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Appendix H

Perimenopause and menopause: topic overview and data strategy

Caution: Some people may find parts of this content confronting or distressing, including content relating to pregnancy loss and termination of pregnancy. Please carefully consider your needs when reading the following information.

H.1 Topic overview

Background

The following topic overview is a summary of the key data gaps based on findings from literature reviews, data scoping and stakeholder consultation activities. Section H.2 identifies existing data sources and options for new data collection.

The impacts and experiences of perimenopause and menopause on individuals and broader society in Australia are poorly understood. A lack of robust data and research limits the ability of policy makers, health services, and support systems to plan and respond effectively to people experiencing perimenopause and menopause.

Menopause occurs when the reproductive capacity of a person ceases, signified by the absence of a menstrual period for one year. Menopause is preceded by perimenopause – a time characterised by changes in menstrual period frequency and regularity, the onset of oestrogen deficiency symptoms, and physical changes to the body and its functioning – which typically lasts 4 or more years (AMS 2022).

Available research shows that the breadth and severity of perimenopausal and menopausal symptoms is large and varied. The majority of people will experience mild vasomotor and cognitive symptoms, and though persistent, the impact on quality of life will not be severe (Gartoulla et al. 2015). Globally, prevalence of moderate-to-severe vasomotor symptoms ranged from 16% in Japan to 40% in Europe, indicating differences between ethnic groups (from a sample of over 25,000 people) (Nappi et al. 2021). In Australia, timely and affordable access to hormone therapies is affected by product shortages, limited subsidies and Medicare Benefit Scheme (MBS) rebates, and prescribing hesitancy due to varying understandings of menopausal hormone therapy (MHT) and its risk factors (Australasian Menopause Society 2025; Community Affairs References Committee 2024).

Stakeholder consultations, reports and published research have highlighted a range of barriers to appropriate care and support for perimenopause and menopause:

- Information on the experiences, needs and barriers to care of people experiencing perimenopause and menopause is limited (AIHW Stakeholder Consultations 2025).
- Limited information pertaining to perimenopause and menopause among under researched and priority populations hinders opportunities to expand menopause care to ensure it is culturally appropriate and beneficial (Community Affairs References Committee 2024).
- Understandings of perimenopause and menopause among many health care providers are inadequate to support timely and high-quality healthcare access and delivery (Community Affairs Reference Committee 2024).

- Tertiary education and ongoing training opportunities for health care providers in perimenopause and menopause are insufficient (AIHW Stakeholder Consultations 2025). As a result, many health care providers lack the skills and/or confidence to deliver appropriate care, leading to poor perimenopause and menopause treatment (Davis and Magraith 2023).

Priority populations

Understanding experiences of different groups within the population is necessary to inform policy and ensure equitable healthcare access and outcomes in Australia. Recognising the intersectionality among different population groups is also important to understand the complexity of these experiences. This section focuses on priority populations that were identified through the stakeholder consultation process and literature review in relation to perimenopause and menopause, but this is not intended to be an exhaustive list. Identifying priority populations is challenging due to the absence of comprehensive national data on experiences of perimenopause and menopause and accessing care (AIHW Stakeholder Consultations 2025). A full list of priority populations considered within the framework and data strategy is available in the Sexual and Reproductive Health Monitoring Framework and Data Strategy document, Section 2.5.

First Nations people

For First Nations people, understandings and perceptions of perimenopause and menopause differ to non-Indigenous Australians. Though limited, research into the experiences of First Nations people indicate the term ‘menopause’ is considered a ‘European word’, with terms such as ‘change of life’ or ‘the change’ preferred (Jurgenson et al. 2014). A clear delineation between men’s and women’s business was also identified, and people living outside metropolitan areas were less likely to report sufficient knowledge on the menopause transition or seek treatment (Jones et al. 2012). Through stakeholder consultations, it was acknowledged that perimenopause and menopause can be viewed through a positive lens by First Nations people. The consultation process also highlighted that MHT is not subsidised through the Closing the Gap program, limiting options for First Nations people to access MHT (AIHW Stakeholder Consultations 2025). There is a need to further explore the experiences of perimenopause and menopause in First Nations people and collect data on associated health outcomes to inform policy and programs.

