



Submission to the Senate Inquiry into issues relating to menopause and perimenopause

Submission prepared by Women's Health in the
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Introduction

Women's Health in the South East (WHISE) welcomes the opportunity to provide input into the Senate Inquiry into issues related to menopause and perimenopause.

WHISE is the regional women's health service for the Southern Metropolitan Region. WHISE is a not-for-profit organisation that focuses on empowering women. We work to improve the health and well-being of women in our region by providing health information and education to governments, organisations, education providers, and community groups. WHISE is the lead of the regional four-year strategy for sexual and reproductive health, *Good Health Down South 2021 – 2025*, the associated action plans, and the bimonthly network in the Southern Metropolitan Region comprising representatives from local and state government, youth and maternal and child health services, health promotion agencies, community health organisations and other community and social services.

Executive Summary

This submission has been endorsed by the HER Centre and Gippsland Women's Health. WHISE's submission will apply an intersectional gender lens to the Terms of Reference supplied by the Senate Community Affairs References Committee, outlining identified areas for strengthening in the provision of health services, education, information and resources, policy and legislation, to ensure equitable access to reproductive healthcare. Our response to the Terms of Reference is informed by evidence and best practice; and was developed in alignment with our strategic priorities of enhancing gender equality, preventing violence against women and improving sexual and reproductive health and mental health outcomes. The submission also includes key recommendations highlighted below, for your convenience.

Key recommendations

Economic consequences

1. **AMEND** the Occupational Health and Safety Act and regulations to include mandates for workplaces to incorporate menopausal health within their occupational health and wellbeing policies.
 - o This is in accordance with Section 21 of the OHS Act:
 - (1) An employer must, so far as is reasonably practicable, provide and maintain for employees of the employer a working environment that is safe and without risks to health.
2. **INTRODUCE** 10 days of paid reproductive leave each year. This includes full-time, part-time, and casual employees.
3. **INVEST in capacity building programs aimed to strengthen healthcare providers** in menopause and perimenopause workplace health management.
 - o This is to ensure practitioners have the knowledge and skills to provide patients with advice on how to manage their menopausal symptoms in the workplace.

- This will be embedded in all standard consultations to discuss treatment and management of perimenopause or menopause.

Physical health impacts

4. **CONDUCT a review into the pre-service medical curricula** to ensure that prospective doctors, nurse practitioners and other primary care providers utilise the evidence-based tools available.
 - This includes for preventative health screening, symptom management, prescription of menopausal hormone therapy (MHT) and other interventions in line with best-practice guidelines (i.e. *Practitioner's Toolkit for the Management of Menopause*, developed by the Women's Health Research Program in the Monash University School of Public Health and Preventative Medicine, and resources from the Australasian Menopause Society).
5. **INTRODUCE accredited post-graduate education pathways** for new and acting health practitioners in the workforce.
 - This is to enable practitioners to expand their competencies in perimenopause and menopause, developed in consultation with the Australasian Menopause Society and other relevant stakeholders.
6. **REFORM the Medicare Benefits Schedule (MBS) patient rebates** to incentivise bulk-billed general practice services and ensure the viability of affordable and accessible menopause related primary care, including osteoporosis screening (DEXA scans). Evaluate all postmenopausal women aged 50 years or older for osteoporosis risk.
 - This is to guarantee patients can access high-quality, equitable healthcare and obtain referrals to specialist services without incurring additional costs.
7. **Extend Medicare to include all migrants** (irrespective of visa category) and abolish waiting periods and visa restrictions for all migrants.
 - This includes temporary migrants on the Pacific Australia Labour Mobility (PALM) scheme, and overseas student health cover (OSHC) deed, which is due to expire in June 2024, and is within the Minister for Health's power to remove (as outlined in Schedule 4d).
8. **EMBED and STRENGTHEN shared care models** to ensure people experiencing menopause and perimenopause have access to holistic and supplementary treatment modalities.
 - This includes naturopathy, traditional Chinese medicine, osteopathy, physiotherapy, dermatology, and endocrinology.
9. **REVIEW referral pathways to specialist support services**, with the aim of removing barriers to care, such as endocrinologists.
 - This includes complex referral pathways, lengthy wait times and prohibitive out-of-pocket costs that limit uptake of services.

Mental and emotional well-being

10. **INVEST in community-based programs that aim to reduce isolation and loneliness**, improve social connection and aid in strengthening other protective factors.
11. **INVEST in programs that aim to ENHANCE access to evidence-based health promotion information** and help-seeking pathways for perimenopausal and menopausal women. Such as:

- The Mastering Menopause Program, currently being developed and delivered by WHISE and funded by the Victorian Department of Health.
 - The menopause information sessions delivered by WHISE and partners from June to October 2023.
12. **INVEST in capacity-building for healthcare providers** to screen for and address mental health concerns.
 13. **EMBED referral pathways** between hospitals/ general practitioners to mental health practitioners (such as psychologists and psychiatrists) that specialise in addressing perimenopausal depression and anxiety.
 14. **INVEST in research and clinical trials** to better understand the neurobiological mechanisms underlying menopausal mental health issues.
 - The aim is to improve the current menopausal hormone therapy (MHT) guidelines for treatment of mental health concerns during perimenopause and menopause.
 15. **FUND a national campaign that raises awareness** of symptoms, and the physical and mental health impacts of perimenopause and menopause.

Impact of menopause on relationships and caregiving responsibilities

16. **INTRODUCE national treatment guidelines that INTEGRATE sexual wellbeing** into the treatment of menopause in primary and specialist healthcare settings.
17. **INVEST in the development of menopause health promotion resources** to improve intimate relationships with a focus on mental health.
 - The aim is to build health literacy in the community and therefore increase help seeking behaviour.
18. **INVEST in programs that aim to establish support networks** and resources specifically tailored to women in the 'sandwich generation'.
 - This could include support groups, similar to *Mastering Menopause Program*, delivered by WHISE as a result of the Victorian Department of Health Women's Health and Wellbeing Support groups funding.
19. **FUND specialist women's health and sexual assault organisations** that aim to prevent and respond to women experiencing physical, mental, emotional, sexual, or financial abuse, and perimenopause and menopause.
 - Such the Victorian Women's Health Services and the Centres Against Sexual Assault
20. **PROMOTE perimenopause and menopause as compounding and co-occurring issue for victim-survivors** through the implementation of the *National Plan to End Violence against Women and Children 2022-2032*.

Cultural and societal factors

21. **PROMOTE positive depictions of middle age and older women** in general health promotion campaigns, to encourage affirming perceptions of ageing and health,
 - With the aim of reducing the stigma surrounding perimenopause and menopause.

