

Advancing Menopause and Menstrual health in Organisations (AMMInO):

A National Study of Employees
in Health and Social Care



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Disclaimer: This report is the result of research undertaken in collaboration with the Scottish Government's Women's Health Plan and NHS Scotland. The research team did not receive any funding from either part to maintain research integrity and independence. The report is not intended to provide exhaustive coverage of menstrual health and menopause at work. While care has been taken to ensure the information contained herein is accurate, we do not accept any liability for any loss arising from reliance on the information, or from any error or omission, in the report. We do not endorse any company or activity referred to in the report and do not accept responsibility for any losses suffered in connection with any company or its activities.

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The Adam Smith Business School, University of Glasgow.

The Adam Smith Business School is the Business School of The University of Glasgow, which was recently ranked 13th globally in the Times Higher Education (THE) World Impact Rankings 2023. Adam Smith Business School is ranked first in Scotland in the most recent National Research Excellence exercise (REF 2021).

The Women's Health Plan.

The Women's Health Plan was published by the Scottish Government in August 2021. The Plan sets out actions which aim to address women's health inequalities by raising awareness around women's health, improving access to health care for women across their lives, and reducing inequalities in health outcomes for women and girls.

NHS Scotland:

The National Health Service, which began in 1948, is the UK's public health system that provides healthcare for a vast majority of the population. NHS Scotland has an annual expenditure of £15.4bn¹ and employs over 180,000 staff across 14 health boards, making it one of the key employers in Scotland.

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¹ <https://publichealthscotland.scot/publications/scottish-health-service-costs/scottish-health-service-costs-high-level-costs-summary-2021-to-2022/>

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Executive Summary

This study seeks to understand the needs of women and people who menstruate who work in the National Health Service (NHS) in Scotland, a critical provider of publicly funded health and social services. Most employees can continue to work through menstruation or menopausal transition without having a disruptive impact on their jobs. However, for those that do have menstrual and menopausal health experiences that have some kind of impact on their working lives, cultural, structural or institutional conditions can negatively impact and exacerbate these experiences.

In 2022, a University of Glasgow research team conducted a survey of over 6,000 employees in NHS Scotland. Respondents worked across a wide range of clinical, administrative, and offsite occupations. It is one of the first studies in the world to undertake high quality independent research across a large population to (i) capture the experience of both menstrual and menopausal health at work, and (ii) generate evidence-based recommendations around best practice based on employees lived experiences.

The survey explored employees' lived experience of menstrual health and menopause at work, including the structural and social factors that supported or impacted their productivity, engagement and experience of the workplace. It also considered organisational factors surrounding reproductive health at work in terms of having implications for the ongoing sustainability of the healthcare workforce, namely around turnover intent both at the organisational-level (i.e., intention to leave their occupations or the NHS) and at the market level (i.e., intention to leave the workforce entirely).

The results from this study revealed the following:

- ***Instances of misdiagnosis, underdiagnosis and late diagnosis remained an ongoing challenge and have an influence on women's careers and capacity to work.***

This has implications for how employees were able to negotiate their work, including the day-to-day navigation of bureaucratic systems for leave entitlements. It can also have more serious consequences for ongoing career development, such as the deferral of promotion opportunities. Negative health encounters may also contribute to employee's reticence to seek formal accommodations in work for fear of being labelled 'problematic' or without sufficient evidence to support their health experiences.

- ***Employees were creative and resilient in how to work through pain, and were often able to manage any disruption due to menstrual or menopausal experiences through 'micro-accommodations', particularly when supported by colleagues and line managers.***

Despite having a spectrum of symptoms, employees often emphasised that they recognised the limitations and 'fixed' nature of their jobs, such as working on site or for long periods of patient interaction. They also approached inadequate facilities and time pressures with a pragmatic attitude and often leveraged their immediate work environs and relationships to help offset menopause and menstrual symptoms and buffer structural challenges. This included: swapping tasks with a colleague during periods of intense symptom activity; taking 'microbreaks', splitting their allocated break time into smaller increments; and creatively used existing spaces as respite areas (such as toilet cubicles or their cars). While the innovative and resilient nature of employees is laudable, these actions may have long-term consequences for employees' personal lives and health trajectories.

- **Organisational culture played a significant role in employees' experiences of reproductive health at work.**

Menstrual and menopausal suppression at work was a key feature of many employees' working lives. Open discussions about the full range of reproductive health experiences was more common for menopause than menstrual health and menstruation but still many employees reported feeling uncomfortable discussing their experiences and need for even minor or temporary accommodations. Underlying this was the perception that managerial staff were already under pressure in terms of limited resources and would not be supportive or enforce an onerous burden of proof for minor accommodations, even for small amounts of time, such as a half day of leave. Additional challenges were encountered when employees experienced menopausal transition or menstrual symptoms alongside a disability or other health conditions.

Culture also facilitated the presentation of 'secondary symptoms' of menstrual health and menopause in the form of ongoing suppression and stigma. For employees discussing menstruation at work, shame was also a poignant feature of their responses, with many discussing incidences causing them embarrassment around their menses or being hyper vigilant around 'leakage freakage' where blood might appear on clothes or furniture while at work. For employees experiencing menopausal transition, indirect problematisation was also a feature of their working lives, where constructive attempts to support menopause were contradicted or undermined by other policies or practices.

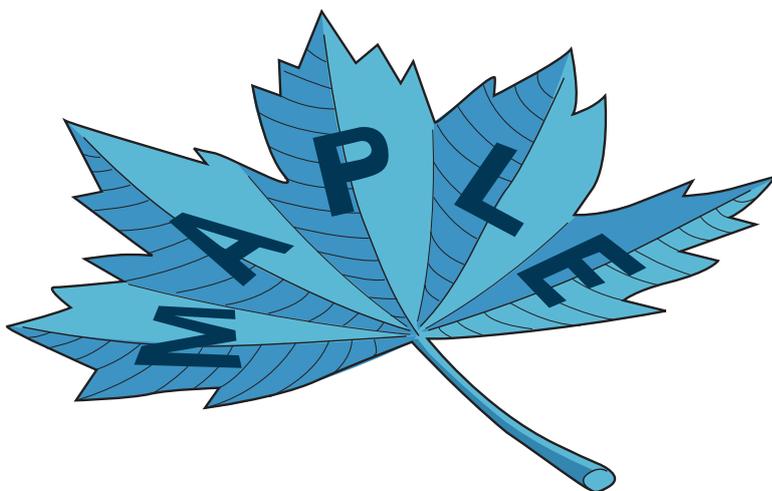
The report makes several recommendations:

In relation to menstrual health, it proposes the MAPLE framework for period positive workplaces: (**M**icroleave, **A**llyship, **P**hysical environment, **L**ine Management, and **E**ducation and awareness).

For menopausal transition, practical recommendations include: line managers who are supportive and themselves supported in providing solutions; a consideration of processes around disclosure and evidence; education and awareness; and agile and temporary changes that enable short-term adaptation while symptoms change as employee move through menopausal transition.

Other recommendations include:

- Engage with cultural un/learnings across the organisation and with key stakeholders surrounding menstruation and menopause.
- Provide structural mechanisms that facilitate best practice and timely support in the workplace.
- Commit to embedding best practice as an ongoing endeavour.



MAPLE (Microleave, Allyship, Physical environment, Line Management, and Education and awareness)

A: Introduction

A1. Background to the study: Women's Health, Women's Lives, Women's Work

Inclusive workforces, where employees feel valued and important throughout the life course, are vital for a sustainable and thriving economy, and for a healthy and well resourced healthcare system

Allowing everybody to have long, enjoyable and productive working lives means recognising every body at work. As organisations move beyond gender parity towards equality², reproductive health is increasingly recognised as a timely and important workplace issue. Understanding and proactively supporting women and employees who menstruate not only helps to recruit and retain workforces, but is central to people achieving a fuller, longer working life.

A majority of employees are able to work while menstruating and transitioning through the menopause. Yet we know little about the quality of their experiences and if they are working in a setting that is meaningfully supportive and contributes to their engagement in work over their career.

This represents a critical gap in our knowledge given the central role of women and those who menstruate to the overall workforce and economy, particularly in the context of skills gaps and the cost of living crisis.

Ensuring that women can fully engage in the workforce throughout their life course is also fundamental to securing their long-term financial and economic security, particularly given evidence that points to women's financial vulnerability in mid to later life.

At the same time, a vast body of research has shown that women face particular challenges in the workplace and are disproportionately affected by broader market-level changes, such as COVID-19³, and gendered ageism, which can contribute to underemployment, uneven career trajectories⁴ and psychologically unsafe work environments. Increasing work intensification, resource pressures and the decrease in state provision surrounding care has also historically compromised women's ability and choice to meaningfully participate in the formal labour force while disproportionately shouldering domestic and unpaid caring responsibilities⁵.