People living in regional, rural and remote areas

People living in regional, rural and remote areas experience reduced access to timely and appropriate healthcare services. The Australasian Menopause Society provides information on practitioners with skills and/or interests in menopause, highlighting that some large regional towns (more than 100,000 people) record only one registered practitioner, while many small towns have no practitioners recorded (Australasian Menopause Society 2024). People may need to travel far for treatment and education, whilst some people may forgo treatment altogether, worsening long-term health outcomes (Community Affairs References Committee 2023).

People with disabilities and/or who are neurodivergent

For people with disability and/or neurodivergence, the experience of perimenopause and menopause can be different. Intellectual disability (in particular, Down syndrome) has been associated with an earlier onset of menopause and with poorer long term health outcomes, linked to lower levels of understanding and reduced capacity to engage in protective health behaviours (Moore et al. 2023). This is confounded by both a culture of silence around reproductive health and disability, and limited knowledge of healthcare practitioners regarding menopause and intellectual disabilities (de Almeida and Greguol 2015). The limited data on people with disabilities and/or neurodivergence during perimenopause and menopause was identified during stakeholder consultations, noting that they are likely to have unattended needs and require additional support (AIHW Stakeholder Consultations 2025).

People who are culturally and linguistically diverse, including recent migrants

Views of perimenopause and menopause are heavily influenced by culture and the perceived role of women, fertility and ageing, while preferences for medical treatment also differ between cultural groups (Stanzel et al. 2020). However, knowledge of positive and negative experiences of perimenopause and menopause among culturally and linguistically diverse people are limited, as are the understandings of cultural safety (Williams 2024). Stakeholder consultations identified a need for further data on how perimenopause and menopause are experienced among people from culturally diverse backgrounds, and how these experiences influence help-seeking behaviours and treatment decisions (AIHW Stakeholder Consultations 2025).

LGBTQIA+ people

Limited research on the specific experiences associated with perimenopause and menopause among LGBTQIA+ communities indicates that heterosexual, lesbian and bisexual cisgender women experience menopause similarly. However, queer women may face additional barriers in seeking culturally safe healthcare (Glyde 2022; Westwood 2024).

Transgender and gender-diverse people are more likely to report not seeking care or treatment for perimenopause and menopause, and likely to report discrimination, refusals to treat, higher levels of distress, and poor access to specialist care when they are not feminine presenting (Sobel et al. 2024; Toze and Westwood 2024). There is no research regarding how people with innate variations of sex characteristics experience perimenopause and menopause. Stakeholders reaffirmed the need for baseline data collections on the experiences of LGBTQIA+ people to inform future policy and programs (AIHW Stakeholder Consultations 2025).

People experiencing early menopause or premature ovarian insufficiency

A small proportion of people will experience menopause prior to the age of 45, with an estimated 8% of people having a final menstrual period between 40-44 (Mishra et al. 2024). When menstruation ceases prior to age 40, a diagnosis of premature ovarian insufficiency (POI) is given. Current research estimates POI is experienced by between 1-4% of all menopausal people, and both early menopause and POI can occur spontaneously without clear cause, from genetic mutations or from surgery, chemotherapy, radiotherapy (collectively known as medically induced menopause (MIM)) (Mishra et al. 2024). Stakeholder consultation identified that limited data exists concerning people experiencing MIM, early menopause or POI and their long-term health outcomes, and the causes (if identifiable) (AIHW Stakeholder Consultations 2025). Earlier onset of menopause can be associated with poorer long-term health outcomes when treatment is not promptly initiated, increasing burden to various facets of the Australian health system (Royal Australian and New Zealand College of Gynaecologists 2020).

Living with chronic and/or complex health needs or comorbidities

Stakeholder consultations highlighted that people with pre-existing health conditions or comorbidities can face additional challenges during perimenopause and menopause (AIHW Stakeholder Consultations 2025). People with cancer or those in remission are often deemed complex cases and can face hurdles when seeking referrals or specialist care, and provider hesitancy when cancer is hormone-dependent. Stakeholders identified a need for clearer referral pathways and guidelines (AIHW Stakeholder Consultations 2025). People with cardiovascular disease, diabetes, metabolic syndrome or mental illness were also recognised as needing more involved evidence-based care that addresses potential risks associated with menopause treatment (AIHW Stakeholder Consultations 2025).

