Submission by the Australian Nursing and Midwifery Federation

Response to the Senate Community Affairs Reference Committee for inquiry into the issues relating to menopause and perimenopause

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Australian Nursing & Midwifery Federation

Annie Butler
Federal Secretary

Lori-Anne Sharp
Federal Assistant Secretary

Australian Nursing and Midwifery Federation
Level 1, 365 Queen Street, Melbourne VIC 3000
E: anmffederal@anmf.org.au
W: www.anmf.org.au

Introduction

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 320,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

The ANMF welcomes the opportunity to provide feedback to the Senate Community Affairs Reference Committee for the inquiry into the issues related to menopause and perimenopause. This submission responds to the Terms of Reference published on 6 November 2023.

As female-dominated professions, nursing and midwifery and subsequently our nurse, midwife and care worker members have a strong interest in issues related to both the provision of care for and experience of menopause and perimenopause. As people are living longer, women are spending up to one-third of their lives in post-menopause. [1]

In 2020, the ANMF contributed a chapter to a book exploring women's experiences with menopause, titled *M-Boldened: menopause conversations we all need to have*.[2] Chapter 17, *Nursing the menopause* provided the ANMF with the opportunity to bring together voices from

across our membership to reflect on their experiences of menopause. ANMF members were uniquely placed to speak on menopause, as not only do many personally face menopause during their careers, but they also carry the responsibility of caring for those experiencing it. Nurses and midwives are well positioned with expert professional knowledge of both the physical and psychological symptoms alongside a commitment to improving health outcomes for women. However, they too deserve support during the menopausal years. Sharing stories, support and connections with friends, family, and peers, along with access to universal healthcare, positive work environments and professional support, are all crucial during menopause. It is essential for there to be an environment where woman can feel safe and supported in sharing their individual experiences of menopause. The stories of our members, Anita Stirling, Sema Mustafa, Elaine Blower, and Faye Clarke, provide important and illuminating insights on nurses personal, professional, and cultural experiences of menopause and perimenopause.

Terms of Reference

Issues related to menopause and perimenopause, with particular reference to:

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

Approximately 90,200 nurses and midwives between the ages of 45 and 54 currently hold registration in Australia.[3] Nursing and midwifery are consistently feminised professions. Women make up approximately 87.3% of this workforce, and therefore the economic consequences of reduced workforce participation and productivity are substantial.[4] Maintaining an attractive workplace for women is integral to ensuring adequate skill mix and workforce size. Ongoing workforce participation is important for the general wellbeing of the women affected by menopause symptoms, particularly for their long-term savings and retirement income. In order to close the gender workplace gap, women need equitable workplace participation opportunities. There are more than 1,700 nurses and midwives in this age group holding non-practicing registration.[5] Determining the barriers to these workers' return to work will help to relieve pressures on the workforce.

As nursing and midwifery are highly female-dominated professions, the economic consequence of menopause and perimenopause is of particular relevance to ANMF members. The nature of nursing and midwifery as 24-hour professions places unique demands on the metabolic health of its workers. A registered nurse and ANMF member said "As I have grown older, and started experiencing menopause, I have experienced poor coping… lack of sleep which impacts my quality of life when I work nights. I reduced my hours… but [while working] 0.8 I am still expected to work four 10-hour night [shifts per month]." Circadian disruption has been correlated to earlier onset of menopause symptoms, which carries an increased risk of adverse health outcomes.[6]

An American analysis of 2001-2010 medical claims data found that women who were diagnosed with menopause symptoms (and aged 40+) had significantly higher medical, pharmacy, and sick leave costs. Further, they used more sick leave and had significantly reduced hourly and annual work productivity.[7] Menopause is often instigated by other medical interventions (cancer treatment, ceasing hormonal contraception, surgery, genetic abnormalities, metabolic disorders) which can also impact use of sick leave and long service leave. Women are more likely to work part-time, leaving them with less sick leave and long service leave, fewer advancement opportunities, and less superannuation accrued throughout their career.

