



## Submission from Maridulu, Budyari Gumal, the Sydney Partnership for Health, Education, Research and Enterprise (SPHERE) to the Senate Community Affairs References Committee regarding the Committee's Inquiry into issues related to menopause and perimenopause.

Re: Inquiry Terms of Reference a-h

### Executive summary

Maridulu Budyari Gumal, the Sydney Partnership for Health, Education, Research and Enterprise (SPHERE) is an NHMRC accredited Research Translation Centre with an ambitious purpose: to change the future of healthcare. We put evidence into practice. Uniquely, SPHERE bridges the fragmented health delivery and medical research landscape in Australia. We keep the consumer at the heart of the research journey: inspiring, motivating and informing the transformation of knowledge-gathering into healthcare delivery.

In response to the Senate Inquiry into issues relating to menopause and perimenopause, SPHERE has listened to and provided a submission from the perspective of the primary stakeholders: women<sup>1</sup> who are affected. We thank the Senate Committee for the opportunity to represent these women at the Inquiry, and to increase the health empowerment [1] of *all* women through partnership with communities, health workers, researchers, educators, and policy makers.

SPHERE consulted consumers, and expert representatives from our 15 thought-leading partners (including clinical-academic institutions, universities, health services, Local Health Districts, research institutes, community groups and primary care collaborators). We identified significant gaps in policy, education, service provision and research translation for the practical management of menopause and perimenopause symptoms<sup>1</sup> within Australia. We implore Senator the Hon Katy Gallagher, Minister for Women, to spearhead the mobilisation of resources to redress the **gendered ageism** in this space and guarantee that perimenopausal and menopausal Australian women are no longer ignored.

To enable women to gain greater control over decisions and actions affecting their health, to ensure that they have access to equitable and individualised care, and to future-proof our economy and society, SPHERE recommends that Australia needs:

- A **population health approach** to perimenopause and menopause management;
- A **Shared Care Model** of service delivery for perimenopause and menopause, including **integrated care hubs** for menopause;
- A structured and committed approach to increasing **education and awareness** in perimenopause and menopause for health-care professionals, workplaces, communities, and individuals; and
- Gender equity in **evidence-based, translational research**.

***This submission is co-led by women for women, many of whom shared their stories with us.***

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<sup>1</sup> Consistent with WHO terminology, this document refers to “women” and “symptoms”. Cisgender women account for most personal experiences described in the domain and gender identity is not routinely included in research data. Menopause and perimenopause are not considered diseases and are a normal part of the ageing process, but their effects detrimentally impact many individuals’ quality of life similarly to a symptomatic disease.



## Background

More than half of the Australian population (50.7%) [2] will experience menopause, yet there is no systemic or co-ordinated plan to capture any data around its economic, social and health care impact. There is little awareness of the associated symptoms, available treatment and long-term consequences among women [3-5], and many health professionals are uncertain and lack confidence about its management [6]. Symptoms may be intensely personal in nature and not openly discussed, even with healthcare providers [7] which contributes to misconceptions, misunderstandings, and a sense of stigma about this significant stage in a woman's life. Indeed, there is evidence to suggest that the majority of women in Australia experiencing severe menopause symptoms receive no treatment [8]. Catastrophically, at a time when women should be emerging into a period of personal, social and financial independence, their biology undergoes an inevitable and unavoidable transition that must be navigated with skill and knowledge that is often lacking at all levels of our population's health and economic frameworks. Left to navigate these challenges alone or in unsupported groups and networks, the problems encountered by menopausal and perimenopausal women are both overt and covert.

Overtly, women are symptomatic of the wide range of physical and psychological impacts arising from the transition from a pre- to postmenopausal status that can vary from a mild to a crippling change. Covertly a woman's body, as a direct consequence of hormonal deficits, starts to undergo pernicious change. These gradual effects of menopause often take their toll on a woman's body unnoticed until an acute condition demands attention. Problematically women confronted by this experience encounter a health system unprepared and poorly structured to meet the needs of perimenopausal and menopausal woman.

Because perimenopause and menopause have long been neglected in clinical training, health policy, healthcare provision and research, many health professionals are under-resourced to treat their patients. Further, many women, workplaces and communities are (knowingly or unknowingly) under-informed about this stage of life. Optimal, individualised, and empowered management of the transition seems, at best, a roll of the dice.