Critical data gaps and priority areas for data development

A review of the literature and stakeholder consultations has identified 8 data gaps relating to the experiences and impacts of perimenopause and menopause in Australia. These findings have informed the following priorities for data development to address these gaps.

Note. Where 'disaggregation' is used, this is referring to disaggregation by geographic and demographic characteristics, including regarding all priority populations listed in the monitoring framework.

Table H.1 Critical data gaps and priority areas for data development

Data gap	Priority for data development
MHT use in Australia, including costs, accessibility of MHT and barriers to access.	Monitor MHT access and use across Australia and disaggregate[1] national data to: • identify barriers to use • understand reasons for MHT use • inform understandings of MHT use and access among priority populations • monitor costs and affordability of MHT use.
Experience of perimenopause and menopause including symptom severity/duration, and impact on quality of life, disaggregated as required.	• Collect national data that consistently monitors perimenopause and menopause symptoms and their severity/duration and the impact of symptoms on daily activities, relationships mental health and other health conditions. This will help understand the need for health care services (to provide support or manage symptoms). • Identify how symptoms and severity vary by population group.

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[1] Age, geographic region (patient, provider, pharmacy) – LGA, SA3, PHN, state, remoteness, ethnicity, language spoken at home, sexual orientation, gender identity, household income, disability type (e.g. autism), socioeconomic status, migrant status, residency/visa/Medicare status, homelessness, provider type (nurse, general practitioner etc.)

Data gap	Priority for data development
Economic impact of menopause, including its effects on workforce participation, disaggregated where possible.	• Assess the impact of perimenopause and menopause on workforce engagement, absenteeism and presenteeism, particularly on industries which experience a gender-bias (e.g. nursing, teaching, early childhood), separate to the confounding impact of other mid-life stressors. • Assess the impact of perimenopause and menopause on income, superannuation and finances. • Monitor the number of workplaces with supportive policies (e.g. menopause leave).
Relationship of perimenopause and menopause with health and wellbeing across the life course.	Identify and monitor the impact of reproductive conditions and other health conditions on experiences of perimenopause and menopause.
Healthcare provider education and knowledge to support people presenting with perimenopause and menopause-related health needs across Australia.	Identify and monitor health care providers delivering appropriate care for perimenopause and menopause, including: • whether providers have undertaken formal training on perimenopause and menopause • health care provider confidence and capacity to treat/manage people presenting with concerns about menopausal symptoms • provider knowledge of MHT and safety and efficacy considerations • provider attitudes towards menopause.
Availability and accessibility of services for perimenopause and menopause care.	Collate national data on service access and provision for perimenopause and menopause, disaggregated by priority populations, including: • wait times to access services/specialists • geographical distribution of services (public and private) • out-of-pocket costs associated with accessing services • alignment with future clinical guidelines.

Data gap	Priority for data development
Experiences of early menopause, premature ovarian insufficiency and medically induced menopause, disaggregated as required.	Collate national data and monitor changes over time in relation to: • early menopause, premature ovarian insufficiency and medically induced menopause and relationships to other health conditions • age of onset.
Health literacy.	Measurement and monitoring of perimenopause and menopause health literacy, disaggregated by population and geography, and the accessibility of accurate and appropriate (culturally, linguistically, practically) information.

NOTE: Where "disaggregation" is used, this is referring to disaggregation by geographic and demographic characteristics, including regarding all priority populations listed in Section 2.5 of the monitoring framework.

Additional data gaps

The following data gaps were also identified but deemed, through the consultation process, to be of a lower priority for data development at this time:

- Further research is needed to determine how culture, language and background influence understandings of perimenopause and menopause. There is a need to determine how culture, language and background influence how people access or do not access health care services, considering:
    - cultural safety
    - cost and opportunities for subsidies
    - stigma and attitudes.
- Research is needed to identify the physical and psychosocial needs of people experiencing early menopause, premature ovarian insufficiency, and medically induced menopause.
- Use of validated tools by healthcare providers and ensuring consistent record perimenopausal and menopausal symptoms and presentations (e.g. ICD/ICPC codes).

