Menopause

Policy Position Statement

Key messages:

PHAA supports women's rights to high-quality information regarding perimenopause, menopause, and post-menopause, the health issues associated with these; and the right to make informed choices regarding their perimenopausal and post-menopausal care.

PHAA also acknowledges that some individuals who undergo menopause do not identify as women. PHAA is committed to inclusion and respect for our members and the wider community.

Key policy positions:

1. Need for continued awareness regarding perimenopause, menopause, and post-menopause, in the context of whole person health and in different settings including families, communities, health care services, and workplaces.
2. Advocate for improved availability, accessibility, and affordability of primary care for women undergoing menopause.
3. Need for health professionals' continued knowledge and awareness about menopause, and best practice guidelines for perimenopausal and post-menopausal care.

Audience: Federal, State and Territory Governments, policymakers and program managers, PHAA members, media.

Responsibility: PHAA Women's Health Special Interest Group

Date adopted: September 2023

Contacts: Abela Mahimbo, abela.mahimbo@uts.edu.au ; Kate Levett, kate.levett@nd.edu.au; Karen Magraith, karens.magraith@bigpond.com; Ruchita Bhansali, ruchitabhansali26j@gmail.com

Citation: Menopause: Policy Position Statement [Internet]. Canberra: Public Health Association of Australia; 2023. Available from: URL

Menopause

Policy position statement

PHAA affirms the following principles:

1. Women have the right to accessible and high-quality information regarding perimenopause, menopause, and post-menopause; and the health issues associated with these.
2. Women have the right to make informed choices regarding their perimenopausal and post-menopausal care.

PHAA notes the following evidence:

3. Menopause is a natural part of biological ageing, a life stage is defined as the final menstrual period (a retrospective diagnosis that is made 12 months later), or the permanent cessation of ovarian function (a more appropriate definition e.g. for women who don't have periods due to a hysterectomy, or menopause occurs when the ovaries are removed). The time leading up to menopause, when women may have changes in their menstrual cycles, such as hot flushes (vasomotor symptoms), sleep disturbance, cognitive changes, mental health symptoms or other symptoms, are due to marked fluctuations in hormones. This is referred to as the menopausal transition (perimenopause) occurring typically between the ages of 45 and 55 years.[1]

4. Early onset of menopause (under 45) and premature menopause (under 40) is not necessarily self-occurring or predetermined. They can be spontaneous or caused by medical or surgical treatments.[2] Women with early/premature menopause need comprehensive assessment, treatment, and support.

5. The menopausal transition and its correlate stages[3] can last for several years in some women, affecting their physical, emotional, mental, and social well-being.[1] This time period is often associated with the most significant symptom burden, due to neurobiochemical changes in the central nervous system.[4]

6. Post-menopausal, women are at an increased risk of several health conditions due to declining hormone levels, in particular an oestrogen deficit, which can significantly impact their quality of life. Perimenopause and post-menopausal women can be impacted by disorders of the central nervous system, mental health conditions, musculoskeletal, metabolic, and cardiovascular changes; skin and urogenital atrophy and sexual dysfunction.[5,6]

7. A systematic review conducted in 2014 suggested that available data for the prevalence of menopausal symptoms in Australian women are not sufficient to allow conclusive findings.[7] However, international data suggest that the prevalence and severity of symptoms are influenced by ethnicity and geographical location.[6]

8. A more recent study conducted among 2020 women living independently in Australia in 2018 found that 75% of post-menopausal women under 55 have vasomotor symptoms (hot flushes/night sweats) and 28% of postmenopausal women under 55 experience moderate to severe bothersome vasomotor symptoms.[8]

9. Menopausal symptoms are known to affect quality of life and work productivity. A 2021 study found 83% of women experiencing menopause were affected at work, but only 70% would feel comfortable speaking with their manager about it highlighting the need for increased advocacy on menopause in workplaces.[9]

10. A woman's prior health, reproductive history, lifestyle, and environmental factors determine their health status during the perimenopausal period highlighting the importance of a whole person, life-course approach in women's sexual and reproductive health.[1]

11. Social determinants like education, culture, and the social context influence women's knowledge, attitudes, and experiences of menopause as well as access to perimenopausal and post-menopausal care. [10,11] Specifically, Aboriginal and Torres Strait Islander [12] and culturally and linguistically diverse (CALD) women [13,14] may have different understandings and needs during the menopausal transition calling for more culturally responsive and sensitive services to meet their specific needs.

