# Issues related to menopause and perimenopause
# Australian Senate Inquiry

## Submission from the
## Affiliation of Australian
## Women's Action Alliances
## (AAWAA)

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**Introduction**

Thank you for the opportunity to contribute to the Australian Senate Inquiry into issues related to menopause and perimenopause. We trust you will accept this submission from the Affiliation of Australian Women's Action Alliances (AAWAA).

The Affiliation of Australian Women's Action Alliances brings together women's liberation groups from the ACT, Tasmania, Queensland, South Australia, Western Australia, and Victoria, all of whom contributed to and endorsed this submission. We advocate for women and girls in all domains that impact our lives and welfare, but especially where we face discrimination or are vulnerable by reason of our sex, including in the field of evidence-based health care. Our membership includes mothers, grandmothers, teachers, public servants, researchers, professionals, businesswomen, retirees, as well as medical, nursing, and legal professionals, all from a diversity of backgrounds. We are non-partisan and secular.

AAWAA is enthusiastic about the prospect of a constructive discussion of women's needs during menopause in Australia and we thank the Senate for allowing us to comment.

We know that symptoms of menopause and the menopause transition[1] can impact significantly a woman's personal life as well her work, but sadly, this knowledge is not translating into a broader change in attitudes, increased awareness, or increased availability of treatments and services for women in the menopause.[2] In relation to accessing treatment, what we present below is a result of what we ourselves have learnt in relation to our own health needs: it is not a result of any public health initiative that, for example, dispels the myths that menopausal hormone therapy (MHT) causes breast cancer (promulgated by the media and based on flawed research), or necessarily as a result of consultation with our GPs.

Much of our material will therefore appear as anecdote, especially in relation to how women seeking treatment for menopausal symptoms are served at the hands of medical practitioners; however, we ask the committee's indulgence in this regard and we respectfully suggest that one of the reasons we need to share this kind of evidence is precisely because we lack in any formal, large-scale studies about women's experiences in trying to get medical help to alleviate menopausal symptoms. This, we believe, tells its own story.

A final note before we continue. We know that other groups will speak in more depth on the medical science, on CALD women's experiences, on the economic impacts relating to homelessness and the burdens associated with caregiving, as well as on workplace relations, socio-cultural factors, and policy responses. Although we have women in our groups who could write on each of these matters separately, we have chosen, instead, to focus on our shared, lived experience in relation to accessing appropriate and timely health care and services, knowing that this matter will cut across many women seeking to manage their health during menopause. We also point to the broader social policy interventions that are desperately needed for vulnerable women of menopausal age.

**Menopause as a public health issue**

Menopause can no longer be seen as a private matter for women to sweat and angst through silently, and in isolation. The simple fact of the marked increase in women's labour force participation over the past almost half-century has ensured that menopause needs to be discussed as a public health concern that affects workplaces every bit as much as private residences.

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[1] Unless noted otherwise, the term 'menopause' is taken, here, to include the peri-menopause.

[2] Menopause affects younger women, too; however for our purposes, we are talking of women in the 'typical' peri-menopausal and menopausal age groups.

Women's labour force participation has increased markedly (by 184%) since 1978, in comparison to men's (74%) over the same period.[3] As regards women aged 45 to 54 years, women's labour force participation over the past forty years has also increased significantly – from 46.6% to 80.2% – whilst men's participation for the same age range has remained stable.[4] As the workforce ages, and as women continue to participate in the labour market in growing numbers at an increasing age, women experiencing perimenopause and menopause are making up more and more of the Australian labour force.

Put simply, as women are now living longer, menopause has become a matter of public health. In Victorian times, the average age of menopause was 57 and the average age of death was 59.[5] Today, the average age of menopause for Australian women is 51,[6] meaning that – as the population ages – women are now spending 30+ years in postmenopause, and many of those years are spent in the workforce and participating in public life. This makes better understanding and awareness of the menopause crucial to future public health planning for Australian women.

**Poor knowledge of menopause treatments and lack of public awareness of the menopause**

Even though this increase in labour force participation has been occurring for over 45 years – and we had the opportunity and knowledge to publicly address and medically treat the menopause effectively during that time – women's health needs in relation to menopause have not been adequately met. This can be largely explained by the influence of a massively flawed and erroneously reported-upon study of the use of MHT – a study that has severely and negatively impacted women's awareness of safe and effective menopause treatments.

