

Fawcett ▶
Equality. It's about time.



MENOPAUSE AND THE WORKPLACE

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Menopause and the Workplace

Fawcett Society
2022

Andrew Bazeley, Catherine Marren,
and Alex Shepherd

Fawcett 
Equality. It's about time.

Foreword

Workplaces and workforces are transforming rapidly. People over 50 now make up almost a third of the working age population, up from a quarter 25 years ago. At Wates, we care for the health and wellbeing of all our colleagues. By definition, this means we are committed to supporting women going through menopause and the more than 30 physical and mental conditions that may be caused by menopause transition.

The built environment sector in which Wates operates is male dominated. We believe that by making our culture more inclusive and our team more diverse, we will become a better, more sustainable, and more successful business. That's why we've set ourselves the target of having a workforce that is 40% female and that includes a greater proportion of BAME, disabled and LGBTQ+ colleagues by 2025.

We recently launched a programme to bring more women into construction and see menopause as a key recruitment and retention issue. So, we're very proud to sponsor this report by the Fawcett Society. It will help increase understanding of the role employers can play in enabling women to have fulfilling working lives. The research has highlighted the significance of the challenge, with one in ten women having left work due to menopause symptoms and just under half finding that the menopause has affected their ability to work.

The real, lasting change that's needed to increase understanding and improve support around menopause can only be delivered through effective collaboration between business, government, and society. So, the provision of flexible working options, better training for managers and leaders, and access to support networks will have their maximum impact only if they're supported by a national public health campaign and easier access to primary care services.

At Wates, we are already taking action to support our menopausal colleagues and have developed detailed guidance explaining the menopause and its impacts in the workplace; the different roles and responsibilities that need to be played by employees, line managers and HR; helpful advice on managing menopause at work; and support for colleagues who need to talk to a GP. In 2021, Wates also became one of the first companies in our sector to support flexible working across our entire business, including colleagues who work on site.

We want to encourage others to make these changes too, and we hope that the recommendations outlined in this report will inform their efforts to create truly inclusive workplaces and menopause-friendly cultures in which all colleagues can thrive.



David Allen

Pronouns: he/his/him

Chief Executive

The Wates Group



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Executive Summary

Channel 4 commissioned Finestripe Productions to produce the documentary "Davina McCall: Sex, Mind and the Menopause". For that programme Finestripe commissioned Savanta ComRes to conduct a representative survey of 4,014 UK women aged 45-55 who are currently or have previously experienced the perimenopause or the menopause, with support from Fawcett on the survey design. We are grateful to Channel 4 and to Finestripe for enabling us to use that data in this report. We are also grateful to The Wates Group, without whose sponsorship this report could not have been produced. Responsibility for the content of this report and its recommendations rests entirely with Fawcett.

Menopause is beginning to move out of the shadows of stigma, but there are gaps in the evidence base. We believe this is the largest survey of menopausal women conducted in the UK. Much of the literature and, due to methodological constraints, our survey, focusses on women's experiences, but we recognise that findings will be relevant to many trans men and non-binary people. Our research has uncovered significant challenges in the workplace with detrimental impacts for menopausal women:

- One in ten who have worked during the menopause have left a job due to their symptoms
- Eight out of ten women say their employer hasn't shared information, trained staff, or put in place a menopause absence policy.
- Almost half of women haven't approached their GPs about the menopause and three in ten of those who have experienced delays in diagnosis.
- Only four in ten women who have talked to their GP about the menopause say they were immediately offered HRT.

Reform is needed, urgently.

Key findings

Menopause symptoms are severely impacting most menopausal women – our society's silence on this is a scandal. 77% of women experience one or more symptoms they describe as 'very difficult'. 69% say they experience difficulties with anxiety or depression due to menopause, 84% experience trouble sleeping and 73% experience brain fog.

Menopause is not just hot flushes. More women described difficulty sleeping and brain fog as being 'difficult' or 'very difficult' than hot flushes or night sweats (70%).

Severe symptoms are worse for working class women. 44% of women described three or more symptoms as 'very difficult', and women in a household where the main earner works in semi-skilled or unskilled manual work were more likely than those where they work in managerial roles to have difficulty with physical and psychological symptoms.

Menopause impacts women's work. 44% of women said their ability to work had been affected, comprising 18% of women who said that their symptoms currently affected their ability to do their jobs, and 26% in the past. 61% said that they had lost motivation at work due to their symptoms, and 52% said they had lost confidence.

One in ten women who have been employed during the menopause have left work due to menopause symptoms. Mapped on to the UK population that would represent an estimated 333,000 women leaving their jobs due to the menopause. 14% of women had reduced their hours at work, 14% had gone part-time, and 8% had not applied for promotion.

Employers are not taking action to support most menopausal women. There is consistent evidence that a mix of appropriate interventions by employers can support women: culture change, training, advice on menopause, adapting absence policies, flexible work, and environmental changes. But for each of these, eight out of ten women in our survey said their employer had not put them in place. When they do, women say that they are helpful.

Disabled women are affected more by menopause symptoms. 22% said they had left a job due to menopause symptoms, compared to 9% of non-disabled women

The taboo around menopause extends to sick notes. 26% of women who have been employed during the menopause had taken time off work due to their symptoms, but just 30% of them gave menopause as the main reason on their sick note. Working class women were even less likely to cite the real reason.

Dress codes cause key workers and working class women discomfort. Three in ten women in the DE social grade say that their uniforms are uncomfortable given their menopause symptoms, while 23% of key worker women also say they are uncomfortable.

Hormone replacement therapy (HRT) is effective at alleviating menopause symptoms, but just 14% of menopausal women are currently taking it. The choice to use HRT must be an individual one, weighing up the risks and benefits. Current research finds that cancer risks are low in medical terms, while there are benefits, particularly from newer forms of HRT, in terms of lower Alzheimer's and osteoporosis risks.

54% of women using HRT say it has given them their life back. Among women who have not tried it, low impact of menopause symptoms was the biggest reason (28% say this). 24% said that worries about the risk of cancer or other illnesses was a factor, while 24% also said that they don't know enough about HRT.

Testosterone has been shown to help with low sexual desire, but just 33% of women are aware of its use in HRT. 54% of women in our survey said they found a loss of sexual desire in menopause difficult, but there is no form of licensed testosterone which is made for women's bodies available on the market.

Women are not approaching their GP surgery about the menopause. Just 55% of women said they had talked to someone at their practice, while 45% said they had not. Even among women with five or more severe symptoms, 29% had not spoken to anyone at their GP practice about menopause.

Women overall said their GPs appeared knowledgeable about menopause. 67% of menopausal women who did speak to their GP agreed that their healthcare professionals seemed well informed about the menopause.

But three in ten women say they experienced delays in diagnosis. 31% of women agreed or strongly agreed that it took many appointments for their GP to realise they were experiencing the menopause or perimenopause, rising to 45% among Black and minoritised women and 42% among women with five or more severe symptoms. .

Only 39% of women who spoke to a GP or nurse said they had been offered HRT once they were diagnosed with menopause. This is despite NICE guidance being clear that HRT, with discussion of risks and benefits, should be a first port of call for treatment.

Recommendations

Our recommendations reflect the needs that our survey and review of literature have uncovered. Women need adequate legal protection in workplaces where a lack of support is seeing them leave jobs in their thousands. Employers need to put in place the simple steps that can support them. In an environment of stigma and taboo, women are under-informed on the menopause and not approaching their GPs, so Government needs to start a nationwide public health campaign and create a route into primary care services. HRT is not being offered in a timely manner, and diagnosis of menopause is too often slow, so work needs to be done on GP training.

Women need protection that works for menopause. Menopause currently sits awkwardly within UK equality law, in the cracks between disability, sex and age protections. Government should consult on reforming equality law to protect menopausal women; either by implementing section 14 of the Equality Act 2010 on dual discrimination so women can bring cases based on age and sex, or creating a standalone menopause provision.

Government should require employers to have action plans on the menopause. The Department for Business, Enterprise and Industrial Strategy, and the Government Equalities Office, should reform the law to require employers to put in place gender pay gap action plans. The guidance setting out how to create a plan should make clear that taking well-evidenced, low-cost actions to support women with menopause is key to closing the gap.

Government should make flexible work the default. All jobs should be required to be advertised with any possible flexible work options, and requests should not be turned down without a good and proportionate reason, so that menopausal women can access this important accommodation to their symptoms.

The Department for Health and Social Care should fund a nationwide public information campaign on the menopause. This should dispel myths that menopause is just about hot flushes, dispel the stigma, and provide women with the information that there is help available for their symptoms.

The Department for Health and Social Care should develop a standardised clinical pathway for menopausal women. This could involve an invitation sent at an appropriate age for all women to discuss potential menopausal symptoms and treatment with their GP, or an appropriate nurse or pharmacist.

Government should ensure GPs and relevant healthcare professionals are trained on the menopause. This should involve work with UK medical schools to ensure that menopause, which affects 51% of the population, is a mandatory part of medical training; it should also involve funding for participation in accredited post-qualification training by at least one GP or nurse in each GP surgery or primary care network, or a community pharmacist, so that women can access up to date care; and comprehensive rollout of a minimum baseline knowledge so all GPs and practitioners can refer and provide initial care.

The Department for Health and Social Care should work with the Medicines and Healthcare Products Regulatory Agency (MHRA) and pharmaceutical companies to bring a testosterone replacement product, designed for women's bodies, to the UK market as quickly and safely as possible. 81% of respondents to our survey said that Government should support all women who want it to take hormone replacement therapy – without a licensed testosterone product for women, we are some way off making that a reality.

Introduction

The menopause is central to women's lived experiences, but it has always been surrounded by stigma. Recent years have seen that stigma begin to be challenged, through ardent campaigning and awareness raising by strong women in the UK: from Karen Arthur's 'Menopause Whilst Black' podcast, to the parliamentary efforts of those such as Carolyn Harris MP and Caroline Nokes MP, from specialist GPs like Louise Newson to the taboo-busting documentary 'Davina McCall: Sex, Myths and the Menopause'. We have begun to see policy change too, with Government recently agreeing to take steps to reduce the cost of hormone replacement therapy and launching a cross-government Menopause Taskforce.¹

Fawcett partnered with Standard Chartered Bank and the Financial Services Skills Commission in October 2021 to release our report, *Menopause in the Workplace: Impact on Women in Financial Services*,² which explored women and trans men's experiences of menopause in that sector, and the steps they wanted to see employers take.

We are delighted to have the support of Wates Group to look further into women's experiences. We partnered with Channel 4 and Finestripe Productions to conduct the UK's largest representative survey of menopausal women. This report explores the data from that survey in greater depth and, coupled with a review of relevant literature and stakeholder engagement, offers recommendations for policy reform drawing on insight which truly reflects menopausal women's experiences of the workplace and health services.

We are grateful for the comments and support that contributed to the process of producing this report from Fawcett staff, Kate Muir and the team at Finestripe, and Dr Louise Newson, although all responsibility for its contents lies with the authors.

1 Department for Health and Social Care. Press release: More support for women experiencing the menopause, 29 October 2021. <https://www.gov.uk/government/news/more-support-for-women-experiencing-the-menopause>

2 Standard Chartered, Financial Services Skills Commission, Fawcett Society. *Menopause in the Workplace: Impact on Women in Financial Services*. 2021.