12. Currently, there is a gap in accessible online health information on menopause for Australian midlife women from CALD backgrounds and those with low or limited health literacy.[15]

13. Menopausal hormone therapy (MHT) is the most effective treatment for vasomotor symptoms and its benefits may exceed risks for the majority of symptomatic postmenopausal women (who are less than 60 years of age or under 10 years since the onset of menopause).[16]

14. Other treatment options include low-dose vaginal estrogen for genitourinary symptoms, and vaginal moisturisers and lubricants for those not choosing hormonal therapy.[16]

15. Non-pharmacological treatments such as cognitive-behavioural therapy, yoga, Chinese medicine, and lifestyle changes have also been shown to be effective in improving vasomotor symptoms and menopause-related quality of life.[17,18]

16. While there are a variety of interventions to help alleviate perimenopausal and postmenopausal symptoms, menopause remains to be a taboo topic rarely discussed within families, communities, workplaces, or healthcare settings. [1] The presence and severity of symptoms experienced may also be predictive of future health conditions, such as high blood pressure or dementia risk.[6] Awareness of and access to high-quality perimenopausal and post-menopausal care is key to healthy ageing and improved quality of life for all women.[1]

17. Some gynaecological and urogenital changes occur in post-menopausal women due to changes in physiology and hormone distribution, which may often go unaddressed due to being overlooked [1] hence the need for person-centred care tailored to meet the individual needs and concerns of every woman. Post-menopausal women may also be at a greater risk of exposure to sexually transmitted infections.[19]

18. Access to comprehensive assessment including screening activities, health promotion, and an individualised discussion of treatment options for women with symptoms is key for effective management. The best place for this to occur is primary care (with the involvement of a team comprising nursing, allied health practitioners, and specialists as required). Despite this, there is currently a crisis in the availability, accessibility, and affordability of primary care resulting in women missing out on care at menopause.

19. There are also significant gaps in health professions' training and understanding of the menopausal

transition, which does not adequately acknowledge the complexities associated with menopause. [20]

20. Implementing this policy would contribute towards the achievement of UN Sustainable Development Goals 3 – Good Health and Wellbeing. and 5 - Achieve gender equality and empower all women and girls

PHAA seeks the following actions:

21. Further research is required to more accurately establish the prevalence and severity of menopausal symptoms in Australian women.

22. Australian women need to be empowered with knowledge regarding the physiological, psychological and social changes in perimenopause, menopause, and post-menopause, so they can proactively seek perimenopausal and post-menopausal care.

23. Further research and understanding of the experiences of menopause among Aboriginal and Torres Strait Islander women are needed to enhance management and support for this group.

24. More accessible health information resources on menopause are needed for women in midlife from CALD backgrounds and those with low health literacy.

25. Further research on how women's experiences at perimenopause and menopause affect their engagement at work (both in paid employment and in other roles) is needed.

26. Increased advocacy on menopause in workplaces through the implementation of menopause awareness programs as these have been associated with improved work and social adjustment for those going through menopause and enhanced knowledge and attitudes of both employees and line managers/supervisors, cultivating a supportive and inclusive work environment. [21]

27. Increased access to comprehensive assessment and management for women undergoing menopause in primary care. There should also be an emphasis on continuity of care as women's needs change as they move through perimenopause to post-menopause.

28. Health care professionals should be adequately trained on menopause physiology and offer non-discriminative, confidential, and culturally appropriate care to improve the quality of life for women undergoing menopause. There should be an emphasis on whole-person or person-centred care focusing on the individual needs of women and high-quality contextualised care plans.

