EVIDENCE REVIEW

Menopause as a Workplace Issue

Prepared for Menopause Friendly UK by Professor Jo Brewis, The Open University

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CONTENTS

1. INTRODUCTION

This evidence review was commissioned by Menopause Friendly Accreditation UK and prepared by Professor Jo Brewis of The Open University Business School.

Professor Brewis sourced the evidence included here using the databases Business Source Complete and Scopus. The time period of the searches was January 2017-January 2025 inclusive and the search terms used were 'work', 'employment', 'unemployment', 'redundancy', 'menopause', 'perimenopause' and 'climacteric', encompassing all relevant combinations.

Professor Brewis also reviewed publications which did not appear in the searches but were nevertheless relevant, such as the Women and Equalities Committee's Menopause in the Workplace (2022) and the All-Party Parliamentary Group on Menopause's Inquiry to Assess the Impacts of Menopause and the Case for Policy Reform (2022) reports; and the British Standard Institute's (2023) Menstruation, Menstrual Health and Menopause in the Workplace. All evidence reviewed was in English and included systematic reviews of previous publications and grey literature published outside of standard academic and/ or commercial channels as well as empirical publications using data collected in the UK.

There was no preference for quantitative empirical publications over qualitative publications. Although qualitative research is often not generalizable, this does not mean that its findings are inherently problematic. Instead such projects usually offer depth of analysis as opposed to the analytical scope which is typical of quantitative projects.

Books, dissertations and theses were omitted from this evidence review due to their length and the time available. Instead, the focus was on pieces of 12 000 words or so. This did not affect the quality of the review unduly, because, first, the material reviewed is likely to contain more contemporary arguments and data than monographs, dissertations or theses. This is due to the shorter time spent in preparing the relevant texts for publication, especially with the advent of journal papers being published online first. Second, parts of monographs, dissertation or theses are often also published as articles, book chapters and conference papers, especially their findings and the implications which are especially significant for this project.

Another exclusion was empirical publications where variables related to occupation, work or employment status were only a small element of the overall analysis. Examples might be where these were treated as demographic variables only or where they were single variables explored for their effects on menopausal people amongst many others like age, ethnicity and education level.

Judgement was also exercised regarding grey literature. For example very short pieces were excluded as were pieces which cited empirical data but gave no sources for or details of these data. The same is true of pieces which simply reported on menopause initiatives at specific organizations with no evaluation. In total, 132 publications are included in the review. Key gaps in the evidence base have also been recorded.

Before proceeding, it is important to establish that everyone who goes through menopause will experience a constellation of symptoms which is unique to them; and that some people will not find this period of their lives difficult at all. This is pointed out in much of the literature that is reviewed here. Also note Verdonk et al.'s (2022: 484) observation that "no particular set of symptoms is unquestionably 'menopausal', except for biomedically defined physiological symptoms which are associated with fluctuating and declining hormone levels". The latter group include hot flushes, night sweats and vaginal dryness as well as erratic periods. As such, and as argued elsewhere in this review, it can be difficult to differentiate between a symptom that is caused by menopause and a symptom that has other origins, like stress-induced headaches or sleep disturbances. Regardless, the recommendations for employers covered in this review will be supportive for staff experiencing these symptoms, their origins notwithstanding.

Relatedly, some evidence discusses the so-called domino effect, where one symptom causes another rather than the second symptom being a direct consequence of menopause. So Mitchell and Gu (2024), for example, suggest that lowered confidence is a byproduct of menopause symptoms, not a symptom in and of itself. Analysis by the Fawcett Society (2022) of survey data also suggests that it is other symptoms which led to lower confidence amongst the menopausal workers who responded as well as lower motivation. Motivation was especially badly affected for those with more than one serious symptom. Grandey et al. (2020: 20), similarly, index the domino effect in writing that research "has not determined whether changes in cognitive performance are explained by hormonal levels or associated symptoms such as [hot flushes and night sweats] …, [variation in] moods, or sleep impairment". They indicate that self-belief that one's cognition is declining may instead be "the source of the problem", and suggest that the

evidence that any or all menopause symptoms impair performance might be better explained by "subjective distress and negative beliefs".

Grandey et al.'s (2020) literature review also cites evidence that the erratic nature of menopause symptoms can damage self-confidence and self-efficacy. Rees et al. (2021: 56) make an associated observation in suggesting that menopausal sleep disturbances may lead to "insomnia, fatigue, irritability and difficulties with short-term memory and concentration as well as muscle and joint discomfort" (also see Wales TUC Cymru, 2017: 7; Evandrou et al., 2021: 101). Nonetheless, the same observation as above applies; that the cause of specific symptoms is less relevant here than the difficulties they can create at work and how this situation might best be ameliorated.

Moreover, the review follows the British Standard Institute's (2023: 1) approach of using the clinical terminology of symptoms to "recognize that, even though menstruation and peri/menopause are not medical conditions, some find that these changes have an impact on their quality of life".

In what follows, the evidence is reviewed in this order:

- Section 2 considers menopause symptoms at work and their effects in the context of the biopsychocultural approach and the impact that work can have on symptoms - i.e., bidirectionality.

- Section 3 looks at lack of support for menopausal staff at work and the negative consequences, such as non-disclosure, individualized coping mechanisms, hampered career progression, disciplinary action and reducing working hours or quitting work altogether.

- Section 4 provides something of a corrective by reviewing the evidence that menopause can be a positive workplace experience.

- Section 5 reviews evidence around what employers can do to support menopausal staff, around policies, processes and awareness raising; initiatives to assist with physical and mental health; environmental adjustments; and menopause champions, peer and one to one support.

- Section 6 considers the limited evidence on the effectiveness of such interventions.

- Section 7 summarizes gaps in extant research which are identified in the evidence base.

- Appendix 1 contains methodological details for the empirical studies reviewed here; whereas appendix 2 is a full list of references for all of the evidence considered.

2. MENOPAUSE SYMPTOMS AT WORK, THE BIOPSYCHOCULTURAL APPROACH AND BIDIRECTIONALITY

This section reviews evidence on the symptoms which are reported to cause difficulties at work as well as how work can make symptoms worse. This evidence is therefore informed by the biopsychocultural or biopsychosocial approach which

> "contends that a woman's experience of menopause must be understood in the context of both her psychological make-up and her socio-cultural location ... [although i]t does not deny the physiological basis of menopause in fluctuating levels of hormones like oestrogen, progesterone and testosterone" (Atkinson et al., 2021a: 50-51).

As such, many of the experiences described point to workplace difficulties created by menopause symptoms; but also to problematic environments, processes and policies in or behaviours or attitudes from others at work, whether perceived or actual. Certainly Banks (2019) suggests that silence or even taboo at work around menopause, and the associated negative stereotypes, makes women feel unsupported. And Verdonk et al. (2022) cite evidence that having to mask one's symptoms at work can be stressful in and of itself. The review returns to both of these observations below.

2.1 PROBLEMATIC SYMPTOMS AT WORK

The evidence identifies specific menopausal symptoms as likely to create challenges at work. This section begins with those which are most commonly reported.

Hot flushes, which are often difficult to hide, cause physical discomfort, embarrassment, anxiety, distraction and fatigue at work. They can affect self-confidence and self-image (particularly amongst those with high-level responsibilities) and cognitive processing; as well as ability to work, performance and productivity at work more generally. There is some evidence that they lead to increased absenteeism and desire to quit. Evidence also points to women's concerns around visible and excessive sweating during hot flushes and the consequent worry of smelling bad (Hardy et al., 2017, 2018a, c; Wales TUC Cymru, 2017; Banks, 2019; Bodza et al., 2019; Grohs and Harriss, 2019; Watkins et al., 2019;

Beck et al., 2020, 2021; Butler, 2020; Grandey et al., 2020; Hardy, 2020; Norton and Tremayne, 2020; Carter et al., 2021a, b; Cronin et al., 2021, 2023; Jack et al., 2021; Rees et al., 2021; Yoeli et al., 2021; All Party Parliamentary Group on Menopause [APPGM], 2022; Brewis, 2022; Verdonk et al., 2022[1]; Whiley et al., 2022; Bupa, 2023; Quental et al., 2023; Theis et al., 2023; Faubion et al., 2024; Fox and Mano, 2024; Hobson and Dennis, 2024; Safwan et al., 2024; Valadares and Rodrigues, 2024; Westwood, 2024; Brewis et al., 2025).[2]

Cognitive symptoms like loss of focus, concentration and ability to absorb new information, absorb or juggle demands, lower confidence, brain fog, reduced decision-making capacity and memory problems are identified as especially problematic in "acute or fast-paced occupational settings" such as the military or healthcare (Cronin et al., 2021: 543). These symptoms can mean tasks take longer to complete because staff are compelled to check and recheck their work; and they might also make fatigue worse (Wales TUC Cymru, 2017; Hardy et al., 2018c; Watkins et al., 2019; British Medical Association [BMA], 2020; Brewis, 2020, 2022; Beck et al., 2020, 2021; Grandey et al., 2020; Hardy, 2020, 2022b; Norton and Tremayne, 2020; Atkinson et al., 2021a; Noble, 2021; Verdonk et al., 2022; APPGM, 2022; Cronin et al., 2023; Faubion et al., 2024; Quental et al., 2023; Rodrigo et al., 2023; Root, 2023; Theis et al., 2023; Willman and King, 2023; Collins et al., 2024; Fox and Mano, 2024; Hobson and Dennis, 2024; Kowalczyk and Cooke-Mwangeka, 2024; Naidu-Young et al., 2024; Royal London, 2024; Safwan et al., 2024; Schurman and Fadal, 2024; Brewis et al., 2025; Pryor, 2025[3]; Rowson and Jones, 2025; Steffan and Loretto, 2025).

Another collection of symptoms which appears frequently in the evidence base includes anxiety, panic attacks, depression and feeling low. These are all said to increase tiredness, affect career progression and relationships with others and reduce self-reported work ability or productivity (Wales TUC Cymru, 2017; Hardy et

[1] However these researchers also cite evidence that menopausal women might think those around them at work react more negatively to hot flushes than they actually do.

[2] Interestingly, however, in Nappi et al.'s (2021) large survey, women tended to suggest that hot flushes and night sweats were more problematic in their home lives than at work. The impact of these symptoms was also reported as relatively low anyway. But Nappi et al. do conclude that a "high proportion of women experience moderate-to-severe VMS, especially in Europe and the US" (page 882). VMS stands for vasomotor symptoms, which is the clinical descriptor for this collection of symptoms.

[3] Pryor's participants pointed out that working from home often made these symptoms easier to manage as they could, for example, consult notes more surreptitiously during an online discussion or use delaying tactics to defer calls from others. They could also take more breaks and access outside space to decompress more easily.

al., 2018c; Grohs and Harriss, 2019; BMA, 2020; Beck et al., 2020, 2021; Hardy, 2020, 2022b; Norton and Tremayne, 2020; Bourgault, 2021; Carter et al., 2021b; Cronin et al., 2021, 2023; Van Heijden et al., 2021; Verdonk et al., 2022; D'Angelo et al., 2023; Quental et al., 2023; Theis et al., 2023; Willman and King, 2023; Hobson and Dennis, 2024; Ryan and Gatrell, 2024; Royal London, 2024; Rowson and Jones, 2025; Steffan and Loretto, 2025).

Heavy and/or erratic periods on the other hand can be challenging to conceal at work due to leakage on to clothes and furniture. For example, a respondent in Atkinson et al.'s (2021b: 666) survey of women working in the UK police service recounted a particularly difficult episode:

> "I had to endure being stuck on a phone to [the] Crown Prosecution Service … I could not end the call as the custody clock[4] was ticking. I had a bad wave of period which soaked my clothing and through to the chair I was sitting on. I was in a busy office with men."

This symptom can also create embarrassment during business travel, meetings and teaching especially as well as trepidation about odours (Wales TUC Cymru, 2017; Banks, 2019; Watkins et al., 2019; Butler, 2020; Norton and Tremayne, 2020; Jack et al., 2021; Nursing Management, 2021; Sang et al., 2021; APPGM, 2022; Brewis, 2022; Verdonk et al., 2022; Whiley et al., 2022; Cronin et al., 2023; Fox and Mano, 2024; Westwood, 2024a; Brewis et al., 2025).

Sleep disturbances such as night sweats leading to tiredness, or fatigue in and of itself, might mean tasks take longer and physical work is more challenging. Mood, self-esteem and energy levels may also be lower, workers can be more error- or accident-prone and more anti-social, irritable and anxious as well as struggling with early starts or night shifts. Loss of sleep can, equally, worsen concentration, memory problems and headache, and reduce self-reported work ability and performance.

To illustrate, some of Hobson and Dennis's (2024: 4) healthcare focus group respondents described their sleep loss and fatigue "as like jet lag, or the tiredness felt like [being] a new parent" (also see Hardy et al., 2017, 2018c; Wales TUC Cymru,

[4] This is the expectation in the UK that someone is charged with an offence within 24 hours of being taken into custody at a police station.

2017; Banks, 2019; Bodza et al., 2019; Grohs and Harriss, 2019; Watkins et al., 2019; Beck et al., 2020, 2021; BMA, 2020; Brewis, 2020; Hardy, 2020, 2022b; Norton and Tremayne, 2020; Atkinson et al., 2021b, 2025; Fawcett Society, Standard Chartered and Financial Services Skills Commission [FSSCFSSC], 2021; Carter et al., 2021a, b; Jack et al., 2021; Noble, 2021; Prothero et al., 2021; APPGM, 2022; Whiley et al., 2022; Steffan and Potoćnik, 2023; Verdonk et al., 2022; Bupa, 2023; Cronin et al., 2023; Rodrigo et al., 2023; Theis et al., 2023; Collins et al., 2024; Faubion et al., 2024; Fox and Mano, 2024; Royal London, 2024; Ryan and Gatrell, 2024; Safwan et al., 2024; Schurman and Fadal, 2024; Valadares and Rodrigues, 2024; Brewis et al., 2025; Steffan and Loretto, 2025).

Note also that several studies cite the Kagan et al. (2021) analysis of longitudinal data[5] from the US Study of Women's Health Across the Nation which concludes that menopausal sleep problems alone cost the US economy some $2.2 billion in productivity annually due to reduced working hours. A different estimate provided by Faubion et al. (2023: 1), using primary survey data, suggests that absence due to menopausal symptoms creates "an annual loss of $1.8 billion in the United States".

Furthermore, irritability and mood swings are challenging to control and conceal at work. They can have a diminishing effect on workplace relationships as well as affecting performance and someone's sense of professionalism (Wales TUC Cymru, 2017; Banks, 2019; Watkins et al., 2019; Bourgault, 2021; Brewis, 2022; Verdonk et al., 2022; Whiley et al., 2022; Cronin et al., 2023; D'Angelo et al., 2023; Willman and King, 2023; Faubion et al., 2024; Valadares and Rodrigues, 2024; Ryan and Gatrell, 2024; Westwood, 2024a; Rowson and Jones, 2025).

The evidence also points to:

- Bone, muscle and joint pain or stiffness, all of which can affect capacity and performance at work and exacerbate fatigue (Grohs and Harriss, 2019; Watkins et al., 2019; BMA, 2020; D'Angelo et al., 2023; Faubion et al., 2024; Royal London, 2024).

- Headaches, especially migraines, which are not only painful in themselves but can seriously impede ability to focus at work (Wales TUC Cymru, 2017; D'Angelo et al., 2023; Fox and Mano, 2024; Brewis et al., 2025).

[5] A longitudinal study is one which captures data from the same group of respondents on the same issue over a period of time.

- Heart palpitations and dizziness, also distressing in themselves and inevitably causing work disruptions (Wales TUC Cymru, 2017; Grohs and Harriss, 2019; Watkins et al., 2019).

- Increased need to urinate, urinary urgency or urinary tract infections, bladder leakage, as well as vaginal dryness/itching/inflammation/discharge/infection, all of which can be disruptive and very uncomfortable at work as well as embarrassing and possibly lead to concerns about "funny odours" (Anna, quoted in Butler, 2020: 703 – also see Wales TUC Cymru, 2017; Grohs and Harriss, 2019; Norton and Tremayne, 2020; Nursing Management, 2021; Bupa, 2023).

- Loss of muscle mass and physical strength, which might affect people in physically demanding jobs as well as making weight gain more likely; decreasing bone density and skeleton mass; and pain in joints and muscles, which can be made worse by menopausal weight gain. All of these symptoms can affect people who need to sit or stand for long periods at work or who don't have adequate break time, as well as impacting sleep in a version of the domino effect. Pain can also make writing and typing challenging and affect dexterity where needed. Weight gain and bloating, moreover, are reported as separate symptoms and can necessitate a change in work wardrobe habits to clothes which are looser, easy to wash and cool to wear (Wales TUC Cymru, 2017; Grohs and Harriss, 2019; Watkins et al., 2019; BMA, 2020; Butler, 2020; Theis et al., 2023; Willman and King, 2023).

- Nausea, which again is both distressing and disruptive (Watkins et al., 2019).

- Olfactory sensitivity to strong smells and photosensitivity to light, both of which can be especially difficult in some workplaces (British Standards Institute [BSI], 2023).

- Skin itchiness and dryness, eye dryness and headaches, which are discomfiting and can affect concentration and the ability to be 'present' at work (Wales TUC Cymru, 2017; Bodza et al., 2019; International Union of Food, Agricultural, Hotel, Restaurant, Catering, Tobacco and Allied Workers' Associations [IUF], 2024).

- Vaginal dryness, which has been suggested to affect ability to and performance at work amongst perimenopausal women especially and to potentially lead to presenteeism[6] (Smith et al., 2020).