22. **INVEST in culturally appropriate (and in language)** perimenopausal and menopausal community health literacy to raise awareness of symptoms, impacts, treatment options, and where to seek help.
23. **FUND research into the impact of perimenopause and menopause** on women from diverse backgrounds.
 - The aim is to evaluate limitations to accessibility, help seeking, and treatment management for women and people who are trans, non-binary, or gender diverse, neurodiverse, women with disabilities, women from culturally and linguistically diverse backgrounds and First Nations women.
24. **INVEST in public health awareness campaigns** that redress many years of misinformation and confusion, on the appropriate use of menopause hormone therapies (MHT) and non-hormonal therapies for women with menopause-associated symptoms.
 - This should include those who might not have symptoms but are seeking to use find out if MHT should be used for its protective factors.

Awareness of treatments

25. **REVIEW evidence-based recommendations for management** of menopausal symptoms in women with a history of breast cancer (or present risk factors for breast cancer), developed by Cancer Australia and published in 2016.
 - This is to ensure all recommendations are up to date.
26. **INTRODUCE protocols and best practice principles** that ensure trainees and primary care providers utilise the evidence-based *Practitioner's Toolkit for the Management of Menopause* to determine appropriate treatment pathways in consultation with their patients.
27. **INCREASE the number of menopause hormone therapies** and menopause symptom management options available on the Pharmaceutical Benefits Scheme (PBS).
 - With the aim of reducing the financial barriers to help-seeking and enhance equity in access to support for menopause and perimenopause.
28. **REVIEW the pre-service medical curricula for perimenopause and menopause** to ensure that primary care providers have the knowledge and skills to provide culturally competent and inclusive care.
 - This includes women and people who are trans, gender diverse and non-binary people, women who are neurodiverse, women with disabilities, women from culturally and linguistically diverse backgrounds, First Nations women, and women in larger bodies.



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A note on inclusive language

This submission uses the term "women" throughout, inclusive of all people who identify as women. WHISE recognises that trans men, non-binary, agender, intersex and other gender diverse people or people assigned female at birth who do not identify as women may also experience perimenopause and menopause and require access to gender-affirming healthcare services to support them and manage their symptoms. We acknowledge the need for the Senate Standing Committees on Community Affairs to consult with organisations that represent those communities, to ensure services are inclusive, equitable and appropriate for all.

Response to the Terms of Reference

Summarised below are a list of key issues identified by WHISE in response to the Terms of Reference listed by the Senate Standing Committees on Community Affairs. The rationale for our response to the Terms of Reference is based on our detailed consideration of existing literature and evidence, our work with key stakeholders in the sexual and reproductive health sector through our regional partnership, *Good Health Down South*, and our health promotion work in the Southern Metropolitan Region. This includes a regional bimonthly working group established in November 2022, specifically to address perimenopause and menopause, and the delivery of two critical projects, being a pilot of community-based information sessions on perimenopause and menopause, of which we delivered 19 sessions to over 340 participants, and a case study on workplaces that have implemented policies to support employees with perimenopause and menopause.

It is also important to note that the key themes and recommendations throughout this submission refer predominantly to experiences of natural rather than iatrogenic menopause, occurring on average at age 51 for women in Australia. We strongly encourage the Federal government to seek further advice regarding the experiences of women in early menopause, experiencing primary ovarian insufficiency, or women whose experiences of perimenopause and menopause were impacted by chemotherapy or other medical interventions.

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

Perimenopause and menopause have a significant impact on women's workforce participation and financial security (Australian Institute of Health and Welfare, 2021), thus exacerbating existing gender inequalities in the workforce and women's access to wealth, both while employed and in retirement.

The majority of Australian women are working while transitioning through perimenopause and menopause, with 78.4% of women aged 45-49 years and 75.8% of women aged 50-54 years and 68% of women aged 55-59 years employed (Australian Bureau of Statistics, 2022). Perimenopausal and menopausal symptoms, including hot flushes, urinary symptoms, insomnia or disrupted or poor-quality sleep, cognitive function including memory and concentration, and mental health

symptoms such as low mood, anxiety or loss of confidence, can impact many women's experiences of work, including job satisfaction, engagement, intention to resign, and self-rated or perceived performance (Carter et al., 2021, Hengel et al., 2023, Rees et al., 2021).

Evidence is mixed regarding which symptoms are most impactful on women's productivity, capacity to work and their experiences in the workplace, with some studies reporting that vasomotor symptoms such as hot flushes were associated with impaired work ability, while others have found that irritability and mood changes were associated with poorer work performance (Bryson et al., 2022).

Overall, however, it is notable that menopause has an impact on women's work, with 83% of respondents to a survey by Circle In noting that their work was negatively affected by menopause (2021). Almost half (45%) of respondents had considered retiring or taking an extended period of leave but the majority (72%) did not, citing financial reasons as the reason for continuing to work (Circle In, 2021). More frequent or severe symptoms are associated with reduced job satisfaction and increased intention to quit.

The impact of perimenopause and menopause on women's participation in the workforce can continue past the menopausal transition. While 75% of post--menopausal women will experience hot flushes, one in four Australian post--menopausal women aged 40--65 years, have been found to experience moderate to severely bothersome hot flushes associated with a perceived impairment of their ability to work. There is some evidence to suggest that employment may be a protective factor for women experiencing perimenopause and menopause, as they may experience fewer or less severe symptoms, have higher health literacy and improved health behaviours in relation to menopause and may reach menopause at a later age (Australian Institute of Health and Welfare, 2021)

However, this is predicated on women feeling supported in the workplace through formal policies, sympathetic managers and colleagues, and roles, duties or environments that allow for flexibility to accommodate symptom management (Adelekan-Kamara; et al., 2023; Bochantin, 2014; Verburch; et al., 2020). In general, it is important to note that work can be a protective factor for mental wellbeing, and that premature retirement can contribute to poorer mental health outcomes, including reduced self-confidence and self-efficacy and reduced social connection (Carbone, 2020).

Women experiencing perimenopause and menopause who wish or need to continue working through their transition should be supported to do so, through the introduction of specific policies that address the need for flexibility to protect employee wellbeing. WHISE has published a case study that examines the introduction, implementation and impact of menopause policies in two workplaces, available on our website (Bush, 2023).

Reduced workforce participation has financial implications, including women's retirement planning and superannuation contributions. Superannuation is vital to a secure retirement, but women retire with an average of 47% less superannuation than men, equivalent to at least \$85,000 lost in superannuation (Australian Human Rights Commission, c2023; Australian Unions, c2023). In addition to introducing strategies to addressing pay inequality, and the impact of the imbalance in unpaid care and domestic work, the government needs to consider how women's reproductive health,

including perimenopause and menopause, may impact women's earning capacity, and therefore their superannuation (Workplace Gender Equality Agency, 2020).

In addition to the financial consequences of reduced participation in the workforce, perimenopause and menopause can impact opportunities for promotion and career progression, reinforcing gender- and age-based discrimination or bias. A survey of over eight thousand women globally found that a significant minority of women indicated that their symptoms of perimenopause and menopause impacted their career progression, including salary increases (18%), leadership roles (15%), bonuses (13%), opportunities for professional development and training (13%), promotion (12%) and selection for a role (12%) (Misiaszek et al., 2023).