Socially, women are further subject to negative cultural narratives and expectations around their roles, responsibilities, and positions in workplaces. Research into UK workplaces⁶ revealed that women are perceived by their employers as 'never the right age', jostled between being (i) too young – and thus immature or not confident in their work or capacities, or likely to take maternity leave (ii) too middle aged – eschewing career development for caring responsibilities, and (iii) too old – and thus disagreeable, intransigent and viewed as 'lacking' in the leadership qualities that favour male stereotypes. Against the background of these stereotypical perceptions, and for many individuals experiencing symptoms and pain connected with their reproductive health, the status quo produced by age-based gender inequality represents a challenging environment in which to work.

² Parity is a statistical measurement of male-female ratios. Equality draws on a number of measures in order to identify and address features of economic life and social dynamics that disproportionately impact women.

³ Queisser, M. (2021). COVID-19 and OECD labour markets: What impact on gender gaps?. *Intereconomics*, 56(5), 249-253.

⁴ Worts, D., Corna, L., Sacker, A., McMunn, A., & McDonough, P. (2016). Understanding older adults' labour market trajectories: A comparative gendered life course perspective. *Longitudinal and Life Course Studies*, 7(4), 347-367.

⁵ Charmes, J. (2019). *The Unpaid Care Work and the Labour Market: An analysis of time use data based on the latest World Compilation of Time-use Surveys* (pp. 161-p). Geneva: ILO.

⁶ Duncan, C., & Loretto, W. (2004). Never the right age? Gender and age based discrimination in employment. *Gender, Work & Organization*, 11(1), 95-115. (see also Imi, S. (2009). Cranky old women? Irritation, resistance and gendering practices in work organizations. *Gender, Work & Organization*, 16(6), 667-683.)

Safeguarding women’s participation in the workplace is particularly important in the context of this study of healthcare workers. As custodians of public health and wellbeing, NHS Scotland is primarily made up of a middle-aged, female-identifying workforce, with the median age of female employees being 44. Nearly 80% of its employees are women, meaning that more than 10% of all women employed in Scotland work for the NHS⁷.

This mirrors the demographics of health and social care sectors across the Global North (World Health Organisation, 2019⁸) where women shoulder the bulk of professional and personal caring, often at the expense of their own health and financial security.

A2. Study objectives

In conducting the AMMI^{NO} study, the research team collaborated extensively with stakeholders within the Scottish Government’s Menopause and Menstrual Health Working Group to devise the following key objectives:

- (i) Capture the experience of menstrual and menopausal health at work for NHS Scotland employees
- (ii) Understand the needs of women, and people who menstruate, surrounding menstrual health and menopausal health support at work.
- (iii) Generate evidence-based recommendations around best practice based on employees lived experiences.

A3. Understanding the Menopause

What is the menopause?

Menopause is a significant hormonal change usually marked as the 12-month anniversary after a person’s final period but is often culturally understood as including the time running up to (perimenopause), and immediately after (post-menopause) this day. See Figure 1 for a graphical representation of the typical phases of menopause transition.

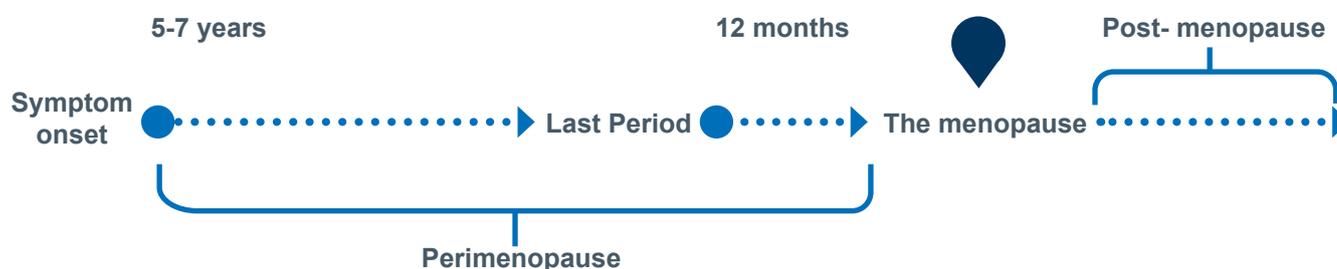


Figure 1. Typical phases of menopausal transition

Menopause is a ubiquitous experience that women, and people who menstruate, will go through. Menopause can occur ‘naturally’ or can also be medically induced: every person will experience menopause differently and the duration of their symptoms and constellation of symptoms will differ.

In the Global North the average age of menopause is 51 years, although for some minority ethnic groups this can be earlier. A small number of individuals (1 in 100) will experience what is known as ‘premature menopause’ before the age of 40⁹.

Medical procedures such as a hysterectomy (removal of the womb and sometimes the cervix) or oophorectomy (removal of the ovaries) can induce menopause, as well as some cancer treatments. Those experiencing significant menstrual conditions such as endometriosis may also be put into a ‘temporary menopause’ at any age with synthetic hormones¹⁰ that induce menopause-like symptoms.

⁷ <https://turasdata.nes.nhs.scot/media/j0vdmul/workforce-report-june-2022-formatted.pdf>

⁸ Gender equity in the health workforce: Analysis of 104 countries: <https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf>.

⁹ This is sometimes medically referred to as premature ovarian insufficiency (POI)

¹⁰ Gonadotropin-releasing hormone (GnRH) analogues

Women who do not have periods¹¹ will still go through menopause. For these individuals and for many other women who cease menstruation through medical interventions or such as contraceptives, the ‘last period’ diagnostic marker becomes challenging to apply. This masking effect means that there may be several under- and undiagnosed women experiencing the menopause or unaware they are in menopausal transition.

Research has indicated that around 75% of those undergoing menopause will experience either no or minimal symptoms, or symptoms that are sometimes frequent or have a disruptive impact. Medical researchers typically ask individuals to rate their symptoms on a scale of how ‘bothersome’ they are; this is a term that will be used throughout this report. The remaining 25% of individuals will experience no significant or bothersome symptoms that impact their immediate and ongoing health trajectories.

There are competing accounts in the extant research around the range of menopausal symptoms. Some studies suggest only a small number of symptoms result directly from the hormonal changes associated with menopause while others have recorded over 40 different symptoms resulting from menopausal transition. In general, symptoms fall into four key categories:

- (i) **Vasomotor:** symptoms affecting temperature control of the body, including hot or cold flushes or night sweats.
- (ii) **Psychological:** symptoms affecting mental health, such as anxiety or cognitive symptoms, such as changes to memory.
- (iii) **Musculoskeletal:** symptoms that affect the joints and muscles, such as aches and pains.
- (iv) **Sexual / vaginal:** symptoms that affect sexual function, such as vaginal dryness and changes to libido.

These symptoms last, on average, between 5 to 7 years with fluctuating intensity, particularly during the period immediately prior to and after the menopausal anniversary. Psychosocial factors have been shown to affect symptom presentation. Menopause usually happens at a time in life marked by competing pressures and demands around work, caring and other community responsibilities: these cumulative stresses can significantly impact symptoms and how they are experienced.

Broader social, cultural and demographic factors also play a role in how menopause is experienced by individuals. For example, research in Australia revealed that culturally, menopause is experienced at a time of life when women have an increased confidence about who they are¹². They have accumulated experiences that give them a resilience and capacity to both find creative ways to deal with adversity and foster a strong sense of self. These resources form an important buffer to managing their reproductive health and shaping the trajectory of women’s participation at work.

Those who identify as men or non-binary and were assigned female at birth may experience the menopause, and their experience and its intensity may be impacted by hormone treatments. Symptoms and experiences can vary depending on the age when individuals engaged with treatment or medical support and intervention. Trans women (those who identify as female or non-binary and were assigned male at birth) will not experience the menopause but may experience hormonal changes and related symptoms as they grow older. There is limited research that records the menopausal experience of transpeople. Some evidence indicates that they will experience greater fluctuation in symptom presentation due to the relationship between age-related hormonal changes and/or hormone therapies. Transpeople are also more likely to encounter discrimination and stigma when seeking healthcare – a key factor that will shape their menopausal experience. Further research is needed to understand the totality of transpeople’s experience of the menopause and establish pathways to best support these experiences.

¹¹This can include women who have with conditions such as Mayer-Rokitansky-Kuster-Hauser Syndrome (MRKH), which affects around 1 in 5,000 women.