H.2 Data Strategy for perimenopause and menopause

The context and scope of each section of this table is described in Appendix J.

Priority area for development	What to monitor (areas of measurement) [(a)]	How to measure it [(b)]	Potential data sources [(c)]	Current status [(d)]	Options for development of existing data sources	Options for new data collections: establish a new collection or standardise and collate existing data	MF domains, subdomains and outcomes
Monitor menopausal hormone therapy (MHT) access and use across Australia and disaggregate national data to: • identify barriers to use • understand the reasons associated with MHT use • inform understandings of MHT use and access among priority populations • monitor the cost and affordability of MHT use.	MHT use and reasons for use. MHT prescriptions dispensed. PBS and private scripts processed. National geographical distribution of MHT users. Barriers to accessing MHT. Out-of-pocket costs for MHT. MHT use among people also receiving scripts under Closing the Gap PBS co-payment scheme.	National surveys Longitudinal cohort studies Pharmacy / prescription data	ALSWH PBS	Very limited / fragmented - refer to Appendix J	Expand/add questions to national surveys/ longitudinal studies. Explore additional analysis of National administrative data collections (e.g. MBS, PBS). Explore data linkage opportunities.	**National survey:** Develop an ongoing nationally representative survey. **Pharmacy data:** Explore feasibility of establishing an ongoing national pharmacy data collection.	3.1 4.1; 4.2; 4.3 6.1; 6.2; 6.3 15.1; 15.2 16.1 O5; O6; O7

Priority area for development	What to monitor (areas of measurement) [(a)]	How to measure it [(b)]	Potential data sources [(c)]	Current status [(d)]	Options for development of existing data sources	Options for new data collections: establish a new collection or standardise and collate existing data	MF domains, subdomains and outcomes
Collect national data that monitors perimenopause and menopause symptoms and their severity/duration and the impact of symptoms on daily activities, relationships, mental health and other health conditions. This will help understand the need for health care services (to support or manage of symptoms).	Presence of menopausal symptoms (including type and category). Severity of symptoms (mild, moderate, severe). Duration and frequency of symptoms. Experience of menopause (positive, negative, neutral). Impact of menopausal symptoms on ability to carry out daily activities. Impact of menopausal symptoms on building and maintaining relationships. Impact of menopausal symptoms on mental health. Impact of menopausal symptoms on other health conditions and management.	National surveys Longitudinal cohort studies Health records (e.g. primary care, specialist services)	ALSWH Jean Hailes National Women's Health Survey 2023	Very limited / fragmented - refer to Appendix J	Expand/add questions to national surveys/ longitudinal studies. Explore data linkage opportunities. Primary health care data.	**National survey:** Develop an ongoing nationally representative survey. **Primary health care data:** Explore feasibility of using the national primary health care data collection (once available).	2.1; 2.2 O1; O2; O3; O4; O17
Identify how symptoms and severity vary by population group.	Variations in symptom presentation and severity between population groups. Influence of ethnicity on symptom presentation and severity.	National survey Longitudinal cohort studies Health records (e.g. primary care, specialist services)	ALSWH	Partially available - refer to Appendix J	Strengthen/improve disaggregated data in any national collections.	**National survey:** Develop an ongoing nationally representative survey. **Primary health care data:** Explore feasibility of using the national primary health care data collection (once available).	2.1; 2.2 15.1 O1; O2; O3; O4

Priority area for development	What to monitor (areas of measurement) [(a)]	How to measure it [(b)]	Potential data sources [(c)]	Current status [(d)]	Options for development of existing data sources	Options for new data collections: establish a new collection or standardise and collate existing data	MF domains, subdomains and outcomes
Assess the impact of perimenopause and menopause on workforce engagement, absenteeism and presenteeism, particularly on industries which experience a gender-bias (e.g. nursing, teaching, early childhood), separate to the confounding impact of other mid-life stressors.	Workplace absenteeism and presenteeism (directly recognised as a result of perimenopause and menopause). Type of employment (Full-time, Part-time, Casual). Industry of employment. Reason for retirement. Intention to reduce workload or retire (directly recognised to be related to perimenopause and menopause). Presence of mid-life stressors.	National surveys Longitudinal cohort studies	ALSWH Jean Hailes National Women's Health Survey 2023	Partially available - refer to Appendix J	Expand/add questions to national surveys/ longitudinal studies. Explore data linkage opportunities.	**National survey:** Develop an ongoing nationally representative survey.	15.1 O1; O2; O4
Assess the impact of perimenopause and menopause on income, superannuation and finances (during and post-menopausal period).	Income earned during mid-life and any changes during onset of menopausal symptoms and post-menopause and any changes in superannuation contributions.	National surveys Longitudinal cohort studies	No data currently exists	No data currently exists	Explore additional analysis of national administrative data collections (e.g. ATO).	**National survey:** Develop an ongoing nationally representative survey.	O2; O4