Published in 2002, the Women's Health Initiative (WHI) study[7] was responsible for creating a devastating media scare campaign[8] which stated that MHT caused a 26% increase in breast cancer risk and whose far-reaching effects have set women's health care in Australia back by 30 years.[9] The social and medical force generated by the WHI study and the inaccurate reporting of the study by the media in Australia cannot be underestimated.

The problems with the study were manifold: Women in the study had an average age of 63, with the oldest participant being 79 years old. Many were given MHT for the first time, and 70% were overweight or obese, 50% were hypertensive, and 50% were past or current smokers (risk factors, also, for heart disease and cancer). Moreover, menopausal symptoms were largely excluded from the participants (e.g., you do not conduct a trial about headaches with people who do not have headaches). All participants were given oral oestrogen (that is, via a tablet – which is not generally prescribed) and an older type of progestogen that is not commonly used now. Neither the type nor dosage of MHT preparations used in the WHI studies are still in use in Australia, and updated preparation options now available to Australian women carry far lower risk and side-effect profiles. However, optimal health outcomes still rely on expert prescription, tailored to the patient. As such, the importance of

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[3] A changing climate for Australian women in the workforce, Property Council of Australia, March 2019.

[4] Workforce participation measures, Australian Parliamentary Library, May 2018.

[5] How long can the menopause last? Louise Newson, September 2021.

[6] Menopause what are the symptoms? Australasian Menopause Society, April 2017.

[7] For a comprehensive review and analysis of the WHI study, see The Women's Health Initiative -- where are we a decade later?, published by Jean Hailes for Women's Health.

[8] Shock, terror and controversy: how the media reacted to the Women's Health Initiative, *Climacteric*, June 2012; The Controversial History of Hormone Replacement Therapy, *Medicina (Kaunas)*, September 2019.

[9] We take this out to the year 2032, as we cannot envisage the damage done by this campaign as being reversed before then, current efforts of this committee notwithstanding.

up-to-date education for medical practitioners cannot be overstated. A re-examination of the WHI data shows that benefits of MHT outweigh the risks for women under 60.[10]

In further regard to awareness, we note that many women either will not talk about the menopause (even to each other) either due to 'embarrassment ' or, quite simply, because we do not recognise the symptoms, as education on the menopause is minimal. In addition to this, ageism and sexism combine to often misdiagnose menopausal symptoms as being related to stress and anxiety[11] and other stigmatised and denigrated 'women's complaints' rather than as a result of significant hormonal changes. Women, often not taken seriously and commonly experiencing 'gas-lighting' as regards our health concerns anyway,[12] are generally reluctant to raise health matters with those to whom we are not intimately connected, let alone matters relating to the 'sensitive' topic of the menopause. Public awareness more broadly of the topic, is even poorer.

**Lack of practitioner knowledge and lack of appropriate treatment**

Despite affecting over half of the Australian population, menopause is approached by medical practitioners as a niche area of interest, rather than a routine part of health care for women. A lack of investment in substantive female sex-specific research, practitioner education, and public health promotion continues to drive a poor understanding of the physiological, psychological, and social impacts of the menopausal transition, and its broader effects on women's health and wellbeing, and contributes to poor practitioner knowledge of effective treatments.

Medical practitioners are also members of the public, and even though we place our trust in them to advise us on specific health matters, we find ourselves too often the recipients of biases and judgements that are commonly made against women – and especially against older women. Attempting to get health treatment in such an atmosphere of distrust and discounting can lead to embarrassment, humiliation, belittling, and scorn, leaving us to feel invalidated, gaslit, and disbelieved.

In particular, we note that practitioners struggle to identify perimenopausal symptoms and then diagnose them using a simple diagnostic tool that has been available for years: the best diagnosis for menopause and perimenopause is via symptoms for women aged 45 and over. This is important, as a woman of this age who is suffering, for example, from interrupted sleep, aching joints, memory lapses, mood swings, and headaches is *less* likely to be suffering stress and/or anxiety and is *more* likely to be menopausal. Concurrently, the lack of education of practitioners to accurately diagnose menopause can contribute to the misdiagnosis of menopause and the nondiagnosis of serious underlying health problems: women of menopausal age can often struggle to have other health issues taken seriously as those issues are swept beneath an incorrect diagnosis of menopause.