Research indicates that workplace accommodations to support women experiencing perimenopause and menopause enhance productivity, presenteeism and staff retention, and improve the occupational health and safety, physical and psychosocial wellbeing of women in the workforce. According to the Australasian Menopause Society, collaborating with employees to integrate menopause within workplace policies can support an inclusive organisational culture and help to address gender- and age-related inequity within the workplace (Bochantin, 2014). This is aligned to the Australian federal government's goal to promote workforce participation for older women.

An important consideration for the development and implementation of menopause workplace policies is the need to avoid pathologizing menopause or inadvertently reinforcing or perpetuating negative social attitudes or perceptions of menopause and women of menopausal age (Carter, Davis and Black, 2021). There is a risk that policies implemented without also addressing the sociocultural attitudes, beliefs and norms that underpin women's experience of menopause and perimenopause, will emphasise differences between genders, perceptions of weakness or incompetence in women employees, and increase discriminatory behaviours towards women in the workplace (Carter, Davis and Black, 2021).

Additionally, it is critical that the development of workplace policies to support flexible working arrangements, reproductive health leave or workplace healthcare, is supported by government legislation. Very few Australian workplaces currently include menopausal health in their policies, and introducing policies that may not be applicable to all employees, or potentially attach additional operational costs to the business, needs to be supported by federal or state governments to avoid discrimination in hiring practices or towards existing employees, or causing undue burden to individual organisations that makes them unwilling or resistant to such policies. The introduction of paid parental leave and family and domestic violence leave by the federal government in 1971 as maternity leave and in 2010 as parental leave, and in 2022 for family and domestic violence, provide a precedent in the critical role of the federal government in establishing entitlements for employees in both small and larger businesses.

This is vital for women employed in feminised roles or industries, i.e. those dominated by female employees, such as nursing, pathology, diagnostic imaging and healthcare, early childhood education, educational aides and teaching, administrative and clerical work, retail, hospitality, tourism, and aged care (Cortis et al., 2023). Due to the nature of these roles, employees typically

have less autonomy or control over their duties including less flexibility in their working arrangements (i.e. the ability to work remotely, or to temporarily alter their duties or role). Migrant and refugee women are also more likely to be working in feminised industries.

WHISE recommends that the federal government amend the *Occupational Health and Safety Act and regulations* to include mandates for workplaces to incorporate menopausal health within their occupational health and wellbeing policies. This is in accordance with Section 21 of the OHS Act, “An employer must, so far as is reasonably practicable, provide and maintain for employees of the employer a working environment that is safe and without risks to health.” This also includes introducing 10 days of paid reproductive leave each year, for full-time, part-time, and casual employees.

An employer must, so far as is reasonably practicable, provide and maintain for employees of the employer a working environment that is safe and without risks to health. This will enable workplaces to create supportive and inclusive environments for women experiencing perimenopause and menopause and encourage retention of women in middle-age and older in the workplace, thus embedding gender equality and addressing gender- and age-based bias or discrimination. Managers, human resource professionals and business owners should consult with employees in decisions about how to improve working conditions for people experiencing menopause and perimenopause, to ensure that adjustments to physical environments, roles and responsibilities reflect the needs of employees.

To support this, WHISE also recommends that alongside the integration of menopause within health and wellbeing policies, there is provision of education and training for employees, in particular managers or supervisors. This is to ensure staff are equipped to allow disclosures and sensitively respond to employee health concerns related to perimenopause and menopause and make appropriate adjustments, including to dress codes and uniforms, thermostats and physical work environment, and remote working arrangements.

Furthermore, WHISE recommends that healthcare providers are provided with education and training to provide patients with advice on how to manage their menopausal symptoms in the workplace, as part of a standard consultation to discuss treatment and management of perimenopause or menopause.

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

Although perimenopause and menopause are inevitable natural health events, they have significant impacts on women's physical health and wellbeing, through the onset of symptoms and the increased risk of poorer health outcomes that occurs as a result of the reduction in female hormones, oestrogen and progesterone.

Physical symptoms of perimenopause and menopause can have a significant impact on women's quality of life. Symptoms are highly varied in presentation, severity and duration and can include

irregular menstrual bleeding, vasomotor symptoms including hot flushes, feeling hot or night sweats, insomnia, fatigue and lethargy, joint aches and muscle pains, breast tenderness, headaches and migraines, genitourinary syndrome of menopause including vaginal dryness and atrophy, pain or discomfort during sexual intercourse, incontinence or other urinary syndromes such as increased urgency or frequency in needing to urinate, metabolic changes including centralised weight gain, and new facial hair and changes to skin elasticity and dryness (Australasian Menopause Society, 2022; Gartoulla et al., 2014;). The variance in menopausal symptoms, combined with limited focus on menopause and the prescription of non-hormonal pharmacotherapy and menopause hormone therapy in pre-service medical curricula, can result in diagnostic delay and undue suffering.

Additionally, some research indicates that the menopausal transition is associated with increased risk of poorer physical health outcomes such as cardiovascular disease, high blood pressure and stroke, and osteoporosis, in part due to ageing, but also related to overall decline in hormones such as oestrogen and the impact of menopausal symptoms such as abdominal weight gain and poorer quality sleep (Kamińska et al., 2023; Li et al., 2021). This can impact women's overall morbidity and mortality, with implications for the healthcare system and economy.

WHISE recommends that the federal government introduce measures in consultation with universities that offer undergraduate and post-graduate medical courses to ensure that doctors, nurse practitioners and other primary care providers employ the evidence-based *Practitioner's Toolkit for the Management of Menopause*, developed by the Women's Health Research Program in the Monash University School of Public Health and Preventative Medicine (Davis et al., 2023). This tool includes recommendations for a comprehensive assessment of a patient's medical history and family history, including illnesses such as breast or endometrial cancer, osteoporosis, diabetes, cardiovascular disease, depression, liver disease and dementia.

WHISE also recommends the introduction of post-graduate education pathways accredited by peak bodies for practitioners already in the health workforce, to enable practitioners to expand their competencies in perimenopause and menopause, developed in consultation with the Australasian Menopause Society and other relevant stakeholders.

Perimenopause and menopause are influenced by the social and structural determinants of health and individual health behaviours and risk factors, including access to healthcare services.

Access to healthcare services varies considerably for women experiencing perimenopause and menopause. The bulk-billing system is in crisis across Australia, with increasing numbers of people paying out-of-pocket costs to see a general practitioner (Royal Australian College of General Practitioners, 2022; Senate Community Affairs Committee, 2019). Most concerning, as noted by the Grattan Institute, poorer people are more likely to live in "bulk-billing deserts" - areas with the lowest rates of bulk-billing clinics or practitioners, thus exacerbating inequalities in health outcomes (Breadon and Fox, 2023). Limited access to general practitioners impacts women's ability to access specialised care, including endocrinologists, as these services require a referral, and often have long waiting times before an appointment can be made (healthdirect, 2020).