Interestingly, one study suggests that psychological and cognitive symptoms have worse effects for working women than the physical symptoms of hot flushes and night sweats (O'Neill et al., cited in Fitzgerald, 2024).

2.2 BIDIRECTIONALITY

Equally, what Atkinson et al. (2021a) call the 'bi-directional' relationship between symptoms and the workplace means that aspects of work itself can make symptoms worse (also see Grandey et al., 2020; Jack et al., 2021; James, 2024). The evidence cites an extensive list in this regard. The most commonly reported issues are again reported first in what follows.

High temperatures, confined spaces, poor ventilation or air quality, exposure to chemicals and humid or dry environments can all aggravate hot flushes, headaches and menopausal skin problems like itchiness or formication[7]. Such environments may also put menopausal workers at risk of heat stress (when the body cannot control its internal temperature, which constitutes a medical emergency), heat exhaustion and heat-related fainting. Evidence suggests that body temperature can increase by as much as 5 degrees during a hot flush (Hardy et al., 2017, 2018c; Wales TUC Cymru, 2017; Grohs and Harriss, 2019; BMA, 2020; Brewis, 2020, 2022; Butler, 2020; Grandey et al., 2020; Norton and Tremayne, 2020; Atkinson et al., 2021a; Bourgault, 2021; Carter, 2021a; FSSCFSSC, 2021; Jack et al., 2021; Kydd, 2021; Martelli et al., 2021; New et al., 2021; Nursing Management, 2021; APPGM, 2022; Riach and Rees, 2022; Women and Equalities Committee, 2022; BSI, 2023; Verdonk et al., 2022; Howe et al., 2023; Rodrigo et al., 2023; Theis et al., 2023; Faubion et al., 2024; IUF, 2024[8]; Safwan et al., 2024; Westwood, 2024a; Brewis et al., 2025; Pryor, 2025).

[6] Presenteeism refers to situations when people go to work even when they are not fit to do so, because of concerns about what will happen if they do not show up.

[7] This refers to the sensation that insects are crawling on the skin.

[8] The IUF also note that low humidity and very high air conditioning can make skin dryness, as well as headaches, worse.

Synthetic, restrictive, heavy or badly fitting uniforms or workwear, equally, can make hot flushes, headaches, itchy skin and formication worse, as can workplace clothing which has not been designed with female bodies in mind. Light-coloured workwear and uniforms are also problematic in the context of menstrual flooding, as is upholstery, which can exacerbate thermal discomfort as well if it is synthetic. And some uniforms can make it obvious that a member of staff has been sweating due to hot flushes, like the "bottle green polo shirt" which one of Hobson and Dennis's (2024: 5) respondents had to wear at work (also see Wales TUC Cymru, 2017; Butler, 2020; Norton and Tremayne, 2020; Nursing Management, 2021; New et al., 2021; APPGM, 2022; Fawcett Society, 2022; Riach and Rees, 2022; Women and Equalities Committee, 2022; Bupa, 2023; Howe et al., 2023; Willman and King, 2023; Acas, 2024; Faubion et al., 2024; Westwood, 2024a; Rowson and Jones, 2025).

Relatedly, personal protective equipment (PPE) can present a challenge for menopausal workers. This includes "powered respirators, breathing apparatus and occlusive[9] clothing that may be required when using particularly hazardous, toxic or very toxic chemicals" or in emergency situations like firefighting (Grohs and Harriss, 2019: 24). Especially post-COVID, masks also fall into this category, as do safety glasses, lead aprons and clothing worn to prevent infection transmission in healthcare environments. This kind of workwear might be very challenging during hot flushes. As one of Hobson and Dennis's (2024: 5) respondents suggests,

> "you can't take it off cause you've got your patient in front of you and I know in the first wave of lockdown we had to wear the full body suit with the visor and everything and I was with this chap once and the perspiration was just like dripping off me. It was collecting in my new gloves which was disgusting".

PPE can, equally, exacerbate sleep problems and heavy periods as well as making dry, irritable or itchy skin worse (also see Wales TUC Cymru, 2017; Norton and Tremayne, 2020; Bourgault, 2021; Kydd, 2021; Bell et al., 2022; Howe et al., 2023; Faubion et al., 2024; Orts Llopis, 2024) [10].

Another workplace challenge identified in the evidence base is inadequate toilet provision. This can include no sanitary disposal bins or bathroom breaks when managing unpredictable or heavy periods and/or needing to urinate frequently or coping with urinary incontinence. It can make urinary tract infections more likely

[9] Occlusive clothing protects the body from the external environment.

[10] Interestingly, though, Atkinson et al.'s (2021) survey data from three UK police services found that wearing body armour did not affect their respondents' job satisfaction.

and cause discomfort, embarrassment and stress. Difficulty in accessing changing rooms at work can also be challenging when someone is experiencing hot flushes or heavy bleeding. For example, a police officer respondent in Atkinson et al.'s (2021b) survey describes how she can't change her uniform whilst she is on the beat and has to go back to base, which is not usually received well (also see Wales TUC Cymru, 2017; BMA, 2020; Brewis, 2020; Laverick et al., 2019; Kydd, 2021; Martelli et al., 2021[11]; Sang et al., 2021; Riach and Rees, 2022; Women and Equalities Committee, 2022; BSI, 2023; Theis et al., 2023; Advisory, Conciliation and Arbitration Service [Acas], 2024; Faubion et al., 2024; Westwood, 2024; Atkinson et al., 2025).

Stress, management roles, constant interruptions, tight or changing deadlines, inadequate breaks and high job demands or workloads are similarly indexed as creating specific challenges for menopausal workers. A heavy workload especially can in and of itself can lead to more hot flushes; and stress and management roles have both been identified as associated with increased psychological symptoms. Having little or no control over one's tasks or workload have been identified as problematic in the same way, in particular in terms of fatigue. The same is true of feeling dissatisfied, discriminated against or under-appreciated at work or being in insecure work.

Similarly, needing to focus and make decisions quickly at work might increase menopausal headaches and night sweats as well as memory and concentration issues; and there is also evidence that even minor stressors trigger hot flushes (Wales TUC Cymru, 2017; BMA, 2020; Brewis, 2020; Grandey et al., 2020; Norton and Tremayne, 2020; Carter, 2021a; Martelli et al., 2021; Van Heijden et al., 2021; Yoeli et al., 2021; Verdonk et al., 2022; BSI, 2023; D'Angelo et al., 2023; Theis et al., 2023; Asiamah et al., 2024a; Faubion et al., 2024; Safwan et al., 2024; Brewis et al., 2025; Pryor, 2025).

Long, unpredictable or rigid hours can also increase menopausal fatigue and interfere with work-life balance as well as exacerbating anxiety, depression and other menopause symptoms. Shift and on call work can likewise be difficult in this respect. And there is some evidence that long working hours, high job strain and challenging work schedules in the early stages of a career are associated with earlier menopause. Worryingly, Laverick et al.'s (2019: 74) police service focus group participants suggested that extant flexible work provision was being eroded by cost

[11] Note however that Martelli et al. also suggest that the 17 studies they reviewed all had methodological flaws including non-representative samples and a focus on one occupation with no comparators.

cutting measures which created particular difficulties for menopausal staff amongst others.

Shift work has in some studies has also been shown to increase the possibility of earlier menopause onset[12] by up to 9% due to effects on the communication between the hypothalamus, the pituitary gland (both located in the brain) and the ovaries. The same is true of the risk of breast cancer in perimenopausal women due to circadian disruption[13] and corollaries like depression or sleeping during the day. In Hong et al.'s (2022) systematic review of relevant studies, evidence points to increased risk of this cancer where women start night shifts before menopause and do this for between one and nine years. No such risk was found in women who started night shifts post-menopause unless they worked like this for more than a decade (also see Wales TUC Cymru, 2017; BMA, 2020[14]; Riach and Rees, 2022; Acas, 2024; Faubion et al., 2024; Hobson and Dennis, 2024; IUF, 2024; Safwan et al., 2024).

Physical effort on the other hand can exacerbate heavy periods and the increases in heart rate which already characterize hot flushes. Relatedly, specific kinds of repetitive workplace movement[15], static work and work which necessitates long periods of sitting or standing, lifting or handling might make joint, bone and muscle pain worse. This kind of work can also aggravate menopausal headaches. Poorly designed workstations fit into this category as well. Moreover, in occupations which require regular physical training, such as the military, menopausal staff may find these demands difficult to meet because of loss of strength, urinary incontinence, aching joints and so on (Wales TUC Cymru, 2017; Carter et al., 2021a; Nursing Management, 2021; Martelli et al., 2021; Brewis, 2022; Riach and Rees, 2022; BSI, 2023; Theis et al., 2023; Willman and King, 2023; Faubion et al., 2024)[16].

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[12] As Riach and Rees (2022) and Faubion et al. (2024) also note, however, the evidence here is mixed.

[13] The circadian rhythm is a 24-hour cycle which our bodies need to be tuned to day and night to keep important physical processes and functions going.

[14] Importantly, respondents to the BMA survey frequently said they would like to reduce their working hours so as to ameliorate their symptoms but felt unable to ask for this accommodation because of extant staff shortages. They were also often keen to avoid night shifts or on call working patterns.

[15] Van Heijden et al. (2021) however, also cite evidence that jobs involving repetitive tasks are associated with later menopause.

[16] Note though that Carter et al.'s (2025) survey, which asked self-report questions on physical activity, standing and sitting time at work as well as menopause symptoms, found no correlation between sitting time and symptoms, nor between standing, physical activity and symptoms. These

Other aspects of the workplace which the evidence identifies as potentially exacerbating menopause symptoms include:

- Artificial light, especially if it flickers, computer and screen work, which can make dry skin and headaches worse (Wales TUC Cymru, 2017; BMA, 2020; BSI, 2023; IUF, 2024; Pryor, 2025).

- Formal meetings and other 'high-visibility' work like making presentations, which can make coping with hot flushes more challenging (Hardy et al., 2018c; Jack et al., 2021; Faubion et al., 2024).

- Learning new things and a requirement for attention to detail, which can worsen cognitive difficulties and are made more challenging by fatigue (Wales TUC Cymru, 2017; Faubion et al., 2024).

- No or limited access to cold drinking water, again making hot flushes more difficult to manage (Wales TUC Cymru, 2017; BMA, 2020; Norton and Tremayne, 2020; Atkinson et al., 2021a; Kydd, 2021; BSI, 2023; Westwood, 2024a).

- No or limited access to rest breaks or rest spaces, especially if symptoms mean someone is tired, anxious or irritable (Riach and Rees, 2022; BSI, 2023).

- Noise, which worsens ability to concentrate and can exacerbate headaches (BMA, 2020; Brewis, 2020; Women and Equalities Committee, 2022; BSI, 2023; Theis et al., 2023; Faubion et al., 2024; Pryor, 2025).

- Punitive absence policies so that taking time off for menopausal symptoms is difficult or even impossible. Where absence processes are badly implemented and return to work discussions are not held after extended absences, this can also mean no adjustments can be made to support the employee. Performance management approaches employing "ongoing review processes which establish appraisals and feedback as permanent and routine aspects of human resource management" can likewise be problematic because "having 'bad days' [...] will generate low scores", similar

findings therefore contradict evidence from other studies. Neither did Carter et al. find that higher physical activity increased symptoms. Asiamah et al.'s (2024b) survey, on the other hand, which used a similar approach, found an ameliorative effect of physical activity on symptoms, but these data did not capture such activity at work specifically. Some of Willman and King's (2023) military participants also suggested that required physical activity helped with their symptoms.

to the use of the Bradford Factor to manage absence (Beck et al., 2021: 514 - also see Prothero et al., 2021; APPGM, 2022; Collins et al., 2024)

- Shared workplaces, and open plan offices especially, because temperature regulation can be challenging here. Cronin et al. (2023: 3766), for example, quote a respondent who raised the issue of "Working with millennial nurses who don't understand hot flushes and then they turn down the air conditioning because they are cold". These workplaces also increase noise levels and visibility to colleagues – for example, when taking layers off or putting them back on again because of changes in body temperature. Equally hot desking and open plan offices might create problems for people who are struggling with their concentration (also see Wales TUC Cymru, 2017; New et al., 2021; Faubion et al., 2024; Pryor, 2025).

- Strong smells, which can trigger olfactory sensitivity (BSI, 2023).

- Working with people who are younger, men or with "clients/ customers/students/end users" because this might "heighten a menopausal women's anxiety around her self-presentation" (Brewis, 2020: no page). It can also exacerbate symptoms like anxiety, depression or irritability. Jobs which involve patient care or working with the public (such as policing or paramedicine) are likewise indexed here, as are poor relationships with colleagues and managers alike and, obviously, any form of menopause-related stigma, harassment or bullying and feeling discriminated against more generally (Wales TUC Cymru, 2017; Prothero et al., 2021; Faubion et al., 2024; Pryor, 2025)

In closing this section, it is also important to review the evidence which points to occupational variations and how these can worsen – or ameliorate - menopausal symptoms. These include exposure to pesticides (for example, for farmers), which has been suggested to both delay menopause and also increase the likelihood of it starting early. Exposure to sulphur dioxide and to lead have similarly been argued to bring menopause forward. Evidence, likewise, exists that early menopause is connected to jobs where workers are more autonomous but also where they experience high strain, challenging schedules and work which is repetitive. Service work has also been identified in this regard, with a suggestion that exposure to second-hand cigarette smoke is the culprit here; and evidence exists that female astronauts may reach menopause earlier as well due to exposure to radiation in space which can damage the ovaries.

And symptoms seem to vary by occupation per se, with farmers experiencing fewer. People who speak a lot at work – such as teachers – are more likely to experience

negative effects on their voices. Equally, musculoskeletal aches and pains may be more prevalent amongst precarious workers; and psychological symptoms amongst manual workers. On the other hand, some evidence suggests that women who work experience fewer and less severe symptoms than those who don't, especially if they are in management roles. Evidence also indicates that symptoms vary depending on whether one is employed or unemployed and that working full-time is a protective factor here, as is feeling supported by one's line manager. Other evidence suggests that women in white-collar jobs may experience menopause later than their blue-collar counterparts and that those in casual jobs often experience stiff or sore muscles and joints.

There is, in addition, some evidence that post-menopausal women in certain working environments are more likely to develop breast cancer. Engel et al. (2018) review evidence from 2002-2017 to identify one study that linked employment in food canning or car plastic manufacturing plants to a doubling of this risk, because of exposure to particular chemicals. Still, the risk was five times higher than average for premenopausal women in these environments. Engel et al. also cite another piece of research which found higher risk amongst post-menopausal workers who are exposed to a specific type of radiation, but point out that evidence elsewhere is very mixed. Equally, they review several studies which report "statistically significant reductions in [breast cancer] risk … amongst women with the most active jobs", especially if they are post-menopausal (page 69) (also see Martelli et al., 2021; Schwarz et al., 2021; Van Heijden et al., 2021[17]; Yoeli et al., 2021; Riach and Rees, 2022; Rose, 2022; Verdonk et al., 2022; Hu et al., 2023; Faubion et al., 2024; Safwan et al., 2024).

In the next section, evidence concerning lack of organizational support for menopausal staff and the consequences will be reviewed.

[17] Note though that these authors also suggest that the evidence around employment versus unemployment is variable. Equally, D'Angelo et al. (2023) found no significant differences in menopausal symptoms or their effects at work amongst women from nine different occupational classes.

3. LACK OF ORGANISATIONAL SUPPORT AND THE CONSEQUENCES

Despite the great strides made in the UK in particular around support for menopausal staff at work, there still appear to be areas where this is either patchy or non-existent. For example, the IUF (2024: 2) cite data from an Unite survey of 11 000 women, 83% of whom reported that they had no support relating to menopause at work. Similarly, a 2019 survey of 2241 nurses run by the Royal College of Nurses found that most felt their employer did not support them during menopause and only 5% knew of a menopause policy in their workplace (Kydd, 2021). Dean (2019: 45) cites the same survey data to the effect that "Many respondents highlighted a lack of understanding and empathy in their way their debilitating symptoms were viewed". Atkinson et al. (2021a), similarly, note lack of support from supervisors in their literature review, as well as high stress levels and very masculine cultures, as exacerbating any difficulties encountered by menopausal staff. They also review evidence identifying criticism, bullying, performance monitoring, capability procedures, discipline and being mocked as reactions to workplace disclosure of challenging menopausal symptoms (also see Westwood, 2024a: 45; Rowson and Jones, 2025).

We see empirical evidence for this in Willman and King's (2023) survey of military personnel, where 'banter' was identified in this male-dominated environment as part of the bias against women in the armed services and likely to lead to negative judgements of their performance. In Collins et al. (2024), Grace talks about not disclosing her menopause symptoms in her financial services organization for similar reasons. Adelekan-Kamara et al. (2023) also index symptoms being trivialized by colleagues in their respondents' clinical workplaces, as well as a male-dominated environment and entrenched hierarchies "preventing intraprofessional and interprofessional discussion about menopausal issues" (page 6). However, and interestingly, these women noted that other women can be unsupportive at work too; perhaps, the authors speculate, because of "the 'queen bee' syndrome, whereby females in a position of leadership distance themselves from women in junior positions and legitimise the inequalities between genders as a method to fit into male-dominated organisations" (page 8).