These symptoms can be treated. And yet, in our experience with GPs, this simple diagnostic has not been used. Instead, most GPs appear to focus primarily on the simple, sudden, and noticeable cessation of menstruation, or on the sole experiencing of hot flushes. For the majority of women with symptoms, their symptoms last an average of four years; for one in ten women, symptoms can last up to twelve years, and so early and accurate diagnosis – and intervention, where required, especially for those whose symptoms are debilitating – is

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[10] The Women's Health Initiative -- where are we a decade later? Henry G. Burger, March 2016.
[11] *Haynes Manual, Menopause*, Louise Newson, 2019.
[12] Women's health concerns are dismissed more, studied less, *National Geographic*, January 2020; *Sex Matters: How Male-Centric Medicine Endangers Women's Health—and What We Can Do About It*, Alyson McGregor, 2020; The doctor doesn't listen to her. But the media Is starting to, *The Atlantic*, August 2018; Women have been woefully neglected': does medical science have a gender problem? *The Guardian*, December 2019.

essential if we are to provide women in this age group who are experiencing such symptoms with improved quality of life and better services.

In addition to a lack of GP knowledge in regard to diagnosis, we have also noted a lack of GP knowledge in regard to the prescription of MHT. In use since the 1960s, MHT has proven effective in tackling the symptoms of menopause, and for the vast majority of women under the age of 60, the benefits of MHT outweigh the risks.[13] MHT has been shown to protect bones[14] and to protect against cardiovascular disease[15] – this is important, especially given that women are more likely than men to suffer from osteoporosis *and* we are less likely to have our heart conditions recognised and treated properly.[16] Indeed, research shows that MHT will not increase the risk of cardiovascular disease if started under 60 years of age[17] and that the benefits are greatest if a woman starts MHT within ten years of her menopause:[18] it can help lower cholesterol levels[19] (high cholesterol being a significant public health problem[20]); it can prevent *and reverse* bone loss that occurs in menopause, even with low doses of MHT;[21] it reduces the risk of type 2 diabetes; it reduces the risk of osteoarthritis; and it may or may not reduce the risk of developing Alzheimer's disease.[22] This shows that MHT can be a prophylactic – but it is not being prescribed as such.

It is important to acknowledge that taking *some* types of combined MHT may be associated with a small increased risk of developing breast cancer and that this increases the longer a woman uses combined MHT; however, when a woman stops taking combined MHT, she has the same risk as a woman who has never taken MHT.[23] Indeed, there has never been a study that shows an increased risk of dying from breast cancer in women who take MHT, there is no increased risk of breast cancer in women who take MHT under the age of 51, and oestrogen-only MHT means no increased risk of breast cancer.[24] It is also important to note that the risk of developing heart disease or cancer depends on many factors (such as age, family history, general health) – and not solely on whether or not a woman takes MHT, and that 1 in 7 Australian women will develop breast cancer in her lifetime.[25]

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[13] Menopause: diagnosis and management, National Institute for Health and Care Excellence, November 2015.
[14] See Consider MHT for bones: New menopause guideline, Royal Australian College of General Practitioners, November 2023; Guidelines & Statements, Healthy Bones Australia; and The 2022 hormone therapy position statement of the North American Menopause Society, Australasian Menopause Society, July 2022.
[15] See Menopause Transition and Cardiovascular Disease Risk: Implications for Timing of Early Prevention, and *Menopause and the Metabolic Syndrome, The Study of Women's Health Across the Nation*, *Archives of Internal Medicine*, July 2008.
[16] The heart disease gender gap, Harvard Health Publishing, September 2022.
[17] Menopause: diagnosis and management, National Institute for Health and Care Excellence, November 2015.
[18] Vascular effects of early versus late postmenopausal treatment with estradiol, *New England Journal of Medicine*, March 2016, and HRT and cardiovascular disease, *Best practice & research. Clinical obstetrics & gynaecology*, February 2008; Menopause and women's cardiovascular health: is it really an obvious relationship?, *National Library of Medicine*, December 2022.
[19] Primary prevention of cardiovascular disease with HRT, *Women's Health*, 2012.
[20] Heart, stroke and vascular disease: Australian facts, Abnormal blood lipids, Australian Institute of Health and Welfare, December 2023.
[21] Menopause: diagnosis and management, National Institute for Health and Care Excellence, November 2015.
[22] Sex, hormones and neuroeffector mechanisms, *Acta Physiologica (Oxford, England)*, November 2010; Menopause impacts human brain structure, connectivity, energy metabolism, and amyloid-beta deposition, *Nature*, June 2021.
[23] Micronised progesterone does not increase breast cancer risk for up to five years duration.
[24] *Haynes Manual: Menopause*, Louise Newson, 2019, p 44.
[25] Risk factors in breast cancer, Breast Cancer Network Australia, 2023.