¹² <https://womenworkandthemenopause.com/>

Existing research around the menopause and work

Over the past decade, the idea of menopause as a workplace issue has increasingly gained traction both in organisations and research science.

Research to date has mainly focused on the following areas:

- Exploring the relationship between menopausal symptoms and work outcomes or career trajectories.
- Uncovering how work-related cultures or structures can impact women's experiences of the menopause.
- Understanding how various workplace stakeholders perceive menopause within the organisational context.
- Establishing workplace practices, policies or guidance that can support menopausal employees.

This body of knowledge is relatively nascent. However, care needs to be taken when assessing the quality of existing evidence. Some caution should be taken when research is subject to a commercial interest, such as private consultancies and for-profit healthcare organisations.

In particular in Europe and the US, there is the growing privatisation and emergence of a for-profit 'menopausal market'. That is, individuals or commercial organisations providing products and services for fee-paying clients, usually in the form of consultation, training programs and workshops. The empirical basis of these services varies and can neglect the complexities of women's health across socioeconomic and cultural strata or individualise symptom experience.

The privatisation of reproductive health products and services may also have a broader impact on access and quality care to the whole population:

- (i) Access: the high-cost barriers effectively limit these resources to only those who can afford to pay for healthcare. Private consultants and organisations also remain free to set their rates without external regulation; in contrast, the fees of pharmaceutical, biotechnology, medical care device and other healthcare service providers (such as pathologists) are usually monitored by a government regulator.
- (ii) Quality of care: as the menopausal market remains in the early stages of growth, there is little regulation around the accuracy and quality of some health-related information, products and services being offered. Many such products and services also tend to focus on the 'major' consumer segments (usually white, middle class, professional women) and neglect the needs of those from diverse backgrounds.

A4. Understanding Menstruation and Menstrual Health at Work

What is menstruation and menstrual health?

The menstrual cycle starts from the first day of menstrual bleeding (the period) to the day prior the next bleed. Periods are the release of menstrual fluid that are not only comprised of blood but include vaginal fluid enzymes, proteins stem cells and endometrial tissue. Menstrual cycles typically range between 23 and 35 days although the timing varies between individuals and can change over the course of a person's life.

In the UK, periods begin on average from the age of 12 but can vary between minority ethnic groups¹³. The experience of the menstrual cycle can change over time due to major events such as pregnancy, stress, or other health episodes across the life course.

More than a quarter (26%) of women in the UK between the ages of 16 and 49 take hormonal medication¹⁴ that changes their menstrual cycle, either as a contraceptive or to help with hormonal or menstrual-related conditions.

¹³Chumlea, W. C., Schubert, C. M., Roche, A. F., Kulin, H. E., Lee, P. A., Himes, J. H., & Sun, S. S. (2003). Age at menarche and racial comparisons in US girls. *Pediatrics*, 111(1), 110-113.

¹⁴Firman, N., Palmer, M. J., Timæus, I. M., & Wellings, K. (2018). Contraceptive method use among women and its association with age, relationship status and duration: findings from the third British National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *BMJ sexual & reproductive health*, 44(3), 165-174.

The experience of menstruation can be accompanied or preceded by symptoms. These are often anecdotally referred to as PMS (premenstrual syndrome), although some suggest this a problematic and loosely defined term that should not be used to refer to all menstrual-related experiences of pain¹⁵.

Menstrual related symptoms can include:

- Psychological and emotional: mood changes¹⁶, anxiety, loss of confidence, the emergence of cravings.
- Somatic: Tenderness in breasts, changes to skin, changing sleeping patterns, cramping and pain, including headaches and radiating pain in lower pelvic region.

Symptoms are usually cyclical – meaning they are present around the same time of the menstrual cycle – but can also vary between cycles in their presentation and severity. The duration of symptoms can vary widely between individuals, with many only experiencing symptoms for a few hours while others have symptoms over a number of days. Pain is the most common experience reported around the menstrual cycle.

For the vast majority, menstrual cycles do not disrupt their activities of life and work, even when women are in significant discomfort and pain. However, a small number of women experience pre-menstrual dysphoric disorder (PSDD), which is the repeated and severe presentation of symptoms connected to the menstrual cycle and was formally classified by the World Health Organization in 2019¹⁷. Increasing, attention has been paid to the health conditions surrounding women's menstrual and reproductive lives. These conditions can cause chronic and debilitating pain and have few meaningful interventions with which to treat the underlying pathology.

For example:

- Displacement of endometrial tissue outside of the uterus (endometriosis) and into the muscular uterine wall (adenomyosis).
- Polycystic Ovarian Syndrome (PCOS): follicles surround the eggs in the ovaries that prevent their release.
- Fibroids: growths that develop around the womb.

These conditions are also challenging to diagnose, as they rely on regular imaging (which can lack sensitivity and specificity and are cost prohibitive) and laparoscopy (keyhole surgery) and are often overlooked in primary care pathways, particularly in under resourced healthcare systems.

Existing research around menstruation and work

There is a growing body of evidence around the relationship between menstruation and work. While there have been attempts to evaluate the costs associated with premenstrual syndrome¹⁸, contemporary research has suggested that menstruation is not a significant explanatory factor in determining absenteeism amongst female employees¹⁹. Research has been encouraging but to date, the evidence base has been confined to studies of small sample size and self-reported job outcomes. For instance, one study of 125 women suggested that despite symptom severity, job performance was not impacted by significant premenstrual-related pain. Instead, these individuals sought to minimise the cost to organisations and colleagues by working around their pain through 'job crafting' strategies, such as changing their working hours.

Other studies have focused on how organisational conditions might disproportionately impact women's health conditions at work. For example, endometriosis, like other intermittent health conditions, may be difficult to support within traditional sick and absence policies and can be considered topics that are 'taboo' or 'off-limits' for the workplace. High quality studies are needed to develop these insights and generate a working evidence base that is generalisable, transferable and valid to broader populations and work contexts.

¹⁵ https://menstrual-matters.comhttps://menstrual-matters.com/wp-content/uploads/2016/10/What_counts_as_PMS-SMCR_2017.pdf

¹⁶ The extent to which these are solely down to menstrual cycle rather than emotional rhythms that both men and women experience has been subject to debate.

¹⁷ <https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/1526774088>

¹⁸ Dean, B. B., & Borenstein, J. E. (2004). A prospective assessment investigating the relationship between work productivity and impairment with premenstrual syndrome. *Journal of occupational and environmental medicine*, 649-656.

¹⁹ Herrmann, M. A., & Rockoff, J. E. (2012). Does menstruation explain gender gaps in work absenteeism? *Journal of Human Resources*, 47(2), 493-508.

²⁰ <https://www.endometriosis-uk.org/sites/default/files/files/Employers-Guide.pdf>

The paucity of research and service provision for menstrual health conditions is reflective of women's health more broadly which has suffered from chronic underfunding²¹. In recognising the role of the sociocultural environment on the women's menstrual health experiences, the World Health Organisation has steered its strategic focus away from issues of menstrual 'hygiene' towards a more holistic and contemporary conceptualisation of menstrual health²².

This represents a fledgling sociocultural response to the historical regulation of women's bodies. Historically the subject of stigma, mysticism and problematisation, the menstrual cycle was miscast as a form of pathological hysteria and mental disturbance²³. These ideas, while dated, are legacies that carry into contemporary workplaces.

Research has shown that menstruation is subject to broader gender-based dynamics and sex-based stereotypes. Significant evidence has highlighted how women's experiences at work are often marked by discrimination and biases that undermine their credibility and thwart career progression, particularly in industries dominated by masculine ideals. For instance, studies have shown that stereotypes of women as having 'unruly' emotions are used to dismiss their expertise and professional contributions. Gender-based inequality over the life course has also resulted in 'leaky pipeline' of female participation in the labour market, despite higher numbers of women in graduating cohorts than ever before.

While a small number of studies have sought to connect economic and work-related outcomes with menstruation²⁴, they often do so through a health economics lens rather than consider the broader organisational and professional contexts in which employees work. Other research has shown that these sociocultural views often prompt women to engage in 'menstrual etiquette'²⁵ where they mask their menstruation and need for accommodations. This is more likely to happen in inhospitable environments that do not provide adequate facilities and ways to support the self-management of menstruation. More organisational studies are needed that pay particular attention to the environmental conditions in which menstruating employees work.