Methodology

Channel 4 commissioned Finestripe Productions to produce the documentary “Davina McCall: Sex, Mind and the Menopause”. For that programme Finestripe commissioned Savanta ComRes to conduct a representative survey of 4,014 UK women aged 45-55 who are currently or have previously experienced the perimenopause or the menopause, with support from Fawcett on the survey design. We are grateful to Channel 4 and to Finestripe for enabling us to use that data in this report. We are also grateful to The Wates Group, without whose sponsorship this report could not have been produced. Responsibility for the content of this report and its recommendations rests entirely with Fawcett.

Participants in Savanta ComRes’ panels were filtered for whether they were male or female; for the age band; and then for whether they had, or were, experiencing the menopause or perimenopause. Definitions of these terms vary in medical and common use, with menopause used to mean both the transition period as a whole and the point when periods have stopped for a year, and perimenopause being used to describe a varying duration of time between cycles beginning to change and the point at which periods stop.³ Both were used in our survey to filter in as many women experiencing the transition as possible. See Appendix B.

This approach enabled us to achieve a large and reliable sample of menopausal women within our available budget. It meant that we did not include results for the 12.2% of women who experience early menopause between 40-45 years of age, the 3.7% who reach the menopause earlier than 40, or women who are older than 55.⁴ It is also unlikely to include the menopause experiences of trans men and non-binary people, given the initial filter – based on population estimates, including trans men and non-binary people would not have been likely to have enabled a sufficiently large sample to use.

Fieldwork was conducted online between 26th January and 4th February 2022. Data was weighted to be representative of UK women aged 45-55 by age and region. The survey was conducted online.

Raw data supplied by Finestripe Productions, producers of the ‘Menopause in the Workplace’ programme for Channel 4 Television.

What is new about our data

Samples for individual ethnic groups in our survey are small, with 321 Black and minoritized women respondents (347 when weighted),⁵ although this sample is fairly representative of the ethnic background of women in this age band. Some differences by specific ethnic minority groups are significant when looking at the overall group of over 4,000 respondents, and we report on these where available. In other cases, we use a white/Black and minoritized ethnicity grouping where it may indicate a meaningful finding, although we recognise that this risks merging quite different experiences and so these findings must be used with awareness of the diversity of experiences of Black and minoritised women. Our sample of 625 disabled women means we can report throughout on differences in experience based on disability.

3 Brewis, Beck, Davis, Matheson. The effects of menopause transition on women’s economic participation in the UK. The Government Equalities Office. 2017.

4 Standard Chartered, Financial Services Skills Commission, Fawcett Society. Ibid. p8

5 Drawing on critical analysis of this term by services led by and for marginalised groups (see Thiara and Roy (2020), Reclaiming Voice: Minoritised Women and Sexual Violence, Imkaan), this literature review refers to ‘Black and minoritised’ women. Whilst groups can be ‘minoritised’ in a number of ways, we specifically use this term to highlight the way in which certain racialised or ethnic groups are constructed as ‘minorities’ through processes of marginalisation and exclusion. Because we used an online panel for which demographic data was already collected, this category includes women who identified as Black, Asian, mixed ethnicity or ‘other’ ethnic background.

Based on our scans of available literature, we believe this is the largest representative survey of menopausal women conducted in the UK. Large-scale surveys have been conducted, including a survey with 5,399 respondents by the TUC and Business in the Community,⁶ but these have been opt-in surveys distributed online. While online panel surveys like ours can be subject to other biases, they are likely to better represent the state of the general population.

In particular, our hypothesis in beginning this work had been that opt-in surveys may result in women with more difficult or negative experiences being more likely to reply, given the issue may feel more salient to them. As our results below show, this does not seem to have been borne out, with our representative sample finding similar results where we can compare.

We have supplemented this survey data throughout with relevant academic and policy research literature. Qualitative responses to a free text question within our survey are included in italics throughout.

6 The Prince's Responsible Business Network. Menopause in the Workplace: A practical guide for HR, Wellbeing and Occupational Health practitioners. Accessed online at <https://www.bitc.org.uk/wp-content/uploads/2020/06/bitc-age-toolkit-menopauseintheworkplace-jun20.pdf>

Menopause symptoms

Menopause symptoms are significantly affecting most menopausal women. 77% of women experience one or more symptoms they describe as 'very difficult'. 69% say they experience difficulties with anxiety or depression due to menopause. Our society's silence on these issues is a scandal.

It's not just about hot flushes: more women described difficulty sleeping (84%) and brain fog (73%) as difficult than hot flushes or night sweats (70%).

Severe symptoms are worse for working class women. 44% of women described three or more severe symptoms, and women in a household where the main earner works in semi-skilled or unskilled manual work were more likely than those where they work in managerial roles to have difficulty with physical and psychological symptoms.

Existing research

The stereotype of women's experience of menopause is primarily of hot flushes, in a context where knowledge among the general public about menopause is limited. A 2020 survey of 2,000 women identified that 42% of women know little or nothing about the emotional and mental effects of menopause, and 51% can name only 3 of the recognised symptoms.⁷ The recent Department of Health and Social Care consultative survey on women's health found that less than one in ten women (9%) said they had enough information on the menopause.⁸

A number of sources have suggested that the depiction of hot flushes as the primary menopause symptom is inaccurate. The Women and Equalities Committee's opt-in survey found that difficulty sleeping and problems with memory or concentration were the most common symptoms, affecting 81% and 75% of women. The Business in the Community survey found that the main symptoms affecting women at work were fatigue, followed by hot flushes, focus and concentration and anxiety (40%, 35%, 34%, and 32% of respondents).

Tiredness and Brain Fog

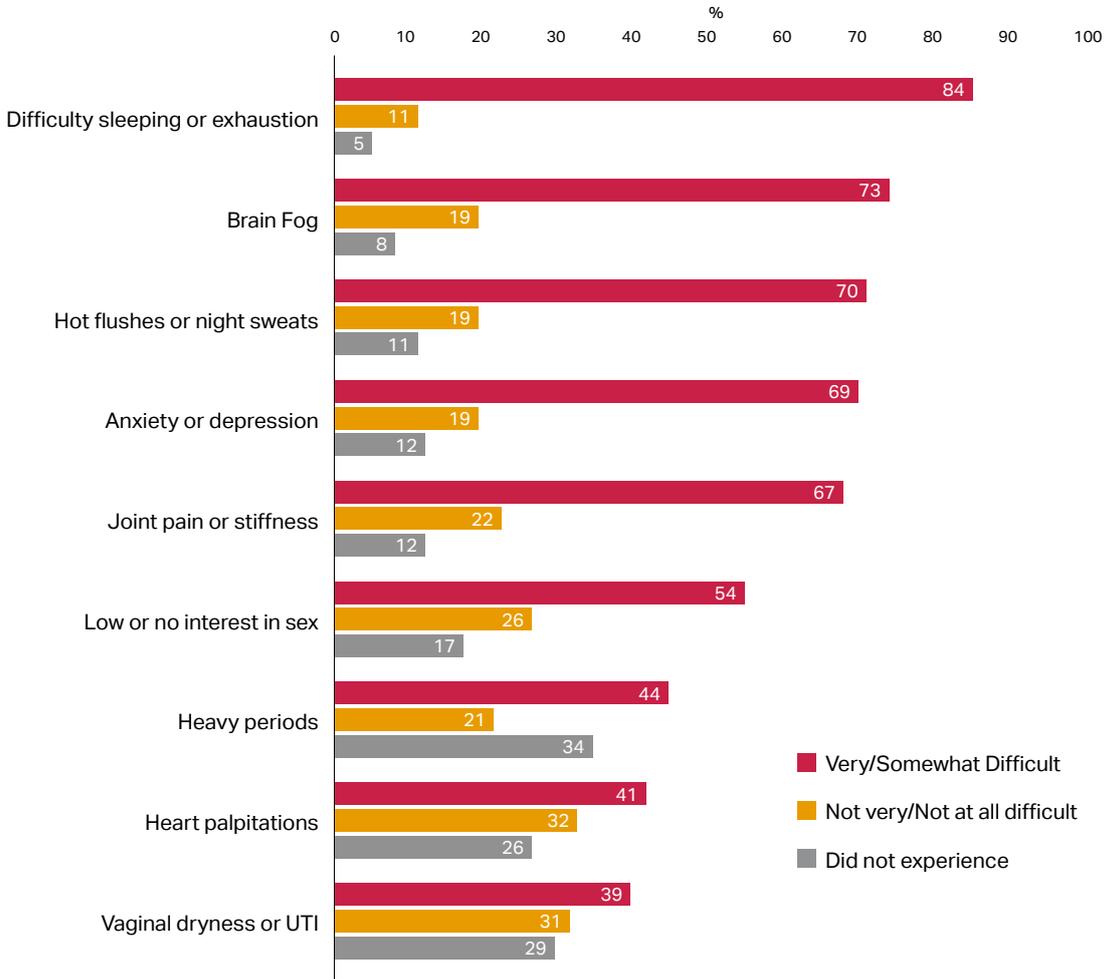
Our survey adopted a different approach to asking about symptoms. To explore the impact as well as prevalence of symptoms, we asked about the extent to which women found a list of symptoms difficult.

7 Gen M. The Gen M Invisibility Report. 2020

8 Department of Health and Social Care. Results of the 'Women's Health – Let's talk about it' survey. 2022.

Fig 1: To what extent, if at all, do/did you find the following symptoms of perimenopause or the menopause difficult?

N: 4,014. Nb. Brain fog denotes responses to "Poor memory or concentration or difficulty focussing on tasks (sometimes called 'Brain Fog')"



The two symptoms most commonly described as either very or somewhat difficult were difficulty sleeping (84%) and poor memory or concentration or difficulty focussing on tasks, sometimes called 'brain fog' (73%). Hot flushes or night sweats were the next most common problematic symptoms (70%), and along with difficulty sleeping they were the symptoms most commonly described as very difficult (by 36% and 44% of women).

"Felt like I was having a nervous breakdown but wasn't aware of this at the time was related to the peri menopause."

"I wasn't aware I was perimenopausal until I watched a programme and also heard other high profile women talking about it on tv. I thought I was cracking up and didn't feel like I knew myself anymore."

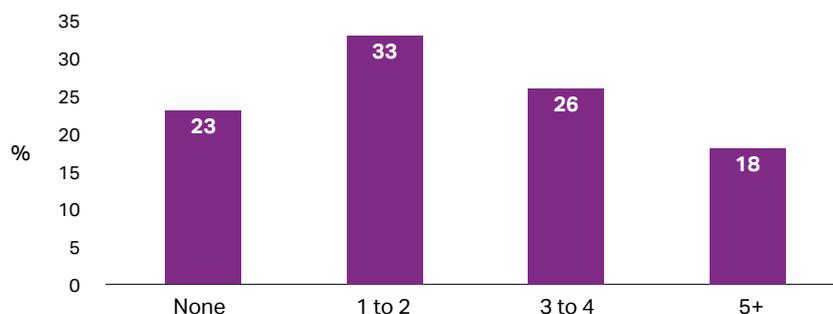
[Survey respondent]

Anxiety or depression (69%), joint pain or stiffness (67%), and low or no interest in sex (54%) were described as difficult by over half of women. Less commonly understood symptoms such as heavy periods (44%), heart palpitations (41%) and vaginal dryness or urinary tract infections (39%) were still described as difficult by over a third of menopausal women.

We analysed women's responses according to how many of the eight symptoms tested that they described as having been "very difficult", which are shown in Figure 2. We found a fairly even distribution. 23% of women said that none of their symptoms had been very difficult, while for a third it was one or two. For 44%, three or more of their symptoms were very difficult.

