Women and Equalities Committee

Oral evidence: Menopause and the workplace follow up, HC 91

Wednesday 22 March 2023

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Watch the meeting

Members present: Caroline Nokes (Chair); Elliot Colburn; Carolyn Harris; Kim Johnson; Kate Osborne.

Questions 180 - 217

Witnesses

I: Karen Arthur, Founder, Menopause Whilst Black; Kate Muir, menopause expert, author and documentary maker; Carol Vorderman, Patron, Menopause Mandate; Mariella Frostrup, Chair, Menopause Mandate.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Karen Arthur, Kate Muir, Carol Vorderman and Mariella Frostrup.

Q180 **Chair:** Good afternoon, and welcome to this afternoon's meeting of the Women and Equalities Committee and our follow-up session on menopause and the workplace. Can I thank you all for coming in to give evidence this afternoon? You will know we published a significant report in July last year, in which we made a number of recommendations to Government, many of which were either only partly accepted or rejected, and the response itself was three and a half months late. Can I start with you, Carol, and ask how you would characterise the Government's response and whether you feel they were taking it seriously?

Carol Vorderman: The fact you just said it was three and a half months late I think characterises it entirely. There are a few facts that we need to begin with. The fact is that women need to be supported more when they go through menopausal years. The other fact is menopausal years can be very difficult and detrimentally life-changing for a large number of women. Also, nearly 16 million women are at work at the moment. And yet Maria Caulfield cannot be bothered to turn up. She has refused your request to turn up today. Worse than that, when confronted with this—I have to admit I was doing a little active work on Twitter yesterday—she said she had written a letter to you with alternative dates a week ago. She was very specific about that and, yesterday, when I said she had refused to come in she replied, "Absolutely not true." We found she had deleted all that from Twitter later.

I was horrified when I was watching Kemi Badenoch, the Minister for Women and Equalities, a number of weeks ago when you were questioning her, Carolyn. As a post-menopausal woman from a working-class background, I just could not get over the patronising statements she made. I thought they were insulting. They were insulting to all women. She basically said to Carolyn that this was a left-wing issue when we were talking about menopause and a pilot in the workplace, and characteristically compared women going through terrible menopausal symptoms with those who would want to have certain things that are given by Government to be given to those with ginger hair, to short people. I just thought, "What am I listening to here?" It is the 21st century. This was like going back 100 years to when women just had the vote. I could not believe it. Women make up almost half of the workforce, yet these are the two women in Government who are meant to be representing the female population. I was disgusted, to be perfectly honest, by both of them—absolutely disgusted.

Q181 **Chair:** We have always made it very clear that we intended to follow up the work and the report and ask Ministers questions about why they had dismissed out of hand the prospect of a consultation on the Equality Act or a trial of menopause workplace leave. When it comes to menopause workplace leave, have you had any sense from the many thousands of

menopausal women who I know will have reached out to you that they think a trial of leave would in any way be forcing them out of work, or would it perhaps be giving them a mechanism to find ways to stay in?

Carol Vorderman: We have to have a trial. It has to be on a large scale if anything is going to change. Everybody sitting here knows the data about the number of women who are leaving work. That is at the far end. This morning I was on ITV's "This Morning", and we were inundated with women talking about the issues they have in the workplace. Interestingly, many of them did not want to give their place of work, because they were concerned about any retribution that might take place.

There were very simple examples: "I've been going through hot sweats for a number of years; I'm finding it really uncomfortable. Not only that, I'm anxious, tending towards depression and brain fog. I just wanted a fan on my desk, but there's a tidy desk policy, so I can't have a fan on the desk." It is ridiculous. It is absolutely ridiculous, and we should call it out for being ridiculous. That was down at the mild end.

Then there were many others who had been harassed, bullied or mocked: "Oh, look at you." This was something that was going on 10 years ago when on television we used to have to apologise, almost, for having a menopausal moment, as it might be said, and go, "Oh, silly me. Oh, gosh. Oh, I'm having a bit of a flush. Oh, silly me." Not any longer. We do not have to do that. This cannot go back in the box.

Q182 **Chair:** There are a lot of very high-profile women who are now prepared to talk about this openly, and to highlight their own menopausal symptoms and their own experience in work. Sometimes that gets characterised as that this is a problem for the middle classes—that it is only those who have the ability to speak out who do. What is your response to that? How is it affecting women from ordinary working backgrounds?

Carol Vorderman: From the response we had on ITV this morning on social media, that is absolutely and categorically wrong. Perhaps it is middle-class women and those with a profile who have the ability—we are here today—to speak out, but there are so many women in the gig economy. There are women at the moment who are struggling to make ends meet. There are women who are not earning a lot of money. They are going through a cost of living crisis; they are worried about their children and their education; they are worried about energy bills. They might be single mothers. For them to challenge their place of work because they are saying, "I need help," and that place of work is saying, "Sorry, love, we'll get a new one in"—it is impossible for them. They are the women who do not have a voice.

That is why this Committee and the work you are doing—and the work that Menopause Mandate and Karen are doing—is very important. It is critical. We are at a critical mass. In the Budget last week, Jeremy Hunt said, "We want more people to stay in the workplace." Really? Then why

aren't your Ministers here answering the Committee's questions? Why? Where are they? Maria Caulfield was having a cup of tea when we were having lunch over in Portcullis House. That is not much of an example, is it?

Q183 **Chair:** Thanks, Carol. Kate, the work you have done both with Menopause Mandate and the documentaries has really highlighted the issue and the scale of the problem. From your work, are there examples of good practice? When we say to the Government, "Trial a workplace menopause leave policy on a large scale with a big public sector employer," are there any private sector employers we could point at who have really been pioneers and led the way?

Kate Muir: I talk to lots of private sector employers. I have talked with Deloitte, Lloyds and B&Q. The private sector is way ahead on this, because they have seen the economic truth, which I think the Government have not worked out, that this is an enormous cost saver. I am sure you have, but the people in charge have not. By paying attention to women who are menopausal at work, you will immediately retain more of your workforce. We did that survey on the second Davina documentary, which showed—I know you all know—that, of the 4,000 women, one in 10 said they were leaving their jobs because of menopausal symptoms.

Now, that was a diverse survey around the country. It was not just middle-class white women; it was everybody. Yesterday lunchtime, I was talking on Zoom to 250 women in the NHS in the Derbyshire area, and lots and lots of them afterwards in the Q&A were talking about struggling with their symptoms. A huge point that we need to make here is that we should put providing medical help very high on our list—not just talking about taboos or policies, but talking about getting your GP to help.

Of course, the private sector is way ahead. AXA and Bupa and those private health policies are all helping women stay in their jobs in the private sector at a high level. They have worked out the cost to the companies. Also, it is showing humanity; it is showing kindness; it is being decent, and it is good for your bottom line. I do not know why the Government cannot see that.

Chair: Thank you.

Q184 **Carolyn Harris:** First, I will declare an interest—in case anybody has any doubt whatsoever—as chair of the APPG on menopause, and as someone who is exceptionally grateful to Mariella for setting up Menopause Mandate in the first place and bringing us all together to become the force of nature that we have become. Mariella, what damage are HRT shortages doing for women out there?

Mariella Frostrup: The HRT shortages are really just an indication of a dismal picture altogether around menopause. In answer to the question about the disappointment of the Government's response to the report, it

is this inability to recognise the culture around menopause and how difficult it is for women to navigate all aspects of it, whether it is in the workplace or whether it is just the basic support they need in terms of health. You fought really hard to get the single prescription. There is minuscule progress being made on that level, and that is very much down to all your efforts.

Ultimately, every day we get reports and we have women getting in touch with Menopause Mandate about, first of all, the difficulty in accessing coherent and universal advice on menopause. It still remains an incredibly difficult postcode lottery as to the HRT that you are prescribed, or whether you will be prescribed it at all—whether your doctor will turn around and say, “I don’t rate HRT,” which is a very common response, or, “You’re not menopausal yet because you’re only 42.” There is a complete lack of recognition of the most important thing, perimenopause, which we all know now starts 10 years before you are menopausal—the day of your last period. To put the HRT shortages as a main point when all around it there are just so many challenges—for a woman to get to the point where she is experiencing HRT challenges can be a process of years, not months.

As much as there are women who will go through menopause and not suffer at all—thank God for that—there are very many women who will suffer symptoms and find themselves either incapable of going to work or struggling at work. I think of the amount of companies I have been to. This is the thing that is really upsetting me at the moment. You go to companies and you give talks, and I honestly think that we have made it fashionable enough for “menowashing” to start occurring. You go to a company, you give a talk, they tell you all the policies they have, and then you go to the loo afterwards and bump into five women who come out of the cubicles going, “It’s all lies. They’re doing nothing. They’re not doing any of this.”

