Submission to the Senate Inquiry on Issues Related to Menopause and Perimenopause

Prepared by the Multicultural Centre for Women's Health

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Multicultural Centre for Women's Health is a feminist organisation led by migrant and refugee women to achieve equity in women's health and wellbeing.

Executive Summary

This submission has been developed by the Multicultural Centre for Women's Health (MCWH), a Victorian-based, national women's health service established in 1978 that works to promote the health and wellbeing of migrant and refugee[1] women and gender diverse people across Australia. We do this through research and publication, participation in advisory groups and committees, written submissions, health education and training and capacity building (see **MCWH Annual Report 2022 - 2023**).

As the national voice for migrant and refugee women's health and wellbeing, this submission uses an intersectional approach to discuss issues relating to menopause and perimenopause for migrant and refugee women and gender diverse people. We contend that reforms arising out of this Senate Inquiry need to recognise and address the role of societal structures — at the intersections of age, class, ability, race, ethnicity, health and socio-economic status — in contributing to menopause-related inequalities migrant and refugee women and gender diverse people experience. As such, all factors that play into stressors at midlife need to be addressed to ensure migrant and refugee women and gender diverse people are fully supported as they transition through menopause.

Australia continues to be a diverse nation; a significant proportion of the female population is born overseas (28.3%) and around 18% of women and girls born overseas arrived during or after 2016. Additionally, 48.5% of the female population in Australia stated that they had a parent who was born overseas.

MCWH recognises the Federal Government's commitment to respond to the intersecting health and wellbeing challenges faced by a growing population of migrant and refugee women as they navigate the life stages of menopause and perimenopause. Our recommendations are focused on creating equitable healthcare systems, strengthening social services, and fostering supportive workplaces that empower migrant and refugee women and communities to navigate menopause and perimenopause with dignity. Our key recommendations are:

1. Sustainably fund tailored programs that promote the leadership, workforce participation, career development, and civic and social inclusion of migrant and refugee women and gender diverse people, MCWH's PACE (Participate, Advocate, Communicate, Engage) Leadership Program is an example of a successful evidence-based leadership program that has been tailored for migrant and refugee women.
2. Remove visa restrictions that make migrant and refugee women more vulnerable to economic insecurity and financial abuse and implement policies that enhance their financial independence.
3. Embed intersectional analysis in policymaking to address the intersecting impacts of migration, social and economic security systems on the lives of migrant and refugee women and gender diverse people.
4. Implement 'reproductive leave' at workplaces that includes leave for treatment and management of perimenopause and menopause symptoms. This should extend across industries and employment types: casual, contract, part-time and full-time workers.
5. Extend healthcare and support services, including Medicare, PBS, NDIS, and social security payments, to include all migrants and refugees regardless of visa status. Including costs associated with diagnosis, treatment, mental health support, and integrative care related to the management of perimenopause and menopause.
    i. Implement Recommendation 30 (4.111) of the Senate Inquiry into Universal Access to Reproductive Healthcare: 'The committee recommends that the Australian government, in consultation with state and territory governments, consider options for ensuring the provision of reproductive health to all people living in Australia, irrespective of their visa status.'
6. Commission new research into the impacts of menopause and perimenopause on migrant and refugee women and gender diverse people's health and wellbeing, in particular, economic consequences and workplace experiences; access to healthcare services, treatments, and information (including digital health technologies); and caregiving responsibilities and social support. Community-led research should be prioritised and delivered through equitable research partnerships with migrant women's organisations.
7. Develop a national framework for the collection and provision of publicly accessible national health data on perimenopause, menopause, associated conditions, mental health (including suicide rates), and workforce data which is disaggregated by age group, gender, sexual orientation, Aboriginal and/or Torres Strait Islander status, ethnicity, place of birth, disability, English language proficiency and visa status, in consultation with community-led organisations.
8. Provide free, culturally, and linguistically responsive mental health support (including suicide prevention services and crisis supports) to all women and gender diverse people as an integral part of sexual and reproductive health, including perimenopause and menopause.

