Menopause and Health Equity: The Role of Peer Support

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Purpose and Objectives

This paper examines how structural and social inequities shape menopause experiences and limit access to care, framing menopause as a critical public health and equity issue. It evaluates peer support programs as scalable interventions to address these barriers by improving health literacy, reducing stigma, fostering empowerment, and supporting self-advocacy. The paper also explores diverse Canadian and international contexts, highlighting research gaps and the need for culturally safe, inclusive, and sustainable approaches to menopause care and peer support implementation.

Introduction and Context

Framing Menopause as a Public Health Issue

Over half the world's population will experience menopause, occurring 12 months after a woman's last menstrual period (World Health Organization, 2022). In Canada, the average age of menopause is 51, with most women reaching it between 45 and 55 (Menopause Foundation of Canada, 2022). Perimenopause, the menopause transition, typically lasts 5–10 years leading up to the final menstrual period and ends at menopause, a single point in time confirmed only after 12 consecutive months without menstruation (Cowell et al., 2024).

Menopause varies widely due to biological, psychological, and social factors (Hickey et al., 2024; Peate et al., 2024). Symptoms include hot flashes, night sweats, mental fatigue, anxiety, depression, cognitive changes, sleep disturbances, joint pain, and urogenital issues (Cowell et al., 2024). Menopause is framed as a public health issue because of its broad demographic impact, individual complexity, and inequities in care (Thomas et al., 2024). While menopause is inevitable for those with typical ovarian function (Cortés & Marginean, 2022), the

transition can affect quality of life, identity, self-perception, intimacy, and relationships (Cronin et al., 2025). Solely treating menopause as a medical issue can be disempowering, potentially overlooking positive effects and leading to over- or under-treatment (Hickey et al., 2024).

These complexities highlight why menopause is increasingly recognized as a critical global health and socioeconomic issue, with over 1.2 billion women worldwide projected to be postmenopausal by 2030 (Coltri, 2025). To address this, global frameworks, such as those of the World Health Organization, call for a comprehensive, empowerment-focused approach to menopause management, supporting patients in gaining confidence and self-determination for self-management and informed decision-making (Hickey et al., 2024).

Reflecting this rising awareness, many high-income countries are integrating menopause into national health and labour policies. For example, in the UK, initiatives like the Women's Health Strategy for England established the UK Menopause Taskforce in 2022 to focus on improving healthcare, education, workplace support, and research (Barber & Charles, 2023). Likewise, Australia is pursuing systemic change, with a parliamentary inquiry currently reviewing menopause-related issues, including its effects on economic participation and healthcare experiences (Thomas et al., 2024).

Given these challenges in care and understanding, women often seek advice from healthcare professionals but frequently report the advice to be unhelpful or that their symptoms were undertreated (Menopause Foundation of Canada, 2022). Research and clinical guidelines have historically concentrated on cisgender, white women residing in high-income countries, leaving the specific needs of diverse populations, such as women of colour, first-generation migrants, transgender individuals, and those in low-income settings, poorly understood (Delanerolle et al., 2025). Lower socioeconomic status and issues like inadequate housing, low

education, and lack of healthcare access are related to a younger age at menopause, more frequent symptoms, and less positive attitudes toward menopause (Namazi et al., 2019).

Current Gaps and Challenges

Despite its prevalence, menopause remains understudied, undertreated, and stigmatized. Research from the Menopause Foundation of Canada (2022) highlighted a significant knowledge gap in both the public and healthcare sectors, with many clinicians lacking experience treating menopausal patients. Menopause research remains limited, often concentrating on narrow demographic groups while failing to reflect the full diversity of the global experience (Cronin et al., 2025). This lack of comprehensive research and representation not only fuels misconceptions but also reinforces the persistent silence and stigma associated with menopause.