The sense is that we are just treading water, which is only heightened by the fact that the Minister cannot be bothered to turn up. They will appoint any number of tsars, ambassadors—you name it—but we are not a minority interest; we are 52% of the population. We would not need a women’s health ambassador or an HRT tsar or a menopause ambassador if we just had equal treatment. Yes, the fact that HRT shortages are ongoing and have not been addressed is absolutely shocking. The fact that an HRT tsar was appointed and she lasted three months and then, basically, it was announced that she had done her job and she was going back to deal with the pandemic, or covid, is a complete travesty. Nothing had been done, nothing has changed, and because there is not a national formulary it is causing incredible issues.

Just anecdotally, last night I had supper with one of my best friends and she burst into tears. I think, actually, it was suicidal ideation. I could not work out what was the matter. She was saying, “I just feel old and it’s pointless and what’s the point of being alive?” This is not a woman

normally given to those sorts of thoughts. I sent her a message this morning and said, "Have you changed your HRT?" She said, "Yeah, the doctor changed it three weeks ago." The way that she is feeling and the depression that she is under is entirely the result of her being given a wrong prescription. This should not be going on in the 21st century.

I hate the idea of it being a class issue. I think we are going down Kemi Badenoch's route when we start talking about middle-class women versus working-class women versus black women. What has been amazing about the menopause movement is that all women have come together, put their foot down and said, "We're not going to take it any more." That is the most important thing. I think every woman has a right—I am a working-class woman, by the way; I just have a very nice accent—to raise her voice about this and should. Sorry, that was long-winded, but—

Carolyn Harris: That's fine. Thank you.

Kate Muir: Could I add something on the shortages? I did a wee bit of research before I came in here. On Sunday, I asked on my Instagram whether anyone still has a shortage of Utrogestan, which is one of the key body identical, safest HRTs that we love. I got 500 responses, and I will just read to you a few of the places where it is unavailable: Liverpool, London, Leeds, Cardiff, Bristol, Sheffield, Glasgow, Edinburgh, Oxford, Surrey, Nottingham, Cornwall, Basingstoke, south Wales, Berkshire, Brighton, Carlisle, Suffolk, east Devon, Leicestershire, Wiltshire, Buckinghamshire, Somerset. I will not go on. I have a whole phone filled with these. Basically, there were about seven or eight places where people were getting Utrogestan.

It is really important, and I do not think, perhaps, the Minister understands why you cannot change to another kind of HRT. Utrogestan is the progesterone part that goes along with oestrogen. You need the two together to protect your womb. If you do not have that to protect your womb and you are taking oestrogen gel on its own, then you are at risk of endometrial cancer.

Let us just make that clear. The women who have been left for a month with just the gel—just the oestrogen—and not been given the progesterone to look after their womb are at risk. It is not a swap. It is not a funny joke. It is a very serious bit of women's health, and there are really only two things you can do. There is also Bijuve, which is not properly available on the national formulary, which is also the good body identical progesterone. It is not just me recommending that; if you look at the best NHS menopause clinics in London, like Chelsea and Westminster, that progesterone is on top of their list as one of the safest, non-clot-giving things to give to women, and it has a lower breast cancer risk.

Yet we are saying to women, "Oh, just go back on the old stuff. Oh, the little risk of breast cancer? Don't worry about it. Just swap your HRT over"—like your friend. That utter contempt for our health really comes

over to women, and women around the country are very, very angry. I also know, because I checked yesterday, that I could get Utrogestan for €5 in Spain, in Paris and in Germany. I do not think there is a Europe-wide shortage. I just think we are not paying for it enough here and we are not getting it in here. We knew about this two years ago. I think it is really a criminal neglect of women and women's health not to sort that out and, actually, the Estradot shortage, which is the other major shortage.

Q185 **Carolyn Harris:** Karen, can I ask you: did you go private to get on HRT? I did—I put my hand up and say that.

Karen Arthur: I did. I suppose it was because of who I knew, because I would not have done it otherwise. Now I access the NHS. I have had a conversation with black women—my hive, as I like to call them—today about the shortages, certainly, and the stress it causes not knowing whether you are going to get it, having to have a pharmacist who is sympathetic who might shop around, or feeling almost guilty that you have the privilege to be able to afford to go private and kind of move around. I feel like there are added layers here that we are missing out.

Can I also acknowledge that, while we are using the word "women" a lot, it is not just women who go through menopause; I want us to be aware that it is "people who experience menopause". We are missing out a whole load of people when it comes to talking about menopause when we only say "women" all the time. I understand why, but I just want to highlight that because it is really important. People are feeling left behind and ignored, and that we are disappearing them, which is not a phrase, but you've got it.

Q186 **Carolyn Harris:** I get that. Did everybody—I mean, I have said quite publicly that the only way I got on HRT was to go private.

Mariella Frostrup: Oh, yes. I spent two years going through extreme anxiety and extreme insomnia, and I had no idea. Yes, that is my fault for being ignorant of what menopause meant and the symptoms, but I thought the symptoms of menopause were a hot flush. I had something once that might have been a hot flush, but that was it. For two years I had this anxiety; I had insomnia; I felt like I was going crazy. I was trying to hold down a full-time job and I had two children who were quite young because I had my children in my early 40s.

It was horrendous from about the age of 47 to 49. I went to my GP numerous times. I did blood tests, which we now know do not really work when you are going through perimenopause and menopause, though they are still the first port of call for a lot of women, if they are taken seriously enough to warrant a blood test in the first place. But a blood test when you are menopausal or perimenopausal is kind of useless, because your hormones are going up and down. Over a period of three months, I was diagnosed, first of all, as postmenopausal, then not

menopausal at all, and then perimenopausal, at which point my GP just went, "This isn't really working, is it?"

To your point about the health companies, AXA and Bupa, providing cover for women, they don't. They only do so if it is paid for specifically by the employer; it is an add-on. I had private health insurance, and when I phoned the company and said, "I'm going to see a gynaecologist," they said, "What are your symptoms?" I said, "Sleeplessness, insomnia." The woman at the end of the line went, "Do you think it could be menopause?" I said, "Oh, well, I do actually. That's what I'm being told." She went, "Not covered." Actually, I moved to a different health insurance company and had exactly the same thing happen to me only a week ago. It is pervasive right across the board.

Menopause is not a possibility; it is an inevitability for every single woman in the land. The fact that we are at this stage now, in the 21st century, really is a kind of human rights abuse of women. It needs to change really radically and very, very soon. The fact, again, that the Minister cannot even be bothered to be here suggests to me that the Government are paying lip service to it and perhaps menowashing themselves, just like the companies that I have visited where women complain about it.

Q187 **Chair:** Can I just interject on that? Sorry, you should never ask a question that you have no clue what the answer is. So menopause is not covered by lots of private health companies.

Mariella Frostrup: Yes—because it's natural, Caroline.

Chair: Okay. But what about erectile dysfunction?

Mariella Frostrup: Covered.

Chair: It is covered. Thank you.

Mariella Frostrup: Because men—excuse me to any men here—suffer specific symptoms of conditions. We are just blanket covered by a sort of herd attitude and menopause is natural and, therefore, it is not considered to be something that you would be privately insured for, or it is something that is dealt with when you go to your GP as an individual, subjectively. If they do accept that you are menopausal, then it is whatever kind of HRT they have on their list and they tick it and that is it. But you are lucky if you get a GP who says, "Okay, I accept that you're menopausal and I'll deal with it."

Q188 **Carolyn Harris:** Just to add to what Mariella said, on social media platforms, if you talk about vaginal dryness, it is removed as being pornography; if you talk about erectile dysfunction, you are even allowed to put up videos.

Mariella Frostrup: You could probably have a GoFundMe page for erectile dysfunction.

Kate Muir: For the private companies, you can pay for an add-on. If you are an enlightened company, you can pay an extra £250 to Bupa and get their menopause service.

Mariella Frostrup: It's per employee, isn't it?

Kate Muir: Yes. There are companies that do that, but it is considered an add-on and not a part of women's life, even though all women go through it.

Mariella Frostrup: That is at the top echelon; most women are not. They do not have the luxury of going to a private doctor or a private gynaecologist. I do not know how long my experience would have continued and been elongated had I not been lucky enough to be able to go to a private gynaecologist.

Q189 **Chair:** Can I just follow up on that? In the commentary around access to private menopause specialists, one of the challenges—and you touched on it, Mariella—is the national formulary and access to testosterone, which is still not licensed for women. Through your work with Menopause Mandate, do you have any indication of frustrations with companies trying to get testosterone licensed for women through the MHRA, and what challenges there are there?

