appg
Menopause

REBUILDING TRUST: TACKLING INEQUITY IN MENOPAUSE CARE

WELLBEING
OF WOMEN

Foreword

By Carolyn Harris MP, APPG Chair

The last five years have witnessed unprecedented progress in bringing menopause conversations into the mainstream. Government initiatives, celebrity advocacy, and growing workplace awareness have begun to shatter the stigma, shame and silence that has surrounded this life transition for too long.

Davina McCall's menopause documentaries in 2021 and 2022 were instrumental in the shift from silence to a social movement. HRT prescriptions became more accessible and affordable thanks to the introduction of the HRT Prescription Prepayment Certificate, which reduces the cost if three or more HRT medications are prescribed over 12 months. The Government's UK Menopause Taskforce and the Women's Health Strategy in 2022 helped shine a light on menopause, while Menopause Action Plans will need to be in place in all large organisations from 2027. This welcome surge of attention was unimaginable a decade ago.

But within this progress lies a troubling contradiction: as the volume of menopause information has grown exponentially, many communities remain excluded from these conversations; their voices remain unheard and their specific needs unaddressed.

Countless women and people from marginalised communities find themselves navigating menopause without culturally relevant support, appropriate resources, or evidence-based healthcare that acknowledges their unique circumstances and challenges.

These gaps in provision and understanding reflect deeper, systemic health inequalities that have persisted for generations. Marginalised communities have long fought to have their voices heard within healthcare – and other – systems that have historically dismissed their concerns and failed to develop sensitive and inclusive responses to their health needs.

The legacy of dismissal has created a mistrust between these communities and healthcare providers, which continues to make them less likely to seek menopause support or trust in healthcare professionals' ability to provide appropriate care.

Crucially, the exclusion of marginalised women and people from menopause research and policy development has perpetuated a cycle where these communities are consistently spoken for rather than spoken with. Barriers to research participation – including language barriers, lack of culturally appropriate recruitment methods, accessibility issues, and fear due to historical exploitation in medical research – have resulted in an evidence base that fails to reflect the diversity of menopausal experiences. This research gap has profound consequences: treatments, support services, and workplace policies have been developed without diverse input and will inevitably fail to meet the needs of some of the most vulnerable in society.

This inquiry represents an important step in addressing these longstanding inequalities. By putting the voices and experiences of a wider group of people experiencing menopause at the centre of the inquiry, we can begin to ensure that the recent progress in menopause awareness translates into meaningful change.

I want to thank everyone who took part in our oral evidence sessions and other calls for evidence for this inquiry. The testimonies and evidence presented in this report highlight both the scale of the challenge and the path forward. It is time to move beyond awareness for some groups, to action that is inclusive and informed by the lived experiences of all women and people navigating menopause in the UK.

EXECUTIVE SUMMARY

This report sets out the barriers to accessing menopause care experienced by women and people from the following communities: disabled and neurodivergent women and people, ethnic minorities in the UK, LGBTQIA+, those experiencing poverty and domestic abuse, and women and people in prisons.

We invited people with lived experience, community representatives, leaders of grassroot organisations and charities, researchers, and healthcare professionals with relevant expertise to present evidence across five online oral evidence sessions during the spring and summer of 2025. The stories shared at these sessions, combined with written evidence and desk research, showed that each community – and the subgroups within them – faced unique challenges when navigating menopause. There were also some clear common areas, which shaped our key recommendations.

The barriers to accessing care fall under three clear themes. For all communities, this starts with a **lack of information** that is tailored to their needs and represents their communities. This feeds into the silence, shame and stigma they feel within their communities, and delays in seeking help.

The next barrier is struggling to find healthcare environments that feel safe and inclusive, with primary care professionals **requiring further evidence-based guidance, awareness and skills** to make sure women and people with menopause from marginalised groups are genuinely heard and supported.

Finally, the exercise of gathering evidence for this inquiry itself, as well as the testimonies gathered, highlighted a significant **lack of research** on menopause in marginalised communities. Decades of being overlooked and feeling unwelcome – in healthcare and more broadly in society – have led to communities lacking trust in the NHS and their rights to equitable care. To rebuild trust and equity, proactive research and partnership with these communities must happen to ensure their voices are heard in menopause care.

BARRIERS TO ACCESS

In the following section, we examine the individual barriers that prevent women and people from marginalised communities from accessing menopause support and healthcare.

Some communities are listed as facing more barriers than others; this is not a reflection of relative levels of challenge experienced by them but rather is based on the amount of evidence that we were able to gather from them in this inquiry. More research and engagement is needed for all communities to ensure their experiences are fully represented in the future.

A note on intersectionality

It is crucial to understand that these barriers rarely exist in isolation. Intersectionality – the overlapping and interconnected nature of social categories such as race, class, disability, and sexuality – means that many women and people face multiple, compounding obstacles at the same time. The cumulative impact of these intersecting identities can be complex and extensive.

For example, disabled women are twice as likely to experience domestic abuse compared to non-disabled women.[1] A disabled woman or person navigating menopause who has also experienced abuse therefore faces an increased burden, having to overcome barriers set out below on multiple fronts.

Each factor amplifies the others, creating complex layers of disadvantage that cannot be adequately addressed by examining each barrier separately. It is essential to view these following chapters with an intersectional lens to understand the true scope of access challenges and for developing support systems that meet women's and people's diverse and overlapping needs.

CHAPTER 1: DISABILITY AND NEURODIVERGENT GROUPS

The experience of menopause is complex and challenging for everyone, but for disabled and neurodivergent women and people, and those with learning disabilities, the transition presents a unique set of compounding difficulties that remain largely overlooked in both research and healthcare provision.

These issues affect a notable proportion of the UK population – 26% of women (8.8 million) in the UK are disabled,[2] and it's estimated that 15% of the UK population is neurodivergent, with this figure likely to be higher due to women being underdiagnosed.[3] It is estimated that there are approximately 750,000 undiagnosed autistic people aged 20 and above across the UK.[4]

Disabled women are far more likely to experience difficult menopause symptoms. More than eight in ten disabled women going through the menopause reported difficulty sleeping (92% vs 83% of non-disabled women), brain fog (85% vs 70%), joint pain or stiffness (82% vs 63%), or anxiety or depression (82% vs 66%) as somewhat or very difficult.[5]

The intersection of menopause with disability, learning disabilities and neurodivergent conditions creates additional challenges – women and people may struggle to distinguish between symptoms related to their condition and those caused by hormonal changes, leading to delayed or inappropriate medical interventions.

Meanwhile, disabled women and people and those with learning disabilities often encounter additional barriers to accessing menopause support, from physical accessibility issues in healthcare settings to communication challenges that prevent them from adequately expressing their symptoms and needs.

Barrier to access 1: Difficulties distinguishing between existing conditions and menopause symptoms make diagnosis and treatment challenging

Menopause can exacerbate symptoms and vice versa, leading to delays in diagnosis due to confusion around overlapping symptoms

Women and people with physical disabilities, learning disabilities and neurodivergent conditions face a dual burden where menopausal symptoms can interact unpredictably with their existing conditions, potentially exacerbating both sets of challenges. The sensory changes, cognitive fluctuations, and emotional changes associated with menopause can affect established coping strategies.

> ***Paula Pierce, National Federation of Women's Institute Trustee:*** *"Now we've realised that the menopause and ADHD sort of come hand in hand. It seems to be exacerbated by the menopause. During menopause, falling oestrogen levels can make ADHD symptoms like forgetfulness, mood swings, and trouble focusing worse – because oestrogen helps regulate dopamine, a brain chemical that's already low in people with ADHD."*

Barrier to access 2: Limited awareness and evidence of the interplay between pre-existing conditions and menopause means healthcare professionals aren't offering adequate personalised care

Women and people with disability and neurodiversity feel dismissed by healthcare professionals, who don't take - or have - time to speak to them or give them space to talk

'Masking' of menopause symptoms due to symptoms of existing conditions not only leads to delays in women seeking help; it also leads to delays in diagnosis of menopause and women feeling they are not being listened to by their healthcare professionals – particularly when the menopause symptoms being discussed are psychological.