Building on these gaps, the Menopause Foundation of Canada Report (2022) highlighted the persistent silence surrounding menopause, with over half of women (54%) viewing it as taboo and many feeling isolated (38%) or unprepared (46%) for this natural transition. Among Indigenous women in Canada, the topic is often considered private or “not talked about” intergenerationally, and the lack of a uniform word for menopause in some local languages hinders shared understanding and dialogue (Taylor-Swanson et al., 2024). Consequently, limited open dialogue leads to confusion, persistent myths, and a widespread lack of understanding about menopause.

These pervasive attitudes are further evidenced in qualitative studies, which reveal that deeply ingrained societal taboos, lack of knowledge, and fear of judgment are barriers preventing women from accessing necessary care (Thavabalan et al., 2025). Together, these barriers result in delayed diagnoses, inadequate support, and diminished quality of life for those affected. Across diverse populations, this reluctance to seek help often stems from the internalization of negative

social attitudes that frame menopause as a subject of embarrassment, shame, or decline (Barber & Charles, 2023).

Need for Inclusive Research

Research on menopause among Indigenous women is scarce. This highlights the need for inclusive, culturally relevant research and support (Sydora et al., 2021). Researchers must recognize that race is a social construct and choose methods that capture the experiences of minoritized populations (Cortés & Marginean, 2022). In many Indigenous communities in Canada, menopause is a silent topic and a barrier to support. For example, research with Cree First Nations women in Maskwacis, Alberta, shows that discussing female issues, including menopause, remains private (Sydora et al., 2021). The Sohki Tehew Group was formed in response. It brings together community members, Elders, and researchers to amplify women's voices and develop culturally appropriate education for women, their families, and partners (Sydora et al., 2021).

Systemic failures in healthcare, education, and social structures have led to ongoing disparities and inadequate menopause care. Many healthcare professionals lack the education and confidence to diagnose and manage menopause well (Talaulikar & Takhar, 2025). In Canada, many primary care clinicians have limited experience treating menopause (Menopause Foundation of Canada, 2022). As a result, most Canadian women who seek medical advice for menopause find it unhelpful or only somewhat helpful. Fewer than one-third say their physician proactively discusses menopause. While many value their healthcare professionals, they express a strong need for better physician education and for their symptoms to be taken seriously (Menopause Foundation of Canada, 2022).

Medical and nursing education often focuses on biological symptoms. It neglects the psychosocial, sexual, and cultural factors shaping menopause (Talaulikar & Takhar, 2025). This limited focus leads to frequent dismissal of symptoms. Mood changes, anxiety, and fatigue are often attributed to depression, anxiety, or aging, rather than menopause (Barber & Charles, 2023). This issue, called diagnostic overshadowing, results in poor diagnosis and management. General practitioners are less likely to identify menopause in women with uncommon symptoms like low mood, tiredness, or general aches. These are often seen as unrelated issues, especially depression (Barber & Charles, 2023; Coltri, 2025). Perimenopausal symptoms can mimic major depressive disorder, like poor sleep, low concentration, irritability, and anxiety. Women's experiences are often overlooked or misunderstood. This pattern of dismissal limits open discussion and makes women feel they must endure symptoms in silence (Thavabalan et al., 2025).

Social and Structural Inequities

The experience of menopause is not "one size fits all" (Williams, 2024). It is profoundly shaped by the complex interactions between biological, physiologic, psychological, social, and cultural factors (Cowell et al., 2024). Structural and social inequities, such as gender bias, ageism, limited health literacy, and institutionalized racism, shape menopausal experiences and access to care (Cortés & Marginean, 2022). These upstream inequities operate individually and intersectionally, creating disadvantages for many women during the menopause transition (Peate et al., 2024).

Social inequities refer to the unfair and avoidable disparities in health outcomes observed within and between populations. Menopause also intersects with gendered ageism, a form of discrimination based on the overlap of gender and age (Rochon et al., 2021). These inequities are

compounded by societal stigma and the normalization of symptoms, which discourage help-seeking and open dialogue (Zahn et al., 2024). Menopausal symptoms and experiences are also shaped by social determinants of health such as socioeconomic status, educational attainment, and employment (Peate et al., 2024; Taylor-Swanson et al., 2024).