Mariella Frostrup: Yes, anecdotally, there are huge frustrations for enlightened medical professionals who would like to be providing all the other options. The fact of the matter is it is not just oestrogen and progesterone that we lose in catastrophic quantities; it is also testosterone. Women have testosterone. It may not surprise the Committee to know that my testosterone is apparently perfectly fine, and maybe Carol's is as well, but testosterone is one of the hormones that we also lose, and it is imperative, not just for sex, but for drive, energy—for so many different things. There is also DHEA, which, in America, you can just buy over the counter. Again, it is incredibly important for an awful lot of women, to raise their energy levels and for all round good health.

The issue is so frustrating because it is twofold; it is extreme ignorance coupled with extreme apathy. That is the toxic mixture, really. With testosterone, now, at least, there is a pump and you can do a little squirt in your hand and rub it on. What is it called? Testogel, isn't it?

Carol Vorderman: Yes, Testogel.

Mariella Frostrup: But when I was first prescribed testosterone by the private gynaecologist, it was called Testim. It came in a tiny little tube, and it reeked—I do not know if any of you have teenage boys—of Lynx Africa or something equivalent. Basically, it was for men, and the dose was for men, and it was in a little tube that was the right dose for men. I was lucky because I was prescribed it, but I was being given something that, basically, had been designed for, and was specifically created for, men.

Kate Muir: I think we are seeing—

Q190 **Chair:** Before you answer, Kate—I am coming to you, and you can add to that—you said "good" HRT, which begs the question, is there "bad" HRT, and how frequently is that still being prescribed? Should there be a national formulary to make sure everyone who needs it gets the good, not the bad?

Kate Muir: I am not a doctor, but I have studied a lot of this. I have been looking at the formularies in, say, London and Glasgow. I looked this morning at the formulary in the NHS menopause clinic in Chelsea and Westminster. At the top of that, it has the safest transdermal oestrogen, which is a gel or a pump that you rub in through your arm. It does not go through your liver; it does not go through your body, and it is best tolerated. It is very unlikely to give you clots; there is less chance of stroke. It is really good. It is basically putting oil back into your body. It is fantastic. It comes out as very well tolerated.

If you go to Glasgow and look at the national formulary, the top one, which they suggest doctors prescribe, is an old form of single-tablet oestrogen, which contains a synthetic progestin, which, in previous studies 20 years ago, has a small increased risk of cancer. It is very, very small; it is tiny. Lots of women want their HRT and they will take a patch or anything with synthetic progestins, and it agrees with some women. But or the majority of women, the best menopause specialists, both in the NHS and privately, are prescribing body identical hormones.

This is incredibly good news, because we are not going to take all these risks that the previous generations did. We are getting a copy of our own hormones back. It is exactly the same molecule; it is made from soy. If you go back 20 years ago to the big women's health initiative, which we all know about here, that was extracted from pregnant mares' urine—that was what the oestrogen was made out of, with a synthetic progestin. That HRT is completely different. It is not comparing apples and pears; it is comparing apples and plastic apples. Literally, this is a synthetic HRT, and now we have this better HRT, but guess what? You cannot get it in Liverpool and Glasgow and—you know. I am laughing, but it is really, really serious. It is ironic that we have this great new preparation, but it is not available to women all around the country.

Mariella Frostrup: Can I just make one point directly in relation to that? The important thing is that that is definitely the best, as it were, in terms of scientific evidence about how well our bodies break it down and whatever, but the most important thing is the element of choice. Women should have choice. Again, anecdotally, I use the gel, and it is great, but I have friends who have used it and it has not worked for them at all. Again, they ended up having to go private or to go the rounds of GPs in order to get the thing that did work for them. For some women, the patch works brilliantly; for me, it did not work at all. The point is that we are all individuals and our conditions are entirely subjective. There are at least

50 different symptoms of menopause, and every single woman has a different biology and needs to be looked at as an individual.

Chair: Thank you.

Q191 **Kim Johnson:** Good afternoon, panel. Carol, thank you so much for raising your frustrations about the Ministers who are responsible for women and equalities. I really appreciate that.

Karen, you alluded to the fact that menopause impacts all women, and it does. However, in terms of treatment and access to information, we know that, disproportionately, black women do not get the same access to treatment or information. Karen, from your experience, where and how should women access that information?

Karen Arthur: I am not going to spout statistics at you. Obviously, I have my podcast, Menopause Whilst Black, so we have these conversations among people who look like me, but that also means that people come to me and send me DMs and messages and talk to me—you know, I am "the menopause lady". I also want to add that there are swathes of women who are not in the slightest bit interested in taking hormone replacement therapy, or cannot take hormone replacement therapy, or do not want to, so there is that as well. Of the people who are taking HRT, half of them are people of colour—half of them are black women. There is a lot going on here; there are lots of nuances, as other people have said. There are different experiences. Every single person who experiences menopause will not experience it in exactly the same way in terms of how they access menopause care.

It also comes down to access and money. Lots of people talk to me about the fact that they did not know that black people took HRT, like it wasn't a thing. There are people who are coming to me—because I have spoken about it and been open about it—saying, "Oh. Well, maybe I can go to the doctor's as well." Then you have the point of accessing the doctor: being able to get a doctor's appointment; being believed when you finally get one; being dismissed, as we have talked about, and the cultural nuances around being believed by doctors, whether it is, "You don't look old enough," or dismissing you on all sorts of grounds.

We need to be very aware of how people of colour particularly, and black people, are experiencing menopause and are able to access proper menopause care, including being given old tablets for hormone replacement therapy. And what about people who do not want to have their menopause medicalised and are more likely and more interested in going a different route? Where is the support for them?

Q192 **Kim Johnson:** Mariella mentioned the myth and misinformation about menopause. Most people's understanding is about inconsistent periods and flushes; the whole spectrum of other things that happen to women during menopause is not often made available. There are some campaigns at the moment. From your point of view, how effective are

they?

Karen Arthur: I am not sure how effective they are; I am not going to lie. I feel like a lot of us in our community are working on anecdotal evidence. It is about, who is the media supporting? Who is the media amplifying? Whose voices are coming out? Yes—you mentioned it before—it is a lot of middle-class white women. But the other side to this is that it is important that we are as inclusive as we can be so that everybody is accessing it, and that means going to people. A lot of us do not want to go to the doctor's because we have had awful experiences, or we have been dismissed.

Somebody sent me something about including people who suffer from endometriosis, adenomyosis, PCOS, PMDD and neurodiversity, as they worsen symptoms in perimenopause. Also, the statistics around black women and fibroids are that we are three times more likely to get fibroids than our white counterparts, and that is also exacerbated in perimenopause. There is a lot of stuff going on here, but it is about going to these people. That is—I don't know—accessing community centres and having meetings, not expecting people to come to you. It is not, "If we build it, they will come." They won't, or they can't. I feel we need to be much more mindful about gathering everybody in.

I recently relocated to a small seaside town, and we had—somebody else set this up, but I went along—our first meeting about menopause. There had not been any before. There were eight or 10 of us sitting around having a cup of coffee—well, I had a glass of wine, but whatever. I was saying to somebody earlier that once one person opens their mouth, the outpouring is almost like "Me too". It is like, "Oh, thank God." Menopause Whilst Black exists because we were not asked before. We are not talking to south Asian women; we are not talking to people from—we need to look at an entire swathe of people from lots of different cultures and lots of different backgrounds, and not assume that one size fits all, because it does not.

Q193 **Kim Johnson:** I know the subject is being covered at the moment in a particular soap. From my point of view, that is a great way of getting the message out there. It is a bit like groups of women having a chat. It is "Emmerdale", for those who don't know. I think it is quite useful.

I want to ask whether you think the narrative around menopause at the moment is inclusive. We have had this discussion this afternoon about working class and middle class. How does the great swathe of women who work on the frontline—as care workers, in nurseries, in shops—get supported in terms of menopause in the workplace?

Karen Arthur: I think the talk is very much around C-suite, higher-end, middle-class women in the workplace. The powers that be have cottoned on to the idea that they are losing money, and I think that is what it comes down to. Often, the support is around menopause policies. Policies are great, but if they do not work or they are just in a folder somewhere

on a computer, it is a load of rubbish. The nuances around that include whether you have someone you vibe with—yes, that is the word I am using—or someone you feel you can talk to within your workplace, or whether you are in a workplace that even mentions menopause.

I was in a workplace that did not mention menopause. I ended up leaving my job behind. There is a statistic one in 10 people who experience menopause leave teaching. I guarantee it is higher than that. That is just the people who filled it in. Do you know what I mean? I feel like we are looking at a certain type of work and we need to go deeper into making sure that every employer has some kind of training and empathy—we are talking about kindness and humanity—for everybody in their charge. We need to make sure that no matter what job someone is doing—if they are doing a job, because we have not talked yet about the people who are at home, the people who are unemployed—everybody is able to and feels comfortable mentioning the fact that they are not able to do their job or they are having a little brain fog or they are bleeding and cannot come in. I think there is a bigger scope. This needs to go so much deeper. Personally, I think we are scratching the surface.

