



CRE WaND submission to the Inquiry into Issues related to menopause and perimenopause.

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Introduction

Non-communicable diseases (NCDs) are responsible for two-thirds of women's deaths. The Centre of Research Excellence on Women and Non-Communicable Diseases (CRE WaND) aims to move women's health beyond reproductive and sexual health to encompass and prioritise the prevention and detection of NCDs.

Menopause is a normal life transition. How women experience its symptoms and changes depends on their culture of origin, health, and personal circumstances. The CRE WaND advocates for a 'healthy menopause'. This includes health care addressing the immediate impact of troublesome menopausal symptoms, health education, and intervention programs that help women manage symptoms and make positive changes that support their long-term health.

Jasper and colleagues' framework for healthy menopause [1] defines it as:

A dynamic state, following the permanent loss of ovarian function, which is characterized by self-perceived satisfactory physical, psychological and social functioning, incorporating disease and disability, allowing the attainment of a woman's desired ability to adapt and capacity to self-manage.

While we acknowledge that the risk of developing chronic illnesses such as diabetes, heart disease, and osteoporosis increases after menopause, we also believe that shifting ageist and sexist societal attitudes that view menopause as a period of decline will do much to empower women and improve their perceptions and experiences of this normal life stage. Health behaviour in midlife is a predictor of health outcomes in later life. The menopause transition provides a window of opportunity for health promotion that encourages positive health behaviours and/or interventions.

A four-paper series on Menopause published in *The Lancet* on March 5th 2024, advocates for a re-evaluation of how society supports and empowers women experiencing Menopause [2]. The series was led by CRE WaND Chief Investigator Professor Martha Hickey, who brought together an international team of experts, including CRE WaND Director Professor Gita Mishra and Investigators Professor Jenny Doust and Dr Hsin-Fang Chung.

Our submission will present findings and recommendations from the series, which advocates for the implementation of health empowerment principles for menopause, presents a practical framework to help guide the diagnosis of early menopause, examines the associations between mental health conditions and the menopause transition, and considers the complexities in diagnosing and managing menopause symptoms after cancer.

This submission also reports on research by CRE WaND members identifying issues relating to the accessibility and comprehensibility of health information available to women from culturally and linguistically diverse (CALD) backgrounds. There is limited evidence describing Australian First Nations and CALD women's attitudes and perceptions towards menopause. Researchers from the CRE WaND are assessing the evidence gaps in these priority populations. We are interested in knowing how CALD women, including those who have migrated here, experience the menopausal transition, how they manage any symptoms and changes in their bodies, and whether

they see a healthcare provider for advice about menopause health. We are also assessing what healthcare providers find challenging and what is helpful when discussing menopause with migrant women.

Acknowledgement of gender identity

Throughout this submission, we use the phrase 'women's health'. We acknowledge that sex and gender are distinct concepts, and the boundaries around what "women's health" incorporates are not always clear. Although it is necessary for us to analyse data and present research on health topics related to the female sex (i.e. menstruation, childbirth, menopause), we acknowledge that not everyone who identifies as a woman experiences these female-specific health issues or identifies as female.

References:

1. Jaspers L, Daan NM, van Dijk GM, et al. Health in middle-aged and elderly women: A conceptual framework for healthy menopause. *Maturitas* 2015; 8(1): 93-8.
2. The Lancet, 2024, Series on Menopause, accessed March 5th, 2024, <https://www.thelancet.com/series/menopause-2024>

Recommendations

Managing menopause after cancer: A centralised multidisciplinary team is necessary to provide the appropriate care for individuals experiencing menopause symptoms after cancer treatment. However, providing care within each tumour stream (e.g. breast cancer patients, colorectal cancer patients, etc.) is not cost-efficient and risks duplication of services.

Depressive symptoms during the menopause transition: The risk of experiencing psychological symptoms during the menopause transition is not uniform, and clinicians should not assume that psychological symptoms are the result of hormonal changes. They should be aware of populations vulnerable to depressive symptoms, including individuals with a previous history of major depressive disorder, those with severe or prolonged vasomotor symptoms, sleep disturbance or experiencing stressful life events.

Societal attitudes to menopause: Encourage a paradigm shift away from the medicalisation of menopause and towards a health empowerment approach to optimise self-management of women's health and wellbeing during and after the menopause transition.

