**MRC/CSO Social and Public Health Sciences Unit Consultation Response**

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| **Title of consultation** |
| Women's Health Strategy: Call for Evidence |
| **Name of the consulting body** |
| Department of Health and Social Care |
| **Link to consultation** |
| [https://www.gov.uk/government/consultations/womens-health-strategy-call-for-](https://www.gov.uk/government/consultations/womens-health-strategy-call-for-evidence/womens-health-strategy-call-for-evidence) [evidence/womens-health-strategy-call-for-evidence](https://www.gov.uk/government/consultations/womens-health-strategy-call-for-evidence/womens-health-strategy-call-for-evidence) |
| **Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this consultation?** |
| The *MRC/CSO Social and Public Health Sciences Unit*, University of Glasgow is an interdisciplinary group of sociologists, anthropologists, psychologists, epidemiologists, geographers, political scientists, public health physicians, statisticians, information scientists, trial managers and others. The Unit receives core- funding from the Medical Research Council and the Scottish Government Chief Scientist Office, as well as grant funding for specific projects from a range of sources. We conduct research to understand the determinants of population health and health inequalities, and to develop and test interventions to improve health and reduce inequalities, using a wide variety of methods including qualitative research, the collection, linkage, and analysis of social survey and routinely collected data, evidence synthesis, randomised controlled trials and natural experimental studies. Several of our staff are engaged with issues related to Women’s Health. Their input is provided below. Further information about the Unit is available at [http://www.sphsu.mrc.ac.uk/.](http://www.sphsu.mrc.ac.uk/) |
| **Our consultation response:** We have focussed the response on discrete areas of women’s health where we currently have active research ongoing. These are menopause, premenstrual dysphoric disorder, sexual health, and maternal health.   1. Women’s voices    1. Women’s experience of menopause   University of Glasgow PhD researcher, Abby Fraser, has completed in-depth research exploring the lived experiences of women through menopause both prior to the first Covid-19 lockdown, and during the first lockdown measures.1 Findings, from 377 women across the UK, highlighted numerous key issues for consideration. Participants reported the **unexpected impact** menopause had made on their day-to-day lives, and how they felt **unaware and unsupported** throughout their menopause experience. Despite menopause being an inevitability for 50% of the population, women found there was an unacceptable dearth of information and support available to them. Respondents suggested that menopause: (i) should  be given the **attention** that other facets of reproductive life already have, such as childbirth; (ii) |

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| menopause **education** should be delivered within the school curriculum; and (iii) online information from the NHS should avoid being **contradictory** or condescending. Those who mentioned how menopause had impacted their lives often referred to it as a "hell", "a lonely place" and “something to put up with”.   * 1. Women’s experience of seeking medical help around menopause   Fraser1 also found that women received variable support from general practitioners (GPs). A lack of training in GPs, and inconsistency around advice surrounding treatment options by GPs was reported. Many respondents felt there was inadequate awareness amongst primary healthcare practitioners around the breadth of menopausal symptoms, and that menopause information was frequently **antiquated and outdated**. This led to some participants being **wrongly diagnosed** with other conditions, or not having their symptoms recognised as being menopausal during consultations. This was a particular issue for respondents who experienced early menopause, as they reported that GPs did not even consider the possibility that they could be menopausal. Of further frustration to participants was **inconsistency** in access to treatment options through GPs. Participants frequently reported being unable to access HRT through GPs when asked, as well as being frustrated with **anti-depressants** as the initial treatment option offered for many symptoms. It is also important to note that when participants were able to find a GP who was knowledgeable around menopause, this was seen as a huge relief to participants, and having proper medical support was very beneficial to improving their menopause experience. Participants made further suggestions including: easier and more available access to primary care menopause experts; easy access to printed menopause literature; midlife health checks and screens as a way to provide support to women who are both pre- and peri-menopausal; and GPs could be more proactive in informing middle aged women about the symptoms of menopause, perhaps before the women herself is menopausal.   * 1. Women’s experiences of poorer sexual health compared with men   Several of our unit researchers led aspects of the British National Survey of Sexual Attitudes and Lifestyles study (NATSAL-3) – one of the world’s largest and most detailed scientific study of sexual behaviour. They looked at a range of sexual health indicators in data from 12,132 participants to see if they clustered together to form distinct groups, and identified six groups. 84% of men were in the ‘good sexual health’ group compared with only 52% of women. The women who were not in good sexual health fell into two groups that were unique to women, mostly a **low interest in sex** group (29%) who tended to be older women. There was also a **highly vulnerable** group (2%) who reported a wide range of risk factors including abortion, STIs and functional problems, and more sexual coercion than other women. The highly vulnerable group tended to be women who are poorer, not in stable relationships and who also report alcohol/drug use and depression, and who started having sex early. This group would benefit from tailored intervention that addresses their sexual health needs holistically. Policy responses should be aware that a greater prevalence and diversity of poor sexual health appears to exist among women than men, with more consistent effects on women’s satisfaction/distress with their sex lives.2   * 1. Women’s experiences of impaired sexual function   Further analysis from NATSAL-3 demonstrated that dyspareunia (painful sex) was the sexual function problem most commonly experienced by women as **distressing**.3 It is known to lead to feelings of  isolation, shame, sexual inadequacy, loss of confidence and feeling out of control. **Less than half** of |

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| women with dyspareunia sought professional help, and among those who did seek treatment, negative experiences were common, including invalidating encounters, lack of diagnosis, and ineffective treatment. There is a need for resources to **support** clinicians who feel uncomfortable broaching the topic of sexual function and pleasure with their patients, including advice on language and on when to refer patients to specialists in sexual health. Further research might explore the extent to which painful sex might usefully serve as a **diagnostic indicator** of other health problems, in the same way that erectile difficulties often signify cardiovascular problems in men.  NATSAL-3 also produced data showing that women with HIV, living in England, were more likely to have **lower sexual function** than women without HIV. This was more common in those who were **postmenopausal** than premenopausal. Furthermore, a recent survey of UK GPs revealed low levels of confidence in managing menopausal symptoms in women living with HIV.4 Therefore, sexual problems in menopausal women living with HIV may go unrecognised and unsupported by healthcare professionals. We advocate that assessment of sexual function be incorporated into the routine HIV clinical care provided to women living with HIV of all ages, and welcome forth coming UK guidelines on the sexual and reproductive healthcare of people living with HIV which recommend routine annual enquiry about sexual function and menopausal status and symptoms.5  1.3 Women’s experiences of seeking help for Premenstrual Dysphoric Disorder Premenstrual Dysphoric Disorder (PMDD) is a severe hormone-based mood disorder affecting 1 in 20 women and individuals assigned female at birth. Although it is a classified disorder, added to the  Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in 2013, and the International Statistical Classification of Diseases (ICD-11) in 2019, it is not widely understood by health professionals, is **often misdiagnosed** and incorrectly treated. Given that 1 in 3 people with PMDD attempt suicide, it is imperative that the evidence-based treatment guidelines are promoted and followed.6 PMDD has a negative impact on a person’s professional and personal life, measured at 3.8 disability-adjusted life years (DALYs) per person.7 According to data by Public Health England, an estimated 78% of the female population are of childbearing age. This level of disability therefore equates, in England, to approximately  **4.2 million DALYs lost to PMDD every year**.8  Several of our unit researchers engage in advocacy work with the International Association of Premenstrual Disorders (IAPMD). One of the organisations recent surveys, of 2512 people with PMDD, found that general practitioners were not rated highly regarding their knowledge or awareness of PMDD.9 Given that many people will first present to their GP it is important that this first port of call has greater potential to identify, manage and/or refer PMDD effectively. Their findings also reported that psychiatrists were rated by patients as less knowledgeable about PMDD than gynaecologists. This is a concern, given that PMDD is classified as a psychiatric disorder in the DSM-5. The evidence points to the need for greater training and education for key health professionals, namely **GPs, gynaecologists, psychiatrists and therapists**. We wish to ensure the Department of Health and Social Care are aware of the evidence-based guidance provided by both the **IAPM****D**10 (a not-for-profit organisation working to bridge the gap between premenstrual and mental health), and the UK-based National Association of Premenstrual Syndrome (**NAPS**),11 who work to promote a better understanding of both PMS and its treatment by the medical profession. They are both leaders in providing support, education and training  to health professionals and people living with PMDD. |