Systemic barriers to accessing appropriate healthcare, including support for the management of menopause and perimenopause, are exacerbated for culturally and linguistically diverse women, in particular migrant and refugee women and gender diverse people. According to the Multicultural Centre for Women's Health, "temporary visa holders who do not have access to Medicare face restrictions when accessing services due to various factors including being subject to restrictive waiting periods, as well as hefty upfront costs" (2022). Women in rural, regional or remote areas also experience additional barriers, due to limited infrastructure and availability of providers, and lack of transport to services.

WHISE recommends that the federal government implement urgent reforms of the Medicare Benefits Schedule (MBS) patient rebates to incentivise bulk-billed general practice services and ensure the viability of affordable and accessible primary care. This will ensure that patients can access high-quality, equitable healthcare and obtain referrals to specialist services without incurring additional costs.

Further to this, WHISE supports recommendations made by the Multicultural Centre for Women's Health in a previous submission in response to the Senate Inquiry on Universal Access to Reproductive Healthcare, that the federal government extend Medicare to include all migrants (irrespective of visa category) and abolish waiting periods and visa restrictions for all migrants, including in relation to temporary migrants on the Pacific Australia Labour Mobility (PALM) scheme, and overseas student health cover (OSHC) deed which is due to expire in June 2024, and within the Minister for Health's power to remove (as outlined in Schedule 4d).

WHISE also recommends that the federal government embed and strengthen shared care models to ensure people experiencing menopause and perimenopause have access to holistic and supplementary treatment modalities, including naturopathy, traditional Chinese medicine, osteopathy, physiotherapy, dermatology, and endocrinology.

WHISE recommends that the federal government conducts a review of referral pathways to specialist support services, with a view to removing barriers to care such as endocrinologists. This includes complex referral pathways, lengthy wait times and prohibitive out-of-pocket costs that limit uptake of services.

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

The relationship between perimenopause and menopause and mental wellbeing is poorly understood by community and practitioners alike. However, the evidence indicates that perimenopause and menopause can have a significant impact on the mental and emotional well-being of women as discussed above, which consequently can have an adverse impact on menopausal employees' participation in the workforce.

While not experienced by everyone transitioning through menopause, the risk of mood changes and symptoms of depression and anxiety are higher during the perimenopause period, even in women without a history of major depressive disorder or generalised anxiety disorder (Australian Menopause Society, 2023). Additionally, the high suicide rate in women aged 45-54 years (AIHW,

2018) may be related to the biological changes associated with menopause (Kulkarni, 2018). Perimenopausal depression may present with symptoms that differ from those of typical depression. Unstable oestrogen levels during this period may impact the brain, predisposing some women to feelings of depression and anxiety. Additionally, some of the common physical, memory and cognitive symptoms related to menopause (such as hot flashes, sleep disturbances, weight changes and brain fog) can exacerbate and/or overlap with mental health symptoms (Australian Menopause Society, 2023). However, this group's specific needs remain somewhat invisible and unmet (Kulkarni 2022a, 2022b).

During menopause, spanning 8-10 years or more, crucial gonadal hormone shifts occur, involving oestrogen, progesterone, testosterone, and their brain steroid precursors (Herson and Kulkarni, 2022). These hormones are recognised as potent neurosteroids and play diverse and vital roles in the brain, impacting mood, cognition neurotransmitters, and neural circuit maintenance. Contrary to common misconceptions focusing on reproductive organs, oestrogen, for instance, significantly influences mood-regulating neurotransmitters like serotonin and dopamine fluctuations in these neurosteroids during menopause destabilise neurotransmitters and brain circuitry, with varied individual expressions, leading to either debilitating mental health changes or minimal impact.

The expanding body of neuroscientific knowledge regarding the influence of fluctuating brain steroids, particularly oestrogen, on mental health highlights the need for a nuanced understanding of menopause anxiety and depression. Recognising these shifts as distinct from conventional anxiety and depression allows for tailored approaches to treatment. However, the lack of mainstream neurobiological awareness hampers our comprehension of menopause mental health issues. Population-wide surveys, despite substantial funding, yield varying results due to differing mental illness definitions, creating an averaged portrayal that neglects the significant number of women facing serious mental health challenges. Survey figures suggest 10% to 65% of menopausal women experience mental ill-health, but these averages should not guide treatment guidelines or dismiss individual experiences. The absence of definitive laboratory tests for menopausal depression and vague perimenopausal definitions overlook crucial mental health challenges. Listening to women's clinical histories reveals mid-40s mental health shifts, prompting consideration of menopause onset.

As such, WHISE recommends the federal government embed capacity-building for healthcare providers to provide them with the knowledge and skills to conduct routine screening for mental ill-health during perimenopause and menopause check-ups. This includes identifying the unique symptoms or presentations of perimenopausal depression and anxiety.

WHISE also recommends that the federal government invest in further research to better understand the neurobiological mechanisms underlying menopausal mental health issues, and centre women's clinical histories and subjective experiences in research and health promotion design. Women often provide valuable insights into their own mental health challenges, which can inform diagnosis and treatment decisions.

Menopause can also bring about a shift in social roles and relationships. Women may experience changes in their relationships with their partners, children and friends, which can lead to isolation,

loneliness and loss in their relationships (Rosenfield, 2009). Women experiencing perimenopause and menopause may experience mental ill-health if they are unable to treat uncomfortable symptoms, while simultaneously navigating the challenges of mid-life (Kirkman and Fisher, 2021).

WHISE recommends that the federal government invest in community-based programs to reduce isolation and loneliness, improve social connection, and strengthen other protective factors. This also includes enhancing access to evidence-based health promotion information to strengthen help-seeking pathways, such as the Mastering Menopause Program, currently being developed and delivered by WHISE and funded by the Victorian Department of Health.

Negative body image during perimenopause and menopause can also impact women's mental health outcomes, as poor body image is associated with low self-esteem, depression, anxiety and poor psychological functioning (Rodgers et al., 2023). Hormone-related weight gain and changes to the shape and size of a woman's body can exacerbate size dissatisfaction, a core pathology for the development of eating disorders (Finch et al; 2023). Weight gain can be triggered by low oestrogen and loss of testosterone (Newson, 2023). Since low oestrogen can impact sleep quality and in turn, hunger hormones, fluctuating hormones can often cause cravings for foods with a high sugar content. These changes can be overwhelming for some women, leading to overwhelm and feeling out-of-control. A societal focus on maintaining youth may fuel unrealistic expectations of body size. To cope with feelings of inadequacy and low self-esteem, restrictive or purging behaviours may surface (University Hospitals, 2023). During perimenopause and menopause, some women experience a worsening or resurfacing of eating disorder symptoms, and some may develop an eating disorder for the first time (Newson, 2023). Furthermore, the severity of menopausal symptoms is correlated with poor body image (Nazarpour et al., 2021). The prevalence of eating disorders during midlife stands at around 3.5% and specific symptoms during midlife can have prevalence as high as 29.3% (Finch et al., 2023). Negative body image during perimenopause and menopause can also be exacerbated by weight stigma from members of their community or their healthcare provider. Weight stigma is a common form of discrimination reported by Australians and a significant barrier preventing people from engaging in health supporting behaviours. Negative body image as a result of weight stigma for instance, is a predictor of physical inactivity, poor diet, smoking, and unsafe sexual behaviours (Davelaar, 2021).

