HOUSE OF COMMONS

Women and Equalities Committee

Oral evidence: Menopause and the workplace, HC 602

Wednesday 17 November 2021

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Watch the meeting

Members present: Caroline Nokes (Chair); Lee Anderson; Theo Clarke; Elliot Colburn; Philip Davies; Alex Davies-Jones; Jackie Doyle-Price; Kim Johnson; Anne McLaughlin; Kate Osborne; Bell Ribeiro-Addy.

Questions 1 - 27

Witnesses

I: Professor Joanna Brewis, Head of Department, People and Organisations, The Open University Business School; Dr Nighat Arif, General Practitioner and Women's Health and Family Planning Specialist, National Health Service and Private; Dr Heather Currie MBE, Chief Executive Officer, British Menopause Society.

Written evidence from witnesses:

Examination of witnesses

Witnesses: Professor Joanna Brewis, Dr Nighat Arif and Dr Heather Currie MBE.

[*This evidence was taken by video conference*]

Q1 **Chair:** Good afternoon, everyone, and thank you for coming here today for the Committee's first evidence session for our inquiry into menopause and the workplace. I am going to ask you briefly to introduce yourselves, but, before I do that, can I alert you to the fact that we sometimes have interruptions and it is entirely possible that we may have one today around 3.00 pm? If you hear the bells going off and we start disappearing you will know why, and we will suspend the meeting while members vote.

If you would like to add anything to your questions, please give a wave and indicate and we will hopefully see and I will bring you in. First, can I check how you want to be addressed? Are you happy to be addressed by your first names?

Dr Arif: First names are fine.

Professor Brewis: First name is fine.

Dr Currie: Yes, agreed.

Q2 **Chair:** Okay, thank you very much. Can you introduce yourselves? I will start with Nighat.

Dr Arif: I am an NHS GP with a specialism in women's health and family planning.

Professor Brewis: I am a professor of people and organisations at the OU Business School where I am also a line manager. I have been researching, campaigning and disseminating information about menopause in the workplace since January 2016.

Dr Currie: I am a gynaecologist in Dumfries. I am a trustee and past chair of the British Menopause Society and I am founder and MD of Menopause Matters.

Q3 **Chair:** To all of you, how do you think the level of public understanding is of menopause and its symptoms?

Professor Brewis: If you had asked me this question five or six years ago I would have said very low indeed. I think things are changing. That is in part because there has been some excellent work done by people who are in the public eye and I am thinking here particularly of Mariella Frostrup and Davina McCall, both of whom produced good documentaries on menopause and its symptoms. It is receiving a lot more coverage in the media also, which is excellent. In large part it is accurate, which is even better. I still think we have a long way to go. There are still a lot of myths out there. It is still something of a to do and I genuinely believe that, from school age upwards, we need to be fully educated about the

menopause, because for the vast majority of people it is normal and it is natural.

Dr Currie: I would go along with that. There has been a huge change in the last few years and, added to the programmes that Jo mentioned, I was involved with Kirsty Wark with the BBC programme a few years ago and from then I think there has been an enormous change in awareness.

There are some aspects of menopause that are still not well-known and not recognised. When it comes to women seeking help, it is sometimes that they do not understand that how they are feeling could be hormonally related. I am particularly thinking about the mood changes, the anxiety, the low mood, the brain fog, difficulty in concentrating, joint aches, vagina and bladder symptoms. Most women are aware of flushes and sweats, but if there are other changes, rather than flushes and sweats, they do not necessarily go down the right channel for help, because they do not recognise that it is hormonally related.

More awareness is needed on the symptoms of menopause and the impact they can have, knowing what to look out for and when to seek help. Overall, I think there has been an enormous change. I do not think there is the stigma and taboo that there was before generally.

I mentioned Menopause Matters. We have a website and a magazine. When I launched the magazine in 2005, and then even in more recent times, I was told no one is going to pick up a magazine in WH Smith with that name on the title. Of course, that made me more determined to make sure it was going to be there, and it is. There has been a huge change, but we are not quite there yet.

Dr Arif: The conversation has definitely opened up and I echo what Jo and Heather are saying. In 2019, the BBC "Breakfast" team did a Wake up to Menopause campaign. That is when I became involved and contacted them, or they contacted me. For the first time, there was an ethnic minority voice to that conversation added to it. It was always seen as a western conversation and women from South Asian and black heritage were partly excluded from that. There were reasons behind that. We have cultural issues in regard to secrecy and shame, unfortunately, but also at this time in my culture what I experience is it is a time of great innovation and it is a great time not to have periods anymore.

Other than periods, there are other things that women experience, and there are long-term effects of health implications that can happen. This is a transition in midlife that women go through—all women will go through it, 50% of the population—but there is a decrease in hormones, oestrogen and progesterone. We need those hormones and if we have a lack of them there is a risk of further complication such as osteoporosis, heart disease, high risk of dementia. These sorts of longer term preventative messages are not being echoed for women, so that we can have preventative steps put in place to look after them in the longer run.

The conversation is opening up in ethnic minority communities. You had Karen Arthur, who was on the Davina McCall programme, myself, we have had literature translated into different languages as well. Dr Louise Newson has done a lot with the Balance app, and the group Noon—which is cofounded by Eleanor Mills—has tried to bring in a rather inclusive conversation looking at LGBTQ communities and the deaf community.

I have three patients who I look after who are deaf, and I only recently realised that there is no word in British sign language for menopause. It is "men" and "pause", which is "stop", which does not mean anything to a woman who is deaf. If you think about it, we are consulting now more by telephone. As a GP 90% of my consultations are by telephone. That excludes a lot of women who have some hearing disability. That is something we must do far more for.

Q4 **Chair:** Thank you. You have touched on a couple of things there on maybe what we need to do. Heather, you mentioned that we need to do more. Can you tell us how else we can improve public understanding?

Dr Currie: There are two main prongs to it. I have been involved as a clinical adviser for the Scottish Government, for the Women's Health Plan for Scotland, which has brought together things that we can do that are achievable. The two prongs are: first, the information for women, and Jo mentioned there is a lot of information around. Most of it is accurate and it is important to guide women to the accurate, trusted resources, so that they are prepared. I was delighted to hear that it was being brought into the school curriculum, because we should start early. We teach about periods and contraception and pregnancy, and it should be a completely natural thing that menopause comes into that.

We are also looking to tie in with one of the screening programmes to give women information, to know what to look out for, and the debate is when you do that. If you wait until 50, a lot of women will have had troublesome symptoms before then, so probably much earlier than that is the better time to do that, so tying in with something that is already there.

First, so women can feel confident to know what to look out for and know when to ask for help, but more importantly simple things that they can do that will help, not only them coping with the transition but also later health, as has been mentioned.

The other side of it is the education of healthcare professionals. Not all women will need to go to seek help and see a healthcare professional, but if they do we want them to get consistent advice. This is tying in with the British Menopause Society "Vision for Menopause Care in the UK", which was published a few years ago and updated quite recently. This is around making sure that every GP practice has someone with a special interest in menopause as part of women's health, and that every region or every primary care team has access to a specialist menopause service. With the British Menopause Society, we are doing loads around that to try

to improve the education and the knowledge so that women do get consistent advice.

That is broadly speaking, but that is the angle that I want to see more of, so that women know what to look out for, what to do and if they do seek help they get consistent advice.

Q5 **Chair:** Thank you for that. Before we move on, did Nighat or Jo want to add anything?

Dr Arif: Social media is playing a huge role in educating the population also. We cannot discount that going forward. As healthcare professionals, where there is misinformation out there when it comes to treatments available, what is available for women? We need to harness social media far more. There are a lot of myths out there that women unfortunately do listen to, do take on board, and we need healthcare professionals to harness that medium as well, to be able to put out accurate information.

