Submission to the Senate inquiry into issues related to menopause and perimenopause

15 March 2024

About Women's Health Matters

Women's Health Matters (WHM) is an independent, non-partisan think tank that works to improve the health and wellbeing of all women in the ACT and surrounding region. We seek to improve access to health information and enhance knowledge and understanding about the causes of health and illness among anyone who identifies as a woman.

We advocate on behalf of all ACT women, especially those experiencing disadvantage and vulnerability. We want women to feel in control of and understand the determinants of their own health and wellbeing. We do this through health promotion and by providing evidence-based social research, policy development and advocacy services to governments, the corporate sector, policy makers, service providers and peak bodies.

Our approach to this inquiry

WHM supports and welcomes the Senate Inquiry into issues related to menopause and perimenopause. We are heartened to see an increased interest in sexual and reproductive health, rights and service access.

As an area of reproductive health, menopause needs to be considered through the lens of reproductive justice. WHM supports and calls for reproductive justice, which acknowledges that reproductive rights include the right to bodily autonomy, the formal and substantive right not to have a child, through abortion and/or contraception, as well as the right to have a child, and the right to parent children without fear of violence or discrimination.[1] We understand that experiences of menopause are intimately related to these reproductive rights and the extent to which people have been allowed to enjoy them.

In all of our work on sexual and reproductive health, we acknowledge the immense impact caused by the deliberate and active reproductive violence that occurs against people in the ACT as in Australia more generally, particularly Aboriginal and Torres Strait Islander people, people with disabilities, people living in poverty, and people being subjected to reproductive coercion, among others. There is much to learn from other areas of sexual and reproductive health about how principles of reproductive justice can be applied to menopause, in a way that acknowledges that the "lived, personal experiences of the individual [are] equally important [to] the evidence-based, scientific knowledge."[2]

[1] See SisterSong, who coined the term reproductive justice: https://www.sistersong.net/reproductive-justice, accessed 4 August 2022, https://msi-australia.medium.com/in-response-to-overturning-roe-v-wade-we-need-reproductive-justice-now-ec7f09f120ce, accessed 4 August 2022.

[2] Alspaugh A, Reibel MD, Im EO, Barroso J. "Since I'm a little bit more mature": contraception and the arc of time for women in midlife. *Women's Midlife Health*. 2021 Apr 9;7(1):3. doi: 10.1186/s40695-021-00062-7.

For example, when discussing contraception, Higgins (2014) states:

> Reproductive justice recognizes that the main reproductive challenge facing poor women of color is not unintended pregnancy by itself, but rather socio-economic and cultural inequalities that provide some people with easier access to self-determination and bodily autonomy than others.[3]

Similarly, it can be seen that menopause needs to be considered not as a discrete medical problem, but rather as a set of commonalities and differences that reflect experiences of inequality such as racism, colonisation, misogyny and homophobia, as well as other lifetime experiences of reproduction (or the absence of reproduction), sexuality, health, relationships and medical interventions.

Research and community projects are beginning to address menopause in this more nuanced way; for example, using community-based participatory research approaches to work with groups of women to explore and articulate their needs in relation to menopause, and to co-create community resources that begin to meet those needs. [4] Such approaches can be supported by broader frameworks of community awareness, professional knowledge and policy coordination that encompass menopause as a central element of sexual and reproductive health. This submission addresses some of these broader frameworks as well as representing the voices of women who have spoken to Women's Health Matters about their experiences of menopause.

As the core of our role, we seek to represent the needs and voices of women in the ACT in relation to their health and well-being, and this includes femme-identifying people and people aligned with this group. In relation to particular health conditions and types of health services, we understand that a number of sex-based topics traditionally understood as "women's health" are, in reality, also important for some trans men and non-binary people, who need sensitive, well-informed and competent responses. Menopause is one such area. While Women's Health Matters does not hold the role of expert or community representative for the health of trans and gender diverse people, we aim to support and amplify where possible the work of LGBTIQ+ communities and health organisations as well as mainstream sexual and reproductive health organisations that take an inclusive approach to gender.

[3] Higgins JA. Celebration meets caution: LARC's boons, potential busts, and the benefits of a reproductive justice approach. *Contraception*. 2014 Apr;89(4):237-41. doi: 10.1016/j.contraception.2014.01.027. Epub 2014 Feb 10.