Fig 2: Number of symptoms that are/have been 'very difficult'

N:4,014



Intersectional impacts

Our large sample allows us to better understand how menopause symptoms affect women from different backgrounds. Among women in the DE social grade – women in households where the main earner works in a semi-skilled and unskilled manual occupation – many symptoms were more difficult than for those in other groups. Physical symptoms of tiredness and pain affected this group more. 88% said difficulty sleeping or exhaustion were difficult, compared to 82% in the AB group (main earner is in managerial and professional occupation), while 72% compared to 62% in the AB group cited joint pain and stiffness as difficult.

Mental health impacts were also larger, with 74% of women in the DE group experiencing difficulties with anxiety or depression compared to 66-67% of those in higher social grade groups.

There is a lack of research on how the menopause impacts women from different ethnic minority groups. A cross-sectional study conducted in Birmingham and Delhi found that Asian migrant women had a similar experience to white women,⁹ while in the US a major study found that African-American, Asian-American and Hispanic women were more likely to experience hot flushes than Caucasian women, while Hispanic and African-American women were more likely to report depressive symptoms and difficulty sleeping.¹⁰

Our research had a small sample size for ethnic minority groups. We found that Asian and Black women were somewhat less likely to experience difficulty sleeping (78% and 76%, compared with 85% for white women), brain fog (60% and 53%, compared with 74%) and anxiety or depression (61% and 52% compared with 70%). These findings do not account for lifestyle factors which were not part of our data, and which have been found to covary in other studies. Other research has also highlighted cultural differences in the extent to which women report their symptoms.¹¹

9 Gupta, Sturdee and Hunter. Mid-age health in women from the Indian subcontinent (MAWHIS): general health and the experience of menopause in women. *Climacteric* 9(1) 13-22. 2006.

10 Green and Santoro. Menopausal symptoms and ethnicity: The study of women's health across the nation. *Women's Health* 5(2) 127-133. 2009.

11 Brewis, Beck, Davis, Matheson. *Ibid.*

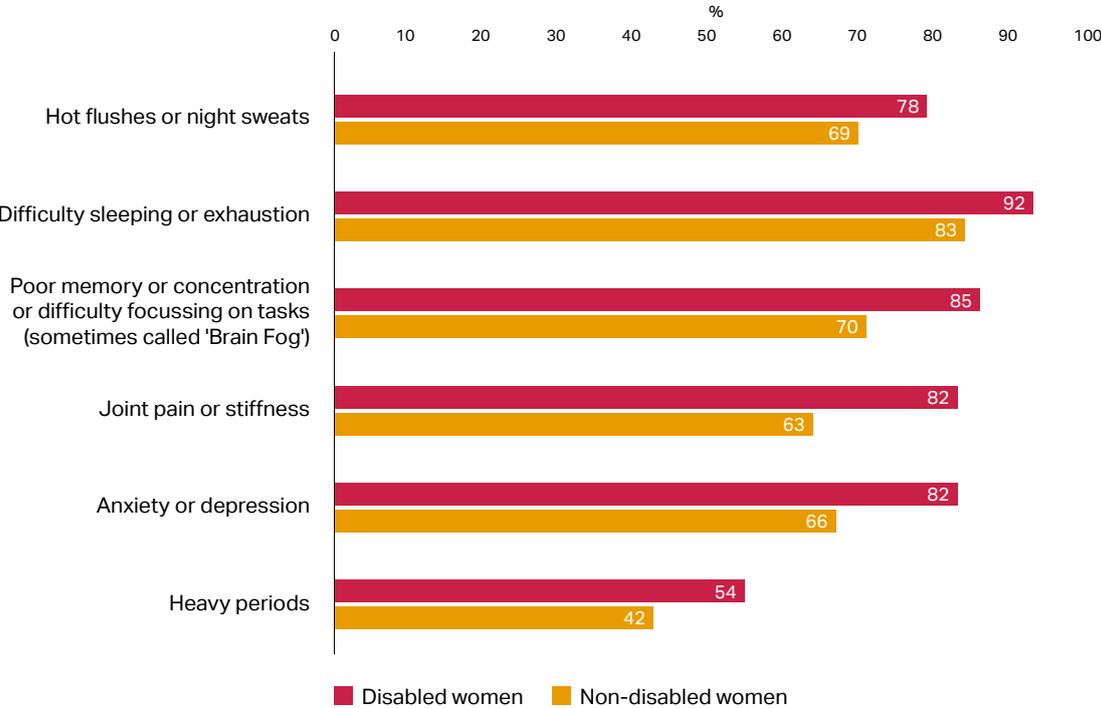
Disabled women were far more likely to experience difficult menopause symptoms. More than eight in ten disabled women going through the menopause reported difficulty sleeping (92%), brain fog (85%), joint pain or stiffness (82%), or anxiety or depression (82%) as somewhat or very difficult.

“It is a concern for me as I have an illness that badly affects my autonomic nervous system and I already experienced many of the menopause symptoms as part of my underlying conditions so I would love to have been able to talk to a specialist both in the menopause and in how to manage it alongside my illnesses but have no idea how to find such a person. I imagine this is the case for many women with chronic illnesses of my age, but how do we find professionals who would know how to help us?”

[Survey respondent]

Fig 3: Symptoms are very or somewhat difficult, by disability status

N: 4,014. 625 disabled women and 3,292 non-disabled women



As outlined above, our dataset does not include a useable sample of data on trans men or non-binary people’s experiences of the menopause, and this project was not able to incorporate a substantive qualitative element. We would welcome research to fill this gap in the UK. The recent Women and Equalities Select Committee (WESC) report identified that non-binary and trans people felt their experiences were not reflected in narratives around menopause;¹² there is a general agreement that trans experiences of the menopause differ,¹³ but this is under-researched. The literature cited throughout this report refers to women’s experiences, but we recognise that many findings will be relevant to trans men and some non-binary people.

12 Women and Equalities Committee. Menopause and the workplace survey results: Fourth special report of session 2021-22. HC1157. 2022.

13 Wales TUC Cymru. The menopause in the workplace: a toolkit for trade unionists. 2017

The impact on women's work

44% of women who have been employed during the menopause said their ability to work had been affected, comprising 18% of women who said that their symptoms currently affected their ability to do their jobs, and 26% in the past.

61% said that they had lost motivation at work due to their symptoms, and 52% said they had lost confidence.

26% of women who have been employed during the menopause had taken time of work due to their symptoms, but just 30% of them gave menopause as the main reason on their sick note.

Menopause has impacted almost half of women at work

Existing research shows that the menopause has a negative impact on women's economic status. A major 2017 review identified evidence for lower productivity, reduced job satisfaction, and problems with time management.¹⁴ WESC identified that 72% of their opt-in survey respondents had felt less able to concentrate, and 67% felt less confident in their abilities. A Nottingham University opt-in survey of women working in professional roles identified that lowered confidence, poor concentration and memory greatly impacted work, more so than life in general, while hot flushes were difficult in both contexts.¹⁵

They also identified that equal proportions of women agreed and disagreed that their performance at work had been affected by menopause. Of those who felt their performance was not affected, a third said that it could have been if they had not worked hard to overcome this risk.¹⁶

Fawcett's work in 2021, an opt-in survey of the financial sector, found that a quarter of women said they were considering retiring early due to menopause symptoms, and half said it made them less likely to want to progress in their role.¹⁷

Our data identified similar findings in a representative sample. 44% of women said their ability to work had been affected now or in the past, comprising 18% of women who said that their symptoms currently affected their ability to do their jobs, and 26% in the past. 52% said that their symptoms had not affected their ability to do their jobs.

14 Brewis, Beck, Davis, Matheson. Ibid.

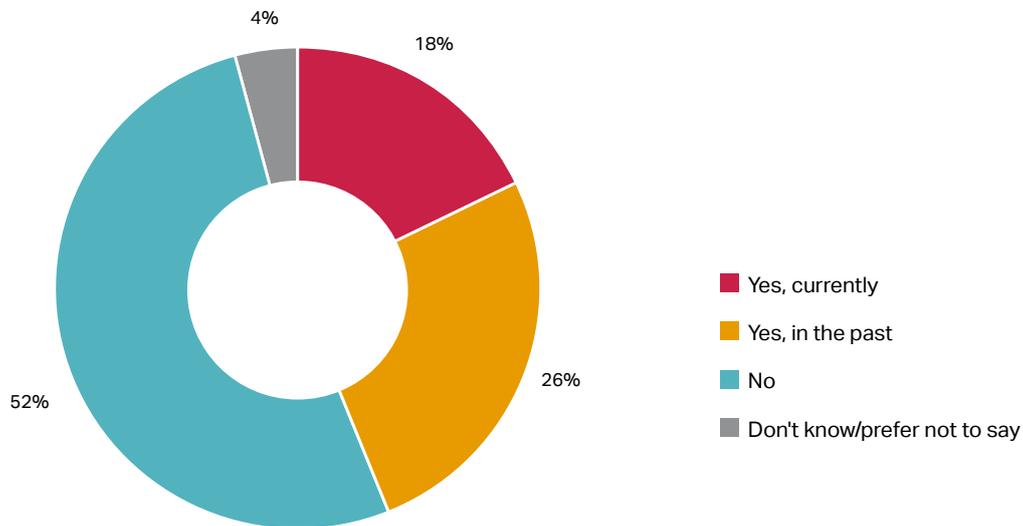
15 Griffiths, Maclennan, Hassard. Menopause and work: an electronic survey of employees' attitudes in the UK. *Maturitas* 76(2). 2013

16 Ibid.

17 Standard Chartered Bank, Financial Services Skills Commission, Fawcett Society. Ibid.

Fig 4: Have menopause symptoms ever affected your ability to do your job, either now or in the past?

N: 3,277 respondents employed during the menopause



The proportion of women whose ability to do their work was impacted is much higher for menopausal women who were not currently in work, but had been during the menopause. 62% said that symptoms had affected their ability to do their job in the past, compared to a combined 42% overall for those affected currently or in the past. Combined with our figures below on leaving work, this suggests a link between menopause symptoms impacting experiences at work, and women's decisions to leave their workplaces.

The figure for those currently affected at work is also higher for women in the AB social group (23%) compared to the C2 social group (household main earner is a skilled manual worker) at 14%.¹⁸

What's on your sick note?

The literature suggests that coping strategies often include concealing symptoms,¹⁹ while Fawcett's 2021 report found that just 22% of menopausal women and trans men disclosed their menopause status at work.²⁰ This was replicated in the Nottingham study, which found that the majority of women were unwilling to disclose their menopause status to managers.²¹ Social stigma combined with women's expectations of gendered ageism from managers and colleagues is likely to sit behind these figures.

Our findings on time off also support the claim that stigma around the menopause is holding women back from sharing their status at work.

18 The DE social group is lower at 12%, but this group also includes households where the main earner is not currently working.

19 Brewis, Beck, Davis, Matheson. Ibid.

20 Standard Chartered Bank, Financial Services Skills Commission, Fawcett Society. Ibid

21 Griffiths, Maclennan, Hassard. Ibid.

Looking at absences overall, we found that 26% of women who had been employed at some time during the menopause had taken time of work due to their symptoms, while 71% had not. Disabled women were more likely to have taken time off (46%). This was mostly for a fairly short duration – a fortnight or less in the last year for 63% of women who had taken time off, and four weeks or less for 74%. Nonetheless, over the whole of their menopause, over a fifth (22%) of women who had taken time off had taken a month or more.

