexual Health Victora). However, translated fact sheets are available through women's hospitals, Jean Hailes and government health translation pages. Again, further research is needed into experiences of menopause symptoms and management among CALD communities to help guide holistic culturally appropriate menopause care in Australian primary care.

There is also limited research, information and health resources regarding menopause symptoms and treatment experience among LGBTQIA+ communities.[7] Most of the research in the LGBTQIA+ community has focused on menopausal experiences of people who identify as lesbians. Researchers have found that there is minimal difference between the number and severity of symptoms for lesbian participants, but they were more likely to report positive feelings towards menopause and midlife sexual function. Genitourinary symptoms of menopause were noted to have a similar negative impact on sexual function.

Many of the challenges for inclusive menopause care for the LBTQIA+ community are barriers that occur when accessing healthcare in general. Some examples of challenges that can occur are:

- Healthcare practitioners not understanding and expecting menopausal symptoms for trans men or non-binary patients
- Need for sensitive communication around body part terms and examinations
- Gender dysphoria
- Concerns and lack of knowledge about the use of menopausal hormone therapy whilst also using gender affirming hormones
- Existing mental or physical health problems that may be exacerbated by fluctuating hormones

**Recommendations:**

(10) Ensure existing and new programs and services are culturally safe and inclusive.
(11) Also develop highly targeted, peer-led services for hard-to-reach populations that include bespoke information, education, resources and campaigns.

**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;**

Australian researchers have found that healthcare providers appear knowledgeable about menopause, but uncertain about its management.[8] Menopausal Hormone Therapy (MHT) prescription appeared limited to women with severe symptoms. They concluded that the upskilling of clinicians providing care for women at midlife and following cancer treatment, concerning the indications for and prescribing of MHT, urgently needs to be addressed. This appears to be an international issue as similar findings and conclusions have been made in recent European research.[9]

Further education is required at medical school, pre-vocational, vocational training and post-fellowship to facilitate clinician recognition of menopausal symptoms and signs and systematic evidence-based management including non-drug, MHT and other management options. This will improve knowledge of menopause care, especially in perimenopause when treatment can be withheld due to 'not being post-menopausal' or ' too young'.

As Tania Glyde (2022) states:

> *Along with understanding minority—and global majority—experiences of menopause, it is perimenopause specifically where much work needs to be done. Insufficient knowledge and awareness of perimenopausal symptoms remains a problem. I have heard accounts of people being told by doctors that they are too young to be in perimenopause. What is strange is that instead of accepting their patients' experiences, some practitioners are still telling them what can and cannot be.*[7]

Funding for further research into best practice menopause clinical education as well as funding for education activities for health professionals could address this gap.

Another barrier to providing appropriate medication management is that Australia has a problem with MHT supply and cost. Australia can have shortages of MHT preparations due to manufacturing and shipping delays. Many MHT products are not available on the

Prescription Benefit Scheme (PBS) making them costly for some patients and can influence the choice of preparation away from a lower risk for VTE and cardiovascular disease (transdermal preparations) to a cheaper but more moderate risk (such as oral preparations).

The 52 mg levonogestrol IUD, which can be a useful part of MHT providing contraception, perimenopausal menstrual control and endometrial protection, still has a low Medicare rebate for insertion in primary care. This can be a barrier to GPs to learn and provide IUD insertion services.

**Recommendations:**

(12) Investing in research on menopause and perimenopause

(13) Increase the investment in under-graduate and pre-vocational training targeting the primary health care sector including GPs, nurse practitioners, sexual and reproductive health nurses and Aboriginal Health Workers.

(14) Increase the investment in undergraduate and pre-vocational targeting the mental health care needs including sexual and reproductive health counsellors, mainstream counsellors, social workers, mental health nurses, mental health OTs, psychologists and psychiatrists.

**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;**

It is critical that people experiencing perimenopause and menopause are supported to participate and thrive within their place of work and professional role. Workplace support can come in many forms, including a culture of open communication and support, policies and guidelines that enable flexible working hours and locations, and strategies to create more comfortable working environments, such as availability of fans and cooling, cold drinking water and access to quiet work rooms. Importantly, employees need to be aware of, and comfortable that they can utilise these supports without prejudice or repercussions to their job security and career progression.[2] Training and workplace guidelines are important, to ensure both employers and employees have greater awareness and understanding of perimenopause and menopause, and the supports that can make a difference to those affected.

**Recommendations:**

FAMILY PLANNING
ALLIANCE AUSTRALIA

(15) Develop guidance for workplaces on supporting employees experiencing perimenopause and menopause

(16) Invest in workplace training and consultancy support to implement this guidance.

FAMILY PLANNING ALLIANCE AUSTRALIA

## References


1. Rees M, Bitzer J, Cano A, Ceausu I, Chedraui P, Durmusoglu F, Erkkola R, Geukes M, Godfrey A, Goulis DG, Griffiths A. Global consensus recommendations on menopause in the workplace: a European Menopause and Andropause Society (EMAS) position statement. Maturitas. 2021 Sep 1;151:55-62.
2. O'Shea M, Howe D, Armour M & Duffy S. (2024). Symptoms of menopause can make it harder to work. Heare's what employers should be doing. The Conversation, 23 January 2024.
3. Howe D, Duffy S, O'Shea M, Hawkey A, Wardle J, Gerontakos S, Steele L, Gilbert E, Owen L, Ciccia D, Cox E, Redmond R, Armour M. (2023). Policies, Guidelines, and Practices Supporting Women's Menstruation, Menstrual Disorders and Menopause at Work: A Critical Global Scoping Review. Healthcare, 11: 2945.
4. Zhang X, Wang G, Wang H, Wang X, Ji T, Hou D, Wu J, Sun J, Zhu B. Spouses' perceptions of and attitudes toward female menopause: a mixed-methods systematic review. Climacteric. 2020 Mar 3;23(2):148-57.
5. Jurgenson JR, Jones EK, Haynes E, Green C, Thompson SC. Exploring Australian Aboriginal Women's experiences of menopause: a descriptive study. BMC Women's Health. 2014 Dec;14:1-1.
6. Jones EK, Jurgenson JR, Katzenellenbogen JM, Thompson SC. Menopause and the influence of culture: another gap for Indigenous Australian women? BMC women's health. 2012 Dec;12:1-0.
7. Glyde T. LGBTQIA+ menopause: room for improvement. The Lancet. 2022 Nov 5;400(10363):1578-9.
8. Davis SR, Herbert D, Reading M, Bell RJ. Health-care providers' views of menopause and its management: A qualitative study. Climacteric. 2021 Nov 2;24(6):612-7.
9. Rozenberg S, Panay N, Gambacciani M, Cano A, Gray S, Schaudig K. Breaking down barriers for prescribing and using hormone therapy for the treatment of menopausal symptoms: an experts' perspective. Expert Review of Clinical Pharmacology. 2023 Jun 7:1-1.