WHISE recommends that healthcare providers are provided with education and training to screen for and address body image concerns with menopausal patients and provide referrals to mental healthcare practitioners such as psychologists and psychiatrists. Psychologists and psychiatrists are equipped to implement cognitive and dialectical behaviour therapy and evidence-based best-practice methods for improving body image such as fitness training interventions to encourage focus on the functionality of the body rather than appearance and encourage self-efficacy; encourage individuals to critically evaluate media images and messaging that they consume that perpetuate a focus on idealised appearance; mindfulness interventions and other techniques to enhance self-esteem (Alleva et al., 2015).

Currently, treatment for mental health concerns during perimenopause and menopause is limited, as practitioners tend to focus on the management of physical symptoms. The use of menopause hormone treatment (MHT) for addressing menopause-related mental health issues continues to be

contentious. Most menopause guidelines, except for NICE guidelines, lack approval for MHT in mental health treatment. Reluctance stems from historical beliefs, limited clinical trial evidence, and concerns over since-disproven Women's Health Initiative (WHI) studies. Contrary to these, ongoing neuroscience evidence highlights gonadal hormones' role as potent brain steroids, suggesting MHT's utility in menopausal mental health. Insufficient trials comparing MHT to antidepressants hinder comprehensive understanding, perpetuated by the misconception that hormone fluctuations do not cause mental health issues. Despite demonstrating MHT efficacy in depression, larger replication studies are essential.

Taken together, new approaches for menopause mental health are urgently needed. WHISE recommends firstly, that mental ill health is recognised as a critical symptom of menopause. Secondly, more research and clinical trials into menopausal hormone treatments are required to improve the current MHT guidelines. Globally, clinical treatment trials with MHT in depression have not been of good quality. Australia can lead the world in this area and such data would provide an evidence base for MHT in mental ill health. Moreover, urgent need for education of mental health and primary health practitioners about menopause-related mental health issues and MHT to enable more options to be discussed with the women they are treating. Far too many mental health practitioners are unaware of the hormone-mental health link, and far too many primary health care practitioners still cling to debunked evidence against MHT from the 2001 WHI study.

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

Menopause and perimenopause can have a significant impact on relationships, family dynamics and caregiving responsibilities. At the same time, middle age is often a period during which significant personal and social changes can take place. Increasingly, women experiencing menopause and perimenopause are primary caregivers to dependent children or provide financial support to adult children who are living in the family home, with 55 per cent of young men aged 18-29 years living with their parents in 2020, and 48 per cent of young women living with their parents during the same period (Wilkins et al., 2022).

Gendered social expectations regarding caregiving mean that women are often responsible for ageing parents, or parents experiencing disability or illness, in addition to their children. This has given rise to a social phenomenon termed the "Sandwich Generation" - women in middle age who are wedged between the needs of their children and parents, while juggling work responsibilities and other personal commitments (Eeles, 2023). Figures from the 2022 Household, Income and Labour Dynamics in Australia (HILDA) survey show females are "considerably more likely" to be carers than males, with 10.3 per cent of females over 15 providing unpaid care compared with 6.3 per cent of males. Additionally, women, aged between 50 and 69, were the biggest providers of unpaid, ongoing care, "with over 12 per cent caring for a person with a disability or an older person".

Women continue to be primary caregivers for family members and children as a result of pervasive social mores and economic inequalities. Traditional gender stereotypes reinforce outdated ideas that women are naturally predisposed or better suited to nurturing or caregiving roles than men, which is underpinned and reinforced by a gender pay gap. Unpaid caregiving is of significant social

and economic value, estimated to be worth \$77.9 billion per annum (Deloitte, 2020). The impact on unpaid caregiving on women, however, is that they are less likely to be able to engage in full-time employment, more likely to have interruptions to their career, more likely to have a substantially lower superannuation balance at retirement and more likely to experience depression or anxiety than non-carers (Carers NSW, 2020). These factors can contribute to and exacerbate symptoms of perimenopause and menopause, and limit capacity to engage in health-promoting behaviours or help-seeking.

WHISE recommends that the federal government invest in establishing support networks and resources specifically tailored to women in the 'sandwich generation'. This could include support groups, similar to the Mastering Menopause Program WHISE is delivering as a result of the Victorian Department of Health Women's Health and Wellbeing Support groups funding. WHISE also advocates for workplace policies that support caregivers, including flexible work arrangements, paid family leave and caregiver support programs, to help alleviate some of the stress faced by women who are juggling caregiving responsibilities with work. In addition, investment in funded professional caregiving could reduce strain on informal or unpaid caregiving.

Perimenopause and menopause can have an impact on intimate relationships, particularly through changes to sexual well-being and satisfaction experienced during the menopausal transition. Libido or sexual desire can be impacted during menopausal transition due to hormonal changes, physical and mental health symptoms including fatigue, weight gain or changes to body shape or composition, low mood or depressive symptoms, reduced self-confidence and vaginal dryness or atrophy, in turn impacting intimate relationships (Castillo-Hernández, Ward-Ritacco and Evans, 2023; Vowels and Mark, 2020). Sexual well-being is a critical part of women's overall physical, mental and emotional health and well-being and has a significant and bidirectional impact on relationship quality (Wellings et al., 2023). Participants in community-based information sessions delivered by WHISE, Peninsula Health, Monash Health Community and Women's Health Loddon Mallee from June to October 2023 often reported pain or discomfort during sex or loss of libido as a major concern and cause of embarrassment or tension in their relationships.

WHISE recommends that sexual wellbeing is integrated in the management of menopause in primary and specialist healthcare settings, as well as the development of menopause health promotion information.

It is also important to recognise that women in menopause and perimenopause may also be impacted by gender-based violence. A report published by UK-based charity AVA (Against Violence and Abuse) in 2021, posited that there is a bidirectional relationship between menopause and intimate partner violence: "Menopause impacts women's relationships, and domestic abuse may impact menopause symptoms, with negative symptoms or experiences compounding or obscuring one another."

WHISE recommends that interventions for the primary prevention of gender-based violence are adequately and sustainably funded and delivered by specialist services, including the Victorian Women's Health Services and the Centres Against Sexual Assault, with expertise in the prevention of and response to violence against women.

WHISE also recommends that primary prevention initiatives to promote gender equality consider perimenopause and menopause as compounding or co-occurring issues for victim-survivors and address this through the implementation of the *National Plan to End Violence against Women and Children 2022-2032*.

