A NARRATIVE ASSESSMENT OF THE RESEARCH ON MENOPAUSE, EMPLOYMENT AND HEALTH

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Abstract.
Western women work full-time and retire later. This narrative literature analysis identifies research gaps on menopause, employment, and health. Menopause-work-health research is scarce. Themed results: Menopause and (1) not recognizing; (2) sickness absence and costs; (3) work skills; (4) job features; (5) psychological and cultural factors; (6) health; (7) mental health; and (8) coping and interventions. Menopausal symptoms might hinder employment. Organizations neglect menopause due of taboo. Menopause, work, and health research requires new theoretical and methodological approaches for global workplaces.
Keywords: *Workability, and health throughout menopause.*

Introduction

Western countries employ half women full- and part-time [1–3]. Women are working more and retiring later. As more women over 45 work, menopause is part of their lives. This narrative literature review examines menopausal, work, and health literature to identify study gaps.

Menopause affects most women [4]. Symptoms' prevalence may impact women's jobs. In a big Dutch study, older and highly educated women reported significant work-related fatigue [5]. Menopause may explain the unexplained work-related fatigue differences between older highly educated men and women.

Few studies have clearly connected menopause to employment, such as worse job performance [6–9], and women and employers are uninformed. Women in this life period don't identify their bodily signs or seek for help, and employers don't know how to build a healthy work atmosphere [2].

Menopause and menopausal complaints

This review views menopause as a physiological process and a female-specific life transition [10]. Menopause, perimenopause, and postmenopause end periods. Perimenopause starts 8–10 years before menopause. Menopause happens after 12 months without periods.

Post-menopause

Menopause symptoms, duration, and age vary [11, 12]. Menopause typically lasts five to 10 years and occurs around 51 [3, 13, 14]. Menopausal symptoms are only biomedically recognized physiological symptoms connected to hormone fluctuations that end the menstrual cycle. Estrogen loss in the mid-40s increases heart disease risk. Thus,cardiovascular risk factors cause hypertension in almost 50% of postmenopausal women. Healthy lifestyle influences cholesterol, weight, and diabetes [15, 16]. Perimenopause causes hot flashes, night sweats, and vaginal dryness [17].

Menopause symptoms such sleeplessness, headaches, tiredness, mood swings, and concentration problems resemble stress, hypertension, and burnout [9, 14, 18, 19]. Thus, non-specific issues may be misattributed to menopause and vice versa.

Doctors may mislead women [20].

Menopause as a life phase

Health concerns may influence women's quality of life throughout the 10- to 15-year menopausal transition [21–23]. Women and society value menopause. Ignorance, ageism, and gender ideology impact menopausal views [24]. Cultures see menopause differently. Aging cultures appreciate menopause [25]. How "natural" or important their past menstruation is influences how women perceive their symptoms [26, 27]. Fertile women may struggle to stop being fertile.

Menopause-negative women complained more, according to Ayers et al. [24]. Cause-and-effect is uncertain. After menopause and midlife, women may focus on careers and self-development [26]. Dennerstein et al. observed that life events, routine activities, family life, and career satisfaction impact menopausal mood [28]. Midlife is commonly marked by age-related health issues, having teenage children or empty nesters, grieving the death of parents, or providing informal care, which is still largely done by women [2, 20, 29]. Women, occupational health doctors, and other professionals struggle to distinguish menopause from other life period occurrences.

Complex interconnections

Job and biological factors impact women's lives. Menopause research is difficult [9]. Dillaway recommends holistic menopause treatment [11, 30]. Women, doctors, and academics define menopause largely by chronological age, she reveals. Age- and time-bound characterisations fail. Health care providers and women themselves may restrict menopausal detection and treatment choices, impact women's complaints, and diminish women's confidence in their bodies, which may lead to insecurity, inadequate therapy, or delayed treatment. Research questions:

1. Where are menopause, employment, and health research?
2. What knowledge gaps exist?

Methods

This literature review included several topics using narrative analysis and studies of various complexity and design [31]. From December 2018 to February 2019, we searched PubMed, CINAHL, MEDLINE, and Science Direct for "menopause AND work" MeSH terms. We picked MeSH keywords over the author's key words since database professionals provide superior content identification. Since PubMed has a low search hit rate, we decided to search both MEDLINE (1946) and PubMed (1996). The fourth search step deleted duplicates from this strategy. English was required.