> ***Rianna Bailey, neurodivergent, perimenopausal mother of two:*** *"I wasn't uncomfortable bringing up the [menopause] conversation, but yes, of course I was dismissed. I was 42. … I'm sure I'm not alone in this, but chronic fatigue [a common menopause symptom] is quite common with neurodivergent people."*

There is evidence that women and people with learning disabilities, particularly those with Down's syndrome, experience menopause earlier than the general population.[6] It is critical that healthcare professionals guide conversations and care based on this knowledge, but too often patients find that their GPs focus on their disability instead of listening and adequately considering their symptoms.

> ***Penni Charteress, Service Lead – Learning Disabilities and Neurodivergent Women, The DIVAS Project, The Women's Centre Cornwall:*** *"Mary's got a learning disability and so her memory isn't great anyway. So sometimes those symptoms, if they're worsened, they're seen as being part of her learning disability… [Those with learning disabilities and neurodivergent people are] really not listened to, and actually the diagnostic process is often assigned to their learning disability rather than professionals recognising that it is the menopause, or the impact of trauma, or really taking time to actually listen."*

More research is needed on the intersection between menopause and chronic conditions, to support guidance that can help primary care professionals in care decisions

The lack of research and clinical guidelines around women and people with disabilities with menopause can make it challenging for GPs to offer treatment, with their only option being to refer them to specialist care. This leads to longer waits for help, often for people who have already delayed seeking help due to additional barriers to accessing treatment.

> ***Julia Wingfield, Spinal Injuries Association and T5 paraplegic:*** *"So bearing in mind you've only got a 10-minute slot when you go into your GP, and they say 'I really don't know what to do with you Julia be honest… I don't know much about spinal injury. I'll refer you to a specialist."*

For some conditions like epilepsy, the research is almost non-existent to understand how hormonal shifts during the menopause may affect symptoms like seizure frequency. No longitudinal studies have followed individuals with epilepsy through menopause, resulting in significant knowledge gaps and a lack of evidence-based practice guidelines for managing epilepsy through the menopausal transition.[7]

> ***Dr Emily Pegg, Consultant Neurologist and Honorary Senior Lecturer, University of Manchester:*** *"It is not known whether HRT may affect seizure frequency; previous research has mixed findings and was conducted 20-30 years ago when HRT treatments were different. As such, findings from this time cannot be applied to today's practice."*

Barrier to access 3: Without a continuous contact point in primary care, women and people experiencing menopause don't feel involved in their care

Disabled, learning disabled, and neurodivergent women and people need additional support in appointments, and time to process information and come back to ask questions

The lack of flexibility when booking appointments, and the rigid structure of questions GPs are required to ask, leave less time for appointments to be fully accessible and doesn't always allow women and people with menopause to have their voices heard.

> ***Rachel Shaw, Operations Manager, Deafinitely Women:*** *"I am profoundly deaf with speech since birth, and I am currently going through the changes. Because of my deafness, I could not attend appointments alone. I had to take my husband to translate for me. But that also meant he asked his own questions, and I didn't always get to share mine. There was no time to book a BSL interpreter, and I regret not insisting, because having three or four people involved didn't feel personal… I wish I had had the courage to ask for a BSL interpreter, so my voice could be fully heard."*

For learning disabled and neurodivergent women and people, the time to process information and then come back to the same GP to ask questions is crucial in ensuring they feel involved in their treatment decisions and that they are not forced into a decision. They need a safe environment to speak up if they do not understand and have reassurance that menopause will be explained to them in a supportive and accessible way.

This environment is challenging to create when follow-up menopause appointments are with different healthcare professionals, making it harder to ask questions related to previous appointments. In addition, neurodivergent women and people often need to explain their conditions and context each time they see a new healthcare professional, which reduces the time available in an already short appointment to ask questions.

> ***Penni Charteress:*** *"I think people have got a fixed view about what reasonable adjustment is, and they only think that it is relative to certain conditions such as a physical disability. But they (professionals and services) don't think about that in terms of cognitive processing – how information might be needed, length of appointments, time to process information."*

Barrier to access 4: Poor coordination between GPs and specialists delays ongoing care for women and people with disabilities who are experiencing menopause

Primary care for menopause is not joined up with existing commitments for lifelong disability specialist care

People with disability often have long-term treatment and support with specialist secondary care teams, which could be an excellent opportunity to integrate menopause and disability care. However, the specialist disability teams expect GPs to manage menopause care and vice versa, meaning women and people are bounced between primary and secondary care with no-one taking responsibility. This is particularly challenging for patients due to the overlapping symptoms and interplay between symptoms of menopause and disabilities.

> ***Julia Wingfield:*** *"Spinal doctors have got to work with GPs, with clinicians in the community. But there's got to be a willingness for those people that are in the community – those GPs, those clinicians – to want to work with spinal units as well. There has to be a dovetailing, there's got to be some joined-up thinking."*

Barrier to access 5: Inaccessible information blocks timely diagnosis and treatment

Information on menopause is not accessible

There needs to be more accessible information available that is tailored for disabled, learning disabled and neurodivergent women and people experiencing menopause to enable them to understand symptoms and treatment options.

> **Professor Rebecca Charlton, Goldsmiths University of London:** *"I work mostly with autistic people and they are great at searching out information - once they are clear that menopause is what is happening. People describe being frustrated by the limited information available."*

Those in the community with learning disabilities say current efforts at easy read resources are still not accessible in terms of explaining menopause in non-technical language – they just see materials with pictures next to paragraphs of complex information. Educational resources need to be created in a range of different formats - such as film or audio clips - that are designed to be accessible for diverse communities including, deaf, blind, neurodivergent women and people and those with learning disabilities.

> **Teresa Waldron, Chief Executive Officer, Deafinitely Women:** *"For Deaf women whose first language is British Sign Language (BSL), there is little accessible information in BSL. It makes it harder for them to seek appropriate support. Even then access to menopause support is not always available."*

It is harder to share information without an established community

Accessible information should be seen as a starting point - for many disabled and neurodivergent people, leaflets and information resources need to be discussed in the community for messages to truly land and have an impact on a person's experience of menopause. This sense of community and sharing also helps them learn how to cope with symptoms. Being disabled or neurodivergent can lead to isolation, making conversations like this in the community harder to come by.

> **DIVA, Heather:** *"I'm autistic, I don't have learning disabilities, but I think they just assume that you'll go away and find out from everybody. Sorry, I'm isolated. I don't have that friendship."*

CHAPTER 2: ETHNIC MINORITY COMMUNITIES IN THE UK

The UK's demographics have changed significantly over recent decades, with ethnic minorities now representing 18% of the population.[8] This diversity can be seen through different cultural perspectives, approaches to health and wellbeing, and lived experiences that shape how different communities navigate life transitions, including menopause. Despite this growing diversity, there is still a concerning gap in our understanding of how menopause affects ethnic minority women and people, with limited research evidence available on their specific experiences within the NHS, with a lot of the information available being from overseas research, articles and blogs.[9]

The research that is available shows worrying disparities in both diagnosis and treatment pathways for ethnic minority women and people experiencing menopause.[10] Recent NHS data on hormone replacement therapy (HRT) uptake reveals stark inequalities in treatment access. Black women are five times less likely to be prescribed HRT (5.2%) compared to White women (23.3%), whilst Asian women are four times less likely (6.2%) to be prescribed it.[11] These gaps are further confirmed by recent national research with even larger sample sizes, which found that HRT prescribing remains significantly lower for Black, Caribbean, and Asian women, even after adjusting for socioeconomic and health factors. A 2025 BMJ study highlights that these disparities are persistent, urgently signalling the need for equity-targeted NHS strategies and researcher action.[12]

These statistics raise critical questions about whether ethnic minority women and people are receiving equitable access to menopause treatments, and what factors are creating barriers to care. Research has shown that demand for menopause care seems to be disproportionately from middle-class White women. This reinforces the need for more granular, ethnicity-specific NHS monitoring and targeted interventions.