[4] Sydora, B.C., Graham, B., Oster, R.T. et al. Menopause experience in First Nations women and initiatives for menopause symptom awareness; a community-based participatory research approach. BMC Women's Health 21, 179 (2021). https://doi.org/10.1186/s12905-021-01303-7. See also Jurgenson, J.R., Jones, E.K., Haynes, E. et al. Exploring Australian Aboriginal Women's experiences of menopause: a descriptive study. *BMC Women's Health* 14, 47 (2014). https://doi.org/10.1186/1472-6874-14-47.

Terms of Reference

This submission responds primarily to the following Terms of Reference of the Inquiry:

- b. the physical health impacts, including menopausal and perimenopausal symptoms, associated medical conditions such as menorrhagia, and access to healthcare services;
- c. the mental and emotional well-being of individuals experiencing menopause and perimenopause, considering issues like mental health, self-esteem, and social support;
- 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;
- 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;
- h. existing Commonwealth, state and territory government policies, programs, and healthcare initiatives addressing menopause and perimenopause;
- and other related matters.

Recommendations

1. Establish a Royal Commission into the health and wellbeing of the Australian health workforce
2. Include sexual and reproductive health education in undergraduate degrees and postgraduate training programs including medicine, midwifery, nursing, general practice and obstetrics and gynaecology on a mandatory basis
3. Provide post-graduate education pathways to upskill the current nursing workforce which are accredited by reproductive health peak bodies
4. Improve LGBTIQ+ inclusion in all levels of health care education
5. Provide ongoing investment to support and develop a bilingual, bicultural health workforce that is professionally recognised and appropriately remunerated
6. Commission research and policy responses on the impact of reproductive health on women's participation in the workforce and the adequacy of existing leave entitlements under the National Employment Standards
7. Provide support for information and navigation resources to assist people to access appropriate care for symptoms of menopause.

Experiences of menopause & perimenopause in the ACT

As a community-based organisation, Women's Health Matters researches the needs and experiences of women in the ACT, with a focus on sexual and reproductive health.

In 2018 we conducted survey research, the findings of which were reported in *Improving choices and options – The views of ACT women about their sexual and reproductive health needs*.[5] This survey collected 510 responses from ACT women and identified that:

> *Women in their late 30s and early 40s were worried about what to expect and expressed being ill-informed about identifiable symptoms of the different stages of menopause. [W]omen experiencing menopause spoke about the poor and delayed advice and support received in managing symptoms of menopausal transitions. The uncertainty of symptoms by women and their healthcare providers, and the uncertainty of having no diagnosis or explanation can lead women (especially women experiencing early menopause) to feel that their menopausal experiences are not legitimate and therefore not treatable or manageable.*

In 2023 we published the findings of our major Survey of Women's Health in the ACT, for which we had 1668 responses across a range of topics including sexual and reproductive health as well as mental health, access to health services and experiences of using services, pregnancy and birth, safety and gender-based violence.[6] The survey was open to women and femme-identifying people, and people who align themselves with these groups, who were at least 18 years old and living in the ACT or surrounding regions. As part of this survey we asked a series of questions about menopause, the findings of which are summarised here.

We asked respondents whether they had reached menopause, defined as, for people with uteruses, the time when menstruation stops (when people stop having periods altogether).

Just over a fifth of all respondents indicated they had reached menopause.

Table 1: Reached menopause

	Freq.	Per cent (%)
No	1,178	70.6
Yes	361	21.6
Unsure	92	5.5
Not applicable	28	1.7
Prefer not to answer	9	0.5
Total	1,668	100

[5] Women's Health Matters (2018), *Improving choices and options: The views of ACT women about their sexual and reproductive health needs* https://www.womenshealthmatters.org.au/wp-content/uploads/2020/10/Improving-choices-and-options-The-views-of-ACT-women-about-their-sexual-and-reproductive-health-needs.pdf

[6] Women's Health Matters, *Report on the ACT Survey of Women's Health*, 2023 https://www.womenshealthmatters.org.au/wp-content/uploads/2023/07/Report-on-ACT-Survey-of-Womens-Health.pdf Accessed 14 March 2024

For those who indicated they had reached menopause (n=361), we asked what age they were when their periods completely stopped. As expected, the majority (over 60%) experienced menopause between 45 and 55 years of age.