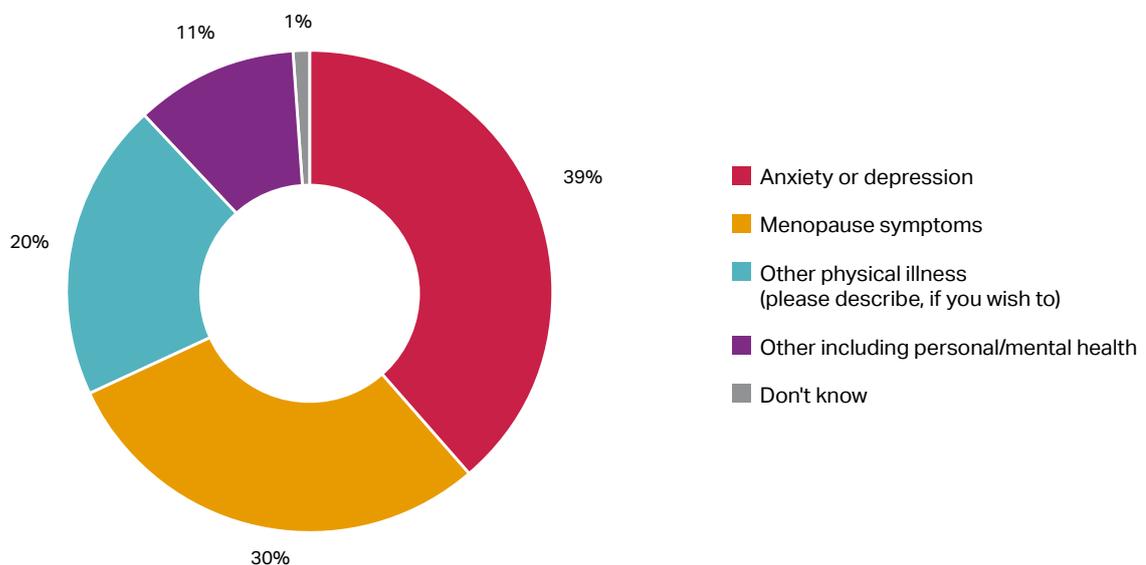
Opt-in research from 2010 with women in professional and managerial roles found that few women who took time off due to symptoms revealed the real reasons in their sick leave applications.²² We asked respondents who had taken time off due to their symptoms for the main reason that they gave to their employer. We found an even worse picture – just 30% of women who had taken time off had said it was due to menopause symptoms.

Almost four in ten women – 39% – had given anxiety or depression as the reason for their time off, and a fifth had cited other physical illnesses as their reason. These women’s decision not to share their menopausal status cannot be criticised, given the evidence below that women face stigma in workplaces where menopause is treated as a joke. These findings show how menopause is still treated as a taboo in workplaces, with women carrying shame and the burden of concealing their experiences.

This is particularly the case for working class women. Among women in C2 and DE occupational groups – skilled, semi-skilled and unskilled manual workers – just 21% and 24% of women cited their menopause symptoms as the reason for absence, compared with 35% of women from social grade AB. 46% of women in social grades C2 and DE say they took the time off for anxiety or depression.

Fig 5: What was the main reason you gave to your employer for taking time off due to menopause symptoms?

N: 850 respondents who took time off work due to menopause symptoms



22 Kopenhagen and Guidozzi. Working women and the menopause. *Climacteric* 18(3). 2015.

The menopause is no joke

Two different opt-in surveys have looked at whether respondents have experienced jokes about the menopause in their workplace – with 30.5% agreeing that they had;²³ or menopause being *treated as a joke* in their workplace, which 56% agreed they had seen.²⁴

41% of respondents who have been employed during the menopause identified that they had seen menopause or menopause symptoms treated as a joke by people at work. This was consistent across region and social grade. Disabled women were much more likely to say they had experienced this, with 58% of disabled women compared to 38% of non-disabled women saying they had experienced it, suggesting that the well-evidenced stigma and harassment that exists around disability may be compounded for menopausal women.

More women who are currently not in work stated that they had experienced menopause being treated as a joke (54%) than those currently in full-time (41%) or part-time work (33%). It is possible that their experiences of discrimination and alienation may have contributed to their decisions to leave work.

“I think in certain jobs employers should be more aware and especially so as I worked in a pub and some men would make comments about periods and the menopause, employers should be made aware this happens and support if that behaviour is going on, it can be extremely embarrassing.”

“There is a stigma around the menopause in workplaces, it’s a joke with most men and I don’t think workplaces realise how horrible it can be.”

[Survey respondents]

Confidence and motivation

Faced with menopause being treated as a joke at work, it is no surprise that many women lose confidence and motivation. Among women who have worked during the menopause, 61% said that they had lost motivation due to their symptoms, and 52% said they had lost confidence. Disabled women were somewhat more likely to say that they had lost motivation (70% compared with 60% for non-disabled women). The greater the severity of women’s symptoms, the more likely they were to have lost motivation. Eight in ten (83%) of women with five or more very difficult symptoms said they had lost motivation in the workplace.

Our sample for women from Black and minoritised ethnicities in work is fairly small so caution should be used in interpreting our results, but we do find that women from Black and minoritised ethnicities report lower levels of lost motivation (54%) and confidence (39%) than white women (62% and 53%).

23 Beck, Brewis, Davies. The remains of the taboo: experiences, attitudes, and knowledge about menopause in the workplace. *Climacteric* 23(2) 1-7. 2019

24 Wales TUC. The menopause: a workplace issue. 2017.

Cutting down or leaving work

One in ten (10%) women have left work due to menopause symptoms. Mapped on to the UK population that would represent an estimated 333,000 women who tell us they have left a job due to the menopause.

14% of women had reduced their hours at work, 14% had gone part-time, and 8% had not applied for promotion. Menopause is clearly a cause of women's careers stalling, and a factor in the size of the gender pay gap.

Research which sheds any light on women's experiences of leaving work, or reducing working hours, has been relatively scant. Our own previous research asked women who are currently working within the financial services sector for their perspectives on future decisions. We found that the menopause had made half of menopausal women and trans men less likely to apply for promotion, and a quarter more likely to leave the workforce before retirement.²⁵ Smaller opinion polls have found that similar proportions of menopausal women are considering leaving their jobs – 18% in 2022,²⁶ and 43% in 2021.²⁷

The Government-funded review in 2017 suggested that most women in the UK do not leave work due to their menopause transition.²⁸ While our research does not track menopausal women in labour force data or use a longitudinal approach, it does suggest that significant numbers of women are leaving work due to their experience of the menopause.

We asked women whether they had done, or considered, a range of decisions in their working lives due to menopause symptoms: moving to part-time work, reducing hours, leaving their job, not applying for promotion, not taking a promotion that was offered, or retiring early. We also asked whether they had been fired or made redundant due to their symptoms.

Leaving work

We found that 10% of menopausal women who are or have been employed during the menopause have left their job due to their symptoms. Mapped on to the total UK population of 5 million women aged 45-55, that would represent 333,000 women leaving their jobs due to the menopause (see Appendix for calculations). A further 13% of menopausal women who have been employed during menopause have considered leaving their job. Disabled women were more likely to have left work due to the menopause (22%), as were women who told us they experienced five or more 'very difficult' menopause symptoms (19%).

25 Ibid.

26 People Management, accessed 11 April 2022 <https://www.peoplemanagement.co.uk/article/1743121/one-million-women-could-quit-due-lack-menopause-support>

27 Latte lounge, accessed 11 April 2022 <https://www.lattelounge.co.uk/42-of-women-consider-leaving-job-due-to-menopause/>

28 Brewis, Beck, Davis, Matheson. Ibid.

"I experienced being bullied at work and people not believing that my illness was real. I worked in a pharmacy, I was anxious, didn't want to go to work. It became that I didn't want to leave the house, it resulted that I walked out of my workplace and never returned."

"Before I knew I was in perimenopause I lost a job because I simply couldn't function any longer. I now work in menopause education because I don't want anyone else to struggle like I did."

[Survey respondents]

3% of menopausal women who were employed during menopause said that they had retired early as a result of their symptoms, while 13% said they had considered it. Notably, of the women in our sample who are currently out of work, only 13% of them said that they had retired early. This suggests that most menopausal women who are out of work have not left the labour market entirely.

"I am trying to just get on as normal, and treat as part of life but the brain fog is really scary and I was lucky I could leave my position which was managerial and take an early pension at 55, if I had been in the workplace still I am not sure I would have coped as the pressure of work and working in accountancy the level of detail needed would have made it impossible."

A similarly small proportion of women, 4%, said that they had been fired or made redundant due to their menopause symptoms. As with leaving work this was higher for disabled women (12%) and women with five or more 'very difficult' symptoms (9%).

"In [my] 2 last jobs I was a victim of intolerance just because I turned 50...I can't have HRT as I am a stroke survivor but I have a Mirena coil which has stopped my extensive and dangerous periods. I think women should be treated better by employers; I was made redundant only because I started to have heavier periods."

[Survey respondent]

Reducing work

A larger proportion of women who are or have been employed during the menopause said that they had reduced their hours at work (14%), or moved to part-time work (14%). Disabled women were more likely to have taken these steps (23% for each), as were women with five or more 'very difficult' symptoms (25% and 24%). 28% of women who work part-time in our sample said that they had moved into that work pattern because of their menopause symptoms. A further 18% of women who have been employed during the menopause said that they have considered reducing their hours, and 14% have considered moving to part-time work. We know that women's concentration in lower-paid part-time work is a cause of gendered economic inequality, and this data suggests that menopause has a role to play in that.

Opportunities

8% of women who have worked during the menopause said that they had not applied for a promotion due to their menopause symptoms, while 4% said that they had not taken a promotion that was offered. In a concerning finding for those who want to promote female talent in the upper reaches of business, more women in the AB social group (main household earner in professional or managerial roles) said that they had not applied for a promotion due to menopause symptoms (9%) compared with women in C2 or DE groups (6%). Disabled women are more likely to have decided not to apply for promotion due to their menopause symptoms than non-disabled women (14% compared with 7%).

The law and menopause

Women clearly face barriers and poor outcomes at work due to the way their employers respond to menopause – but what protection do they have? Menopause sits awkwardly within the main UK equality law, the Equality Act 2010. It is a result of a combination of the protected characteristics of sex and age. There is provision in the Act for 'dual discrimination' on this basis to be addressed, but that part of the act – section 14 - has not been brought into force by the Government.

The other route for women to take discrimination claims is by treating menopause symptoms as a disability, which was the route taken in the case of *Rooney v Leicester City Council*.²⁹ Ms Rooney worked as a social worker for the council, and experienced severe perimenopausal symptoms including depression, anxiety, hot flushes and insomnia, and the Employment Appeal Tribunal ruled that this constituted a disability for the purposes of the Equality Act. However, there is no guarantee that all menopausal women would be able to access this protection, particularly if their symptoms are less severe.

Treating menopause as a disability has some positive aspects, because disability discrimination law requires employers to make reasonable adjustments to workplaces. Given the impact that we demonstrate (below) that things like dress codes have on menopausal women, this protection is likely to be useful. Other aspects of the treatment of disability in equality law however, like the option of positive discrimination in recruitment, may seem less relevant to the menopause – and women may rightly have concerns about a natural stage of life being treated as a disability. A standalone menopause provision could have the potential to overcome these issues, although as we set out in the next chapter, we cannot place the entire burden on women to seek their rights – employers and Government must play their part proactively.

Recommendations

Women need protection that works for menopause. Government should consult on reforming equality law to protect menopausal women by either implementing section 14 of the Equality Act 2010 on dual discrimination, or creating a standalone menopause provision.

29 [2021] EA-000070-DA

What are employers (not) doing?

There is consistent evidence that a mix of appropriate interventions by employers can support women: culture change, training, advice on menopause, adapting absence policies, flexible work, and environmental changes.