We can and must do better. We present our consumer-led, evidence-informed proposals to address the following gaps:

- Failure to prevent or provide early treatment of menopause symptoms, especially those that increase the risk of long-term sequelae.
- Inequitable access to patient-centric shared care for women experiencing perimenopause and menopause.
- Paucity of education in perimenopause and menopause for health professionals, workplaces, communities, and individuals.
- Negligible robust research data at a population level, which would better inform diagnosis, treatment and management of perimenopause and menopause and contribute to a reversal of the long-standing gender biases in medicine.





## Population health approach

Considering more than 50% of the population are women and greater than 1/3 of most women's life occurs after menopause [9], and 36.5% of all Australian women are aged over 50 [2], a dedicated population health program is urgently needed and long overdue.

*Jane\* is a fit and active 47-year-old. She runs 15km each week and is training for the City to Surf. She has noticed that her menstrual cycle has become irregular over the last year and some months she has no period. She feels generally well, but she is experiencing hot flushes, night sweats and changes in her mood.*

*Jane's training for the City to Surf is brought to a halt when she is diagnosed with a stress fracture in her foot. Further investigations show she has low bone mass density, and she tells her doctor that she is feeling bloated, has constipation, and is putting on weight. Her level of fitness is dropping, and she misses running.*

Jane's story illustrates the insidious nature of many perimenopause and menopause symptoms. Women at this stage of life or later, if not identified and managed at this time, are vulnerable to an inevitable loss of bone density [10], but many will be unaware of such changes until they experience a fracture. Jane's injury had a significant impact on her lifestyle, quality of life and wellbeing. Some fractures can result in chronic pain, disability, loss of independence or even death [11]. Early treatment to maintain Jane's bone density will reduce her overall fracture risk [12]. The individual and societal cost of this one menopause related issue is associated with a heavy burden on the woman's quality of life, the Australian Healthcare system [13] and Treasury (with an estimated total financial cost of \$AUD 1.7 billion for women over 50 in 2017, [14]). A preventative health approach is needed to mitigate the combined toll that this and other long-term consequences of menopause take on the public purse and our community (including cardiovascular disease and cognitive impairments which are the leading causes of death for women [15]) and the burden will increase with time. In the year 2050, the Australian Bureau of Statistics predicts that 24% of all Australians will be women aged over 45 [16]. It is crucial to the resilience of Australia's economic future and social fabric that these costly, yet preventable, outcomes are addressed immediately.

*Olivia\* downplayed her symptoms in her consultation with one of SPHERE's GP representatives, an expert practitioner in the field of perimenopause and menopause, until her attention was drawn to a "puddle on the floor" resulting from severe hot flush. Olivia had previously been leading an active and healthy lifestyle but was having difficulty sleeping and was struggling with life. Within three months of commencing Menopause Hormone Therapy (MHT), Olivia's quality of life was "transformed".*

SPHERE has heard similar stories of women in the workplace failing to attribute their symptoms as the treatable effects of perimenopause, including nurses experiencing hot flushes like Olivia's that are so significant they are "dripping" over patients. In addition to the debilitating social consequences arising from hot flushes and the inevitable anxiety they incur, other common symptoms of menopause, such as disturbed sleep, joint pain, night sweats and mood changes can affect a woman's health and wellbeing. With a fluctuating onset, symptoms are often individually dismissed by women or trivialised by others as the effects of stress or challenging life events, yet each may be part of the cumulative menopausal transition. If most severe menopause symptoms are

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\* The names of SPHERE's consumer partners have been changed to protect their identities.





left untreated [8] detrimental effects compound and interact with each other, impacting wellness, with diminished wellbeing exacerbated by stress [17].

*Emma\* has been married for 35 years and has three children, two of whom are teenagers. She had her last period 18 months ago but continues to experience menopause symptoms which are detrimentally affecting her quality of life and her marriage. Emma visits her GP and reports that she is worried about brain fog, fatigue, and low libido. She has hot flushes and night sweats if she stops taking the anti-depressant medication she has been prescribed by another doctor; she cannot recall the dosage and is only intermittently compliant with the regimen. Emma reports that she drinks 3 units of alcohol every day and that she does not exercise. Her BMI is 35.*

Emma presents a complex case. Teasing apart her symptoms, discussing lifestyle changes that may be beneficial and having an informed risk weighted discussion about the pros and cons of available treatments takes *time*. Our colleagues at the Royal Australian College of General Practitioners (RACGP) tell us that to conduct a menopause consultation “*properly and well*” requires an appointment of a duration that is not supported by the current Medicare Benefits Scheme (MBS) structure for general practice consultations. GPs also note that when a consultation of sufficient length is possible within a clinic schedule, the out-of-pocket cost is prohibitive for many women. Yet the issue must be managed in primary care to make a significant impact at a population level, given the broad-based nature and complexities of the population(s) affected in Australian societies. Equitable access to treatment is a broader issue than just the availability and choice of treatments on the PBS (also of significant concern relating to menopause, but not considered here). The paucity of data pertaining to Indigenous and some priority populations is an unmet need requiring immediate attention.