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| 1. Information and education on women’s health    1. Areas where menopausal women have identified a shortage of information availability   Further findings from Fraser1 highlighted areas where women identified a shortage of available information. These include: (i) **general awareness**, such as encouragement to seek help, loneliness and the impact of menopause on relationships, awareness in men/husbands/partners, and the range of severity and duration of symptoms; (ii) **management of menopause**, such as HRT guidelines, non-HRT interventions, strengthening exercises, counselling following surgical menopause, bone density maintenance, testosterone use, maintaining body shape, nutritional advice and managing symptoms through lifestyle factors; and (iii) **symptoms**, such as, vaginal atrophy, memory less, stress and anxiety, cognitive changes, sleep disturbance, hair loss, cardiac arrythmia, emotional changes, painful sex, fatigue, incontinence, muscle and joint pain, and body changes.   * 1. Women’s awareness of further research needed in menopause   Fraser’s research also highlighted areas where people with menopause thought that more research was needed.1 Table 1 indicates areas where menopausal women would like access to more information, but have been unable to source it.  Table 1. Areas for further research and information | | | | | |
|  | **Physiology/symptoms related to menopause** | | | |  |
|  | - | Interactions between menopause and | - | Menopause and progress of Alzheimer’s |
|  | stress | - | Vasomotor symptoms and circadian |
| - | Menopause and mental health |  | rhythm |
| - | Menopause and memory loss | - | Menopause and emotional changes |
| - | Role of hormone changes in | - | Menopause and thyroid cancer |
|  | symptomatology | - | Menopause and gut/vaginal microbiota |
| - | Menopause and cardiovascular disease | - | Menopause experience and history of |
| - | Menopause and pre-eclampsia |  | periods/parity/contraceptive usage |
| - | Menopause and neurological conditions | - | Menopause symptoms and covid |
| - | Menopause/hormonal changes and | - | Heritability of menopause experience |
|  | asthma |  | from mother to daughter |
| - | Variation of symptom experience | - | Menopause and brain structure/function |
| - | Menopause and endometriosis |  |  |
|  | **Clinical approaches to menopause** | | | |
|  | - | Treatment for those unable to take HRT | - | Clinical effectiveness of HRT vs. self- |
| - | Contraception and fertility during |  | management of symptoms |
|  | perimenopause | - | Use of vitamins (B12 & B6) during |
| - | Improving diagnostic processes for |  | menopause |
|  | confirming menopause | - | Reproductive depression |
|  | **Social approaches to menopause** | | | |

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|  | - | Wider social roles and approaches to | - | Menopause and neurodivergency |  |
|  | women during menopause | - | Comorbidity of menopause experience + |
| - | Interaction between peri-menopausal |  | other diseases (e.g. cancer) |
|  | woman and the family | - | Documented lived experiences of women |
| 2.2 Patient led advocacy  It is important to highlight that due to the current perceived lack of information, people have undertaken patient led advocacy. Two examples of these include: (i) **the #MakeMenopauseMatter** campaign led by Diane Danzebrink, which recently led to menopause being added to the school curriculum in England and Wales;12 and (ii) the **Together in Surgical Menopause** resource website, founded by patients who struggled accessing information [post-oophorectomy.13](https://post-oophorectomy.13/) These were in response to the lack of useful public information on menopause.   1. Women’s health across the life course    1. Issues related to the perinatal period   Women are disadvantaged in the perinatal period by under resourced specialist services and lack of adequately trained specialist staff, exacerbated in rural areas of Scotland. Our PhD researcher, Jessica Moran, worked alongside the Scottish Government on the 2019 needs assessment by the Perinatal Mental Health National Managed Clinical [Network.14](https://Network.14/) Although the findings specifically relate to NHS Scotland, it is important to highlight them for this consultation, as critical **learning points** may be translated to NHS England. Findings include that: (i) GPs are usually the initial source of advice and assessment where mental health difficulties arise in the perinatal period. There was clear feedback that GPs would benefit from additional **education and training** in prescribing during pregnancy and breastfeeding; (ii) several health boards had **specialist perinatal health midwives,** with