But for each of these, eight out of ten women in our survey said their employer had not put them in place. When they do, most women say that they are helpful.

Research has identified changes which help

The 2017 Government-commissioned review of menopause in the workplace concluded that there is consistent evidence about the appropriate interventions that employers can make to support women, and that the best approach is a mix of actions to support women in all their diversity. They cite culture change, training, specialist advice on menopause, adapting absence policies, flexible work, and environmental changes (e.g. to toilets, heating/cooling, and hot desk policies).³⁰

"I spent most of my time when I used to work with my head in a fan and colleagues laughing at my hot flushes. It was too hot in the office for me and I felt hot sweaty and embarrassed all the time."

[Survey respondent]

Our 2021 study found support among menopausal women in the financial services sector for the integration of menopause support into existing diversity and equality policies.³¹ This is supported by tentative findings that this approach can be as effective as setting out specific menopause policies.³²

However, studies identify that there is little evidence to date on the degree to which these kinds of policies are implemented.³³ The TUC's online survey of over 5,000 respondents found that just 18.8% said that their workplace provided information on the menopause at work, and just 10.2% said that their workplace had menopause guidelines or policies.

Most women's employers are not taking action to support them

We asked women who had been employed during the menopause whether their employer took any of the following steps, which are attested in the research literature as being valuable when supporting menopausal women in the workplace:

- Shared information about the menopause with staff e.g. via intranet or notice board
- A support network for menopausal women
- Senior leaders have made statements about menopause to raise awareness
- Introduced menopause training or a briefing session for managers
- Introduced menopause training or a briefing session for all staff
- Have a designated person you can speak to about the menopause
- A policy for staff to take time off for menopause reasons

30 Brewis, Beck, Davis, Matheson. Ibid.

31 Standard Chartered Bank, Financial Services Skills Commission, Fawcett Society. Ibid.

32 Targett, Beck. Menopause as a well-being strategy: organisational effectiveness, gendered ageism and racism. Post Reproductive Health 28(1) 23-27. 2022.

33 Brewis, Beck, Davis, Matheson. Ibid.

As Figure 6 shows below, the answer was overwhelmingly 'no'. The proportion of employers currently undertaking these simple steps appears to be in line with the very low figures found in opt-in surveys. There is a clear case for action by employers and government to remedy this situation. Most of the steps we surveyed about are ultra-low-cost, ranging from simple awareness raising to allocating a point of contact role to existing staff. Those which do bear a cost, in the form of an absence policy and training, are likely to be far outweighed by the benefits of avoiding some of the impacts we have outlined.

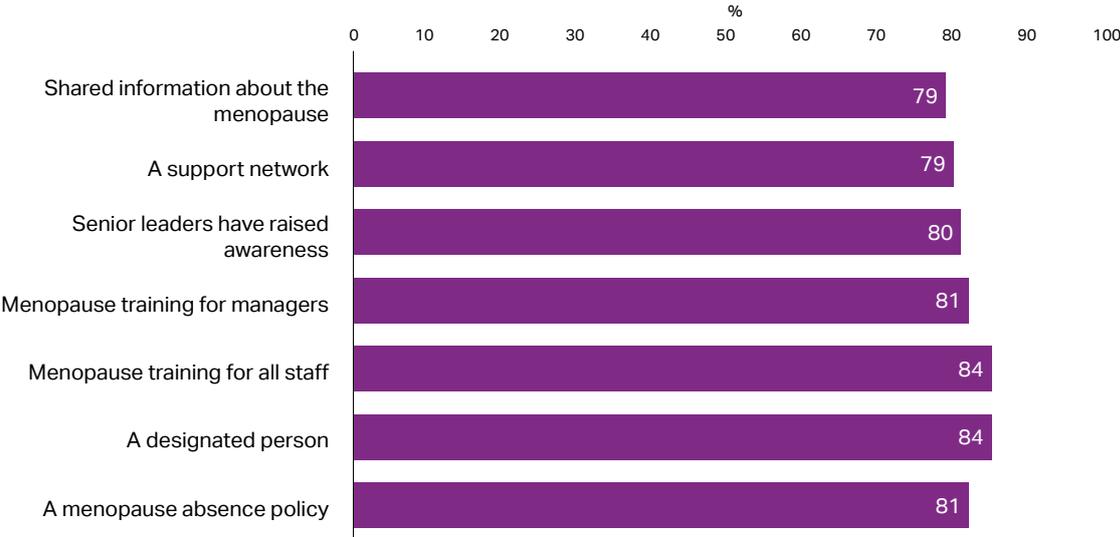
"I used to get really angry and easily upset at work. My manager gave me a written warning instead of talking to me about how I was feeling."

"Just that employers need to be a bit more lenient for those going through menopause. I strongly agree that there should be a counsellor at work to discuss menopause with women going through it."

[Survey respondents]

Fig 6: Most employers are not taking action: % saying their employers did not do the following

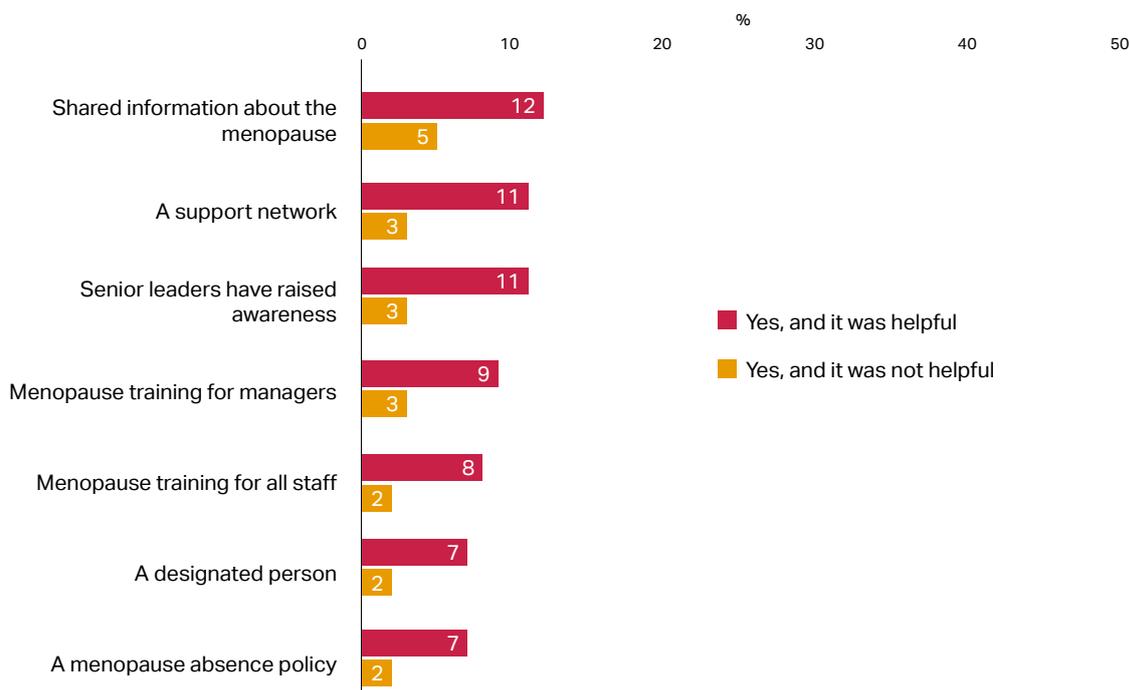
N: 3277 respondents who have been employed during the menopause



When women said that their employers had taken action the majority felt that these steps were helpful. Simple information sharing was the most common action for employers, with 17% of women saying they had seen this. Those who found it helpful outnumbered those who said it was not helpful by more than 2:1, the highest ratio among the actions. This suggests that more intensive steps like training or a menopause absence policy are more helpful, but less frequently taken by employers at present.

Fig 7: Most employers are not taking action: % saying their employers did not do the following

N: 3276 respondents who have been employed during the menopause



Women living in London were significantly more likely to say that their employer has taken action than in the UK as a whole. 18% of women in London said their employer had put in place a menopause support network, compared with 14% in the UK as a whole, while 14% of women in London said their employer had a menopause absence policy, compared to 9% in the UK as a whole.

Dress codes cause problems for many women

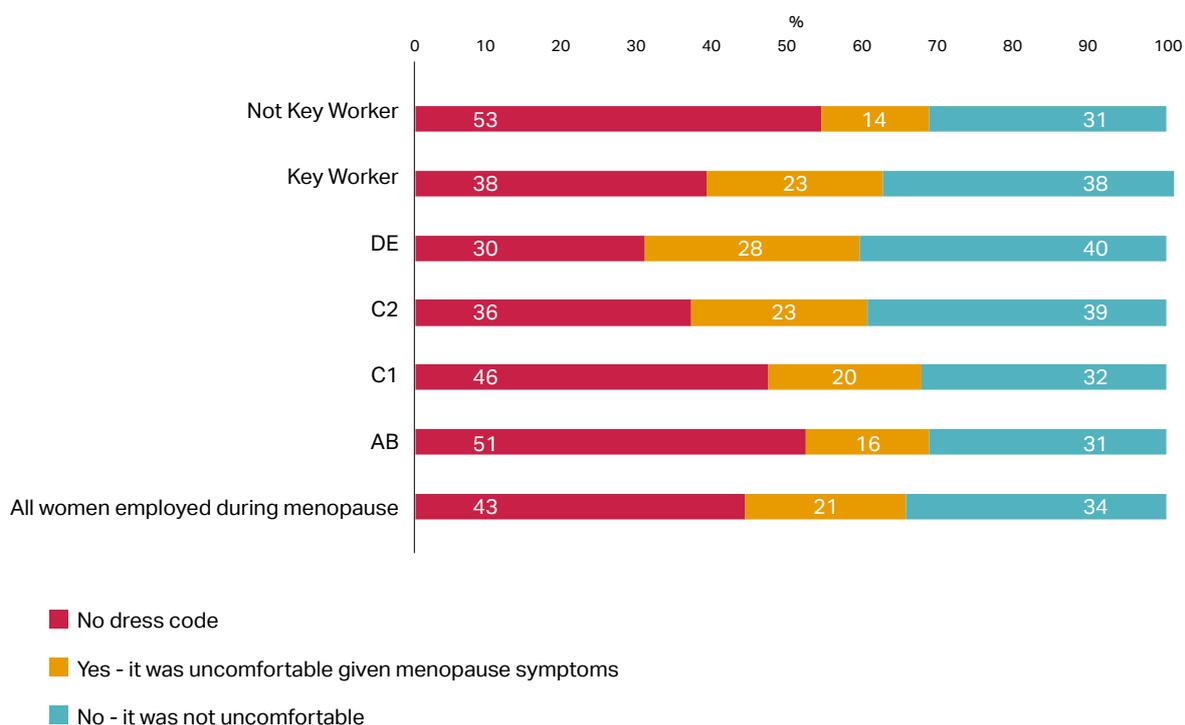
Some respondents to the WESC inquiry noted that uniforms made of breathable materials would have helped them during the menopause.³⁴ However, there has been little evidence to date of the extent to which dress codes and uniforms impact menopausal women in the workplace.

We asked respondents who had been employed at any point during the menopause whether they had a dress code or uniform at work, and whether that was uncomfortable given their menopause symptoms. Around four in ten women (43%) had no experience of a dress code. Two in ten (21%) said they had, and it was uncomfortable, while for a third (34%) their workplace dress code had not been a problem.

34 Women and Equalities Committee. Ibid.

Fig 8: Most employers are not taking action: % saying their employers did not do the following

N: 3,276 respondents who had been employed at any point during the menopause



This data differed significantly by social group. Almost 3 in 10 (28%) women in the DE occupational grade said they had experienced discomfort due to their uniform, while 16% of women in the AB group said they had. 23% of key worker women experienced discomfort due to their dress codes, compared with 14% of non-key worker women.