Risk weighted MHT is available for women like Emma. Importantly each woman’s appreciation of risk and reward is highly individual and if able to access informed patient-centred decision making, Emma could have been offered regular appointments to identify and manage her menopause symptoms from the outset, during perimenopause. It is plausible that their silent creep may not have had such a devastating effect on her health, quality of life and relationships. Designated “menopause” appointments would not only empower individual women in their own treatment choices, but the associated Medicare billing code would generate an invaluable corpus of population data to inform policy and treatments.

### **Key proposals**

- SPHERE recommends that all women should be offered routine screening for perimenopause and menopause symptoms at an appropriate age, with lifestyle advice and ongoing management as required, including post-menopause if necessary. This evaluation should include assessment of risk for associated future diseases including osteoporosis, ischaemic heart disease, stroke, breast cancer and dementia.
- Establishment of Medicare rebates for menopause consultations with specific billing codes.
- Facilitating longer consultations for menopause within general practice.





## Integrated Shared Care

Current health care models, particularly in specialty settings, compartmentalise menopause and medical conditions, when a holistic approach is required. If issues pertaining to perimenopause and menopause are considered at all, expertise and excellence are constrained within disease-based boundaries.

*Sara\* was still only 27 years old when first referred for review at a specialised complex menopause clinic. Sara was born with Mosaic Turner's Syndrome. She grew up looking a little different to other children and she experienced health issues which affected her bones, her bowels and the development of her reproductive organs. Sara received a lot of medical treatment as a child, including hormone therapy to induce puberty. Sara's body is unable to make certain hormones and without replacement, she is rendered menopausal.*

*The combined oral contraceptive pill was used initially before she was switched to oral MHT at the age of 22. A few months after this change, Sara was admitted to hospital with severe headache, vomiting, lack of coordination and slurred speech. Sara had a stroke. She had suffered a venous clot causing swelling of her brain and her hormone medication was abruptly ceased as it was considered causative. She was told she could never use MHT again due to risk of another clot and stroke.*

*After five years with no hormone treatment, Sara, now 27, is experiencing hot flushes "up to every hour", joint pains, insomnia, urinary issues and worsening depression and anxiety. She is no longer able to work, is socially isolated and has suffered the breakdown of her long-term relationship. Sara tells her doctor that she "sometimes feels life is not worth living". Her bone density is now lower than 99.5% of women her age. She is both relieved and disappointed to learn that alternative topical MHT does not carry the same clot risk and is provided with prescription for topical oestrogen, which will also lower her risk of coronary heart disease.*

Sara's story starkly highlights the need for a shared care model for management of menopause related issues, especially for patients who have a condition placing them at risk or biological certainty, like Sara, of premature ovarian insufficiency (POI; defined as loss of ovarian function before the age of 40 [18]). Women who experience POI are at higher risk of cardiovascular disease, osteoporosis and fracture, cognitive impairment and dementia, and lower life expectancy than women who go through menopause at an older age [19]. Continuity of treatment is therefore essential. Large-scale epidemiological studies demonstrate no observed increase in venous thromboembolism events with use of transdermal oestrogen preparations [20], indicating that hormone therapy *per se* was not contra-indicated for Sara. An integrated approach to her care would likely have spared her several years of severe menopausal symptoms and the long-term health consequences of unnecessary hormone deprivation. Sara's case also highlights the lack of transfer of responsibility for care provision between health sectors as patients move for social, education and employment reasons. Transitional care remains an ongoing issue for all women like Sara who suffer chronic care conditions requiring transfer from paediatric services to the under-resourced, uncoordinated, and over-stretched primary and tertiary care sectors. A truly *comprehensive* healthcare system should be proactive, multi-disciplinary, and supportive, providing integrated care over a woman's lifespan.

Included in the nearly 4% of women worldwide who experience POI [21] are individuals who have received cancer treatment [22]. At a time when they may still be coping with severe illness and aggressive treatment, they are also faced with the sudden onset of menopause symptoms.