Cultural ideas surrounding menstruation play out in the workplace and broader economy in particular ways. Menstrual leave has been present in some Asian countries such as Japan²⁶ since the 1940's with the first instances of menstrual leave were found in the former Soviet Union in 1922²⁷. Current policy debates around menstrual leave have prompted some organisations to adopt menstrual leave policies in Europe and the in Europe and the United States²⁸ as well as India²⁹. Leave at the national-level is still not guaranteed in the US, UK and Europe with the exception of recent developments in Spain³⁰. While this legal entitlement represents welcome recognition for debilitating experiences, cultural and structural change is needed from policymakers and workplaces in order to make sure legislative measures do not have unintended consequences, such as reinforcing stereotypes or myths that make some employers and managers hesitant to employ women.

²¹ Smith, K. (2023). Women's health research lacks funding—in a series of charts. *Nature*, 617(7959), 28-29.

²² <https://www.who.int/news/item/22-06-2022-who-statement-on-menstrual-health-and-rights>

²³ Risse, G. B. (1988). Hysteria at the Edinburgh Infirmary: the construction and treatment of a disease, 1770–1800. *Medical history*, 32(1), 1-22.

²⁴ These studies are often called burden of disease studies and are foundational to health economic analyses and similar to types of study run for many health conditions within public health.

²⁵ Moffat, N., & Pickering, L. (2019). 'Out of order': The double burden of menstrual etiquette and the subtle exclusion of women from public space in Scotland. *The sociological review*, 67(4), 766-787.

²⁶ Dan, A. J. (1986). The law and women's bodies: The case of menstruation leave in Japan. *Health Care for Women International*, 7(1-2), 1-14.

²⁷ Baird, M., Hill, E., & Colussi, S. (2021). Mapping Menstrual Leave Legislation and Policy Historically and Globally: A Labor Entitlement to Reinforce, Remedy, or Revolutionize Gender Equality at Work?. *Comp. Lab. L. & Pol'y J.*, 42, 187.

²⁸ https://www.linkedin.com/posts/gargi-nair_on-this-labor-day-i-am-happy-to-share-activity-6926608442417721344-nq5o/

²⁹ <https://www.zomato.com/blog/period-leaves#:~:text=At%20Zomato%2C%20we%20want%20to,period%20leaves%20in%20a%20year.&text=A%20note%20for%20men%20%E2%80%93%20our,t%20be%20uncomfortable%20for%20us.>

³⁰ <https://www.ohchr.org/en/press-releases/2023/02/spain-un-experts-hail-new-feminist-legislation>

At present, menstrual health training and education for employers remains relatively new in the UK³¹: a contrast to the highly saturated and established market for period-based products. However, recent legal developments (see: *Douglas vs The Clancy Group of Companies*³²) have strengthened the case for employer responsibilities in supporting women's menstrual health at work.

A4 Guidance on the structure of the report

Following extensive consultation from key stakeholders mentioned previously and included in Appendix 2, as well as during the development of this study, the report is structured as follows:

- **Methodology** – outlines the method and process of data collection and analysis.
- **Findings** – provides an overview of general social and cultural experiences of menopause and menstruation.
 - The findings surrounding menstruation and menopause at work are introduced sequentially. While some findings overlap, this structure was chosen to enhance usability, particularly given that with the UK context at least, many organisations are at an earlier stage of supporting menstrual health at work compared to menopause.
- **Discussion and Recommendations** – integrated to highlight the evidence-based strategies that policymakers and organisations can undertake to ensure workplaces are proactive and effective in supporting reproductive health support.

The report refers to 'respondents' and 'employees' as the group we surveyed that includes women, and those who have menstruated. While this is an important point of inclusion, the structure of the report also seeks to recognise the significant intersection between gender and age-based bias – often referred to as 'gendered ageism' – that has a significant impact for women specifically on the reception of menopause and menstrual health in and around the workplace.

Direct quotations are anonymised, although we have included details of occupation, job status and their Band. Band refers to the way pay is organised in NHS Scotland. Further information on Bands to help support the reading of this report can be found in Appendix 1.

³¹ Endometriosis UK has recently launched an endometriosis employer training program: <https://www.endometriosis-uk.org/endometriosis-friendly-employer-scheme>

³² https://assets.publishing.service.gov.uk/media/616551c38fa8f52984062217/Ms_C_Douglas_v_The_Clancy_Group_of_Companies_-3327257-2019-_Reasons.pdf

B: Methodology

In collaboration with key stakeholder groups, the research team developed an online survey to understand and capture the reproductive health experiences of women at work in the NHS.

The survey contained a mix of closed and open-ended questions that enabled the team to use scientifically validated measurements and capture rich qualitative data that could build a robust and accurate portrait of individuals' experiences of reproductive health within the NHS.

Key areas of the survey are outlined below:

- (i) Personal demographics: age; gender; stage of reproductive health; previous and current medical interventions; ethnicity; religion; disability status
- (ii) Occupational demographics: occupation; job band; contract type; team size; gender and age composition of immediate work environment
- (iii) Experience of menstrual / menopausal health: symptom frequency, duration, intensity and level of disruption; symptom management approach (current and ideal)
- (iv) Organisational factors, structural: level of job autonomy; managerial support; voice mechanisms; bureaucratic burden; access to adequate facilities; existence of organisational policies
- (v) Organisational factors, interpersonal: perceived social support at work (peer and supervisory)
- (vi) Turnover intent, 12-month time horizon: organisational turnover (intent to leave the job in the next 12 months); job crafting (intent to change work hours or conditions); workforce turnover (intent to withdraw completely from the labour market)

To enhance response quality and ensure a positive user experience, a number of design features were built into the online survey:

- Visual analog scales
- Gamification of complex questions
- Non-forced responses
- Untimed responses
- Option to complete the survey in multiple sittings
- Inactive survey messages and reminders to complete

The survey and all research materials were awarded ethical approval by the University of Glasgow (reference 400220052).

B1. Inclusion criteria

Respondents needed to fulfil the following requirements to participate:

- (i) Be a current employee in the NHS
- (ii) Over 18 years of age
- (iii) Identifying as female or a person who menstruated
- (iv) Provide informed consent to the collection of their data

Recruitment

The recruitment strategy was designed in collaboration with several key stakeholders in several employee and management representative groups across NHS Scotland to maximise response rates and respondents' user experience.

The survey was made available both online and in pen and paper format. It was launched on the 18th October 2022 and closed on the 30th November 2022 and was distributed via key stakeholder channels.

Each of the 14 NHS boards was provided with an extensive communications pack to support its promotion that contained information about the survey, posters with QR code links and content for newsletters and other staff documents (see Appendix 1).

Key organisational contacts responsible for survey distribution included the following:

- HR Directors and Deputy HR Directors
- Wellbeing Champions
- SWAG Scottish Workforce and Staff Governance representatives
- Employee Directors
- The Scottish Partnership Forum
- The Scottish Government's Menopause & Menstrual Health Working Group Ethnic Minority Forum
- NHS Strategic Communications Leads
- NHS Equality & Diversity Leads

Details about the survey were communicated directly to respondents through a variety of channels including staff intranet wellbeing pages, newsletters, direct email communiques from representatives of the groups, in addition to clinical leaders such as the Nursing Director and Chief Medical Officers.

Posters were displayed in staff areas to attract the attention of staff who did not have regular access to emails. Information about the survey was also tweeted through ScotGovHealth, the official channel for Scottish Government news on NHS Recovery, Health and Social Care.

The research team also proactively liaised with unions and employee groups for bodies, such as the Scottish Ambulance Service to maximise reach and inclusion. Employees were also invited to request paper copies of the survey either through text or email. Surveys were sent with an addressed and stamped envelope to remove costs or logistical barriers to participation.

B2. Overview of Sample

Of those responding to the menstrual health survey:

- 74% were premenopausal, and 23% were early perimenopausal.
- 28% were on medication that temporarily stopped their period, such as a form of contraception.
- 8% had sought medical support over the past 12 months for endometriosis, 6% for fibroids or polyps, and 6% for PCOS.

Of those responding to the menopause survey:

- Of those that were menopausal, 35% were early menopause, 16% were late perimenopause, 30% were early post menopause and 19% were late post menopause³³.
- Approximately 14% of respondents were shift workers.
- Out of the respondents who had experienced menopause (past and present), 74% had gone through natural menopause, while 6% had a surgically induced menopause (such as an oophorectomy or hysterectomy). 3% had experienced an induced menopause as a result of another medical condition or treatment, such as cancer.

In both surveys, of those who chose to disclose, 8% considered themselves as having a disability³⁴.

There were also voluntary questions around ethnicity and sexuality. The overwhelming majority of respondents self-identified as white (97% for both menstrual and menopausal health) and straight/heterosexual (menstrual health, 90%; menopause, 97%).

Despite engagement with relevant network and employee community groups there were very low numbers individuals who self-identified as belonging to a minority ethnic group or LGBTQI+. This meant statistical analyses for these populations was not possible. However, the experience of these individuals explored through in-depth qualitative analysis of their open text responses.