Priority area for development	What to monitor (areas of measurement) [(a)]	How to measure it [(b)]	Potential data sources [(c)]	Current status [(d)]	Options for development of existing data sources	Options for new data collections: establish a new collection or standardise and collate existing data	MF domains, subdomains and outcomes
Monitor the number of workplaces with supportive policies (e.g. menopause leave).	Workplaces with policies in place that support people during the perimenopause and menopause period. Workplaces with specific reproductive leave policies in place.	Workplace audit of policies National surveys	No data currently exists	No data currently exists	Expand/add questions to national surveys/ longitudinal studies.	**National survey:** Develop an ongoing nationally representative survey. **Other suggestions**: Explore the development of a national audit of workplaces to monitor supportive policies.	15.1 17.1; 17.2
Identify and monitor the impact of reproductive and other health conditions on experiences of perimenopause and menopause.	Impact of chronic health conditions (e.g. diabetes, cardiovascular disease) or other reproductive conditions (e.g. endometriosis, PCOS) on the experience of perimenopause and menopause including symptom severity, presence of conditions and connection to age of onset of perimenopause and menopause.	National surveys Longitudinal cohort studies Health records (e.g. primary care, specialist services) Data linkage	ALSWH (linkage)	Very limited / fragmented - refer to Appendix J Requires significant development	Expand/add questions to national surveys/ longitudinal studies. Explore data linkage opportunities.	**National survey:** Develop an ongoing nationally representative survey. **Primary health care data:** Explore feasibility of using the national primary health care data collection (once available).	2.1; 2.2; 2.3 O1; O4; O17

Priority area for development	What to monitor (areas of measurement) [(a)]	How to measure it [(b)]	Potential data sources [(c)]	Current status [(d)]	Options for development of existing data sources	Options for new data collections: establish a new collection or standardise and collate existing data	MF domains, subdomains and outcomes
Identify and monitor healthcare providers delivering appropriate care for perimenopause and menopause, including: • whether providers have undertaken formal training on perimenopause and menopause • healthcare provider confidence and capacity to treat/ manage people presenting with concerns about menopausal symptoms • provider knowledge of MHT and safety and efficacy considerations • provider attitudes towards menopause.	Healthcare providers undertaking formal training during tertiary education or continuing professional development. Availability of formal training opportunities. Healthcare provider confidence in perimenopause and menopause care. Healthcare provider knowledge of perimenopause and menopause, MHT and appropriate uses. Healthcare provider attitudes towards menopause. Providers supplying relevant referrals as required. Patients self-reporting receiving satisfactory care.	National surveys Longitudinal cohort studies Workforce surveys Clinical audits Patient experience surveys Continuing professional development training Health records (e.g. primary care, specialist services)	No data currently exists	No data currently exists	Explore additional analysis of National administrative data collections (e.g. National Health Workforce Data Set).	**Workforce survey:** Explore the value of developing a national audit of healthcare providers or workforce survey. **Other suggestions**: Explore potential for PREMs in data collection.	5.1; 5.2 7.3 10.3; 10.4 11.1 O5; O7