Table 2: Age when periods stopped

	Freq.	Per cent (%)
Before 40 years of age	40	11.1
Between 40 and 45 years	52	14.4
Between 45 and 55 years	223	61.8
Over 55	46	12.7
Total	361	100

The following sections identify themes and issues from the quantitative and qualitative data gathered by this survey.

Except where noted, the quotes reproduced here were given as answers in response to an optional open-ended question asked of all 1668 survey participants (not only those who told us they had gone through menopause): "Is there anything else you would like to tell us about experiencing (or not experiencing) menopause?"

Information and awareness

As has been widely identified in other submissions and reports, many women lack information about menopause and when they begin seeking to understand more about menopause, they often find that useful information is lacking in the kinds of health services and settings that might otherwise be expected to provide it:

> *"The GP gave me no information or support. I had to join a Facebook group to access information about symptoms."*

> *"It's a complete mine field of confusing information and no real support and most women suffer in silence. I have been suffering my symptoms for 10+ years and feel like it's never going to be over and there's nowhere to go to get good support and advice."*

Other responses showed what an important and positive impact it can have when a medical professional is well-informed and equipped to help with symptoms of menopause:

> *"I didn't realise that depression is one of the symptoms of peri-menopause/menopause. I thought I was going mad, and my baby would be taken from me. Thankfully my GP listened to me and tested my hormones immediately, and then started HRT."*

Menopause as a result of medical conditions, treatments or procedures

Our survey showed a significant minority (40 respondents or 11% as shown in the table above) experienced "premature menopause" (under the age of 40), which typically occurs as a result of other medical conditions, treatments or procedures. Twenty-four respondents (or 7%) reported in the optional free text field that they had had a hysterectomy, and in many of these cases people had undergone menopause as a result of their hysterectomy.[7]

> *"I still have ovaries, so at some point will experience hormonal menopause. The focus of menopause on the period itself is limiting and makes it harder for me to get information or understand what will happen to my body."*

> *"I don't know when I reached menopause because I had a subtotal hysterectomy following complications from menorrhagia and my subsequent blood tests of hormones had conflicting results. However, I can assume that I have now gone through it because of my age and a period on Tamoxifen."*

These results have implications for how health professionals and campaigns communicate about menopause. For the majority of people, menopause will coincide with the predicted cessation of periods in the context of a range of life changes experienced in common with many – but not all – menstruating people. For others, menopause is more characterised by hormonal changes associated with medical interventions and conditions. Early or premature menopause brought about through chemotherapy, for example, is often not well understood or managed. For such people, the focus in menopause health education on periods may not speak to their experience in a way that feels relevant.

Contraception in perimenopause and leading into menopause

Another issue identified in responses to our survey is that it can be difficult to identify menopause depending on contraceptive use, and likewise, difficult to know what kind of contraception is necessary or optimum at different life stages. Reponses included:

> *"Currently taking only the active contraceptive pill. I don't know at what age I should be thinking of menopause"*

> *"Have an implanon inserted for last 7years. Ergo, no periods since 2015. But I am 51. Have been commenced on Esteogel to assist with hot flushes/night sweats...which I assume is perimenopausal"*

> *"Using mirena is making it difficult to tell what is happening with respect to menopause but am clearly approaching tail end of perimenopause"*

> *"Using Mirena now for 8 years with no menses"*

> *"Currently have the Mirena, so assume no due to age (40) but am unsure as have always had hormone issues"*

[7] In the next iteration of the Women's Health Matters' survey, we will consider how to amend the survey instrument to better reflect the range of menopause experiences.

"It was difficult to know when menopause was due to use of Mirena and no bleeding. It probably happened earlier than I expected and I later found out I had osteoporosis at age 53 after breaking arm in 2 places after fairly simple fall. Menopause a bit early for my two older sisters and 1 had osteoporosis so there was a genetic tendency."

The current medical advice is:

- Use contraception until at least one year after your natural periods stop.
- If you are under 50 at the time of your last period, use contraception for another two years.[8]

However, responses to our survey, together with research on the issues of contraceptive use in midlife[9], suggests that there is a need for better information and support to people navigating these concurrent developments. Linked with these considerations is the issue of pregnancy for people in perimenopause, and the lack of understanding that may be faced when seeking support from medical practitioners, workplaces and others.