*Kathy\* was 48 when she was diagnosed with breast cancer. While the tumour was of an intermediate grade, the extent of disease had been caught early with no spread, requiring local excision and sentinel node biopsy and radiotherapy. She was told that she had a 96% chance of disease-free survival and that early detection and management had probably saved her life. Her oncologist recommended improving that outcome by adhering to 5 years of anti-estrogen therapy. Always prone to vasovagal syncope, the onset of a medically induced menopause was devastatingly incapacitating. At unpredictable times, but almost daily in its onset and frequency, Kathy would experience waves of flushing followed by a syncopal event that required her to find a prone position to “let it pass”. One day this happened in a traffic jam in an urban tunnel causing considerable disruption and consternation for Kathy and those required to attend to her at that time in what became an emergency. Her oncologist recommended and tried alternative types of estrogen blockade over the course of a four-year treatment program none of which changed the symptom complex and left her symptomatic, frustrated and fearful of what might happen next. After a risk weighted discussion revealed that a “25% increase in survival” would improve her cancer cure from 96 to 97% Kathy decided to forego estrogen blockade and decrease the frequency and severity of her symptoms. However, her panic disorder remains and to this day; she will not drive through any of the myriad urban tunnels that dot our landscape preferring to take the long way around.*

Kathy experienced an iatrogenic, therapeutically induced, and predictable sudden-onset anxiety disorder that includes phobic panic attacks that have persisted beyond the course of her estrogen blockade. In the same way that Sara’s hormone status should have been considered after her stroke, Kathy would have benefited from a healthcare model that recognised that treating her menopause symptoms was part of her cancer care.

*Sonja\*, a practising psychologist, embarked on an expensive program of neurological-cognitive assessments at age 55 because “her cognitive capacity had shrunk to such an extent that she thought she had early onset dementia”. Appropriate treatment from an endocrinologist eventually eliminated Sonja’s “brain fog”, but she had already suffered unnecessary anxiety about her health and ability to work, as well as incurring the inconvenience and expense of unwarranted medical assessments.*

While not all women experience crippling psychological symptoms like Kathy and Sonja, the menopausal transition is associated with an increased risk of depression and anxiety, even in women with no history of mental health disorders [23]. Many women are ill-prepared to recognise a decline in their mental health or are unable to report its significance when seeking treatment. “Brain fog” and “mood swings” have long been normalised and their effects, which may be debilitating, are trivialised, or ignored. Indeed “hysteria” is an archaic term that traces its origins to a pejorative view that women are inherently unstable and emotionally labile. Perimenopause and menopause are a physical and psychological burden women continue to bear, having been tarnished throughout their reproductive years as somehow unstable or less than fully competent on a monthly basis. Predictably in view of the occult shame and stigma surrounding menstruation and its cessation, i.e. menopause, that is particularly pernicious in the mental health space, women fear being written off as less than capable or compromised, especially in the workplace.

**In response** to the fragmented nature of treatment for women, the NSW Menopause Taskforce, co-led by Dr Amanda Beech, is in the process of establishing four major menopause health hubs across the state. These centres, two of which are already treating women, offer gold standard shared care for women experiencing severe menopause symptoms, including an escalation pathway for the





management of complex cases. Women can access integrated care provided by menopause experts in one location, thereby reducing the number of individuals lost to follow up and providing a whole-woman approach to management of symptoms in the short- and longer term.

### **Key proposals**

- Increase the provision of integrated care hubs for menopause, providing a convenient, shared care, one-stop-shop for all women experiencing menopause symptoms.
- Provision of health care services (gynaecology, endocrinology) and psychological support and counselling for young persons undergoing early menopause, including their carers and families

## **Education and Awareness**

SPHERE's stories of women with lived experience of their menopause are examples of the symptomatic drivers, often co-occurring and at times masked by, or mistaken for a "lifestyle" event or "career" choice. Yet this complex stage of a woman's life remains neglected in the mainstream medical curriculum [24, 25], and is overwhelmingly represented in a negative fashion, as a "failure" of women's bodies, in the medical texts that reference it [26].

*Louise\* reported "my ophthalmologist wrote to my endocrinologist recommending she cease prescribing MHT as it was causing her to have dry eyes".* On the advice of her endocrinologist, Louise did not stop using her MHT because of the broader implications for her quality of life and future health.

The inadequacy of undergraduate medical training in menopause is not unique to Australia. A recent Freedom of Information Request made by a menopause campaigner in the UK revealed that 41% of UK universities do not have mandatory menopause education on their curricula [27]. Worldwide, the prevailing assumption must be that clinicians will acquire unstructured training and experience in managing a woman's menopause ad hoc or self-initiated via post-graduate professional development programs.