Q194 **Kim Johnson:** Did you want to come in, Mariella?

Mariella Frostrup: I just wanted to say that I do not think it is that we are looking at a different kind of company. Basically, there is nothing mandatory about it. That is one of the recommendations that the Government decided was not necessary. I think the only companies that are responding to and displaying interest in menopause policies are companies that are at the top end and are doing it for public relations reasons; they do not necessarily have a real understanding themselves of what menopause policies should look like. That is why it is so important that there is a mandatory workplace trial put out there, across the board, that means you cannot just hide away and not address it and think, "That isn't for me," or, "There's no reason for my company to get involved in it." That is the important thing really: it needs to come from here.

The other thing, of course—speaking to the experience of women of colour and black women, working-class women, and south Asian women—is that the point at the moment is that you have to be a bully to be heard when it comes to menopause. You have to walk into your GP with a piece of paper with the NICE guidelines on it, and you have to carry Davina's book or my book or someone else's book, and you need to go, "I want this because this, this, this and this." Most women do not feel the confidence to go and do that. A society is only as good as the way it elevates those who are in the weakest position. We are not doing that, and we should be desperately ashamed.

Carol Vorderman: May I add some voices from working-class women who contacted the show this morning? As you absolutely rightly say, when it is not mandatory, the essence is you are in a fight. I will not say their first names, apart from one, but one lady said, "Last year, I had a hysterectomy as I had heavy bleeding due to the perimenopause. At

work, I’ve been followed to the toilet and questioned about the amount of time I spend in there. Also, a few weeks ago, I was very ill, resulting in absence from work, and it was marked down as sickness and diarrhoea. My boss is fully aware of my medical issues, but there’s absolutely no support for me at all.”

Now, these are working-class women. More or less three quarters of people who work in the health sector and in education are female. There was a lady who said, “Last week I was forced to resign from a job I love because of the menopause. I was suffering with the symptoms: brain fog, irritability and forgetfulness. My employer claimed I was incapable of doing my job. The menopause was used in my defence, but it wasn’t taken into consideration.” I am sure you have heard these stories before.

Another lady said, “I work in the care sector. I’m going through the menopause at work.” These are working-class women. Like you rightly say, they do not have the voice; they do not necessarily have the confidence or the ability, or the structure and the process to go through. That lady continued, “I experience senior members of staff being rude, rolling their eyes and undermining me. We also had air conditioning in the office, which was never allowed on when I asked for it to be switched on. At one point, it all got too much, and I contemplated suicide. I had the very worst experience of suffering from menopause in my workplace.”

These stories go on and on and on and on. Hundreds of them have been coming in, and these women have to be listened to. They have to be, and it has to change. We keep coming back to the same conversation. It is the 21st century, and where are the Ministers? It shows me that they do not have any willingness. They don’t give a stuff about what is happening to all these women. They don’t care.

Q195 **Chair:** Mariella, can I just take you back to the comment you made about how you have to be a bully; you have to walk into your doctor with a list of what you want and why you want it? Should there be better information on gov.uk—on NHS resources and the DHSC’s pages on gov.uk—that gives women the tools to know what they can and should be asking for?

Mariella Frostrup: Absolutely, there should be, but let us not forget that the NICE guidelines say the first thing a woman should be recommended, if she presents menopausal symptoms, is HRT. That is not the experience that most women have. You take in the NICE guidelines because you need to get your doctor to understand that that is the recommendation, which obviously is not an ideal situation.

I think we have to row right back. The fact of the matter is that, unfortunately, the level of menopause training that GPs in this country go through is minimal to derisory. There are many doctors out there who have probably studied menopause for maybe half an hour or a morning in the entirety of their medical training. It is an opt-in. Considering that it is

going to affect 52% of the population, that seems extraordinary to me. They will do puberty, they will do fertility, but when it comes to menopause it really is rare to find a GP who has decided to specialise in it. Women are going in to see doctors who do not know about it.

Recently, Jeremy Hunt's Budget encouraged older doctors to come back to work. Part of the worry about that is they are completely clueless about menopause, so it is not going to make anything better for women who are suffering at the moment. I just do not understand why we cannot get to a point where every surgery in this land has one person who is trained in menopause. If your surgery does not, then you should be sent to someone who does. You should be able to say to your GP, "Have you trained in menopause? If you haven't, please can I see someone who has?" That seems to me another basic human right.

So yes, Government information, great, but most women are not sitting there, going online and looking at Government information before they go to a doctor's appointment. They just want help.

Q196 **Chair:** Should the ICBs—the integrated care boards—be making sure that, if there is not a specialist in every surgery, there are at least peripatetic specialists who are rotating? Should they be doing it? I know they are not doing it. Kate is shaking her head.

Kate Muir: I just think we don't need specialists. Every single doctor should be able to handle every single woman who has menopause, whether she needs HRT or whether she needs other help. There has been a real attempt among GPs themselves, many of whom are absolutely fantastic at always contacting all of us and having a conversation with us. There is a layer of warrior GPs out there who absolutely have women's backs. I think over 30,000 have taken the Confidence in the Menopause course, a six-hour course put out by the Menopause Charity and FourteenFish. That teaches a very useful thing: how to prescribe HRT, because it is quite complicated. Even if every GP could spend an hour watching a video if they thought they were not fully informed on prescribing HRT, that would make such a difference to women. Not one of our bunches of hormones are the same in this room. We are all very different and we all need different levels of hormones. It is not a slap the patch on and disappear situation. You have to titrate these things.

Mariella Frostrup: As a woman, I do not want to go and see a GP who has watched a video for an hour and is then diagnosing me through the worst medical, transitional passage of my life. I have been very lucky, and I have not been very ill in my life until menopause. I do not want someone who has just watched a video.

The other thing is that it does not have to be doctors—nurses are amazing. But then we have to stop treating HRT as though it is something incredibly complicated. They are very happily doling out antidepressants. It often seems the medical profession is happier to dole out antidepressants to women—which actually do not have an impact on

the mood swings you have during menopause—than it is prescribing HRT. We need a wholescale revolution in the way in which HRT is perceived. Nurses are perfectly fine. If you could go and talk to a nurse who understands and is educated about the symptoms and says, "Okay, we'll do a blood test and probably you need a bit more oestrogen," that would be a huge leap.

Kate Muir: Yes, I was just trying to do it really cheaply—in fact, free of charge—because nobody seems to want to—

Mariella Frostrup: I don't want it to be cheap for 52% of the population. I want it to be fully invested in.

Kate Muir: No, I know, but nobody wants to spend any money on this, and that is our big problem. I was thinking, "What are the cheap-as-chips solutions if you're not going to spend a penny on it?" The thing is that you could give every single woman who is 40 and walks into a doctor's surgery a list of the menopause symptoms and a little note, and they could go either, "I'm fine, I'm here for my thyroid, I'm here for my something else," or they could look down the symptoms and go, "Oh my God, I've got 10 of them. What are my answers, either on HRT or not?"

Mariella Frostrup: What about the 40-plus appointment that we all get a letter inviting us to in our early 40s? Women go and nobody talks to you about the menopause. It is the most extraordinary thing. The absolute, unavoidable thing that is going to happen to you in your 40s is you are going to go through perimenopause. If that was made to be focused for women, in particular, on the very thing they are going to go through, then that would be a huge step in the right direction.

Q197 **Chair:** Can I ask you about priorities? Back in January, the Minister wrote to all MPs with the eight priorities for the women's health strategy. Menopause featured in the HRT priority—good—and it was mentioned in the expansion of women's health hubs—good—but it did not feature in the priority around information, and it did not feature in the priority around health and the workplace. A big omission.

Mariella Frostrup: A huge omission. A ridiculous omission. The greatest omission there could possibly be in terms of what women are asking for, which is support through a transitory period with people who are trained to understand what they are going through. In the Government response to the recommendations, the fact that they said that all GPs are trained in menopause was just not true. It is actually not true, rather than a misconception. It is absolutely, blindingly obviously not true.

This sense that it is all already dealt with is just a complete whitewashing situation where they do not want to engage with the fact that it is as bad as it is out there, because, yes, it will cost money. And why shouldn't women be invested in? We haven't been, ever, when it comes to women's health. Women's health has been overlooked: we have been not counted in medical tests; we have been prescribed things that were for men and

just given a little bit less because we are like the spare rib. Why shouldn't women's health be invested in? I would rather it was invested in than we had a tsar or an ambassador or a Minister for women. Really, just put the money there and do something.

Q198 **Elliot Colburn:** Thank you, panel. I want to continue this theme around menopause and access to NHS services and healthcare more generally. Kate, can we continue this theme of GP training and how we go about improving the knowledge and confidence of NHS staff, whether that be doctors or nurses—or pharmacists, even—to adequately provide support for women going through the menopause? Obviously, the reaction to our report has been a very non-interventionist approach and just trusting the medical profession to get on and do it. It is quite clear that they are not going to do that, so how do we encourage the medical profession to better improve its own standards when it comes to training and deployment?