People designing community and health education need to address the fact that while the focus is on the cessation of periods, for many people this is a long process that can be masked and interrupted by the impact of different contraceptive methods. Crucially, from the point of one or even a few missed periods, people will not necessarily know in advance whether those missed periods signal menopause. For these reasons people need access to information and health professionals who are able to assist with unpacking complex factors and not dismissing or oversimplifying patients' experiences.

Support for symptoms of menopause and perimenopause in the ACT

Our survey found there is a significant need for better access to medical support for people experiencing menopause symptoms or concerns.

Sources of support available currently

In the ACT the main available support for menopause is through Sexual Health and Family Planning ACT's Menopause Centre[10], which provides a dedicated service for those seeking information, support, and medical management of menopause. It is staffed by experienced female doctors who have a special interest in this area. One of our survey respondents noted:

"I attended the menopause clinic which was helpful."

[8] Better Health Channel, 'Menopause and sexual issues', https://www.betterhealth.vic.gov.au/health/healthyliving/menopause-and-sexual-issues Accessed 14 March 2024.

[9] Alspaugh et al, 2021; Harris ML, Egan N, Forder PM, Coombe J, Loxton D. Contraceptive use among women through their later reproductive years: Findings from an Australian prospective cohort study. *PLoS One*. 2021 Aug 11;16(8):e0255913. doi: 10.1371/journal.pone.0255913.

[10] Canberra Menopause Centre, https://shfpact.org.au/index.php/menopause/224-menopause-centre Accessed 14 March 2024.

Recently, a Menopause Café (free monthly drop in sessions in-person or online) has been set up to create a space for everyone who wants to talk about menopause, with no set agenda and open to all genders and ages.[11] This Canberra-based initiative is based on similar models in the UK and elsewhere.

As respondents to our survey mentioned, it can be difficult to find (and then to get an appointment with) a doctor who is well-equipped to assist with menopause and perimenopause:

> *"Hard to find a GP in Canberra who specializes in perimenopause"*

As well as other research translation and information-sharing functions, the Australasian Menopause Society maintains a list of doctors who have a specific interest in women's health at midlife and menopause, and the promotion of healthy ageing. This list can be sorted by state and territory, so ACT-based doctors can be identified.[12]

While this list currently contains 20 practitioners (a mix of GPs and specialists) our broader research has identified that there are barriers to accessing GPs and specialists in Canberra in general.

Barriers to accessing GPs and specialists

In our survey, we asked respondents to rate their overall access to GP consultations (not just in relation to menopause). Over a third rated their access as 'Excellent' or 'Very good,' while around a quarter rated their access as 'Fair' or 'Poor.' Those who reported their access to a GP was only 'Fair' or 'Poor' were asked about their main reasons for this being difficult. The key factors most commonly reported were difficulty getting an appointment (61%) and problems with it being too expensive (24%).[13] Looking at access to different types of medical care, access to specialists generally (not just reproductive health specialists) was among those types rated most poorly.

The survey results show overall positive assessment of the care received from doctors generally, with over three quarters agreeing or strongly agreeing that the care they had received in the last few years had been good. However, there were some concerning findings about people's inclinations to seek health care in general, with over a third agreeing or strongly agreeing that they only go to the doctor if there is no other option, and a quarter of respondents agreeing or strongly agreeing that they avoid seeing a doctor wherever possible.

In a separate question, we asked to what extent respondents felt they had been taken seriously by doctors when explaining symptoms or health concerns over the last few years. While a majority felt they had been taken 'Completely seriously' or 'Mostly seriously', over a third of respondents felt that doctors had taken them only 'Somewhat seriously' or 'Not at all seriously'.

These findings about access and help-seeking generally have implications for people's ability and inclination to seek help with symptoms of menopause in particular.

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[11] Brazil F, Everything you need to know about this weekend's free Menopause Café, HerCanberra, 31 January 2024, https://hercanberra.com.au/life/conversation/everything-you-need-to-know-about-this-weekends-free-menopause-cafe/ Accessed 14 March 2024.

[12] Australasian Menopause Society, Find an AMS doctor, https://www.menopause.org.au/health-info/find-an-ams-doctor Accessed 14 March 2024.