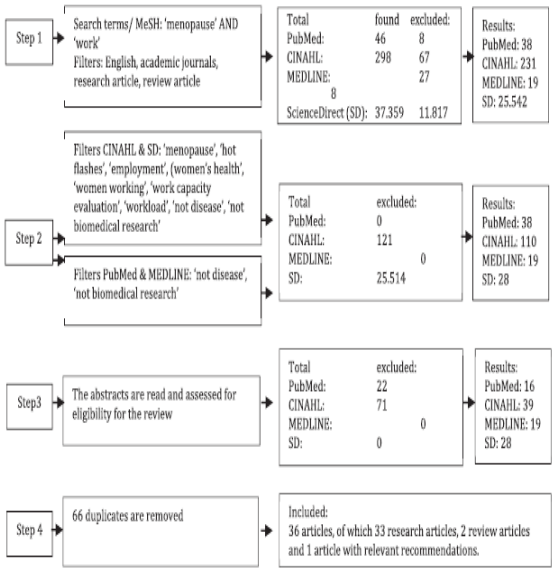

Fig. 1. Flowchart of empirical studies and reviews.

contextualize our findings. Removed medically excluded items (see Fig. 1 Flowchart).

Articles failed. Two researchers evaluated abstracts after deleting duplicates. 36 items were evaluated last (see Appendix).

Researchers read chosen articles. Comparing themes. 27 papers supplemented these 36 to contextualize and understand our findings. Snowballing and article references produced more contextualizing articles. These studies mostly ignored menopause and work.

Results

Not recognizing menopause

Women and employers get little menopausal and occupational health education [25, 32]. Fenton and Panay say this surpasses pregnancy leave [33]. Women value menopause and workplace taboos. Career effects of menopause are seldom discussed [8, 25]. High-ranking women shun menopause [2, 33]. Hammam et al. discovered that postmenopausal women with poor physical working conditions no ventilation, rigid hours, no opportunity to change tasks or jobs had greater health problems [34]. Supervisors seldom stated this. Hardy et al. showed that an open culture and a supervisor with basic menopausal awareness facilitated menopause and work conversation, while male supervisors, male dominance in the workplace, stigmatization, fear, prejudice, and shame were obstacles [35]. Communication needed comprehension, problem-solving, and humor, yet being taken seriously was difficult. Education and training may reduce menopausal symptoms [36].

Menopause and sickness absence and costs

Few research examined menopause, absenteeism, productivity loss, and expenses. According to Geukes et al., three quarters of symptomatic menopausal Dutch women seeking professional care for health concerns are at risk for illness absence and perhaps early labor market departure [1]. Menopause is linked to poorer job productivity, short-term sick absence, and higher employer and health care expenses [23, 37–39]. Insomnia and sadness in menopausal women caused productivity loss and greater expenses [40, 41]. Perhaps not all women state the "true" reasons for sick leave or time off [8]. Evidence is inconclusive. Menopausal status did not affect job performance, illness absence, or turnover intention in Hardy et al electronic's survey [42].