Additionally, there is an increased risk of deep vein thrombosis with combined MHT if taken as a tablet – but this does not happen with a patch or gel – and there is a small increased risk of stroke in women taking either oestrogen alone or combined MHT as tablets[26] – and tablets are not the preferred prescription method, anyway.

Women in our groups have attempted to get treatment for menopausal symptoms but have been told by medical practitioners that they (the practitioner) will not prescribe perfectly safe hormones on account of 'breast cancer risk.' GPs are trained to weigh risks and consequences. If the consequences are so low for combined MHT, but the benefits so large, then we question GPs' professional reluctance to prescribe a cheap and simple treatment that will benefit both the public health and an individual woman's quality of life.

There is also confusion around 'natural' bio-identical vs synthetic hormones in Australia. This stems from TGA policy that compounded pharmaceuticals are not subject to regulation, giving rise to uncertainty about effect and consistency in pharmacy-compounded bio-identical hormones. There are, however, several pharmaceutical TGA-regulated, *body*-identical MHT treatments available for prescription from a doctor, for which studies show women report a greater satisfaction and reduced side effects;[27] however, these are not available on the PBS and are of greater expense.

Related to this, we are concerned that combined therapeutic treatment is not available on the PBS. Whilst oestrogen is available at a subsidy, progesterone is not, and this increases costs to women in the perimenopausal stage, and causes unnecessary suffering to those who cannot afford treatment at all, should they even be prescribed it.

This is all knowledge that we have found for and shared amongst ourselves – and yet finding a GP informed to the same level is difficult. Women should be able to expect to have the risks and benefits explained clearly and accurately to us by our GPs and we should be allowed to make our own decisions.

Finally, lack of practitioner knowledge leads to women seeking out ineffective 'natural treatments' that in our experience have little to no effect, and that there is little to no evidence for in terms of their efficacy, and that only serve to remove women from our hard-earned money; in other words, it leads to the financial exploitation of an already vulnerable group, i.e., older women.

**Social policy interventions for vulnerable women of menopausal age**

Although timely and affordable therapies and interventions (including non-pharmaceutical interventions) from a properly educated cohort of health professionals should be seen as a baseline for treatment of menopausal symptoms, this will mean little if women are not in a position to seek out those therapies or interventions to begin with.

Women who experience menopause are at a life-stage when other problems expose us to socio-economic forces in ways that compound our vulnerability. This is especially the case in areas of care-giving (the burden of which falls to women, both for children and for elderly parents), poor health, poverty, mental illness, and lack of financial stability (e.g., through lack of adequate superannuation, caused by sacrifices made earlier in the lifecourse). Means and circumstances often coalesce to leave older women in situations where they are often unlikely to have the time and wherewithal to seek out and access services they desperately need. These services do not only include GP consultations, but also carer support services, homelessness services, mental health services, and other allied health services.

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[26] *Haynes Manual: Menopause*, Louise Newson, 2019, p 45.
[27] The bioidentical hormone debate: are bioidentical hormones (estradiol, estriol, and progesterone) safer or more efficacious than commonly used synthetic versions in hormone replacement therapy? *Postgraduate Medicine*, January 2009.