[13] Women's Health Matters, *Report on the ACT Survey of Women's Health*, p1

Satisfaction with access to support services in relation to menopause

More specifically, we asked people who had experienced menopause how satisfied they were with their access to support services in relation to menopause. The results show significant levels of dissatisfaction, with over 40% of people reporting they were 'Dissatisfied' or 'Very dissatisfied', compared with only 23% reporting they were 'Extremely' or 'Very satisfied'.

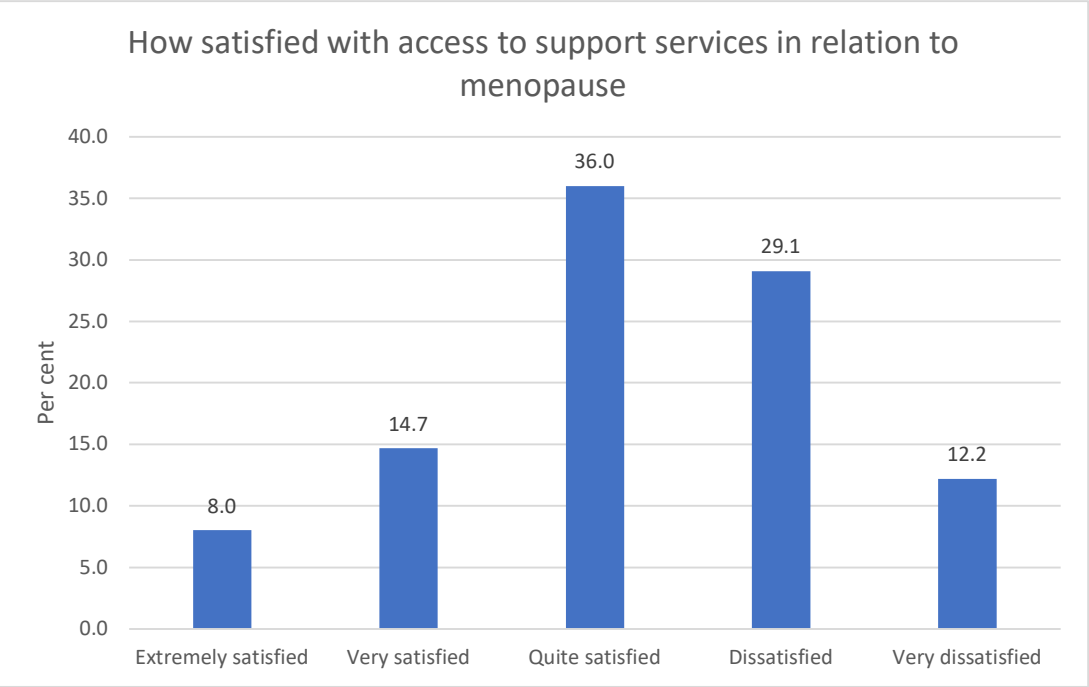

Figure 1: Satisfaction with access to support services in relation to menopause

> *"Access to services for menopause is poor and relies on word of mouth. Trying to get any help with menopause is hard work and you're mostly told that's what happens with menopause."*

Whole of life foundations for health during menopause

It is important to note that care for people experiencing perimenopause and menopause builds on, and should not be seen as separate from, other healthcare both before and during this stage. For example, as the Monash University Women's Health Research Program notes, the strongest predictor of menopause-related depression is premenopausal depression.[14]

[14] Monash University Women's Health Research Program, Submission to the Inquiry into Menopause and Perimenopause, (submission number 11), https://www.aph.gov.au/DocumentStore.ashx?id=ae396d85-2865-45aa-9390-c6122a6e938b&subId=753082 p.1. Accessed 14 March 2024.

We found high levels of psychological distress in our survey of ACT women generally, including young women. As the Monash program has stated, delivering better mental health outcomes for women in midlife will depend on investments in improving mental health in younger Australian women.[15]

One of our survey respondents, who was not yet going through menopause, explained her current difficulties in the absence of adequate investment:

> *"I really need access to psychological support more than the ten sessions [available through the mental health treatment plan]. I have history of mental health and physical health issues. I gave birth with complications and subsequent postnatal depression and anxiety. Wait times were too long to update plan. There was a barrier by waiting to get into see my GP and appointments available."*

A whole-of-life-course view on women's mental and physical health is needed, rather than an approach that focuses on isolated interventions alone.