Menopause and work ability

High and Marcellino showed that menopausal symptoms, notably irritability and mood swings, adversely harmed older female employees' job performance, but less so for managers [43]. In their early studies, Ilmarinen et al. and Tuomi et al. created the "Job Ability Index" (WAI) to examine job demands and worker health and resources [44–46]. Older employees should balance physical and mental job demands and examine menopause's impact on work performance. Geukes et al. recently examined healthy working women, typical of the Dutch female population, and found that physical and psychological menopausal symptoms were related with poorer job capability and more sickness absence [7]. The ladies had modest vasomotor symptoms (VMS) that did not influence their work performance (see also [47]). VMS topped work-related difficulties [6]. Jack et al. found that menopausal problems affected women's willingness to work and increased turnover or intention to quit [32]. In another study, women specifically related menopausal symptoms to job performance. Worked harder to hide health difficulties [8]. Recently, Geukes et al. reported that women with substantial menopausal complaints (VMS, somatic, and psychological symptoms) are eight times

more likely to have employment impairment [1].

Menopause and job characteristics

Work improves women's self-esteem, health, and mental health [1, 14, 48]. Since "raising children" is virtually done, midlife women may work and develop themselves [3]. Job autonomy and support affect health. Bariola et al. found supervisor support, full-time employment, workplace temperature control, and autonomy improved symptoms [49].

Women's occupational characteristics are linked to cardiovascular disease, sleeping problems, VMS, and depression [14, 50–52]. In a Lithuanian case-control study of women with myocardial infarction, Malinauskiene and Tamosiunas (2010) studied menopause, cardiovascular risk, and work [53]. Controlled for socioeconomic position, menopausal women with little work autonomy had the highest cardiovascular risk, while those in the second and third quartile had a step climb. Evolahti et al. found that psychosocial job aspects and menopausal women's cholesterol were positively correlated with work autonomy [54]. These results need rethinking menopause's implications on employment, performance, and sickness.

Menopause and psychosocial and culturalfactors

Menopausal symptoms may cause anxiety, tension, and embarrassment, according to Sarrel [9]. Hot flushes may impair self-confidence, especially for women in demanding jobs [8, 33, 55]. VMS, overweight, financial instability, married status, and informal care chores affect vocational capacity and well-being, according to Gar-toulla and colleagues [6]. Griffiths et al. say hiding menopausal complaints may be stressful [8]. Stress worsens menopause [9]. Menopausal women overestimate others' hot flash responses [56]. Health issues, emotions, activity, temperature, etc. caused menopausal women's hot flashes and perspiration. Study women's menopausal attitudes. Jack et al. found three time-related motifs among Australian university women [57]. First, some women perceived menopause as a "period of time"—a time for reflection, a second opportunity, new objectives, or putting their career in "its place" and putting themselves first. Second, some women called menopause a "spiral" because their bodily experiences were not in sync with time, as required by the organization: unpredictable hot flashes or severe menstruations that require frequent toilet visits cause confusion and discomfort during travels, meetings, and education activities planned months in advance. Third, moms, workers, supervisors, and the organization formed menopausal ties. Women's menopausal silence turned into vocalization. The ladies discussed their moms and working till retirement.

Work and menopause

Menopause and health issues like depression and VMS [22] or sleeping problems [58] that impair women's job are investigated. Malinauskiene and Tamosiunas evaluated menopausal and cardiovascular risk in working Lithuanian women [53]. Smoking, drinking, and mental health affect menopausal women's cardiovascular risk. Depression, insomnia, and night sweats are unknown [14, 52]. Worsley et al. examined the relationship between moderate to severe VMS and moderate to severe depression using Gartoulla et al. data [6, 59]. Moderate to severe VMS independently predicted depressive symptoms after adjusting for age, BMI, relationship status, education, job, informal care, financial and housing conditions, and hormone supplementation

(HST).

Woods and Mitchell performed one of the few longitudinal studies on women's work and social interference over 18 years in connection to age, menopausal status, stress, cortisol levels, self-reported health, and menopausal symptoms such hot flashes, sleeping difficulties, depression, and memory loss [19]. To assess job and relationship impacts, menstrual calendars, yearly health reports, morning pee samples, and diaries were examined. Self-reported health reduces work-related menopausal symptoms [19]. Self-reported stress differs from cortisol. Concentration and depression affect work and relationships independent of health and stress. Depression and inattention harmed job and social life. Researchers say menopause doesn't affect everyday living.