Kate Muir: Universities are not going to teach the menopause until 2024, so we will have to wait for that to enter the medical curriculum. The younger generation—lots and lots of them—are on it; they have been looking at the media and learning things for themselves. It is not a compulsory module as part of the Royal College of GPs. It comes under women's health, but it is not there. I think it should be a compulsory module. We have had a conversation with them about that and, indeed, it may change. I think we should all start talking to them.

One of the things that really shocked me recently is I went through the NHS policy for managers in the NHS about handling their own staff. It is a 25-page policy, and it does not once mention HRT or going to your doctor or taking time off for medical help, or whatever. It basically says, "We will make reasonable adjustments, and here are a couple of websites you could look at"—the NHS website, the BMS website. If the NHS itself has a menopause policy of 25 pages that is not tackling the medical issue, where do we begin? There are so many people just kind of pasting wallpaper over this whole situation. Medical training would not take long. It could be absolutely fantastic. It just should be automatically there as a very ordinary thing, like pregnancy and contraception. It is bonkers.

Q199 **Elliot Colburn:** Does that go back even as far as education? Obviously, that is very topical at the moment; there are talks about relationship and sex education in schools. Are we missing a trick not better equipping young girls at school with the knowledge about what is going to happen to their bodies when they get older?

Kate Muir: It is now in there, isn't it?

Mariella Frostrup: It is in there. First of all, not just young girls, but young boys as well, because until both sexes—all of us—are aware of what happens to women's bodies, not just when it is deemed useful by society, but perhaps post that point, then we are not really getting anywhere. It is there; it has been there for two years, but basically it is a

box-ticking exercise. There is no inspection; there is no checking. Again, anecdotally, there are 10 schools in my immediate area in Somerset and not a single one of them has taught menopause in any shape or form. Yes, absolutely, there needs to be education, but there is no point in just putting it there and then no one actually ensuring that it is utilised.

Karen Arthur: As someone with three decades of teaching and pastoral experience, sex education is hit and miss. We all rejoiced when we thought menopause was going to be on the curriculum, but that will depend on so many things: resources; whether the headteacher is on it; the person who is able to deliver it, and whether they are in; whether it is just one lesson. What if the kids are away? There are so many things. It is absolutely a tick-box exercise.

Q200 **Elliot Colburn:** Pulling it back to health for a second, I want to pick up a little bit more this issue of who provides this treatment. A lot of our discussion and a lot of our inquiry was focused on GPs in particular, which is to be expected given the feedback we have been receiving. However, Mariella, you spoke about the fact that it does not need to be GPs; nurses could do it. I know from talking to the pharmacy sector that pharmacists have quite in-depth knowledge of the people who come in and see them. Is that part of the problem—that we are just assuming we need to better train GPs, and we are not talking about expanding the responsibility for providing menopause healthcare support across the NHS workforce rather than just putting it in a box and saying, "This is a GP issue"?

Mariella Frostrup: Absolutely. Most women will go through menopause with not debilitating but just slightly life-complicating symptoms. For most of them, if you could go to a pharmacist and say, "Look, here's the NICE guidelines. I've got all these symptoms. I'm 43. I think I need HRT," and the pharmacist would then do that, that would be a huge plus. But you have to be educated yourself about what you are going through in order to get to the point where you can go to someone.

The same applies to having nurses at practices. There are starting to be really good menopause groups at certain GP practices. I was talking to a nurse the other day at a GP surgery near me in Somerset and she had set up this group. Basically, women would come there, talk about it, learn about it from her and then go to the doctor and go, "I'm definitely"—and they were discovering that the doctors were taking them more seriously. Also, I suppose, to a degree, you are not wasting GPs' time unless you have significant things that need to be dealt with.

As I say, for a lot of women, it is a transitory phase and it is manageable, particularly if you are able to use HRT to support you. The other thing that complicates all this is the attitude to HRT, ever since the women's health initiative in 2002. There are 16 million women in this country who are most likely menopausal and there are, I think, now 800,000 who are taking HRT. Or is it just over that, Kate?

Kate Muir: It is 14%.

Mariella Frostrup: Yes, 14%. That is directly the result of erroneous information given to women nearly two decades ago that led to a whole generation abandoning the very thing that would stop them having heart disease, stop them getting osteoporosis, stop them suffering debilitating symptoms at work. It was wiped out. If that had happened with any other kind of condition, there would be civil lawsuits. There are 50,000 women, they reckon, in America who have died as a result of not taking HRT during menopause. Think of the amount of money it would save the NHS not having to deal with all the things that women are going to end up getting if they do not access HRT. Today, the cover of *The Times* was about the pill—

Chair: That is literally what was just being passed to me.

Mariella Frostrup: —and the fact that contraception gives you 20% more chance of breast cancer. It is not true. It is 20% more chance of an incremental chance. It is something like 0.9% that it is heightened. If you drink two glasses of wine a day, you have a much greater chance. But again, it is on the cover of *The Times*, and there will be girls and mothers and women thinking, "Oh, I'd better give up contraception." The fact that it is only just being studied now is, frankly, an indictment of the tawdry state around women's health. Again, it is another scary headline, and that one in 2002 has decimated the only real support that women can have and need during menopause.

Q201 **Elliot Colburn:** Absolutely. Carol, could I come on to you? You must hear from women all the time regarding the symptoms they are experiencing and their experience of the healthcare system and going through the NHS. What is their view, anecdotally, of how their GP is treating them? Do they have confidence in the medical professionals they are going to see?

Carol Vorderman: Not particularly. A lot still are being told, "Oh, well, you'll get over it. Why are you bothering me?" It is still there, and everything Kate and Mariella have said is absolutely true. It is not good enough. It does tend to be the older GPs when you go back and ask the women about their GP. There are some good areas of practice, but it just shows how this has to come from the top. It cannot be, "Oh, well, let's everybody be nice and let's everybody be good." Menopause Mandate is trying, and Davina, and "This Morning"—there are lots of groups of people who are trying, aren't there, Karen? There are lots. But it needs to come from the top. It should not have to be a fight from the bottom. It should not have to happen that way, for all the reasons you have heard. For the Government to reject five of your recommendations, and then only part accept six and fully accept one, it is insulting to womenkind. It is absolutely insulting.

One point I really do want to make is that we are talking about women and their condition and the suffering they may or may not go through, whether that is in the workplace or elsewhere, but it is also about the families. I did a big interview, probably seven years ago, about having

menopausal depression. It was like, "Me? Really? Menopausal?" "Yes." I was put on bioidentical hormones and within 48 hours all those desperate feelings of darkness had gone.

I live in Bristol and I have to travel to London for work. I would stay up all night thinking, "Well, am I going to drive, or shall I get the train? Am I going to drive, or shall I get the train?" I would ring up in the morning and pull a sickie. I would say, "Oh, I've been ill. I've thrown up in the night." I had not. It was all of that. To live through that, and then for it to be so easily remedied, and not with antidepressants. Within 48 hours, every single thought like that disappeared.

I was very lucky, as we have said, because I could go to a professor privately about that, but when I spoke about it originally on ITV we were inundated. I mean, thousands and thousands of people were ringing in—not only women, but husbands. They love their wives. They don't want to see their wives going through this pain and agony. They are not saying, "Oh, you've changed." It is not that. It is like, "What can I do to help?" They are literally asking, "What can I do to help?" The answer is, "I don't know." That is how it was then.

Since then, organisations have been set up, there has been a lot more information and a lot more process in the media—the good media—which has helped a lot. But—you were talking about *The Times*, and particularly in the *Daily Mail*—there are often scary headlines, because that is the clickbait world we live in now. It has to come from the top. It has to come from Government down. Everybody else is trying their best, but it has to come from there. I want them to say, "Right. We are going to have a pilot. We're going to have this model of menopause policies for the workplace."

An awful lot of people who work in the public sector, if not the majority, are female. I want the Government to say, "This is what it is; we'll try it out. This is what we're going to do." When it comes from the top, all employers will listen, and women will be helped, and their families will be helped. Their sons, their daughters, their brothers, their sisters, their friends are all worried about them. I was more or less suicidal. I did have those thoughts. "Well, what can we do, Mum? What can we do?" "I don't know. I'll just stay in bed another day." And then it was so easily resolved.

Mariella Frostrup: That is the thing: you cannot talk about bringing people over 50 back into the workplace and completely ignore the fact that without menopause policies in place, women will not go back to the workplace, because they are struggling.