CALD and First Nations perspectives: Research on the cultural and societal factors influencing perceptions and attitudes toward menopause and perimenopause among culturally and linguistically diverse populations is scarce and cannot be generalised to other populations. Given that the menopausal transition offers the opportunity to promote healthy ageing, investment into research on the influences of the culture of origin towards menopausal perceptions and management of related symptoms is needed, followed by robust translation and implementation of practical research findings, which are codeveloped to meet the needs of target populations.

Diagnosing and treating early menopause

- Establish the causes of early natural menopause to understand who is at risk, especially in diverse populations.
- Reduce diagnostic delay of early menopause through better education for women and clinicians and the application of clinical guidelines to support diagnosis and management.
- Assess the safety and effectiveness of pharmaceutical and non-pharmaceutical treatment options to manage the symptoms of early menopause, improve quality of life, and reduce chronic disease risk.

Menopause care for migrant populations: In order to provide comprehensive menopause health consultations to migrant women from CALD backgrounds, primary care providers have recommended:

- A Medicare item number reflecting the time involved
- A practice nurse with qualifications in women's health
- Women's health services where migrant women can be referred
- A one-stop website that provides health information in relevant community languages
- Accessible interpreter services.

Responses to the terms of reference

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

Managing menopause after cancer

Diagnosing menopause after cancer is challenging as the symptoms from menopause and treatments can overlap. In addition, the general diagnostic criteria of 12 months without a period does not apply, because ovarian function can return years after treatment. Most patients with troublesome symptoms cannot access effective treatments [1]. Clear guidelines are needed to support the management of menopausal symptoms after cancer.

Recommendation: A centralised multidisciplinary team is necessary to provide the appropriate care for individuals experiencing menopause symptoms after cancer treatment. However, providing care within each tumour stream (e.g. breast cancer patients, colorectal cancer patients, etc.) is not cost-efficient and risks duplication of services.

The Victorian [Menopausal Service After Cancer \(MSAC\)](#) successfully models a centralised, cross-disciplinary service with a patient-centred approach to delivering care for menopausal symptoms after cancer treatment.

References:

1. Hickey, M., Basu, P., Sassarini, J., Stegmann, M. E., Weiderpass, E., Nakawala Chilowa, K., Yip, C.-H., Partridge, A. H., & Brennan, D. J.. (2024). Managing menopause after cancer. *The Lancet*, 403(10430), 984–996. [https://doi.org/10.1016/s0140-6736\(23\)02802-7](https://doi.org/10.1016/s0140-6736(23)02802-7)

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

The third paper in The Lancet series on Menopause, *Promoting good mental health over the menopause transition* [1], reviews the risk for mental health conditions over the menopause transition. The authors conclude that there is no compelling evidence for a uniform increase in major depressive disorder or depressive symptoms (which can be disruptive but present at a sub-clinical threshold). However, some subpopulations are vulnerable and primary carers should place greater focus on identifying and supporting individuals with these risk factors.

The sub-populations that are at higher risk of presenting with depressive symptoms include:

- Individuals with vasomotor symptoms (VMS) that are severe or disrupt sleep.
- Individuals experiencing a long-duration menopausal transition.
- Individuals experiencing psychosocial risk factors, e.g. financial stress, unemployment, or stressful life events.
- Individuals who are vulnerable to fluctuations in sex hormones (notably oestradiol variability and declining progesterone) may be more likely to experience depressed mood.

Individuals with a prior history of major depressive disorder also have an increased risk of experiencing major depressive disorder over the menopause transition.

The authors also found no compelling evidence that the risk of anxiety, bipolar disorder, or psychosis was universally elevated. However, they note that data on these topics was scarce.

Recommendations:

The risk of experiencing psychological symptoms during the menopause transition is not uniform, and clinicians should not assume that psychological symptoms are the result of hormonal changes. They should be aware of populations vulnerable to depressive symptoms, including individuals with a previous history of major depressive disorder, those with severe or prolonged vasomotor symptoms, sleep disturbance or experiencing stressful life events.