Each woman has a unique experience affecting not only on her health, but her personal and working life. There is no one symptom that brings every menopausal woman to her GP. Nor is the GP the first person to whom she may present. She may present, for example, to her physiotherapist, pharmacist or psychologist. It is essential that clinical training reflects the fact that each woman is different and there is no one-size-fits all diagnostic pathway or management strategy. Education that is easy to access and relevant to the many health professionals who interact with the women experiencing and/or being treated for the symptoms of menopause needs to be prioritised [28].

In the same way the pubertal transition, a woman's first exposure to hormones that will determine her reproductive future, is an intensely unique and labile personal experience recognised as an important developmental milestone fraught with numerous social and health related consequences, the same is not afforded to woman as they experience their next transition. Moreover, it is a commonly held misconception due to widespread lack of community awareness for this change to be associated with a woman's reproductive health, when the perimenopause and menopausal transition is unrelated to reproductive health in any meaningful way other than its conclusion. The menopause is not a temporal episode like a pregnancy, nor secondary amenorrhoea temporarily interrupting a woman's capacity to conceive (i.e. reproductive health) but a permanent post pubertal milestone all women transition that the other half of the population do not. Recognising the economic and social





impact of pregnancy for example, parental leave has been negotiated for both genders, but a woman's menopausal transition is misclassified and ignored. Yet it can disrupt working lives to the extent that women may reduce their hours of work or leave their place of employment which beyond the impact on the woman's financial and professional independence, results in the loss of significant corporate knowledge and expertise. These misrepresentations occur at the highest levels of policy engagement and frameworks and need remediation when 83% of women with menopause symptoms feel their work has been negatively affected by their experience and 45% of symptomatic women considered retirement or extended leave as a result. Sixty percent of the women who responded to this survey reported that support at their workplace was "poor" or "below average" [29]. The level of community awareness, medical teaching and policy settings must be addressed across all medical, allied health, community and professional (government and non-government) fields.

**To support** the extension of expert menopause hubs into rural, regional and remote areas (without excluding metropolitan participation and capacity building) SPHERE's Maternal and Women's & Health Clinical Theme has partnered with the NSW Menopause Taskforce to implement an online educational program which uses the internationally renowned ECHO™ model [30]. The *MenoECHO™* program is aimed primarily at GPs, endocrinologists, gynaecologists, nurses and allied health professionals interested in increasing their awareness and knowledge of perimenopausal and menopause issues. *MenoECHO™* uses practical case-based learning led by an expert panel including and supported by SPHERE members. Sessions take place bimonthly, with topics increasing in complexity, guided by feedback from attendees. Participants can also bring their own complex cases for discussion. To date, around 650 health professionals have registered with *MenoECHO™* Australiawide. Australia could be leading the way internationally in the provision of a far-reaching, effective, and *cost-effective* post-graduate clinical training program in menopause. SPHERE suggests that programs like *MenoECHO™* may also serve as formal training pathways for clinicians choosing to specialise in the treatment of women with perimenopause and menopause symptoms. Currently, there is no obligation for a health professional to undergo post-graduate training or maintain professional development in the field – there is no accreditation process. This leaves consumers at the mercy of an unregulated marketplace.

SPHERE has also developed a suite of **consumer awareness modules** that cater to the Personal Development, Health and Physical Education (PDHPE) syllabus in many secondary school settings. The modules were trialled in NSW secondary school settings during the COVID pandemic due to the rapid requirement for online content and sufficient evidence to inform an educational piece of work suitable for school age children. Osteoporosis and the acquisition of normal bone health as a marker of pubertal development and maturational ageing has been shown to have good uptake and knowledge transfer. A similar suite of perimenopause and menopause educational modules could be developed to cater for the inevitable transition when it occurs.







## **Key proposals**

- Implementation of mandatory continuing professional development and case-based learning opportunities for health workers to acquire necessary skill and confidence to manage complexity with conviction.
- Review of current practice clinical guidelines for healthcare providers to ensure proper education, support and clinical management is provided to younger women who will have early menopause due to cancer treatment
- Expand the scope of the *MenoECHO™* program to provide training for all clinical disciplines and ensure continued roll out of the program beyond New South Wales and throughout Australia.
- Perimenopause and Menopause to be a priority for the Office for Women and included in the Australian Public Service (APS) guide ensuring gender equality through its gender analysis and impact assessment framework [31].
- Declassify menopause as a “reproductive health” issue. A woman is not defined by her capacity or desire to reproduce. Menopause is a standalone health event for all women that cannot be circumvented or manipulated and loss of reproductive capacity does not define it.
- Improve community awareness for both genders about inevitable consequences of the perimenopause and menopause in women by developing a suite of online educational tools suitable for incorporation into secondary education or remote learning opportunities

## **Evidence-based translational research**

Where there are disparities in health outcomes between women and groups of women, modifiable factors including (but not limited to) access to, and the understanding of, appropriately trained [24] and reimbursed health professionals require further study. There are gaps in our knowledge about individual and societal attitudes to perimenopause and menopause among Aboriginal and Torres Strait Islander people and CALD communities including Pasifika and the broader multicultural context of a modern Australian society. Inequities and cultural differences exist, not least the societal expectation of menopause and perimenopausal transition as a “change of life”. Policies and interventions need to be in place to address more than what to others is perceived to be a natural age-related phenomenon when for many “change” is not desired, required or necessary.