only providing a specialist midwife as a formal link to the local perinatal mental health service; (iii) one health board had **dedicated provision** for maternity services, but no other board has specific provision for perinatal psychological interventions; (iv) there are 2 specialist Mother and Baby Units (MBU) in Scotland for treatment of severe perinatal mental illness. Both are located in the Central belt and neither unit is resourced across all disciplines to provide **fully comprehensive** care. There was clear evidence that MBUs were often full and unable to take admissions, with Leverndale MBU unable to admit 44 women in 2018; and (v) the problems described above are particularly acute for women in **rural areas** where they may be isolated, have to travel long distances for services and be more vulnerable to stigma when seeking help for perinatal mental health difficulties in communities which are insular. These are important issues to inform the consultation for NHS England.   1. Women’s health in the workplace    1. Workplace related issues for menopause   The menopause research conducted by Fraser,1 already described above, also generated data regarding  women’s health in the workplace. Key findings include:  **Space:** Participants raised the importance of being able to adjust the workspace in order to accommodate more physical symptoms of menopause such as hot flushes/sweats e.g. regulating temperature in shared  workspaces. There was discussion of methods to accommodate menopause without individuals feeling | | | | | |

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| singled out or needing to disclose their private symptoms. Space also played a crucial role in the experience of cognitive/emotional symptoms in the workplace. Respondents felt that open working spaces made them feel more exposed when experiencing symptoms of anger of forgetfulness. Again, the issue with provision of more private areas was brought up in relation to this, as respondents felt they would appreciate a space they could retreat to in order to compose themselves.  **Responsibilities:** The most significant impact of menopause symptoms was on ability to fulfil job responsibilities through symptoms of poor concentration, brain fog and fatigue. Added anxiety in the workplace came from the respondent’s concern that their competency and work ability was being doubted by co-workers when they were experiencing loss of concentration or difficulty remembering words when at work. This was particularly pronounced when co-workers were younger, or male. Amongst job roles which were on short-term contracts, this worry extended to respondents concerns over perceived reduced work competency affecting job contracts being renewed. In response to this anxiety over ability to complete work, some respondents mentioned that they would work over lunch breaks/overtime to maintain a high output. Flexible hours were reported as beneficial allowing people to work around periods of intrusive symptoms and increase their resilience against the impact of menopause on their work lives. There was concern amongst respondents that when working from the office is phased back in, that they will not be able to take the same actions, and their productivity will reduce.  **Time:** Another area of consideration relates to the ability to take extended periods of time off in order to deal with severe menopausal symptoms. Respondents had disclosed that they have taken sick leave in the past when going through menopausal symptoms but used another health issue as the reason when booking this time off. Additionally, respondents felt that there was not enough evidence available to them, which they could take to their line managers to justify taking time off due to menopause. Discussion around how time could be taken off, and whether it would fall under sick leave raised questions over the pathologisation of menopause if sick leave were to be taken, compared to leave of absences such as maternity leave. Other issues raised included mandatory comfort breaks during meeting, as opportunities for bathroom/cooldown/take a drink etc, alongside suggested 2hr ‘meeting- free’ periods over lunchtime.  **People:** When asked about who should be the focus of any menopause policies or education, the respondents felt that efforts should not just be targeted at women in midlife. A widespread dispersal of information to male, and younger colleagues would be beneficial to forming a positive workplace attitude towards menopause. Reasons for this included that targeted information towards women in the midlife might risk singling out the individual as menopausal – requiring disclosure of status. Suggestions for how workplace education could take place, included: posters, mandatory training, staff presentations, digital vignettes for information screens and social media.   1. Research, evidence and data    1. Inclusion and representation   When discussing issues and developing policies in relation to menstruation it is important that we use language that is **inclusive** of all people who menstruate so that those who do not identify as cis women are not excluded from policies. In IAPMD’s study of 2518 people with PMDD, 64 participants did not  identify as cis women.9 It is also essential that language used within policies and within the workforce |