Menopause and mental health: stress, fatigue, and burnout

In their longitudinal study, Mishra and Kuh discovered that work stress is a key risk factor for worse quality of life in menopausal women [21]. Workplace stress was linked to cognitive performance in Polish peri- and post-menopausal female intellectual professionals [60]. Work social relationships, lack of support, and job complexity induced stress. Postmenopausal women had negative correlations between most cognitive functions, stress intensity, and stress-inducing factors.

Matsuzaki et al. evaluated menopausal symptoms and work stress in 45–60-year-old Japanese nurses [61]. Fatigue, irritability, and focus plagued most nurses. Managers sobbed. Overwork strained them. Functional levels and vocations help.

Verdonk et al. evaluated Dutch employees' post-work recovery requirements and variables. Highly educated women aged 50–64 needed rehabilitation due to excessive job demands, low autonomy, and poor self-reported health [5]. Burnout may result from work-related stress or fatigue [20]. Burnout, like menopause, may cause weariness, insomnia, cognitive disorders including attention and memory loss, rumination, and emotional issues like rage and instability. High job expectations and work-related challenges cause long-term fatigue. Chronic fatigue may cause major health problems. Women and clinicians confuse menopause with tiredness, postponing health care [11].

Menopause and coping and interventions

Individual coping strategies

Individual coping techniques are described [2, 8, 33]. Sleeping problems and fatigue are hard to address. Heat flashes may be alleviated by layering or bringing a mini-fan. Women may use restrooms and windows. Double-checking and to-do lists may assist focus and forgetfulness. Changing tasks or schedules is mentioned. Lifestyle-based coping includes diet, exercise, and more sleep [2, 8, 33].

Women seldom joke about menopause [8]. Some women compensate for menopausal symptoms by working more, taking sick leave or vacations without explanation, or adjusting hours [2, 33]. Thus, complaint-handling techniques outnumber workplace adaptation and openness strategies.

Women-focused interventions

Contraindications and unknown health effects make HST contentious [62–66]. Diet and non-hormonal medication are becoming more popular for VMS and depression [67]. Cognitive and behavioral therapy and mindfulness-based treatment treat menopause-related health concerns, including depression [68, 69]. Few studies relate therapy to women's employment.

Hunter et al. published a 2016 randomized controlled trial strategy for a cognitive

behavioural therapy-based menopausal self-help intervention [70]. They expected VMS and night sweats would reduce sickness absence, presenteeism, work stress, turn over intention, job satisfaction, and productivity. Psychoeducation, relaxation, breathing, cognitive, and other programs lasted four weeks. Hardy et al. observed that cognitive behavioral therapy improved VMS, night sweats, job performance, and presenteeism [71].

Retrospective cohort investigation by Geukes et al. assessed working women's job performance with severe menopausal symptoms [72]. Menopause clinic first-timers were observed for 3–9 months. First, patients had a 60-minute intake with a professional nurse about menopausal symptoms and lifestyle, a consultation with a gynaecologist to help with treatment decisions, and a short follow-up. Nurse returned after 3–9 months. After follow-up, all women complained less and performed better. Rutanen et al. evaluated Finnish women's work performance and physical activity [73]. After six months of aerobics training, the women reported greater mental health and lower physical demands than the control group, but no WAI improvements.

Ariyoshi surveyed and studied Japanese media company female journalists, administrators, and salespeople [74]. Three case studies, nurse consultation data, and menopause-related unwell days were evaluated. It decreased menopause-related sick leave and turnover. A professional nurse and human resource management can create and administer customized menopausal therapy for working women, according to the study.