Relatedly, Beck et al.'s (2020) survey data suggest that some respondents had felt supported or helped as a result of disclosure but others had disclosed to someone who didn't know a great deal about menopause (6.1%), didn't know how to help them (4.7%) or failed to provide any support (also 4.7%). The Fawcett Society's (2022) analysis suggests that 41% of survey respondents had experienced

menopause being joked about at work, with 58% of women with disabilities reporting this. Similarly, Atkinson et al.'s (2021b) police service respondents describe being the butt of inappropriate workplace humour due to menopause or being made to feel as if they were slacking off. In a telling turn of phrase, the authors suggest these women often "felt they had much to give and were aged more by culture than biology" at work (page 668). Even in what we might see as a more caring profession, Bodza et al. (2019) suggest that the women counsellors they interviewed felt unsupported even by their peers at work, who they had presumed would react more empathetically.

Cronin et al. (2021: 544), likewise, point to symptoms being especially challenging to manage at work due to "stigma, embarrassment, silence of other women about their experiences, or lack of information available on the topic", a point also made by Hardy et al. (2018c), Hardy (2020) and Norton and Tremayne (2020). And a Chartered Institute of Personnel and Development (CIPD, 2023a) survey suggests that 84% of respondents who felt unsupported by their employers or managers also said their symptoms negatively affected their work.

All of this considered, it is unsurprising that many people choose not to disclose their challenging menopause symptoms at work. The next sub-section focuses on the evidence in this respect.

3.1 NON-DISCLOSURE AT WORK

Butler (2020), Atkinson et al. (2021a), Van Heijden et al. (2021) and Verdonk et al. (2022) all point to fears around disclosure of any menopausal difficulties at work. Beck et al. (2023) cite reasons for this non-disclosure including concerns that others will then scrutinize the affected worker's performance or capability or not respect their confidentiality, embarrassment and wanting to protect their privacy. They suggest that non-disclosure is especially likely when someone is managed by a man or by someone who is younger than them. Hardy et al.'s (2019b) phone interviews also suggest there are specific challenges in disclosing to a male manager, as well as fears around receiving a negative response, feeling embarrassed to disclose, thinking one should be able to cope at work without support and worrying that whoever one discloses to will feel the same way. Equally, their respondents cited concerns around menopause being "a personal issue and one that was not appropriate to discuss with a colleague or a line manager" (page 33).

Similarly, Atkinson et al.'s (2021b, 2025) survey data suggest that, in 'hypermasculine' organisational cultures like those in the police service, disclosure is

less likely; whereas police staff working in mainly female environments were able to discuss their symptoms openly and support each other. Only 39% of their menopausal respondents had told their manager they were experiencing symptoms, although rates of disclosure were much higher when they were managed by another woman and the same is true where they had particularly bad symptoms. As Atkinson et al. point out, the latter is probably because these symptoms were causing significant challenges at work. Pryor (2025) makes a similar point about some of her participants being compelled to open up at work because they weren't receiving support from their line managers.

Other evidence Beck et al. (2023) index points to worries that more open discussion of menopause at work will increase gendered ageism as opposed to reducing it (also see Atkinson et al., 2021b, 2025; Targett and Beck, 2022). Interestingly, in Daly et al.'s (2024: 170) story completion study, those responding at times echoed exactly these perceptions: that a menopausal worker had "a responsibility to think carefully about the information that she shares with her work and how this might reinforce existing negative stereotypes of (older) menopausal women, their competence, and the incongruence of this with leader stereotypes". Many also felt this worker needed to consider what the career consequences might be for her before disclosing; and the suggestion was made that progression in an organization is likely to be hampered by any such disclosure because of gendered ageism.

The British Standards Institute (BSI, 2023: 3) echo much of this, adding that

> "Other elements [hampering disclosure] which are sometimes forgotten are cultural differences, stigmas, neurodivergence and intersectionality. The additional burden of discrimination on employees from marginalized backgrounds might deter them from disclosing their situation and seeking support."

They add that workers in precarious jobs may well feel unable to disclose for fear of losing their employment. Wales TUC Cymru (2017: 40) make a series of similar points and suggest women can worry that their organization won't take their concerns into proper consideration as well as having concerns about future job security or career development. As they also point out, again echoing the BSI, when "workers are from an agency, are fixed term, or are part time, they may feel particularly vulnerable and maybe even less likely to disclose".

Acas (2024), relatedly, add not knowing one's manager very well and thinking they won't be empathetic to the list of reasons for non-disclosure. Bupa (2023) suggest non-disclosure is also likely when someone believes others at work don't know very

much about menopause. Similarly, Bodza et al. (2019) quote one of their respondents who had discussed fatigue as one of her menopausal symptoms with her male supervisor but wasn't comfortable raising any more intimate symptoms with him.

Grandey et al. (2020) also cite evidence that women often do not disclose at work, due to embarrassment and/or fear of reputational damage and career consequences; as do Safwan et al. (2024). And, as Ryan and Gatrell (2024: 541) point out, this can be particularly challenging for women who have less autonomy at work and no personal, private workspace, because "symptoms like hot flushes or heavy menstrual bleeding" are harder to conceal than they might be for their more privileged counterparts. Similarly, Pryor (2025) notes lack of privacy for many workers around needing to manage psychological symptoms as an issue. One of her respondents had to resort to shutting herself in a toilet to decompress as she had no alternative. Atkinson et al. (2021) make the opposite point about their respondents who have more freedom to decide when and where they work and so more opportunities to manage or conceal their symptoms.

Westwood (2024a) indexes all the above reasons for non-disclosure as well as a feeling that menopause is not an appropriate topic for discussion at work per se. Whiley et al.'s (2022) respondents also suggested menopause is something of a social taboo at work, that they worked to hide their symptoms and were especially reluctant to talk about this topic to men or younger colleagues. They felt embarrassed and believed they were judged as incompetent when their symptoms became visible, for example not being able to call up specific details of a task or project on cue.

In Vodafone's wide-ranging survey of 5012 menopausal workers across five countries including the UK, moreover, 33 per cent said they concealed symptoms at work; with 43 per cent not feeling able to ask for any support. This was even worse for those who had gone through early menopause (< age 45), where the figure rose to 63 per cent. Of those who had taken time off as a result, 75 per cent had felt they couldn't tell their line manager why they had been absent (Brown, 2021)[18]. Beck et al.'s (2020) survey data showed that less than half (45.8%) of their respondents had disclosed their menopausal status at work, because they felt it was a personal issue, worried that others would judge them or felt "their abilities would be questioned" (page 161). They were also much likelier to have told a woman of a similar age to them than another colleague. In a later publication drawing on the same data, Beck

[18] Interestingly, the CIPD (2023a) identify the exact same percentage of people who said they would not tell their employer the real reason for any menopause-related absence.

et al. (2021) suggest women also worry about confidentiality when considering disclosure as well as pointing to a lack of management training in the relevant issues, lack of policy and an unsupportive culture in their workplaces as well as ageism. Similarly, slightly more than half of Targett and Beck's (2022) survey participants had disclosed, but only a small minority had told a male colleague.

Even more striking patterns are evident in data from the BMA (2020: 3) survey, where only 16% of their 1860 menopausal or postmenopausal participants had told their manager about their symptoms. A further 47% wanted to but weren't sufficiently comfortable. Many reported an unsupportive culture in their workplace, where "doctors are frequently expected to go 'above and beyond' in order to provide the best care" (page 6), which also made disclosure hard. Those in specialisms where men predominated were especially worried that revealing anything at work would not be received well and likely exacerbate the gendered inequality they already experienced. In a qualitative study which also recruited doctors, Adelekan-Kamara et al. (2023) suggest their respondents were similarly hesitant to disclose at work, because of embarrassment, concerns about professionalism and being unsure how others might respond, especially men. Similar accounts were evident in Cronin et al.'s (2024) survey data from healthcare staff.

Steffan and Potoćnik (2025: 7), on the other hand, suggest their respondents tended to see menopause as "a natural, biological cycle of bodily ageing", not as an illness, and so didn't disclose accordingly and instead worked on coping alone. Disclosure was also hampered by beliefs that this would not be received well at work. However, at the same time these women typically viewed menopause as a threat to their identities, something that was 'being done' to them and fundamentally changing who they were. They worried about keeping their jobs whilst trying to cope with their symptoms as well and spoke of masking at work to avoid any negative perceptions of their abilities[19]. In an earlier study by the same authors (Steffan and Potoćnik, 2023), the participants also tended to think it was up to them to manage their symptoms at work, as well as assuming male managers and colleagues in particular would not be supportive. As such, they did not disclose any issues they were having.

In a Royal London (2024: 26) survey, likewise, only 49 per cent of the women involved

[19] On the other hand, some of these respondents engaged in internal narratives positioning menopause as the reason why their performance was being hampered as opposed to they themselves being culpable. This is a much more positive take.

> "were comfortable having a conversation with their employer about their experiences around menopause, and only 41% felt their employer had created a culture where talking about menopause was no longer taboo".

Similarly, less than a third of the respondents to the Women and Equalities Committee (2022) survey had disclosed their menopausal status to anyone else in their organizations; and only 12% had specifically requested accommodations on this basis. Again worries about how others would react and privacy were the main concerns here. In the FSSCFSSC (2021) survey, amongst the menopausal women and transgender men who responded, just 22% had felt able to disclose their menopausal status at work, with the majority preferring to stay silent, mainly due to concerns about being stigmatized or having their performance judged. Interestingly it was senior women who were more likely to stay silent because of worries about repercussions for their positions. The same was true of people in male-dominated or younger workforces who were concerned about being stereotyped. The professional women whom Root (2023) interviewed shared similar concerns. For example, Debbie said:

> "You don't want to walk around with a big M on your forehead and [be] labelled as a female going through menopause … Others will see me as less capable. I don't want to identify as menopausal as I don't think it defines me" (page 83).

These women worked instead to hide the cognitive symptoms they were experiencing from their colleagues at work, particularly men. They were especially keen not to have anyone else behave differently towards, lose regard for or feel sorry for them. They also mistrusted menopause policies where these were in place, not wanting to ask for reasonable adjustments such as flexible working patterns because "in senior roles the reason becomes very blatant" (Carolyn, page 85). Relatedly, Steffan and Loretto's (2025) respondent Natalie said that she hadn't disclosed at work because none of the women who were more senior to her had.

As James (2024: no page) argues, staying silent at work "underscores and promotes, or at least fails to challenge, business preferences for productivity and the vilification of anything that fails to meet the very high standards of the fictitious 'ideal worker'". It also leaves any stigma attaching to menopause untouched, as well as the idea that people need to manage their symptoms unaided and individually. That said, this strategy is more than understandable given what many women clearly see as the considerable risks of disclosure. Relatedly, Rowson and Jones

(2025: 7) describe the ideal worker as someone who is "disembodied and ageless, hence it disadvantages menopausal women by exposing them to ageist and sexist attitudes in the workplace". They agree with James that, as a result, too much emphasis is placed on women managing their own symptoms and not enough on the workplace contexts which "do not consider menopausal women's bodies" (page 10), identifying the shame and guilt that can result. Indeed Daly et al.'s (2024), story completion methodology, where a fictional worker had disclosed her symptoms at work, saw numerous participants assuming this worker would feel guilty about accepting any suggested adjustments, generally appearing 'difficult' and talking about menopause publicly when she should be able to manage her symptoms alone.

However, as Business in the Community (2023: 4) point out, "Disclosure should always be a matter of personal choice". As such, some staff won't want to share their experiences at work no matter how supportive the environment is, and this should always be respected. Equally, Beck et al. (2021) underline the problems in relying on disclosure so that staff can access support at work given what appear to be reasonably high levels of reluctance to do in many organizations.

As this sub-section has established then, many menopausal workers decide to cope with their symptoms at work themselves. The next sub-section reviews the relevant evidence.

3.2 COPING AT WORK

Staying silent often requires workers affected by menopausal symptoms to develop strategies for coping at work. Beck et al.'s (2023) literature review indexes how they use specific forms of 'kit' for this purpose – such as cold packs for hot flushes, blankets, heaters, dark cushions in case of menstrual flooding and caches of period products or wearing such products on a 'just in case' basis. They also mention choosing dark, baggy and/or breathable clothes for work and bringing spare clothes to work. Other women opt to make themselves less visible – e.g., avoiding warm environments at work, not applying for promotion, self-care outside of work and taking HRT to ameliorate symptoms when at work. Cronin et al.'s (2023) focus group participants likewise pointed to bringing in fans, wearing layered or thin clothing, wearing more than one period product at once and list-making to aid recall.

Butler's (2020: 703) respondents also mentioned buying their own black cushions to protect the pale upholstery of their office furniture from menstrual blood. In addition, related to reducing the temperature at work, they talked about "propping

the [office] door open when they could 'get away with it'" since this was not permitted. One described "accidentally [gesturing inverted commas] breaking the hinge, so the door couldn't shut properly. I know, I know, but I did. Don't you dare quote me on that". FSSCFSSC (2021) respondents indexed other coping strategies, for example lengthening their working days so they could take more breaks; planning meetings at times when they knew they would be more clearheaded; and using post-it notes as memos. Similarly, Laverick et al.'s (2019: 71) police service focus group respondents mentioned layering work clothes and bringing spare clothes to change into. At the same time though, they said that wider changes in the service, including inter-force collaboration and mobility, meant it was becoming challenging to find somewhere to store any spare clothes.

Carter et al. (2021b: 986) suggest that such efforts to "maintain workplace performance may cause [them] … to increase their work output with potential to exacerbate pre-existing depressive symptoms". Rowson and Jones (2025: 11) also index this additional labour, and identify it as a product of a "framing of menopause as a personal issue … [which] implies that the burden to cope with symptoms and manage workplace consequences lies with the woman". Grandey et al. (2020) add that this also means they will not be able to access any supportive accommodations at work; and Business in the Community (2023) agree, whilst also indexing symptom concealment and extra compensatory effort in this respect.

Relatedly, Adelekan-Kamara et al. (2023) describe what they call a superhero mentality amongst the menopausal doctors they interviewed whereby, as one respondent said, "We just plough on … there is that sort of suck it up mentality and just plough on" (page 6). These women were also concerned about the impact any sick leave they took would have on their already under-staffed teams, as well as indexing the intense workloads they faced which left little time for self-care. Root's (2023) respondents indexed working longer hours to conceal their cognitive symptoms – for example, to fully digest any important material and to check that they weren't making errors; whereas Pryor's (2025) participants talked of extended working days at home to compensate for the breaks they took to assist with menopausal fatigue (also see Hardy et al., 2018b; Atkinson et al., 2021b, 2025; Beck et al., 2021; Steffan and Potoćnik, 2023; Hobson and Dennis, 2024; Brewis et al., 2025[20]).

[20] Importantly, Brewis et al.'s interview data suggest that even the fear of being seen negatively at work because of one's menopausal symptoms can be debilitating. For example, they quote Alison, an NHS nurse, suggesting that on her bank shifts she wouldn't take additional breaks to cope with her symptoms because she doesn't have the same relationship with colleagues elsewhere as she does on her home ward and feels they might think she is being lazy (page 15).

Steffan and Potoćnik (2025), on the other hand, explore the role of resilience in coping with problematic menopausal symptoms at work. They found that high levels of individual resilience ameliorated the relationship between psychological symptoms and the extent to which their respondents found these distressing. They also report that some of these women chose to centre themselves more as a coping mechanism, for example refusing overtime requests or additional workload; or, in a more negative instance, reducing their hours without explaining why. In their earlier study (2023), the same authors found that focusing on which goals were most important or seeking additional resources to help them cope at work actually saw women with problematic psychological symptoms reporting lower work performance. However, the reverse was true for problematic physical symptoms. Steffan and Potoćnik explain this as possibly due to the fact that these activities not only use psychological resources in and of themselves but also exacerbate psychological symptoms when performance continues to be affected.

Steffan's (2021) sole-authored article also underscores individual resilience as something her respondents thought was necessary to manage symptoms at work so they could control their bodies and not attract any untoward attention. This meant, for example, that they looked to conceal their menopausal bodies in terms of gaining weight by wearing loose clothing, and no longer went for career development opportunities as a result. At the same time these women also talked about feeling alone and experiencing their bodies as unstable and stigmatized. They were, further, worried about unpredictable symptoms like hot flushes during long meetings; felt that they were judged negatively compared to their younger colleagues; and often invested additional effort at work accordingly.

Sometimes, however, the menopausal body makes itself noticed at work regardless of any efforts to the contrary. The example of a police officer who experienced menstrual flooding whilst on a lengthy phone call in a shared office was cited in section 2 (Atkinson et al., 2021b: 666). Similarly, Brewis et al. (2025: 9) quote their respondent Josee as follows:

> "Sometimes I thought 'Oh [my menstruation] is done', and then a bit later there was another tsunami. That uncertainty, that has bothered me most. I can't even count the times. . . I have had a number of times when I was at a client's and I got up and then 'Oooohhh, please push the chair back under the table!'. And that was just so horrible. And you have even prepared by putting on black trousers. You try to take everything into account and then it still happened. [Blood] leaked through on all sides."

Finally, sickness absence is frequently reported in the evidence as a specific tactic that workers use to manage their symptoms. Still, this comes with problems of its own as the next sub-section suggests.

3.2.1 SICKNESS ABSENCE AS A SPECIFIC COPING MECHANISM

Pore (2022) suggests that 64% of the HR directors surveyed by Peppy reported staff taking time off sick due to their symptoms, with a third of these people saying this had happened "quite a few times" (no page). The CIPD (2023a) survey also suggests that 53% of the women who took part had taken sick leave because of their symptoms but 18% had not disclosed why. These data suggest, encouragingly, that LGBTQ+ respondents reported being much more willing to disclose. However, ethnic minority respondents were substantially more likely to report embarrassment about sharing the reason for their absence, which may point to cultural differences or perhaps a sense of racist attitudes at work. In the CIPD (2023b) guide for people managers, they add that their data suggest that, of those who need to be off sick long term due to their menopause experience, the average length of absence during a career is 32 weeks. Similarly, amongst Cronin et al.'s (2024) survey respondents, 60% of those with "moderate or severe symptoms" had either had time off, arrived late at work or left early for this reason.