Professor Brewis: I do not have very much to add to that, but I would say that I read a very worrying paper recently, published last year, that suggested that women who were least likely to be prescribed HRT are those who live and work in the most impoverished areas in the UK. That is something that badly needs addressing. Women need to be equipped to go to their GP with the kind of information that will help their doctor prescribe what is right for them or advise on what is right for them. I completely echo what Heather was saying about general practitioners, in particular, needing to be more aware of HRT as a very valid remedy, not for all women but for a lot of women, and not to subscribe to the mythology that has been dogging this treatment since the early 2000s.

Q6 **Bell Ribeiro-Addy:** Do you think there is enough research on how menopause symptoms impact the daily lives of women and people generally who experience menopause, and what information it might be useful to have?

Dr Arif: I am biased in that respect, because I speak to a lot of black and South Asian community women, and 13% of the population are from ethnic minority communities. However, if you look at any research that is done into the experiences of these women there is very little; it is very scant. I tried to put together an article for MegsMenopause to try to look into this and there was very little. In fact, I had a discussion with my mother about it—she was going through it—and I said to her, "I think you are having hot flushes" and she said to me, "This is a white woman's condition" so that puts it into the perspective of where we are. This was only about two years ago and she was talking to her daughter, who does women's health and was a GP. You can understand how that conversation went down, because women are women regardless of where they are.

I realise that the symptoms they experience are variable. If I give you some examples, 10% of women do not experience flushes. Flushes can be taken into context. If your symptomology is flushes and periods,

women who have a Mirena coil or might be on the contraceptive pill such as progesterone-only will not get periods, so how do they know that they are going through the menopause and what age does it start? If you look at Asian women they are most likely to give you physical symptoms. In Punjabi they will say, "Everything hurts from head to toe" because joint pains, sleep problems, maybe tummy problems that they might be experiencing, palpitations, for example they will complain about crawling insects underneath their skin, so that is electric shock-like symptoms, dry skin, oral symptoms, the physical symptoms are what they will come with first. That is what I hear a lot but they will not possibly come forward with the psychological symptoms.

There are a huge amount of psychological symptoms that women experience—memory fog, anxiety, depression, loss of confidence, low mood, depression-like symptoms, lack of libido. If you look at ethnic minority women, 10% of consultations will have a documentation of their sexual dysfunction. Heather and Jo will agree with me that, going through this transition in life, it might be normal but it impacts your sexual function a lot. Vaginal atrophy is such a taboo subject.

If you come back to looking at what is researched, there is very little out there. We definitely need to do more. However, we are getting better and there are lots of questionnaires that are now being done and asking women from those communities to talk to us to see what we can do better. That is slow, because this is still within my community a very taboo subject. If you look at trans communities, they are even more excluded from this conversation. As I was saying earlier, the deaf community is further excluded, so we have a long way to go.

Dr Currie: I am co-editor of the journal of the British Menopause Society. We get quite a number of submissions about the impact of symptoms on women in other countries, but very little about Asian women and so on in this country. I absolutely agree that there is a need for more research there. We do not know what information they are accessing and what ways of giving that information would be more acceptable. Definitely I would add to that, there is a need in the UK for this research.

Professor Brewis: I echo completely what Nighat and Heather have said. If you focus down on the workplace in particular—and even now four years after our evidence review was published, what was then a very small literature is only slightly larger now—there is a long way to go in terms of understanding issues in the workplace.

One of them is that variability of symptoms and the individuality of, and I do not like the "J" word, but the menopause journey, if you like. We know nothing about how women of different racial or ethnic origins might experience the conjunction between menopause and work. We know nothing about trans women. We know nothing about women who identify as anything other than heterosexual. We know nothing about women in

the gig economy. Really, the majority of the research that focuses on the workplace is about professional or managerial white, middle-class, able-bodied women. That does need to change because, although there is a lot of excellent work going on at organisational level in terms of changing the climate and putting really good adjustments in place for people who are going through menopause, a lot of those mechanisms and recommendations are based on research that is done on a very small group of women. There is a lot that we could do to improve our knowledge there and be able to tweak some of the recommendations that we are currently able to make to employers.

Dr Arif: I was going to add to what Jo was saying, because she listed where we are lacking. One of the other areas that we are lacking are young women. With primary ovarian insufficiency you will get menopausal symptoms, but women in their 20s and 30s can go through this. Again, one in 100 women will get primary ovarian insufficiency in the UK. However, where are my black women, their voices? Where are my Arab women, my South Asian women and Bangladeshi women?

I deal a lot with Pakistani women for whom English is not their first language, so they will be given anti-depressants or diagnosed as fibromyalgia instead, but they are young women whose periods are stopping. Their fertility is affected. We still live in a community—especially the communities that I work with—where arranged marriages happen. If you have had an arranged marriage and the woman is going through primary ovarian insufficiency the family does not know, but they think that they have been sold a dud daughter-in-law and want a divorce. This is having a huge impact within our communities on a wider range and we need to tackle this.

Q7 **Bell Ribeiro-Addy:** Heather, why do you think there is still such social and cultural stigma attached to menopause and what can we do about it?

Dr Currie: As we said, I think it is getting better. I think people now are much more comfortable, apart from the groups that we have talked about. We have done a lot getting the middle-class white, Caucasian people talking about it and there is a load of work to do, as we have just been describing. People are less uncomfortable now in mentioning it. Those of us here, did our mothers ever mention menopause? Mine did not. I have been a gynaecologist for 30-odd years and yet my mother never mentioned the word "periods" and never mentioned the word "menopause". It was absolutely taboo, so it is less.

Generally, it has been seen very negatively and seen as a time of getting older and loss of fertility and the turning around—as has already been referred to—is it is great not to have periods. That is a fantastic aspect of menopause. Also, I think at the moment while there is lots of awareness some of it is going a little bit sensationalist and some women may be getting the impression that it is going to be terrible for everyone, which it isn't. It can have a big impact, but for many women it is not so bad.

What do we do about it? As we have talked about, it is just keeping on talking about it, providing the education, focusing more and more on the groups that are difficult to access and that do not have the same resources easily available to them that the majority of women do. Therefore, focusing on those hard-to-reach groups and keeping the awareness going, but in a measured way, not a sensationalist, dramatic way. We do not want people to be scared. We just want them to accept this is a transition, this is going to happen, "I am prepared for it. I know what to look out for. I know I can seek help if I need to".

Q8 **Bell Ribeiro-Addy:** Nighat, as a GP, there seems to be a lot of stigma within the medical profession towards perimenopause and menopause symptoms overall, and we have even heard it reported that GPs have told women that these are symptoms that they will just have to live with. How, if at all, do you think this affects society's perception of menopause?

Dr Arif: Society already knows that this is a transition but it is normal. That it is a hormonal transition that you are going through. We need oestrogen in our body. If you think about it, oestrogen is a lubricant. We need it for everything, all the mechanisms in our body. Unfortunately, where you get the disparity is between healthcare professionals and the training that they have.

If I talk about my personal training as a GP I think at medical school I probably had a half an hour lecture, "Oh, there are periods. There is pregnancy. There is fertility, endometriosis, polycystic ovarian syndrome and then there is menopause, but it is a transition that women go through" and that was it. Then when I was training as a GP I was lucky that I had six months of gynaecology. I had a very good gynaecologist who trained with me and she was very pro-menopause, if that is the right term. She was intuitive with regards to the symptoms that women were experiencing.