This chapter seeks to explore these issues by examining the experiences of ethnic minority women and people navigating menopause within the UK healthcare system, exploring the intersections of culture, identity, and medical care during this significant life transition.

Barrier to access 1: Stigma, shame and silence about menopause due to cultural backgrounds and norms means ethnic minority women and people are less aware of symptoms and are less likely to speak up and seek help

For women and people from some cultures, expressing a need for help and being clear about the challenges they face can be counter to cultural expectations. Cultural norms often mean that women from marginalised groups aren't aware of what menopausal symptoms are, and they may feel unable to speak up or seek help.

> **Nina Kuypers, Founder, Black Women in Menopause:** *"It's not just a lack of information. It is about the social pressures that shape behaviour and access to care… it's that weight of cultural silence that decreases that awareness. It compounds the psychological, the emotional and spiritual total of menopause."*

Research involving women from ethnic minorities with lived experience of perimenopause and menopause revealed a widespread lack of awareness of symptoms. Many described how women in their community would feel embarrassed to talk about experiences, viewing menopause as a natural phase that women should simply endure without complaint.[14]

> **Chani Schreibhand, Founder Editor of The UPLIFT Jewish Women's Magazine:** *"It's very taboo at the moment. Even the fact that I have to call it midlife rather than menopause shows you how taboo this is."*

This stigma is further exacerbated by the existing shame around talking about mental health in some cultures, with many women and people downplaying or struggling to articulate their emotional and psychological symptoms during medical appointments. Within some communities, there is a strong cultural expectation to dismiss emotional difficulties rather than address them openly.

> **Madhu Kapoor, Founder, M for Menopause:** *"Although I speak English fluently, I found it challenging to fully express my mental health experiences such as mood swings, irritability, and anger – I downplayed my mental health struggles with the GP, as I had done throughout my life. Within the South Asian community, there is a cultural expectation to shrug off emotional difficulties rather than address them openly, which shaped how I presented my mental health concerns during the appointment."*

Although there are signs of younger generations being more open about talking about menopause, the stigma, shame and silence around menopause in ethnic minority communities is a clear example of how marginalised groups are being left behind in a broader trend of speaking more openly about this life transition.[15]

> **Sahir Ahmed-Evans, Wellness and Menopause Coach:** *"I'm very passionate about talking about this topic and bringing it up to the women in my community. And I get messages daily about how they are glad that somebody in our community is bringing it up because it's very much a taboo subject. Nobody wants to share their experiences, nobody wants to talk about it."*

The Menopause GAP project documents how increases in general public and commercial menopause awareness have not translated into improved outcomes for ethnically diverse and minoritised groups.[16]

> **Black PauseTrack study[17] participant:** *"I was talking today to a White middle-class woman who said everyone talks about menopause now, it's not really taboo. And I said, Yes, because it might not be taboo in your space. It doesn't mean it's not in other spaces, it's still a massive taboo."*

Cultural stigma around menopause often comes from people witnessing their mother's experience and behaviours.[18] It can also be because it is associated with loss of fertility and femininity, which are important in some cultures.[19]

Barrier to access 2: Healthcare professionals' low awareness of cultural nuances means women don't feel listened to or respected

Ethnicity impacts the age of menopause onset, but awareness is low amongst the public and healthcare professionals

It is now well established that women and people from some ethnic groups experience the onset of menopause earlier than the UK average (51 years). The average age of menopause in Black women is 49.6 years, in Indian women (living in India) it is 46.7 years and the mean age of menopause for Pakistani women is 47.16 years.[20] However, this is not well-researched in a UK context, and awareness of the younger age of onset is low among healthcare professionals.

> ***Nina Kuypers, Founder, Black Women in Menopause:*** *"My journey was, oh, well, let's go down the type 2 diabetes route. Even though I didn't have the symptoms that indicate diabetes apart from the night sweats. Why? Because of race and age. I was 'too young' to be menopausal."*

Healthcare professionals lack awareness of cultural factors around menopause and can demonstrate unconscious bias when delivering care

Women and people from ethnic minorities may have additional concerns about menopause and its treatment, and awareness of these culturally-influenced worries and issues among healthcare professionals is low. In addition to having to explain cultural factors that healthcare professionals are not aware of, women and people with menopause symptoms also have to repeatedly dispel assumptions about their lifestyles, symptoms and pre-existing conditions, based on their ethnicity. This frustration is exacerbated by having to deal with a new GP at each visit.

> ***Madhu Kapoor:*** *"From the moment you walk in, you are prejudged you might be vegetarian, don't drink alcohol and they don't even check your notes. Then to top it all on each visit you see a different GP, there is no continuity in appointments and you have to start over to explain again. It's exhausting and makes it hard to trust the system when going through the symptoms of menopause. Even harder if you cannot express yourself or even speak fluent English."*

There is also a fear among ethnic minority women and people in the UK that healthcare professionals are unable or unwilling to discuss culturally relevant alternative therapies that might be considered to treat menopause, creating an additional barrier to seeking help.

> ***South Asian PauseTrack study participant:***[21] *"I don't necessarily want to go to the doctor and be put on HRT. Really. And I keep thinking about, you know, what are the remedies that we must have used? So, like, you know, I've heard people talk about Ujuan and fennel seeds."*

Barrier to access 3: Years of dismissal and historic mistreatment mean women and people from ethnic minorities in the UK lack trust in the NHS

Some healthcare professionals continue to hold assumptions that stem from outdated and harmful beliefs dating back centuries. These biases still influence medical practice today. Women and people giving evidence to the inquiry highlighted harmful stereotypes such as the false notion that Black women have a higher pain tolerance and that Asian women have a lower pain tolerance. Such misconceptions can affect the quality of care they receive. This problem is worsened by the underrepresentation of ethnic minorities in medical research, leaving limited evidence on how menopause treatments affect them.

> ***Nina Kuypers:*** *"I think there are many challenges that intersect on the histories of dismissal and the systemic neglect within healthcare. It's a mixture of the historical distrust of what has happened in the past and not seeing any outcomes – within the African culture of going down the non-pharmaceutical route, there's a misconception of being seen as strong and just getting on with it. Then there's the pharmaceutical side of HRT, and the lack of knowledge of what it can and can't do, and who it's been tested on."*

> ***Sahir Ahmed-Evans, Wellness and Menopause Coach:*** *"[Doctors are] just assuming that as a Brown woman walks in, that her symptoms are in her head. No, this pain is not in the head. It's actually it's a valid, viable pain and it could very likely be down to perimenopause."*

Women and people from ethnic minority communities in the UK feel dismissed by healthcare professionals because they may use different language to describe symptoms

Menopause symptoms can be misinterpreted and missed by healthcare professionals who lack cultural intelligence around the different terms used by ethnic minority women and people. With research being mostly conducted on Caucasian women, the words used by them to describe symptoms like hot flushes, night sweats and brain fog, are most commonly recognised by healthcare professionals. But ethnic minority women and people may describe feeling achy all over, itchy, cold or heat rising, or that there's a fire inside them.[22]

The crossover between cultural norms and spirituality is important in this context too, with some women and people potentially attributing a 'heavy feeling' or other menopause symptoms to a spiritual imbalance. This spiritual element may contribute to ethnic minority women and people trying to help themselves through various natural and complementary interventions, before seeking medical help.[23]

> ***Nina Kuypers:*** *"Many feel unheard or dismissed, and healthcare professionals may not fully understand cultural nuances. There's also a subtle language issue: some women describe symptoms using words that aren't recognised by their doctors, which can delay treatment and leave them frustrated and invisible. It's a powerful reminder of how important cultural intelligence is in providing effective care."*

Ethnic minority women and people in the UK are more likely to have their symptoms dismissed or misattributed to other conditions common to their ethnic background

Research studies demonstrate ethnic minority women in the UK who consult their GPs about one or more menopause symptoms often leave without these symptoms being linked to the menopause. A reason for this dismissal and delayed diagnosis[24] of menopause could be confusion between existing health conditions, which are common to their ethnicity and menopause symptoms.