A small study of Dutch women (n=60) experiencing menopause symptoms found they were 8.4 times more likely than women who were not experiencing menopause to report their workability as low and had significantly higher Greene Climacteric Scale scores suggesting higher levels of psychological, somatic, vasomotor, and sexual complications. Further, the women experiencing menopause had significantly lower Work Ability Index scores, meaning they reported being less able to perform duties due to physical and mental work demands.[8]

A study using the National Child Development Survey (NCDS) which is a birth cohort survey following all those born in one week in England, Scotland and Wales in 1958, collected data on time in employment and work histories and found that women who were identified as experiencing early menopause (before aged 45) spent significantly less time in employment in their 50's by a factor of 9 percentage points, compared to women who did not experience early menopause. Further, the number of menopause symptoms faced at age 50 led to reduced full-time employment rates by around 1-2% per additional psychological symptom reported.[9]

Menopause symptoms among health practitioners can lead to reduced performance, absenteeism, and intention to leave the profession in favour of a less demanding position.[10] Appropriate interventions and supports are therefore needed to help retain experienced nurses, midwives, and personal care workers, and reduce gender inequity inherent in the workplace[11]. This is of particular importance considering the increasing average age of health workers, increased retirement-aged, and decreased attraction of new to workforce workers. Addressing the inequalities which arise in menopause and perimenopause is integral to the objectives of gender equity.

Having sympathetic managers, working from an evidence-based perspective, can help workers to manage menopause symptoms. A 65-year-old Registered Nurse who works full time night shift was told by her manager having a small fan to help with temperature regulation through menopause is an infection control risk. There is no evidence to suggest that portable fans spread infection in low-risk areas without directional airflow. Minor changes to work environments which may drastically improve workers' comfort should be available and accessible.

Some suggested workplace interventions include: robust industrial safeguards delivering flexible working arrangements, increased sick leave, long service leave, and carers leave to facilitate symptom management and concurrent responsibilities, flexible working arrangements where appropriate, employee support programs including targeted exercise programs to maintain work fitness, mental health and specialist services, awareness training for managers, and menopause-friendly uniforms (including reinforced groin, sweat wicking fabrics, stretch).

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

Perimenopause is associated with a range of biological and psychological symptoms that can impact well-being, work performance, and everyday life functioning. Vulnerable populations, such as Aboriginal and Torres Strait Islander peoples, LGBTQI+ individuals, those from culturally and linguistically diverse backgrounds, people with physical or intellectual disabilities, socioeconomically disadvantaged people, or those who live rurally or remotely, may struggle to access appropriate care to reduce the physical impacts of menopause symptoms. Comorbidities

such as metabolic disorders, mental health conditions, cancers, or gynaecological issues, may exacerbate menopause and perimenopause symptoms, and may increase the risks associated with menopause, such as heart disease, stroke, and certain cancers.

The management of these symptoms and mitigation of their impact oftentimes requires access to healthcare services such as GPs for prescription medications and psychological health experts to assist with experience of anxiety and/or depression.[12,13] Access to treatment could be expanded and made more accessible by enabling nurses and nurse practitioners to work to full scope of practice and be given the ability to prescribe specialist women's health medication and treatments.

Nurses are uniquely suited to providing menopause and perimenopausal education to women, including healthy teaching and health education. Further, nursing interventions are key in reducing risk of comorbidities and the management of menopause symptoms.[14] Investing in the availability of women's health nurses is a cost-effective way to increase accessibility to preventative healthcare.

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

Changes in oestrogen and progesterone levels during perimenopause, menopause and post menopause can lead to mood swings and emotional susceptibility, further leading to increased risk of developing affective disorders such as depression or anxiety.[15,16] Trans men and women and non-binary people may experience menopause through a complex lens related to their gender identity and may require additional supports while facing high levels of discrimination and less understanding of their experience.

Menopause symptoms predict body esteem, which in turn affects overall self-esteem.[17] Robust employee assistance programs including specialist healthcare coverage and mental health services, can help to support individuals experiencing menopause and perimenopause. Women's health nurses with education and training in mental health supports are well-placed to manage menopause and perimenopause symptoms in psychologically vulnerable communities.

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

The burden of care responsibilities largely falls to women and for this reason the ANMF recognises that the intersection of work and care effects our membership on a daily basis.

In 2020, it was estimated that there were almost 2.8 million informal carers, comprised of around 906,000 primary carers and 1.9 million non-primary carers. The demand for informal carers is expected to grow by 23% from 2020 to 2030.[18]

The average age of carers in Australia was 51 according to the latest Australian Bureau of Statistics Survey of Disability, Ageing and Carers in 2018, and 75% of carers aged 45-54 were female.[19]

The median divorce age for women is rising, currently at 43.0 years for females.[20] This is indicative of people generally marrying later in life, but with the median age of divorce landing just prior to the average age of menopause, this puts additional pressure on women at this point in their life.