The statistics for carers in regard to the burden placed on women – and poorer women, at that – are telling. ABS's Survey of Disability, Ageing and Carers[28] for 2018 shows that females were more likely to be carers (12.3% of all females) than males (9.3% of all males) and seven in ten (71.8%) primary carers were women: many of these women will be in menopause. Half (50.2%) of all carers lived in a household in the lowest two equivalised gross income quintiles, twice that of non-carers (25.6%), and again, we know that women of menopausal age will make up a significant proportion of the cohort. The statistics relating to the gender gap in retirement savings are similarly unequal for women: in the 2019–20 financial year, the median superannuation balance for females over 65 years was 80% of that for males, $168,000 compared with $208,200.[29]

With all this said, however, addressing two fundamentals in social policy will alleviate many of these concatenating problems for older women: 1) better access to affordable housing, and 2) an increase in income support to the point where older, disadvantaged women can move out of poverty. Addressing these most basic of matters will be an effective public health measure in and of itself, and are championed by over 60 peak bodies and community organisations, including Health Justice Australia, the National Council of Single Mothers and their Children, UnitingCare Australia, and the Public Health Association Australia.[30]

**De-sexing the language around women's health care, and the need for clear messaging around menopause**

Here, we touch upon the matter of the de-sexing of the language around health care for women and girls. Such language includes the terms 'pregnant people,' 'chest feeders,' and people who 'have a cervix.'[31] As academics and researchers have noted, this practice results in confused messaging, with serious implications for the sex-specific health care messaging that women need, messaging that can be especially confounding for migrant and refugee women.[32] Doctors have also warned that blurred lines between biological sex and gender identity can lead to serious medical errors.[33] There will be many instances in which correct and accurate sexed language around women's health needs in menopause is required, and not just for clear messaging to consumers: language that fails to acknowledge correct sex risks conflating data that can tell us about the different health requirements between females and males,[34] and even threatens to undo efforts to close the data gap on the very same.[35] We note that a similar de-sexing has not occurred in relation to men's health care.

**Medically induced early menopause**

Finally, and on a sensitive matter, we are also concerned about non-natural or iatrogenic menopause that can impact females who undergo hormonal and surgical interventions to align their gender identities with their sexed bodies. These interventions include the use of testosterone and/or hysterectomies. We note that the demand for these interventions is

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[28] Survey of Disability, Ageing and Carers, Australian Bureau of Statistics, October, 2019; figures for 2022 are due to be released in June 2024.
[29] Gender Indicators, Australian Bureau of Statistics latest release.
[30] Over 60 peak bodies and community organisations call for adequate income support and investment in social housing, Australian Council of Social Service, April 2022.
[31] The Queensland Government, for example, refers to "a woman or a person with a cervix", whilst the ACT removes women entirely by suggesting that a pap smear is only needed if you "have a cervix".
[32] Effective communication about pregnancy, birth, lactation, breastfeeding and newborn care: The importance of sexed language, *Frontiers in Global Women's Health*, February 2022.
[33] Don't de-sex the language. Doctors warn of danger over gender-inclusive terms, *Sydney Morning Herald*, December 2023.
[34] AIHW data by sex and gender, Australian Institute of Health and Welfare, August 2023.
[35] See letter to the NHMRC signed by over 120 researchers, Don't de-sex the language. Doctors warn of danger over gender-inclusive terms, *Sydney Morning Herald*, December 2023.

increasing: the Society for Plastic Surgeons estimates that more than 64,000 females are candidates for these interventions.[36] We are troubled by current transgender protocols that provide little or no information on the risks of iatrogenic menopause[37] and we note a concerning lack of research on this subject both in Australia and overseas.[38]

This is a growing and under-recognised cohort and they will need life-long care if they are to enter middle- and old-age in good health. We hope the committee will not forget this vulnerable group in its deliberations.

**Recommendations**

Although we know that women in menopause have special health needs and, for example, that MHT relieves symptoms and has a preponderance of long-term, positive health effects, we still need research on menopause and how it impacts women's lives. As we noted in our introduction, the fact that we must report largely based on our experiences as women and not from a basis of publicly available research shows how much this research is needed. We therefore respectfully submit the following recommendations.

a. **Allocate funding through the National Health and Medical Research Council (NHMRC) for improved and expanded menopause health and medical research.** Evidence-based practice can only be developed and improved on the back of high-quality research data. It is imperative that research is incentivised and supported for the development of robust data around the physiology of the menopausal transition and its immediate impact on physical and mental well-being (that is, better care for symptom management). We also need robust research on the impact of menopause on women's longer-term health outcomes – particularly around impacts on cardiovascular disease, bone health, neuropsychiatric conditions, and brain health/ dementia – and how these conditions might be improved by early hormonal and/or other interventions.