In the survey data analysed by the Fawcett Society (2022), 26% of these respondents had taken menopause-related absence but only 30% of this group asked for this to be recorded on their sick notes. Others had anxiety, depression or other physical problems recorded instead. Again the figure relating to absence for women with disabilities was much higher, at 46%. Significantly, most of these absences had been of relatively short duration – i.e., four weeks or fewer in the previous 12 months. This is the kind of absence pattern which is most likely to set off organisational triggers such as the Bradford Factor.

Relatedly, the Women and Equalities Committee (2022) survey saw 31% of respondents reporting having time off due to their symptoms; and one of Bodza et al.'s (2019) female counsellors had temporarily stopped practising because she did not feel fit to continue. Prothero et al. (2021) report that 20% of their perimenopausal or postmenopausal paramedic respondents had taken sick leave for the same reason, but only half had disclosed why at work.

Other evidence suggests that menopausal symptoms can create blockages in career development as well as leading to disciplinary action at work. The next sub-section reviews this material.

3.3 STALLED CAREER PROGRESSION AND DISCIPLINARY ACTION

The CIPD (2023a) found that 19% of their respondents identified menopause as being quite detrimental in this respect, with a further 8% saying their symptoms had been very detrimental. Amongst those with disabilities or long-term health conditions and ethnic minority women, the figures were much higher, at 36% and 38% respectively. Support from others at work was, however, identified as having a substantially ameliorative effect here. Business in the Community (2023), similarly, draw attention to how menopause-related breaks in careers and missed promotions, as well as reduced working hours, affect a woman's income, exacerbating the gender pay gap and with a knock on effect for the gender pension gap.

Relatedly, FSSCFSSC (2021) survey data indicate that nearly half the women and transgender men respondents who were experiencing the menopause felt less inclined to try to obtain a promotion; and 52% suggested they were disinclined to accept additional responsibilities. Only a third of this group of respondents wanted an upwards move anyway. Small groups had actually moved downwards or reduced their responsibilities (4% in both cases), because they did not feel able to cope any more due to their symptoms.[21] The survey data analysed by the Fawcett Society (2022), similarly, see 8% of respondents deciding not to go for promotion for the same reason; and 4% not accepting a promotion when it was offered. And Root's (2023) respondents reported feeling overwhelmed when offered new projects, and being reluctant to accept them.

[21] Importantly, a strong theme in the FSSFSSC (2021: 30) data was that "among women who did not apply for a promotion, stepped down from a senior role, or left the workforce, [...] many did not know at the time of their decision that they were experiencing the menopause". Instead they worried they had dementia or brain cancer. This very much underscores the need for training and awareness raising in workplaces, something to which this review returns in section 5.

In addition, 9% of the CIPD (2023a) survey participants suggested their symptoms had led to disciplinary action being taken against them at work due to performance dips. Once more, the figures were higher amongst women with disabilities or long-term health conditions and ethnic minority women, at 16% and 24%. LGBT+ respondents were also more likely to report this experience, at 16%. Similarly, some of Willman and King's (2023) military respondents spoke of anxiety about not being able to perform to standard in safety-critical activities or when commanding others; as well as refusing promotions because of the effects of their symptoms. In the survey data analysed by the Fawcett Society (2022), only a small number (4%) of respondents said they had either been sacked or made redundant because of their symptoms. However, worryingly, this figure rose to 12% for women with disabilities and 9% for those with a collection of serious symptoms. Relatedly, Prothero et al. (2021) quote a paramedic who had been put on performance management due to her symptoms.

In Steffan and Potoćnik's (2023) qualitative data, several women said they had been compelled to leave a job or were sacked because of the lack of support, one having lost her house as a result. Importantly, one had found another post in a more compassionate organisational setting whereas another had been able to return to her teaching job after disclosing her symptoms and securing accommodations accordingly. Beck et al. (2021: 516) also quote a respondent who had been entirely managed out of her workplace because of her psychological symptoms and a period of sick leave to recover from these.

The next sub-section reviews evidence around reducing hours or leaving work altogether due to problematic menopause symptoms.

3.4 REDUCING HOURS OR LEAVING WORK

Pore (2022) reports Peppy survey data from UK HR directors which see 38% reporting that they knew of women who had left their jobs due to menopausal symptoms. Royal London (2024: 26) survey data indicate that 49% of their female respondents had thought about quitting their jobs. On the other hand, 82% would have been. much more inclined to stay with better workplace menopause support. The Fawcett Society (2022) also found that 10% of the Channel 4/Finestripe survey respondents had left their jobs because of their symptoms. This figure was even higher for women with disabilities, at 22%, and those with five or more serious symptoms, at 19%. 3% had taken early retirement, 13% had thought about quitting and a further 14% now worked fewer hours. Women with disabilities and those with

five or more problematic symptoms reported reducing their hours in greater numbers, at 23% and 25% respectively.

Hobson and Dennis's (2024) healthcare respondents also reported that their menopause-related anxiety had meant them reducing their hours or responsibilities at work; and some of Pryor's (2025) professional services interviewees had left a job or avoided applying for promotions. One of these women took a £10 000 salary cut when she quit a senior role and moved elsewhere due to lack of support in the previous role.

Evandrou et al. (2021), in analysing longitudinal UK survey data, found that 53.5% of the respondents reported at least one problematic symptom at age 50. They report that these women were 43% more likely to have left work altogether - and 23% more likely to have reduced their hours - by the time they reached 55, compared to their peers. Those whose partners did not work were less likely to leave work, although this is concerning as it signals presenteeism. Women who took HRT on the other hand were more likely to reduce their hours, perhaps signalling the severity of their symptoms. Those who left work were more likely to have "hot flushes, [...] night sweats, joint aches and pains, anxiety, depression, tearfulness, feeling of panic, trouble sleeping, or forgetfulness". Those who reduced their hours on the other hand were more likely to have "hot flushes or forgetfulness" (page 99). Evandrou et al. also suggest that

> "[t]he finding that severe menopausal symptom complaints led to an increased risk of exiting employment or reducing working hours, suggest that it is the presence of a combination of menopausal symptoms which is associated with productivity loss rather than a specific symptom" (page 101).

Bryson et al.'s (2022) analysis of data from the same survey is, relatedly, suggestive that women who experience early menopause have lower overall employment rates from their mid-40s onwards by some 9 percentage points than their counterparts[22]. These researchers also found that, for every additional menopause symptom reported (the average being 8), women's employment rates fell by half a percentage point in their 50s. As they therefore argue, "a woman experiencing the mean

[22] It is worth adding that this finding refers to employment rates overall, however. No significant difference was found for full-time employment specifically. As such, Bryson et al. suggest that those going through early menopause became less likely to work part-time than their peers. They also caveat their findings in that there was a significant recession in the UK as the women in the study entered their 50s, which in and of itself would have probably affected their employment.

number of symptoms might expect a reduction in her employment and full-time employment rates by around 4 percentage points, compared to a similar woman with no menopausal symptoms" (page 6). Where these symptoms were especially problematic, the equivalent dip was 1.7% per additional symptom for employment rates overall.

Bryson et al. also found that psychological menopausal symptoms – specifically "anxiety/depression, tearfulness, panic, forgetfulness, palpitations and irritability" (page 6) - were especially correlated with lower employment rates in these women's 50s. For every additional symptom in this group, this rate fell by 1.3 percentage points, with the average number of such symptoms being 2.76. Again, when such symptoms were especially problematic, the dampening effect on employment rates rose to 3.9 percentage points. Equally, with especially problematic vasomotor symptoms, the same effect was more than 2.5 percentage points on employment rates overall but was not seen for full-time employment.

Moreover, amongst those who provided data for Schei and Abernethy's (2023) secondary analysis, 74.2% had considered leaving their jobs, especially if they had severe symptoms and felt their work performance was being negatively affected as a result. Notably though, this was again less likely when these people felt supported at work and able to tell their line manager. Importantly, those who reported that their performance at work was affected by their symptoms were more likely to report psychological symptoms like depression, irritability and anxiety. Cronin et al. (2024) found the same connection between symptom severity and intention to quit amongst the healthcare respondents to their survey, with 64% saying they wanted to reduce their hours, 47% wanting to leave work altogether and 44% wanting to leave their employer. FSSCFSSC (2021) survey data likewise indicate that 25% of the women and transgender men responding said they were inclined to leave work altogether before retiring.

Similar patterns are identified in BMA (2020: 8) survey data where many respondents were

> taking a step back in their career or moving to a lower paid role. There were multiple examples of respondents leaving partnerships and becoming salaried GPs or locums, or ending their careers as clinical leaders or directors [...] because of inflexibility and a lack of support [during menopause.]

Safwan et al. (2024) also cite evidence that vasomotor symptoms can be connected to a desire to leave one's job. And they refer to a study of Irish hospital staff where

35% of the women surveyed reported making career decisions based on their menopause symptoms, with others changing roles or even leaving work altogether. CIPD (2023a) survey data, relatedly, indicate that 17% had thought about quitting their jobs due to feeling unsupported, with 6% having actually left. Having a disability or a long-term condition increased these figures to 24% and 8%; but feeling supported at work was once more identified as considerably ameliorative in this regard.

All of this is concerning for a variety of reasons. As Royal London (2024) point out, when women reduce their hours or leave work together, this not only worsens their financial security in retirement but may also affect their access to workplace resources such as wellbeing support. James (2024) refers to leaving work or reducing hours as the 'exit strategy' for managing difficult menopause symptoms alongside work, and suggests it is often a last resort. Again she points to its implications, not least of which are individual financial and social losses as well as those "for sectors (such as the care sector and education and public sector) where women dominate" (no page). And, as James asserts, it exacerbates the gender pay gap as well as the predominance of men in senior workplace roles (also see APPGM, 2022).

However, and importantly, not all experiences of menopause in a workplace context are negative. The review turns to this next.

4. MENOPAUSE IN THE WORKPLACE AS A POSITIVE EXPERIENCE

To begin with, Grandey et al. (2020) cite evidence that the decline in oestrogen during menopause and a shift towards testosterone may in fact make women more assertive at work, more willing to advocate and call attention to injustice. They also suggest that work can be a helpful distraction from difficult symptoms. Whiley et al. (2022), likewise, cite instances when their respondents talk of how capably women manage across home and work at the same time as experiencing menopause, and emphasize that this is not something which men have to deal with. Occasionally these women also "tried to reframe menopause as natural, and refute its pathologizing associations" (page 908), suggesting it can be liberating.

Similarly. Laker and Rowson (2024: no page) point to an emerging theme in menopause in the workplace discussions, which "celebrates menopause as a period of personal growth and professional wisdom". Ryan and Gatrell (2024), moreover, mark the end of periods as a potentially positive milestone, alongside increased ambition, self-belief and energy and less concern about one's appearance. Amongst female leaders especially, they also note reduced sexual harassment or objectification and increased credibility and authority due to ageing. Steffan and Potoćnik (2025: 8), relatedly, suggest that their post-symptomatic participants "engaged in a narrative of renewed personal strength, which enabled a clarity to reposition oneself at work, commonly discussed as increased/renewed resilience, of which confidence was a component" (also see Atkinson et al., 2021b: 667-668; Verdonk et al., 2022: 484; Daly et al., 2024; Fox and Mano, 2024).

Similarly, Butler's (2020) interview data point to how her interviewees relied on each other for 'common sense' advice and reality checks, as well as describing how on occasion they played up their symptoms at work for fun. For example, Anna describes how badly their line manager had reacted to her having a significant hot flush in front of him and how she and her friends subsequently leveraged this by faking hot flushes to embarrass him (pages 705-706).

Finally, James (2024), in the third of the strategies she suggests workers use to handle challenging menopauses at work, discusses what she calls negotiation of different ways of working. She sees this as much more beneficial than either silence or exit, because "it forces organisations to confront and navigate an issue that has long been a taboo topic conveniently ignored by employers and downplayed by workers" (no page).

In the section which follows, the evidence about how employers can best support menopausal staff will be reviewed.

5. WHAT CAN EMPLOYERS DO TO SUPPORT MENOPAUSAL STAFF AT WORK?

Recommendations for employers in the evidence base flow logically from the negative experiences reported by workers as reviewed in preceding sections. Before moving to consider these recommendations in detail, however, some preliminary commentary is needed. For example, Faubion et al. (2024: 744) make the important point that

> "Attempts to implement specific interventions to improve women's menopause experiences in the workplace should consider the objective of the intervention, whom it will target, how to measure outcomes, and potential legal or other ramifications should a policy change occur (and equally important, the potential legal ramifications should policy changes not occur)" (see also Hardy, 2020; Theis et al., 2023; Fitzgerald, 2024).

NHS England's (2022: 23) advice on the importance of "collecting and analysing data and identifying trends … to determine the impact of any menopause support programme initiated[23]" is likewise relevant here. The BSI (2023: 17-18) also emphasize the importance of starting with data to establish the most appropriate way forward for any given organization, and add that cost-benefit analysis can be undertaken upfront where senior management need to be persuaded of the value of workplace menopause support. Benefits could include financial savings, heightened productivity and motivation, avoiding legal and reputational detriment, improved staff loyalty and so on. The BSI also recommend evaluating on a rolling basis after the initiative has been introduced and adjusting accordingly. Evaluations can encompass exit interviews[24]; in person and online training session attendance, completion and feedback; who is using flexible working approaches and how; menopause absence data; and so on.[25]

[23] See Appendix 4 in this publication for more detail of how employers could do this.

[24] Also noted as useful by Banks (2019).

[25] The BSI (2023: 29-30) provide a very comprehensive checklist to use in both planning a menopause initiative and evaluating it after launch.

Relatedly, Faubion et al. (2024) advise that consideration of the organization's reasonable adjustments approach for employees with disabilities may serve as a useful framework here, especially since menopause can be legally considered as a disability for some people (also see Westwood, 2024a: 113-116). The argument made by Crawford et al. (2022: 1588), that many of these recommendations will "make the workplace more amenable to *everyone*", is also worth underlining. Indeed Laverick et al. (2019: 71) quote one of their female police officer respondents as being concerned that initiatives targeted specifically at menopausal staff might be counterproductive by singling them out. Instead, as this officer argues, air conditioning and cold water for example will be valuable for all personnel. And, as the BSI (2023) point out, when menopausal staff need adjustments of whatever kind at work, they should be able to access these without having to explain why.

As importantly, Rodrigo et al. (2023: 106 – also see Safwan et al., 2024: 4; Hardy, 2022b: 1; Women and Equalities Committee, 2022: 21) counsel on the importance of any initiatives being both flexible and sensitive to the organisational culture. This is so that employers and employees alike can "choose interventions that are most appropriate for them depending on symptom presence or absence, type of employment and workplace requirements". Similarly, the BSI (2023: 16-17) offer helpful guidance for small and medium sized enterprises which are unlikely to have the same resources as larger employers. They suggest that SMEs, for example, could draw on evidence-based resources which are already available for free online; or consider working together with other local SMEs to appoint a shared menopause champion. The BSI also recommends putting together guidelines in these contexts as policies are more demanding to compile.

The need for a bespoke approach is echoed by Saal (2024), who recommends that surveys are undertaken by employers to find out what their menopausal workforce would most benefit from before designing any such initiative. These can, suggests Saal, be usefully accompanied by employee resource groups drawn from a diverse selection of staff, including men. These ERGs can support the development and implementation of menopause interventions as well as acting as an important source of contact and continual review thereafter. Schurman and Hadal (2024) make very similar observations, as do Royal London (2024). Verdonk et al. (2022: 492) on the other hand advocate for a mapping of "health problems, job characteristics and sickness absenteeism in relation to female-specific health problems" before developing a menopause initiative.

Importantly, any such interventions must be implemented so that "outdated perceptions and/or negative social attitudes about menopausal women are not

reinforced" (Carter et al., 2021b: 986; also see Hardy et al., 2018a[26]; Grandey et al., 2020; Quental et al., 2023; Root, 2023; Westwood, 2024a; Steffan and Potoćnik, 2025). An important element of this is to avoid any suggestion that menopause is somehow pathological or inevitably disabling, something which renders those who experience it less able or competent than their counterparts. As Carter et al. (2021b: 987) go on to say, "The misconception that all women will experience debilitating symptoms could lead to increased negative social attitudes toward older female workers". They also suggest that initiatives like better monitoring of harassment and bullying or increased mental health support will benefit all staff, not just those struggling with menopause.

Laker and Rowson (2024) agree, and point out that negative stereotyping can lead to heightened stress for menopausal workers as they navigate these at work.[27] And Ryan and Gatrell (2024: 539) are insistent that "the bio-medical narratives that position middle-[…]age women as normally unwell" are, in their words, constraining and pathologizing. For example, they argue that menopause is not a health condition, something which as noted earlier is also observed by the BSI (2023), who agree that an excessive focus on problematic symptoms in workplace initiatives will only reinforce menopause stigma. Equally, Targett and Beck (2022: 26) emphasize the importance of not depicting menopause as "overly or only negatively".[28]

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[26] Interestingly, Hardy et al. found that the only negative work outcome associated with the menopause in their survey data was intention to quit as influenced by bothersome hot flushes at work. They suggest that better understanding of the effects of specific symptoms at work may "reduce general stereotyping of 'menopausal women' and address women's concerns about being perceived as 'not good enough at their jobs' because they are going through menopause" (2018: 6).