Availability of Menopause Hormone Therapy (MHT)

We are aware of current problems with the availability of different types of Menopause Hormone Therapy (MHT) in Australia.[16] There are also ongoing discussions about the medicalisation of menopause and concerns about the potential overuse of these therapies, alongside evidence that MHT is a suitable option to be considered for the 25% of women who will have moderate to severe symptoms impacting on their quality of life.[17]

Unfortunately, the costs of treatment continue to make it inaccessible for some, as described by this survey respondent:

> *"Affordability of HRT medication. There are no known medications on the PBS. Meds that I'm supposed to be taking cost $60 a month. I'm a single parent with a child with high medical needs so being able to afford the medication every month is just not possible. I feel that we are being discriminated against for being a female."*[18]

Although we are not in a position to offer solutions on the problems of MHT availability, we acknowledge that for a significant number of women, access to this medication is important for their wellbeing.

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[15] Monash University Women's Health Research Program, p. 1

[16] Australasian Menopause Society, Menopausal Hormone Therapy (MHT) discontinuation and shortages Feb 2024, 8 February 2024. https://www.menopause.org.au/hp/news/menopausal-hormone-therapy-mht-discontinuation-and-shortages-feb-2024 Accessed 14 March 2024; Branley, A, Hormone replacement therapy patch shortages are having a big impact on the women who need them, ABC News, 4 November 2023, https://www.abc.net.au/news/2023-11-04/hormone-replacement-therapy-patch-shortage/103010428 Accessed 14 March 2024.

[17] The Lancet, Menopause 2024 (Series from the Lancet journals), 5 March 2024, https://www.thelancet.com/series/menopause-2024 Accessed 14 March 2024; Australasian Menopause Society, Lancet Series on Menopause 2024, 6 March 2024, https://www.menopause.org.au/hp/gp-hp-resources/lancet-series-on-menopause-2024 Accessed 14 March 2024.

[18] While some MHT medications continue to be listed on the Pharmaceutical Benefits Scheme (and can therefore be dispensed to patients at a Government-subsidised price), some have been removed and others are not listed. See note 16 above. Presumably the survey respondents is saying here that the PBS does not list any of the medications that she has been told by a doctor are suitable for her.

Reproductive health leave and flexible working

Paid reproductive health leave recognises the value of reproduction for society, and that reproductive bodies involve changes which are not illnesses and so are not suited to sick leave. Reproductive health leave may support workforce capacity, with evidence indicating people with endometriosis and menopausal symptoms may drop out of inflexible workforces, and that reproductive health leave may support retention in feminised sectors such as aged care, nursing and teaching.[19]

Some responses in our survey emphasised the stigma and discrimination experienced by older women in workplaces, and that talking about menopause makes a person more likely to be targeted with negative attitudes:

> *"You suffer in silence and you're discriminated against at work if you mention menopause. It labels you as 'too old.'"*

However, it is also true as other submissions to this inquiry have pointed out that in their 50s some women are beginning (or continuing) to hold positions of relative authority and power, compared with earlier stages in their lives. Menopause symptoms can co-exist with career progression, and individual experiences will vary depending on the severity of symptoms, workplace and personal support available, and the ability to access appropriate healthcare, among other factors.

Some researchers have cautioned policy-makers against overemphasising the negative impacts of menopause, separate from other factors affecting women's work experiences during midlife (such as caring responsibilities, general health and mental health, financial stress and the quality of employment).[20] Nevertheless, the availability of appropriate workplace support and entitlements has the potential to improve women's experiences of work, with the benefits that higher quality employment entails for health and financial security. Reproductive health leave is one such key support.

While it has a long international history in the form of menstruation leave, availability of reproductive health leave in Australia is currently limited, and is being driven by a handful of organisations and unions. These include the Victorian Women's Trust,[21] Health and Community Services Union,[22] Modibodi,[23] Victorian Greens,[24] the Queensland Council of Unions,[25] and ourselves at Women's Health Matters.[26]

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[19] Mark E. Schoep et al., "Productivity Loss Due to Menstruation-Related Symptoms: A Nationwide Cross-Sectional Survey among 32 748 Women," *BMJ Open* 9, no. 6 (June 1, 2019): e026186, https://doi.org/10.1136/bmjopen-2018-026186.; Petra Verdonk, Elena Bendien, and Yolande Appelman, "Menopause and Work: A Narrative Literature Review about Menopause, Work and Health," *Work* 72, no. 2 (January 1, 2022): 483–96, https://doi.org/10.3233/WOR-205214.