Remember, it is not just stopping periods. When you are in the perimenopausal phase you will get prolonged periods, heavy periods. You might get scanty periods, and your moods will change in the fluctuations. If you have primary ovarian insufficiency and your ovaries are not working 50% of your testosterone has gone down, which will also impact on your libido and fatigue.[1] This was something that I learned, but I was not given any formal training. In the RCGP there is an e-module that you have. If you want to do specialist training later on there is a cost added to it. As GPs we are generalists. We are not masters of any one specialism and we are bombarded with a lot of information constantly. It really comes down to what it is that you are keen to have as your specialism.

I do remember that my male colleagues were hindered a lot just for being male. If there was a woman who had come into A&E for example,

[1] The witness provided additional follow-up evidence to clarify this point [MEW0089]

she has palpitations, hot flushes, she has been having night sweats, we would do all the battery of tests for thyroid and none of us would ever think of perimenopause or menopause even as a differential diagnosis. This was something that was never on the list. We would think of thyroid conditions and all other heart-related conditions, but it would not be on your differential. That is something that we need to change. It should be right up there for a woman knowing about her age and then healthcare professionals being aware of the symptoms.

If it was my male colleagues it would be seen as, "Oh, well, Nighat, you are the female doctor. This is something that you have to do". This is another area of our societal views in medicine. If I can be bold enough to say so, I think there is misogyny within medicine when it comes to women's health. There are lots of things that we are lacking with regards to understanding. Pain is normalised; if a woman has really heavy periods it is okay. If she has birth pain relief that she needs, well, she does not really need it until right to the end.

We have normalised way too many things. We have normalised menopausal symptoms, hence why we say, "Oh, it is a transition and you will just go through this" because we normalised it. What if she is not able to sleep? What if she is having aches and pains? What if one in four women are suicidal or one in four women around the time of their perimenopause are thinking of leaving the workplace? Unfortunately, this is an institutional thing that needs to change. Societal views have to change in regards to how much value we place on the work that women do, and that comes back to how much value we put around women's health.

Q9 **Bell Ribeiro-Addy:** Jo, in addition to what may have been said before, are there particular groups who experience menopause for whom the stigma is different, or worse, and what do you think we could do about that?

Professor Brewis: I can certainly comment on that to the best of my ability. I should probably clarify my expertise is specifically about the workplace, but I think I would amplify what Nighat and Heather have already said. For young women it is often even more confusing and distressing than it is for those of us who are experiencing it at supposedly the right age. I think there is also some real understanding—and I am thinking about this particularly in the workplace but I suspect in the wider society as well—that for some women menopause is literally a cliff-edge experience. If they have for example an ovariectomy that will plunge them into menopause immediately and it is not clear to me whether they are well-informed about that. It is bad enough having an ovariectomy but then to go through what can be some quite dramatic menopausal symptoms as well must be incredibly distressing.

In particular, it is transgender men and other gender diverse people about whom we literally know nothing. Nighat referenced someone who is doing some brilliant work in this area. I am aware of Tania Glyde who is

doing work in this area but, other than that, there is nothing. I can only imagine going through the process of either transitioning to become a transgender man, whether that is surgical or social, or deciding that you are going to embark on the journey of divesting yourself of gender altogether and describing and understanding yourself as gender diverse, non-binary or gender fluid, but still having—for want of a better expression—biological plumbing that will mean that you go through menopause.

I cannot imagine how distressing that must be, because transgender and gender non-conforming people have so much that is set against them in society, and so much that is set up to make their lives a misery. To have to deal on the one hand perhaps with menstruation and then later in life with menopause must be just horrendous. The stigma is bad enough about being trans or gender diverse without adding in what the body is doing to you at the same time.

Q10 **Bell Ribeiro-Addy:** Heather, is there anything you would like to add to that?

Dr Currie: Yes, thank you. There are two aspects. I would like to add young women to that. Not only can the diagnosis be absolutely devastating in a young woman who has not yet had her children, or may have had children but not completed a family, and all the friends, neighbours and the dog are becoming pregnant. It is just a horrendous diagnosis. Also, when it comes to treatment, I am aware of some young women where the treatment option that seemed to be most appropriate might be a patch, but she does not want to wear a patch because she does not want her partner to see it or anyone else to see it when swimming or anything like that.

There is absolute stigma more so with younger women and we do need to support them. They have been mentioned already and often they can be really young when they are having symptoms. If we are going to be sending out information along with the screening programme it must be at the right age, because it will miss some women if we leave it until into their 40s, for example, so that is why we need to start earlier. Definitely there is stigma around young women and also around the specific treatments. Sometimes we take that into account, so for a young woman who does not want to become pregnant her choice might be a contraceptive pill rather than HRT, because she would rather take something that her friends are taking than something that her granny is taking. You must take all that into account.

Also, talking about stigma, there is stigma about certain of the symptoms. Flushes and sweats are so well known now, and, yes, they have been made fun of in the past: that is not fair, but at least they are recognised. Often there is a stigma around the mood changes and a feeling that, "I cannot cope but I should be able to and everyone else is around me and it is all my fault". The way of viewing those symptoms also can certainly be an issue and there is a stigma. I think the biggest

stigma is still around the vaginal and bladder symptoms, and many women have a significant impact from these. That is something that we need to keep talking more about, to try to address that and know that there are effective treatments.

Again, it is the linking that this is hormonal. Often these symptoms arise quite a few years after periods have stopped or a few years after stopping hormone therapy by which time there is no reason someone should link the running to the toilet often, having to plan the journey, having to take spare clothes, vaginal dryness and discomfort affecting relationships. Why would you link that with hormonal, if you did not know about it beforehand? Those areas are where I see the stigma still exists.

Q11 **Bell Ribeiro-Addy:** Very quickly to all of you, if there is one thing that the Government could do to reduce stigma around menopause what would you say?

Dr Arif: First, I think awareness in different languages would be great. I worked with Elizabeth Ellis with her "Know your Menopause" campaign. We translated posters into Urdu, Welsh and various other languages as well. They have become very popular. The Urdu one is now used as a research project in Pakistan by the Sindh University to look at women's experience there and also whether the symptoms correlate. As Heather was saying, we do get it from other countries, but are they the same in this country? Like I say, some of the symptoms like flushes are in context.

I am reminded of an Arab woman I spoke to and I said, "Do you get flushes?" and she said, "Stand in the Dubai heat and you will know what a flush is", so you must look at the fact that we have to be able look at the nuances within these symptoms themselves. What we need also is like these conversations about vaginal atrophy, teach our children the real terms for their anatomy parts, their gynaecological parts as well and not to be ashamed of it.

We have done a leaflet on vaginal atrophy in Urdu, and what was interesting was that I did not even know that the language we use is important. We must look at where the root cause is. Sexism and misogyny must be tackled and if we can tackle them that would be brilliant, because then we are not ashamed of what women's biology does. In Urdu the word for menopause is "banjh", which means barren, that is it, literally you are barren. We know that is not the case. In Punjabi it is even worse. It is essentially, "The woman is off the rag now" because that is essentially what women are capable of doing. The language is important. If we can get that from the top then that is brilliant.

If we can get more information available to other women, make it accessible, make them safe places for women to be able to talk about, then that is brilliant. Social media plays a huge part in this, if we can get support on that. I would be absolutely happy if the Department of Health

and Social Care made a video on vaginal atrophy. That would make my day. We need to normalise this conversation but not normalise women's pain and psychological symptoms.

Professor Brewis: I completely echo everything that Nighat said. I have already mentioned getting it on the educational agenda in people's younger lives. One of the things that I think is the backdrop to this conversation—and we have alluded to it—is the fact that there is an enormous amount of gender ageism that circuits around understanding of the menopause. Nighat attested to it, it is that really toxic combination of sexism shading into misogyny and ageism, which comes together and is amplified in the way that we can react to menopause, this notion, "Oh, older women have bodies, I do not want to hear about that, that is too much information". That is also reflected.