Applying an intersectional perspective makes clear how overlapping systems of oppression, patriarchy, racism, and ageism shape menopausal experiences and restrict bodily autonomy. There is a widespread lack of knowledge about menopause in the general population (Taylor-Swanson et al., 2024; Springer & Osborne, 2025). Improving menopause health literacy supports self-advocacy, informed decision-making, and equity in care (Hickey et al., 2024).

Peer Support as a Model for Advancing Health Equity

Benefits of Peer Support

Peer support is recognised as a crucial component of effective health management and a promising, scalable intervention for improving the well-being of menopausal individuals. It is defined as the provision of emotional, appraisal, and informational assistance by a member of a created social network who possesses experiential knowledge of a specific challenge and similar characteristics to the target population (Harris et al., 2015). The "peerness", the shared characteristics such as age, gender, disease status, or socioeconomic status, enables peers to relate to and empathise with the person they are supporting in a way a non-peer would not (Harris et al., 2015).

Peer support offers diverse assistance. Emotional support expresses caring, empathy, and encouragement, boosting self-esteem. Informational support provides advice, suggestions, alternatives, and relevant health management information (Harris et al., 2015). Peer support also

supplies practical information and guidance that healthcare professionals may not offer or that peers may deliver more effectively (Aboumatar et al., 2018).

These programs value lived experience and mutual learning, offering a promising, low-cost, scalable way to support psychosocial well-being during menopause (Springer & Osborne, 2025). Peer-led interventions improve health literacy, reduce isolation, promote open discussion, and enhance mental health and quality of life (Delanerolle et al., 2025). Evidence shows peer interventions foster trust, build community, and encourage positive change with fewer resources than expert-led models (Springer & Osborne, 2025).

Peer support models also align with equity-focused public health goals by using relational, community-driven approaches that complement traditional clinical care. Developed through community-based participatory research frameworks, these initiatives are designed in collaboration with participants to ensure cultural relevance and accessibility for diverse populations (Taylor-Swanson et al., 2024).

The literature on systemic implementation, health equity, and fidelity, such as that on Community Health Workers (CHWs) and Peer Recovery Specialists (PRSs), strongly emphasises the value of a professionalised peer workforce. Compensation reduces health inequities and barriers, ensuring programs are accessible to individuals facing financial or workload constraints (Harris et al., 2015; Alavi et al., 2024). Relying solely on volunteers can limit the diversity and reach of the peer workforce.

A professional model enables required training, core competencies, and supervision (Aboumatar et al., 2018). Training in health literacy, boundaries, and trauma-informed practices ensures safe intervention, especially for sensitive topics like menopause. Ongoing support prevents burnout and emotional distress among peer supporters (Harris et al., 2015).

Compensating peer supporters boosts program sustainability. Paid roles improve retention and organisational capacity and ensure equitable support for participants (Aboumatar et al., 2018; Hopkins & Gremmen, 2022).

Toward a Menopause-Specific Peer Support Model

Peer support interventions, emphasizing shared experience and mutual support, offer a scalable strategy to improve psychosocial well-being and address health literacy gaps during the menopause transition. A main outcome of peer-led education is a measurable increase in menopause knowledge, essential for informed decision-making and self-management (Hickey et al., 2024). Increased knowledge gives individuals the confidence and self-determination to participate in decision-making and manage their health (Hickey et al., 2024). Peer support is effective for emotional benefits, reducing isolation, and helping women manage the psychosocial symptoms of menopause (Cowell et al., 2024).