Interventions aimed at the workplace

The British UNISON (The Public Service Union) manual says menopause is too often considered as a private affair rather than a public health issue [75]. UNISON recommends employers to realize menopausal women may need additional aid at work [75]. Griffiths et al. recommend addressing four issues: supervisor understanding that menopause may cause work problems, flexible scheduling, information and resource availability, and workplace temperature and ventilation [8, 76]. Supervisor awareness training [33]. They suggest a positive mentality and company culture make menopause discussions comfortable. Confidential counselors, preferably female colleagues with competence, are needed since women feel uncomfortable addressing these issues with their (male) supervisor [2]. These authors propose flexible sick leave for menopausal issues but warn against its risks. When menopausal symptoms arise, taking extra breaks or departing early may improve a menopause-friendly workplace [33].

Hickey et al. studied the Menopause Rating Scale (MRC) with work performance, error frequency, autonomy, and turnover intention [14]. Support was offered to symptomatic women. Participants chose temperature control, flexible hours, healthy aging lectures, flexible work spaces, exercise programs, and table fans. Healthy ageing and menopausal-friendly workplaces benefit organizations. Risk inventories and assessments should incorporate menopause-related needs. Situational factors and work situations may aggravate menopausal symptoms [8, 13, 42]. Hardy et al. analyzed women's employer perceptions [13]. Due to a lack of knowledge, awareness, and organizational norms, several women found menopause in the job difficult. Organizational strategies for women in this time are favorable, according to studies [2,

13, 14, 76–78]. Hardy et al. studied menopausal communication [79]. In their research, supervisors of three big British firms (one public and two private) got a 30-minute online training to promote awareness, understanding, and attitudes regarding menopause and improve their communication skills with staff. Most learners suggest the program to colleagues.

Discussion

State of the art

Menopause and employment are seldom studied [4, 77]. Our initial cautious conclusions are that (a) menopause may reduce women's work ability in this life stage, but evidence is inconclusive; (b) menopausal complaints may explain older women's higher sickness absence rates; (c) women with menopause complaints continue to work (presenteeism); and (d) women remain silent about their complaints (taboo) and seek individual solutions to cope with work.

Menopausal women may struggle to work [1]. Reduced employment capability causes sickness absenteeism, turnover, and other health issues. Poor working conditions, such as a lack of professional autonomy or workplace control, increase menopausal symptoms [42, 49]. Healthy lifestyle changes help women manage menopausal symptoms at work (working more hours to make up for lower productivity). Self-help and supervisor-education may work. Women and managers like them [8, 71]. Due to taboos and ignorance, women, health care professionals, and employers seldom discuss menopause at work [35, 79].

Workplace menopause policies are seldom discussed. It's simple to connect women's workplace health difficulties to menopause's taboo. Menopause is more personal than societal or corporate. Since women rarely receive workplace interventions or professional support, the lack of understanding about menopause, employment, and health directly impacts their health and labor market position. Women's individual solutions may (and do) decrease work well-being and lead to exiting the labor market [40]. Midlife and elderly women rely on work. Work empowers, fulfills, develops, and heals [80]. Menopausal research and organizational policy are few, suggesting older women's job and health are less important. Working women in this life period are resilient, but job intensity, an aging workforce, and labor market shortages challenge them. Women's employment, retirement, and society depend on good health. Menopause and employment need research and policy.

Knowledge gaps and directions for new research

This literature research showed knowledge gaps. First, we must understand why research and organizations consistently ignore a topic that impacts almost all working women. Menopause, reproductive health, breast cancer, endometriosis, and intimate partner violence are public health issues [81]. Women's health advocates have pushed for gender bias in medical research and education for decades [81]. We found epistemic inequalities in organizational and health research. Women study perpetuates the menopause taboo, which values youth over midlife, intellect over body, and output over reflection [82].