I think it was Heather talking about the way in which we understand menopause. Nighat has just illustrated it beautifully, the common discourse is that it is an ending, a decline, about failure, about things stopping and you somehow not being fully female anymore. If we could start to challenge that narrative and perhaps put some more emphasis on some of the amazing things that midlife women do, the fact that we are often reaching the top of our careers in midlife, for example, the fact that we are juggling a million different things, often elderly parents, typically now teenage kids or kids that are even younger, and trying to break through those assumptions that we are over the hill, that we are hysterical, we are of a certain age, we are losing our value to society.

All the evidence that I have been privy to in social science at least says that menopausal women either feel completely invisible and overlooked or they feel visible but in very problematic ways, in that they can be the butt of jokes and be poked fun at. Those would be my thoughts.

Dr Currie: I have been thinking about what the Government can do. A lot of it is our gift within the medical profession to look at the education, the consistency of advice and what resources are available. It is up to the medical profession and healthcare professionals and societies to look at the education and expand that, and to make sure that it does become that everyone doing GP training gets good exposure to menopause care and hopefully develops a special interest. As a health professional it is incredibly interesting, and it is a constantly moving field with views and research and it is just such a satisfying area to be in when often you can help so many women with simple measures.

The other aspect, I guess, is the education that has been mentioned starting at an early age, and then also what the focus of a lot of this is around the workplace and what is going to be required of organisations. That work is incredibly important, because even if it is not talked about at home, if there is support and talk in the workplace and encouraging women to then seek help and talk about it more at home then that is another way of tackling it.

Dr Arif: The way the Government could help is when it comes to prescribing. As a GP, I prescribe HRT all the time, the leaflets that come in some of the HRT that we have, if the MHRA could please update that, because they are not fit for purpose. As an example, I talk about vaginal oestrogen, which is a treatment that is used once every night, so such as Vagifem, I have some with me if anybody wants to have a look at it, and it is a pessary that you put in once every night and then you reduce to twice a week.

This is a brilliant treatment for treating a whole load of symptoms that come with vaginal atrophy, but the leaflet in there talks about breast cancer, clots, strokes, heart attacks. It does not apply to topical vaginal oestrogen, so we have been lobbying against that for a long time to say to the MHRA, "Please can you change this?" What happens is as a GP I have 10 minutes in my consultation room. I say to the patient, "Look, this is vaginal atrophy, I am going to prescribe HRT". She goes home, she reads the leaflet, "I don't want breast cancer, Dr Arif" so the risks of breast cancer with transdermal patches or body-identical HRT needs to be much better regulated.

On that point, we need better regulation when it comes to bioidentical hormone replacements. This is done through private companies. I am not saying that they are wrong, but there is a lack of research around there. As an NHS GP this is where we come into a bit of contention with what private doctors are doing. They are prescribing lozenges or bioidentical HRT, but I cannot prescribe that on the NHS. I cannot prescribe testosterone on the NHS. It is a bit of a postcode lottery whether you get an NHS specialist who will be able to do it in your CCG. If the Government could help us, please help us regulate hormone replacement therapy.

Q12 **Elliot Colburn:** I would like to move on to some questions about diagnosis and treatment and if I could start with Nighat. We have received evidence as part of this inquiry that some women have experienced difficulties in getting properly diagnosed and receiving proper treatment. Is this something that you have also experienced and, if so, why do you think this is happening?

Dr Arif: I can honestly tell you I get thousands of messages. As part of my work under lockdown I started to make TikToks, as you do, but mostly they are educational TikToks around women's health and telling them how they can get the diagnosis. The women are brilliant. A lot of my patients are very self-sufficient. Women are great. They know their bodies really well and we need to be able to give them the confidence to say, "Do you know what? The symptoms that you are having could be menopausal".

In 2015 the NICE guidance was updated. Women below the age of 45 need to have an FSH or an LH if I want to rule out other conditions. Unfortunately, menopausal symptoms overlap with so many other diagnoses, for example, thyroid conditions or if you are a diabetic or if

you are anaemic in particular. Women below the age of 45 should be getting a baseline blood test to make sure that is okay. The NICE guidance is very clear. Women over the age of 45 do not need a blood test, however some doctors do not realise that, so they will send a woman away for a blood test. Now, an average blood test could be a one to two-week wait, then the results come through and that is a five-day wait to get the results in. You might not see the same GP. There are hurdles that a woman has just to try to get the diagnosis.

However, in saying that, a normal FSH and LH blood test does not mean that the woman cannot be perimenopausal, because she could be having periods, she could be in that age group of perimenopause, so from the age of about 40 to about 52, because she has not had one year of no period. One year of no period means menopause, so she could be in that gap, and therefore we need to have the clinical tools as a GP to be able to confidently say to her, "I think this is your diagnosis even though the blood tests might be normal". That comes with education and awareness and clinical experience that we need then to be getting out. There is no significant test that I say, "Hurrah". I cannot CT a woman and say that this is perimenopause, so we need to get better at that.

Q13 **Elliot Colburn:** Heather, same question to you.

Dr Currie: I completely agree with diagnosis. We have clear guidance from NICE from 2015 that women over 45 do not need a blood test, so on the one hand we have some examples where women do have a blood test, which is unhelpful because as we heard it may give a normal result. It does not mean she is not having the symptoms and it may then delay offering appropriate treatment. On the other hand, we have someone where the symptoms are not recognised and a blood test is not taken in a younger woman when it should be. It is all around the education, which is crucial for women to be able to get an appropriate diagnosis.

Some women are very keen on having a blood test when it may not be necessary, so that is the other side of it. It is the appropriate use of assessing symptoms and also blood test or not, depending on their age and the type of symptoms. Again, I guess it is about understanding the transition. With surgery it is very unusual to have a completely normal cycle with no symptoms whatsoever and suddenly it stops.

You have this number of years of the perimenopause, this crazy time when ovarian function is up and down like a yo-yo and hormone levels are fluctuating and there is no point in a blood test because it is going to be different the next minute, the next hour, the next day. Often it is around the education so some women may have been told in the past it cannot be menopause because they are still having periods. That is true, it is not the final period yet, but it is this perimenopausal thing, when often some of the worst symptoms are starting in that time with these changing levels of hormones and erratic periods, which can be unexpected, heavy, soaking through clothing and nasty and horrible. There are options; there are treatments and women do not have to put

up with that. As we have heard, we have normalised it, "This is what it is" but that does not mean we should not do something about it.

Q14 **Elliot Colburn:** Thank you, Heather and Nighat. You both mentioned there the importance of education. When it comes to reforms and making it easier for menopausal women to access the diagnosis and the treatment that they need would you say that is No. 1, the top priority and, if not, what would be priority No. 1 in terms of reform for you?

Dr Currie: Yes. That is a huge priority. I am not sure whether that is more important than the women having access to the right information; I think they are equally important but when they do pluck up courage and say, "Right, I am going to sort this out. I realise what is going on now" they absolutely must have consistent advice. There is a lot of focus on primary care teams. I think they do an amazing job, but they cannot be experts in everything. That is why there is a focus around having someone with a special interest, but then the woman must recognise the symptoms to know to ask for the person with a special interest.

If she just says she has joint aches or mood changes or palpitations then that does not necessarily spring out, "Oh, let us get you to see the person who is interested in menopause" because there is such a range of symptoms and we can so easily get it wrong if we do not make that hormonal connection. I have seen women who have been referred to cardiology for the palpitations, to neurology for the headaches, to rheumatology because of the joint aches, a whole load of wasted time and still not the right treatment, unless you make that link so absolutely a priority of getting consistent advice.

There is a lot of focus on primary care, as I have said. I think they do an amazing job. For ourselves in secondary care and ourselves as menopause specialists, our priority should not only be looking after the women but supporting our local primary care teams and that is one of my aims as well across the country.