In both surveys, there was a similar demographic and occupational distribution mirroring a previous studies

³³ Swedish rounding is useful throughout (where over .5 is rounded up and under .5 is rounded down)

³⁴ This question asked them to self-identify as having a disability based on the definition provided within the UK Equalities Act 2010

undertaken by the research team in the healthcare sector that have referred exclusively to 'women'.

B3. Analysis

Quantitative analysis

Following data cleaning, the number of respondents totalled $n = 6,453$. A small number of online respondents clicked on the survey opted to not participate after reading information and ethical protocol ($n=68$).

The statistical analysis sought to identify relationships between responses surrounding menopausal or menstrual experiences and perceptions of workplace practice and policy.

Based on existing organisational knowledge and subject expertise in the research team, a number of hypotheses were tested, particularly with respect to turnover intent – an outcome of primary concern for the NHS and associated stakeholders.

Where data analysis suggested there were relevant patterns emerging, stratified analyses were undertaken in groups of special interest, for example, shift workers.

Quantitative analysis

For both the menstruation and menopause surveys, there were a number of open text questions that invited respondents to share or describe their experiences in their own words. This opportunity was taken up by many respondents who often reflected in significant detail and richness about their experiences.

This resulted in a large dataset that was subject to qualitative thematic analysis. For example, one open text question inviting respondents to describe their menopausal experience at work in their own words was answered by just under 1600 of the respondents and resulted in over 190,000 words.

Textual data was analysed using established qualitative analysis techniques. These techniques seek to provide a level of conceptual generalisability through identifying the relationships and patterns between different themes and ideas.

A process termed 'coding' was undertaken, paying particular attention to when ideas, experiences or opinions contradicted each other, both across the different respondents, and within the same respondents' different answers.

Gradually an analytical story emerged that not only informed the overall structure of this report, but guided the quantitative analysis through identifying what relationships may be important to explore statistically.

C. Findings 1: Menstrual Health, Menstruation and Menopause in Society

C1: Social cues about menstruation and menopause:

'More than just hormones and hysteria'

To understand menstrual health and menopause in a workplace context requires attention to the broader social and cultural landscape surrounding menopause and menstrual practice.

Experiences of menopause and menstruation are situated within social and cultural ideas that shape how people experience their body or think about the bodies of others. It is important to acknowledge these ideas and the profound impact they have on the organisational climate and by extension, the individuals who must work within them. This study, for instance, uncovered how the taboo surrounding reproductive health led to self-censorship and masking behaviours amongst employees who were concerned about being perceived as 'problematic' and 'complaining'.

Respondents related how their early experiences shaped their own opinions of, and behaviours surrounding, women's reproductive health:

“

My mother was a very 'stop making a fuss and get on with it' kind of person and I have lived my life like that. I do think that I have some serious brain fog issues and have put it down to age whether menopause or just age related I do not know.

Medical and Dental support, Band 6, Full-time, menopause survey

“

I am lucky and have a very supportive partner but have never spoken to him about the menopause. I suppose I am from a generation that just gets on with it.

Allied Health Professional, Band 8, Full-time, menopause survey

“

I think menstrual health affects our day to day lives in ways that many of us will never fully admit unless directly asked, yet in a kind of stereotypical British-ness we just get on with it.

Allied Health Professional, Band 6, Full-time, menstruation survey

There were a variety of opinions around how to discuss menstruation and menopause in a way that was inclusive, but also acknowledged the disproportionate impact on women and girls. A small number did not agree the survey should refer to 'women, and people who menstruate'. Others felt that there was a danger that inclusive language may have a secondary consequence of occluding what was already stigmatising health experience:

“

This has become even more complicated recently with the use of terms which lose sight of focus that this is experienced by women and the toxicity of language around women's health has meant that you daren't mention menopause at work and the impact upon women as doing so is now seen as transphobic or bigoted against another group. [...]. As a consequence, we tend not to discuss sex-based (particularly women's health issues) in the health service anymore as getting the terminology wrong could lead to discrimination or ostracization.

Allied Health Professional, Band 6, Full-time, menopause survey

“

I feel that the craze of political correctness to not offend every single variation of human, and the reference to "people who menstruate", "people with a uterus", "people who get pregnant", actually diminishes my entity as a woman who have been born as such and have gotten on with it all my life (past and future), experiencing discrimination along the way.

Medical and Dental, Band undisclosed, Part-time, menstruation survey

“Having women only spaces in schools, public toilets and workplaces is also very important. We are living in a changing world & rightly so becoming more accepting and inclusive but that shouldn't be at the detriment of another group. I remember being 15, leaked through my school clothes during math class, wasn't allowed to go to the toilet, too embarrassed to let the teacher know so just sat there till the class was over. To then go to a unisex toilet where boys could walk in would have stopped me from going. I would have rather left school and missed classes.

Phlebotomy, Band 2, Part-time, menstruation survey

Respondents often relayed clear memories of formative experiences from years or even decades ago. These had often involved some element of shaming, usually at school. There was a hope across both survey groups that the next generations may have the opportunity to learn or talk about reproductive health in different ways that may alter whether they felt it was a legitimate topic for workplace discussion.

Those over the age of 45 were less likely to report having affirming, open conversations more broadly when they were growing up. This was countered by discussing how, as they grew older, they were more likely to discuss their bodies with close friend and colleagues. There was also a hope that the next generation would have a more supportive experience in workplaces:

“I would like to be one of the next generation of women who have a positive experience with a good positive support network.

Allied Health Professional, Band 5, Part-time

“There is very little education both in schools and in the workplace about menopause. [...] Ignorance leads to fear and shame, I believe we are standing at a crossroads in society, where this next generation is wanting to age differently. Education on both puberty and menopause open up the conversations, taking away stigma and shame

Allied Health Professional, Band 4, Part-time, menopause survey

Younger respondents were more likely to discuss learning about menstrual health at school (none mentioned learning about menopause at school), although this did not always translate into workplace discussions:

“I am a millennial and I feel that my generation does talk about menstrual health more than the older generation. I'm not embarrassed to speak with my friends or family about my painful periods; however, I'm embarrassed to talk about it with my line manager who is a male, and in his 50s/60s.

Other therapeutic, Band 6, Full-time, menstruation survey

“Young females get a fair amount of support in the school environment to prepare them for their first periods but women 30+ receive absolutely no education on this and it is rarely spoken about. Lack of education means that people struggle for longer than necessary with sometimes debilitating symptoms which could be resolved. Senior

Manager, Band 7, Full-time, menopause survey

Others discussed the importance of the media in making menopause and menstruation discussed more openly in recent times:

“I think the recent TV programme with Davina McCall has helped our generation & future to realise that menopause isn't something that should be swept under the carpet.

Administrative Services, Band 3, Full-time, menopause survey

“ I think that the current menopause generation is better placed now than previous generations as it’s no longer taboo to talk about it and there is a wealth of information on the tv/web that can help

Technical, Band 6, Full-time, menopause survey

At the same time, there was concern that the availability of accurate and accessible information should not be limited to the media. Similarly, while several respondents mentioned using apps, there was concern over how their data might be used by others, given that apps were often commercial.

“ I am not sure the media attention has helped us in my profession as I hear people frequently admit they are ‘sick of hearing about it’.

Nursing and Midwifery, Band 7, Full-time

C2: The Gendered Health Trinity: Under, mis-and late diagnosis around menstrual conditions and menopause

How menstruation was experienced more broadly had an impact on how women worked and their work capacity. Employees commented on the differences in their ability to work before and after medical support:

“ Not since Aug 2021 [has my work been disrupted] after having gyn support; however, my work was disrupted on several occasions before the treatment.

Nursing and Midwifery, Band 5, Full-time.

A number of respondents to the menstrual health survey had sought support for menstrual related conditions in the past 12 months, including 8 % for endometriosis, 6% for fibroids or polyps, 25% for heavy periods and 6 % for PCOS. 13% of respondents in the menstrual health survey were also currently or had been on an IUD for menstrual health (rather than contraceptive) reasons.

It is unclear what proportion of the 25% seeking healthcare support for heavy periods had a formal diagnosis for an underlying condition. This is important given that a variety of accounts pointed to the challenges of the menstrual experience being acknowledged culturally. One respondent suggested this was down to a myriad of reasons including lack of healthcare funding and a need in society to better ‘understand periods are more than just hormones and hysteria’ (Clinical Researcher, Band 6, Part-time).