We have had thousands of testimonies uploaded anonymously on Menopause Mandate, and I would say 80% of them are about people who have unfortunately gone to their GP and not been given the advice that they should have been, or been given advice that is completely contrary to the NICE guidelines, or been given antidepressants, or told that they

are too young, or patronised. To your question, it really is pretty bad; the majority of experiences that I am told about are bad. Alice Smellie, who is part of Menopause Mandate, is the only person I know who had a good experience. After three weeks of feeling a little bit unwell, Alice went to her doctor, because she had been working with me on the book, and said, "I think I'm menopausal," and the doctor said, "Oh, you'll want some HRT then." She took it and she was fine; that was it. It should be like that for every woman. That should be the norm.

Q202 **Elliot Colburn:** Can I continue talking about the women's health strategy and the remit of the women's health ambassador? Mariella, you have been very clear in saying that it is not a case of needing ambassadors and tsars and strategies; it is equal opportunities and equal funding, recognising that everyone is going to go through this. But let's assume that we are going to have a women's health strategy and a women's health ambassador, and that those roles and documents are all going to stay in place. Are they too large a remit to genuinely allow the headspace to focus in on the menopause as something that women will go through? Is there simply too much that could be captured by a women's health strategy and a women's health ambassador for individual parts, like menopause, to be given the attention that they need? Is it just too big?

Mariella Frostrup: I don't really know. Menopause policy should be part of a greater understanding and embrace of women's health strategy. Anything that marginalises any more or feels like it is patronising women is not helpful and actually creates a worse situation for women, particularly in the workplace. I think it should be covered by equalities; we do not have a men's health ambassador. There are probably men out there who would argue that with the way prostate cancer is dealt with, maybe there should be, but there certainly should not just be a women's one. I do not think it is too big a scope. The women's health strategy does need an enormous amount of investment and creative, blue-sky thinking. Ultimately, I don't know, but I am really uncomfortable with it being marginalised in that way.

Kate Muir: I am very comfortable with it, but Dame Lesley Regan really, really understands women's health and HRT. HRT is part of the women's health hubs. Whether—

Mariella Frostrup: But there are 21 women's health hubs and 16 million menopausal women. We are not going to get menopausal hubs around the country. I think Dame Lesley is absolutely amazing and we are working with her on our Women in Work summit. It is the idea of this titular role that I am not sure about. Every time I have seen it happen, nothing has come of it, apart from the fact that someone has been given a titled role.

Kate Muir: I think we have to give her time. I think she is really keen, intellectually grasping with it, working with the Government, and I think we have to give her a moment to—

Mariella Frostrup: Could she not have got the Minister to come here today, then? If they are that serious about it, maybe she could have—

Kate Muir: I am not in control of that, but I will tell you what I am interested in. Maria Caulfield is the Minister for Mental Health and Women's Health. As you know, Caroline, mental health is massive in the menopause, and the mental health aspects of it are what women have remained silent about for so long and struggled through. When we did our big poll for the TV, 69% of women said they had suffered from low mood, anxiety or depression in the menopause; 84% were suffering from sleeplessness; 73% were suffering from brain fog. Women have been gaslit about all that for a very, very long time, and this is it erupting here in this Committee. It is great that we are discussing it, but we have so far to go. I think £25 million has been put forward for the women's health hubs; there are 34 million women, so we have less than a pound each, but it is a beginning.

The fact that all parties are trying to co-operate on this Committee—you are here, and you talk to one another all the time about this—and change the future for women gives us a great deal of hope. I know we are talking about the struggle that we are all having from all points of view, but there is also this thing that women have come together and become this huge movement over the last three years. We really, really care about other women. I think this is a tipping point, and we want to ride it in the right direction.

Q203 **Chair:** We all want it to be a tipping point. I think the frustration of this Committee was that we came up with some really well thought-out recommendations, most of which were rejected or only partly accepted. I am with Kate here; I think Lesley Regan is great.

Mariella Frostrup: Absolutely. As I say, we are working with Lesley Regan. I think the women's health hubs are a brilliant idea as well, because for a lot of women that takes away that sense of fear about going to a medical professional about things you feel uncomfortable or insecure about. God, I would love to live in a country where there was a women's health hub in every town and women had access to it. I just feel that starting to create a small number of women's health hubs without dealing with the lack of training and the absence of commitment is the issue.

Chair: That is the Committee's frustration. We had a report and there was no commitment to additional action—no new action. That is my overriding concern. Government information is a two-edged sword, isn't it, but there is no drive to make sure that Government information is top quality so that women and employers have a resource that they can trust and know is going to be accurate. I know there are some brilliant organisations out there offering a whole range of support, but I want there to be a downloadable menopause workplace policy so that any company can look on gov.uk and say, "There it is. There's what we have to do." We could not get that. Elliot, are you done?

Q204 **Elliot Colburn:** I have one more question, if that is all right. I know that my colleague wants to move on to the workplace, which is a key part of our strategy.

Karen, I want to come to you for one last question around how well women, and particularly black women, are engaged with when these sorts of health strategies are developed. We know about health disparities from some of the previous work we have done in this Committee; black maternal health is one of the big ones that we have been looking at, for example. How well are women—particularly black women and women of colour—being engaged with when developing health strategies that actually meet their needs?

Karen Arthur: I want you to imagine, if you can, a black person listening to the headlines or reading the news, knowing—let's go back to covid, for example—that covid was something that disproportionately affects black people. You mentioned maternal health, where black people are four times more likely to die in childbirth in the UK. I mentioned earlier black people being three times more likely to suffer from fibroids, which can be exacerbated during perimenopause. Imagine knowing all this information and putting two and two together and recognising that it stands to reason that menopause is going to be another thing for which you are disproportionately not going to receive the care that you want.

I was listening to the stuff about how there needs to be training and it needs to take everybody into account, and that people should be able to access menopause care or HRT, or go to the doctor's and feel safe and listened to. But add on to that the layer that a lot of this can also be down to cultural bias. We need to make sure there is training; where is the anti-racist training? There was a lot of kerfuffle in 2020 about training everybody, and everybody was going to advocate for people of colour and all the rest of it. That seems to have fallen by the wayside.

There is a massive amount of work that needs to be done in terms of making sure that black people trust the medical profession. There was a report as recently as 2016 that said that 50% of medical students believed that black people had a higher pain threshold, or that we had thicker skin and so had to use more numbing cream. That is absolute rubbish. That is—you can read it yourself.

Mariella mentioned that you have to be a bully. I absolutely agree that you have to be able to and feel confident enough to advocate for yourself. I can advocate for myself. I will sit in front of a doctor and say, "Yeah, no, we're not doing that, okay?", but I know my stuff. There are lots of people who do not trust the medical profession in the first place. Getting them to go to a doctor when they are anxious—this is anxiety. This is hyper-vigilance: "He"—or she—"is going to dismiss me anyway. They are going to say that I don't need care." It might not be HRT, but it might be. You talked about the fact that 14% of people who experience menopause take HRT. Half of those are black people.

So you've got some work to do. I feel strongly that menopause education for GPs should be mandatory; I do not think it should be one person, at all. That goes hand in hand with education around anti-racism, unconscious bias, cultural nuances and so forth. We need to pull people in, not expect them to come.

Q205 **Elliot Colburn:** Sorry, Chair; I promise that this is the final question. You mentioned earlier being particularly cautious around language and making sure that people who do not identify as women who will be going through the menopause—particularly trans men, for example—are included in this conversation. Is there an added layer of challenge there? Again, we have done work as a Committee in health disparities for the trans community. We see it in trans women accessing prostate cancer care, for example, and in trans men with the menopause. Does that stem from the same problems with GP training?

Karen Arthur: I don't think it is the same problem—racism and homophobia are different things—and I am not an expert in trans rights and non-binary rights, but I do know that there are people out there who are experiencing menopause who are feeling excluded. As recently as the little meeting I went to on Thursday, when I was talking about people who experienced menopause, someone actually said to me, "Thank you for saying 'people' and not 'women'". It seems like such a little thing, but it starts with language. The language is exclusionary. While I do not know the specifics around the difficulties that trans men and non-binaries have in accessing menopause care, surely the first step is to acknowledge that they exist. Am I wrong?

Elliot Colburn: No, not at all.

Chair: No, you are not wrong.

Mariella Frostrup: I do not think you are wrong, but with 16 million women out there whose rights are not being recognised and who are being given the wrong information or not being given health advice, I sort of feel like I would like to deal with the majority, and then that will filter through to the minority, in a way. This is a complete miscarriage of justice against women. It is because we are women that it has not been taken note of over the centuries. It is because we are women that this mythology has been allowed to fester around it. The effect of that ending will be enhancing for everyone's lives—men, trans men, trans women, everybody—but ultimately, this has been a woman problem for way too long.

Karen Arthur: I hear you. I am completely with you on that, but our history, or experience, is that a lot of this stuff does not trickle down. That is why I say that.

Mariella Frostrup: Well, it has not even trickled down to the 16 million yet, so we have work to do.