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 are several sociocultural factors that impact the way menopause and perimenopause is viewed in Australia, including gendered social norms, negative perceptions of ageing and discourses or narratives regarding fertility, infertility and desirability (Smith, 2020). Pervasive beliefs and attitudes regarding women's ostensibly natural or defining role and social value as mothers, contributes to the grief, isolation and feelings of failure and inadequacy that can accompany loss of fertility. often linked to gendered ageism and discourses around infertility and desirability. Menopause continues to be a stigmatised issue, further compounding the physical and mental health symptoms, and difficulty in help-seeking: "The stigma of menopause, with its associations of hysteria and incompetence, the shame of ageing, and the taboo about revealing menopausal symptoms, compounds the distress and struggle" (Nosek, Kennedy and Gudmundsdottir, 2012).

Studies suggest that women's adjustment to and acceptance and experience of menopause is shaped by the social context in which this transition occurs. For instance, women who understand menopause as a part of healthy ageing rather than a disorder or illness, have more positive experiences during menopause (Al-Eassa et al., 2012; Ayers, Forshaw and Hunter, 2010). Women's attitudes towards menopause are also a predictor of quality of life during menopausal transition, including experiences of vasomotor and psychosocial symptoms (Jafari et al., 2014; Bello and Daramola, 2016; Nazarpour et al., 2016). Therefore, positive depictions of menopause and perimenopause, as well as a broader cultural shift regarding ageing and health are vital to consider in the development and dissemination of health promotion information targeting community and capacity-building for practitioners.

WHISE recommends that the federal government embed positive depictions of women in middle age and older in general health promotion campaigns to encourage affirming perceptions of ageing and health, thus reducing stigma surrounding perimenopause and menopause.

Additionally, WHISE recommends that the federal government invest in perimenopausal and menopausal health literacy in the community by funding a national campaign that raises awareness of symptoms and physical and mental health impacts of perimenopause and menopause and encourages help-seeking through primary care. We encourage the federal government to develop this campaign in consultation with relevant stakeholders and people with lived experience, and with consideration for access to information in languages other than English and culturally appropriate messaging. In addition to raising awareness of perimenopause and menopause, this campaign

should challenge stigma and increase positive perceptions of perimenopause and menopause linked to healthy ageing and longevity.

Perimenopause and menopause are significantly impacted by the social determinants of health, those non-medical and changeable factors that influence health outcomes include income and welfare, education, employment and job security, housing and access to services and amenities (WHO c2023; Junes et al., 2012). There is some evidence that indicates that women of colour, women with disabilities and neurodiverse women may have different experiences of menopause and perimenopause (Jermyn, 2023).

While evidence indicates that there may be considerable differences in perceptions of and attitudes towards, perimenopause and menopause, as well as age of onset, experiences of symptoms and access to healthcare and treatment, there is a paucity of literature and research that assesses the appropriateness of existing diagnostic tools and treatment for women and people who are trans, non-binary or gender diverse, neurodiverse, women with disabilities, women from culturally and linguistically diverse backgrounds and First Nations women (Chadha et al., 2016; Jones et al., 2012).

WHISE recommends that the government commissions research into the impact of perimenopause and menopause on women from diverse backgrounds, as well as evaluating access to appropriate support and treatment, for women and people who are trans, non-binary or gender diverse, neurodiverse, women with disabilities, women from culturally and linguistically diverse backgrounds and First Nations women.

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;

Limited awareness of the diverse range of symptoms of menopause and perimenopause, as well as symptom management options, among women in Australia is a barrier to health-promoting behaviours and help-seeking. From June to October 2023, WHISE delivered 19 menopause information sessions with Peninsula Health, Monash Health Community and Women's Health Loddon Mallee, to over 340 participants from the community, with content including physical and mental health symptoms, lifestyle adaptations to support improved symptoms, pharmaceutical interventions and menopause hormone therapy. These sessions were successful in increasing participants' knowledge and confidence in issues pertaining to menopause and perimenopause, with pre-session survey data reflecting low self-rated knowledge. Participants reflected on the importance of accessible, community-based health promotion information in the post-session survey:

"All the information about perimenopause...I had no idea about."

"Thank you so much. A very informative session. There should be more like these for people and to understand what local support options are available."

"Thank you for the content. This was exceptionally helpful in identifying options and navigating life into the future."

"I just thought this was something women put up with. Now I know better."

This highlights an urgent need for investment in perimenopausal and menopausal health literacy in the community, through mass campaigns and the delivery of community-based health promotion and education that raises awareness of symptoms and physical and mental health impacts of perimenopause and menopause and encourages help-seeking through primary care. One of the key issues that need to be addressed through awareness-raising is menopausal hormone therapy.

Menopausal hormone therapy (MHT) is underutilised by women in Australia, despite its safety and efficacy. Less than 11.3% of Australian women with symptoms of perimenopause or menopause are using menopausal hormone therapy (MHT) approved by the Therapeutic Goods Administration (Herbert et al., 2020). This is due to practitioners under prescribing MHT to eligible patients, and misinformation in the community regarding the safety of MHT, leading to reluctance to seek it in primary care and from specialists. In a recent qualitative study, many women cited cancer risks and concerns about over-prescription as reasons for negative attitudes towards MHT use (Herbert et al., 2020). These attitudes are attributable, in part, to disproven claims of the 2002 study from the Women's Health Initiative, which concluded that MHT increased the risks of coronary heart disease, breast cancer, stroke and venous thromboembolism. These assertions have since been demonstrated to be false, but the negative associations with MHT remain in popular consciousness, with symptomatic women choosing to forgo MHT use (Crawford et al., 2019).

MHT is associated with symptom relief, including reduced vasomotor symptoms and genitourinary syndrome, joint and muscle pains and sleep disturbances, as well as improved sexual satisfaction and quality of life (Davis et al., 2023; Lee et al., 2020; De Villiers et al., 2016). There is also evidence to suggest that MHT can reduce the impact of poor health outcomes due to oestrogen deficiency, including loss of bone density, risk of fractures and osteoporosis, as well as coronary heart disease (Davis et al., 2023; Lee et al., 2020; Magraith and Stuckey, 2019).

Health practitioners have a critical role in improving patients' knowledge of and adherence to treatments, including MHT, as well as conducting timely preventative screening for bowel, breast and cervical cancer as part of holistic menopause care, and referring patients to specialists for further treatment.

WHISE recommends the introduction of measures to ensure that trainee and practicing doctors, nurse practitioners and other primary care providers utilise the evidence-based *Practitioner's Toolkit for the Management of Menopause* to determine appropriate treatment pathways in consultation with their patient (Davis et al., 2023), and follow best-practice guidelines from the Australasian Menopause Society on the prescription of MHT for the management of symptoms (Australasian Menopause Society, 2023).

WHISE also recommends a review of the evidence-based recommendations for management of menopausal symptoms in women with a history of breast cancer, developed by Cancer Australia and published in 2016, to ensure all recommendations are up to date.

Primary care consultations regarding menopausal or perimenopausal symptoms are also an opportunity for practitioners to review personal and family medical history with an emphasis on venous thromboembolism (VTE) and cardiovascular disease and provide evidence-based health promotion and support regarding smoking cessation, minimising alcohol intake, exercise and physical activity, and nutrition and healthy diet.