References:

1. Brown, L., Hunter, M. S., Chen, R., Crandall, C. J., Gordon, J. L., Mishra, G. D., Rother, V., Joffe, H., & Hickey, M M. (2024). Promoting good mental health over the menopause transition. *The Lancet*, 403(10430), 969–983. [https://doi.org/10.1016/s0140-6736\(23\)02801-5](https://doi.org/10.1016/s0140-6736(23)02801-5)

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;

Applying the principles of health empowerment to menopause

The first paper in The Lancet menopause series, *An empowerment model for managing menopause* [1], proposes that the principles of health empowerment should be applied to menopause. The current disease-based approach, common in high-income countries, views menopause as a hormone deficiency disease with symptoms and long-term health risks best managed by hormone replacement therapy. The over-medicalisation of menopause can lead to disempowerment and over-treatment.

Taking a health empowerment approach would provide women with evidence-based information on symptoms and treatments, empathetic clinical care, and workplace adjustments. The principles of empowerment have not yet been applied to menopause. In other health domains, empowerment is considered an effective tool for optimising the self-management of health and reducing healthcare costs.

In our proposed model, empowering women to manage menopause includes:

- Access to **realistic and balanced information**, preferably before the onset of menopause. Women need access to unbiased, easy-to-understand information that is not influenced by industries or organisations attempting to sell medications, remedies, or services. Women also need to be aware of symptoms' likely nature, duration, and impact.
- Access to **tools supporting decision-making** about treatments, including non-pharmacological and non-hormonal options.
 - MyMenoPlan (<https://mymenoplan.org/>) was developed by the US National Institutes of Health (NIH) without commercial funding. It provides evidence-based information about what to expect over the transition and tools to understand what stage of the transition a woman is in and to develop a treatment plan based on their symptoms, risk preferences, health issues, and preferences for taking or avoiding medication.
- Access to **supportive and informed clinicians** willing to listen and offer treatment if necessary. Clinicians also need to be aware of the cultural and social differences.
- **Shared decision making**
- A **menopause-friendly work environment**, including informed management and, where possible, flexible work hours and practical adjustments to uniforms and air temperature.
 - Menopause at Work (<https://www.menopauseatwork.org/>) is an open-access suite of resources to help workplaces support menopausal transitions.

- A society-wide approach to **challenge stigma and gender-based ageism** that views menopause as the beginning of a period of decline and decay.

Recommendation: Encourage a paradigm shift away from the medicalisation of menopause and towards a health empowerment approach to optimise self-management of women's health and wellbeing during and after the menopause transition.

Immigrant perspectives on menopause

Evidence on the perceptions and attitudes towards menopause has been studied worldwide. Systematic international reviews conducted by CRE WaND researchers investigated immigrant women's experiences of menopause, their perceptions of menopause-specific healthcare, and their self-management strategies. The findings were similar across studies: immigrants reported more vasomotor and mental health symptoms and poorer overall health than non-immigrants, their self-management strategies were influenced by their culture of origin, and they were mostly dissatisfied with the clinical care that they had received.

Immigrant women's culture of origin shaped their beliefs about menopause. Generally, in cultures and societies where women gain social status during or after menopause by becoming an 'elder', attitudes towards menopause are positive, and any physical symptoms are mostly managed with lifestyle changes [2]. A decline in health or wellbeing after menopause was accepted as a normal part of ageing that didn't require medical attention [2] [3].

Caution must be taken when generalising global findings to an Australian context. The majority of studies explore women's symptoms of menopause. Very few used qualitative research methods to explore perceptions and beliefs about menopause.

Menopause in the context of Australian CALD and First Nations Peoples

Despite the increasing numbers of multicultural groups in Australia, studies on menopause and perimenopause with CALD and First Nations populations are limited to a handful of small qualitative studies. This limits generalisability to specific population group(s). There is a need to investigate cultural and societal factors influencing perceptions and attitudes toward menopause and perimenopause in migrant women and First Nations women in an Australian context.

Australian Indigenous women

Only one study has explored perceptions and experiences about menopause in First Nations women in Australia. Data was collected in 2011-12 from interviews with 25 women in Geraldton, Western Australia. The study's age and specific geographic area limit the generalisation of these findings to other populations.

Amongst the women in Geraldton, vasomotor symptoms were common, but psychological symptoms like mood change were the most distressing. These symptoms were often misattributed to 'going mad' unless the women had sought health care. Menopause being 'women's business' and therefore not discussed openly contributed to low health literacy around perimenopause and consequently to women not seeking help for symptoms. Although labelled 'women's business', the women interviewed also felt that the men in their lives would be more supportive if they understood more about menopause too. Fear that their symptoms were due to an illness also contributed to the women's trepidation to seek help for bothersome symptoms and indicated a need for

more information. Women's attitudes towards menopause were mixed; however, there was a perception that it marked the next stage of life, a time when women gained more respect from their community [4].