Priority area for development	What to monitor (areas of measurement) [(a)]	How to measure it [(b)]	Potential data sources [(c)]	Current status [(d)]	Options for development of existing data sources	Options for new data collections: establish a new collection or standardise and collate existing data	MF domains, subdomains and outcomes
Collate national data on service access and provision for perimenopause and menopause, disaggregated by priority populations, including: • wait times to access services/ specialists • geographical distribution of services (public and private) • out-of-pocket costs associated with accessing services • alignment with future clinical guidelines.	Average wait time to see GP or healthcare provider specialising in menopause. Specialist menopause services offering appointments (in-person, telehealth, and to new clients). Geographical distance to service. Geographical distribution of providers or specialist menopause services (public and private). Out-of-pocket cost to access a health service/ provider. Clinical practice occurring in alignment with clinical guidelines. Provision of menopause health assessments (i.e. MBS items).	National surveys Longitudinal cohort studies Medicare records Provider mapping	MBS	Very limited / fragmented - refer to Appendix J Requires significant development	Explore additional analysis of National administrative data collections (e.g. MBS).	**National survey:** Develop an ongoing nationally representative survey. **Workforce survey:** Explore the value of developing a national audit of healthcare providers or workforce survey. **Other suggestions**: Explore feasibility of developing geo-mapped database of healthcare providers and data on service availability and accessibility.	4.1; 4.2; 4.3 5.2 6.1; 6.2; 6.3 8.1 9.1; 9.2; 9.3 17.1 O7; O16; O17
Collate national data and monitor changes over time in relation to: early menopause, premature ovarian insufficiency and medically induced menopause and relationships to other health conditions age of onset.	Prevalence of early menopause, premature ovarian insufficiency and medically induced menopause. Presence of associated reproductive conditions. Cause (if known). Age of onset (of the different types of menopause).	National surveys Longitudinal cohort studies Medicare records Data linkage	ALSWH MBS	Partially available - refer to Appendix J	Expand/add questions to national surveys/ longitudinal studies. Explore data linkage opportunities. Explore additional analysis of National administrative data collections (e.g. MBS, PBS).	**National survey:** Develop an ongoing nationally representative survey. **Primary health care data:** Explore feasibility of using the national primary health care data collection (once available).	2.1

Priority area for development	What to monitor (areas of measurement) [(a)]	How to measure it [(b)]	Potential data sources [(c)]	Current status [(d)]	Options for development of existing data sources	Options for new data collections: establish a new collection or standardise and collate existing data	MF domains, subdomains and outcomes
Measurement and monitoring of perimenopause and menopause health literacy, disaggregated by population and geography, and the accessibility of trustworthy and appropriate (culturally, linguistically, practically) information.	Knowledge of options for the management and treatment of perimenopause and menopause and self-reported barriers. Knowledge of the health outcomes associated with menopause. Knowledge of where to access trustworthy and appropriate information. Measurement and monitoring of the accessibility of trustworthy and appropriate (culturally, linguistically, practically) information resources.	National surveys Longitudinal cohort studies Information audit	No data currently exists	No data currently exists	Expand/add questions to national surveys/ longitudinal studies.	**National survey:** Develop an ongoing nationally representative survey. **Other suggestions:** • Undertake a social media content analysis. • Explore options to evaluate/ audit information resources available.	1.1; 1.2 12.1; 12.2; 12.4 15.1; 15.2; 15.3

Note: The focus of this work is on addressing gaps in information and data and to not duplicate work currently being undertaken or in development.

(a) The aim is to report priority populations for all areas of measurement where possible. This includes age, geographic region (patient, provider, pharmacy) – LGA, SA3, PHN, state, remoteness, ethnicity, language spoken at home, sexual orientation, gender identity, household income, disability type (e.g. autism), socio-economic status, migrant status, residency/visa/Medicare status, homelessness, provider type (nurse, general practitioner etc.).

(b) In the absence of comprehensive prevalence/primary data, multiple supplementary data sources may need to be used.

(c) Only nationally representative data collections with established time-series data are included in this table (see section 4.1 Data sources assessment criteria for more information). Other data sources out-of-scope for this table, that may be considered for future research include: 45 and Up Study, ACT Women's Health Survey, the PATH Study, Australian Women's Midlife Years Study, VITAL Registry.

(d) 'Very limited/fragmented data' indicates that only one or two data points/questions are available in the current source; whereas 'Partially available' means that it includes data that could partially answer some of the priority areas for development but still requires significant development/expansion. Refer to Appendix J for a summary of existing national data sources that capture some SRH data across the initial priority areas.

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