“Face masks are essential in my workplace as a healthcare Assistant, I have struggled with this as it raises my temperature along with flushes. Employers could supply good safe breathable masks which I think would help considerably.”

[Survey respondent]

What should be done

These findings set out a damning picture of work in the UK for menopausal women. Very few women we surveyed described their employers taking even simple steps to support them in the workplace, or provide information that could prove life changing.

A route to change this could be requiring employers to set out action plans on the menopause. Fawcett has long called for mandatory employer action plans to tackle their gender pay gaps, rather than just reporting on them – the UK are behind the curve internationally by not mandating any action,³⁵ and research when reporting was introduced found that only 48% of employers had produced any kind of plan, regardless of the quality.³⁶

35 Fawcett Society and GIWL. Bridging the gap? An analysis of gender pay gap reporting in six countries. 2021

36 Government Equalities Office. Gender Pay Gap Information Regulations 2017. Summary of reported data for 2017/18. 2018.

This is clearly an area which needs reform, and this presents a good opportunity for guidance to require employers to take action and support menopausal employees. Our survey finds that women would support this change. 81% agreed that every employer should have an action plan to help employees with the menopause.

Fawcett's previous work on menopause has also highlighted the important role that positive flexible working policies have on menopausal women,³⁷ in addition to the vital role they can play in enabling mothers, carers, and disabled people (all of whom may also be menopausal) to progress at work. We recommend that Government require all employers to include the possible flexibility options within all job advertisements. Trials at the insurer Zurich found that doing so increased the proportion of women applying to senior roles by 19%.³⁸ Employers can take this step themselves ahead of legislative change.

Recommendations

Government should require employers to have action plans on the menopause. The Department for Business, Enterprise and Industrial Strategy, and the Government Equalities Office, should reform the law to require employers to put in place gender pay gap action plans. The guidance setting out how to create a plan should make clear that taking well-evidenced, low-cost actions to support women with menopause is key to closing the gap.

As a first step, Government should produce guidance on closing the gender pay gap which goes beyond recruitment and progression to include the menopause.

Employers should set out their own action plans to support menopausal employees. The areas set out in our report point the way toward simple steps which are attested in the evidence to support women – training, information sharing and leadership, networks and solidarity, flexible work, and absence policies and dress codes which support menopausal women.

Government should make flexible work the default. All jobs should be required to be advertised with any possible flexible work options, and requests should not be turned down without a good and proportionate reason, so that menopausal women can access this important accommodation to their symptoms.

37 Standard Chartered Bank, Financial Services Skills Commission, Fawcett Society. Ibid.

38 Hacothen, Davidson, Roy-Chowdhury, Bogiatzis-Gibbons, Burd and Likki. Changing the default: a field trial with Zurich Insurance to advertise all jobs as part time. Government Equalities Office. 2019

Hormone Replacement Therapy

Hormone replacement therapy (HRT) is effective at alleviating menopause symptoms, but just 14% of menopausal women are currently taking it.

54% of women using HRT say it has given them their life back.

Among women who have not tried HRT, low impact of menopause symptoms was the biggest reason (28%). 24% said that worries about the risk of cancer or other illnesses was a factor, while a 24% also said that they don't know enough about HRT.

Testosterone has been shown to help with low sexual desire, which causes 54% of menopausal women difficulty, but just 33% of women are aware of its use in HRT.

What the medical evidence shows

Our research demonstrates the scale of the impact that women describe due to menopause symptoms. Eight out of ten women experience difficulty sleeping, while seven out of ten experience brain fog. For 44% of women menopause impacts their ability to do their job, while one in ten have left work.

There are a range of methods women use to reduce the impact that symptoms have, and US studies suggest that around 30-80% of women who experience hot flushes try non-hormonal therapies.³⁹ Many women find that these can be helpful, and the British Menopause Society does advise taking lifestyle steps to support the menopause transition, although research evidence on some, such as exercise to reduce hot flushes, is limited.⁴⁰

Benefits and risks

Hormone replacement therapy (HRT) is when women are prescribed hormones to replace those produced by the body in lower levels during the menopause. The hormones can be replaced with a combination of oestrogen, progesterone, and testosterone; and they can be taken through a range of tablets, patches, gels, or spray. Vaginal hormonal creams, gels, pessaries and rings can also be given but as these only work locally, they are not HRT.⁴¹ Compared to placebos, HRT is highly effective at relieving the symptoms of menopause our respondents described.⁴²

Generally, women with a uterus (i.e. who have not had a hysterectomy) may be prescribed oestrogen and progesterone,⁴³ while women without a uterus usually only need oestrogen. The different forms in which these hormones are offered can make a difference to outcomes. In particular, older forms of synthetic progestogens, often taken orally, differ from newer micronised progesterone (sometimes called body identical) forms (as explored below).⁴⁴

39 Biglia, Bounous, De Seta, Lello, Nappi and Paoletti. Non-hormonal strategies for managing menopausal symptoms in cancer survivors: an update. *Eancermedicalscience* 13:909. 2019.

40 Daley, Stokes-Lampard, Thomas, MacArthur. Exercise for vasomotor menopausal symptoms. *Cochrane Systematic Review*. 2014. Sternfeld et. al. Efficacy of exercise for menopausal symptoms: a randomized controlled trial. *Menopause* 21(4) 330-338. 2014.

41 NHS website, Hormone Replacement Therapy, accessed 12 April 2022 <https://www.nhs.uk/conditions/hormone-replacement-therapy-hrt/>

42 MacLennan. Evidence-based review of therapies at the menopause. *Int J Evid Based Healthc* 7 112-123. 2009

43 In order to protect against endometrial cancer risk.

44 Newson and Lass. Effectiveness of transdermal oestradiol and natural micronized progesterone for menopausal symptoms. *British Journal of General Practice*. 68 (675) 499-500. 2018.

In 2003, findings of the Women's Health Initiative (WHI) Randomized Trial of oestrogen and a progestogen (synthetic progesterone) in a sample of 16,608 menopausal women identified a higher risk of breast cancer growth and development.⁴⁵ This study has been recognised as resulting in significant reductions in the number of women using HRT worldwide,⁴⁶ and studies in other countries have found that women search more frequently for HRT information relating to breast cancer than hot flushes.⁴⁷

However, subsequent reviews of the literature have concluded that oestrogen-only HRT is associated with lower breast cancer risk.⁴⁸ Progestogen and oestrogen combined may be associated with an increased risk. However, this risk is low in medical and statistical terms,⁴⁹ and the follow-up to the WHI study found a reduction in all-cause cardiovascular or cancer mortality in women who took HRT.⁵⁰

"I just wish there was a tablet to stop the hot sweats, I won't go on HRT because of the all the horror stories and I knew a woman who took HRT and she developed breast cancer so I definitely won't be taking it."

[Survey respondent]

Newer forms of HRT

Evidence from a large-scale French study also identifies that the type of progestogen offered makes a significant difference. Newer forms of micronised⁵¹ body-identical progesterone were associated with no increase in breast cancer risk after five years' use, and a smaller increase than older forms of progestogens when taken for five or more years. There is also evidence that micronised progesterone reduces the impact of side effects.⁵²

Beyond breast cancer risk, studies agree that HRT reduces the risk of both type 2 diabetes and osteoporosis while it is being taken. HRT taken within 10 years of menopause is linked with a lower risk of cardiovascular disease.⁵³ Transdermal HRT (that is, dispensed via patches, gels or spray) has no increased risk for venous thromboembolism or stroke, while oral HRT does have an increased risk.⁵⁴

More recent peer-reviewed evidence, released after the most recent review by NICE, the body which provides guidelines on medicines, explored a large-scale dataset of medical insurance records in the US. They found that HRT use lowered women's risk of neurodegenerative diseases like Alzheimer's disease and dementia, which disproportionately affect women. Newer body identical forms of HRT have greater efficacy in this respect.⁵⁵ Research suggests that the protective effects occur when HRT is begun when perimenopause symptoms begin.⁵⁶

45 Chlebowski, Hendrix, Langer et al. Influence of Estrogen plus Progestin on breast cancer and mammography in healthy postmenopausal women: the Women's Health Initiative Randomized Trial. JAMA 289(24) 3243-3253. 2003.

46 Constantine, Graham, Clerinx, Bernick, Krassan, Mirkin and Currie. Behaviours and attitudes influencing treatment decisions for menopausal symptoms in five European countries. Post Reprod Health. 2(3) 112-122. 2016.

47 Hajesmaeel-Gohari, Shafiei, Ghasemi and Bahaadinbeigy. A study on women's health information needs in menopausal age. BMC Women's Health 21 434. 2021

48 LaCroix AZ, Chlebowski RT, Manson JE, et al. Health outcomes after stopping conjugated equine estrogens among postmenopausal women with prior hysterectomy: a randomized controlled trial. JAMA 2011; 305:1305-1314

49 MacLennan. Ibid. Hamoda, Panay, Pedder et. al. The British Menopause Society and Women's Health Concern 2020 recommendations on hormone replacement therapy in menopausal women. Post Reproductive Health. 2020.

50 Newson and Lass. Ibid.

51 A process which enables the hormone to be more steadily absorbed into the bloodstream

52 Hamoda, Panay, Pedder et. al. Ibid.

53 Boardman, Hartley, Eisinga, Main, Roqué i Figuls, Bonfill Cosp, Gabriel Sanchez, Knight. Hormone therapy for preventing cardiovascular disease in post-menopausal women. Cochrane Database of Systematic Reviews 2015, Issue 3. Art. No.: CD002229. DOI: 10.1002/14651858.CD002229.pub4.

54 NICE. Summary of evidence for 2019 surveillance of menopause (2015) NICE guideline NG23. <https://www.nice.org.uk/consultations/672/10/long-term-benefits-and-risks-of-hormone-replacement-therapy>

55 Kim, Soto, Branigan, Rodgers and Diaz Brinton. Association between menopausal hormone therapy and risk of neurodegenerative diseases: Implications for precision hormone therapy. Alzheimers Dement (NY) 7(1). 2021

56 Mosconi and Diaz Brinton. How would we combat menopause as an Alzheimer's risk factor? Expert Review of Neurotherapeutics 18(9) 689-691. 2018.

Micronised progesterone is currently only available as the drug Utrogestan in the UK. Campaigners have highlighted geographical inequalities in access Utrogestan, which is not available on the NHS in Scotland,⁵⁷ and, as highlighted in the documentary with which this report shares a dataset, parts of the UK such as the North East, East Anglia, Wales, and Northern Ireland.

"I was put on a tablet HRT for nearly 2 years. It helped with the hot flushes but nothing else. I am now on a slow release patch which has cleared my brain fog and made my life so much better."

[Survey respondent]

An individual choice

This report does not and cannot offer medical advice to individual women, who will need to weigh up risks and benefits given their own medical history and experiences of menopause, with support from medical professionals. However, it is clear that some of the concerns present in the public discourse about HRT do not reflect the current state of medical evidence, and that HRT is effective for many women at treating menopause symptoms.

The evidence base for impacts of HRT in the workplace is underdeveloped, but there is some evidence to suggest that it can reduce the impact of symptoms which affect menopausal women in the workplace.⁵⁸

How many women are taking HRT?

Prior to the 2003 study which raised national alarm bells about risks associated with HRT, a survey of a million women in the UK between 1996-2000 found that a third of women aged 50-64 were taking HRT.⁵⁹ Our survey, albeit with a different age group of women,⁶⁰ found a much lower incidence of women now taking HRT.