Second, menopause must be studied in relation to: temperature, ventilation, nightshifts, chemical exposure, and heavy lifting, and (b) health issues later in life. To help women attain their full potential, we need to understand how psychosocial working circumstances like dealing with

menopausal symptoms at work, workplace expectations, job autonomy, and social support are connected to subsequent health difficulties like cardiovascular disease. We must understand how to build businesses that sustainably employ women in this life cycle, particularly those with severe menopausal symptoms.

Third, we need cross-cultural menopause-work studies. Most studies include women in education, health care, or administration, reflecting labor sector gender segregation [80]. However, "female-typed" and "minority" sectors like the military, police, and industry require study on women's health and menopause [83]. Minority status may complicate menopause and health issues. Gnudi et al. study retired women's lower back pain and lifetime physical employment demands [84]. The study was omitted because menopause indirectly influences work-health interactions. However, the writers addressed women's jobs in farming, ceramics and glass, paper, and steel that demand heavy lifting, pushing, and hauling. Only Ilmarinen et al. related menopause to a career [44]. Ariyoshi and Cau-research Bareille's on female kindergarten teachers' early retirement tried to correlate menopause to work [74, 85]. Small studies. Chau et al. researched night shifts and reproductive health in Cinahl, Med-Line, and other databases [86]. They discovered 20 pregnancy, fertility, and menstrual cycle publications but none on menopause or work. We agree with their need to critically evaluate labor market demographics and labor shortage research priorities. Women with breast cancer working nights have been investigated [87]. Hot flashes and uniforms, adverse stereotypes that hamper women's functioning and exclusion of women in "typical male" circumstances, or sexism and ageism against working women during menopause might be studied. Comparative intercultural studies also lack. Kaufert noted in 1996 that menopausal research outside of the US and Europe use similar methodological study designs, even if their cultural, economic, and social circumstances, particularly the status of aging women, are quite different [34, 88, 89]. White, middle-class, urban, healthy women dominate knowledge. Multicultural communities need research and advice.

Fourth, there is a need for innovative method- rationales. GCS, WAI, and MEN-QOL were used in most menopausal studies. Work and menopause are intertwined, thus we need complicated research techniques. Job-menopause research is tough. Researchers struggle to identify menopause and menopausal difficulties as life phases and relate them to other health conditions since they are dynamic objectives. These difficulties show menopause's multiple levels, requiring greater scientific and theoretical research. Jack et al. advocate feminist research [57]. Their research goes beyond endocrinology (hormone fluctuations) and psychology to study menopause (coping and self-management techniques). Menopause and work need transdisciplinary, intersectional research [e.g. 81]. Thus, we suggest using existing scales and instruments, mixed-method research designs, narrative, ethnographic, and participatory action research designs with stakeholder and end-user methods [90]. Participatory research may map several perspectives and encourage discussions between employers, employees, and other stakeholders on experiences, difficulties, and support, such as HR policy [91]. Our practice instructions should be followed carefully

due to various open ends. Our literature review suggests that occupational health professionals, including physicians, develop guidelines for menopause and work; organizations map health problems, job characteristics, and sickness absenteeism in relation to female-specific life stages; and employers, employees, and the public develop a broad awareness-raising program about menopause at work.

Strengths and limitations to the study

Few studies restrict the review. To enhance our results, we added numerous quality research. Quotes may generalize and exaggerate scientific findings. Western studies employ self-report measures like the WAI, which may not be valid for menopausal women or cross-culturally. Studies only demonstrate that VSM, sleeping troubles, stress, anxiety, and humiliation may severely effect women's work performance and well-being. Menopause and age-related work perks are ignored. These instruments may misrepresent women's experiences. Other research may illuminate women's embodied experiences at this point.

Conclusion

Our menopause-job-health literature review is unusual [77]. Even though there are more studies on menopause, health, and work, the epistemic gap continues. Despite our critical perspective, this review's pioneering research inspires additional research. Working women today are resilient but stressed. Health benefits women, labor, and society. Menopause and employment need research and policy.

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