Q206 **Kate Osborne:** Thank you all for coming today and for everything that you do in highlighting the many issues that people are facing in menopause and perimenopause. Carol, we touched on the Committee's recommendations. One of those, which was accepted in principle, was around appointing a menopause ambassador to work with businesses, unions and others to develop and disseminate good practice. We now have a brand-new voluntary menopause employment champion. What would you say to her if she was here with us today?

Carol Vorderman: Given that the Government response to your report was three and a half months late, and the menopause taskforce has not sat since June last year, I would say, "Have you seen the Minister recently? What has she said to you? What power do you have? How much can one person do part time?" It just isn't enough. We keep going back to the same thing: it is not enough. It is just like, "Oh, that's a nice little tweak." I am sure she is a wonderful lady. This is not personal. This is about the point that everything we have said here has to come from the top down.

When I read the Government's eventual response to your report, it was a whitewash. It was, "Oh, and now we've done this. Oh, this is very nice—Jackanory, tell a story. Oh, we've done this. Oh, that's lovely. Oh, isn't life lovely?" No, it isn't. You have rejected, in part or in full, 11 of the 12 recommendations. You have said that you do not want to make menopause a characteristic in law: "Oh, well there are sex discrimination laws. That'll do." It won't do. It doesn't do.

I am sure that the ambassador will do her job as best she is able, but it is not enough, and I am sure that the Committee will go back and say all that. What year are we in now—2023? Really? It is like, "Oh, well, we've got a nice lady coming in and she's going to do a little bit of work here and tweak along there, but we'll continue to just ignore the rest of it and the basis of it." Not good enough.

Q207 **Kate Osborne:** Thank you. Mariella, did you want to come in there?

Mariella Frostrup: Only about the protected characteristic and the idea that it discriminates against men. I just return to the point that menopause is not a possibility in our lives as women and trans men; it is an inevitability. It is going to happen to every single one of us. I find the idea that it should not be a protected characteristic baffling. I do not understand why the Government did not accept that recommendation.

Q208 **Kate Osborne:** You share our frustrations, along with millions of other women out there.

Kate, you said earlier that one in 10 women are leaving the workplace early, and Karen, you said it is maybe more than that. I would agree with that assessment. Would supporting women in the workplace with menopause leave and policies do more to keep over-40s or over-50s women in the workplace than the measures announced by the Chancellor in the Budget?

Kate Muir: Yes, I think this is a really cheap way of doing it and the measures announced are much more expensive. Really, the time that women struggle is perimenopause. It is about recognising the symptoms. For instance—I always have a statistic—44% of women get incredibly heavy periods in perimenopause. We should give them time to deal with that—to go away and have a bit of time off.

Is menopause leave a brilliant idea? It is temporarily. We need to be tackling our symptoms and looking after women. If we were looking after the women, then menopause leave would not really be a particular necessity; it is because the system is absolutely wrong at this moment that we need to compensate for it. If you can go to your doctor or your boss and say, "Look, these are my problems. Can I work flexibly? Can I do this?", that can make a difference.

I was talking to NHS staff yesterday. If you are on a 12-hour shift, you cannot really have menopause leave. It is completely understaffed. You are holding a drip. You cannot even run to the bathroom. You certainly cannot work from home, as was suggested in some of the policies. There are some women and non-binary people on the frontline who are doing these incredibly tough jobs that really need help—medical help, probably, for most of them—to survive doing those jobs.

Q209 **Kate Osborne:** A better understanding from employers, the Government—across the board. Does anybody else want to come in on that?

Mariella Frostrup: I just think that guidelines from Government to employers would be a really good start. Again, it is one of the recommendations that was just that little bit too much trouble.

Q210 **Chair:** Mariella, you referenced the front page of *The Times*, and Carol, you said there were good and bad media. Is one of the basic problems misogyny in some sections of the media?

Mariella Frostrup: I think that there is a deep-rooted culture of dismissiveness when it comes to many issues around women's experience. I think it is in part historical and in part pure misogyny. We have been listening in horror over the last few days about the Met police. To say there is not a culture of misogyny would probably mean I should be put on some kind of medication, but ultimately, we should not dismiss it as only that.

On the thing about good and bad media, I do not think the cover of *The Times* today is bad media; it just reflects that we take a story and because our understanding around it is shaped by ignorance a lot of the time, we do not fully understand the implications of the story. If you did not actually read the article, the cover of *The Times* today could be read as telling women that they have a 20% greater chance of getting breast cancer by taking contraception. But if you read the article, it doesn't say that.

I think that there hasn't been enough space. I don't know about your books, but ours did not get reviewed in any paper. Not a single newspaper thought it was worth writing a review of it. Even a scathing and appalling review would have been welcome, just to be noticed. There is certainly a culture of abhorrence around menopause that we are trying to break down. I suppose in many ways I see it as the last frontier for equality, which is why I go back to the idea of wanting it to be dealt with by an Equalities Minister rather than someone singling out women as needing extra help. That is just infuriating and patronising, to an extent, especially in this day and age. This room is full of working women who do not need to be siloed off into a little minority group any more.

Kate Muir: I still think the newspapers do not understand the science of this at all. We are all learning the science of this as we go along, but there are very simple things. We know that HRT protects against osteoporosis. There are science papers that show that if you take HRT, your bone density grows by 3% a year. If you go to the NHS website, it says one of the first-line treatments for women to prevent osteoporosis is HRT—super-duper. One out of two women over 50 get osteoporosis. Are we telling people to go and do that? No. If you go to the women's health strategy, you find that HRT is not mentioned in the whole section on women and osteoporosis; instead, a drug that costs £5,000 a year is suggested as what we should be using. If the people writing the women's health strategy can't do the basic maths, Carol—*[Laughter.]* It is extraordinary. The basic maths is that HRT is £120 a year; a hip replacement is £12,000. Now, can you explain that to the Minister, take it to the media and get people to understand? Why do we have to have all these Zimmer frames? Why do we have to live these lives?

If these issues were better covered by science journalists who really understood it and were not just saying, "Oh, they're a bunch of women; they don't know what they're doing"—we do know what we are doing. We have really researched our papers, our science, our knowledge, our communities, and we are bringing that to people. It is the responsibility of the media to make sure they write better articles and not create a divide among women, because we all want the same thing, which is proper menopause care. We all agree on that.

Chair: I am glad I've got you on maths, although I've probably got the wrong panellist on maths.

Kate Muir: Yes—Carol will do the maths.

Q211 **Chair:** Could say a tiny bit about the cost to the economy of not getting this right? I am really fixated on the cost of recruiting a replacement when a woman has left work compared with the cost of implementing an effective workplace menopause policy.

Kate Muir: I can do it for the NHS, where 40% of women are over 45. They are perimenopausal and menopausal—those women we have been banging pots for. I think there are something amazing like 120,000

vacancies in the NHS. We did a study with the Balance app and looking at ONS statistics on how much it cost to retrain a doctor or a nurse. We got someone else to crunch all that, and we worked out that if one in 10 women of that age did not leave the NHS, in terms of training and re-recruitment you would save £700 million on those women. That is where our crisis lies. We are bringing in doctors from everywhere. If we could hold on to our own doctors and give them flexible working and be a little kinder, then we might solve a huge hole in our health and other economy. We need to look at the bigger picture; I have not done it beyond the NHS.

Q212 **Chair:** Thank you for that. Before I go back to Elliot, just one final question on education. The Government are going through a review of RSHE—relationships, sex and health education. As yet it is unclear how one feeds information into that, but has anyone on the panel thought about how they might feed into the Government the importance of making sure that menopause, having been included on the curriculum, stays on the curriculum?

Mariella Frostrup: Or is actually utilised on the curriculum, as Karen was saying.

Karen Arthur: My experience is—it was called PSCHE before—

Chair: Yes, they changed the name.

Karen Arthur: You got it once a week, and then it came down a bit, in favour of "harder" subjects. When you got to years 10 and 11, it was on a drop-down curriculum, so you had it for six weeks, let's say, and then you would have something else. People have to take that seriously in itself. We are taking maths, English, IT—those subjects—seriously, but then RSHE is not taken as seriously, possibly because you do not take an exam in it.

On top of that, making sure that menopause becomes important within RSHE is going to be a battle, but it is an important battle to try to win. That education starts in schools, so that children are having these conversations, so that by the time that they and their friends are experiencing menopause, life is just so much easier. Part of the massive issue around menopause is that for lots of people it is new. It is still new, and they still do not know what they are going through. I have natural conversations with people who say, "Oh, I forgot this," or, "I really feel I can't do my job," or, "I'm not feeling myself," and I go, "So, how old are you?" and then broach the subject: "Had it occurred to you that you might be"—and then the penny drops. That would be made so much easier if we started those conversations earlier. We are at the vanguard now, but we are not letting go now, are we?