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| does not create a ‘hierarchy of symptoms’ which may serve to further stigmatise psychological or mental health symptoms above physical symptoms. Key to representation in research is **meaningful participation**. Research on womens’ health should actively involve people of ethnic minorities, older age, those with disabilities and those within the LGBT+ community. The language that we use must, therefore be inclusive (e.g. using the term ‘people who menstruate’). It is essential that those with lived experience do not become **burdened** with the responsibility of advocacy and providing solutions. Those involved within future research need to truly feel they have a meaningful voice- but there also needs to be an element of realistic expectations within these discussions to avoid such activities feeling tokenistic. We would also suggest that a key gap for research exploring mental health and wellbeing is the lack of attention to **menstruation**. For example, we would suggest that completion of mental health surveys should take into account where the person completing is within their menstrual cycle as this may impact their responses. As we are aware of the effects that menstruation can have on physical activity, sleep and mental health and wellbeing, we would suggest that this information would play a key role in interpreting findings and yet, to our knowledge, is rarely recorded or reported. A recent measure has been tested and validated for specifically researching and clinically diagnosing PMDD. This measure is known as the **Carolina Premenstrual Assessment Symptom Scale (CPASS)** and is a step towards standardising measures for PMDD.15 However, standardising and normalising measures for menstruation in general are equally important.  5.2 Lack of standardisation in measurements of age at menopause within epidemiological/clinical studies  There are several limitations to both measuring menopause (e.g. age at final menstrual period) within populations and interpreting the [results.16](https://results.16/) These issues include: **(i) that measurement of final menstrual period may only be confirmed retrospectively.** This increases the difficulty of recruiting women who are newly post-menopausal for cross-sectional studies. Additionally, many current cohort studies use the midpoint between 2 cohort waves where menstruation is present and then absent as age at final menstrual period. Such data are then often analyzed using discrete categories or “binning” (eg. <45, 46- 50, 51-55, 56+), which may obscure any smaller trends in age at menopause; **(ii) a person’s true age at menopause may be masked pharmaceutically** via the use of hormone treatments – highlighting the importance of defining menopause as the cessation of menstrual cycles, rather than all forms of bleeding;  **(iii) a person’s true age at menopause can be difficult to identify** due to the irregularity of menstrual cycles resulting in durations longer than 12 months where a woman appears to be anovulatory, especially towards the later peri-menopause when menstrual cycles tend to be longer; and **(iv) there is no clinical diagnostic tool able to discern menopausal status through measuring hormone levels** While FSH levels may be diagnostic for cases of early menopause (<45), FSH levels are unreliable for assessing menopausal status due to fluctuations in levels throughout peri-menopause. It is therefore **important to assess how menopause is being defined in research studies**, given the many issues surrounding data collection.  5.3 Hierarchy of evidence used regarding HRT risks and prescription guidelines  The hierarchy of biomedical knowledge in the space of prescription guidelines for HRT is another area of concern. Prescription guidelines for HRT in the UK were highly **restricted** in response to the results from  the Million Women Study and Women’s Health Initiative. Changing HRT prescription guidance has not |

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| only caused a rift between clinicians and prescribing bodies, but is also a large factor in the inconsistency found by women accessing HRT through GPs.1 Given the considerable change in prescribing guidelines in the late 1990s/2000s, GPs’ training on HRT may vary considerably depending on when they were trained. It may be worthwhile to consider not only the epidemiological literature (eg. from Million Woman Study) in decisions around HRT prescribing guidelines, but also input from clinicians who exercise their professional judgement over whether to prescribe HRT to patients in regards to the individual’s risk factors and symptom severity. This may address some of the animosity between professional bodies and epidemiological studies into HRT and disease risk.17 We recommend that both clinicians’ and patients’ input on the efficacy of HRT in treating menopausal symptoms will be beneficial in advising on the consequences of budget cuts to Category C medications by the DHSC and PSNC, which many forms of HRT belong to. The subsequent HRT shortages in the UK from 2019-present have caused considerable difficulty to both women unable to continue their normal HRT regime, and for clinicians having to prescribe alternatives.  