One study showed that South Asian women living with diabetes were told their vulval itching, unresolved by anti-fungal pessaries, was due to their diabetes, highlighting the challenges for them, and clinicians, of unpicking symptoms in the context of multiple health concerns. Even when dealing with clinicians who are from the same cultural background and speak the same language, women and people with menopause symptoms report feeling dismissed. In one study of Urdu speakers, there was a general feeling of distrust towards medical care among the groups, despite complimenting primary healthcare staff on being ‘very good.’ Eight of the 14 women said they had not felt listened to when speaking with a male clinician, even if he spoke Urdu.[25]

CHAPTER 3: LGBTQIA+ COMMUNITIES

LGBTQIA+ communities represent a significant and growing portion of the UK population, yet their experiences of menopause remain largely invisible within mainstream healthcare and research. One in seven LGBTQIA+ people (14%) avoid seeking healthcare for fear of discrimination from staff,[26] and 57% of trans people avoid healthcare altogether due to fear of discrimination,[27] highlighting the systemic barriers that prevent equal access to care.

This reluctance to engage with healthcare services becomes particularly concerning during menopause. For LGBTQIA+ individuals, menopause is not simply a biological process but a complex experience intersecting with identity, healthcare accessibility, and the challenge of navigating predominantly heteronormative medical systems.

The diversity within LGBTQIA+ communities means that menopause experiences vary considerably across different identities and circumstances. Cisgender lesbian, queer, pansexual and bisexual individuals face unique challenges in healthcare settings where assumptions about heterosexuality and "traditional" family structures may influence care provision.

Meanwhile, transgender men, non-binary individuals, and other gender-diverse people who experience menopause often encounter additional layers of complexity, from accessing appropriate hormonal treatments to dealing with healthcare providers who may lack understanding of trans-specific needs.

This chapter will highlight the experiences of LGBTQIA+ people navigating menopause in the UK and examine the intersection of sexual orientation, gender identity, and menopause.

Barrier to access 1: Lack of inclusive language and representation means LGBTQIA+ communities are excluded from conversations about menopause, and representation comes with a fear of backlash

Language is not inclusive - either in peer or NHS support

Many women and people experiencing menopause rely on hearing from others in the same situation for information and support. When language used in these conversations is not inclusive, LGBTQIA+ communities miss out on this peer support.

> ***Helen Juffs, holistic health champion who has spoken about their experience as a queer person going through menopause:*** *"When I started my menopause journey 10 years ago, there was very little information generally and I couldn't find anything specific to queer menopause and the language that was used in online chat rooms was really not inclusive and I left as a result."*

Involvement in decisions and research feels tokenistic and has broken trust

LGBTQIA+ communities are tired of being involved in co-creation in a tokenistic way and being repeatedly promised inclusion and representation only to be let down. This, alongside high-profile debates and changes in legislation both inside and outside of healthcare that have left these communities feeling devastated and excluded, has led to a breakdown in trust of the Government. This distrust extends to a healthcare system that has historically let these communities down through exclusionary language and treatment, and which must do more to engage with them and make them feel safe in healthcare settings.

> ***Laura-Rose Thorogood, CEO of Make Birth Better and Founder of LGBT Mummies:*** *"It's really important that the language is inclusive of all queer people that menopause impacts. Often, we co-produce work and have to consistently amend and address the fact many people that don't use the word woman also go through menopause. …There's a real level of distrust with the government that when we share our trauma, we share our experiences and we're promised inclusion, it just reverts to exclusion anyway… And our voice is lost again. And that's why people aren't coming forward."*

For many in LGBTQIA+ communities, language on menopause that is seen as centring around women and fertility – used by healthcare professionals and in NHS resources – will prevent them from seeking help.

> ***Helen Juffs:*** *"Menopause isn't just about women. It's not just about reproduction and fertility either. There's a whole gamut of people who are put off by those words."*

Fear of backlash or threats against menopause ambassadors

LGBTQIA+ communities face a critical visibility gap in the menopause conversation. Without seeing or hearing from people who share their identities discussing menopause, many individuals feel isolated and hesitant to seek medical support or engage in peer conversations about their experiences. Whilst community members recognise the urgent need for ambassadors and advocates, potential representatives often remain silent – deterred by fears of judgement, discrimination, or hostile reactions that could affect both their personal and professional lives.

> ***Dr Yvette Pyne, GP with special interests in women's health and trans health:*** *"When I worked on an LGBTQ Menopause film, there was a significant issue recruiting people to do pieces to camera who were LGBT and experiencing menopause because they were scared and the producers of the film are wary about releasing it more widely because again, fear of backlash to them or to the people on film."*

Barrier to access 2: Very few tailored information resources exist, and there is a lack of awareness about the ones that do exist

It is clear that the lack of inclusive language is a huge barrier to access for LGBTQIA+ communities. Using appropriate language is one part of creating tailored information resources – these communities face specific challenges when it comes to menopause, and information resources need to be sensitive to issues like gender identity, the additional challenges faced by trans men in the menopause, and existing additional barriers to accessing healthcare.

Experts who presented at our evidence sessions and published literature all point to the lack of tailored resources. But for the few resources that do exist, there is also very low awareness of them. At a recent LGBTQIA+ menopause event, less than 1% of attendees were aware of the existing LGBTQIA+ specific menopause resources.

Barrier to access 3: There is a lack of training and evidence-backed guidance for healthcare professionals on issues faced by LGBTQIA+ communities

Alongside the lack of tailored resources for LGBTQIA+ communities, there is also a lack of information for healthcare professionals about the challenges that this community faces. The Royal College of Obstetricians and Gynaecologists has acknowledged healthcare professionals need to proactively do more to ensure an empathetic and inclusive healthcare experience, and that it is vital to address the disparities that LGBTQIA+ individuals face with higher levels of social isolation and poverty.[28]

> **Dr Yvette Pyne:** *"From a clinical perspective, it's very, very limited. From a public facing perspective, there's plenty of it, but none of it is using inclusive language."*

Clinical guidelines are sometimes not appropriate for these communities, and the research is lacking in the best way to treat menopause for some LGBTQIA+ groups. This means some queer communities face additional barriers to accessing medicines due to lack of evidence, or guidelines that provide few or no alternatives for them. One example is the new National Institute for Health and Care Excellence (NICE) 2024 guidelines for identifying and managing menopause,[29] which do not include people who are currently (or have previously taken) gender affirming hormone therapy.

> **Laura-Rose Thorogood:** *"Queer people are often refused medication that heteronormative people are just given... If you're queer, [you're told] 'there's not enough evidence, I don't feel qualified to support you.' It's just what we have to put up with, unfortunately."*

A 2024 study showed there is a significant lack of GP awareness of the additional challenges menopause brings for trans or non-binary people, with masculine stereotypes leading to exclusionary healthcare experiences,[30] and a lack of sensitivity towards procedures and conversations that may make them feel uncomfortable.

> **Study participant:** *"I didn't really receive much support... GP at time hadn't made the link between changing hormones, and vaginal atrophy leaving me vulnerable to UTI - hadn't thought to consider my situation as a non-binary trans man as similar to menopausal / postmenopausal woman."*

> **Tania Glyde, psychotherapist working with Gender, Sex and Relationship Diverse identified clients, giving evidence to the 2021 Women and Equalities inquiry on menopause:** *"If someone is queer, trans or non-binary they may experience mockery or hostility when trying to access care... they may find being touched, being seen naked, or having certain words used about body parts or genitals, very challenging, and they may not feel confident that a practitioner will be aware of this and ask for consent, or discuss anything with them first. There is a strong need for gender-affirming healthcare across the board."*[31]

Barrier to access 4: Menopause symptoms can exacerbate existing challenges faced by LGBTQIA+ communities

Women and people with menopause, who are not from marginalised communities, report feelings of being ignored or silenced, and experiencing misogyny and ageism. LGBTQIA+ communities experience these issues plus additional barriers.