Immigrant women from Horn of Africa Nations

The CRE WaND team initiated a qualitative study that explored menopause-related health literacy and experiences of menopause-related health care among women from Horn of Africa nations – Eritrea, Ethiopia, South Sudan, and Sudan. The 11 women interviewed had migrated to Melbourne, Australia. The women viewed menopause as a normal life phase that did not warrant accessing menopause-related information and care. They preferred healthcare providers who could speak their language but were unhappy with their lack of proactive engagement in providing menopause-related information. Limited education, low literacy and being unfamiliar with the internet were barriers to health literacy among these women [5].

Immigrant women from Vietnam

Another CRE WaND-led qualitative study explored menopause-related health literacy and experiences with menopause-related health care among Vietnamese-born women. In this qualitative study, 12 interviews were conducted with women living in Melbourne who had migrated as adults. The women identified menopause as a natural event and obtained menopause-related information from family and friends. They felt that Vietnamese-speaking general practitioners were a reliable source of health information. However, 'shyness' prevented them from asking menopause-related health questions, and their GPs didn't initiate these conversations either. Limited English language proficiency affected these women's capacity to access, understand, evaluate, and use menopause-related health information [6].

Literacy and health literacy

Health literacy is a person's ability to understand, evaluate and use health-related information. Low health literacy is more common in people from culturally and linguistically diverse (CALD) backgrounds who experience language and cultural barriers to accessing health services and information. According to the 2016 Census, 22.5% of the immigrant population who arrived in Australia between 2011 and 2016 had very poor knowledge of English or very limited English or didn't speak English at all.

Researchers from CRE WaND reviewed the accessibility of Australian internet-based information on women's midlife health issues. We focused on information available to women with low health literacy or from culturally and linguistically diverse backgrounds. Overall, we found gaps in accessible online health information for women from CALD backgrounds and with low health literacy. Only five of the 16 reviewed websites had information in languages other than English – primarily text-based factsheets. The Jean Hailes for Women's Health Website and the Victorian Government's health website contained the most accessible information [7].

Recommendations:

- Research on the cultural and societal factors influencing perceptions and attitudes toward menopause and perimenopause among culturally and linguistically diverse populations is scarce and cannot be generalised to other populations. Given that the menopausal transition offers the opportunity to promote healthy ageing, investment into research on the influences of the culture of origin towards menopausal perceptions and management of related

symptoms is needed, followed by robust translation and implementation of practical research findings, which are codeveloped to meet the needs of target populations.

References

1. Hickey, M., Lacroix, A. Z., Doust, J., Mishra, G. D., Sivakami, M., Garlick, D., & Hunter, M. S. (2024) An empowerment model for managing menopause. *The Lancet*, 403(10430), 947–957. DOI: [10.1016/s0140-6736\(23\)02799-x](https://doi.org/10.1016/s0140-6736(23)02799-x)
2. Stanzel K., Hammarberg K. & Fisher J. (2018) Experiences of menopause, self-management strategies for menopausal symptoms and perceptions of health care among immigrant women: a systematic review. *Climacteric*. 21(2):101-110. DOI: [10.1080/13697137.2017.1421922](https://doi.org/10.1080/13697137.2017.1421922).
3. Stanzel K.A., Hammarberg K. & Fisher J. (2021) Challenges in menopausal care of immigrant women. *Maturitas*. 150: 49-60 DOI: [10.1016/j.maturitas.2021.05.008](https://doi.org/10.1016/j.maturitas.2021.05.008)
4. Jurgenson J., Jones E., Haynes E., Green C. & Thompson S., (2014). Exploring Australian Aboriginal Women's experiences of menopause: a descriptive study. *BMC Women's Health*, 14:47 DOI: [10.1186/1472-6874-14-47](https://doi.org/10.1186/1472-6874-14-47)
5. Stanzel K.A., Hammarberg K. & Fisher J. (2021) Not everybody is an internet person, Barriers for menopause-related health literacy among migrant women from the Horn of Africa, *Health Promotion Journal of Australia*, 32, S1 p. 61-68. 2. DOI: [10.1002/hpja.326](https://doi.org/10.1002/hpja.326)
6. Stanzel K., Hammarberg K., Nguyen T. & Fisher J. (2020) 'They should come forward with the information': menopause-related health literacy and health care experiences among Vietnamese-born women in Melbourne, Australia. *Ethnicity & Health*. 31():1-16. DOI: [10.1080/13557858.2020.1740176](https://doi.org/10.1080/13557858.2020.1740176).
7. Bandyopadhyay, M., Stanzel, K., Hammarberg, K., Hickey, M. and Fisher, J. (2022) Accessibility of web-based health information for women in midlife from culturally and linguistically diverse backgrounds or with low health literacy. *Australian and New Zealand Journal of Public Health*. 46: 269-274. DOI: [10.1111/1753-6405.13192](https://doi.org/10.1111/1753-6405.13192)