5.3 Current research in our unit related to Premenstrual Dysphoric Disorder  Current research by two of our Masters of Public Health students identifies the link between **eating disorders and PMDD.** The first is a systematic review, exploring the association of PMDD with negative eating [behaviours.18](https://behaviours.18/) The second is a qualitative study, exploring the lived experiences of people with PMDD and their eating [behaviours.19](https://behaviours.19/) We wish to highlight these in our consultation response as the evidence-base clearly demonstrates the link between **cyclical** mood disorders and disordered eating.   1. Women’s experiences during COVID-19    1. Menopause experience during Covid lockdowns   **Change to symptoms**: In the study by Fraser1 many participants reported changes to their menopausal symptoms during lockdown, including: increased anxiety and depression; frequent low mood and mood swings; increased levels of irritation and anger; poor quality of sleep and fatigue; weight gain and loss of muscle mass; and increased intensity of hot flushes and night sweats. Conversely, while there were those who reported their symptoms feeling worse, there were others who stated that they felt their symptoms were better during lockdown — some reported that their anxiety and tiredness lessened especially since they found they had more time to themselves. With the reported changes in menopausal symptoms along with the restricted access to healthcare that occurred during the lockdown, initial analysis indicates that many respondents took to increasing their exercise and using self-care strategies (such as mindfulness and meditation) to try and feel better. Along with the reduced access to healthcare, additional barriers to treatment existed through the continued shortage of HRT. While many women reported that HRT was helping them cope during the lockdown, they also reported difficulties in accessing their usual type of HRT, or were given alternative forms which did not suit them as well. Thus, there was added anxiety over whether they would have continued access throughout the remainder of lockdown. **Home life:** Some respondents felt they had no choice but to cope during lockdown, and that they just had to get on with it, even while dealing with menopause. However, in addition to the more negative experiences of lockdown, women also responded that they found themselves enjoying the slower, more relaxed pace of life that lockdown brought and also found themselves with more time to themselves.  Others noted that they had more of an opportunity to rest or to catch up on lost sleep during the day, |

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| allowing them to feel like they could manage their symptoms better than before lockdown. As the UK lockdown started in March, it encompassed several spells of hot weather and heatwaves within the UK. This warm weather presented its own issues for respondents — especially those susceptible to hot flushes and night sweats. The heat was mentioned on several occasions in reference to how it impacted the comfort of respondents, and caused more pronounced hot flushes. However, those who experience hot flushes did also report that by staying at home they could be more comfortable by wearing lighter clothes, being able to cool off outside or in the bathroom, and being less self-conscious about flushing in front of other people. However, while flushing may have become more comfortable at home, direct coronavirus-related measures like temperature checks, queues for shopping and mask wearing impacted women who had flushes outside of the house. Some women worried that having a flush may be seen as a symptom of coronavirus by others while out in public or produce a higher temperature at temperature checks. Mask wearing was also mentioned as being a factor in overheating.  **Work life***:* Key workers, particularly in the healthcare sector, reported the main difference to working during lockdown was being too hot in the PPE now required during the whole shift. Anxiety and tiredness were also increased, usually in response to rapidly changing working guidelines, and the stress of working on the front line of care and service provision. When respondents were working from home — especially if they had not previously — there were positive changes reported in relation to menopause. The most common benefit reported was being able to adjust the workday better e.g. being able to start at more convenient times and able to take more breaks. Some reported this was particularly beneficial as they could start work later in order to catch up on lost sleep, and that they could break up their workday to help deal with symptom impact on work.  **Caring responsibilities***:* Respondents mostly reported caring for their children, grandchildren, and parents during lockdown. For those impacted by menopause symptoms, the main difficulties were caused by low mood, irritability, mood swings, tiredness, and fatigue. Caring, especially for shielding and vulnerable family and friends, was reported as stressful and causing some added anxiety to respondents, who also described experiencing lower tolerance and patience. This sometimes led to respondents feeling guilt about how their ability to care for their children or parents was being affected by menopause, and the general stress of lockdown.  6.2 Lessons from women’s experiences of menopause during lockdown  It is difficult to disentangle the impact of menopause from the other responsibilities and stressors of women during middle age. Menopause often occurs concurrently with children growing up, parents growing old, and job responsibilities changing. As such, women report that it is difficult to pinpoint which symptoms of tiredness, mood changes and mental health etc. are caused by menopause compared to other stresses and circumstances during life. It is therefore important to note that any changes in how peri-menopausal women felt during lockdown could arise from a **combination** of regular work stress, particular lockdown stress, and the additional impact of menopause. Furthermore, the seismic shift in being required to stay at home may also highlight the shortfalls of life before the pandemic which **disproportionately** impacted women during menopause. The slower pace of life, ability to take more breaks and more time to relax that women noted as being an enjoyable part of lockdown could indicate that the fast paced demands of life before lockdown had a particularly **negative impact** on women during  menopause. The advantages to working from home, especially when the impact of symptoms can be |

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| alleviated easier through **flexible working** and flexible workplaces, might also indicate that women during menopause could benefit from these features being included in the normal workplace.  **References**   1. Fraser A. Menopause experience during 2020 UK Covid-19 lockdown: Center for Open Science; 2021 [Available from: osf.io/dz53k]. 2. Parkes A, Waltenberger M, Mercer C, et al. Latent class analysis of sexual health markers among men and women participating in a British probability sample survey *BMC Public Health* 2020 doi: <https://doi.org/10.1186/s12889-019-7959-7> 3. Mitchell KR, Geary R, Graham CA, et al. Painful sex (dyspareunia) in women: prevalence and associated factors in a British population probability survey. *BJOG* 2017 doi: 10.1111/1471-0528.14518.5 4. Chirwa M, Ma R, Guallar C, et al. Managing menopause in women living with HIV: A survey of primary care practitioners. *Post Reprod Health* 2017 23(3):111-15. doi: 10.1177/205336911771218 5. Waters L, et al. BHIVA/BASHH/FSRH guidelines for the sexual and reproductive health of people living with HIV - consultation draft, 2017. 6. IAPMD. Evidence-based treatment guidelines for Premenstrual Disorders (PMDs). 2020 7. Halbreich U, Borenstein J, Pearlstein T, et al. The prevalence, impairment, impact, and burden of premenstrual dysphoric disorder (PMS/PMDD). *Psychoneuroendocrinology* 2003;28 1-23. 8. Public Health England. Health matters: reproductive health and pregnancy planning, 2018. 9. Hantsoo L, Sajid H, Murphy L, et al. Patient Experiences of Health Care Providers in Premenstrual Dysphoric Disorder: Examining the Role of Provider Specialty. *J Womens Health (Larchmt)* 2021 doi: 10.1089/jwh.2020.8797. 10. IAPMD. International Association of Premenstrual Disorders n.d. [Available from: iapmd.org]. 11. NAPS. National Association of Premenstrual Syndrome n.d. [Available from: pms.org.uk]. 12. Danzebrink D. Make Menopause Matter n.d. [Available from: [https://www.change.org/p/rt-hon-elizabeth-truss-mp-make- menopause-matter-in-healthcare-the-workplace-and-education-makemenopausematter]](https://www.change.org/p/rt-hon-elizabeth-truss-mp-make-menopause-matter-in-healthcare-the-workplace-and-education-makemenopausematter). 13. TISM. Together in Surgical Menopause 2021 [Available from: [http://www.surgicalmenopause.co.uk/]](http://www.surgicalmenopause.co.uk/) accessed 10th June 2021. 14. Scottish Government. Perinatal mental health services: needs assessment and recommendations. Edinburgh, 2019. 15. Eisenlohr-Moul TA, Girdler SS, Schmalenberger KM, et al. Toward the Reliable Diagnosis of DSM-5 Premenstrual Dysphoric Disorder: The Carolina Premenstrual Assessment Scoring System (C-PASS). *Am J Psychiatry* 2017;174(1):51-59. doi: 10.1007/s11920-018-0962-3 16. Fraser A, et al. The Evolutionary Ecology of Age at Natural Menopause: Implications for Public Health. *Evolutionary Human Sciences* 2020;2(e57) doi:10.1017/ehs.2020.59 17. British Menopause Society. BMS response to Lancet paper on the link between different forms of HRT and breast cancer incidence, 2019. 18. Miranda M, Matthews L. Eating behaviours of people with premenstrual dysphoric disorder: a systematic review. University of Glasgow, ongoing. 19. Nkeng R, Matthews L. The eating behaviours of people with premenstrual dysphoric disorder: a qualitative study. University   of Glasgow, ongoing. |
| **When was the response submitted?** |
| 11th June 2021 |
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