[27] Lavelle et al. (2024) are vocal critics of menopause policies in higher education workplaces. They argue that such policies both exaggerate and trivialize menopausal experiences, and "pacify" and "patronize" women as well as over-emphasizing how different they are from men (page 969). A key argument is what they see as an over-glossy rose-tinting in the relevant messaging as well as an undercurrent of "aspirational self-improvement, a continual pull to doing more, being more successful, being hyper present" (page 971). Lavelle et al. also accuse such policies of universalizing menopause experiences; and, in their emphasis that menopause symptoms are temporary, "further inscrib[ing] valued [workplace] norms of constancy, regularity and consistency rather than the undesirable [menopausal] norm of perpetual change and unpredictability" (page 973). An additional complaint is the onus being placed on menopausal staff to disclose to their line managers to secure any accommodations whilst at the same time they might be coping by making themselves less visible, as discussed earlier. This also, Lavelle et al. suggest, means these staff are being made responsible for the whole process. Equally, they argue that listing reasonable adjustments is demeaning because it implies that menopausal workers don't know what they need.

[28] These arguments seem to relate to Steffan and Potoćnik's (2023) suggestion that some women would prefer that menopause is not discussed at work at all in order to avoid exacerbating gendered ageism.

Relatedly, gender and age inclusivity is identified as important. This means that any workplace policies, adjustments or processes need to be equally encompassing of and available to transgender men, people with variations in sex characteristics[29] and non-binary people who may also experience menopause. The same is true of younger cis women who experience premature (< age 40) or early menopause or those who enter menopause suddenly due to having their ovaries removed or medication like the breast cancer drug Tamoxifen.

It should also be acknowledged in organisational initiatives that menopause experiences can vary by ethnicity, race, cultural or national origin, religion and sexuality as well as with various disabilities, health conditions and neurodiversity. Gottardello and Steffan (2024), for example, discuss the specific problems which neurodiverse staff might face in navigating menopause at work and the need for appropriate support mechanisms including tailored educational resources (Wales TUC Cymru, 2017; BMA, 2020[30]; Carter et al., 2021b; FSSCFSSC, 2021; Riach and Rees, 2022; BSI, 2023[31]; Business in the Community, 2023; CIPD, 2023b; IUF, 2024; Acas, 2024; BSI, 2023; Laker and Rowson, 2024; Westwood, 2024b).[32]

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[29] These people may also be described as "intersex" or as having "differences in sex development (DSD)" (Acas, 2024: 6).

[30] The BMA survey data include a respondent who had gone through early menopause and reported that seeing patients who were pregnant or young children was especially challenging.

[31] The BSI note that gender-neutral language is important in any organisational communication around menopause – such as not describing period products as feminine hygiene products (page 15). They recommend that, where they exist, LGBTQ+ staff networks are consulted on gender-inclusive approaches. See also Women and Equalities Committee (2022: 24).

[32] Also note Wales TUC Cymru's (2017: 12) important observation that transgender women may also experience symptoms which mimic menopause due to ongoing hormone treatment, a point echoed by Westwood (2024b). Wales TUC Cymru add that women who don't have English as a first language

> "may have more difficulties in communicating symptoms or difficulties they are experiencing. They may not describe things in the same way and some words may not have a direct translation from one language to another. This may make it more difficult for women to access medical advice or ask for help or adjustments at work" (page 15).

Similarly FSSCFSSC (2021) data suggest that black women in financial services may find it especially difficult to discuss menopausal symptoms at work because they have so few black colleagues and feel that their performance is always under the microscope as a result. Women of colour described specific difficulties in balancing expectations at work with cultural expectations in their home lives; women with disabilities spoke of symptoms exacerbating these or being difficult to isolate from the effects of their disabilities; and women who lived with other women also thought their menopausal experiences were distinct from those of women who are partnered with men.

Another significant issue is ensuring that whatever employers put in place not only caters for the uniqueness of menopause experiences but also allows for different jobs, settings, tasks and environments across any one organization. Consider, for example, the differences in workplace experience between a member of staff who is employed to do physically demanding work in a warehouse and one who does intellectually taxing work at a computer. The BSI (2023: 4), in a very helpful summary of "how characteristics can influence an employee's experience of menstrual health or menopause", suggest that

> "The level of agility, fear or physicality required by a job (such as manual handling, cleaning, risky activities, health and safety, danger, travel) can compound symptoms in different ways. There can also be expectations on aesthetic presentation: for example, some jobs require smart, customer-focused presentation at all times" (see also Cronin et al., 2021; Riach and Rees, 2022; Faubion et al., 2024; Rowson and Jones, 2025[33]).

On the other hand, resource constraints or the demands of a particular sector - for example, staff shortages or the need for 24-hour care in the NHS – can make some adjustments very difficult to implement in practice as well as meaning that attendance at information, training or support sessions can be difficult (Dean, 2019, 2023; APPGM, 2022; Dennis and Hobson, 2023; Cronin et al., 2024; Hobson and Dennis, 2024; Kowalczyk and Cooke-Mwangeka, 2024). Bourgault (2021), relatedly, alerts us to the challenges created when an intensive care nurse needs to use the toilet frequently against a demand for continuous one-on-one patient care. And Kydd (2021: 1) points out that "hospitals and care homes are required to provide a warm environment for patients and clients".

It is also important that no assumptions are made about someone's menopausal status or that any changes in performance, behaviour, attitude or attendance are

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[33] Consider also Crawford et al.'s (2022: 1586-1587 – see also Wales TUC Cymru, 2017: 16) important point that labour force differentials are racialized – in other words,

> "Asian and white women are more likely than Black and Hispanic women to be employed in management, professional, or related occupations. By contrast, Black and Hispanic women are more likely than Asian and white women to work in lower-wage service industries."

Although this point is made in a US content, it is also the case in the UK. As such, women of certain ethnic origins are more likely to be in jobs where uniforms are required or breaks are limited.

attributable to menopause symptoms (Hardy et al., 2019b). Intrusive questioning should likewise be avoided, as should any minimization of symptoms. As Myhill and Sang (2023: 223-224) point out, such assumptions and questions can in fact constitute harassment under the Equality Act (2010), which has been borne out at employment tribunals (also see Dillard-Wright and Hall, 2022).

Lastly in terms of these preliminaries, the BSI (2023: 13) advise employers to clearly specify senior team responsibilities in terms of introducing menopause support initiatives and, where appropriate, to identify a specific senior leader with overall accountability. The FSSCFSSC (2021) report also recommends that any such initiatives be integrated within EDI and wellbeing provision alike, as the menopause is relevant to both.

The following sub-sections outline the various things which employers can consider introducing, depending on context, organisational culture, staff composite, staff needs and resources. The review groups these mechanisms into four categories.

5.1 POLICIES, PROCESSES AND AWARENESS RAISING

One very frequently indexed approach is to develop menopause policies or guidelines, depending on what best suits the organisational culture. These can include an explanation of why the document is needed in a specific workplace context as well as information about what menopause is, including the range of physical but also psychological symptoms and that these are always unique to the individual. Such documents should always include an emphasis that, for the vast majority of those who go through it, menopause is both normal and natural; and may also not be problematic at all. Other useful additions are risk assessment protocols (for example, so that lifting and manual handling can be avoided where menopausal bone, muscle or joint pain is an issue[34]). Relatedly, such documents can suggest tailored adjustments to support menopausal staff; and checklists could be provided to support the appropriate interventions.

[34] As Acas (2024) point out, risk assessments are legal requirements for UK employers anyway and should be done on a regular basis. Westwood (2024a) makes the same observation; as do the CIPD (2023b) and the Equality and Human Rights Commission (EHRC, 2025). Some of Pryor's (2025: 18) participants also emphasize that "workplace adjustments should be individualised, but that a common approach to requesting them is needed", such as risk assessments or menopause-sensitive performance reviews. The IUF (2024: 19-23) provide a useful example of a generic risk assessment checklist around menopause.

Any policy or set of guidelines should be evidence-based with appropriate references and be "developed in conjunction with unions" (Wales TUC Cymru, 2017: 37[35]) where appropriate. They need to cross-reference and be consistent with other HR documents like those focused on absence and sickness reporting, equality, diversity and inclusion, health and safety, wellbeing and flexible working, violence and harassment; and be regularly evaluated, reviewed and updated as necessary.

Alternatively, these other documents can be altered to encompass the specific needs of menopausal workers. Inclusion passports are also recommended, in other words, "short documents which can help employees and managers record adjustments". These are particularly beneficial when "an employee's role or line management changes [...] as a tool to facilitate continuity" (BSI, 2023: 12 - also see Hardy et al., 2017, 2018c; Wales TUC Cymru, 2017; Banks, 2019; Dean, 2019, 2024; Grohs and Harriss, 2019; Beck et al., 2020; BMA, 2020; Hardy, 2020, 2022a, 2022b; FSSCFSSC, 2021; Carter et al., 2021b; Critchley et al., 2021; New et al., 2021; Noble, 2021; Rees et al., 2021; APPGM, 2022; Cornock, 2022; NHS England, 2022; Verdonk et al., 2022; Women and Equalities Committee, 2022; Adelekan-Kamara et al., 2023; Bupa, 2023; Business in the Community, 2023; CIPD, 2023a; Howe et al., 2023; Steffan and Potoćnik, 2023; Acas, 2024; Faubion et al., 2024; Fitzgerald, 2024; IUF, 2024; Laker and Rowson, 2024; Royal London, 2024; Saal, 2024; Safwan et al., 2024; Pryor, 2025; Quickfall, 2025).

Another well-supported intervention is absence policies which allow staff to choose menopause as a reason for being off but avoid such absences being included in 'trigger points' for performance intervention such as the Bradford Factor. These policies should also encompass time off for medical appointments. Contingency plans should be in place to cover unplanned time off. Approaches like these can ameliorate menopause-related presenteeism, which should always be discouraged (Hardy et al., 2017, 2018c; Kerns, 2017; Wales TUC Cymru, 2017; Banks, 2019; Dean, 2019, 2024; Hardy, 2020, 2022b; Norton and Tremayne, 2020; 50 Plus Choices Employer Taskforce, 2021; Atkinson et al., 2021a; Evandrou et al., 2021; FSSCFSSC, 2021; Prothero et al., 2021; Rees et al., 2021; Fawcett Society, 2022; Kendall-Raynor, 2022; NHS England, 2022; Nordling, 2022; Verdonk et al., 2022; Women and Equalities Committee, 2022; BSI, 2023; Bupa, 2023; Business in the Community, 2023; CIPD, 2023a, b; Fitzgerald and Aldrick, 2023; Goodwin, 2023[36]; Acas, 2024;

[35] Note that Wales TUC Cymru also provide a template menopause policy for adaptation (pages 47-52) as well as a sample menopause risk assessment checklist (pages 58-64).

[36] Goodwin cites a Lensa study of Google search data which suggests that demands for 'menopause leave' rose by 336% between 2022 and 2023.

Faubion et al., 2024; IUF, 2024; James, 2024; Royal London, 2024[37]; Safwan et al., 2024; Schurman and Hadal, 2024; Westwood, 2024a[38]).

The evidence, relatedly, suggests that women don't always realize they are menopausal and may well attribute the symptoms to something else – early onset dementia for example. As such, practical, evidence-based, easy to access menopause advice is also identified as extremely valuable in workplaces. This could include sessions or resources on HRT, mental health, seeing a GP, balancing menopause symptoms and work, exercise and diet and other aspects of lifestyle. Such advice should always describe but not prescribe. FAQs are also a helpful resource. All of this could be provided via apps[39].

An alternative is to direct staff to appropriate external resources like those provided by the British Menopause Society. All advice should be equally accessible to non-office based staff and regularly updated. Studies also point to the value of supporting staff to develop their resilience to navigate menopause more easily at work[40] (Kerns, 2017; Hardy et al., 2018c; Banks, 2019, 2022; Beck et al., 2020; Norton and Tremayne, 2020; Cronin et al., 2021; Evandrou et al., 2021; Prothero et al., 2021; Rees et al., 2021; Van Heijden et al., 2021; APPGM, 2022; Fawcett Society, 2022; Hardy, 2022a, b; Adelekan-Kamara et al., 2023; BSI, 2023; Bupa, 2023; Business in the Community, 2023; Cronin et al., 2023; Schei and Abernethy, 2023; Asiamah et al., 2024a; Faubion et al., 2024; Laker and Rowson, 2024; Royal London, 2024; Safwan et al., 2024; Brewis et al., 2025; Pryor, 2025; Quickfall, 2025).

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[37] Royal London add that employers could offer group income protection insurance as a benefit to protect those who need to take long periods of absence from work.

[38] Note that Westwood quotes the Women and Equalities Select Committee Review and their use of evidence from the Discrimination Law Association which suggests that absence trigger points could lead to employment tribunals based on indirect discrimination due to sex for menopausal women. Westwood goes on to say that the same might be true where environmental factors at work like bad ventilation or inadequate access to cold water or unforgiving uniform or workwear policies exist (pages 111-112).

[39] Schei and Abernethy, for example, describe the Peppy app, which offers "evidence-based menopause content, courses and events run by expert practitioners, as well as one-to-one video and chat-based conversations with menopause nurse practitioners and others such as nutritionists, counsellors and fitness instructors" (2023: 2).

[40] An important caveat here is provided by Rottenberg and Gilchrist (2025). Their analysis of policy documents suggests that these "position individual workers as responsible for self-optimizing their productivity by successfully managing their menopause through informed decisions" (page 11) through the provision of resources like these and the encouragement of open discussion of menopause at work. Their argument is underpinned by the suggestion that women should not be over-responsibilized for any menopause-related challenges at work.

But the evidence establishes that it is not only menopausal staff who should be able to access information of this kind. As such, training and awareness raising, again using evidence-based resources, is recommended for the whole workforce. This can create good practice and cultural change, encouraging open conversations about menopause at work. It should emphasize how variable menopause experiences can be and for which reasons as well as indexing the relevant phases of menopause and physical and psychological symptoms. Information about how symptoms interact with work will also, hopefully, enable affected staff to feel comfortable in disclosing their symptoms. At the same time, this awareness raising should recognize that some people will not want to discuss their menopause at work.

It should also avoid reinforcing negative and stigmatizing stereotypes about menopause – such as by presenting an overly-medicalized perspective – and instead normalize it as a (mainly) natural phase of life. Inaccuracies around when someone might attain menopause or when symptoms start and stop need to be avoided. The evidence also notes that expert external speakers can be ideal for engaging staff in this regard; and that accounts of lived experience are helpful and informative as well. Further, effective training across the board reduces the need for menopausal staff to act as what Pryor (2025) calls 'pathfinders', where they have to educate others about their experiences.

Training should be provided to three main groups, so the evidence argues. First line managers need to be aware of the possible impact of menopause symptoms at work and be able to support affected staff effectively. A key element of this is having sensitive, respectful and empathetic conversations where listening is paramount, body language indicates careful attention and the staff member is able to express how they are being affected. It is also imperative that line managers act on disclosures, suggest ways that the individual could be supported at work and record, provide and review relevant adjustments accordingly[41].

Assurances of confidentiality unless staff agree to their information being passed on are important as well. Line managers should, further, be advised not to give medical advice – staff should be encouraged to talk to a healthcare professional such as their GP instead. They should also be made aware of the relevant legal frameworks – e.g., the Health and Safety at Work Act (1974), the Workplace (Health, Safety and

[41] Dean (2019: 38) offers several examples from *Nursing Standard* survey data where workplace policies were ignored in practice. One respondent reported that "I suffer extreme hot flushes but am told I have to wear a plastic apron which ties up and covers my front and back, leaving me soaked in sweat when doing the drug round".

Welfare) Regulations (1992), the Management of Health and Safety at Work Regulations (1992, 1999)[42] and the Equality Act (2010)[43] [44] – as well as the consequences should these be breached.[45] Alternatively this information about the relevant legislation can be included in menopause policies or guidelines, as described above. Staff also need to feel assured that any adjustments they require will not lead to any form of detriment or penalty; as well as being signposted to any additional internal resources they can use, like an Employee Assistance Programme. Further, line managers can be advised to consult HR, Occupational Health or the health and safety team as appropriate where they need additional guidance.

As part of line manager training, another important message is that menopause experiences are unique to everyone who experiences this phenomenon. As such, one size fits all approach to menopausal staff will be ineffective. As the CIPD (2023b: no page) say, "Don't make assumptions – everyone is different, so take your lead from the individual". Business in the Community (2023) and the Women and Equalities Committee, 2022; also advocate for getting existing staff networks on board with any such training – such as a LGBTQ+ network – or individuals with lived experience to advise on inclusivity and diversity.

However, this does mean recognizing that some staff – for example, transgender men, non-binary people and people with variations in sex characteristics – will

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[42] As Westwood (2024a: 120-121) points out, health and safety law has been indexed in employment tribunals based on menopause, around whether or not risk assessments have been done. However, as she adds, employees cannot use this legislation to make claims against their employers.

[43] Note that the Equality Act imposes additional obligations on public sector employers in the form of the Public Sector Equality Duty. This means that they must pay "due regard to eliminating unlawful discrimination, advancing equality of opportunity and fostering good relations between people who share a 'protected characteristic' and those who do not" (Wales TUC Cymru, 2017: 20).

[44] The EHRC (2025) provide a short video which explains what employers are obliged by law to do around menopause. Another video explains relevant workplace adjustments.