9. Support community-based, health promotion and preventative programs that act as liaison points to clinical mental health services, to ensure the delivery of culturally responsive and safe support for migrant and refugee women and gender diverse people.
10. Collect data and fund research into suicide and self-harm that is inclusive of migrant and refugee women and gender diverse people in menopausal and perimenopausal stage to ensure suicide prevention initiatives can be tailored to their specific needs.
11. Target investment into tailored carers programs for migrant and refugee women and gender diverse people that provide culturally responsive support. Migrant women's organisations should be prioritised in leading the co-design and delivery of these programs.
12. Provide accessible in-language and culturally appropriate health education and resources for partners of migrant and refugee women and gender diverse people experiencing perimenopause and menopause symptoms.
13. Implement Recommendation 25 (4.96) of the Senate Inquiry into Universal Access to Reproductive Healthcare: 'The committee recommends that the Australian Government consider options and incentives to expand the culturally and linguistically diverse (CALD) sexual and reproductive health workforce including leveraging the successes of the 'Health in My Language' program.'
    i. Invest in the delivery of health education on menopause (including associated conditions) and capacity building on digital technologies, for migrant and refugee women and gender diverse people. This includes resourcing the design and delivery of health information tailored for partners and carers who are supporting someone approaching or experiencing menopause.
14. Support the co-design of menopause-related health information in languages other than English to enhance health literacy. The development of these resources should be led by or produced in consultation with relevant community stakeholders, so that a variety of attitudes and approaches to menopause and perimenopause are reflected, and should include information relating to identification of menopausal symptoms and pathways for accessing treatment.
15. Invest in co-design research to better understand migrant and refugee women and gender diverse people's attitudes, perceptions and their level of health literacy relating to menopause and perimenopause.
16. Integrate cultural responsiveness across all curricula by ensuring perimenopause, menopause, and associated conditions on different population groups are included as a core component of all medical, nursing, mental health, and allied health training curriculums, including for general practitioner, gynaecology, endocrinology, and psychiatry.
17. Promote medical research and clinical trials that are culturally responsive and inclusive of diverse demographics, such as migrants and refugees, LGBTIQA+ people, Aboriginal and Torres Strait Islander people, and people living with disabilities, to ensure that medical knowledge base is relevant, and treatments are appropriate and responsive to Australia's diverse population.

18. Create a well-rebated, long consult Medicare item for thorough perimenopause and menopause assessments; this could be achieved through inclusion in the current Medicare Benefits Schedule (e.g. Health Assessment).
19. Support the ongoing capacity building and professional development of employees and employers, particularly, health professionals and interpreting workforce, in intersectional approaches to providing culturally and linguistically responsive care or support, particularly through all life stages.

Background

On 6 November 2023, the Senate referred an **inquiry into the Issues related to menopause and perimenopause** to the Senate Community Affairs References Committee for inquiry and report by 10 September 2024.

There is a current consultation listed on the Senate Standing Committees on Community Affairs website, which is open until 15 March 2024. MCWH appreciates the opportunity to provide a submission. This submission is written in response to the Committee Terms of Reference points 'a-f'.

MCWH consents to this submission being published on the inquiry website and shared publicly online.

Consultation Response

MCWH welcomes the opportunity to make a submission to the Senate Inquiry on issues related to menopause and perimenopause. Our submission directly addresses the Inquiry's Terms of Reference and is based on our work with migrant and refugee women in advancing sexual and reproductive health and rights. MCWH also welcomes the opportunity to share our recommendations at a public hearing and/or future consultations.

MCWH's submission and recommendations outlined here have been endorsed by Women's Health Victoria. Additionally, MCWH supports the joint submission by the Victorian Women's Health Services.

In this submission, 'women and gender diverse people' is used to include cisgender women, transgender women and non-binary and gender diverse people. Unless specified, where literature is cited, we have used the term 'women' as most research does not clarify authors' identifications of gender. MCWH recognises this approach is limiting and not always inclusive of non-binary and gender diverse people, who may experience significant barriers to accessing support for their health and wellbeing.

Terms of Reference Response

This section is framed in direct response to the Committee **Terms of Reference**, items a-f.