Just 14% of our respondents are currently taking HRT, while 7% said that they used to take HRT but have stopped. That means 79% of perimenopausal and menopausal women have never tried HRT. Our data shows significant variation in usage by social grade – 16% of women in the AB social group were using HRT, while only 12% of those in the DE group are accessing it.

We can split our data between women who described themselves as perimenopausal, menopausal, or post-menopausal within the 45-55 age range. 22% of those who describe themselves as menopausal are taking HRT, more than those who are perimenopausal (11%) or post-menopausal (8%). 14% of post-menopausal women used to take HRT but have stopped, while 9% of menopausal women and 4% of perimenopausal women have done so.

"Haven't seen a doctor because I can't afford the prescription."

[Survey respondent]

57 The Herald. Utrogestan petition. 'Women can't get the safest HRT'. 27 August 2021

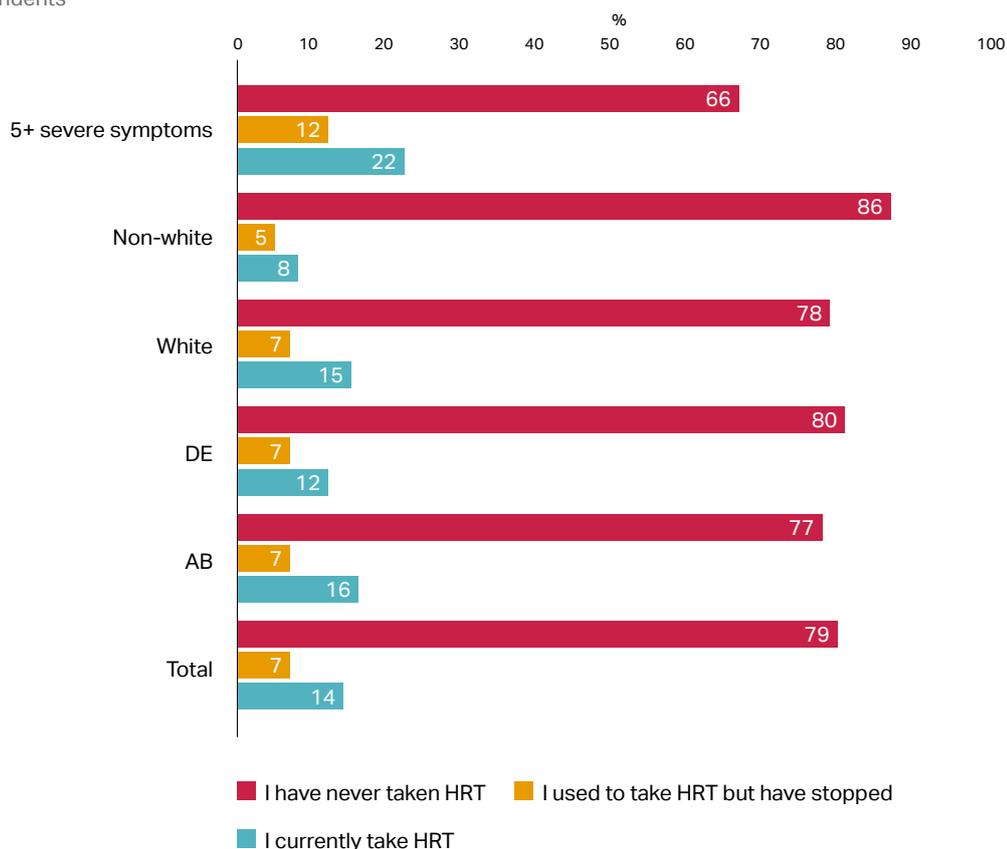
58 Brewis, Beck, Davis, Matheson. Ibid.

59 Million Women Study Collaborators. Patterns of use of hormone replacement therapy in one million women in Britain, 1996-2000. BJOG: An International Journal of Obstetrics and Gynaecology. 109(12) 1319-1330. 2002.

60 Although the Million Women study found that HRT use was twice as high at age 50-54, while we find current use at 16% among 53-55 year olds.

Fig 9: Do you or have you taken hormone replacement therapy (HRT)?

N: 4,014 respondents



We also found a large disparity between white women, of whom 15% were taking HRT, and Black and minoritised women overall, of whom just 8% were taking it. This reflects the findings of a small opt-in study of Black women in the UK, which found that just 10% were taking HRT.⁶¹

Understandably, more women with five or more severe menopause symptoms were taking HRT, but only 22%, or less than a quarter, of women in this group were taking HRT while 12% used to but had ceased.

What impact does it have?

We asked women currently taking HRT – a weighted sample of 578 women – the extent to which they agreed or disagreed with a range of statements.

54% of menopausal women taking HRT agreed that it had given them their life back, compared with 18% who said that it “is not helping me much”. 36% of women taking HRT and who are currently working said that it had helped them to be productive at work, and 36% of key worker women also said this. Just 2% said that they planned to stop HRT because of the side effects.

We asked the sub-sample of 265 women who had stopped taking HRT for their views on a number of statements. 27% said that the side effects were too severe, while 20% said that their menopause symptoms improved and they stopped needing it. 17% said that they were worried it would increase their risk of cancer, but 16% said that it didn’t help and their doctor or nurse did not try another type of HRT. 12% said they would like to try again, but cannot get access.

61 Wokoma and Oboh. Black women and menopause; survey of menopause transition among black women in the United Kingdom. *Post Reproductive Health* 2021 27(4) 226-231

Our samples for some of these responses are small, so should be treated with caution. What is clear is that a majority of women taking HRT express agreement with a strongly positive view of its impact, and over a third of working women say it increases their productivity. Among those who stopped, a mix of side effects, fear, and natural improvements in symptoms were behind their decision.

"I was having terrible hot flushes and unable to have a decent night's sleep but HRT patches have helped and I don't have the flushes anymore and am able to get some proper sleep."

[Survey respondent]

Women who have not tried HRT

Of the women in our sample who had not tried HRT, the vast majority – 92% – had heard of it. We presented this group with a range of statements relating to perspectives on HRT and reasons for non-take-up of the treatment. Among them, the greatest proportion (28%) said that they did not need HRT as their symptoms were not a problem for them – as we would expect, this was true for 53% of those who reported no severe menopause symptoms.

However, the second most commonly agreed with statement was that "I am worried that it would increase my risk of cancer or other illnesses", which 24% of women said. This rose to a third (33%) among women of colour, and 32% among respondents with five or more severe menopause symptoms, suggesting a fairly large group of women for whom concerns about cancer are outweighing potential significant benefits. A quarter of women (24%) said that they didn't know enough about HRT, while a fifth (21%) said they would like to know more about it.

"I want to take HRT but don't feel I can bother my GP."

"Can't get access to HRT...tried and never any stock available!"

"I really am bothered with low mood, brain fog... opt out of things due to low mood. People don't take it seriously enough, my mum died of a heart attack she was using her patches that's why I'm dubious of it."

[Survey respondents]

Testosterone and HRT

54% of women responding to our survey said that they found a loss of interest in sex during the menopause difficult, and of these 26% said that they found it very difficult. NICE guidelines suggest that, for women who experience this loss of libido, and where oestrogen and progesterone do not help, testosterone may be offered.⁶² However, testosterone is not currently licensed in the UK for use in women to treat menopause, meaning that it can only be supplied off-label,⁶³ and that the available testosterone products on the UK market are designed for men with a high concentration of the drug.⁶⁴ A licensed testosterone product for women is available in Western Australia and can be imported through a special license from the UK medicines regulator, the MHRA.⁶⁵

62 National Institute For Clinical Excellence. Menopause: diagnosis and management NICE guideline [NG23]. 2019

63 I.e. prescribed by a qualified medical professional outside the terms of that medicine's licence.

64 Johansen, Hirschberg, and Moen. The role of testosterone in menopausal hormone treatment. What is the evidence? Acta Obstetrica et Gynecologica Scandinavica. 99(8) 966-969. 2020.

65 British Menopause Society. Tools for clinicians: Testosterone replacement in menopause. 2019.

A review of available evidence in 2020 concluded that treatment of menopausal low sexual desire with testosterone improved sexual function and led to more satisfying sexual episodes and sexual desire compared with a placebo, with mild side effects.⁶⁶ This echoes the findings of past reviews.⁶⁷

We found that just 33% of women had heard of testosterone being used to treat menopausal symptoms as part of HRT. Women with more severe symptoms were slightly more likely to have heard of its use.

Given that a quarter of menopausal women in the UK say they find loss of interest in sex caused by the menopause very difficult, a situation where a treatment that research has shown to alleviate menopause symptoms is unavailable as a licensed medicine is not an acceptable one.

“Testosterone needs to be licensed for women so that women can be prescribed it.”

[Survey respondent]

Recommendations

The Department for Health and Social Care should work with the Medicines and Healthcare Products Regulatory Agency (MHRA) and pharmaceutical companies to bring a testosterone replacement product, designed for the female body, to the UK market as quickly and safely as possible. 81% of respondents to our survey said that Government should support all women who want it to take hormone replacement therapy – without a licensed testosterone product for women, we are some way off making that a reality.

66 Johansen, Hirschberg, and Moen. Ibid.

67 Bolour and Braunstein. Testosterone therapy in women: a review. International Journal of Impotence Research 17 399-408. 2005.

GPs and the Menopause

45% of women said they had not talked to someone at their GP practice about menopause, Even among women with five or more severe symptoms, 29% had not spoken to their GP or a nurse.

31% of women agreed that it took many appointments for their GP to realise they were experiencing the menopause or perimenopause, rising to 45% among women of colour and 42% among women with five or more severe symptoms.

Only 39% of women who spoke to a GP or nurse said they had been offered HRT once they were diagnosed with menopause. This is despite NICE guidance being clear that HRT, with discussion of risks and benefits, should be a first port of call for treatment.

Existing research

For women seeking support with their menopause symptoms, either for HRT, lifestyle changes, or other forms of medical support such as antidepressants for hot flushes, their GP surgery is likely to be their first point of contact.⁶⁸ Opt-in survey research, including a body of evidence collected by Newson Health Research and Education, has suggested that some women are having a negative experience of taking menopause-related concerns to their GP.

One opt-in online survey of 5,187 women found that 7% attended a GP surgery more than ten times before receiving adequate health or advice, and that 44% who eventually received treatment had to wait for a year or more. That survey found that 79% had visited their GP about their symptoms.⁶⁹ Another found that one in four women (26%) discussed hormones with their doctor, while 30% were prescribed antidepressants.⁷⁰

The Department for Health and Social Care's own opt-in survey of nearly 100,000 respondents to inform its Women's Health Strategy found that 64% of women feel comfortable talking to healthcare professionals about the menopause, compared to 85% for general physical health concerns and 77% for menstrual wellbeing – suggesting a stigma that goes beyond those which affect other women's health issues.⁷¹

Women are not approaching their GP about the menopause

Our data found that large numbers of women are not approaching their GPs, or a nurse at their GP surgery, about the menopause. Just 55% of women said they had talked to someone at their practice, while 45% said they had not. Women who were in the higher end of the age range of our sample (52-55) were more likely to have raised this topic with a GP, at 58% compared with 50% for women aged 45-48 – but that means that 42% of women aged 52-55 had still not discussed the menopause with their frontline health workers.

68 In many other countries it is likely to be a gynaecologist. Constantine, Graham, Clerinx, Bernick, Krassan, Mirkin and Currie. Ibid.