The lack of large-scale, translational research for evidence-based clinical practice in perimenopause and menopause plays a significant role in inequity of access to treatment as well as the broader gendered ageism underlying menopause services. The extent to which isolated and underserved communities in regional, rural and remote areas can be adequately serviced by modern technology-based solutions requires further evaluation and improvements where necessary. Similarly, studies for the management of menopause using non hormonal pharmacological or non-pharmacological interventions are required for those women symptomatic of menopause for whom conventional MHT is contraindicated or not tolerated.

**SPHERE supports** collaboration (A/Prof Erin Morton) and the continued development of a Virtual registry of perimenopause and menopause in Australia (VITAL). VITAL has been officially registered with the World Health Organisation and the Australian Commission on Safety & Quality in Healthcare clinical trials and registry platforms. It collects information on Australian women’s experience of perimenopause and menopause through online submission. VITAL is building a knowledge base of lived experience about perimenopause and menopause that will inform and improve care pathways and the effectiveness of treatments. Importantly, VITAL also empowers women to contribute to the future of perimenopause and menopause care. It is essential that this valuable resource is adequately





funded, integrated across digital health platforms and championed to facilitate collection, collation and dissemination of data in Australia. Moreover, incorporation of health service data from Medicare, PBS, Registry and inpatient admitted data using modern computational engineering, unique to SPHERE (the Research & Operational Data Environment; RODE) in a federated way would provide a unique lifespan approach to the potentially modifiable factors influencing a woman's transition through and beyond the menopause. Unanswered questions about menopause and frailty, dementia and cardiovascular risk would increasingly become apparent from the support of such a resource in the short and long term.

### **Key proposals:**

- Improve the evidence base for factors influencing Indigenous women and women in priority populations experience of menopause and/or access to interventions that are culturally appropriate and acceptable to them.
- Understand and test strategies to overcome the barriers for women in remote, rural and regional areas obtaining access to current best evidence for management of the menopause and perimenopause.
- Improve the evidence base for non-hormonal pharmacological and non-pharmacological interventions to manage the perimenopause and menopause.
- Increase clinical trials of new novel therapeutic targets for women experiencing menopausal symptoms
- Provide support for integrating data with VITAL that studies the impacts of menopause at and beyond the time of the perimenopause.

## **Conclusion**

Menopause and its precursor, the perimenopause, is not a rare condition in search of a cure. The cause is known, and its treatment is clear. Rather it is a failure of implementation, health service integration and public health policy to provide a known treatment in an individualised, risk weighted, culturally appropriate and equitable fashion. Those risk assessments can change with time and circumstances for every woman and require vigilant surveillance from an educated, confident and accessible medical and clinical workforce. Social policy settings must recognise the potential impact at a time women, already carrying an inequitable reproductive burden, are at increasing risk of isolation and neglect. SPHERE's recommendations to target prevention of severe menopause symptoms and their longer-term sequelae through a shared care model rely not only on changes to healthcare policy and guidelines, but also on improvements to community awareness and acceptance, undergraduate and continuing professional clinical education programs and the continued generation of a robust evidence base. There is a longstanding and urgent need to address these unmet needs to improve the awareness, identification and treatment of perimenopause and menopause symptoms and their long-term sequelae.

Our goal is to minimise the health impacts and maximise the quality of life for all women who must inevitably pass through this phase of life. This is no longer "just" a women's health issue; it affects not only individual women, but also their partners, families, workplaces, and our communities. The time has come to recognise the physical, mental, and economic burdens of menopause and perimenopause and to ultimately achieve better health, social and economic outcomes for the women affected, and in doing so the Australian community.