> **Tania Glyde:** *"We know that things are bad enough for cisgender heterosexual women in menopause. They still cannot be assured of decent standardised treatment from the healthcare system, and still risk experiencing ageist and infantilising attitudes when seeking information and support. However, for LGBTQIA+ people the situation can be even more challenging."*

Many people from the LGBTQIA+ communities may also face additional barriers - disability, ethnicity and poverty - and this intersectionality makes access to support and resources even more challenging.

> **Laura-Rose Thorogood:** *"There's just no access to resources... You deal with a lot of assumptions about what that looks like for a queer woman or person... There's that intersectionality of being Black and queer, being disabled, being from an area of social deprivation. You're already dealing with a multitude of barriers on your journey. And then you're hit with menopause."*[32]

> **Helen Juffs:** *"Many people who are queer tend to be neurodivergent as well. That's a big overlap. So again, you're excluding people. If you're not offering them different ways of engaging."*

Barrier to access 5: Menopause can resurface gender identity struggles and impact treatment choices

Gender identity issues can reappear with menopause

For transgender and non-binary people, studies have shown that issues around connection with ‘female-ness’ may appear when identifying support resources and finding space to talk about menopause experiences with others. A 2024 study also highlighted wider issues of societal prejudice creating real barriers in being able to express their experiences as a trans or non-binary person experiencing menopause.[33]

> **Study participant:** *“I have found navigating menopause as a non-binary person challenging, in that it is such a conceptually ‘female’ experience, and there are so few resources available that respect my experience of my body or my interactions with the world… I don’t think it’s actually changed my gender identity, but it has made me feel less happy/secure with it.”*

Compounding this feeling of exclusion due to the ‘female-ness’ of menopause care, other studies have shown that menopause can separately affect gender identity in non-binary or transgender people or led to new realisations about gender identity.[34]

> **Study participants:** *“It’s made me feel more female when I only just became comfortable with being non-binary.”*
>
> *“I found I could affirm my identity as a man better after my periods stopped.”*

These feelings can make conversations around hormone therapy even more sensitive, particularly for those who feel affected by the histories, controversies and abuses around the interaction between hormones and sexual/gender identity, or those who may have experienced a degree of fluidity around identities.[35]

Repeatedly feeling excluded or the need to contextualise means people don’t feel safe or included

Having to repeatedly explain and answer questions that are not relevant to your situation and context makes people feel unsafe and excluded in healthcare settings. And for some people, having to repeatedly explain their identity can be traumatic, particularly for those who had a challenging experience with revealing their identity to family, friends or colleagues.

> **Stonewall respondent:**[36] *“Coming out as transgender was the hardest thing I’ve ever done and having to explain it over and over again to medical professionals that were supposed to be helping me, almost made me end my life.”*

CHAPTER 4: POVERTY

Research shows that poverty is associated with earlier onset of menopause,[37] with poorer women and people also more likely to suffer more symptoms or more severe symptoms, to undergo a hysterectomy, and have more barriers to treatment. This chapter examines the complex relationships between poverty and menopause experiences.

Barrier to access: Access to care and information is challenging for those experiencing poverty

Women and people without fixed residence or ID find it hard to get an appointment in the first place

For women and people experiencing both homelessness and menopause, the first barrier can be getting a GP appointment without a form of photo ID or a home address. They may be missing from the already patchy health data system.

> ***Dr Hannah Loret, researcher at the University of Dundee:*** *"[Women experiencing homelessness] weren't even able to get a GP appointment… They are supposed to be able to get a GP appointment without photographic ID, but that's not the case in practise."*

Those in poverty or who are experiencing homelessness face digital exclusion

Women and people with economic disadvantage may not have access to a phone and would therefore find accessing menopause information and care harder.

> **Dr Hannah Loret:** *"It's not just about the access to healthcare, it's also about access to good quality information that many women simply didn't have the equipment to find."*

Not being close to transport links and not being able to afford travel to support centres for information in lieu of getting support online is an additional barrier. For women and people whose energy is poured into survival, retaining information received at these centres can be challenging, and these spaces offer them a chance to come back and ask questions when they are able to.

Lack of respect for personhood from healthcare professionals

Women and people experiencing homelessness and menopause may miss out on opportunities to prevent their health spiralling into a situation where it becomes hard or impossible to recover to full health, due to judgement and lack of respect when in healthcare settings. This may also lead to them missing out on treatment for menopause due to a lack of respect by healthcare professionals for personhood – the legal and philosophical concept of being given rights and moral worth associated with being a person.

> **Dr Hannah Loret:** *“The prevention just wasn’t there… a lot of it was based around stigma and abstinence – women should abstain from any sort of substances or any sort of substance use before they could access routine psychological support.”*

A lack of respect for personhood can extend beyond healthcare and be seen in a lack of consideration given to issues such as housing.

> ***Charis Tiwala, a Christian charity offering support and assistance to people who are in, or affected by, the sex industry:*** *“It’s important to consider menopause as an aspect of health when considering what type of accommodation a woman may need. For example, not housing a woman in group housing on a floor with a lot of male residents or reduced access to good ventilation, bathrooms or washing machines.”*

CHAPTER 5: DOMESTIC ABUSE

For women and people who have experienced domestic abuse, their backgrounds and experiences have a huge influence on how they will experience menopause and, as a result, the issues they will face when seeking treatment.

Trauma and abuse can significantly alter both the timing and severity of symptoms. Experience of abuse was associated with delayed onset of perimenopause symptoms, about 35% slower than women who reported no abuse,[38] highlighting how abuse can impact the biological processes of menopause. The two-way relationship between domestic abuse and menopause creates particularly vulnerable circumstances for women and people experiencing both. Research demonstrates that lifetime intimate partner violence (IPV), sexual assault, and current symptoms of post-traumatic stress disorder (PTSD) are associated with a significantly increased risk for potentially disruptive menopause symptoms.[39] This effect means that women and people may struggle to distinguish between symptoms caused by hormonal changes and those resulting from trauma, creating barriers to appropriate support and treatment.

> ***Dr Emma Williamson, Training and Programme Manager for IRISi,[40] a social enterprise dealing with Gender-Based Violence in healthcare settings:*** *"Menopause impacts women's relationships, especially with their intimate partners and family members... domestic abuse impacts menopausal symptoms with negative symptoms or experiences, compounding or obscuring one another. Menopause may be a key time when women are looking for support to escape domestic abuse."*

The transformative nature of menopause can also alter the dynamics of abusive relationships in unexpected ways. Two-thirds (67%) of women surveyed about their divorce or separation reported an increase in domestic abuse during menopause,[41] suggesting that this life transition may intensify existing tensions.

For some women and people, however, the psychological changes associated with menopause can paradoxically provide a catalyst for recognising and challenging abuse.

> ***DIVA Heather, domestic abuse survivor:*** *"I didn't start standing up to him until we were married 18 years... I [started] seeing things with new eyes".*

Barrier to access 1: GP appointments about menopause do not always work for survivors of domestic abuse

Care is not always trauma-informed

For survivors of domestic abuse and sexual abuse having to talk about physical health – and gynaecological health in particular – can be triggering. There is a lack of awareness among GPs and other healthcare professionals around the impact of trauma, domestic abuse and sexual abuse. Even if asking the right questions, healthcare professionals may not be adequately equipped to respond in a supportive way.

> **Dr Emma Williamson:** *"If you're a specialist in the practise looking at menopause, you're taking responsibility for that, then domestic abuse training would be absolutely essential… We don't want this to become a tick box exercise, which can happen if you have short training with no opportunity to practise."*

Short appointment times with set questions which don't look at the whole woman or person can miss hidden abuse

Ten-minute appointments make it challenging to have appropriate conversations about menopause symptoms, which can be triggering for women and people who have experienced sexual abuse to talk about. It also means that GPs may not feel they have the time to ask questions that could reveal an issue with domestic abuse, or that they can stray from the set list of questions that would allow a woman or person experiencing domestic abuse the space to explain their situation.