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

The economic consequences of menopause and perimenopause are significant for migrant and refugee women, given they are already one of the most economically marginalised groups in Australia (Arashiro, 2021). In general, female recent migrants and temporary residents reported having higher unemployment rates compared to males in the same category – 8.3% and 3.9% respectively (ABS, 2019a). Personal income data also indicates a continuous gender pay gap across the working lives of migrant women (ABS, 2019b). This highlights the way in which gendered inequalities intersect with migration-related social inequalities throughout migrant and refugee women's lives.

More specifically, recent research exploring the economic costs of menopause and perimenopause suggests that women face substantial financial costs when accessing healthcare to manage their menopausal symptoms (Sauer et al., 2023). In addition, some women experience significant adverse symptoms that force them to reduce their work hours or leave their employment completely (Sauer et al., 2023). These experiences consequently impact women's workforce participation and productivity. However, it is important to note that conversations around menopause and workplace supports have been 'heavily skewed towards the experience of women in professional occupations, and often those who are white and middle class' (Riach, 2022). There needs to be more attention to the salience of intersectionality as a lens to deepen understandings of menopausal experiences in the workplace (Atkinson et al., 2021; Steffan, 2021). Intersectionality highlights the systemic barriers that actively push migrant and refugee women in Australia into insecure and underpaid work across cleaning, aged care, health care, and childcare sectors. As such, we need to better understand and account for the menopausal experiences of migrant and refugee women who are also employed in precarious modes of work, as this area of the labour market is less likely to see provisions and supports that proactively challenge inequality or discriminatory practices surrounding menopause. As Yoeli et al. note, menopausal women in casual jobs will 'likely not benefit from the recommendations, innovations, or protections of the 'menopause at work' policies introduced by organisations and unions' (2021, p.8). Given Australia's increasing reliance on migrant workers and the wide extent of permanent casualisation, we need to ensure workplace interventions aimed at supporting women experiencing menopause also extends to migrant and refugee women and gender diverse people. For instance, 'reproductive paid leave' should be implemented across industries and for all employment types (casual, contract, part-time and full-time workers).

Notably, the opportunities for financial wellbeing and economic security differ for migrant and refugee women and these trajectories affect migrant women's capacity to accumulate savings, build assets (e.g. superannuation) and have retirement plans. For instance, migrant women who arrive in Australia as adults face barriers and challenges obtaining full employment are therefore more likely to be in underpaid sectors of the economy, such as the care industry, where they are employed on a part-time or casual basis (Hach & Aryal-Lees, 2019). Moreover, once migrant and refugee women enter the workforce, they face barriers to advancement to senior level positions, having significant implications for their average wages over time (Arashiro, 2021).

Additionally, due to structural barriers created by an inequitable visa system, many migrant and refugee women have limited economic rights and are therefore financially dependent on their partners. As noted by Harmony Alliance, when migrant and refugee women are dependent on their

partners, ‘their partners may not build assets in their names, leaving them with no assets or wealth of their own. Older women who come to Australia as dependents are particularly vulnerable to this’ (2020, p.2). Notably, dependent migrant and refugee women also face extended waiting periods of up to 10 years to qualify for the Age Pension, where five of those years must be of continuous residence in Australia – time spent in Australia on a temporary visa is not counted towards the qualifying residence period.

To address the barriers that contribute to migrant and refugee women’s economic insecurity, we need to ensure interventions responding to the economic consequences of menopause and perimenopause are inclusive of the political and socio-economic realities of migrants and refugee women’s experiences and addresses their needs throughout their lives.

Recommendations:

- Sustainably fund tailored programs that promote the leadership, workforce participation, career development, and civic and social inclusion of migrant and refugee women and gender diverse people. MCWH’s PACE (Participate, Advocate, Communicate, Engage) Leadership Program is an example of a successful evidence-based leadership program that has been tailored for migrant and refugee women.
- Remove visa restrictions that make migrant and refugee women more vulnerable to economic insecurity and financial abuse and implement policies that enhance their financial independence.
- Embed intersectional analysis in policymaking to address the intersecting impacts of migration, social and economic security systems on the lives of migrant and refugee women and gender diverse people.
- Implement ‘reproductive leave’ at workplaces that includes leave for treatment and management of perimenopause and menopause symptoms. This should extend across industries and employment types: casual, contract, part-time and full-time workers.