## Expert biographies

Dr Amanda Beech is a leader in SPHERE's Maternal and Women's Health (MWH) Clinical Theme and has coordinated this submission. Dr Beech is an Obstetric Medicine Physician and a Women's Health Endocrinologist at the Royal Hospital for Women (RHW) and conjoint senior lecturer at the University of New South Wales. She currently co-chairs the Menopause Taskforce in NSW and is the Director of the Secondary Fracture Prevention Service at the RHW. Her team includes Dr Sophie Gates who provides Research Support for the MWH Clinical Theme, drafting most of this submission; Dr Caitlin Corkhill, an early career endocrinologist specialising in Women's Health and Dr Kate Luckie supported by a GP advisory committee and education committee ensuring relevance to the target audience. They support an unrestricted Australia-wide case-based GP education & training module (MenoECHO™) with over 650 registrations. They collated many of the consumer stories for the submission from clinicians and experts involved in the program as well as the evidence supporting this submission. Consumer stories are given with consent of the patient and deidentified for the purposes of this submission and case presentation.

A/Professor Erin Morton is a South Australian academic who has long advocated for greater research and data surrounding the impact and management of the menopause. She established the first dedicated Women's health database dedicated to the study and management of menopause (VITAL).

Dr Joanna Bruce is a practice owner of *Myma* Health, a GP practice that exclusively looks after women's health, particularly through the menopause transition. She is also Censor for NSW/ACT for the RACGP. Joanna also works at Jarrah house which is a residential facility for women struggling with drugs and alcohol and therefore sees directly the impact of cost of health care on lower socioeconomic groups, she also volunteers for Street Side Medics providing health care for the homeless in Sydney.

Kris Pierce, Director, Consumer Engagement and Advocacy, Child Unlimited Clinical Theme (SPHERE). Kris is a rare disease advocate and health professional with her Masters Degrees in both Health Science and Wellness and a background in nursing. After a 14-year odyssey Kris's family received the diagnosis for their son, Will, who has SCN2A. Kris consults to hospital boards, industry and community groups, ensuring quality consumer engagement across the health and disability sectors. Kris is passionate about empowering consumers to have a voice in their care and outcomes.





## References

1. World Health Organisation, *Health Promotion Glossary*. 1998.
2. Australian Bureau of Statistics. *Population: Census*. 2021 [cited 2024 February 9]; Available from: <https://www.abs.gov.au/statistics/people/population/population-census/2021>.
3. Tariq, B., et al., *Women's knowledge and attitudes to the menopause: a comparison of women over 40 who were in the perimenopause, post menopause and those not in the peri or post menopause*. BMC Womens Health, 2023. **23**(1): p. 460.
4. Shahzad, D., et al., *Women's knowledge and awareness on menopause symptoms and its treatment options remains inadequate: a report from the United Arab Emirates*. Menopause, 2021. **28**(8): p. 918-927.
5. Herbert, D., et al., *Australian women's understanding of menopause and its consequences: a qualitative study*. Climacteric, 2020. **23**(6): p. 622-628.
6. Davis, S.R., et al., *Health-care providers' views of menopause and its management: a qualitative study*. Climacteric, 2021. **24**(6): p. 612-617.
7. Department of Health & Social Care. *Policy paper: women's Health Strategy for England*. 2022 [cited 2024 12 February]; Available from: <https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england#menopause>.
8. Worsley, R., et al., *Low use of effective and safe therapies for moderate to severe menopausal symptoms: a cross-sectional community study of Australian women*. Menopause, 2016. **23**(1): p. 11-7.
9. Baber, R., *Treating menopausal women: Have we lost our way?* Australian and New Zealand Journal of Obstetrics and Gynaecology, 2021. **61**(4): p. 493-495.
10. Greendale, G.A., et al., *Bone mineral density loss in relation to the final menstrual period in a multiethnic cohort: results from the Study of Women's Health Across the Nation (SWAN)*. J Bone Miner Res, 2012. **27**(1): p. 111-8.
11. Bliuc, D., et al., *Compound risk of high mortality following osteoporotic fracture and refracture in elderly women and men*. Journal of Bone and Mineral Research, 2013. **28**(11): p. 2317-2324.
12. Lorentzon, M., et al., *Menopausal hormone therapy reduces the risk of fracture regardless of falls risk or baseline FRAX probability-results from the Women's Health Initiative hormone therapy trials*. Osteoporos Int, 2022. **33**(11): p. 2297-2305.
13. Australian Institute of Health and Welfare. *Chronic musculoskeletal conditions: Osteoporosis and minimal trauma fractures*. 2023 [cited 2024 13 March 2024]; Available from: <https://www.aihw.gov.au/reports/chronic-musculoskeletal-conditions/osteoporosis>.
14. Tatangelo, G., et al., *The Cost of Osteoporosis, Osteopenia, and Associated Fractures in Australia in 2017*. Journal of Bone and Mineral Research, 2019. **34**(4): p. 616-625.
15. Australian Institute of Health and Welfare. *Deaths in Australia*. 2023 [cited 2024 13 March 2024]; Available from: <https://www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia/contents/leading-causes-of-death>.
16. Australian Bureau of Statistics. *Population Projections, Australia, 2022-2071*. 08 March 2024]; Available from: [https://explore.data.abs.gov.au/vis?fs\[0\]=People%2C1%7CPopulation%23POPULATION%23%7CPopulation%20Projections%23POP\\_PROJ%23&pg=0&fc=People&df\[ds\]=PEOPLE\\_TOPICS&df\[id\]=POP\\_PROJ&df\[ag\]=ABS&df\[vs\]=1.0.0&pd=2050%2C2050&dq=0...1.1.1.A&ly\[cl\]=SEX\\_ABS&vw=tb](https://explore.data.abs.gov.au/vis?fs[0]=People%2C1%7CPopulation%23POPULATION%23%7CPopulation%20Projections%23POP_PROJ%23&pg=0&fc=People&df[ds]=PEOPLE_TOPICS&df[id]=POP_PROJ&df[ag]=ABS&df[vs]=1.0.0&pd=2050%2C2050&dq=0...1.1.1.A&ly[cl]=SEX_ABS&vw=tb).