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;

Diagnostic delays for premature and early menopause

The typical age for menopause is 50-51 years. However, early menopause, defined as menopause between the ages of 40 and 44 years, affects around 12% of women globally. A further 2-4% experience premature menopause, also referred to as premature ovarian insufficiency (POI) [1].

As a consequence of reaching menopause at an earlier age, many individuals are also at increased risk of future chronic diseases, including osteoporosis and cardiovascular disease and would benefit from earlier interventions. However, evidence for the efficacy of pharmacological treatments (including Menopausal Hormone therapy and non-pharmacological treatments) is largely based on studies of women who experience POI or menopause at the typical age [1].

A clinical framework for the diagnosis and management of early menopause

While clinical guidelines exist for the diagnosis and management of POI, there are no guidelines for diagnosing and supporting early menopause. Individuals who experience early menopause face diagnostic delays of 2-5 years, and many see multiple clinicians during this time [1]. These individuals may experience significant distress and feel less supported than those who reach menopause at the average age.

We have developed a practical framework to guide clinicians through the diagnosis and treatment of early menopause. This framework is detailed in the second paper in The Lancet menopause series, *Optimising health after early menopause* [1]. The framework (see Figure 1) takes into account the severity of an individual's symptoms, their age and medical history, and their priorities and preferences for treatment of symptoms and long-term health.