[45] Importantly, Myhill and Sang (2023: 216) cite Scottish Legal analysis which suggests that the number of employment tribunals referencing menopause increased by 300% between 2018 and 2020. The Women and Equalities Committee (2022: 19) also suggest that many more claims are brought but end up being settled and thus aren't reported by the government. And Myhill and Sang (2023) stress that 'gender reassignment', as the Equality Act describes it, is another protected characteristic, so that there are grounds for transgender and non-binary workers to bring tribunal cases based on menopause, although this hasn't happened yet (page 217). And they point out that, although there is a cap on awards for monetary loss due to unfair dismissal at tribunals (currently £115 115 or gross annual pay, whichever amount is lower), there is no such cap on awards when the Equality Act has been breached. Moreover, claimants can ask for compensation for injury to feelings under this Act.

probably find it very difficult to disclose their symptoms as this can mean outing themselves at work (see also Hardy et al., 2017, 2019b; Wales TUC Cymru, 2017; BMA, 2020; Hardy, 2020, 2022b; Carter et al., 2021b; Jack et al., 2021; APPGM, 2022; Bell et al., 2022; Crawford et al., 2022; NHS England, 2022[46]; Women and Equalities Committee, 2022; BSI, 2023; Bupa, 2023; Dean, 2023, 2024; Rodrigo et al., 2023; Steffan and Potoćnik, 2023; Acas, 2024; Fox and Mano, 2024[47]; Fitzgerald, 2024; IUF, 2024; James, 2024; Royal London, 2024; Ryan and Gatrell, 2024; Westwood, 2024a[48], 2024b).

HR professionals also need menopause training, especially so they can apply policies or guidelines themselves and advise others accordingly. And all other staff groups, regardless of age or gender, should likewise be educated to improve their knowledge, awareness, acceptance and ability to support menopausal colleagues. Organisational support for menopausal staff should, relatedly, be clearly signalled at induction (Hardy et al., 2017, 2018b, c, 2019a[49], 2019b; Kerns, 2017; Wales TUC Cymru, 2017; Banks, 2019; Dean, 2019, 2022, 2023, 2024; Grohs and Harriss, 2019; Beck et al., 2020; BMA, 2020; Grandey et al., 2020; Hardy, 2020; Norton and Tremayne, 2020; 50 Plus Choices Employer Taskforce, 2021; Atkinson et al., 2021a;

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[46] Note that NHS England provide a very helpful appendix to their guidance which outlines the menopausal experiences that transgender and non-binary employees and staff with variations in sex characteristics may have, and provides constructive advice to managers accordingly. The BSI (2023: 4) also note that "For trans and non-binary people, the experience of menstruation and/or per/menopausal symptoms can contribute to gender dysphoria".

[47] In Fox and Mano (2024), Joanna Fox describes a series of specific adjustments that she agreed at work to address her menopausal symptoms. These included consideration of a named colleague to cover for her if she experienced a migraine and telling students she had a medical issue which meant she may need to urgently use the bathroom during teaching sessions.

[48] Westwood also makes the very important point that the first successful tribunal case in the UK – *Merchant v British Telecom* in 2012 – won in part because Ms Merchant's line manager had made assumptions about her menopausal experience based on those of his wife and a BT HR adviser (pages 112-113).

[49] Hardy et al. developed and tested a 30 minute online training package for line managers covering why they need to know about menopause, what it is, the effects of symptoms at work, how line managers can support menopausal staff, how to discuss the menopause with staff, action points for next steps and a quiz to evaluate their learning. It also included additional downloadable resources such as an infographic of a guide for managers. In a range of significant results, the participants reported that: their knowledge had increased; they felt less embarrassed and were more confident in discussing menopause at work; and that they intended to raise the topic at work with someone else. The vast majority thought the training was useful and would recommend it to others as well as saying that workplaces should be offering this kind of training. Notably as well, Cronin et al.'s (2024) healthcare survey respondents noted that online training would be useful in their work context as they were often too stretched to attend face to face events.

Carter et al., 2021b; Critchley et al., 2021; FSSCFSSC, 2021; New et al., 2021; Noble, 2021; Prothero et al., 2021; Rees et al., 2021; APPGM, 2022; Bell et al., 2022; Fawcett Society, 2022; Hardy, 2022b; NHS England, 2022; Targett and Beck, 2022; Verdonk et al., 2022; Women and Equalities Committee, 2022; Adelekan-Kamara et al., 2023; BSI, 2023[50]; Bupa, 2023; Business in the Community, 2023; CIPD, 2023a, b; Cronin et al., 2023; Dennis and Hobson, 2023; Howe et al., 2023; Lynn, 2023; Quental et al., 2023; Root, 2023; Steffan and Potoćnik, 2023, 2025; Strober, 2023; Acas, 2024; Faubion et al., 2024; Fitzgerald, 2024; IUF, 2024; Laker and Rowson, 2024; Saal, 2024; Safwan et al., 2024; Schurman and Fadal, 2024; Rowson and Jones, 2025).

Moreover, to ensure the organisational message around menopause remains visible to all staff, regular communications across all relevant channels are recommended, including personal stories and requests for ongoing feedback about interventions. These communications can also include workplace posters where appropriate, which avoid any stigmatizing, trivializing or euphemistic language like 'the change' and instead "is direct, clear and free from negative connotations" (Laker and Rowson, 2024: no page – also see Hardy et al., 2017; Banks, 2019; Beck et al., 2020, 2021[51]; FSSCFSSC, 2021; Noble, 2021; Business in the Community, 2023; CIPD, 2023a; Dean, 2024; Faubion et al., 2024; Saal, 2024; Pryor, 2025).

Also on the subject of processes, performance reviews, promotion processes and overall performance management which account for menopause symptoms where appropriate are recommended. These mechanisms need to be supportive and based on trust as well as providing appropriate and regular feedback. They should allow for extended timelines so any performance dips which might be menopause-related stand out less starkly and set timescales for performance improvement where required which are not punitive (Beck et al., 2021; 50 Plus Choices Employer Taskforce, 2021; Carter et al., 2021b; BSI, 2023; CIPD, 2023b; Acas, 2024).

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[50] The BSI (2023: 22-28) provide an excellent toolkit for both line managers and HR staff, which encompasses guidance on confidential conversations with staff, adjustments which might support them, managing a team where the needs of menopausal staff need to be balanced against those of others around work patterns and risk assessments. They also offer guidance on wider organisational cultural change, which encompasses many of the recommendations listed here (pages 33-36).

[51] Beck et al. (2021) suggest that staff they spoke to at university menopause cafes were unaware of the existence of a menopause policy in their workplace despite the cafes having been launched in conjunction with the policy. Relatedly, 20% of Targett and Beck's (2022) council worker respondents said their employer provided information about the menopause but 85% wanted it. Similarly, only 28.2% knew there was some form of guidance in place; and almost half felt they couldn't discuss menopause at work. This was in a workplace where information was on offer and menopause had been woven into the approach to wellbeing.

Recruitment and selection processes which take account of potential applicants who might be struggling with their menopausal symptoms likewise fall into this category. The BSI (2023: 31-32) provide some key considerations here including around more menopause-friendly job design and job descriptions; advertising; assessing applications; holding interviews; making selection decisions; and inductions. They also advise that anyone involved with recruitment and selection is trained appropriately (also see Women and Equalities Committee, 2022: 21). The 50 Plus Choices Employer Taskforce (2021: 31), on the other hand, recommend "Returner programmes to include and highlight post-menopausal opportunities as well as post-maternity".

Finally in this category, the evidence identifies flexible working arrangements as helpful in supporting many menopausal staff. The right to request such arrangements now of course applies in the UK from the first day of someone's employment. They can include earlier or later start times (perhaps at short notice due to a bad night's sleep) and adjustments to the end of the working day where required. Other patterns might be shorter shifts, a reduction in shift work, more rest time between shifts or a predictable shift pattern.

Equally, working from home can be helpful where this is possible. WFH arrangements need to ensure an appropriately equipped and more conducive environment and avoid creating a sense of isolation from colleagues, reducing access to workplace support mechanisms or exacerbating problems associated with the gendered division of domestic labour. Part-time work and job sharing arrangements can also be used. Guidance and support related to working patterns or on-call working for menopausal staff, or adjustments to these arrangements to allow for symptoms where possible, should likewise be available.

In addition, flexible work arrangements might incorporate changing working hours to avoid very hot times of day where possible, job/task rotation or moving the location where someone works. Employees with menopausal olfactory sensitivity may also need to be relocated to more suitable environments at work. Any of these arrangements could be implemented on an ad hoc, informal basis given that menopause symptoms fluctuate and may persist for some time.

Protected time in some cases can also make sure menopausal staff are able to catch up with tasks where necessary. Certainly women with more autonomy at work are generally said to be able to cope better with their symptoms. Moreover, any

flexible arrangement may only be needed by staff on a temporary basis[52] (Hardy et al., 2017, 2018c, 2019b; Wales TUC Cymru, 2017; Kerns, 2017; Dean, 2019, 2023, 2024; Grohs and Harriss, 2019; BMA, 2020; Brewis, 2020; Grandey et al., 2020; Norton and Tremayne, 2020; 50 Plus Choices Employer Taskforce, 2021; Brown, 2021; Carter et al., 2021b; Critchley et al., 2021; Evandrou et al., 2021; FSSCFSSC, 2021; Noble, 2021; Nursing Management, 2021; Prothero et al., 2021; Rees et al., 2021; Bell et al., 2022; Crawford et al., 2022; Hardy, 2022b; Kendall-Raynor, 2022; NHS England, 2022; Nordling, 2022; Verdonk et al., 2022; Women and Equalities Committee, 2022; Adelekan-Kamara et al., 2023; BSI, 2023; Bupa, 2023[53]; Business in the Community, 2023; CIPD, 2023a, b; Howe et al., 2023; Lynn, 2023; Theis et al., 2023; Acas, 2024; Faubion et al., 2024; Fitzgerald, 2024; Hobson and Dennis, 2024; IUF, 2024; James, 2024; Kowalczyk and Cooke-Mwangeka, 2024; Laker and Rowson, 2024; Royal London, 2024; Safwan et al., 2024; Pryor, 2025; Rowson and Jones, 2025).

5.2 PHYSICAL AND MENTAL HEALTH INITIATIVES

These can include specialized occupational health or Employee Assistance Programme support, a menopause and/or mental health helpline and/or in person or virtual psychological therapy/counselling[54] [55]. Mechanisms in this category might also encompass free access to resources like symptom monitoring or mood or period tracker apps, in person or virtual medical and lifestyle advice from an

[52] This is true more broadly, as Crawford et al. (2022: 1587) point out: "Workplace adjustments for menopausal symptoms are not a forever-or-never proposition". Norton and Tremayne (2020) make the same point.

[53] Bupa also recommend that staff be supported to work wherever makes them feel most comfortable, as for some people home is not a conducive environment, as also pointed out by Brewis (2020).

[54] Cronin et al. (2021: 545) emphasize that "the digital therapeutic marketplace is largely unregulated and there is [a] risk of unethical and commercial vendors taking advantage of market opportunities that may exist". As such, any support of this kind that employers provide via third parties must be "safe and evidence-based".

[55] Note that Hardy et al. (2018b) also report the considerable success of their self-help cognitive behavioural therapy booklet. 88.1% of the women who were assigned to the group using this training said it had been valuable in managing their hot flushes at work in terms of frequency and impact. In the follow up interviews, 52% said it had improved their work life overall – for example, becoming more aware of what might trigger hot flushes at work; breathing through hot flushes; and feeling more confident.

accredited practitioner[56] [57], coaching for well-being including menopause and mid-life MOTs[58].

Other recommendations include private medical insurance, covering the cost of HRT prescriptions or a health or lifestyle cash plan to allow employees to seek specialist support elsewhere. Such a plan could also pay for gym membership, yoga, mindfulness, Pilates or fitness classes or equipment; as well as access to other forms of treatment like physical therapy or specialist support for urinary or pelvic floor problems. Alternatively workplace exercise and mindfulness, meditation and other relaxation programmes and access to sports centres could be introduced (Hickey et al., 2017; Kerns, 2017; Wales TUC Cymru, 2017; Hardy et al., 2018c; Grohs and Harriss, 2019; Beck et al., 2020; BMA, 2020; Norton and Tremayne, 2020; 50 Plus Choices Employer Taskforce, 2021; Atkinson et al., 2021a; Brown, 2021; Cronin et al., 2021; FSSCFSSC, 2021; Noble, 2021; Nursing Management, 2021; Prothero et al., 2021; Rees et al., 2021; Van Heijden et al., 2021; APPGM, 2022; Bell et al., 2022; Dunn, 2022; Kendall-Raynor, 2022; NHS England, 2022; Rymer et al., 2022; Verdonk et al., 2022; Business in the Community, 2023; CIPD, 2023a, b; Cronin et al., 2023; Rodrigo et al., 2023; Strober, 2023; Theis et al., 2023; Willman and King, 2023; Asiamah et al., 2024a, b; Faubion et al., 2024; Kowalczyk and Cooke-Mwangeka, 2024; Royal London, 2024; Saal, 2024; Safwan et al., 2024; Schurman and Fadal, 2024).

5.3 ADJUSTMENTS TO THE WORKPLACE ENVIRONMENT

These include rest areas so menopausal staff can decompress, as well allowances for more frequent breaks if needed. Being able to take time out from work is identified as especially important in warm workplace environments; where staff are

[56] Rymer et al. (2022) introduced a menopause clinic for staff at the hospital where they worked and it was very quickly oversubscribed. It was rated at 8.9/10 for satisfaction. For example, participants commented "I was given a letter to get further support from my GP and action plan should my GP not be willing to help" and "I have suffered for a long, long time and found [I] really needed this help. I am already seeing the difference a couple of weeks later" (page 246).

[57] Willman and King's (2023) survey of serving military personnel identified specific challenges related to deployments changing and with them medical care and serving overseas being particularly difficult as were medical consultations online when in a shared work area. Defence Primary Healthcare services seemed to provide mixed support, with some being very good. However, at times women were prescribed medication for their symptoms (e.g., antidepressants) as opposed to the root cause (i.e., HRT). Equally a lack of knowledge about menopause was identified amongst male and military clinical professionals in DHPC.

[58] Business in the Community have a separate toolkit on developing this sort of provision.

customer/patient/student/client/end user facing; when the work environment is noisy; where workers are affected by menstrual flooding; or when staff need to sit or stand for extended periods. Private rest spaces which can be booked and locked are ideal. Staff may also want to go outside to get fresh air and those who use screens may need more regular breaks as well, Quieter areas to use for work that requires more concentration or where staff are experiencing headaches or fatigue can likewise be useful. Normalizing the use of these facilities also needs to happen to make staff comfortable in taking them up (Hardy et al., 2017, 2018c; Kerns, 2017; Wales TUC Cymru, 2017; Grohs and Harriss, 2019; BMA, 2020; Hardy, 2020, 2022b; FSSCFSSC, 2021[59]; Noble, 2021; Prothero et al., 2021; Bell et al., 2022; Cornock, 2022; Crawford et al., 2022; NHS England, 2022; Nordling, 2022; Verdonk et al., 2022; BSI, 2023; Bupa, 2023; Business in the Community, 2023; CIPD, 2023a, b; Lynn, 2023; Rodrigo et al., 2023; Acas, 2024; Dean, 2024; Faubion et al., 2024; IUF, 2024; Kowalczyk and Cooke-Mwangeka, 2024; Royal London, 2024; Pryor, 2025).

Another environmental adjustment that is very frequently mentioned in the evidence is the ability to control workplace temperature, including appropriate ventilation. This could encompass providing USB, desk or larger fans, (de)humidifiers, ice packs for the wrists, feet and chairs[60]. Wales TUC Cymru (2017: 28) also recommend the use of thermal mapping "to identify hot and cold spots in the workplace and review[ing] office seating plans to be positioned based on suitability and need". They give specific guidance on how to conduct such an exercise on page 45 of their toolkit.

The BSI (2023: 11) suggest that, where hotdesking is in operation, organizations can support menopausal staff by providing information on "where sunshine is strongest at certain times of the day; physical proximity to washrooms, quiet rooms, and where to find warmer or cooler parts of the building". The FSSCFSSC (2021: 42) report on the other hand recommends that staff who are menopausal may benefit from fixed desks in this scenario so fans and so on can remain in situ. Their respondents suggested that asking for this kind of arrangement should be available to all staff, as it may well benefit workers with disabilities and would also reduce any potential embarrassment (also see Hickey et al., 2017; Kerns, 2017; Hardy et al., 2017, 2018c; Dean, 2019, 2023, 2024; Grohs and Harriss, 2019; BMA, 2020; Grandey et al., 2020; Hardy, 2020, 2022b; Norton and Tremayne, 2020; Atkinson et

[59] This report also advocates that organizations "build in breaks between meetings" so staff can use the toilet if they are experiencing flooding or recover from a hot flush (page 41).

[60] Note that Carter et al. (2021b) suggest that the evaporation of sweat after a hot flush may also cause menopausal people to feel uncomfortably cool; and that high levels of air conditioning can discomfort other staff.

al., 2021a; Carter et al., 2021b; Cronin et al., 2021; Evandrou et al., 2021; New et al., 2021; Noble, 2021; Nursing Management, 2021; Prothero et al., 2021; Rees et al., 2021; NHS England, 2022; Nordling, 2022; Verdonk et al., 2022; Bupa, 2023; Business in the Community, 2023; CIPD, 2023a, b; Cronin et al., 2023; Howe et al., 2023; Theis et al., 2023; Acas, 2024; Faubion et al., 2024; James, 2024; IUF, 2024; Kowalczyk and Cooke-Mwangeka, 2024; Laker and Rowson, 2024; Royal London, 2024; Saal, 2024; Safwan et al., 2024; Pryor, 2025).