Also in secondary care, sometimes if women are seeing a gynaecologist you would think they would absolutely get expert advice there, but unless a gynaecologist has taken a special interest in the menopause, believe it or not, they also may not be that up to date and not make the links. It is very difficult then for the GP if the patient has been given inconsistent advice, from who they see as a specialist, to then go back and have the GP challenge that. In some situations, the GP or practice nurse might know more than the gynaecologist who is seen as the women's health specialist. Therefore, it is not just primary care that we are talking about for education.

Dr Arif: When it comes to women's health in primary care, especially when you are training as a GP and you want to hone in on women's health, you have to pay for a lot of it, you pay for your courses. I do family planning and I do Mirena coils. I had to pay £700 to £800 to do the course and then there is the training you go on, which can be an

extra £400 to £500 depending on where you train. Then you have to recertify every five years, showing your evidence. There is a lot of money that is taken from doctors just to train in the menopause.

If you think about it, 50% of the population goes through this. If I equate that to resus training that affects men and women, which is for free as a GP, as a doctor, as you are training through. We get annual resus training. How many people are we going to see who drop dead in front of you on the street or at the surgery? Very few. You are going to see more women with menopausal symptoms who will come in. I have to pay for that training. I have to retrain, recertify and go through the rigmarole. The cost is huge.

If you look at the effects of the cost of the menopause on the NHS it is even greater. As Heather alluded to earlier, women get sent for unnecessary tests. That is a cost on the NHS. That is a saving we could make, which could run into millions. We could have women who we are able to support earlier and get preventative stuff in. South Asian women are at a high risk of osteoporosis. We could think about giving them oestrogen as a preventative, as a treatment, if they are known to have osteoporosis. Again, savings within the NHS because it costs us millions when we have an osteoporotic fracture in a femur for women.

We have to rethink the fact that this is going to affect every women you know and who you love. We all come from a woman, she is going to go through the symptoms as well. Therefore, just like we would do cardiac training for free for doctors, we need to implement this as well. Training is a hindrance. That is why doctors are not that keen about going into it, "Why should I pay so much money when that is not something I am going to have an interest in?" That is No. 1. The Royal Colleges need to look at that and allow more free access and maybe even every two years you go on a training course.

As Heather alluded to earlier, it is an ever-evolving field. When I started as a doctor 14 years ago I never had a conversation involving black and Asian women when it came to women's health, very rarely. We know the outcomes for black and Asian women. For black women, one in five are likely to have severe complications from birth. Why was I not told this when I was a medical student or aware of this? These are the conversations and that, as it is ever evolving, maybe every two years we get updated for free. I think there is capacity for our doctors to be able to do that. If the Government can help, it would be brilliant.

The other thing is that we need to be able to allow the confidence for doctors to be able to say, "I'm really scared about this area, I don't know about it". There is a real stigma among doctors saying they do not know, so they would rather avoid it and go to their failsafe. If a woman comes in with psychological symptoms and it could be perimenopause but they do not know how to prescribe HRT, "I'll give you antidepressants because that is my easier route. I understand antidepressants. I get it a bit more

but I'm a bit confused about HRT, whether this is going to cause you breast cancer or not. You have a family history and I don't really know about Utrogestan, Oestrogel or patches. I don't really know about vaginal atrophy", so you fall back to your failsafe.

This is something, because it is an ever-evolving field, we can easily implement and start at medical school in order to teach students about this.

Q15 **Elliot Colburn:** Thank you, Nighat. Can I please clarify one point on the issue of costs and training? Does the reaccreditation also bear a cost to you as well, every five years there is a cost to that too?

Dr Arif: There is a cost to that, which varies between £100 to £250 depending if you kept membership for the last five years or not.

You have to produce an audit. There is nothing wrong with reaccreditation. The process is very robust. It is a brilliant process if you are in it and doing it. However, these are added costs. What is the incentive? For GPs as a whole there are different strands. There are going to be locum GPs, salaried GPs and GP partners and your wages depend on where you are in that career basis. If you are a locum doctor and know you are not going to stay with the patients for long, then what is your incentive? Yet as a locum doctor you have to learn resus, you will not get away without knowing about basic life support.

I feel when it comes to the menopause knowing about the symptoms and knowing about the treatments is your basic life support for women, because one in four feel suicidal and I see that in my surgery.

Elliot Colburn: Very helpful. Thank you, Chair.

Chair: Thank you, Elliot. I am aware of time. We are over halfway through our time but we are not halfway through our questions so if we can be mindful of that as we move on.

Q16 **Theo Clarke:** Thank you, Chair. First, to Dr Arif, we have heard from a number of people who have told this Committee that HRT has been a lifeline. I think it is fair to say they are also quite anxious about what the risks are. Could I ask you to explain a bit further what the current risks and benefits of HRT are?

Dr Arif: The WHI studies that were done—Heather and Jo, I hope you agree with me—were pretty flawed studies. They were not randomised control studies.[2]

We have to look at the background risk women have. I will talk about breast cancer first. In the UK currently—these are Cancer Research UK statistics—one in eight women have a risk of getting breast cancer. That is just our statistics. It is because our own oestrogen works on our receptors in our breasts and unfortunately we do, as women, have higher

[2] The witness provided additional follow-up evidence to clarify this point [MEW0089]

risk of breast cancer. If you smoke, if you drink two glasses of wine a night, if you are overweight and your BMI is over 30, genetics and a sedentary lifestyle, you have a 50% increased chance of breast cancer. Therefore, there are other factors that will affect your risk of getting breast cancer even if you are not on HRT. There are eight women here, unfortunately one of us will get it. It might be me; I do not know.

Then you are looking at the risk of HRT on top of that. If you have oral combined HRT, a woman who has a womb needs oestrogen and progesterone, her risk does increase of breast cancer. It is a slight increase compared to smoking or being overweight, which increase it more. If a woman has hormone replacement therapy—she has a womb, she will need oestrogen and progesterone—and we give it through the skin as a patch or as a gel and we give her micronised progesterone, the background risk does not increase. The studies show that for women who do not have a womb, who have oestrogen-only hormone replacement therapy given as a gel or as patch, their baseline risk does not increase at all.[3]

In fact, there are no deaths from breast cancer of taking HRT. There are even earlier studies that suggest that women's risk decreases if they have had a hysterectomy and are on HRT.

The other thing is that progesterone can be given as capsules or as a Mirena coil. There are other ways of making sure we are counteracting and not having unopposed oestrogen. The risk of clots is even less if you are taking HRT through the skin or taking micronised progesterone or progesterone through a Mirena coil.

Topical vaginal oestrogen, another group of HRT we give to women that is a pessary that goes up the vagina to treat vaginal atrophy, there are no risks of breast cancer or clots with it. However, the leaflet that comes in the box says it does. This is where we get a lot of misinformation that is given to women.

The risks are over-amplified to a degree and that is where we are getting a lot of confusion as well. There are other risks associated with womb cancer if you have oestrogen unopposed but we would tackle that by giving progesterone. There is a small risk of ovarian cancer and a small risk of stroke, which comes down under the heading of "clots" but we know that transdermal oestrogen does not increase your risk of clots. I hope Heather agrees with me on that one.

Dr Currie: The breast cancer thing is the one that most worries women and healthcare professionals. It was studies in the early 2000s, which focused on risks of HRT without balancing them against benefits, which led to a huge change in confidence in both the taking of HRT and the prescribing of it

[3] The witness provided additional follow-up evidence to clarify this point [MEW0089]

Where we are at the moment is that HRT does, for most women taking HRT under the age of 60 or within 10 years of the menopause who have troublesome systems, provide more benefits than risks but it is not perfect. For every woman we have to make sure she has the information so she can make an informed choice.