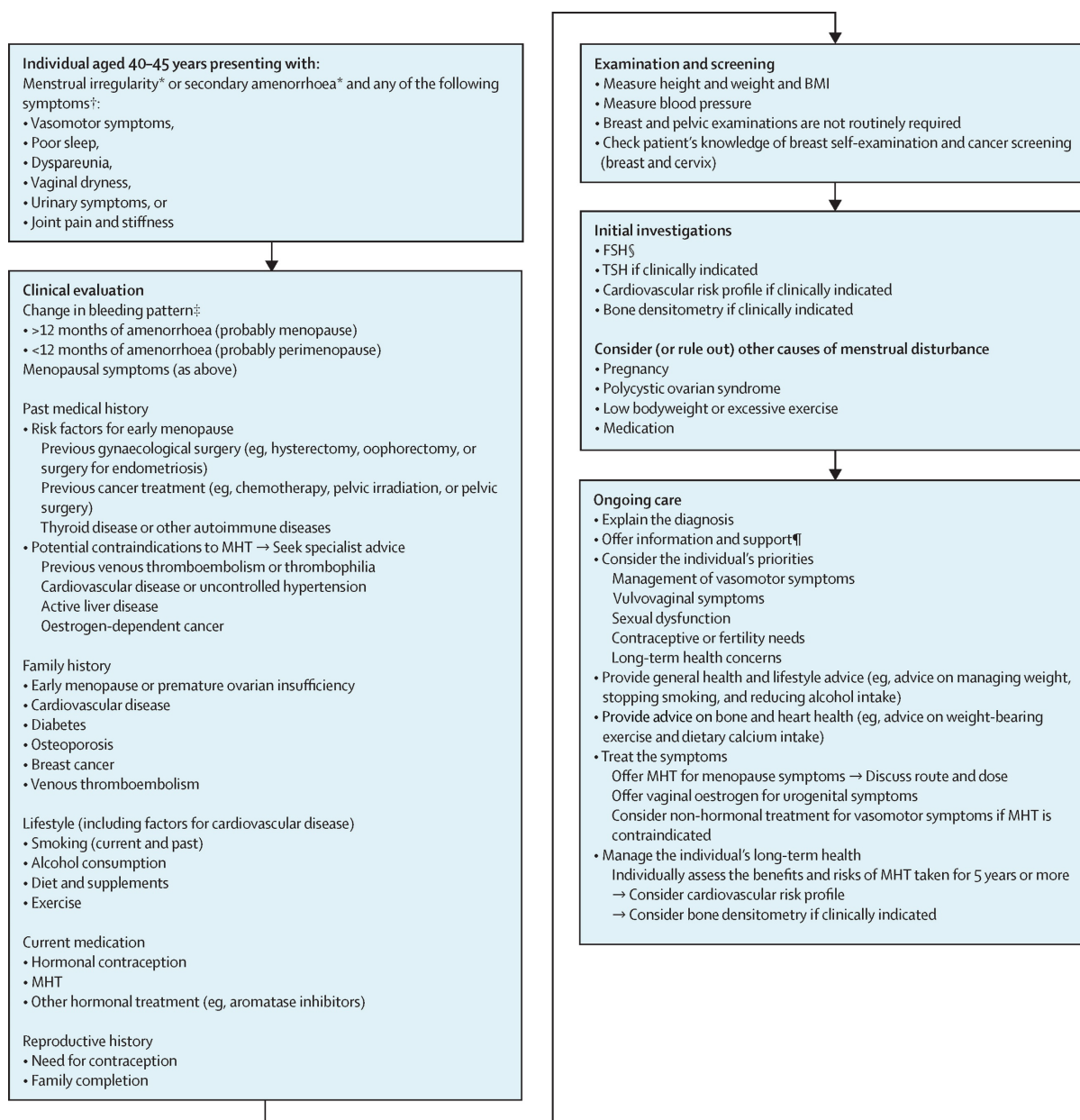


Figure 1: Practical framework for diagnosis, evaluation, and management of early menopause from *Optimising health after early menopause*, Mishra, G. D. et al. *The Lancet*, Volume 403, Issue 10430, 958 - 968

Recommendations:

- Establish the causes of early natural menopause to understand who is at risk, especially in diverse populations.
- Reduce diagnostic delay of early menopause through better education for women and clinicians and the application of clinical guidelines to support diagnosis and management.
- Assess the safety and effectiveness of pharmaceutical and non-pharmaceutical treatment options to manage the symptoms of early menopause, improve quality of life, and reduce chronic disease risk.

Early menopause in diverse populations.

In high-income countries, around 8% of women experience early menopause between the ages of 40-44 years. In middle and low-income countries, the prevalence can be much higher. For example, in China, the prevalence of early menopause is around 11%, and in India, it is much higher, at 20.2% [1]. Growth in migration to Australia, particularly from these two countries, highlights the importance of establishing whether individuals from culturally and linguistically diverse populations are more likely to experience early menopause.

Migrant women's experiences of menopause-related care

An anonymous online survey conducted by the CRE WaND research team explored primary healthcare providers' (PHCPs) views about the menopause-related care needs of migrant women from low- and middle-income countries. The PHCPs believed that migrant women from low- and middle-income countries had limited knowledge of menopause, difficulty accessing information, and were unlikely to initiate conversations about menopause-related health issues. Despite this, less than a third of PHCPs routinely offered menopause-related information during consultations. They cited short appointments, lack of culturally and linguistically appropriate menopause information, and lack of confidence in providing menopause-related care as the main barriers to providing comprehensive menopause-related care to migrant women [2].

Recommendations: In our survey, the majority of PHCPs agreed that in order to provide comprehensive menopause health consultations to migrant women from CALD backgrounds, they need:

- a Medicare item number reflecting the time involved
- a practice nurse with qualifications in women's health
- women's health services where migrant women can be referred
- a one-stop website that provides health information in relevant community languages
- accessible interpreter services.

References:

1. Mishra, G. D., Davies, M. C., Hillman, S., Chung, H.-F., Roy, S., Maclaran, K., & Hickey, M. (2024) Optimising health after early menopause. *The Lancet*, 403(10430), 958–968. DOI: [10.1016/s0140-6736\(23\)02800-3](https://doi.org/10.1016/s0140-6736(23)02800-3)
2. Stanzel K., Hammarberg K. & Fisher J. (2019) Primary health care providers' attitudes and beliefs about the menopause-related health care needs of women who have migrated from low- and middle-income countries to Australia. *Australian Journal of Primary Health*. 26(1):88-94. DOI:[10.1071/PY19132](https://doi.org/10.1071/PY19132).