Relatedly, easy access to cold drinking water appears frequently in the evidence, including for peripatetic workers and especially in warm workplace environments (Hardy et al., 2017, 2018c; Wales TUC Cymru, 2017; Dean, 2019, 2023, 2024; BMA, 2020; Grohs and Harriss, 2019; Norton and Tremayne, 2020; Carter et al., 2021b; Noble, 2021; Nursing Management, 2021; Rees et al., 2021; Bell et al., 2022; Kendall-Raynor, 2022; NHS England, 2022; BSI, 2023; Bupa, 2023; Business in the Community, 2023; CIPD, 2023b; Howe et al., 2023; Rodrigo et al., 2023; Faubion et al., 2024; IUF, 2024; Saal, 2024).

Next is breathable/non-synthetic, layered, loose, differently sized or elasticated/adjustable work uniforms or work wear. The evidence adds that this should be easy to wash, lightweight, dark-coloured and loose (including shoes); and recommends that upholstery is made from dark coloured and breathable fabrics like cotton or bamboo and covers are provided for plastic seating. Adjustments to dress codes such as permission to remove jackets or ties where necessary are also suggested; as is the provision of spare uniforms.

For PPE specifically, the evidence recommends either limits on time for wearing such equipment or guidance and support on working in it where this is unavoidable. It also suggests that organizations ensure PPE is "designed to fit women comfortably and not aggravate menopausal symptoms" (IUF, 2024: 14 – also see Hardy et al., 2017, 2018c, 2019b; Wales TUC Cymru, 2017; Banks, 2019; Dean, 2019, 2022, 2023, 2024; Grohs and Harriss, 2019; Norton and Tremayne, 2020; Atkinson et al., 2021a, 2021b; Critchley et al., 2021; Cronin et al., 2021; FSSCFSSC, 2021; New et al., 2021; Noble, 2021; Nursing Management, 2021; Prothero et al., 2021; Rees et al., 2021; APPGM, 2022; 2022; Cornock, 2022; Crawford et al., 2022; Kendall-Raynor, 2022; NHS England, 2022; BSI, 2023; Bupa, 2023; Business in the Community, 2023; CIPD, 2023b; Lynn, 2023; Theis et al., 2023; IUF, 2024; James, 2024; Safwan et al., 2024).

Relatedly, appropriate, easy to access and (if possible) self-contained toilet facilities for all staff groups are identified as important in the evidence. It also recommends washing and changing facilities with lockers to store clothes, "including when travelling or working in temporary locations [such as community nursing]" (Dean,

2019: 38). Guidance and support should be provided where access to toilets is limited[61]. Shift workers need to be considered here as well; as does providing adequate toilet breaks. Again where possible, gender-neutral toilets as well as men's and women's should be available, all of which contain bins to dispose of period products. Free period products should also ideally be made available in all toilets, and to all staff, and hand sanitizer packs (Hardy et al., 2017, 2018c; Wales TUC Cymru, 2017; BMA, 2020; Grandey et al., 2020; Hardy, 2020, 2022b; Norton and Tremayne, 2020; Carter et al., 2021b; FSSCFSSC, 2021; Noble, 2021; Nursing Management, 2021; Prothero et al., 2021; Rees et al., 2021; APPGM, 2022; Bell et al., 2022; Kendall-Raynor, 2022; NHS England, 2022; BSI, 2023; Business in the Community, 2023; CIPD, 2023b; Dean, 2023, 2024; Howe et al., 2023; Lynn, 2023; Theis et al., 2023; Faubion et al., 2024; IUF, 2024; James, 2024; Saal, 2024).

Other environmental adjustments include access to natural light which includes blinds or curtains to block out very bright sunlight. This also encompasses the capacity to adjust artificial lighting and consideration of whether cool-coloured artificial lighting could be used to reduce heat levels (Wales TUC Cymru, 2017; Nordling, 2022; BSI, 2023; Business in the Community, 2023). Equally, acoustic considerations around reducing noise levels might be useful for some menopausal workers, including the provision of noise-cancelling headphones (BSI, 2023; Business in the Community, 2023). The evidence also recommends ensuring work stations or work demands like lifting, handling or staying still do not exacerbate menopausal joint, bone or muscular pain; and that alternative equipment such as ergonomic chairs is provided where necessary. Further, recording devices for staff whose memory or concentration is affected by menopause can be offered so they can take notes more easily (Hardy et al., 2017; Norton and Tremayne, 2020; Nursing Management, 2021; Kendall-Raynor, 2022; BSI, 2023; Bupa, 2023).

5.4 MENOPAUSE CHAMPIONS, PEER AND ONE TO ONE SUPPORT

Menopause – or health and wellbeing - champions, coaches or advocates can raise awareness, signpost colleagues to information and train others. They can also emphasize that the organization will support staff who are having menopause-related difficulties, monitor risk assessments and encourage cultural change around menopause as a workplace issue. In addition, champions can promote more

[61] Critchley et al. (2021) note that anaesthetists often work alone in operating theatres where this is the case.

positive accounts of menopause as a workplace issue, as well as sharing their own stories and running informal support groups as discussed below. These people need to be properly trained and have protected space in their work time to take such a role on. Senior staff being open about their experiences as well as visibly promoting workplace menopause support has also been identified as valuable (Hardy, 2020, 2022b; Beck et al., 2021; FSSCFSSC, 2021; APPGM, 2022; Fawcett Society, 2022; NHS England, 2022; BSI, 2023; Bupa, 2023; Business in the Community, 2023; Cronin et al., 2023; Acas, 2024; Dean, 2024; Fitzgerald, 2024; Laker and Rowson, 2024; Steffan and Loretto, 2025).

Informal workplace support networks, such as menopause cafes, can be in person, online or a combination of the two. Like ERGs, these can serve as useful sources for consultation and feedback as well as promoting organisational menopause initiatives. Butler (2020) also remarks on how her respondents supported each other as an organic community at work and were better able to cope with their symptoms as a result; as do Grace in Collins et al. (2024) and some of Pryor's (2025) participants. Protected time to attend peer support events[62] is, further, valuable as is resource provision for those who organize them (see also Wales TUC Cymru, 2017; Hardy et al., 2018c; Dean, 2019, 2024; Grohs and Harriss, 2019; 50 Plus Choices Employer Taskforce, 2021; Atkinson et al., 2021a; FSSCFSSC, 2021; Noble, 2021; Prothero et al., 2021; Rees et al., 2021; APPGM, 2022; Fawcett Society, 2022; Hardy, 2022b; NHS England, 2022; Nordling, 2022; Adelekan-Kamara et al., 2023; BSI, 2023; Business in the Community, 2023; Cronin et al., 2023; Steffan and Potoćnik, 2023; Faubion et al., 2024; Hobson and Dennis, 2024; Laker and Rowson, 2024; Royal London, 204; Safwan et al., 2024; Pryor, 2025; Quickfall, 2025).

The evidence also recommends ensuring staff know who they can speak to about any difficulties they are having, for example their line manager, an HR professional, a union representative, a colleague they know well or an occupational health worker. Alternatives should be provided as well so workers are comfortable approaching the relevant person. All points of contact should be appropriately trained and be aware of the importance of confidentiality (Kerns, 2017; Wales TUC

[62] Beck et al. (2021) point out that some staff at their university were compelled to use their lunch breaks to go to menopause cafes on campus, which suggests a lack of understanding on the part of their line managers.

Cymru, 2017; Hardy et al., 2018c, 2019b; Hardy, 2020, 2022b; Norton and Tremayne, 2020; FSSCFSSC, 2021; Noble, 2021; Fawcett Society, 2022; Bupa, 2023; Acas, 2024; IUF, 2024; Royal London, 2024).

Finally in this category, private, confidential and regular one-to-ones between line managers and their staff are recommended. The same is true of line managers checking in more informally if increased absence rates or performance dips are noticed (Dean, 2019, 2024; Nursing Management, 2021; Kendall-Raynor, 2022; NHS England, 2022; BSI, 2023; Bupa, 2023; CIPD, 2023b; Acas, 202463; Asiamah et al., 2024a; Faubion et al., 2024).

The next section considers evidence for the effectiveness of employer initiatives to support menopausal staff. This is, as will become clear, rather limited.

[63] Acas give specific advice on how to approach these conversations (page 5); as do the CIPD (2023b) under the heading "It's good to talk about the menopause" and the EHRC (2025) in another of their short videos.

6. EVIDENCE FOR THE EFFECTIVENESS OF MENOPAUSE INITIATIVES AT WORK

As Faubion et al. (2024: 744-745) assert, the evidence for effectiveness of employer intervention is somewhat lacking in academic research. Their evidence review identified only six studies in this regard, all of which were published from 2018 onwards. As they point out, each is also flawed in terms of participant dropout rate, participants failing to fully comply with the relevant protocol or an absence of random sampling which affects the ability to generalize beyond the study sample. No control groups were used either. All indicated "significant improvements in menopause knowledge and attitudes, but only one study[64] was able to document improvements in work outcomes and menopause symptoms while at work" (page 745).

Dennis and Hobson (2023) conducted their own evidence review, finding twelve studies in total, although these date back further. Their conclusions are very similar and in particular they note "there is currently no published intervention which effectively improves the ability of working menopausal women to improve their performance at work". Dennis and Hobson describe this as "an urgent gap in the existing literature" (page 6). They advocate for "well-designed high-quality RCTs[65]" in this area (page 7).

Howe et al. (2023) note the same evidence gap in their scoping review. Whilst there is information on how menopause interventions were designed, there is – they suggest - much less on why these were deemed necessary and how they were implemented, and even less on their impact. As Howe et al. comment, this "means that knowledge of uptake, implementation, and evaluation of practices is limited, which creates difficulties for informing evidence-based implementation of interventions that may benefit women at work" (page 20).

Rodrigo et al. (2023) undertook a systematic review which identified five studies in the same area. The relevant interventions spanned "self-help [cognitive behavioural

[64] This is Hardy et al. (2018b), who discuss the cognitive behaviour therapy programme which they successfully trialled with menopausal workers.

[65] This abbreviation stands for randomized controlled trials, where participants are assigned randomly to either a group that receives an intervention or a group that doesn't (control/comparator group).

training/CBT[66]], Raja yoga, health promotion (including menopause consultations, work-life coaching, and physical training) and awareness training" (page 105). These report that symptoms were improved by yoga, CBT and health promotion; CBT reduced presenteeism and improved ability to adjust to menopause experiences; and awareness training improved attitudes and knowledge around menopause. As with the Faubion et al. review, however, only the CBT intervention led to better workplace outcomes. Similar deficiencies were noted across studies including failure to account for other factors which may have explained the results, possible subjectivity in self-reports of outcomes, poor participant compliance with the intervention and short durations. Equally, "long-term follow-up data were lacking" (page 105). Also see Verdonk et al. (2022: 489) and Safwan et al. (2024: 4) for a shorter review of the effectiveness of workplace interventions. Notably, and as Verdonk et al. point out, most of the interventions discussed here are aimed at individual women as opposed to being at workplace level.

The next, and final, section of this review identifies the gaps which still exist in the evidence base considered here.

[66] Again, this refers to Hardy et al. (2018b).

7. GAPS IN THE EVIDENCE BASE AROUND MENOPAUSE AS A WORKPLACE ISSUE

Although the evidence base is far larger than it was in 2017, as Verdonk et al. (2022: 491) point out, more research on the bidirectional relationship between menopause and work is still very much needed, especially in the following areas. Again, the gaps which are most commonly identified are dealt with first.

To begin with, and as established in section 6, evaluations of employer initiatives of various kinds around menopause as a workplace issue are lacking, including their impact on work ability, absence, intention to quit and performance, and their cost-effectiveness. It is argued that what Dennis and Hobson (2023: 6) call "the underlying mechanism of improvement" – for example as regards presenteeism, disclosure and openness, wellbeing and women's management of their symptoms, anxiety and depression - needs to be better understood (also see Hardy et al., 2017, 2018a, 2019a; Cronin et al., 2021; Jack et al., 2021; Van Heijden et al., 2021; Bryson et al., 2022; Hardy, 2022b; Verdonk et al., 2022; Faubion et al., 2024; Hobson and Dennis, 2024; Safwan et al., 2024; Pryor, 2025[67]; Rowson and Jones, 2025).

The evidence also identifies a need for more comparative research of various kinds. For example, it suggests comparisons of the experiences of people who work full-time versus part-time are required; as well as establishing a lack of evidence about the menopausal experiences of those in low paid and/or precarious work, like freelancers, gig economy workers and agency workers, and the self-employed. As Yoeli et al. (2021: 20) point out, "[m]enopausal women in casual jobs will likely not benefit from the recommendations, innovations or protections of the 'menopause at work' policies introduced by organisations or trade unions" (see also Atkinson et al., 2021a; Jack et al., 2021; Evandrou et al., 2021; Van Heijden et al., 2021; Riach and Rees, 2022).

Then there is the allied suggestion that research pays too much attention to women in white collar, professional or managerial jobs based in urban contexts where they typically have more autonomy over their working day. In contrast, there is much less evidence about other sorts of jobs, including those where PPE is required for hygiene or safety reasons, where the work is by its nature high risk, where there is understaffing or exposure to chemicals and high levels of noise or jobs which

[67] Pryor specifically advocates for research which assesses hybrid working and its relationship with menopause.

require shiftwork, physically demanding manual work like heavy lifting or specialist equipment (Grandey et al., 2020; Atkinson et al., 2021a; Jack et al., 2021; Kydd, 2021; Sang et al., 2021; Yoeli et al., 2021; Verdonk et al., 2022). It has also been argued that research comparing the experiences of perimenopausal and postmenopausal women at work would be valuable, as well as understanding the experiences of those who do not have symptoms.

Relatedly, there is a general absence of evidence about micro-level differences in menopause experiences at work, like those between cis, heterosexual women and LGBTQ+ workers, women with disabilities[68] and those who go through premature, early or sudden onset menopause due to surgery or medication. Equally, not enough is known about how menopause experiences at work might vary with migration status, whether someone has children or not and religious beliefs (Atkinson et al., 2021a; Jack et al., 2021; Sang et al., 2021; Bryson et al., 2022; Hardy, 2022a; Riach and Rees, 2022; Targett and Beck, 2022; Whiley et al., 2022; Beck et al., 2023; Howe et al., 2023; Quental et al., 2023; James, 2024; Safwan et al., 2024;

[68] As Riach and Rees (2022) point out, there is evidence that: women who have Down's syndrome or type 1 diabetes experience earlier menopause; and those with conditions like migraines, bipolar disorder or rheumatoid arthritis may find that menopause exacerbates them. Women with autism may also find that regulating their emotions and communication become yet harder as does 'masking' their autism. Wales TUC Cymru (2017: 15-16) make the same point about women with autism; as well as noting diabetes and management of blood sugar levels during menopause and pointing out that menopausal symptoms and diabetes symptoms can be difficult to disentangle, including mood swings and temperature changes. They also include arthritis and mental health conditions, as well as multiple sclerosis, chronic fatigue syndrome, fibromyalgia, skin conditions and hyperthyroidism as potentially creating the same kind of confusion. See also Westwood (2024b: 3), and the BSI (2024: 4, 15), who note that ADHD symptoms can be exacerbated by menopause and add that neurodiverse staff can find that sleep problems, cognitive processing and sensory sensitivity are exacerbated by menopause. The CIPD (2023a) survey found that women with disabilities or long term health conditions were, in turn, more negatively affected by menopausal symptoms at work, in particular around being able to do physical tasks and needing to take time off. Gottardello and Steffan's (2024) interviews with neurodiverse workers suggest that their emotional lability and depression worsened during menopause, as did capacity to concentrate, remember things and sleep properly. All of these were pre-existing issues connected to their neurodiversity but were exacerbated by menopause. The respondents also suggested that, because symptoms are often erratic, this impeded the routines they had in place to be able to cope at work. Moreover, "Participants described the additional strain placed on their ability to mask the impact of neurodiversity at work due to the physical and mental fatigue caused by menopausal symptoms" (page 4). They also suggested that positive aspects of their neurodiversity, such as being very creative, were dampened during menopause; and that relationships at work became even harder to navigate. Some reported that they were considering moving to less demanding roles as a result and others had left their jobs altogether.

Gottardello and Steffan, 2024; Westwood, 2024b[69]; Brewis et al., 2025; Pryor, 2025; Rowson and Jones, 2025).

Another frequently identified issue in the evidence base, as noted earlier in this review, is an over-emphasis on the negative side of menopause as a workplace experience. It is also suggested that evidence focuses too much on visible symptoms like hot flushes rather than things like cognitive difficulties and tiredness. Equally, this argument extends to a lack of attention to women's agency or resistance to dominant stereotypes when experiencing menopause; and how we might best address the stereotypical negativity which surrounds menopause, as a workplace issue as elsewhere.

For example, Quental et al. (2023) argue that more positive accounts of menopause are badly needed – such as periods ending, no longer needing to be concerned about getting pregnant, feeling more assertive and wiser and ceasing to be worried about whether others find one attractive. They emphasize different cultural lenses in this respect, such as discourse around a second spring in Chinese medicine; and suggest, as per the biopsychocultural approach, that these have an impact on menopausal experiences (also see Hardy et al., 2018a; Butler, 2020; Hardy, 2022a; Whiley et al., 2022; Beck et al., 2023; Daly et al., 2024; James, 2024; Laker and Rowson, 2024; Ryan and Gatrell, 2024).