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

Menopausal and perimenopausal symptoms have significant health implications on women’s physical wellbeing. Evidence suggests that around 80% of Australian women will experience menopausal symptoms (e.g. hot flashes, night sweats, palpitations, and migraines), and that at least 20% will experience them severely enough to significantly impact their everyday lives (Jean Hailes Foundation, 2022; Davis et al., 2023). However, there is limited evidence on how menopause and perimenopause impact migrant and refugee women and gender diverse people because there is a lack of consistent, disaggregated and publicly accessible national health data. Furthermore, this national data is also not inclusive of trans, non-binary, and gender diverse people, who face significant barriers to accessing health services and support. Additionally, there is also a lack of dedicated funding for community-led research that specifically focuses on migrant and refugee women's experiences of menopause and perimenopause. Despite the paucity of research on migrant and refugee women and gender diverse people’s experiences of menopausal transition and postmenopausal life, the available evidence from comparative studies shows that physical

symptoms, such as frequency of hot flushes, night sweats, and skeletal and muscular pain, were experienced more by immigrant women than non-immigrants (Stanzel et al., 2018).

Moreover, the Australian Institute of Health and Welfare (2023a) describes menopause as a life stage which marks the end of the reproductive years and is expected to occur around the age of 50, with some experiencing it earlier than this. However, due to a lack of research on migrant and refugee women and gender diverse people's experiences of menopause and pre-menopause, it is uncertain if the age noted in this definition applies to all people. This is particularly concerning as the age of menopause is associated with increased risks of non-communicable diseases such as cardiovascular disease. The lack of data on migrant and refugee women and gender diverse people's experiences of menopause presents challenges for the implementation of health promotion initiatives and thus limits their capacity to access culturally appropriate and meaningful prevention and early intervention measures.

Addressing the physical health impacts of perimenopause, menopause and associated conditions is inextricably tied to increasing access to healthcare services for all Australians. Presently, Australian women have poor access to healthcare services when it comes to perimenopause and menopause, including assessment and treatment (Davis & Magraith, 2023). This is further exacerbated for migrant and refugee women and gender diverse people who experience a range of systematic barriers which limit their ability to access safe, affordable, and culturally responsive healthcare in Australia. For example, many temporary visa holders do not have access to Medicare, which significantly limits their capacity to access services, and are subject to extensive waiting periods and costly appointments and treatments (Shannon, 2021). In regional and remote areas, the barriers experienced by migrant and refugee women and gender diverse people are further amplified due to limited transportation and infrastructure, including limited access to interpreters, culturally appropriate healthcare, and in-language information. Furthermore, it is difficult and expensive to get integrated support from other health specialists (e.g., physiotherapists, psychotherapists, dieticians etc.) which play an important role in the effective health care and management of people experiencing perimenopause and menopause (Davis & Magraith, 2023).

Research and data collection is needed to gain a deeper understanding of the menopause physical health impacts and experiences of migrant and refugee people, and what this looks like in the context of Australia. What the current evidence does indicate, is that migration impacts on all aspects of women and gender diverse people's health and wellbeing. In addition, there is heterogeneity in menopausal experiences, highlighting the diversity within communities, and the importance of tailoring programs and services to meet the needs of migrant and refugee women and gender diverse people.

Recommendations:

- Extend healthcare and support services, including Medicare, PBS, NDIS, and social security payments, to include all migrants and refugees regardless of visa status. Including costs associated with diagnosis, treatment, mental health support, and integrative care related to the management of perimenopause and menopause.
    - Implement Recommendation 30 (4.111) of the Senate Inquiry into Universal Access to Reproductive Healthcare: 'The committee recommends that the Australian government, in consultation with state and territory governments, consider options

for ensuring the provision of reproductive health to all people living in Australia, irrespective of their visa status.'

- Commission new research into the impacts of menopause and perimenopause on migrant and refugee women and gender diverse people's health and wellbeing, in particular, economic consequences and workplace experiences; access to healthcare services, treatments, and information (including digital health technologies); and caregiving responsibilities and social support. Community-led research should be prioritised and delivered through equitable research partnerships with migrant women's organisations.
- Develop a national framework for the collection and provision of publicly accessible national health data on perimenopause, menopause, associated conditions, mental health (including suicide rates), and workforce data which is disaggregated by age group, gender, sexual orientation, Aboriginal and/or Torres Strait Islander status, ethnicity, place of birth, disability, English language proficiency and visa status, in consultation with community-led organisations.