Recommendations for improving the uptake of MHT among Australian women experiencing perimenopausal or menopausal symptoms include educational campaigns targeting both healthcare providers and the public to dispel misconceptions surrounding MHT, particularly addressing disproven claims from the 2002 WHI study. It is also important to promote the benefits of MHT such as symptom relief, including reduced vasomotor symptoms, improved sexual satisfaction, and enhanced quality of life, as well as its potential to mitigate health risks associated with oestrogen deficiency.

Evidence regarding the efficacy of non-hormonal interventions to support symptom management during menopause is mixed. There is some evidence to support use of common anti-depressants, such as serotonin–noradrenaline reuptake inhibitor (SNRI) antidepressants venlafaxine and desvenlafaxine and the selective serotonin reuptake inhibitors (SSRIs) escitalopram and paroxetine for the management of vasomotor symptoms, sleep disruptions and mental health symptoms (Magraith and Stuckey, 2019). Some lifestyle and behaviour modifications can also improve overall wellbeing during menopause and perimenopause. However, further research is required to establish the efficacy of supplements, alternative therapies, complementary and herbal therapies, off-label treatments, and other non-hormonal treatments for menopausal symptoms, as the clinical efficacy and long-term safety is unsubstantiated or insufficient.

Based on the limited existing research from international settings, and the anecdotal experiences of women who provided consultation to the development of this submission, it is suggested that perimenopausal and menopausal care in general practice is inconsistent or inadequate in addressing the concerns of patients (Harper et al., 2022; El-Eassa et al., 2012). A UK-based study found that “many of the women felt that they were going mad, especially when their GPs had no idea what was wrong with them and only offered antidepressants or selective serotonin reuptake inhibitors’ (SSRI), which the women knew were incorrect, in many cases” (Harper et al., 2022).

A critical area for upskilling in primary care is utilising existing symptom tracking resources and monitoring menstrual bleeding patterns for the diagnosis of perimenopause and menopause. There is no systematic evidence to support hormonal testing to diagnose menopause for the majority of women aged 45 years and older, however, measurement of follicle-stimulating hormone is currently used in primary care (Davis et al., 2023; Australasian Menopause Society, 2022; Magraith and Stuckey, 2019). This requires a more thorough understanding of the varied nature of perimenopausal and menopausal symptoms by doctors and nurse practitioners to reduce the risk of diagnostic delay and enhance symptom management.

Practitioner knowledge of perimenopause and menopause symptoms, risks, treatment and management in presentations for trans, gender diverse and non-binary people, women who are neurodiverse, women with disabilities, women from culturally and linguistically diverse backgrounds and First Nations women, and women in larger bodies is more limited (Moseley, Druce and Turner-Cobb, 2020). These populations already experience poorer physical and mental health outcomes, due to increased exposure to discrimination, social exclusion, poverty, and other risk factors, as well as more limited access to appropriate healthcare services and social support.

WHISE recommends a review of the pre-service medical curricula for perimenopause and menopause to ensure that prospective doctors, nurse practitioners and other primary care providers have the knowledge and skills to provide culturally competent and inclusive care for trans, gender diverse and non-binary people, women who are neurodiverse, women with disabilities, women from culturally and linguistically diverse backgrounds and First Nations women, and women in larger bodies.

Enhancing patient and practitioner knowledge of the availability, efficacy and safety of treatments, is critical, but addressing cost-related barriers is also necessary to ensure uptake of available support. While there are several MHT products available in Australia, including cyclical, continuous combined, oestrogen-only and progestogen MHT available as tablets or capsules, pessaries, transdermal patches, and gels, not all these options are available on the Pharmaceutical Benefits Scheme (PBS) (Australasian Menopause Society, 2022). This significantly limits the affordability of treatment, especially for women who already experience financial disadvantage through the gender pay gap and disproportionate impact of the cost-of-living crisis on women.

The decision by MHT supplier Sandoz, for instance, to increase the price of transdermal oestrogen, in 2021, was met with opposition by members of the medical community: "The price increase will be prohibitive for low-income women who do not receive healthcare card benefits, which given the gender pay gap has increased by 14% this last financial year, is another blow." (Liotta, 2021).

As such, WHISE recommend that the federal government increase the number of menopause hormone therapies and menopause symptom management options available on the Pharmaceutical Benefits Scheme (PBS), to reduce the financial barriers to help-seeking and enhance equity in access to support for menopause and perimenopause.

References

Australasian Menopause Society (2022) [Diagnosing Menopause](#), Australasian Menopause Society, accessed 18 December 2023.

Australasian Menopause Society (2022) [AMS Guide to Equivalent MHT-HRT Doses](#), Australasian Menopause Society, accessed 3 January 2024.

Australian Bureau of Statistics (2022), [Employment in the 2021 Census](#), Australian Bureau of Statistics, accessed 8 December 2023.

Australian Institute of Health and Welfare (AIHW) 2023, [Australia's mothers and babies](#), Australian Institute of Health and Welfare (AIHW), accessed 18 December 2023.

Al-Eassa AA, Al-Fadel AM, Al-Ajmi MA, Al-Najjar AA, Makboul GM and Elshazly M (2012), 'Knowledge and attitude of primary care doctors towards management of postmenopausal symptoms,' *Alexandria Journal of Medicine*, 48(2).

Alleva JM, Sheeran P, Webb TL, Martijn C and Miles E (2015), 'A meta-analytic review of stand-alone interventions to improve body image,' *PLoS One*, 10(9), p.e0139177.

Atkinson C, Beck V, Brewis J, Davies A and Duberley J (2021), 'Menopause and the workplace: New directions in HRM research and HR practice,' *Human Resource Management Journal*, 31(1), pp.49-64.

Australian Human Rights Commission (2012) [The gender gap in retirement savings](#). Australian Human Rights Commission, accessed 3 January 2024.

Australian Super (n.d.). [The Future Face of Poverty is Female](#), Australian Super, accessed 21 December 2023.

Ayers B, Forshaw M and Hunter MS (2010), 'The impact of attitudes towards the menopause on women's symptom experience: a systematic review,' *Maturitas*, 65(1), pp.28-36.

Bello FA and Daramola OO (2016), 'Attitude to the menopause and sex amongst middle-aged women in a family medicine clinic in Ibadan, Nigeria,' *Obstetrics and Gynecology International*, October 2016.

Breadon R, and Fox L (2023) [The real crisis in bulk billing](#). The Conversation, accessed 20 December 2023.

Bryson A, Conti G, Hardy R, Peycheva D and Sullivan A (2022), 'The consequences of early menopause and menopause symptoms for labour market participation,' *Social Science & Medicine*, 293(114676), pp.1-12.

Carers NSW (2020) *National Carer Survey: Summary report*, Carers NSW, accessed 31 January 2024.

Carter S, Davis S and Black KI (2021) 'Menopause workplace policy: The way forward or backward?', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 61(6), p. 986. doi:10.1111/ajo.13445.

Carbone S (2020), [Evidence review: the primary prevention of mental health conditions](#). Vic Health, accessed 8 December 2023.