b. **Mandate the inclusion of substantive training and education on the menopausal transition in the curriculum of all Australian medical and nursing schools, ensuring an adequate baseline of knowledge for all graduating medical practitioners.**
Australia needs investment in the development of continuing education and specialised training for existing practitioners through organisations such as the Australasian Menopause Society. We also submit a strong recommendation for the inclusion of menopause-specific education for nursing and allied health curriculums, including those for physiotherapists, occupational therapists, exercise physiologists, and dieticians.

c. **Support research into mental health during menopause through funding of initiatives such as the recently launched HER Center through Monash University.**[39]

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[36] See PICO set, Medical Services Advisory Commission, Application 1754, Patient consultations and surgical procedures for gender affirmation in adults with gender incongruence, and Patient consultations and surgical procedures for gender affirmation in adults with gender incongruence, February 2024.

[37] See, for example, updated WPATH Standards of Care, which don't specifically mention testosterone or hysterectomies. We note that some overseas online health guides warn of possible consequences, but Australian guidelines and sites do not. See Healthline.com, What to Expect from Menopause If You're Transgender or Use Gender Affirming Hormone Therapy, and Australia's Health Direct, Gender affirming surgery

[38] See LGBTQIA+ menopause: room for improvement, *The Lancet*, November 2022. This article also provides an example of the de-sexing of language around menopause.

[39] HER Centre Australia takes the lead in women's mental health, Monash University, October 2022

We need to mandate training on the effects of menopause in the curriculum for psychiatry in Australia, and further development of training resources for mental health support workers is also needed, including for psychologists, mental health nurses, and social workers. This must include the development of culturally appropriate resources for Aboriginal service providers and those working with CALD women.

d. **Develop public health promotion campaigns, in plain language, to improve public awareness around the menopausal transition.**
There needs to be further investment in female-specific health promotion around women's healthy ageing, for example, the different presentation of cardiovascular disease in women versus men, the increase in risk of dementia in post-menopausal women, and so on. Specific campaigns aimed at CALD and/or refugee women must also be developed and implemented.

e. **Improve access to medical and specialised nurse practitioner services through the inclusion of specific items under the MBS and expand treatments available through the PBS.**
Resourcing for women's aged health in rural and remote communities needs to be improved, including permanent MBS items for telehealth services and culturally appropriate health promotion initiatives for older women in remote Aboriginal communities.

f. **Improve subsidies and rebates available for access to nursing and allied health services under the Medicare GP management plans.**
This needs to include specific support for mental health and psychological interventions, and other nursing and allied health services such as dieticians and exercise physiologists, to assist with lifestyle-based interventions and support.

g. **Improve access to affordable housing for older women.**
Invest in innovative housing models for women including options to provide affordable and appropriate single-unit dwellings for older women. Practical measures include promoting older women as preferred tenants and ensuring housing for older women is not confined to the outer suburbs so that women are close to essential services and networks.

h. **Increase income support.**
AAWAA groups support the Raise the Rate[40] campaign call for an increase to the rate of Jobseeker and other income support payments to at least $78 a day, and for payments to be indexed in line with wages as well as CPI to ensure that they remain adequate over time. Income support is, in itself, a measure that improves public health.

i. **Ensure plain and correct language is used to communicate and collect information about the menopause.**
Mandate the correct and accurate use of female-specific language in government-produced, menopause-related materials. The language needs to be plain, clear, unambiguous, and must not confuse consumers and patients. When collecting data, the government should mandate that all health-related data collection must record correct, birth/biological sex so that we have an accurate representation and understanding of women's health needs and situations in menopause.

[40] RaiseTheRate.org.au

**IN CONCLUSION**
Menopause is not an illness, and neither is it a medical condition: it is a normal component of the female life cycle; however, it *is* a women's health issue with social and economic consequences. We commend the Australian Senate for addressing the matter of menopause and hope it can be seen for the public health issue it is. We hope this inquiry will serve to drive immediate action to remedy critical gaps in the treatment and understanding of the menopause for Australian women.

We stand ready to assist with further evidence, should you require it.