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

Perimenopause and menopause can have significant impacts on people's mental health and wellbeing while being tied to other multifaceted midlife stressors and life experiences. For instance, research suggests that for migrant and refugee women who are experiencing menopause, poorer mental health outcomes are more closely linked to their experiences of lack of social support, financial stress, and social isolation, rather than solely to their menopausal status (Stanzel et al., 2018).

MCWH's mental health and wellbeing research report highlights how socio-cultural factors and systemic inequalities impact migrant and refugee women and gender diverse people's mental health and wellbeing (Tran et al., 2023) In particular, we note that migration-related stressors such as social isolation, loneliness, acculturation, separation from family, conflict in their country of origin, and insecure employment contribute to the stress experienced across the settlement journey. (Tran et al., 2023)

Migrant and refugee women's mental health is also significantly influenced and further exacerbated by the challenges experienced when accessing support such as racial and gender discrimination, complex healthcare systems, lack of accessible health information, inadequate in-language and interpreting services, lack of culturally and linguistically responsive services, long waiting times and costly services (Tran et al., 2023). These barriers limit migrant and refugee women and communities' access to social support that is essential to their overall health during the perimenopause and menopausal transition (Zou et al., 2021). Considering the significant statistic that 40% of perimenopausal women who see their primary healthcare provider, also have symptoms associated with depression, it is critical that migrant and refugee women and gender diverse people can readily access healthcare across the life stages (HER Centre Australia, 2024).

Currently, there is no consistent and accessible national data on suicide rates for migrant and refugee women and gender diverse people in Australia. However, we know that women of menopausal and perimenopausal age groups (40-54) are overrepresented in suicide rates, making up

25.8% of deaths by suicide in Australia, and this is higher for women living in regional and remote areas of Australia (AIHW, 2023b). Given these statistics, it is important that data is collected and accessible across demographics, so we can better understand the mental health experiences of migrant and refugee women and gender diverse people and develop effective and meaningful suicide prevention programs. Suicide prevention initiatives and policies in relation to perimenopause and menopause need to be considered alongside other measures aimed at supporting the health and wellbeing of women and gender diverse people. MCWH's research on migrant and refugee women's mental health demonstrates the importance of embedding a social determinants and intersectional framework in the planning and development of health policies and programs (Tran et al., 2023). This thinking should be applied to the perimenopause and menopause life stages to effectively support migrant and refugee women and gender diverse people.

Recommendations:

- Provide free, culturally, and linguistically responsive mental health support (including suicide prevention services and crisis supports) to all women and gender diverse people as an integral part of sexual and reproductive health, including perimenopause and menopause.
- Support community-based, health promotion and preventative programs that act as liaison points to clinical mental health services, to ensure the delivery of culturally responsive and safe support for migrant and refugee women and gender diverse people.
- Collect data and fund research into suicide and self-harm that is inclusive of migrant and refugee women and gender diverse people in menopausal and perimenopausal stage to ensure suicide prevention initiatives can be tailored to their specific needs.

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

Caregiving duties tend to increase for many women around the same time as their experience of menopause (Mishra et al., 2022). Caregiving, in general, is gendered and racialised in nature, evidenced by the data which shows that women spend more time doing unpaid care work than men and that 20.6% of unpaid carers in Australia are migrant women from non-English speaking countries (ABS, 2022; Wilkins et al., 2022).

Caregiving responsibilities and related stressors can contribute to poor mental health and wellbeing outcomes during perimenopause and menopause (Davis et al., 2023**;** Mishra et al., 2022). This is particularly significant for migrant and refugee women as our research highlights how migrant and refugee unpaid carers experience significant challenges, such as long-term financial vulnerability, stress related to multiple and intergenerational caring responsibilities, difficulties navigating the Australian healthcare system, and social isolation and loneliness. These challenges directly impact their mental health and wellbeing and is further exacerbated by a lack of culturally appropriate and accessible support services (Aryal, 2017). Many migrant and refugee people are also long-distance caregivers, which often involves the transnational care of someone in their family or social network who needs assistance. This type of care can take many different forms, such as financial support, emotional support through regular contact, and practical support such as organising appointments or in-home care. Long-distance caring can be fulfilling for carers but can also be emotionally and physically challenging as distance often limits their capacity to provide the necessary support. This is

especially relevant to migrant and refugee women as they tend to spend more hours than men providing transnational emotional support (Sethi et al., 2022).