> **Dr Emma Williamson:** *"If you have a short appointment and you're trying to get to the bottom of menopause symptoms, it's not always easy. Then for the clinician to feel that they can ask about domestic abuse being a possible contributing factor… Clinicians - who are not IRISi trained - are either not asking or not being trained to ask [about abuse] properly, or safely."*

In addition, wider use of digital medical records can pose dangers to victims-survivors of abuse. "Safe" information sharing within clinical teams and with patients is essential.

Barrier to access 2: Lack of community for women and people living with domestic abuse leads to a serious lack of peer support and signposting to medical help

Specialist services are a lifeline for survivors of domestic abuse. Abusers use isolation as a weapon, cutting survivors off from support to increase control and hide the abuse. It is very common for perpetrators to stop survivors from seeing their family and friends or prevent them from seeking medical help for menopause. Physical safe spaces are crucial sources of reliable information and peer support, but resources for these spaces are limited and funding is regularly being reduced or cut.

> **Heather:** *"If it wasn't for the Women's Centre, I wouldn't know anything, apart from my own mum's experience. The only thing I knew about her going through it was the fact that she bled so heavily during her menopause that she had to sit on newspaper."*

For women and people experiencing domestic abuse, the need is more than just information. They need peer support and a community where they feel safe to learn about the menopause, especially as they are more likely to suffer digital exclusion.

> ***Penni Charteress:*** *"For survivors of domestic abuse and sexual abuse, having community and having connection is really key and part of recovery. It's about not relying on just giving people information and expecting them to understand it. It's about providing follow-up and other opportunities and not relying on technology to do that."*

CHAPTER 6: WOMEN IN PRISONS

The female prison population in England and Wales represents just 4.1% of the overall prison population, and 16% of women (compared with 4% of men) are serving sentences of less than 12 months.[42] As an often-fleeting minority, this population faces unique and often overlooked healthcare challenges that are compounded by the institutional environment.

The impact of this extends beyond individual health outcomes, with an estimated 17,000 children annually affected by maternal imprisonment.[43] Significantly, between 2003 and 2023 the number of women aged 50 or above in prisons increased by 179.5%, from 184 to 514, with the proportion rising from 4% to 15%.[44] This demographic shift means that a growing proportion of incarcerated women and people are entering or experiencing menopause whilst serving their sentences, creating complex healthcare needs within an environment historically designed around male experiences.

Women and people in prison represent one of society's most marginalised groups, often carrying multiple vulnerabilities that intersect with their menopausal experiences. Many have experienced childhood trauma, domestic abuse, mental health problems, and homelessness – factors that, as we have described, can impact the timing and severity of menopausal symptoms. This chapter explores how the prison environment shapes women's experiences of menopause.

Barrier to access 1: The process for accessing medication for menopause, and medication generally, is convoluted

Being incarcerated can be a distressing and disorientating experience. Everything that a woman or person with menopause relied on in the outside world to manage symptoms disappears, and the onus is on that person to make an appointment to get access to their medication.

Medication cannot be brought into prison and prescriptions can take months to be transferred to the prison medical team. It can also be very hard for women and people to get standard non-prescription medication. For example, paracetamol and ibuprofen that may be used to manage menopause symptoms like heavy painful periods, headaches and joint pain are often not given, leaving women and people in pain for prolonged periods of time.

Time outside of cells is restricted, and accessing medications means much of this time ends up being spent queuing and submitting applications to see medical teams – at the cost of other essential activities. This means people are sometimes forced to go without food to take menopause medication.

> ***Diane Gould, woman with lived experience:*** *"I spent 12 weeks of queuing in the morning for medication, just to be told each week my prescription hadn't come through. When it finally did come through, the queue for meds was at the same time as breakfast, so I couldn't then have breakfast because it's got to be an hour after you've had your medication for breakfast. So it stopped me then having breakfast at all.. and I then just didn't eat 'til dinner time."*

Without access to medical records, and under high stress conditions, women and people struggle to access treatment and are back at 'square one', with symptoms returning sometimes interpreted as misbehaviour by staff

Once this barrier has been overcome, it can feel like starting the process for treating menopause symptoms from scratch because medical records are not immediately shared between healthcare settings in the community and prisons.

> ***Diane Gould:*** *"I finally did get to see a doctor after being in about seven weeks. But I only got my thyroid medication. I didn't get my HRT medication. So I went to the doctor and explained I needed my HRT medication and the doctor came, said to me, 'No, I think you're depressed, we'll try you on antidepressants."*

At a time of high stress, women and people experiencing menopause are expected to take control of their health, which can be overwhelming

> ***Lucy Russell, Head of Policy and Public Affairs, Women in Prison:*** *"At any given time, about a quarter of the women are on remand, which means that you're not sentenced and that you've probably gone into prison very, very quickly. So you won't have had any medication, you won't have had a prescription, you might not actually know which prison you're in, which I know sounds weird, but it can become so disorientating."*

For women and people who are without medication for menopause symptoms, or for those who have gone too long in prison without medical attention, the impact on how they behave can become very visible in a prison environment. This can result in the behaviour of those experiencing menopause being mistakenly interpreted as misbehaviour by staff who don't understand menopause.

> ***Tashy Penhale, Manager of The Nelson Trust team based at HMP Eastwood Park:*** *"We did have one lady whose behaviour changed very remarkably. She saw a locum GP who started her on HRT and within about four weeks, the change in her was completely different, for the better... Up until that point, she was writing letters of threats to kill to her probation officer. She was trying to set fire to her cell."*

Barrier to access 2: Lack of staff means long waits for appointments that regularly get cancelled, and are not always trauma-informed

The process for booking appointments, plus the likelihood they will be cancelled again with no rebooking system, will deter people from seeking help with menopause symptoms.

> ***Diane Gould:*** *"The medical staff are fantastic. There's just not enough of them. They are expected to cover every house and the wing. And if that riot bell goes off, if you've got an appointment, they're running to the emergency."*

With overstretched staff, trauma and specialist training can either become deprioritised or done without adequate depth. For women and people in prison who have experienced trauma, being able to talk about your reproductive health can be very challenging, particularly when dealing with male medical staff and those not trained in trauma-informed care.

In addition, menopause can be triggering for women and people who have been unable to have children due to long prison sentences, and care is often not sensitive to issues like this.

Barrier to access 3: Menopause in prison comes with additional dignity considerations

Symptoms like hot flushes and erratic heavy bleeding are not accounted for in prisons, leaving women and people with dirty clothes and bedding

Experiencing menopause in prison leads to additional challenges; night sweats and erratic bleeding require more shower time and a desire to wash sheets and clothing more frequently, hot flushes will mean women and people in prison want ventilation, and some work in areas such as a hot laundry room - become unmanageable. The rigidity around the security rules in prisons means these needs are compromised, along with the dignity of those experiencing menopause in these conditions.

> ***Lucy Russell:*** *"There's a real gap. Being able to wash and change your bedsheets, being able to wash your underwear, change your clothes, being able to be clean and fresh, and then looking at ways that temperature can be managed. And I recognise this is extremely difficult because prisons are often very, very old buildings. They often have to have rules about windows. They often have to have limited kind of things inside the cell for lots of different, both safety and security reasons. But at the moment there is just no way to manage your temperature and your discomfort."*

Practical considerations of routine and safety when taking prisoners off site are not balanced with considerations for dignity

When attending hospital appointments, no consideration is given to practicalities of waiting and attending the appointment. Women and people who have experienced trauma or sexual abuse may find it intimidating having to travel to the appointment with a male officer – sometimes handcuffed to him on the journey – and the thought of potentially having to see a male doctor can also be traumatic. They then have difficult experiences once in the healthcare setting that deter them from seeking help for menopause.

> ***Diane Gould:*** *"They marched me through all the hospital and when we got to the department where I was having the check, they actually opened a store cupboard and sat me in a store cupboard with the officers. I wasn't allowed to sit in the waiting room because I was in handcuffs."*

Barrier to access 4: Access to information on the menopause is limited in prisons

Without access to information – or peer support – to help understand menopause, women and people feel isolated and unaware of what's happening

There is very little information available to women and people in prisons about menopause and most cannot access the internet to find support and information. Most women and people said they had not seen menopause information in their prison.