Peer support interventions draw on lived experience, offering benefits distinct from professional care, and are especially impactful during the isolating menopause transition (MT). In menopause, peer support addresses traditional healthcare gaps, reduces stigma, and boosts health literacy. Equity-focused models that use co-design, cultural safety, and trauma-informed practice are valuable for underserved groups. Addressing health disparities requires culturally competent, contextually relevant care (Cronin et al., 2025; Taylor-Swanson et al., 2024). Multi-level approaches considering individual, interpersonal, and community factors are key to reducing inequities during the menopause transition (Cortés & Marginean, 2022). Future menopausal care must be inclusive, personalized, and gender-sensitive, recognizing diverse experiences across populations (Talaulikar & Takhar, 2025).

Studies and pilot projects on menopause peer support show several positive outcomes: Reduction in symptoms and distress: Peer counseling for African American breast cancer survivors saw a significant drop in menopausal symptoms (notably hot flush scores) and emotional distress (Zahn et al., 2024). Support groups improve women's quality of life and reduce vasomotor and psychosocial symptoms (Harris et al., 2015). Enhanced health literacy and empowerment: Peer support clarifies complex information and helps people assess its usefulness (Harris et al., 2015). Women gain knowledge and confidence to negotiate and manage their health. This empowers participants to seek help and advocate for better care. Normalization and reduced isolation: Peer groups offer a safe place to share experiences, provide emotional support, and reduce isolation (Aboumatar et al., 2018). Sharing with peers normalizes struggles as participants realize others face similar challenges (Cowell et al., 2024). Menopause Cafés help women feel less alone (Coltri, 2025).

Discussion and Conclusion

Menopause is a significant public health issue, closely tied to health equity and shaped by structural and social inequities (Cronin et al., 2025; Cortés & Marginean, 2022). Peer support, which is organized, community-based, and provides emotional and informational assistance from individuals with lived experience, can complement clinical care by fostering empowerment, inclusion, and knowledge-sharing among people experiencing menopause. While healthcare professionals provide important guidance, practical advice, and emotional support are often more accessible, relatable, and impactful when delivered by peers (Aboumatar et al., 2018).

This review demonstrates that menopause experiences are shaped by structural and social inequities, highlighting the need to move beyond a purely biomedical framing. This perspective

necessitates a paradigm shift from treating menopause merely as an endocrine deficiency to recognizing it as a multifaceted social and economic challenge (Thomas et al., 2024)**.**

Policy implications should include integrating peer support into community and primary care programs. Healthcare providers could be incentivized and resourced to initiate group-based educational programs for menopausal women and their families, thereby reducing the burden on general practices by minimizing the need for individual counseling appointments. (Cowell et al., 2024). Peer support also complements traditional care, which is often fragmented and insufficient (O'Reilly et al., 2023), offering a scalable intervention that enhances access to support and information (Springer & Osborne, 2025). This model aligns with empowerment-focused approaches, which define empowerment as actively gaining knowledge, confidence, and self-determination to self-manage health (Hickey et al., 2024). Evidence indicates that such programs lead to statistically significant improvements in knowledge and reductions in menopausal symptoms (Zahn et al., 2024).

Future research should prioritize equity, diversity, collaboration, and comprehensive evidence generation to address the existing limitations and enhance care (Cronin et al., 2025). Qualitative studies should examine how structural racism, as well as other socio-cultural, commercial, and political determinants, shape menopause experiences across socio-cultural contexts (Zahn et al., 2024; Wood et al., 2025). Given findings that many primary care clinicians in Canada have limited experience treating menopausal patients (Menopause Foundation of Canada, 2022), policymakers should invest in and scale community-based and group educational programs to improve access and reduce clinical burden (Thomas et al., 2024). Moreover, funding frameworks should include dedicated resources for training and compensating peer support

workers, integrating them with clinical teams and virtual platforms to enhance reach and sustainability.

In conclusion, addressing menopause as a public health and equity issue requires moving beyond medicalized approaches to embrace the social, economic, and cultural realities shaping experiences. Integrating peer support into care models can empower individuals, bridge gaps in current systems, and promote more equitable access to information and support. By prioritizing community-driven interventions and investing in research that highlights diverse experiences, policymakers and practitioners can contribute to more effective, inclusive, and sustainable solutions for those experiencing menopause.

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