It is important to appreciate the significant impact of caring responsibilities on migrant and refugee women, in order to understand how it interconnects with the perimenopause and menopause transitions. For example, research shows that women in midlife who provide caregiving to someone they live with, reported poorer physical and mental health, stated that they had three or more chronic conditions, had less physical activity, and had higher levels of anxiety, stress, and depression. Concerningly, these carers were also less likely to access recommended health checks, such as pap tests (Mishra et al., 2022). MCWH's previous research into informal and unpaid care also found that migrant and refugee carers have 'smaller family networks and lower rates of service use compared to the Australia-born population, potentially placing strain on caring families and leaving complex health needs unmet' (Aryal, 2017).

To effectively support migrant and refugee women and gender diverse people through perimenopause and menopause, their social networks and family relationships also need to be understood as core factors in their health and wellbeing. Approximately one in five women will experience negative impacts on their relationships with their partners, and for some this also extends to family and friendship dynamics, as a result of menopause symptoms combined with other midlife stressors (Davis et al., 2023). Greater social support is directly linked to increased physical and emotional health of people experiencing menopause. Improvement in mental health outcomes have also been observed for women going through menopause, when their partner had adequate understanding of menopause and was able to provide emotional support (Namazi et al., 2019).

Recommendations:

- Target investment into tailored carers programs for migrant and refugee women and gender diverse people that provide culturally responsive support. Migrant women's organisations should be prioritised in leading the co-design and delivery of these programs.
- Provide accessible in-language and culturally appropriate health education and resources for partners of migrant and refugee women and gender diverse people experiencing perimenopause and menopause symptoms.

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;

Literature focusing on the 'cultural and societal factors' has revealed a wide spectrum of perceptions and attitudes towards menopause and perimenopause, having significant impacts on how this transition itself is experienced. The diversity of perceptions relating to menopause illustrates the fluidity of culture on understandings of health and illness that varies between individuals within the same and across communities. For instance, some women associate menopausal transition with achieving 'wise woman status' and having an increased influence on their family. Additionally, many think being feminine and maternal are not given up with menopause but rather they are re-defined to new roles. In contrast, some women view this transition as a loss of feminine qualities. (Zou et al., 2021).

Currently, there is limited evidence exploring the culturally informed constructions of menopause among migrant and refugee women in Australia. However, the available evidence also confirms that there is a variety of attitudes toward menopause from being seen as a deficiency or loss, a phase shrouded in silence and secrecy, to being seen as a positive life event (Ussher et al., 2019). Notably, a paper analysing the psychosocial meanings of menopause and midlife concluded that some migrant women 'rejected the medical view of menopause' (Stanzel et al., 2018, p.51). The diversity of perceptions and attitudes towards menopause highlights the importance of investing in research and policy analysis that uses an intersectional and feminist approach to understanding menopause. This is to ensure migrant and refugee women are not viewed as a singular entity with a homogenous experience of menopause, and importantly, to avoid 'one size fits all' policy analysis and implementation.

Health literacy relating to menopause and perimenopause is crucial in ensuring migrant and refugee women and gender diverse people are aware of menopausal symptoms, management options and pathways to accessing treatment. Lack of culturally and linguistically appropriate health information and education has been noted as a significant barrier to accessing menopause-related healthcare (Jahangirifar et al., 2023). Based on our extensive experience and expertise in delivering culturally and linguistically appropriate health education for migrant and refugee communities, we note the importance of providing in-language resources about menopause and information on navigating the health system to ensure migrant and refugee women have the tools and knowledge they need to make decisions about their own health.

In addition, bilingual educators and interpreters need to be recognised in the provision of healthcare and should be supported to develop and enhance their skills on an ongoing basis. We should be working towards a fully integrated system that facilitates referral pathways between clinical care and health education for migrant and refugee women and gender diverse people in order to increase their capacity to access to a broad range of treatment options for menopause and perimenopause.