17. Arnot, M., E.H. Emmott, and R. Mace, *The relationship between social support, stressful events, and menopause symptoms*. PLoS One, 2021. **16**(1): p. e0245444.
18. Panay, N., et al., *Premature ovarian insufficiency: an International Menopause Society White Paper*. Climacteric, 2020. **23**(5): p. 426-446.
19. Xu, X., M. Jones, and G.D. Mishra, *Age at natural menopause and development of chronic conditions and multimorbidity: results from an Australian prospective cohort*. Human Reproduction, 2020. **35**(1): p. 203-211.
20. Scarabin, P.Y., *Progestogens and venous thromboembolism in menopausal women: an updated oral versus transdermal estrogen meta-analysis*. Climacteric, 2018. **21**(4): p. 341-345.
21. Golezar, S., et al., *The global prevalence of primary ovarian insufficiency and early menopause: a meta-analysis*. Climacteric, 2019. **22**(4): p. 403-411.
22. Yeganeh, L., et al., *Women's perspectives of early menopause: development of a word cloud*. Climacteric, 2020. **23**(4): p. 417-420.
23. Alblooshi, S., M. Taylor, and N. Gill, *Does menopause elevate the risk for developing depression and anxiety? Results from a systematic review*. Australas Psychiatry, 2023. **31**(2): p. 165-173.
24. Macpherson, B.E. and N.D. Quinton, *Menopause and healthcare professional education: A scoping review*. Maturitas, 2022. **166**: p. 89-95.
25. Armeni, E., et al., *Menopause medical education around the world: The way forward to serve women's health*. Current Opinion in Endocrine and Metabolic Research, 2022. **26**: p. 100387.
26. Niland, P. and A.C. Lyons, *Uncertainty in medicine: Meanings of menopause and hormone replacement therapy in medical textbooks*. Social Science & Medicine, 2011. **73**(8): p. 1238-1245.
27. Menopause Support. *Menopause Support Survey Reveals Shocking Disparity in Menopause training in medical schools*. 2021 [cited 2024 16 February]; Available from: <https://menopausesupport.co.uk/wp-content/uploads/2021/05/Web-info-Shocking-Disparity-in-Menopause-Training-in-Medical-Schools-1.pdf>.
28. Davis, S.R. and K. Magraith, *Advancing menopause care in Australia: barriers and opportunities*. Medical Journal of Australia, 2023. **218**(11): p. 500-502.
29. Circle In. *Driving the change: Menopause and the workplace*. 2021 [cited 2024 09 March]; Available from: <https://circlein.com/wp-content/uploads/2021/03/Circle-In-Menopause-and-the-workplace.pdf>.
30. Arora, S., et al., *Outcomes of Treatment for Hepatitis C Virus Infection by Primary Care Providers*. New England Journal of Medicine, 2011. **364**(23): p. 2199-2207.
31. Department of the Prime Minister and Cabinet. *Including Gender: An APS Guide to Gender Analysis and Gender Impact Assessment*. 2024-2025 [cited 2024 16 February]; Available from: [https://www.pmc.gov.au/sites/default/files/resource/download/aps-guide-gender-analysis-impact-assessment\\_0.pdf](https://www.pmc.gov.au/sites/default/files/resource/download/aps-guide-gender-analysis-impact-assessment_0.pdf).