We heard there about different types of HRT. There are pros and cons of either way. A big study from America that told us about the risks of HRT did also tell us about benefits of HRT, it is just they were not publicised initially and came out of the woodwork later on. That used a tablet form of HRT: taking it through the mouth is still a very reasonable option for many women and is very convenient.

As I said, breast cancer is the biggest concern. It is a small risk. For every 1,000 women taking HRT for more than five years over the age of 50—depending on which study you look at, there is not an absolute number that every study agrees with—it is something like an extra five to eight per 1,000 women over five years and it is duration dependent.

There is a risk with any form of HRT that goes through the whole body. As we heard, there is no risk with using it vaginally and there are different forms of vaginal oestrogen. However, if we take it through either the mouth or the skin then it is associated with a risk. There are different types of HRT that have different levels of risk. Whether it is through the mouth or the skin does not affect the risk of breast cancer. With any type, the risk is small and we have to try to help women to get that into perspective. [4]

Breast cancer is a horrible, horrible disease. Women's perception of risk varies. If a woman has seen a family member with breast cancer, even if I say to her, "It's only an extra five or eight per 1,000 over five years", to her that might be too enormous to consider wanting to take it. She might think, "Oh, actually that is still too much for me to consider and I would rather cope with symptoms in a different way", and we can cope with them in a different way. Generally, what we try to do is help women to get it in perspective.

For most women there are more benefits than risks. It is the most effective treatment we currently have for controlling menopausal symptoms. That is where we have to individualise because the symptoms to one woman are completely different to the next woman. Also, it is not just about the presence of symptoms, it is what the impact is. The impact is hugely affected by what other stresses she has her in life, what other things she has to cope with. For many women, as they transition from this time of ovaries producing plenty of oestrogen to not producing much at all, also their life is changing. Therefore, the life stresses at one stage might be different at another stage, which also influences whether or not she feels she wants to control symptoms.

[4] The witness provided additional follow-up evidence to clarify this point [MEW0090]

Hugely important, as has been mentioned, is the effect on bone health. We know that after the menopause with less oestrogen our bone health can be affected with increasing risk of osteoporosis and fractures, which is a huge burden to women, society and the NHS. Oestrogen is really good for our bones. However, there are other diet and lifestyle things that are also good. If we take it early within this transition it is also probably good for our hearts.

Therefore generally, yes, there are risks but the risks tend to be small. When we are individualising we would go by the woman's symptoms, what the impact is and we would also think about her medical history. That would influence decisions around types of HRT and also what the woman's preference is—the most important aspect.

Q17 **Theo Clarke:** Dr Currie, I have a second question for you. The Government are due to publish their Women's Health Strategy by the end of this year. I would be interested to know what you would like to see in that strategy.

Dr Currie: I am in Scotland so I would love it to be similar to the Women's Health Plan for Scotland because we are really proud of that and it is a women's life-course approach.

There are opportunities. A woman's health is affected by various things that happen through her reproductive and post-reproductive years. At each stage there are things that can influence later health, both in terms of symptoms she might have and also in terms of her later heart health and bone health. It is being aware of the different aspects of a woman's health and her hormonal health and what impact that can have later on, so it is recognition of these different phases.

Even the basic thing of periods; understanding why periods happen, what we can do about them, how inconvenient they can be, what the options are for managing periods, understanding how to get good information to all the different groups we have mentioned and the many more we have not mentioned, and understanding around what resources are available at each stage so women can make informed decisions.

I have not been involved with the development of the Women's Health Strategy. I think they are looking at pathways, which is an important aspect. I want women's health to be really high on the agenda and recognised, and for it to look at the different things that can help women along the way.

Dr Arif: The benefits of hormone replacement therapy. They are, like you were saying, a life-saving treatment for patients. The other benefits that, as Heather was saying, were overlooked in the study were that it lowers your risk of dementia, lowers your risk of osteoporosis, lowers your risk of heart disease and lowers your risk of type 2 diabetes. These are chronic conditions that impact and cost a lot of resources within the NHS.

Therefore, we should be able to have these conversations openly about risks and benefits with our patients.

Q18 **Jackie Doyle-Price:** Jo, I would like to ask some questions on your area of expertise now, menopause in the workplace and the economy. We have been told that over 90% of women have said their symptoms had a negative impact on their work. What are the consequences of women experiencing these symptoms in the workplace?

Professor Brewis: That is a really big question, I will try to 'nutshell' it. There are all sorts of different effects of symptoms at work. Some of them we can quantify and attach cost values to and some are more to do with an individual woman's wellbeing and how her wellbeing and her ability to cope at work spills over and might impact people.

In terms of the symptoms that are coming up again and again and again in the research as being particularly difficult to cope with at work, the two related ones that come out a lot are fatigue and insomnia. That obviously makes you irritable, makes your cognitive powers less effective, your ability for decision-making disappears and your concentration disappears. Hot flushes, again, can make you feel very unprofessional. They can be very embarrassing. They can make you feel dirty. They can affect your sense of yourself as an important professional. Focus and concentration, also, in and of itself, anxiety and worry come out time and time again. Emotional outbursts as well, the mood-swing scenario we have talked about in previous discussion earlier today. Again, people worrying that they look like they have no self-control. Their decision-making is affected. They feel like they are losing their empathy because they are not in full control of their emotions. The other one I have become aware of recently is that there have been some recent pieces on how difficult menstrual flooding is at work and the ways in which women have to navigate menstrual flooding in order that it does not show through on their clothes. Those are the sorts of individual level emotional and physical effects symptoms can have.

Work can make symptoms worse in lots of different ways. Stress can exacerbate symptoms. Inadequate ventilation and temperature control, lack of natural light, exposure to noise, lack of access to appropriate toilet facilities, having to wear heavy, synthetic or constricting workwear and physical demands can really exacerbate menstrual flooding, for example. There is a whole range of different ways in which work can affect symptoms.

There is also some very, very good data now on quantifiable cost. For instance, there has been a study published earlier this year that I regard as ground breaking. It used the National Child Development Study and compared Waves 8 and 9, which are the two most recent waves available for public use. What that study proved was that women who reported at least one problematic menopausal symptom—just one, most of us have more than one—at the age of 50 were 43% more likely to have left their jobs by the age of 55 and 23% more likely to have reduced their hours.

What really worried me about that study was that although HRT was shown to be very ameliorative in that particular relationship, even where women have very problematic symptoms if their partner was out of work, in other words they were the sole breadwinner, they were much less likely to leave work. Then they were obviously at work coping with it and did not have the option, which is not desirable in many ways, of leaving.

We know about the gender pay gap. We know that it is highest between men and women in their 50s. We know that feeds into the gender pension gap, which I think currently stands at a terrifying 40%. We know that midlife and older women need financial security and we know they also need the medical health benefits, social support and self-esteem that can be derived from work.

To finish, we also know that if women leave work or reduce their hours it costs employers an enormous amount of money. There has been some statistical work done by Oxford Economics that suggests if a women, for example, earns £25,000 a year it is going to cost her employer more than £30,500 to replace her. There has also been some research that suggests that if women are experiencing hot flushes and night sweats and they are not getting either medical or workplace support they are saying they are losing something like 60% of their work productivity compared to women who do not have that symptom. The estimate is that is costing the global economy something like £150 billion a year.

Sorry, that was a big long ramble but I wanted to cover everything.

Q19 **Jackie Doyle-Price:** There was plenty there. I am glad you mentioned menstrual flooding because that is a taboo that is not often addressed, so thank you for that.

More broadly, are there any other numbers we can put on the cost to the economy and society generally? You mentioned that last figure, is there any other data?