Recommendations:

- Implement Recommendation 25 (4.96) of the Senate Inquiry into Universal Access to Reproductive Healthcare: 'The committee recommends that the Australian Government consider options and incentives to expand the culturally and linguistically diverse (CALD) sexual and reproductive health workforce including leveraging the successes of the 'Health in My Language' program.'
    - Invest in the delivery of health education on menopause (including associated conditions) and capacity building on digital technologies, for migrant and refugee women and gender diverse people. This includes resourcing the design and delivery of health information tailored for partners and carers who are supporting someone approaching or experiencing menopause.
- Support the co-design of menopause-related health information in languages other than English to enhance health literacy. The development of these resources should be led by or produced in consultation with relevant community stakeholders, so that a variety of attitudes and approaches to menopause and perimenopause are reflected, and should

include information relating to identification of menopausal symptoms and pathways for accessing treatment.

- Invest in co-design research to better understand migrant and refugee women and gender diverse people's attitudes, perceptions and their level of health literacy relating to menopause and perimenopause.

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;

Lack of access to Medicare and PBS by many migrant and refugee women and gender diverse people due to visa restrictions (e.g., temporary visa holders) can limit their access to treatments for menopause and perimenopause symptoms. This is especially restrictive for those going through perimenopausal and menopausal transitions where longer appointments may be necessary for a comprehensive and individualised assessment, requiring added costs for extended appointments. Even for those who do have access to Medicare, booking longer appointments is often difficult and expensive.

It is well known by now that a significant barrier for those seeking menopause healthcare in Australia is finding a GP who has the knowledge to confidently discuss the management and treatments for menopause, as this varies considerably across healthcare providers (Roberts, 2024). Finding appropriate healthcare is even more challenging for migrant and refugee women and gender diverse people since there are limited healthcare professionals that can deliver culturally responsive and safe care in relation to menopause and perimenopause.

For LGBTIQA+ communities, negative experiences of gynaecological healthcare including, refusal of care, microaggression, derogatory comments, deliberate misgendering, invasive questioning and lack of cultural understanding, further impact on the quality of healthcare they receive. Furthermore, long waiting periods due to limited healthcare providers providing inclusive and safe care, as well as the financial burden of having to pay more for longer appointments directly impact on LGBTIQA+ people's health (Thomas et al., 2023). It is essential that the evidence-base which informs the training of health professionals is built on medical and clinical research which reflects the diversity of Australian society. The challenges experienced by medical professionals in providing health care have a flow on effect to migrant and refugee women and gender diverse people's experiences and health care outcomes. More needs to be done to ensure health and medical professionals have adequate training to effectively support patients through menopause and that they can also provide culturally and LGBTIQA+ responsive and safe healthcare.

In addition, lack of access to Medicare and PBS by migrants particularly those on temporary visa holders can impact access to treatment. This is especially restrictive for those going through perimenopausal and menopausal transitions where longer appointments are necessary for a comprehensive and individualised assessment, requiring added costs for extended appointments. Even for those who do have access to Medicare, booking longer appointments is often difficult and expensive.

Recommendations:

- Integrate cultural responsiveness across all curricula by ensuring perimenopause, menopause, and associated conditions on different population groups are included as a core component of all medical, nursing, mental health, and allied health training curriculums, including for general practitioner, gynaecology, endocrinology, and psychiatry.
- Promote medical research and clinical trials that are culturally responsive and inclusive of diverse demographics, such as migrants and refugees, LGBTIQA+ people, Aboriginal and Torres Strait Islander people, and people living with disabilities, to ensure that medical knowledge base is relevant, and treatments are appropriate and responsive to Australia's diverse population.
- Create a well-rebated, long consult Medicare item for thorough perimenopause and menopause assessments; this could be achieved through inclusion in the current Medicare Benefits Schedule (e.g. Health Assessment).
- Support the ongoing capacity building and professional development of employees and employers, particularly, health professionals and interpreting workforce, in intersectional approaches to providing culturally and linguistically responsive care or support, particularly through all life stages.

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