69 Newson and Lewis. Impact of Perimenopause and Menopause on Work. Accessed online at <https://balance-website-prod.s3-eu-west-1.amazonaws.com/uploads/2021/10/Menopause-and-work-poster-RCGP.pdf>

70 Newson and Lewis. Delayed diagnosis and treatment of menopause is wasting NHS appointments and resources. Accessed online at <https://d2931px9t312xa.cloudfront.net/menopausedoctor/files/information/632/BMS%20poster%20Louise%20Newson%202021.pdf>

71 Department of Health and Social Care. Ibid.

Disabled women are more likely to say that they had talked to their GP, at 65% compared to 53% of non-disabled women. Women with five or more severe symptoms were also more likely to say they had spoken to their GP, but despite their difficulties 29% of women in this group said that they had not spoken to anyone at their practice about their menopause symptoms.

“At the moment I am trying to control my symptoms with my diet and vitamins, I feel that when I go to the GP, I do not feel confident with their advice, especially when they offered me anti-depressants.”

“I feel like I am having menopause, all the symptoms apply to me. I am actually considering talking to my GP but haven’t done yet. What delays me to consult GP is that I know how busy they are, and I have a fear of not being taken seriously.”

“If it was easier to speak to a nurse or GP I would definitely enquire about HRT. Their services are too difficult to access now.”

[Survey respondents]

Three in ten women say they experienced delays in diagnosis

Most menopausal women who did speak to their GP felt that their healthcare professionals were well informed about the menopause. At 67%, a significant majority of women agreed or strongly agreed that they seemed knowledgeable about the menopause or perimenopause, while 14% neither agreed nor disagreed and 18% disagreed or strongly disagreed.

However, when we asked whether women agreed or disagreed that it took many appointments for their GP to realise they were experiencing the menopause or perimenopause, 31% agreed or strongly agreed. Our sample size for women of colour who had been to their GP is small but we find a significant difference with white women – 45% of women of colour said that it took many appointments to reach a diagnosis, while 30% of white women agreed. Concerningly, agreement was also higher among women who experienced five or more severe menopause symptoms, with 42% of women in this group agreeing that it took multiple appointments compared with 18% among those who reported no severe symptoms.

“Not all symptoms are the same for women, currently my periods are 3/4 months apart, I am thankful to my GP who diagnosed me early and gave me supportive websites to view and I was aware early, migraines was my first indication that I was going through the menopause.”

“I was not aware I was perimenopausal as it came at 44 years, and did not know that my joint pain problems were related to menopause. A few doctors examined me and prescribed various treatments for joint pain and it NEVER occurred to them to ask if I was perimenopausal and think it might be related! Unbelievable! I basically self-diagnosed, found a private menopause consultant, paid a fortune only to get my diagnosis confirmed! Started HRT, all joint pains (alongside the other text-book classic symptoms of menopause) disappeared within a week. But the struggle it took!!!”

“I have been really shocked by the wide range of symptoms caused by perimenopause that I previously had no knowledge of. Am also very disappointed that my GP would not recognise anxiety as a major symptom, despite evidence available. I am hoping to try HRT in the next couple of weeks.”

[Survey respondents]

GPs and HRT

The first line of NICE guidance on menopause for managing short-term menopausal vasomotor symptoms (i.e. hot flushes and night sweats), or psychological symptoms, is to offer or consider HRT after a discussion of short-term and longer-term benefits and risks.⁷² Our research suggests that this may not be happening. Just 39% of women who had talked to a GP or nurse about the menopause said that they had been offered hormone replacement therapy as soon as the woman knew she was experiencing the menopause or perimenopause.

This rises slightly, as we would hope, among women who experienced more than three severe menopausal symptoms, to 42% among women experiencing 3 or 4 severe symptoms, and 44% among those experiencing five or more.

However, among those with five or more severe symptoms, it was still the case that 46% of women said that their GP or nurse had not offered hormone therapy as soon as their menopause diagnosis was confirmed.

On the other side of the equation when it comes to HRT, 28% of women who had spoken to their GP or a nurse about menopause agreed that the health professional had given information which made them worry about taking HRT. Almost half (45%) of women who used to take HRT but have stopped agreed that this had happened, and so did 37% of women with five or more severe symptoms. Our quantitative data does not allow us to explore the extent to which this information was a fair reflection of the current medical understanding of risks relating to HRT, but it does indicate that a little over a quarter of women are coming away from their GPs with worries about HRT.

“I have discussed my symptoms with GP but she wanted to rule out everything else, i.e. vitamin deficiency, other tests before she attributed symptoms to menopause and wouldn't prescribe HRT. I haven't had a period for over 2 years.”

“Told I couldn't take HRT as still having periods and doctors will only recommend when periods have completely stopped.”

[Survey respondents]

HRT and antidepressants

Prescriptions of antidepressants during menopause will not necessarily be invalid: doctors may prescribe them due to existing or underlying mental health conditions, and they can also be an effective treatment for hot flushes in women for whom HRT is not recommended for medical reasons.⁷³ However, NICE clinical guidelines are clear that antidepressants have not been shown to help with low mood during menopause, if that symptom is distinct from diagnosed depression.⁷⁴ Commentary on this issue in the media suggests that women are being incorrectly prescribed antidepressants rather than being offered HRT for menopausal mood symptoms.⁷⁵

The findings from our survey are not sufficiently detailed to be conclusive on this issue, but they do suggest that there may be incorrect prescribing happening in the UK. We asked respondents to our survey who had talked to a GP or nurse about the menopause whether they had been offered antidepressants for their menopause or perimenopause symptoms. 6% said they had been offered them for their hot flushes or night sweats, in line with guidance that SSRI antidepressants can be

72 National Institute For Clinical Excellence. Ibid.

73 Biglia, Bounous, De Seta, Lello, Nappi and Paoletti. Ibid.

74 National Institute For Clinical Excellence. Menopause: diagnosis and management NICE guideline [NG23]. 2019

75 Women's Health Concern, Ursula Hirschhorn. HRT instead of anti-depressants. 30 June 2015.

effective for these symptoms. However, 28% said that they had been offered antidepressants for low mood, anxiety or depression caused by menopause (i.e. not underlying or separate conditions), while a further 8% said they had been offered antidepressants but refused them.

“Feel pretty much that I’ve been misdiagnosed and doctors are all too keen on prescribing anti-depressants and anxiety medication without checking hormone levels first and there is no talk of any help in any workplace I’ve ever worked in and I’ve had many jobs.”

“I am already on medication for anxiety as I have been for a long time so my doctor mentioned the HRT to me or I could increase my anxiety medication, which I agreed to and it has helped.”

[Survey respondents]

The changes women want to see

Almost half of menopausal women have not spoken to anyone at their GP practice about their menopause symptoms, and that includes three in ten of those with the most severe symptoms. Placed alongside the evidence about a lack of knowledge about menopause symptoms among the public, there is a need for a public information campaign about the menopause.

Women in our survey agreed. 81% of women agreed (and just 4% disagreed) that Government should run a public campaign to inform people about the menopause.

There is also a strong case for creating a clear clinical pathway into primary care services for women experiencing menopause symptoms. There is a parallel to be drawn with the existing clinical pathways that relate to women’s health, from smear tests to breast cancer screening. Women are proactively contacted in relation to these aspects of their health, but despite its near-universal impact on women at some point in their life, the same is not true for menopause.

Our polling demonstrates support for this change. 87% of women agreed, and 60% of women strongly agreed, that all women in their 40s and 50s should be invited for a routine appointment by their GP to discuss the menopause and sent a list of menopause symptoms by the NHS.

“I received a leaflet from my doctor but felt less informed after reading it and a little deflated/disappointed that I had to research more (when I had the interest) about it but I lack motivation and just haven’t bothered as I worry some info may not be reliable online.”

[Survey respondents]

HRT treatment may not be right for every woman, but our research finds that for those who take it, it offers life-changing alleviation of symptoms, and all women who are struggling with menopause symptoms should be able to access the healthcare they need. Our survey suggests that not all GPs are following the NICE guidelines in offering it to women who present with significant impacts from menopause symptoms, and that some may be offering antidepressants where they are not appropriate.

We do not seek to blame GPs for this situation, as they deliver a vital service in difficult circumstances, particularly post-Covid. A freedom of information request by campaigner Diane Danzebrink has found that 43% of UK medical schools do not include the menopause as a mandatory part of the training they provide to doctors.⁷⁶ This issue is reflected in responses to the expert element of the Government's Women's Health Strategy consultation, which highlighted that menopause training often relies on self-directed training.⁷⁷

We agree with the British Menopause Society⁷⁸ that the government needs to ensure that at least one person in each GP surgery or primary care network has up-to-date, accredited training so that they can provide evidence-based healthcare to menopausal women; and that all GPs and practice nurses are trained to spot the basics so that menopausal women do not slip through the net.

"Ensure your GP listens to you, it took my urology consultant to get my vagina HRT."

"The menopause gave me suicidal thoughts and anger it was five years before my doctor listened to me. The first time I mentioned my symptoms my female doctor dismissed my symptoms saying she didn't suffer any of my symptoms."

[Survey respondents]

Recommendations

The Department for Health and Social Care should fund a nationwide public information campaign on the menopause. This should dispel myths that menopause is just about hot flushes, dispel the stigma, and provide women with the information that there is help available for their symptoms.

The Department for Health and Social Care should develop a standardised clinical pathway for menopausal women. This could involve an invitation sent at an appropriate age for all women to discuss potential menopausal symptoms and treatment with their GP or an appropriate nurse or pharmacist.

Government should ensure GPs and relevant healthcare professionals are trained on the menopause. This should involve work with UK medical schools to ensure that menopause, which affects 51% of the population, is a mandatory part of medical training. Funding for participation in accredited post-qualification training should be available to at least one person in each GP surgery or primary care network, so that women can access up to date care. Finally, comprehensive rollout of a minimum baseline knowledge should be provided so that all GPs and practitioners can refer and provide initial care.

76 Menopause Support. Menopause Support survey reveals shocking disparity in menopause training in medical schools. Menopause Support website. 2021

77 Department of Health and Social Care. Results of the written evidence submitted by organisations and experts to inform the Women's Health Strategy for England. 2022.

78 Currie, Abernethy and Hamoda. Vision for menopause care in the UK. British Menopause Society.

Appendix A

Calculations of figures for women affected

According to the most up-to-date available ONS mid-year population estimates,⁷⁹ there were 5,001,387 women aged 45-55 in the UK in the middle of 2020.

Our dataset included 4,014 respondents, but to arrive at that sample we filtered down from 4,975 women, as some younger women in the 45-55 age bracket did not identify that they had experienced menopause symptoms. As a result, we can use proportions of the whole 4,975 group to map our findings onto the whole UK population.

For the proportion of women leaving work, we had 332 respondents, so:

$$332/4975 * 5001387 = 333,761$$

⁷⁹ Office for National Statistics. MYE2: Females by single year of age and sex for local authorities in the UK, mid-2020. 2020.

Appendix B

Filter Question

To identify women to include in our sample we asked the following question:

The **menopause** (sometimes referred to as “the change”) is the point when a woman stops having periods. **Post-menopause** refers to women who have passed this point.

In the years before your period stops, women often experience a range of symptoms which are called the **perimenopause**. These can include: hot flushes, night sweats, difficulty sleeping, low mood or anxiety, problems with memory or concentration, joint pain, heavy periods, vaginal dryness or discomfort, and low interest in sex.

Do you believe you are currently experiencing the perimenopause or menopause, or that you have already experienced it?

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Fawcett Society
Studio 222
China Works
100 Black Prince Road
London, SE1 7SJ

www.fawcettsociety.org.uk
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