The average age of first-time mothers in Australia is 31.1, meaning that during menopausal years, many women will be responsible for at least one child in addition to the caring responsibilities of ageing parents and family members.[21] "Sandwich" generation caregivers, providing care to the generation above and below simultaneously, report substantial financial and emotional difficulties, high caregiver role overload, and low use of support services, with high labour force participation.[22]

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;

Our understanding of menopause is primarily based on research undertaken in Caucasian populations.[23] While there is little research that focuses on menopause among First Nations communities, there is significant research that demonstrates that biological, cultural, socioeconomic and lifestyle factors impact upon perceptions and experiences of menopause.[24,25] Considering the disproportionate rates of adverse health outcomes among First Nations and lower rates of healthcare access, it can be reasonably assumed that First Nations women would experience higher rates of menopause comorbidities.

Addressing menopause experiences among First Nations communities and providing specialist support services that are culturally sensitive is required. The construction of appropriate, high-quality, culturally safe resources could assist in preventing cultural stigma and reducing barriers to accessing care. The New South Wales government published a menopause and perimenopause checklist targeted towards multiple ethnic groups, Aboriginal and Torres Strait Islander peoples, and people with intellectual disability in 2023.[26]

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;

A small Australian study (n=32) found that 75% of postmenopausal Australian women younger than 55 years of age are not using menopausal hormone therapy, which has been identified as the most effective treatment.[27] [14]Results suggest that health practitioners are not adequately prescribing or informing women of menopausal treatments. This is supported by another Australian study that found that while 17% of women reported moderate to severe vasomotor symptoms only 11.3% of them used hormone therapy, the findings of which extrapolated suggest that 455,000 women are likely to have moderate to severe vasomotor symptoms, with most women (385,000) remaining untreated.[28] In a cross-cultural study around 50% of Australian women reported not knowing the risks and benefits associated with hormonal treatments.[29]

In a study of Australian women's understanding of menopause and its consequences among 32 Australian women, it was found that while most women reported being aware of menopause related symptoms and roughly what to expect, notably hot flushes and sweats, and mood changes, many were unaware of the healthcare options.

A small 2021 survey among 10 GPs, 10 Gynaecologists, and 10 Pharmacists found that the health practitioners were able to identify short and long-term symptoms however their knowledge and confidence of providing menopause related care was limited. Further, some of the practitioners noted difficulty in finding resources and a lack of menopause-specific education opportunities. All of the practitioners were supportive of further midlife women's health training.[30]

A survey among 117 Australian healthcare workers regarding their attitudes and beliefs about the menopause-related care needs of women who have migrated from low- and middle-income countries to Australia, found that less than one-third (29.9%) routinely provided menopause-related information to midlife migrant women. The healthcare workers stated that barriers included too short consultation times and a lack of culturally and linguistically appropriate resources about menopause and related issues.[31]

Access to treatment could be expanded and made more accessible by enabling nurses and nurse practitioners to work to full scope of practice and be given the ability to prescribe specialist women's health medicines and treatments.

Nurses are uniquely suited to providing menopause and perimenopausal education to women, including teaching and health education. Further, nursing interventions are key in reducing risk of comorbidities and the management of menopause symptoms.[32] Incentivising nurse's roles such as women's health nurses, in addition to expanding access to nurse practitioners' ability to prescribe, would reduce the requirement for this to be undertaken by GPs, gynaecologists, and pharmacists and increase geographic, financial, and approachable access to menopause and perimenopausal healthcare services.

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;

Most women are unwilling to discuss menopause related symptoms with line managers. Women have identified the required organisational support as 1) greater awareness among managers about menopause as a possible occupational health issue, 2) flexible working hours, 3) access to information and sources of support at work, and 4) attention to workplace temperature and ventilation.[33,34]

Circle In Victoria determined one in eight women experiencing menopause left the workforce due to their symptoms, and another two in eight would do so if they could afford to.[35] Increased awareness among employers is integral to keeping women in the workforce throughout perimenopause and menopause.

In the UK, a Menopause Employment Champion was established in order to tackle stigma and increase awareness of how menopause and perimenopause affects individuals in their career and in the workplace. A similarly public role in Australia may help to increase awareness amongst employers of workers, and encourage workplaces to promote workplace supports.