Responses suggest three key aspects - underdiagnosis, misdiagnosis and late diagnosis - that marked women’s menstrual healthcare encounters that were relevant to their subsequent experience of employment and ability to fully engage in the workplace. It is important to note that, several respondents noted that when comprehensive, accurate, and timely healthcare support was provided, it made a significant difference to respondents in both their lives and their work. Even when respondents situated themselves as not having a ‘normal’ experience, the impact of a positive healthcare experience made it possible – though not necessarily easy – to work through their symptoms:

“ I was bleeding every day for just over two years from March 2020. I have been on the combined pill since I was 15 due to my PCOS and then it got changed to the mini pill. I am now 30 and have the IUD to try stop or lessen my periods. I now bleed for two weeks a month which is a massive improvement.

Pharmacy, Band 2, Full time/ Part Time, menstrual survey

It is also important to highlight that challenges around under-diagnosis, misdiagnosis and late diagnosis are both situated in, and can be a consequence of systemic issues of under resourcing in a landscape where a majority of healthcare providers seek to provide the best care possible.

Underdiagnosis

Respondents shared times when their experience of menstruation had been undermined, minimised or dismissed as ‘just’ periods or ‘just’ menopause, even when symptoms were debilitating and prevented full inclusion public and professional life.

“Mixed experience seeking medical support. GP Generally supportive and wanting to help me find a cause and solution. Poor experience with gynaecology at first and was dismissed. Was then seen by another gynaecologist a few years later who was supportive and understanding, but felt I didn’t need surgery. Was then admitted to hospital 3 months later for a severe pain attack and was put on the list for surgery by another gynaecologist. [...]. Again pain was dismissed as chronic pain and the doctor wouldn’t let me speak about my experience and kept cutting me off. She was also pushing for me to go back onto prostap (a gonadotrophin-releasing hormone -GnRH-agonist) but I refused due to the mental health impact it had on me previously.

Nursing and Midwifery, Band 5, Full-time

“[I felt] Dismissed. Despite 2 ECM’s and uterine scar tissue, I am never taken seriously, instead told just “one of those things” as a woman you are expected to handle. Always a male GP with no real concept of the pain and discomfort [...] This is my body, and I’m telling health professionals that something is not right, and I’m being told, without even so much as an ultrasound, that I must be wrong. I’m fine, it’s just the way it is, take some paracetamol and a hot bath... you’ll be right.

(Anon)

In discussing their experiences of being dismissed or viewed as exaggerating their experiences of pain or discomfort by healthcare professionals, respondents also referred to the vicarious experience of others and how this influenced whether or when they sought support from healthcare professionals:

“I don’t bother as other people have went to GP for it and do not get taken seriously.

Administrative, Band 5, casual/fixed term, menstrual survey

“I have had endometriosis since my mid-teens although this wasn’t diagnosed until my early 20s. It has always been problematic with work as it is often viewed as ‘just period pain’ and I found it difficult to describe how debilitating it can be and not wanting to ‘moan’. I started with unusual symptoms last year and after bloods and a scan was referred (again) to gynaecology which after waiting 7 months finally got the answer I wanted - total hysterectomy only to be told there is a year’s waiting list. I have GNRH injections with covering HRT. [...] am feeling better but feel I have a weight hanging over me waiting for the operation.

Other Therapeutic, Band 8, Fulltime, menopause survey

For both groups of respondents, there was evidence that women’s health underdiagnosis had an impact on health-seeking behaviours surrounding menstruation. This could accumulate over a lifetime; Individuals also delayed seeking medical care due to previous encounters which were negative and unhelpful, such as feeling they had been blamed or shamed by their primary care provider. This was particularly the case for those who had ongoing menstrual conditions:

“As a teenager attended GP for heavy periods – did not feel taken seriously. Reluctant to seek treatment as an adult for irregular and heavy periods as I feel as though it will be dismissed outright due to me being overweight.

Nursing and Midwifery, Band 4, Full-time, menstrual survey

Misdiagnosis

Reproductive-related misdiagnosis refers to instances where responders felt symptoms were not identified or misattributed by healthcare professionals. Respondents shared a number of times this had happened around menopause:

“ I had a few hot nights, some joint pain (which my male GP told me was not a menopausal symptom!)...

Childrens Services, Band 6, Part-time, menopause survey

“ Last year I had a number of panic attacks before getting out of my car to go into work. That was horrible. I went to my GP who organised an ECG etc but I knew it was anxiety caused by menopause.

Childrens Services, Band 8, Full-time, menopause survey

In many cases, respondents felt physicians had overlooked menopause as the underlying cause of mental health and cognitive symptoms. For some this had significant consequences for the ways they worked and even their trajectories within the labour force.

Visited the GP they prescribed anti-depressants cos of symptoms you had mentioned. This made me lightheaded and sleepy at times which was not good for where I work. I wish when I was peri menopausal, there was more help as I felt I had to retire early at 56yrs and return on half my hours 18.75hrs.

Anaesthetic Nurse, Band 5, Part-time menopause survey

This was more likely to happen when women were not viewed as a ‘typical’ age for experiencing menopausal transition:

“ I went through a premature menopause. I had no idea that this was happening as was in my late 20’s and the Dr misdiagnosed as PMS.

Allied Health Professional, Band 7, Full-time, menopause survey

“ I had an endometrial ablation around 18 years ago (48/49 years of age) which stopped my periods altogether. I also have an underactive thyroid. My GP told me I was too young to be going through the menopause and put my symptoms down to my thyroid condition. [...]. Very bad hot flushes, approximately 20/30 in an 8-hour working period. Muscle and joint pain, which involved me attending physio appointments. Stomach problems, cramps, sickness which I put down to the menopause but again my GP said no. This caused me to be off work for 4 weeks and I ended up in A and E due to heart/chest pain which was diagnosed as costochondritis. I haven’t put these episodes as taking time off work due to the menopause as I was told by my GP on several occasions that these symptoms were not caused by the menopause.

Ward Assistant, Band 3, Full-time, menopause survey

“ I had a very early menopause due to surgery. I was not well counselled on my symptoms and when consulting with my GP lots of other avenues were explored involving many tests and referrals. I didn’t think this was all menopause related until much later and any medical support I sought didn’t lead me to this conclusion earlier. As a result, I had many years of symptoms that impacted on my home and work life. I changed profession and spent years thinking there was something serious wrong with me.

Senior Manager, Band 8, Full-time, menopause survey

Misdiagnosis also occurred through attributing systems to other causes or events. One respondent who self-identified as having a learning difficulty discussed the additional challenges of having to self-advocate when they had a feeling something was being missed; in their account they shared that:

I was referred for fertility treatment due to difficulties conceiving in my 30's. I found the care I received poor. I was not listened to, and symptoms were dismissed as either grief of my mum dying or work-related stress. I had not heard of endo at that time but thought it odd that my grief/stress only manifested in heavy periods, fainting, vomiting and abdominal pain once a month. Since then I have had good and not so good care.

Allied Health Professional Band 6, Part-time, menstrual survey

Late Diagnosis

Delays to formal diagnosis and subsequent treatment were reported in significant numbers for both menstrual and menopausal health conditions. While this was partially due to delayed health seeking behaviour respondents noted that recent resource constraints and COVID-19 pressures had resulted in understaffing, service deferral, and long waiting lists.

While respondents were sympathetic to this – and often experienced this in their own jobs as health service providers – they emphasised the impact of delayed diagnosis on their own work and life. For example, delays resulted in the ‘pause’ of quality of life and work for significant periods of time.

“*The wait list for hysterectomy is 5 years. I feel like they just wait long enough so they can say “you’re nearly at menopause so no point in getting surgery now”. Doctors have told me things like: you don’t know if you’ll want kids (I don’t, and I’m asexual so don’t have sex); there is no treatment for endometriosis so diagnosis is pointless; go on the pill/coil/other contraceptive treatment (note: this is despite nearly suiciding last time I was on contraceptives).*

Research, Band 6, Part-time, menstrual survey

By comparison, another woman who had ongoing painful menstrual symptoms since she was 13 discussed the difference affirming interactions made:

“*(It was the) first time I felt listened to and not an inconvenience when seeking help for periods. This was the first time I had spoken to this GP practice about my periods since joining practice years or so before. I feel that the GP really understood the impact on my wellbeing and my health. Did clinical checks and for the 1st time I heard even if all the clinical checks are fine, we still need to do something to help you. It is amazing what just being listened to and heard does to help you feel human. I went to see gynae and was stunned by the response of consultant. Not only did she say that there were treatments available but that I should have been able to access those treatments 15 years ago.*

Administrative Services, Band 6, Full-time, menstrual survey

For menopausal respondents, one of the challenges in late diagnosis was around not knowing when to go to their healthcare provider for support. The retrospective marker of ‘no period for 12 months’ meant that it was only latterly that some became aware of the possibility of menopause transition. For others, such as those on long-term contraception or other procedures that stopped periods or other procedures, the final period anniversary was even more ambiguous:

“*I didn’t really know that I had been through the menopause due to having had an ablation and no bleeding for several years.*

Medical and Dental support, Band 6, Full-time, menopause survey

“I came off the contraceptive pill 2 years ago and they (GP) said if you don’t bleed after a year after you stop taking it then you are menopausal.