Castillo-Hernández IM, Ward-Ritacco CL and Evans EM (2023), 'Depressive symptoms, but not moderate-to-vigorous physical activity, impacts sexual well-being and menopause-specific quality of life in middle-aged women,' *Women & Health*, pp.1-13.

Chadha N, Chadha V, Ross S and Sydora BC (2016), 'Experience of menopause in Aboriginal Women: a systematic review,' *Climacteric*, 19(1), pp.17-26.

Chang SR, Yang CF and Chen KH (2019), 'Relationships between body image, sexual dysfunction, and health-related quality of life among middle-aged women: A cross-sectional study,' *Maturitas*, 126, pp.45-50.

Crawford SL, Crandall CJ, Derby CA, El Khoudary SR, Waetjen LE, Fischer M and Joffe H (2019), 'Menopausal hormone therapy trends before versus after 2002: Impact of the Women's Health Initiative Study Results,' *Menopause*, 26(6), pp.588-597.

Cortis N, Naidoo Y, Wong M and Bradbury B (2023), [Gender-based occupational segregation: a national data profile](#), Fair Work Commission, accessed 18 December 2023.

Davelaar CMF (2021), 'Body image and its role in physical activity: a systematic review,' *Cureus*, 13(2).

Davis SR, Taylor S, Hemachandra C, Magraith K, Ebeling PR, Jane F and Islam RM (2023), 'The 2023 Practitioner's Toolkit for managing menopause,' *Climacteric*, pp.1-20.

Deloitte (2020), [The Value of Informal Care in 2020](#), Deloitte, accessed 31 January 2024.

Eeles S, (2023) [Meet the 'Sandwich Generation' — the growing sector of women caring for their children and their parents](#), ABC News, accessed 25 January 2024.

Gartoulla P, Islam MR, Bell RJ and Davis SR (2014), 'Prevalence of menopausal symptoms in Australian women at midlife: a systematic review,' *Climacteric*, 17(5), pp.529-539.

Harper JC, Phillips S, Biswakarma R, Yasmin E, Saridogan E, Radhakrishnan SC, Davies M and Talaulikar V (2022), 'An online survey of perimenopausal women to determine their attitudes and knowledge of the menopause,' *Women's Health*, 18, p.17455057221106890.

Healthdirect (2023). [The role of an endocrinologist](#). Healthdirect, accessed 20 December 2023.

Herbert D, Bell RJ, Young K, Brown H, Coles JY and Davis SR (2020), 'Australian women's understanding of menopause and its consequences: a qualitative study,' *Climacteric*, 23(6), pp.622-628.

Jafari F, Hadizadeh MH, Zabihi R and Ganji K (2014), 'Comparison of depression, anxiety, quality of life, vitality and mental health between premenopausal and postmenopausal women,' *Climacteric*, 17(6), pp.660-665.

Jones EK, Jurgenson JR, Katzenellenbogen JM and Thompson SC (2012), 'Menopause and the influence of culture: another gap for Indigenous Australian women?' *BMC women's health*, 12, pp.1-10.

Kamińska MS, Schneider-Matyka D, Rachubińska K, Panczyk M, Grochans E and Cybulska AM (2023), 'Menopause Predisposes Women to Increased Risk of Cardiovascular Disease,' *Journal of Clinical Medicine*, 12(22), p.7058.

- Koch, P.B., Mansfield, P.K., Thureau, D. and Carey, M., 2005. "Feeling frumpy": The relationships between body image and sexual response changes in midlife women. *Journal of Sex Research*, 42(3), pp.215-223.
- Kopenhager T and Guidozi F (2015), 'Working women and the menopause, *Climacteric*, 18(3), pp.372-375.
- Kulkarni J (2022), 'Depression: a major challenge of the menopause transition,' *Medicine Today*, 23(10), pp. 16-22.
- Kulkarni J (2022), 'The misunderstood female factor,' *Nature Outlook*, 608.
- Lee SR, Cho MK, Cho YJ, Chun S, Hong SH, Hwang KR, Jeon GH, Joo JK, Kim SK, Lee DO and Lee DY (2020), 'The 2020 menopausal hormone therapy guidelines,' *Journal of menopausal medicine*, 26(2), p.69.
- Li Y, Zhao D, Wang M, Sun JY, Liu J, Qi Y, Hao YC, Deng QJ, Liu J, and Liu M (2021), 'Combined effect of menopause and cardiovascular risk factors on death and cardiovascular disease: a cohort study,' *BMC Cardiovascular Disorders*, 21(1), pp.1-13.
- Liotta, M., (2021) [Menopause hormonal treatments to retain PBS listing](#). RACGP, accessed 21 December 2023.
- Magraith K and Stuckey B (2019), 'Making choices at menopause,' *Australian journal of general practice*, 48(7), pp.457-462.
- Moseley RL, Druce T and Turner-Cobb JM (2020) 'When my autism broke': A qualitative study spotlighting autistic voices on menopause,' *Autism*, 24(6), pp.1423-1437.
- Nazarpour S, Simbar M and Tehrani FR (2016), 'Factors affecting sexual function in menopause: A review article,' *Taiwanese Journal of Obstetrics and Gynecology*, 55(4), pp.480-487.
- Nazarpour S, Simbar M, Majd HA, Torkamani ZJ, Andavar KD and Rahnemaei F (2021), 'The relationship between postmenopausal women's body image and the severity of menopausal symptoms,' *BMC Public Health*, 21, pp.1-8.
- Nosek M, Kennedy HP and Gudmundsdottir M (2012), 'Distress during the menopause transition: a rich contextual analysis of midlife women's narratives,' *Sage Open*, 2(3), p.2158244012455178.
- Rodgers RF, Laveway K, Campos P and de Carvalho PHB (2023), 'Body image as a global mental health concern,' *Cambridge Prisms: Global Mental Health*, 10, p.e9.
- Royal Australian College of General Practitioners (RACGP), (2022), [RACGP: Free falling bulk-billing rates a sign of things to come](#). RACGP, accessed 4 January 2024.
- Wellings K, Gibson L, Lewis R, Datta J, Macdowall W and Mitchell K (2023), "'We're Just Tired": Influences on Sexual Activity Among Male-Partnered Women in Midlife; A Mixed Method Study,' *The Journal of Sex Research*, pp.1-14.



Whiteley J, DiBonaventura MD, Wagner JS, Alvir J and Shah S (2013), 'The impact of menopausal symptoms on quality of life, productivity, and economic outcomes,' *Journal of Women's Health*, 22(11), pp.983-990.

Wilkins R, Vera-Toscano E, Botha F, Wooden M and Trinh TA (2022), *The Household, Income and Labour Dynamics in Australia Survey: Selected Findings from Waves 1 to 20: the 17th Annual Statistical Report of the HILDA Survey*, University of Melbourne, accessed 2 January 2024.

Workplace Gender Equality Agency (2020), [Women's economic security in retirement](#), Workplace Gender Equality Agency, accessed 2 January 2024.