Mariella Frostrup: No, and the issue is that health education has ended at puberty. Basically, that is when the interest in the women's fertility journey ends. That is the problem right across the board, whether it is

education in schools, medical schools, universities, GPs or businesses. The interest stops once fertility starts and that is it. Ultimately, that is the elephant in the room.

Q213 **Elliot Colburn:** I have a final set of questions around menopause as an equality issue. We have spoken a bit about health, the workplace and education. We touched on the fact that the Government rejected the recommendation to make menopause a protected characteristic. The problem with that is that, in the evidence we received, many women were struggling to bring a discrimination claim based on sex, because it was not a sex-based offence, even though it was happening to women. Many were told to bring a claim based on disability, even though it is not a disability; it is something that every woman goes through.

We are left with this legal problem that it is very difficult to bring discrimination claims on the basis of menopause. The Government have said that they are confident that there are already legal routes to access help. I think I can guess the answer, but the question I am going to put to you is whether you agree and what experiences you might be able to share. If I could start with Mariella and then work down the panel, that would be great.

Mariella Frostrup: It is a question that should go back to the Government. If these legal protections do exist, how exactly do they work? Can they give us examples and illustrate why they believe that system to be enough? From what I have seen, the evidence is overwhelmingly that there is no legal protection for women in the workplace. The idea that it should not be a special characteristic is just ridiculous. They compared it to men with long-term health conditions, but it is not a long-term health condition. It is not something that you may or may not get. It is a liminal phase, and every single woman will go through it. I feel very sorry for men with long-term health conditions, but it is a completely different scenario. It illustrates that terrifying coupling of ignorance and a patronising attitude to menopause and menopausal women in the workplace. Ultimately, it has to change.

Karen Arthur: I don't think I can add to that, if I am honest.

Carol Vorderman: I totally agree. Picture yourself as a working-class woman—Sarah, for instance, who I spoke to on air this morning. She said: "I've been suffering with perimenopausal symptoms for years. Last year, I needed time off work. My symptoms were debilitating, but it was made very clear that my company's expectations were for me to be in the workplace for every hour of my contract. I had worked there for 15 years and there was a complete lack of respect. I was 37 when I started perimenopause." What does Sarah do? She has to become a warrior. She has to challenge her employer. She has to have fights and arguments and people ignoring her. She then has to say, "Well, I'm going to take you to tribunal." So already she has already lost her job, hasn't she?

Mariella Frostrup: And let's not forget, Carol, that she is feeling terrible.

Carol Vorderman: And she is feeling terrible, all at the same time. It is not anywhere near enough. The pilot scheme that you proposed, which Kemi Badenoch apparently said was a left-wing issue—that is completely confusing—should have been taken up. We should find best practice and that should be enforced, so that Sarah does not have to go through that process. Sarah should be able to say, "Look, here's the policy," just as we have for pregnant women or disabled people—whatever it might be. It should be a protected characteristic, unquestionably.

Kate Muir: You do not get legal aid for an employment tribunal, so not many people are going to take that route. We have to have an overarching policy so that we look after people.

I have been discovering the number of women who basically self-manage themselves out of their jobs, quite quietly, and the number of women at senior level—this is really important in terms of women staying in the boardroom—who sign NDAs in the time of menopause. They are going through all these symptoms and they sign an NDA to say, "Oh, I'm going off to set up my own consultancy," or whatever excuse it is. They cannot say why they have left, and they cannot mention that they have signed an NDA at all, yet after that, they go home, they sit down and they think, "Oh my God, maybe I'm menopausal; maybe I can do something about it." Then they realise and they are back in action, but nobody is going to give them a job back, because they have just disappeared for no reason, it is not clear, and they cannot say why. There are lots of these NDAs and lots of lawyers dealing with them. It is really worth watching that silent world going on that we cannot see.

Karen Arthur: That is incredibly common in teaching.

Q214 **Chair:** I was going to ask if you wanted to add to that from the teaching profession perspective, Karen.

Karen Arthur: I despair at the number of senior or middle managers who got to their 50s and went really quiet. Often it was a subject of staffroom talk—"Oh, they're never where they're supposed to be." Now I am having conversations with these women who I used to work with, who are now in their 70s and 80s, and they are disclosing that they were crying in the toilets, or they just were not coping. I am also one of those people who was not coping and so ended up just disappearing. You just disappear.

Mariella Frostrup: Yes, you just want to step back and get out of the way.

Karen Arthur: It is really common. So, yes, I co-sign what Kate just said.

Carol Vorderman: We must not forget the number of women who are freelancers and self-employed. If the guidance ever comes through from

this Government, it must be not just for employers, but for freelancers. A lot of women are freelancers.

On the subject of teachers, I have a story from another women. I am going to keep on reading their stories, because they are real people. "I have just handed in my notice for a teaching job, and I feel so down. I blame myself for my irritable mood and lack of confidence." She should still be teaching. We need wonderful teachers.

Karen Arthur: Tribunals are hard work. How many times do you hear of somebody going to tribunal, but you do not hear about the outcome until two years later? Imagine being menopausal and also having to deal with that. There are so many people who have grounds or feel that they have grounds for tribunals, but do not have the physical and mental capacity to even think about it. All they can do is just go. What a waste!

Elliot Colburn: Exactly; we were talking about the impact on the economy weren't we? Thank you all very much.

Q215 **Chair:** I regard employment tribunals as a failure of workplace policies. If the policies worked, you wouldn't end up at a tribunal. Would it be accurate in your view to say that it is not good enough to say that disability discrimination legislation covers it?

Mariella Frostrup: Absolutely not.

Carol Vorderman: Not good enough.

Chair: Thank you. I think that was the message we got from the Minister: "Well, it's all covered." What we have heard from women is that it is not.

Q216 **Carolyn Harris:** There are some things that we have not had an opportunity to touch on today, but all of us, through our own networks, will have had these cases. Through Menopause Mandate, we have had some collective sharp intakes of breath over recent news stories, where we have all said in unison: "Menopause." We do not think about how much the Government are spending on pensions for women who have not paid in enough because they have had to finish work early. They will get a reduced state pension and need pension credit. How many women are out there claiming long-term sickness benefit? It is all costing the Government money. For me, probably the most painful is the 16% rise in suicides among menopausal women. That is all because we are not doing the right thing, predominantly in the workplace, as well as in the medical profession.

Mariella Frostrup: It is not predominantly in the workplace; it is both in the workplace and in terms of support health-wise. The only thing that we have not talked about is that there are alternatives to HRT. They may not be as effective, but there are lots of women who choose not to take it for one reason or another, and that should absolutely be their choice. It is information that we are fighting for, not for everyone to be forced into

HRT. What we need, ultimately, is that degree of knowledge out there for women to be able to access and make informed decisions. I think that will make a difference in all aspects of how menopause is dealt with. Both are important: the work thing is incredibly important, but if women cannot actually get themselves feeling better, then they are not going to want to go to work anyway, no matter what legal protection they have.

Karen Arthur: Everybody is affected—not just people experiencing it directly, but everybody. This is a human rights issue, and it is a global conversation.

Q217 **Chair:** Kate, can I finish with a question to you? The NHS is encouraging colleagues to record menopause-related absence on their record system in order to be able to help the organisation get a better understanding of the scale of the problem and the impact it is having on staff, and put in place necessary support services. Is one of the problems that there is a lack of data collected by employers?

Kate Muir: Massively. I do not think anyone else has done that yet. It would be really interesting to know how women are affected day to day, but they should not have to feel that they are being stigmatised at the same time. Is everybody going to report in? It is a really subjective, tricky area.

One other thing I want to mention—I know it is in all our heads—is that we need to think about women who have had breast cancer and women who are going through surgical or chemical menopause. They have very specific and complicated needs. I know that we are talking in a very general way, but I am very aware, from talking to those women every day, that they need even more help and even more complex solutions for what they are going through. We need to think about them too—for example, the woman who is 26 and has had her ovaries removed and is working a 12-hour shift.

Mariella Frostrup: You must have come across that a lot when you were making the programme. We are talking about 26-year-olds and 32-year-olds who have had hysterectomies and have not even been told that they are going to go through menopause as a result of the operation. They get through the operation, which is already incredibly traumatic, and then suddenly they find themselves deep in menopause overnight, and nobody has given them any advice or support or told them what they can do to get through it. It is like the dark ages, quite honestly.

Chair: That is a really good point to end on, that it is like the dark ages—thank you. Let me say for the record that we are expecting the Minister to come in front of us in June. The Employment Minister has also offered to come, alongside Helen Tomlinson, the workplace menopause ambassador. I am not sure whether we will have all three of them in front of us, but certainly that will be another follow-up session to our report. There will not be any let-up in the follow-up to our report. Thank you all for your evidence this afternoon; it is much appreciated.