Professor Brewis: The ones I have provided you with are the ones I would regard as perhaps the more reliable ones, if that makes sense. There are other surveys that have been done. There was something done by Health & Her last year, which has a really good headline figure but unfortunately I have not been able find out anything about the methodology by which this figure was arrived at. However, I will give it to you anyway for the sake of argument. They suggested that something like 370,000 women had either left work or were considering leaving work because of their menopausal symptoms. When I calculated that out, using ONS data, what we are looking at there is something like 8.5% to 9% of women in the menopausal age bracket, so that is quite a substantial amount. However, not all women have terrible menopausal experiences and we have suggested that as well.

What I will add quickly is that there is very good and very reliable evidence to suggest that HRT, as I have said, can have an ameliorative

effect on wanting to leave work or reduce hours. That was the NCDS study.

There has also been some brilliant work done using longitudinal data in the States, which looks at women who had stopped taking HRT because of things like the WHI study and The Million Women Study. Researchers had something like 22,000 women in their sample. Based on that data they were able to suggest that 30% of those women who had stopped taking HRT had to leave work because their symptoms were simply unbearable.

There are lots of costs of not advising women properly about medication for menopausal symptoms, as Heather and Nighat have amply demonstrated.

Q20 **Jackie Doyle-Price:** Thank you. Since the Government commissioned research in 2017, how much progress do you think the Government have made in terms of tackling discrimination? I can see by your face not much.

Professor Brewis: I am going to be brutally honest here because I was advised to brutally honest. I do not think very much has changed. The Women's Business Council did some early, and I think very good, preliminary work as part of the Staying On Action Group, which I was a part of. Then obviously the WBC was reconfigured to concentrate on the gender pay gap.

Of course, I understand that political priorities change. It is no news to anybody that we have been through and are still dealing with Brexit. It is no news to anybody that we have been through and are still dealing with a pandemic. I guess I can understand why it slipped off the agenda. However, honestly, I do not see that a lot has changed from when we published the report, which was July 2017.

Dr Currie: A lot has changed. We do not know how much has been due to Government input or just, as we have talked about, more TV programmes, radio programmes and more in the media. I do not know what has caused the improvement in awareness. A lot of organisations now are having menopause webinars, menopause support groups, policies and frameworks, whatever they want to call them. In even the last couple of years that has exploded, which is fantastic. However, I do not know if we would ever be able to say whether that is credit to what the Government have done or whether it is a combination of everything else going on and more people talking about it now

Q21 **Jackie Doyle-Price:** I generally think that Governments get in the way rather than encourage things.

I will ask each of you this question. If there is something you think the Government can do to make progress in this area, what would it be?

Dr Currie: If the Government can do to what, sorry?

Jackie Doyle-Price: Make more progress.

Dr Currie: Make more progress to do with the workplace, if there was a mandate around every organisation had to have something, whether they called it a policy or a framework. What it was would depend on the type of organisation, the size of it, the type of work people were doing. However, just something to be able to understand that, "We have staff here who either are already or are going to be menopausal. We need to listen to them and give them a safe place to be able to talk about it". That would be amazing.

Dr Arif: First, I think it is 2021 and we are talking about the menopause for the first time so I applaud the Government for doing that. Thank you very much, it has made me very happy. Also, having an ethnic voice added to that even more, inclusion is so valuable.

What the Government can do is implement, as we would do with any other condition. For example, if we look at hormone deficiency conditions, such as diabetes where you have deficiency in insulin—I know it is a bit more complex than that—or if you have a thyroid condition you are deficient in thyroid. The menopause is, if we think about it, a transition where you are deficient in hormones.

There are workplace policies already in place for that. I did a webinar for Coca-Cola and the BBC. We need to be seeing that in the NHS as well. The majority of the workforce in the NHS is women, women from ethnic minority backgrounds as well. We have seen that under Covid because they have been adversely affected, with the number of deaths we have had from Covid in black and Asian ethnic minority communities.

If we can keep women retained within those posts, from consultant levels all the way down to the hospital porter, then the NHS will really benefit from this in the future. Unfortunately, I am seeing GP colleagues leave. I am seeing consultants, surgical consultants, women right at the top end of their surgical field, finding that the gowns are too heavy, the masks are too heavy and in the procedures they are doing the lights cannot be adjusted because they are all done for men who are doing surgery in there. We cannot be having that; we already do suffer a lot with not enough work staff in the NHS and we cannot have women leaving.

Professor Brewis: I would like to touch very briefly on the law, if I may. I am going to be bold here and say I would really like section 14 of the Equality Act to be enforced. The menopause is a fundamentally intersectional phenomenon. It fundamentally, for most people who go through it, involves a combination of sex and age. Currently it is not possible to claim direct discrimination on the basis of more than one characteristic. I do not think that necessarily weakens tribunal cases but I think it would strengthen them if you could bring in more than one, particularly around direct discrimination. Obviously that is possible with disability discrimination and it is possible with indirect discrimination. The

vast majority of the cases that have either been through or are going through tribunals are about direct discrimination.

The other thing we tend to overlook, and I think where a lot of work could be done, is around the health and safety at work legislation. I am thinking here about HASAWA and the attendant regulations that have been passed since 1974. That is particularly because you do not actually have to be harmed under the Act, risk of harm is sufficient. Also, a lot of the risks that coverage in HASAWA refers to around breaches of duty of care are things that would probably make life very difficult for a lot of menopausal women. It is things like having to stand for a long time or sit for a long time, having a non-ergonomic workstation, high temperature, long working hours; all of these things are also connected to making menopausal symptoms worse.

If the Government, particularly in the shape of the HSE, could start to raise employers' awareness of that, because I do not think it is going to be very long before somebody catches on that this is another route to take employers to some form of legal reckoning, if you like. I am sure everybody is aware that we have already had three successful tribunal cases around the menopause, all of which have come via the Equality Act. I know there are more in the pipeline. There is one I am watching with interest locally to me here that I think has every chance of winning.

Jackie Doyle-Price: Thank you, that is great.

Q22 **Alex Davies-Jones:** Thank you to the witnesses for joining us today, it has been incredibly insightful.

Jo, if I come to you first, please. How much progress do you think employers have made since the Government Equalities Office research in 2017?

Professor Brewis: I am not going to draw a causal link, if you do not mind. I do think there has been an enormous amount of progress. I feel as if what is going on, on the ground, has certainly outstripped academic research, ironically. If you had asked me this question in the summer of 2017 I probably would have been able to count the number of employers who were actually doing something on the fingers of one hand and now they are in their thousands. In fact, a recent estimate suggested that something of the order of millions of workers are now potentially covered by some form of menopausal policy, framework or guidelines in the workplace.

It is across sectors and in some cases the sectors you would least expect. The police and emergency services have done brilliant work in this area. There is also education and higher education. The NHS is a bit slow to the party but they are getting there. Infrastructure, Network Rail, for example; retail; finance and accounting; housing associations; we have just accredited our first law firm as menopause-friendly; utilities like Severn Trent Water and E.ON; pharmaceuticals like GSK; local and national government; charities; I could go on.

The missing piece of the jigsaw at the moment, which of course is a very large part of the UK economy, are micro and small enterprises. If we are using that strict definition of SMEs as 249 employees or below, then probably that is the sector where we really need to concentrate and try to persuade—perhaps not necessarily micro employers but small and medium employers—that, exactly as Heather said, they can do things to support their menopausal staff that do not need to cost an enormous amount of money but would make a huge difference to those people's lives.

Q23 **Alex Davies-Jones:** That follows on nicely to my next question. We are seeing a struggle for SMEs to adopt these menopause policies or making their workplaces menopause-friendly for their staff. Is it just a financial issue or are there other challenges that they are facing that are preventing them from implementing these policies and helping their staff?