The ANMF advocates for Menstrual and Menopause Workplace Wellbeing Policies, including specified employment conditions providing for Menopause Leave (however titled).

h. existing Commonwealth, state and territory government policies, programs, and healthcare initiatives addressing menopause and perimenopause;

Jean Hailes for Women's Health

Circle In: Victorian Women's Trust

Family Planning Australia

Australasian Menopause Society Workplace Training

NSW Government Toolkit

Monash University *A Practitioner's Toolkit for Managing Menopause*

Victorian Department of Health *Listening to women's voices, Results of the Victorian women's health survey 2023*

i. how other jurisdictions support individuals experiencing menopause and perimenopause from a health and workplace policy perspective; and any other related matter.

United Kingdom Menopause Taskforce and Menopause Workplace Champion

More research is needed on the impacts of shift work during and before menopause and perimenopause.

Conclusion

The ANMF appreciates this opportunity to provide feedback to the Senate Community Affairs Reference Committee for the inquiry into the issues related to menopause and perimenopause. Despite the nursing and midwifery workforce being largely feminised, workers have not been immune to the gender pay gap phenomenon on a micro-level. Our female-dominated professions therefore have a strong interest in issues related to both the provision of care for, and experience of, menopause and perimenopause. The implications of gendered workplace discrimination are further exacerbated by the fact that nurses and midwives have been subjected to an historic undervaluation of their work. The ANMF therefore considers measures to address gender equality, as crucial to removing the economic and social penalties many of our members have encountered as a consequence of their gender. These measures are also vitally important in challenging the gender-based assumptions that have failed to allow for proper recognition of the highly skilled and technical work our members perform.

References

[1] Peacock K, Carlson K, Ketvertis, K, Doerr, C. (2023). Menopause (Nursing). https://www.ncbi.nlm.nih.gov/books/NBK568694/#:~:text=The%20nurse%20should%20educate%20the,health%20nurse%20should%20offer%20counsel.

[2] Harris C. (2021). M-Boldened: menopause conversations we all need to have. Cheltenham (UK): Flint.

[3] Nurse and Midwife Board of Australia. (30 September 2023). Nurse and Midwife – Registration Data Table. https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx.

[4] Peacock K, Carlson K, Ketvertis, K, Doerr, C. (2023) Menopause (Nursing). https://www.ncbi.nlm.nih.gov/books/NBK568694/#:~:text=The%20nurse%20should%20educate%20the,health%20nurse%20should%20offer%20counsel.

[5] Nurse and Midwife Board of Australia. (30 September 2023). Nurse and Midwife – Registration Data Table. https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx.

[6] University of New South Wales Social Policy Research Centre. (6 November 2023). Gender-based Occupational Segregation: A National Data Profile. Cortis, N, Naidoo, Y, Wong, M, Bradbury, B. Sydney: UNSW Social Policy Research Centre.

[7] Stock, D, Knight, JA, Raboud, J, Motterchio, M, Strohmaier, S, Willett, W, Eliassen, AH, Rosner, B, Hankinson, SE, Schernhammer, E. (2019). Rotating night shift work and menopausal age. *Human Reproduction*, 1;34(3):539-548. DOI 10.1093/humrep/dey390.

[8] Kleinman NL, Rohrbacker NJ, Bushmakin AG, Whiteley J, Lynch WD, Shah SN. (2019). Direct and indirect costs of women diagnosed with menopause symptoms. *Journal of Occupational and Environmental Medicine*. 55(4):465-70.

[9] Geukes M, Van Aalst MP, Robroek SJW, Laven JSE, Oosterhof H. (2016) The impact of menopause on work ability in women with severe menopausal symptoms. *Maturitas*. 90:3-8.

[9] Bryson A, Conti G, Hardy R, Peycheva D, Sullivan A. (2022) The consequences of early menopause and menopause symptoms for labour market participation. Social Science & Medicine. 293:114676.

[10] Vanderzalm J, Deschenes S, Kunyk D. (2023) Women's health nurses' experiences of menopause: Considerations for nurse leaders. *Nurs Manage*. 54(6):34-40.

[11] ANMF Submission to the Inquiry: Gender Segregation in the workplace and its impact on women's economic equality. 3 March 2017 https://www.anmf.org.au/media/kzbhslhi/anmf_submission_gender_segregation_in_the_workplace_and_its_impact_on_women.pdf

[12] Management of perimenopausal and menopausal symptoms. (2023). BMJ. 383:p2636.