Events, Band 5, Full-time, menopause survey

C3. Alternative pathways to managing menstrual and menopausal health

Across the groups, there was evidence that respondents wished to consult a wide variety of sources to educate themselves around menstruation and menopause. However, one of the challenges of navigating reproductive health was the difficulty in accessing balanced information:

“Speaking as an NHS patient rather than an employee, I found the pro- and anti-HRT arguments (in the literature: and as for the Internet, don’t even go there, as the young people say) are so polarised it’s impossible to feel you’re getting unbiased advice or access to a genuine range of other women’s experience, and this really needs to be addressed.

Analyst, Band 5, Full-time.

This meant that often women’s approaches to their menopausal and menstrual health were cumulative in terms of experiences of what worked for them as well as advice provided by significant others such as family or friendship circles.

“I am looking into other alternative methods, as so far, I have not received much help through conventional methods.

Health Science Services, Band 2 Part/Fulltime status undisclosed.

In term of medication, analgesics such as ibuprofen and paracetamol were central to working through menstrual symptoms. They were used by 40% of menstrual health survey respondents to support their menstrual symptoms. For many this offset what would otherwise be a disruptive experience:

“Paracetamol or Ibuprofen for around two days during menstruation due to stomach pain/cramps. This pain can, on occasion, cause me to feel faint or sick if I don’t take pain relief.

Ambulance Services, Band 5, Full-time

Some respondents discussed ‘mixing’ a variety of medications, and while some reflected that this could cause negative side effects. There was also a pragmatism in finding something that they felt helps them to manage symptoms and continue working. One respondent who attested to the mixing of a variety of approaches, also felt the intersecting effects of another health condition with menstrual health could be accidentally positive, although this has not been proven or evidenced as effective elsewhere:

“Paracetamol, ibuprofen, aspirin, buscopan, cocodamol. I am awaiting diagnostic laparoscopy for suspected endometriosis. I also get naproxen and dihydrocodeine prescribed. Taking all these drugs (often exceeding maximum dose and taking them in combination) still results in me screaming in pain into my pillow, or already crying waking up in pain. For another health issue, I have been on anticoagulation treatment (apixaban) and this has nearly entirely stopped pain, discomfort, and all other associated period symptoms (e.g. flu like symptoms). Apixaban is literally a miracle in this regard and should be researched.

Research, Band 6, Part-time

12% of the menstrual sample used herbal or alternative therapies to support their menstrual health. These included TENS machines, heat patches and acupuncture, as well as supplements such as: evening primrose oil; CBD oil; starflower oil; red clover; St John's Wort; sage; agnus castus; and chastberry extract.

Vitamin supplementation was also common, including vitamin D; B12; omega 3 and ferrous fumarate to help with iron deficiency due to menstruation. Some also sought to nutritionally supplement through the consumption of foods such as soy, turmeric and flaxseed at various points of their menstrual cycle. Remedies were established through an often lengthy process of trial and error before settling on a comfortable, regular practice:

“ I use CBD balms, oil and gummies to help with any pain and before I had my IUD inserted, I was using CBD infused tampons to help with pain and cramping (to good effect).

Nursing and Midwifery, Band 5, part/full time status undisclosed

Despite positive results, respondents often hedged their reflections with caveats such as, 'not sure if this works' or 'unsure of the science/evidence base behind this though!'. This speaks to the lack of accessible evidence and support for reproductive health-related concerns. Although some respondents were conscious of the possibility of a placebo effect, they were reluctant to discontinue their finely-honed regimes, for fear of impacting their ability to work.

Respondents were also keenly aware of the economic impact of their menstrual and menopausal health. In particular, the additional medicines and therapeutic supports needed to manage symptoms, or financial costs arising from menstrual and menopausal experiences, formed a substantive financial burden. These excess costs often pushed women into making difficult economic trade-offs, particularly with recent inflationary pressures.

“ Over the years I've tried many over the counter medications / herbal alternatives / exercises / magnesium sprays / vitamins / deep breathing techniques / migraine head patches / hot water bottles..... some help for a short period of time, others have not helped. Many years of my life and many hundreds (if not more) of pounds have been spent by me on trying to gain control of my body.

Allied Health Professional, Band 4, Part-time

“ For almost 40 years I have suffered with heavy painful periods that, at its worst has caused me to faint due to the pain [...] I have lost count of the financial cost over the years in terms of replacing clothing, bedding, and mattresses.

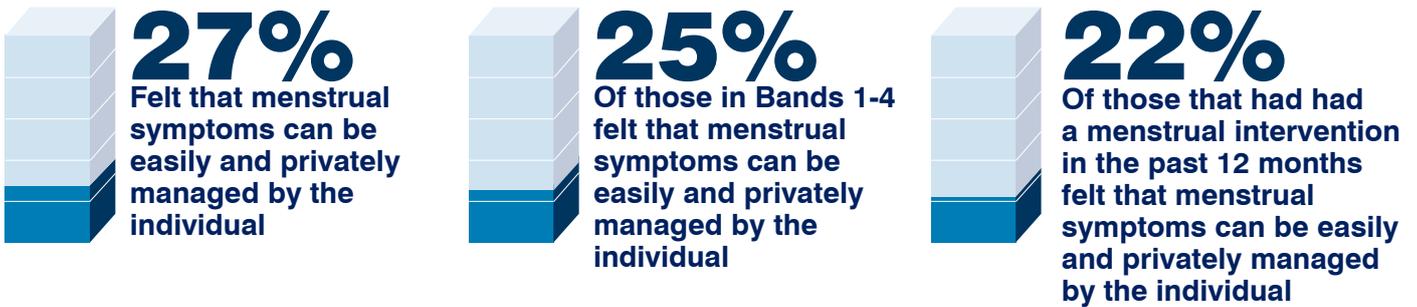
Administrative Services, Band 7, Full -time

D. Findings 2: Menstrual Health and Work

D1. Menstrual Health and Work

Employees responding to the menstrual health survey had a wide variety of health experiences. Even those that did not have a formal menstrual health-related condition, such as endometriosis, still recalled periods of disruption due to symptoms, particularly when working conditions or organisational cultures compelled them to suppress or defer their menstrual experiences.

Overall, the picture that emerged was that respondents felt that it was possible to manage menstrual symptoms individually. However, confidence in doing so was less for those in the lower job bands or who had experienced a menstrual health-related medical intervention in the past year.



Some employees felt menstruation was a uniquely personal experience not to be shared. A small number of individuals (5%) felt that there was no need for specific menstrual health workplace policies and practices, indicating that there needs to be a way of ensuring employees can choose to privately manage menstruation should they wish. Others deferred disclosure because of a fear for inconveniencing both colleagues and the healthcare services. Motivations for managing menstrual symptoms was often attributed to a desire to not let their immediate colleagues down, given that many were working in areas where resources were stretched. When they did take leave, this was often as little time as possible:

“ I have never taken sick leave from work in relation to my menstrual cycle, but I have often considered it and I am acutely aware that on days that I am experiencing increased pain levels I don't function as well and I am concerned about the service I provide at these points.

Optometry, Band 7, Full-time

“ I very rarely have any bleeding due to having the Mirena coil but any time I do have bleeding, even if it's a small amount I'm in severe pain and need to take sick leave off work, it's beyond my control and I never know when it's going to happen so sometimes have to be off sick last minute which I hate having to do as it can leave my colleagues short staffed.

Nursing and Midwifery, Band 5, Full-time

“ I do not have time to go to the bathroom as my work requires me to be in the lab/cleanroom for long periods of time. I always keep spare trousers, underwear, pads and tampons in my locker just in case. Thus, I end up worrying a lot and this affects my work and how it is difficult to go to the bathroom multiple times in a day without causing disruption or upset with my colleagues.

Analyst, Band 5, Full-time

Two thirds of respondents agreed that workplace conditions, environments and cultures could make a significant difference to experiences of menstrual health at work. This consensus was higher for respondents working in job bands 1-4 (72%).



Only 13% of respondents stated that their workplace had policies that mentioned menstrual health. There was a slight preference for menstrual health to be integrated into a variety of practices (such as flexible working options) rather than just stand-alone policies.