Professor Brewis: I cannot comment on SMEs particularly because there is not data around that and I am not cognisant enough of the particular challenges they face. I do think employers can worry about introducing this sort of policy. One reason is what I call 'what-aboutery', which is the worry that employees are going to say, "Oh, but you don't have a policy about X condition and you don't have a policy about Y condition". I simply go back and, exactly as both Heather and Nighat have pointed out, this is something that affects 50% of the population so it is something we should be paying attention to. Unlike pregnancy and maternity, which we know are much better dealt with in the workplace than they were 20 or 30 years ago, this is something that will happen to everybody who has a womb.

Q24 **Alex Davies-Jones:** Exactly. Many of the respondents to our survey told us that their workplace does not have a policy, there are no clear guidelines in place for them, they do not know where to turn or what rights they have at work.

Professor Brewis: Absolutely. The other thing—this is legitimate as well but my belief is the only way around it is through it—is that women worry this could become yet another metaphorical stick to beat them with. I have been told, "Please, will you stop talking about this because it is making us look weak". I suspect, although I am not quite old enough to remember, we had very similar discussions around pregnancy and maternity provision in the run-up to the passage of the Sex Discrimination Act.

Also, a lot of this is education. That is the piece we keep coming back to in this conversation. Our team tends to say that the menopause is not a women's issue. I know it sounds bizarre at first hearing but what we mean is that it is not just a women's issue, it can affect everybody around a woman if she is struggling. Nighat put it beautifully earlier when she said we all come from women; we all know women, we all love women. Whether or not we have the capacity ourselves to go through the menopause, if we are around somebody who is struggling that will have a

knock-on effect. The awareness piece and the education piece could go a long way.

There is also—a bit like the 'what-aboutery'—the perception that somehow this is special treatment. I do not believe it is. I believe it is levelling the playing field.

Q25 **Alex Davies-Jones:** Yes, it is equality. What are the advantages and disadvantages then of making a menopause policy mandatory in the workplace?

Professor Brewis: That is a very good question. I think Heather 'nutshelled' it beautifully earlier. I personally would not advocate for a policy to be mandatory. Our strong belief, and this is exactly what Heather was alluding to, is that this is very much 'horses for courses'. It is about what will work in the context of that organisation. In the context of the Open University, which employs thousands of people and is very bureaucratic—the most bureaucratic environment I have ever worked in and that is saying something—we are moving towards a policy. If we do not get one that is very unlikely to have any sticking power, because we have to have a piece of paper to wave around to give it some heft and give it some weight.

I was on a webinar last night with Theresa Winters from Santander—again, thousands of employees and a very, very big financial services organisation. They decided not to introduce a policy. Instead, they have something they call "guidelines".

The things can function very differently. You could simply have a "menopause hub" that has lots of information and people could be directed to it and route it out a bit to other related things that will be helpful for them.

I am completely with Heather here. I would like to see the expectation that something is done by all employers. Maybe not necessarily micro-employers but from small upwards that some form of account is paid to supporting menopausal staff at work, at least awareness and education are taken seriously in that organisation and that whoever has line management responsibility for people who will go through the menopause, and equally staff who are going to go through the menopause themselves, know what can be done at work. That is what I would advocate for.

Dr Currie: I completely agree. My plea was if there was something that every employer did and was aware of that would be great. What I should have added on, but Nighat picked up beautifully, is to start with the NHS. As one of the biggest employers of women we cannot expect our staff to give the best care if they are really struggling themselves. For every trust, for every board, whatever you call it, north of the border or south of the border, wherever, for them to have something would make an

enormous difference to some people, not only to the staff but to the patients they are looking after.

Q26 **Alex Davies-Jones:** Finally from me, Jo, you mentioned some of the things employers can do in terms of basic practical things like ensuring there is a heating or air-conditioning system, the right temperature for women going through the menopause and that they have an educational platform or a line manager who is aware of the issues.

Is there anything else in a basic guideline or policy, whatever we call it, all workplaces should have to support staff going through the menopause?

Professor Brewis: Again, this is a 'horses for courses' type operation. These are the things we would like to see that will not be relevant or fit in all organisations. As well as general education and awareness for everybody, line managers need to be trained particularly in having difficult conversations and what might constitute a reasonable adjustment, which is really important. If it is a big organisation and they have health or employee assistance programme support, those staff need to be aware as well. We have seen some really problematic advice being given by EAP staff in particular to menopausal women. Absence policies need to allow for the fact that menopause symptoms come and go, so repeated short absences should not trigger performance management. Informal support groups and menopause champions, advocates or allies are wonderful. Flexible work, and we know that a lot of us can work very successfully from home now, we are fully aware of that. We have talked about good ventilation and temperature control, cold drinking water. Decent toilets and, if possible, free sanitary wear and access to showers. Paying attention to how the workplace is furnished. Do not furnish your chairs with pale grey upholstery and do not make people wear uniforms that are pale from the waist downwards. Ergonomic support because of muscle and joint pain, so wrist rests and footrests for both in-the-office work and working at home. Uniforms or workwear that are not heavy or synthetic but can be layered, so taken off and put on again. Rest areas, good menopause-friendly food, decaf hot drinks, 'eat the rainbow' type salad and fruit offerings. Reduction of noise exposure where at all possible, which could be as simple as noise-cancelling headphones in an open-plan office. This is a little bit extracurricular but yoga, exercise, meditation or CBT sessions that are offered at work, preferably for free, can alleviate symptoms. There is a lot.

Alex Davies-Jones: There is a lot to do.

Q27 **Chair:** Thank you. Everybody has been so brilliant with their timekeeping in that second half of the session I do not know if any of the members have any questions they want to come in with. If not, I invite you all to say anything else on any of the aspects of the inquiry and the questions we have already put to you. Is there anything else you would like to add?

Dr Arif: I wanted to say thank you so much for such an inclusive conversation. Even until 2019 it was always seen as a 'white woman's

condition', if I may use that term and there was very little else on it. It is not seen as, "This is the white women's experience" and other. I feel it is not like that at all, I feel it is very, very inclusive. We have talked about trans-men and their experience as well.

We have talked about communities that have disabilities and the deaf community. I hope I have done them justice by raising that there are issues because general practice has changed so much. We are doing telephone triaging and I do worry about the fact that those who have a hearing impairment are having difficulty accessing GPs at the moment and we are looking at that. Within our surgery as well we are opening up more face to face but every practice works differently.

A lot of my work has been done with women from my community. My father is an imam, I have grown up knowing and loving women and religion plays a huge part. We did not touch upon some of that. However, we need to also look at faith communities and their perceptions, such as Jewish women and their experiences with their periods because some of the stories you hear from there is that it is that awareness that needs to come up. That only will happen with collaboration and also integration. I am aware that within our communities we need to be less insular and integrate far more because this is a conversation that is far more reaching within our communities. I am honoured to have been part of this, thank you.

Professor Brewis: Thank you so much for inviting me. I have really enjoyed the session; it has been a real privilege.

I wanted to say that if any of the Committee members are interested in what we would call 'best in show', employers that really are blazing a trail, there is a scheme that has been up and running for about six months now called Menopause-Friendly Accreditation. We have an independent panel of seven or eight members. I am one of the experts, in inverted commas. So far we have accredited four organisations, probably the best known of which is the triumvirate of HSBC, First Direct and M&S Bank. If you type in "Menopause-Friendly Accreditation" you can watch videos that show what these amazing employers have been doing. I will say we are very rigorous and we set very high standards, this is why we refer to them as 'best in show'. Thank you.

Chair: Thank you very much. That concludes our first evidence session of this inquiry. I thank you all so much for your very interesting and valuable contributions.