[13] Burt VK, Altshuler LL, Rasgon N. (1998). Depressive Symptoms in the Perimenopause: Prevalence, Assessment, and Guidelines for Treatment. Harvard Review of Psychiatry. 6(3).

[14] Peacock K KK, Doerr C. Menopause (Nursing): StatPearls Publishing; 2022.

[15] Saˇgsöz N, Oˇguztürk Ö, Bayram M, Kamacı M. (2001). Anxiety and depression before and after the menopause. *Archives of Gynecology and Obstetrics*. 264(4):199-202.

[16] Mulhall S, Andel R, Anstey KJ. (2018). Variation in symptoms of depression and anxiety in midlife women by menopausal status. *Maturitas*. 108:7-12.

[17] Olchowska-Kotala A. (2018). Body esteem and self-esteem in middle-aged women. Journal of Women & Aging. 30(5):417-27.

[18] Deloitte Access Economics: The Value of Informal Care in 2020. deloitte-au-dae-value-of-informal-care-310820.pdf

[19] Australian Institute of Health and Welfare (07 September 2023). Informal Carers. https://www.aihw.gov.au/reports/australias-welfare/informal-carers .

[20] Australian Institute of Family Studies (March 2023). Divorces in Australia: Facts and figures 2023. https://aifs.gov.au/research/facts-and-figures/divorces-australia-2023.

[21] Australian Institute of Health and Welfare. (13 December 2023). Australia's mothers and babies. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/overview-and-demographics/maternal-age.

[22] Lei, L, Legget, AN, Maust, DT. (2022). A national profile of sandwich generation caregivers providing care to both older adults and children. *Journal of the American Geriatrics Society*. 71:799-809. DOI: 10.1111/jgs.18138.

[23] Davis, SR, Knight, S, White, V, Claridge, C., Davis, BJ, Bell, R. (2003). Climacteric symptoms among indigenous Australian women and a model for the use of culturally relevant art in health promotion. *Menopause: The Journal of the North American Menopause Society*. 10(4): 345-351. DOI: 10.1097/01.GME.0000054819.03576.43.

[24] Parsons MA, Obermeyer CM. (2007). Women's midlife health across cultures: DAMES comparative analysis. *Menopause.* 14(4):760-8.

[25] Jones EK, Jurgenson JR, Katzenellenbogen JM, Thompson SC. (2012). Menopause and the influence of culture: another gap for Indigenous Australian women? *BMC Women's Health*. 12(1):43.

[26] https://www.nsw.gov.au/toolkits-and-resources/perimenopause-and-menopause-toolkit/symptom-checklist?utm_source=miragenews&utm_medium=miragenews&utm_campaign=news.

[27] Herbert D, Bell RJ, Young K, Brown H, Coles JY, Davis SR. (2020). Australian women's understanding of menopause and its consequences: a qualitative study. *Climacteric.* 23(6):622-8.

[28] Worsley R, Bell RJ, Gartoulla P, Davis SR. (2016) Low use of effective and safe therapies for moderate to severe menopausal symptoms: a cross-sectional community study of Australian women. Menopause. 23(1):11-7.

[29] Sayakhot P, Vincent A, Teede H. (2012). Cross-cultural study: experience, understanding of menopause, and related therapies in Australian and Laotian women. *Menopause.* 19(12):1300-8.

[30] Davis SR, Herbert D, Reading M, Bell RJ. (2021) Health-care providers' views of menopause and its management: a qualitative study. *Climacteric*. 24(6):612-7.

[31] Stanzel KA, Hammarberg K, Fisher J. (2020) Primary healthcare providers' attitudes and beliefs about the menopause-related care needs of women who have migrated from low- and middle-income countries to Australia. *Australian Journal of Primary Health.* 26(1):88-94.

[32] Vanderzalm J, Deschenes S, Kunyk D. (2023) Women's health nurses' experiences of menopause: Considerations for nurse leaders. Nurs Manage. 54(6):34-40.

[33] Griffiths A, MacLennan SJ, Hassard J. (2013). Menopause and work: An electronic survey of employees' attitudes in the UK. *Maturitas*. 76(2):155-9.

[34]Jack G, Riach K, Bariola E, Pitts M, Schapper J, Sarrel P. (2016) Menopause in the workplace: What employers should be doing. *Maturitas.* 85:88-95.

[35] Circle In (30 March 2021). Driving the change: Menopause and the workplace. https://circlein.com/research-and-guides/menopause-at-work/.