> ***Diane Gould:*** *"There were ladies my age who when I said to them, are you in the menopause? They hadn't got a clue what I was talking about because there was no support in prison or any information in prison for them to realise that that's what was happening to them."*

Additionally, women and people report feelings of isolation because there are no support groups or supportive voices telling them that they were going through something expected. Logistical challenges around running support groups in prisons – such as needing to be escorted from place to place and having set times for movement – prevent them from being set up.

> ***Tashy Penhale:*** *"We would like safe spaces for women. We would like menopausal groups. We manage to do drug recovery groups, so why can't we bring that in for our women [experiencing menopause]?"*

KEY RECOMMENDATIONS

This inquiry has revealed the scale of the challenge of breaking down barriers to menopause care for marginalised communities. The key recommendations below have been made because, when implemented, they will improve access to care for multiple marginalised communities and they will have the biggest impact on breaking down barriers.

1. Cultural intelligence training for healthcare professionals to help in understanding the needs of all communities

a. Healthcare professionals must be better trained to understand the background, culture and context of all patients, and trained to ask questions and respond appropriately so that all women and people experiencing menopause are truly heard.
b. Evidence-based training must be co-created with these communities and focus on ensuring healthcare professionals recognise and understand the wider factors that influence a person's experience of menopause, so they are able to address their needs.
c. NHS employers must ensure time is allocated for this training, which should form a vital part of Continuing Professional Development (CPD) for all healthcare professionals.

2. Improve patient experience through digital records, sharing of data, appointment adjustments and continuity of care

a. Essential data about a patient's background – and tailored information to support conversations – should be made clear to healthcare professionals before each appointment, so women and people experiencing menopause from marginalised communities do not have to repeatedly correct assumptions or repeat information that may be traumatic to share.
b. Patients should be given the right to request to see the same GP for return visits about the menopause, if possible, in addition to the right to ask for a female GP. Extended appointment times should be made available where possible to vulnerable groups. It should be made clear to patients when booking appointments to discuss the menopause that these options exist.
c. There should be better collaboration between different care settings to help ensure women and people get timely access to menopause care and prevent delays in access to medications. From community care, to specialist services, to prisons.

3. Safe spaces need to be created to both provide the forum for women and people to share with and open-up to their peers, as well as to create an additional access point to healthcare professionals trained in menopause

a. In line with the Government's 10-Year Health Plan that aims to shift care from hospital to community, community health providers such as existing women's health hubs or neighbourhood health services should ensure virtual or physical safe spaces for menopausal women and people are prioritised.
b. In setting up neighbourhood health models, the NHS should work with local Voluntary, Community, and Social Enterprises (VCSEs) that have established trust, to provide menopause support and care to the marginalised groups within their communities.

c. Menopause specialists trained in helping marginalised communities, and informed peer discussions about menopause, should be available to support the needs and demographics of local communities. This is particularly important for populations who can't access other forms of support such as women and people in prisons or experiencing homelessness.

4. Community-specific information resources.

a. The NHS and healthcare organisations should create resources for diverse communities about menopause, co-created with community representatives and cascaded via trusted grassroots organisations or community contacts.

5. Investing in research into the experience of diverse communities with the menopause and closing the evidence gaps in the intersection between menopause and other factors.

a. Funding needs to be directed towards proactively identifying the barriers to accessing treatment in marginalised communities and ways to overcome them. as well as filling in vital evidence gaps on the impact of menopause and treatments for menopause on those with existing conditions or disabilities.
b. Research is needed to fill in vital evidence gaps such as; the impact of menopause and treatments on those with existing conditions and disabilities, the relationship between domestic abuse and menopause, and how menopause presents in some trans men.
c. The evidence-base can be improved by ensuring representative samples are included in mainstream menopause research, as well as funding dedicated research on the menopause in these communities.

CONCLUSION

The recommendations outlined in this report – spanning cultural intelligence, safe spaces, community-specific resources, dedicated research, and clearer patient information access – represent a comprehensive framework for addressing the systemic inequalities that we see in menopause care in the UK. If implemented effectively, these measures have the potential to fundamentally transform not only individual health outcomes but also the broader relationship between marginalised communities and healthcare services.

Perhaps most significantly, these recommendations address the critical issue of trust, which is a recurring theme throughout the testimonies gathered during this inquiry. Years of dismissal, historic mistreatment, and a lack of cultural understanding have created deep-seated mistrust between many marginalised communities and healthcare providers. By supporting healthcare professionals to recognise and respond to the diverse needs of all patients, ensuring shared decision making is embedded in healthcare, establishing safe spaces within local health services, and ensuring that essential patient information is accessible at the point of care, we can begin to rebuild these fractured relationships. The co-creation of community-specific resources through trusted grassroots organisations offers a pathway to reaching women and people who have been systematically excluded from the mainstream conversation on healthcare, whilst dedicated research funding would demonstrate a genuine commitment to understanding and addressing the specific challenges faced by different communities.

For this inquiry, we took evidence from a cross-sample of marginalised communities, but that is by no means conclusive of the experience of all such communities. More research is needed to understand menopausal experiences from all marginalised communities.

The next steps must focus on translating these recommendations into concrete policy and practice changes. This includes working with the NHS; relevant medical training bodies such as the NHS's Workforce, Training and Education directorate, professional bodies including the Royal College of General Practitioners and the Royal College of Obstetricians and Gynaecologists; commissioners; health and social care providers and workplaces to:

- Embed cultural intelligence training within professional development frameworks
- Secure dedicated funding streams for community-specific menopause research
- Establish clear guidelines for the implementation of trauma-informed care approaches.

Equally important is the development of robust monitoring and evaluation frameworks to assess the impact of these changes and ensure that they are genuinely improving outcomes for marginalised communities. Regular review and adaptation of these measures will be essential to maintain their relevance and effectiveness as our understanding of diverse menopause experiences continues to evolve.

ACKNOWLEDGEMENTS

This report would not have been possible without the courage and generosity of the women and people who shared their deeply personal experiences of menopause within challenging circumstances. Their willingness to speak openly about their experiences in healthcare, the impact of trauma, discrimination, and disadvantage on their menopausal journeys, and their hopes for better care has provided invaluable insights that must drive meaningful change.

We also acknowledge the community organisations, healthcare professionals, researchers, and advocates who supported this work by facilitating connections with participants, providing expertise, and ensuring that diverse perspectives were represented throughout the process. Their commitment to amplifying marginalised voices and working towards more equitable healthcare provision has been instrumental in shaping both the scope and direction of this inquiry. The path towards truly inclusive menopause care will require continued collaboration between all these stakeholders, and we are grateful for their ongoing dedication to this vital work.

The APPG on Menopause is supported through sponsorship funding from Astellas Pharma and Theramex. Sponsors have no editorial control over the work programme or reports of the APPG.