PHAA resolves to:

29. Advocate for the above steps to be taken based on the principles in this position statement.

ADOPTED September 2023

References

1. World Health Organisation. Menopause. https://www.who.int/news-room/fact-sheets/detail/menopause
2. Shuster LT, Rhodes DJ, Gostout BS, Grossardt BR, Rocca WA. Premature menopause or early menopause: long-term health consequences. Maturitas. 2010;65(2):161-6.
3. Harlow SD, Gass M, Hall JE, Lobo R, Maki P, Rebar RW, Sherman S, Sluss PM, De Villiers TJ, STRAW+ 10 Collaborative Group. Executive summary of the Stages of Reproductive Aging Workshop+ 10: addressing the unfinished agenda of staging reproductive aging. Climacteric. 2012;15(2):105-14.
4. Woods NF, Mitchell ES. Symptoms during the perimenopause: prevalence, severity, trajectory, and significance in women's lives. The American journal of medicine. 2005;118(12):14-24.
5. Dalal PK, Agarwal M. Postmenopausal syndrome. Indian journal of psychiatry. 2015;57(Suppl 2):S222.
6. Monteleone P, Mascagni G, Giannini A, Genazzani AR, Simoncini T. Symptoms of menopause—global prevalence, physiology and implications. Nature Reviews Endocrinology. 2018;14(4):199-215.
7. Gartoulla P, Islam MR, Bell RJ, Davis SR. Prevalence of menopausal symptoms in Australian women at midlife: a systematic review. Climacteric. 2014;17(5):529-39.
8. Gartoulla P, Worsley R, Bell RJ, Davis SR. Moderate to severe vasomotor and sexual symptoms remain problematic for women aged 60 to 65 years. Menopause. 2015;22(7):694-701.
9. Circle In (2021). *Driving the change: Menopause and the workplace.* Retrieved from: https://circlein.com/research-and-guides/menopause-at-work/
10. Namazi M, Sadeghi R, Behboodi Moghadam Z. Social determinants of health in menopause: an integrative review. International Journal of Women's Health. 2019;637-47.
11. Constantine GD, Graham S, Clerinx C, Bernick BA, Krassan M, Mirkin S, Currie H. Behaviours and attitudes influencing treatment decisions for menopausal symptoms in five European countries. Post Reproductive Health. 2016; 22(3):112-22.
12. Jones EK, Jurgenson JR, Katzenellenbogen JM, Thompson SC. Menopause and the influence of culture: another gap for Indigenous Australian women?. BMC Women's Health. 2012;12:1-0.
13. Stanzel KA, Hammarberg K, Nguyen T, Fisher J. 'They should come forward with the information': menopause-related health literacy and health care experiences among Vietnamese-born women in Melbourne, Australia. Ethnicity & Health. 2022;27(3):601-16.
14. Strezova A, O'Neill S, O'Callaghan C, Perry A, Liu J, Eden J. Cultural issues in menopause: an exploratory qualitative study of Macedonian women in Australia. Menopause. 2017;24(3):308-15.
15. Bandyopadhyay M, Stanzel K, Hammarberg K, Hickey M, Fisher J. 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. 2022;46(3):269-74.
16. Stuenkel CA, Davis SR, Gompel A, Lumsden MA, Murad MH, Pinkerton JV, Santen RJ. Treatment of symptoms of the menopause: an endocrine society clinical practice guideline. The Journal of Clinical Endocrinology & Metabolism. 2015;100(11):3975-4011.
17. Diem SJ, LaCroix AZ, Reed SD, Larson JC, Newton KM, Ensrud KE, Woods NF, Guthrie KA. Effects of Pharmacologic and Non-pharmacologic Interventions on Menopause-related Quality of Life: A Pooled Analysis of Individual Participant Data from Four MsFLASH Trials. Menopause (New York, NY). 2020;27(10):1126.
18. Taylor-Swanson L, Thomas A, Ismail R, Schnall JG, Cray L, Mitchell ES, Woods NF. Effects of traditional Chinese medicine on symptom clusters during the menopausal transition. Climacteric. 2015 Mar 4;18(2):142-56.

19. Lusti-Narasimhan M, Beard JR. Sexual health in older women. Bulletin of the World Health Organization. 2013; 91:707-9.
20. Macpherson BE, Quinton ND. Menopause and healthcare professional education: A scoping review. Maturitas. 2022. https://doi.org/10.1016/j.maturitas.2022.08.009
21. Rodrigo CH, Sebire E, Bhattacharya S, Paranjothy S, Black M. Effectiveness of workplace-based interventions to promote wellbeing among menopausal women: A systematic review. Post Reproductive Health. 2023;29)