[20] Monash University Women's Health Research Program submission, pp.1-2.

[21] https://www.vwt.org.au/projects/menstrual-workplace-policy/ Accessed 14 March 2024.

[22] https://hacsu.asn.au/Why-HACSU-is-fighting-for-Reproductive-Health-and-Wellbeing-Leave~25689 Accessed 14 March 2024.

[23] https://www.modibodi.com/blogs/womens-underwear-online/modibodi-launches-menstrual-menopause-miscarriage-leave Accessed 14 March 2024.

[24] https://greens.org.au/vic/news/workers-would-get-reproductive-leave-under-plan-address-gender-inequality Accessed 14 March 2024.

[25] https://itsforeverybody.au/?page_id=88 Accessed 14 March 2024.

[26] https://www.womenshealthmatters.org.au/womens-health-wellbeing/womens-health-matters-reproductive-leave-policy/ Accessed 14 March 2024.

Existing policies differ in terms of the number of days in the entitlement, ranging from 5 days to 24 per calendar year. Their scope also differs: Victorian Women's Trust and Modibodi have a more limited focus on menstruation and menopause and for Modibodi, miscarriage. HACSU, WHM and the Victorian Greens have a much wider reproductive health scope to their claim, policy and platform. WHM supports a wider reproductive health scope and the explicit inclusion of abortion and fertility treatment, both to destigmatise abortion and because lack of paid leave adds to the high cost of abortion care.

A strength of the Victorian Women's Trust and Modibodi policies is their inclusion of flexible work arrangements, which also appear in the HACSU claim and our WHM policy. The combination of leave and flexibility have an explicit aim of revolutionising gender relations in the workplace by allowing women and people with uteruses to be more embodied at work. WHM supports combining a broad scope of reproductive health with these flexible arrangements. There is a need to build the evidence on reproductive health leave, and drive support within the Australian community.

Reproductive leave and flexible work arrangements should be available for people experiencing symptoms from menopause. We believe this leave should have a broad scope and not only be limited to particular issues, such as menstruation or menopause, but should incorporate a wide range of reproductive health-related issues and conditions, in part because this flexibility will encourage a wider and more diverse range of people to make use of it.

Conclusion

Our research in the ACT community affirms that many people do not know whether they are experiencing perimenopause and, for various reasons, are not in a position to discover usable pathways to getting support with their health in relation to menopause. People often do not know where they should go for support, for example to a GP, other public health service or a specialist. And not all health professionals, including GPs, are well equipped to respond to such requests, or to explore all the relevant symptoms and issues with patients.

We need clearer information about menopause and the promotion of easily-interpreted pathways to care, including clinical (primary care) with treatment options supported by Medicare, and in community settings. These options need to be established alongside better community awareness more generally and access to high-quality information.

Many positive steps are already underway, such as the information being provided by the Australasian Menopause Society and, locally, by the Canberra Menopause Centre and Menopause Café. The need to build on these foundations is clearly demonstrated by our survey results, as well as the wealth of other research and expertise driven by the experiences of people going through menopause.

We believe that efforts to improve support for menopause and women's midlife health should be situated within broader developments to strengthen access to sexual and reproductive health services and rights. Our recommendations (given above) reflect this, drawing on our previous proposals to the Senate inquiry into universal access to reproductive healthcare as well as on that inquiry's report.[27]

[27] Women's Health Matters, Submission to the Senate Inquiry Into Universal Access to Reproductive Healthcare, 2022 https://www.womenshealthmatters.org.au/wp-content/uploads/2023/05/FINAL-WHM-Submission-to-Senate-inquiry-into-universal-access-to-reproductive-healthcare-1.pdf Accessed 14 March 2024; Senate Standing Committee on Community Affairs, Ending the postcode lottery: Addressing barriers to sexual, maternity and reproductive healthcare in Australia, 2023

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https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ReproductiveHealthcare Accessed 14 March 2024