References

1. Census 2021. Office for National Statistics (2021). https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/bulletins/disabilityandcrimeuk/2019#domestic-abuse

2. Department for Work and Pensions Family Resources Survey (2025) https://www.gov.uk/government/statistics/family-resources-survey-financial-year-2022-to-2023/family-resources-survey-financial-year-2022-to-2023#disability-1

3. Embracing neurodiversity in the workplace. NHS Employers (2025) https://www.nhsemployers.org/articles/embracing-neurodiversity-workplace

4. Autism in England: assessing underdiagnosis in a population-based cohort study of prospectively collected primary care data. O'Nions, Elizabeth et al. The Lancet Regional Health – Europe, Volume 29, 100626

5. Menopause and the Workplace. The Fawcett Society (2022) https://www.fawcettsociety.org.uk/Handlers/Download.ashx?IDMF=9672cf45-5f13-4b69-8882-1e5e643ac8a6

6. Langer-Shapland, K., Minton, S. J., & Richards, N. (2023). 'It should be more outspoken and not hushed away, not like put in a dark box': An interpretative phenomenological analysis of experiences of menopause voiced by women with learning disabilities. *British Journal of Learning Disabilities*, 51, 509–521. https://doi.org/10.1111/bld.12527

7. *From The Intersection of menopause and epilepsy, Voinescu PE et al. EMJ Neurol. 2025;13[1]:102-113. https://doi.org/10.33590/emjneurol/JPEB4231*

8. UK Government 2021 Census Data. https://www.ethnicity-facts-figures.service.gov.uk/

9. Menopause in ethnic minority women. The British Menopause Society (2023) https://thebms.org.uk/wp-content/uploads/2023/07/20-BMS-TfC-Menopause-in-ethnic-minority-women-JULY2023-B.pdf

10. Menopause and the Workplace. The Fawcett Society (2022) https://www.fawcettsociety.org.uk/Handlers/Download.ashx?IDMF=9672cf45-5f13-4b69-8882-1e5e643ac8a6

11. NHS Hormone Therapy Report 2024. https://wellbeingofwomen.blob.core.windows.net/www/documents/Eclipse_-_HRT_Report_-_Pub_Apr_24_V2_1.pdf

12. BMJMED 2025;4:e001349. doi:10.1136/ bmjmed-2025-001349

13. Accessing Equitable Menopause Care in the Contemporary NHS – Women's Experiences. Abi Eccles et al. British Journal of General Practice 5 September 2025; BJGP.2024.0781. DOI: 10.3399/BJGP.2024.0781

14. Perimenopause and/or menopause help-seeking among women from ethnic minorities: a qualitative study of primary care practitioners' experiences. MacLellan et al. British Journal of General Practice 2023; 73 (732): e511-e518. DOI: 10.3399/BJGP.2022.0569 https://bjgp.org/content/73/732/e511

15. Health Inequalities, menopause experiences and digital health. PauseTrack (2024). https://cdn.prod.website-files.com/66fe52c6ff6d875cf468d57f/6836dfe2c9f7b3eead6e1484_2024%20Report%20-%20Compressed.pdf

16. Beyond the Hype: Reclaiming Menopause with Evidence, Equity, and Empathy. BMJ blog. 2025. https://blogs.bmj.com/ebn/2025/10/05/beyond-the-hype-reclaiming-menopause-with-evidence-equity-and-empathy/

17. Health Inequalities, menopause experiences and digital health. PauseTrack (2024). https://cdn.prod.website-files.com/66fe52c6ff6d875cf468d57f/6836dfe2c9f7b3eead6e1484_2024%20Report%20-%20Compressed.pdf

18. Health Inequalities, menopause experiences and digital health. PauseTrack (2024). https://cdn.prod.website-files.com/66fe52c6ff6d875cf468d57f/6836dfe2c9f7b3eead6e1484_2024%20Report%20-%20Compressed.pdf

19. Menopause in ethnic minority women. The British Menopause Society (2023) https://thebms.org.uk/wp-content/uploads/2023/07/20-BMS-TfC-Menopause-in-ethnic-minority-women-JULY2023-B.pdf

20. Menopause in ethnic minority women. The British Menopause Society (2023) https://thebms.org.uk/wp-content/uploads/2023/07/20-BMS-TfC-Menopause-in-ethnic-minority-women-JULY2023-B.pdf

21. Health Inequalities, menopause experiences and digital health. PauseTrack (2024).

22. Bridging the gap in menopause care for minority ethnic women. University of Oxford (2023). https://www.phc.ox.ac.uk/blog/bridging-the-gap-in-menopause-care-for-minority-ethnic-women

23. Menopause in ethnic minority women. The British Menopause Society (2023) https://thebms.org.uk/wp-content/uploads/2023/07/20-BMS-TfC-Menopause-in-ethnic-minority-women-JULY2023-B.pdf

24. The Health of Women from Ethnic Minority Groups in England. King's Fund 2025. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/the-health-of-women-from-ethnic-minority-groups-england

25. MacLellan J, Dixon S, Bi S, Toye F, McNiven A. Perimenopause and/or menopause help-seeking among women from ethnic minorities: a qualitative study of primary care practitioners' experiences. Br J Gen Pract. 2023 Jun 29;73(732):e511-e518. doi: 10.3399/BJGP.2022.0569. PMID: 37130614; PMCID: PMC10170522.

26. The Diversity Dividend. NHS Employers (2023) https://www.nhsemployers.org/system/files/2023-08/diversity_dividend.pdf

27. Trans lives survey 2021: Enduring the UK's hostile environment. TransActual (2021). https://transactual.org.uk/wp-content/uploads/TransLivesSurvey2021.pdf

28. Royal College of Obstetricians and Gynaecologists (2025). https://www.rcog.org.uk/news/blog-pride-month-raising-the-profile-of-queer-menopause/

29. Menopause: identification and management. NICE 2024. https://www.nice.org.uk/guidance/ng23

30. Toze, M., & Westwood, S. (2024). Experiences of menopause among non-binary and trans people. International Journal of Transgender Health, 26(2), 447–458. https://doi.org/10.1080/26895269.2024.2389924

31. Response to the House of Commons Select Committee on Women and Equalities. Enquiry on Menopause (2021) https://committees.parliament.uk/writtenevidence/41281/pdf/

32. Response to the House of Commons Select Committee on Women and Equalities. Enquiry on Menopause (2021) https://committees.parliament.uk/writtenevidence/41281/pdf/

33. Toze, M., & Westwood, S. (2024). Experiences of menopause among non-binary and trans people. International Journal of Transgender Health, 26(2), 447–458. https://doi.org/10.1080/26895269.2024.2389924

34. https://www.tandfonline.com/doi/10.1080/26895269.2024.2389924?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed#d1e259

35. https://www.tandfonline.com/doi/10.1080/26895269.2024.2389924?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed#d1e510

36. Chaka L. Bachmann, Becca Gooch, 2018. LGBT in Britain - Trans Report. Stonewall

37. https://menopause.org/press-releases/poverty-shown-to-reduce-womens-ovarian-reserves

38. Allsworth JE, Zierler S, Lapane KL, et alLongitudinal study of the inception of perimenopause in relation to lifetime history of sexual or physical violence Journal of Epidemiology & Community Health 2004;58:938-943.https://jech.bmj.com/content/58/11/938

39. Gibson CJ, Huang AJ, McCaw B, Subak LL, Thom DH, Van Den Eeden SK. Associations of Intimate Partner Violence, Sexual Assault, and Posttraumatic Stress Disorder With Menopause Symptoms Among Midlife and Older Women. JAMA Intern Med. 2019 Jan 1;179(1):80-87. doi: 10.1001/jamainternmed.2018.5233. PMID: 30453319; PMCID: PMC6583410. https://pmc.ncbi.nlm.nih.gov/articles/PMC6583410/

40. https://irisi.org/

41. Balance Survey (2022) https://www.balance-menopause.com/news/menopause-puts-final-nail-in-marriage-coffin/

42. Statistics on Women and the Criminal Justice System 2023. Ministry of Justice. https://www.gov.uk/government/statistics/women-and-the-criminal-justice-system-2023/statistics-on-women-and-the-criminal-justice-system-2023-html

43. Prison Reform Trust (2022): https://prisonreformtrust.org.uk/urgent-call-to-provide-better-support-for-kids-with-mums-in-prison/

44. Louise Robinson, Adam O'Neill, Katrina Forsyth, Leanne Heathcote, Kim Barnett, Jane Senior, Kerry Gutridge, Catherine A. Robinson & Jennifer Shaw (2025) Older women in the criminal justice system: a brief report from a nominal group, The Journal of Forensic Psychiatry & Psychology, 36:1, 24-36, DOI: 10.1080/14789949.2024.2437447. https://www.tandfonline.com/doi/pdf/10.1080/14789949.2024.2437447#:~:text=Moving%20forward%2C%20structures%20must%20be,met%2C%20and%20their%20voices%20heard.&text=At%20the%20end%20of%20March,Ministry%20of%20Justice%2C%202023a).&text=Women%20in%20prison%20have%20different,65%20(AgeUK%2C%202023).

WELLBEING OF WOMEN

www.wellbeingofwomen.org.uk