Another cluster of evidence gaps focuses on the lack of methodological variety in research in this area to encompass the highly complex connection between menopause and employment. For example, Verdonk et al. (2022: 492) argue for an increase in "mixed method research designs, as well as narrative, ethnographic and participatory action research[70] designs with stakeholders and end users". Evidence about how menopause affects work is also said to over-rely on self-reporting of effects on work performance. Objective testing of symptoms is identified as lacking, for example measuring hormone levels or physiological signs like changes in sweating or how menopausal hormones play a role in allostasis. This is the process which governs how our bodies adapt to their environments and how such

[69] Westwood also points out that these characteristics can intersect with each other to produce further variegation in menopause experiences.

[70] Narrative research tends to focus on the stories that people tell about particular experiences. Ethnographic research on the other hand usually involves some degree of participant observation by the researcher in the phenomenon of interest whereas participatory action research signals a focus on the before, during and after of a change of some kind where those being researched actually become co-researchers to collaborate on identifying research questions, selecting methods and data analysis techniques and analysing the data themselves.

adaptation creates an allostatic burden – or load – in our endocrine, immune and cardiovascular systems. Some evidence is suggestive that allostatic load can create a certain physical toughening in post-menopausal women.

Equally, it is recommended that future research emphasizes "easily assessed, meaningful measures, such as the number of lost work hours, retirement intentions, and levels of presenteeism" (Safwan et al., 2024: 4 – also see Grandey et al., 2020; Dennis and Hobson, 2023; Asiamah et al., 2024a). Elsewhere the lack of longitudinal/prospective research with the same group of participants to better understand whether it is work or menopause symptoms which creates specific challenges is identified. Such research would also, the evidence base suggests, allow an evaluation of specific issues like the connection between early menopause and shift work. This kind of work could, further, explore how experiences vary over time and any factors that might explain this, like a change in occupation. Research might also use control groups for comparison, such as men or younger women; or experimental designs to isolate the relationship between menopause symptoms and outcomes at work (Grandey et al., 2020; Martelli et al., 2021; Van Heijden et al., 2021; Hu et al., 2023; Asiamah et al., 2024a; Pryor, 2025).

Elsewhere the evidence base notes that not enough is known about the perceptions of others at work to "assess beliefs and attributes made about the [menopausal] stage" (Grandey et al., 2020: 26). This should, it is suggested, include evaluations of how best to encourage their understanding of and openness about menopause as a workplace issue, as well as their perspectives on workplace menopause initiatives and, for line managers especially, what might make it easier for them to discuss menopause with their staff when appropriate. It has also been argued that studying how men experience gendered ageing in the workplace would be beneficial; and that the perspectives of HR and occupational health professionals around menopause as a workplace issue are likewise lacking in the evidence base. Daly et al. (2024: 176), further, argue that this kind of research needs to investigate perceptions of workers who are "underrepresented in dominant menopause discourses", like LGBTQ+ employees and black and minority ethnic women (also see Hardy et al., 2017, 2019b; Atkinson et al., 2021b; Hardy, 2022a; Adelekan-Kamara et al., 2023; Brewis et al., 2025).

Other gaps identified in the evidence base include the following:

- Comparisons of the extent to which women who take HRT and those who have opted not to are able to manage their symptoms at work (Grandey et al., 2020; Cronin et al., 2021).

- Connecting work ability, engagement and performance together to assess how these interact over time for menopausal workers (Van Heijden et al., 2021).

- Consideration of a wider range of symptoms and how these interact with work, given "their differential relationship with employment outcomes" (Steffan and Potoćnik, 2023: 1214), and the reverse scenario, where various outcomes are evaluated as to their association with specific symptoms. Equally, Evandrou et al. (2021) suggest we need more data on why women with severe symptoms leave work or reduce their hours in greater numbers than those without (also see Hardy et al., 2018a, 2019b).

- Data on whether physical activity at work needs to reach a certain level to ameliorate menopause symptoms and whether "the duration of sitting bouts and the frequency and duration of breaks from sitting may be influential" (Carter et al., 2025: 5). It is also argued that there is a lack of experimental research involving representative samples to test for a causal relationship between such activity and symptoms per se, with objective symptom measurements and measurements of type of activity rather than frequency (also see Asiamah et al., 2024b).

- Evaluations of the impacts of trade union campaigning, support and advice around menopause at work (Atkinson et al., 2021a).

- Gendered ageism at work in respect to menopause (Verdonk et al., 2023)

- Identity shifts – for example, taking on a leadership position during menopause (Grandey et al., 2020)

- Lack of research on the economic costs of menopause as a workplace issue (Howe et al., 2023).

- Lack of research on 'resource depletion', which compares the involuntary effects of menopausal symptoms like sleeplessness to voluntary sleep loss (e.g., working long hours) on employment (Grandey et al., 2020).

- Line managers' role in supporting menopausal staff via policy implementation is poorly understood (Atkinson et al., 2025).

- Male allyship around menopause at work (Grandey et al., 2020).

- Mid-life complexity, because "menopause at work is part of a wider tapestry of events and concerns, which may include caring responsibilities for children or parents, other health issues, ageing, relationship status and quality of relationship, and financial security" (Jack et al., 2021: 63). More research is therefore needed on mid-life women as the 'sandwich generation': navigating looking after children of whatever age who are still at home and/or elderly relatives and/or grandchildren whilst balancing the demands of work and menopause, all of which may create overload (Ryan and Gatrell, 2024)[71].

- More collaboration between medical researchers and those in work and employment studies (Van Heijden et al., 2021).

- More research on the efficacy of self-help cognitive behavioural therapy programmes at work, including whether these ameliorate menopausal symptoms like fatigue or loss of confidence (Hardy et al., 2018b).

- More research on the effect of women leaders on organisational cultures vis-à-vis menopause; and on how these leaders navigate menopause at work (Grandey et al., 2020; Whiley et al., 2022).

- More research on how women mask or manage the 'concealable stigma' of menopause at work, as well as what enables them to do this – i.e., the coping strategies described earlier. Related gaps include how reappraising menopause or working to challenge stereotypes affects working life. It has also been argued that this sort of research needs to be comparative across different occupations and employment statuses (Van Heijden et al., 2021; Grandey et al., 2020; Yoeli et al., 2021; Hardy, 2022a).

- More research on how prioritizing goals or seeking additional resources to help one cope at work impacts on psychological symptoms, as well as additional investigation of the role of resilience in managing symptoms per se and whether teaching these strategies to working women is beneficial (Steffan and Potoćnik, 2023).

[71] This point about the complexities of mid-life for women especially, which can also mean it is difficult to separate the relevant effects from menopause symptoms, is also made by Wales TUC Cymru (2017), Banks (2019), Norton and Tremayne (2019), Butler (2020); Crawford et al. (2021), Jack et al. (2021), Verdonk et al (2022), BSI (2023), Business in the Community (2023); Bupa (2023), Collins et al. (2024), Ryan and Gatrell (2024), Strober (2024) and Steffan and Loretto (2025).

- The physiology of hot flushes, how these contribute to "the thermal comfort requirements of women" (Carter et al., 2021: no page) and appropriate mitigation at work. A related gap in knowledge concerns the relationship between this symptom, ventilation and temperature at work and the role of workwear and uniforms here (also see Verdonk et al., 2022)

- Punitive sanctions at work due to menopausal symptoms (Beck et al., 2023).

- Unintended effects of workplace menopause initiatives which imply "that women are weak, that work is unhealthy for them, or that they are receiving special treatment" (Grandey et al., 2020: 28).

- Whole-life perspectives on menopause

> "wherein the work-nonwork interface in career development [...] is incorporated, and wherein so-called societal, organisational and psychological concerns related to this interface are dealt with [... This]would also imply that stakeholders surrounding the individual career holder (i.e., their family, friends and peers, supervisor, colleagues and employer) are taken into account" (Van Heijden et al., 2021: 16 – also see Verdonk et al., 2022: 491).

- Working from home and its impact on menopausal staff (Brewis, 2020; Riach and Rees, 2022).

In conclusion, then, this review has established that there is compelling evidence for menopause as a workplace issue as well as for what employers can do to support menopausal staff. However, there is still some way to go to plug the gaps in the evidence base.

APPENDIX 1: METHODOLOGICAL DETAILS FOR EMPIRICAL STUDIES

Adelekan-Kamara et al. (2023): semi-structured interviews with 21 female doctors who had either gone through or were experiencing menopause, 5 non-menopausal female doctors and 14 male doctors, all working in the UK.

Asiamah et al. (2024a): online survey of 154 menopausal clinical NHS staff in England.

Asiamah et al. (2024b): online survey, 324 menopausal working women in England.

Atkinson et al. (2021b, 2025): online survey of 1684 women in three large UK police services, including officers, staff and volunteers. 1197 respondents were either perimenopausal or postmenopausal.

Beck et al. (2020): online survey, 5399 respondents, mostly based in the UK (3.5% based in the US, Canada, Ireland, Australia, Denmark and Germany). 91.6% were women. 43.4% were menopausal, 16.8% post-menopausal and 12.3% weren't sure but thought they might be.

Beck et al. (2021): partly autoethnographic[72] in reflecting on the authors' experiences of collaborating on the launch of a menopause policy in a UK university, also draws on online survey described above.

Bodza et al. (2019): semi-structured interviews with three UK counsellors who had all had menopausal symptoms.

Brewis et al. (2025): interviews with 50 menopausal women, 40 working at a Dutch university and 10 in a UK NHS Trust. The NHS staff were in the main interviewed more than once.

British Medical Association (2020): survey sent to all members, 2 000 respondents. 1860 had experienced menopausal symptoms.

[72] Autoethnography refers to a research method where the researcher writes about their own experiences and connects them to wider social and cultural structures and norms.

Bryson et al. (2022): secondary longitudinal data taken from the UK National Childhood Development Study. This captures data from a sample of all people born in the same week in March 1958 throughout their lives.

Butler (2020): semi-structured interviews (16) and focus groups (2) with 23 women working in administrative jobs in UK local government. One woman was interviewed and took part in a focus group as well.

Carter et al. (2025): online survey, 264 perimenopausal or postmenopausal women based in the UK.

CIPD (2023): survey of 2 000 plus working women in the UK, aged between 40 and 60 who "who are currently employed and could be experiencing menopause transition". This survey also featured "boosted representation around several protected characteristics including race, disability and sexual orientation" (page 5).

Collins et al. (2024): autoethnographic account of one of the authors' (Grace) experience of menopause at work. She worked in the male-dominated financial services sector and had a range of menopausal symptoms following a surgical menopause at 50 but very little organisational support. Grace is a pseudonym.

Cronin et al. (2023): online and face to face focus groups with 48 nurses from England, Denmark, the US, Australia, New Zealand and Finland, all identifying as menopausal and aged 45 and over.

Cronin et al. (2024): case study of a UK healthcare organization, using an online survey (n = 167; 92% female and 8% male; 73% working full-time), a review of 13 menopause documents and seven interviews with managers.

Daly et al. (2024): using an imaginary scenario, respondents were asked to answer questions and finish a story about an employee whose menopausal symptoms were affecting her at work. One version of the story featured a male manager, the other a female manager. 48 people working in a UK education organization took part, most aged between 35 and 54. Most identified as women.

D'Angelo et al. (2023): addition to the longitudinal Health and Employment After Fifty study to survey 409 working female participants across 24 English GP practices about their menopause symptoms.

Dunn (2022): interviews with seven menopausal women who had had workplace coaching.

Evandrou et al. (2021): longitudinal data from the same survey as Bryson et al. They used Waves 8 and 9, where the female respondents (n = 3109) were aged 50 and 55.

Fawcett Society, Standard Chartered and Financial Services Skills Commission (2021): survey of 2 400 plus women and men at various levels in UK financial services, as well as focus groups.

Fawcett Society (2022): Analysis of survey data from a representative sample of 4 014 UK-based women aged between 45 and 55. Data were gathered by Savanta ComRes on behalf of Channel 4 and Finestripe Productions for a 2022 Davina McCall documentary. The Fawcett Society advised on the compilation of the survey questions.

Fox and Mano (2024): duoethnography[73] of gendered health issues in midlife and how these intersect with work in UK higher education.

Gottardello and Steffan (2024): semi-structured interviews with 43 peri- or post-menopausal UK-based workers aged over 40, all of whom were neurodivergent.

Hardy et al. (2017): online survey, article reports qualitative data about menopause as provided by 137/216 female respondents aged 45-60 working for a trade union and professional association in England, Wales and Northern Ireland. All were peri- or postmenopausal.

Hardy et al. (2018a): data reported are from the same online survey as above but capture all 216 female respondents.

Hardy et al. (2018b): 124 UK-based women with frequent and severe hot flushes and night sweats were assigned to either a group which trialled a self-help cognitive behavioural therapy booklet including a relaxation and breathing programme on CD or a control group for 20 weeks. 27 women from the first group were interviewed when the trial ended.

[73] This is how the authors describe their method, which consists of autoethnographies written by each of them.

Hardy et al. (2019a): 98 line managers from three large organizations volunteered to trial a short online menopause awareness training course, with 63.3% evaluating the course immediately after completing it and 62.3% four weeks later.

Hardy et al. (2019b): 15 phone interviews with menopausal women in the UK.

Hobson and Dennis (2024): four online focus groups with 14 menopausal women employed in NHS Wales, aged between 34 and 59.

Laverick et al. (2019): 31 focus groups across 14 UK police services involving 250+ participants from different staff groups. Both men and women took part. Part of a wider study on austerity and change initiatives and how these affected older women in the service.

Naidu-Young et al. (2024): interviews with 7 female leaders in sports in UK higher education.

Nappi et al. (2021): online survey completed by 3460 postmenopausal women in five European countries including the UK (n = 405), Japan and the US. All had experienced or were experiencing significant hot flushes and night sweats.

New et al. (2021): 13 women attending a workshop at the University of Lancaster, UK, aged between 47 and 60, to discuss how comfortable they found their working environment in terms of temperature and what might help. All were either perimenopausal or postmenopausal.

Pore (2022): Peppy survey of 504 UK HR directors.

Prothero et al. (2021): online survey, 522 female paramedics in a single UK ambulance service, 55% of whom were either perimenopausal or postmenopausal.

Pryor (2025): online semi-structured interviews with 11 respondents across four UK universities, all of whom worked in professional services roles and were perimenopausal or recently post-menopausal.

Quickfall (2025): unstructured interviews using a life story approach plus biographical data from an online survey. Respondents were 10 female academics in England, aged between 31 and 60.

Root (2023): qualitative interviews with five working menopausal women in the UK, all of whom were experiencing cognitive symptoms.

Rottenberg and Gilchrist (2025): analysis of five UK policy documents[74] on menopause.

Royal London (2024): survey of 3 000 people across the UK, both men and women.

Rymer et al. (2022): evaluation of the introduction of a virtual menopause clinic for workers at Guy's and St Thomas' Hospital Trust, using a survey which was completed by patients and clinic staff

Sang et al. (2021): qualitative online survey data from 627 higher education participants. 82% were based in the UK, the remainder in Australia, South Africa, North America and the EU. Most were aged between 25 and 45, with 17% being either perimenopausal or postmenopausal. 99% were cis women with 11% "identifying as queer, agender, non-binary or men" (page 5). 95% were academics in a range of roles, the remainder worked in professional services.

Schei and Abernethy (2023): analysis of data from 21 555 users of the Peppy menopause app which they were offered as a free employment benefit. Data supplied as part of these users' registration process. 93.67% were aged between 40 and 60; 93.25% identified as female (others were male, non-binary or gender non-conforming and some preferred not to say). Most were perimenopausal, others weren't sure or were post-menopausal. They all reported more severe symptoms than the wider population.

Smith et al. (2020): online survey, 524 UK-based working women who had self-reported vaginal dryness. 38% were peri- or postmenopausal.

Steffan (2021): 21 interviews with UK-based women, all aged 50 or above, taken from a wider study about bodily ageing.

Steffan and Loretto (2025): 80 semi-structured interviews, using a life-course approach, with UK-based women working in four occupations (finance, self-employment, manufacturing and social care). All aged over 50. Data taken from a larger study about health issues at work.

[74] These are NHS England (2022); the most recent NICE guidelines on menopause; Fawcett Society (2022); Women and Equalities Committee (2022); and the government response to the WEC report.

Steffan and Potoćnik (2023): 21 interviews with UK-based women, all aged 47 or above; combined with two online surveys, one to test the validity of various measures and the other to test hypotheses derived from the interview data (n = 239 and n = 142).

Steffan and Potoćnik (2025): online survey, 685 UK-based women, 59.2% of whom worked full time. 53 were interviewed in a second phase of data collection.

Targett and Beck (2022): online survey of workers at a UK council (n = 189) where a menopause initiative had been introduced via their wellbeing strategy as opposed to in a standalone policy. Most were in mid-life and had experienced menopause, were in perimenopause or thought they might be.

Watkins et al. (2019): email survey of women firefighters, n = 840, based in the UK, Ireland, North America, Australasia and mainland Europe (14 different countries in total).

Whiley et al. (2022): qualitative interviews with six menopausal working women in the UK.

Willman and King (2023): online survey of women aged over 40 serving in the UK armed services who received military healthcare (so excluding reservists), n = 465. 80.9% thought they were perimenopausal.

Women and Equalities Committee (2022): 80 plus written submissions from a variety of sources, survey on menopause at work (n = 2 000 plus) and oral evidence from a range of experts.

APPENDIX 2: REFERENCES

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