D2. The Bi-Directional Relationship Between Menstrual Health and Work Menstruation Impacting Work

It is important to note that a majority of employees reported being able to work through their menstrual cycle at work and felt they could self-manage without any significant changes to their working practice.

At the same time, working through menstruation and menstrual health experiences did not mean that respondents were thriving or feeling fully engaged or fulfilled by work. 61% felt that over the past 12 months, their work had been disrupted³⁵ by menstrual symptoms. For a majority, this was for a relatively short period of time and often possible to manage without significant intervention.

For example, more than a fifth (22%) of those experiencing heavy bleeding only experienced disruption to work or under an hour each time, while 21% of those having menstrual-related migraines only experienced disruption for 2 hours or under. 29% of those experiencing nausea only had disruption for 2 hours or under.

This is not to dismiss the significance of their experiences but rather highlight that many symptoms did not require a huge amount of time to address. For those experiencing disruptive symptoms, these included heavy bleeding constipation or diarrhoea, anxiety, joint and muscle ache, nausea and migraines. Pain was widely discussed:

“Pain can make concentrating a problem. As I have been at home more, I have found it easier to sit with a hot water bottle or to lie down for half an hour or move around to see if that helps. I probably wouldn't be able to do this in the office.

Senior Manager, Band 8, Full-time

“On first day of period arriving, I experienced quite bad period pain, one paracetamol did not work so I took 2. For about one hour I struggled to do my job on a ward and left the ward and had to use the toilet alot during this time until the pain relief worked. I did not tell anyone about this.

Occupational Therapist, Band 6, Part-time

Some had the ability to arrange workload around predicted menstrual experiences:

“I notice slight changes to productivity, focus and general functioning across menstrual cycle. While these changes are not noticeable to others, I do take precautions (reducing other energy consuming activity) and try to reduce stressors at certain parts of the cycle to reduce the impact of that phase on my functioning at work.

Psychological Therapist, Band 7, Full-time

³⁵We defined 'disrupted' as 'you feel that menstrual symptoms affect how you would usually go about your work'

However, other employees discussed how the challenge of predicting periods or knowing how long symptoms may last for also had an impact on their work:

“Now and again, I get a really bad one (period) that is really difficult or catches me off guard.

Records Clerk, Band 2, Full-time

“Irregular periods mean I can be caught short at work or experience PMS at very frequent intervals, meaning difficulty concentrating at work. Poor sleep and brain fog. I can also become suddenly fatigued and then just as quickly it lifts and I am able to carry on with my day.

Administrative, Services, Band 5, Part-time

Repeatedly, respondents referred to pain as being debilitating. This is of course not exclusive to menstrual health: any form of pain in the workplace is likely to have an impact on one’s ability to fully engage in work. However, despite this pain, there was often resistance to taking off time:

“I can’t bring myself to phone in “sick” just because I’m on my period as it’s not an illness

Charge Nurse, Band 6, Full-time

“Yes [menstruation disrupts work] but I have never been off work. I suffer from abdominal cramps, back pain, and very heavy periods, meaning that I have to regularly leave the unit to change sanitary products or take analgesia.

Clinical Educator, Band 7, Full-time

“I have never taken time off work but at times I am very aware that my mood, level of energy and pain experiences have impacted productivity at work.

Nursing and Midwifery, Band 7, Full-time

Other respondents shared how they felt their menstrual health could make them fall foul of absence procedures or other policies:

“Unfortunately, my menstrual health was bad enough to stop me working for a day or two during my cycle, by the end every month. Most of the problems were during my studying time and I had surgery, and my periods were stopped before I started working professionally but I can recognize that needing regular time off due to the severity of symptoms would quickly have led to an occupational health referral. Occupational health referral is helpful to advocate for the employee and provide guidance for the employer

Administrative, Band 3, Part-time

“On heavy days my work has been impacted as I have to take strong painkillers which don’t get rid of the pain, and wear portable heat pads. I am distracted and not as focussed due to pain and bleeding. I have had to have sick time off work due to being unable to cope with heavy bleeding, nausea, D&V caused by my period. It has impacted my work due to being put on ‘absence management’ = stress+++

Nursing and Midwifery, Band 5, Part-time

There were also a variety of examples where flexibility had provided the opportunity for respondents to work through symptoms. These often relied on flexibility and discretion of supervisors:

“ I am fortunate I work in the community close to where I live, therefore I have a supportive management team who would be happy for me to go home until I feel well again, and I will catch up once pain has passed.

Occupational Therapist, Band 6, Full-time

When menstrual conditions were severe and not supported either through healthcare or workplace supports, they impacted both the hours that women could work, and influenced their career trajectories in the longer-term.

“ I now do not have periods so do not have this worry, but if they came back. I would definitely lose my job. Period sickness along with other health conditions causing absences would mean there was no way for me to work even part time. Other conditions mean I have had to drop from full-time to part time, if my periods re-started I wouldn't know what to do. I would not have job or financial security at all.

Administrative Services, 2, Part-time

“ Menstruation was part of the decision making for leaving clinical setting.

Administrative Services, Band 6, Full-time

“ Prior to a 10mths ago I was afraid to take a permanent contract as I'd be off a week every month when the pain and bleeding confined me to my bed/home. I use to work bank as I could then control when I worked. Not picking up shifts when my period was due. Then my periods became very unpredictable, and I'd have to take time off. This prompted me to start the new treatment to stop my periods. Things are much improved, and I've taken a contract. However, I occasionally still get pain and try to continue with work, but I've missed a couple of shifts as it's simply too painful.

Coordinator, Band 3, Full-time

“ I suffer fatigue due to the anaemia which affects my ability to work. When I am bleeding, I can hardly move without blood coming out and this is despite wearing the largest tampons and incontinence pads. I work in a stroke ward so manually handling is a big part of my job, and this makes it difficult, the only saviour is that there are toilets nearby to change frequently. in the days I bleed I am in pain and feel weak if the flow is large. I can feel very low in mood re-menstrual, I want to go for a full-time job but don't know if I would manage.

Healthcare Support worker, Band 3, Part-time

The degree to which menstruation impacted work was often due to conditions surrounding where and how they worked. For example, the intensity of work could lead to menstruation being perceived as disruptive:

“ Meetings ran back-to-back, skipped toilet break and bled through.

Nursing and Midwifery, Band 6, Part-time.

For others, working in the community could bring about particular challenges for working through menstruation:

“ Due to heavy bleeding and working in the community I can become extremely anxious going on visits. I often need to bring a change of uniform or need to go home to get changed due to heavy bleeding.

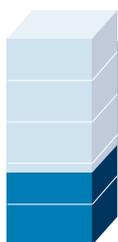
Health Visitor, Band 7, Part-time.

“ When passing clots and having heavy period and not having facilities to do personal care as working in community was making me feel uncomfortable and made me apprehensive to go to work on those days.

Staff Nurse, Band 5, Part-time

Work impacting menstruation

73% of respondents felt that their menstrual cycle had not been impacted by work in the past 12 months. However, this differed for those working in shifts. Several respondents shared that 'Shift work upset the rhythm' of their menstrual cycle (Nursing and Midwifery, Band 7, Full-time)



35%
of employees working regular night shift felt their cycle had been impacted by their work,



27%
of employees not working regular night shifts felt their cycle had been impacted by work

“Going between nights and days and doing long shifts usually makes me irregular, and I tend to get heavier more severe periods

Paediatric Registrar, No Band disclosed, Full-time

Working conditions were reported as having an impact on menstrual health. For example, respondents discussed shift patterns as impacting menstrual cycles or exacerbating menstrual-related symptoms.

“I have noticed that because I do shift work, including night shifts, my periods are less regular and less predictable.

Nursing and Midwifery Healthcare Support, Band 3, Full-time

“Changing shift patterns seem to impact how heavy or painful my periods are. When I had a year off work, and could sleep more regularly, they improved considerably.

Nursing and Midwifery, Band 6, Full-time

There was no consensus over whether menstruation was perceived as more of less disruptive for those working in the healthcare sector vis a vis those not working in healthcare, with nearly equal number of respondents agreeing (32%), disagreeing (31%) or neither agreeing or disagreeing (38%). This view was consistent across Bands. However, work-related environments could have a significant impact on menstruation and menstrual health, such as stress.

“Stress impacts Endo (Endometriosis) which has knock on effect for mental health work has been exceptionally stressful, long hours, rural community work doesn't allow for pad changes. It can be a nightmare to manage.

Nursing and Midwifery, Band 7, Casual/Fixed term

“If I am feeling more stressed due to work then my period is likely to be late, and often I am more likely to have worse PMS symptoms such as tender boobs, fluctuating emotions and cramps.

Health Psychologist, Band 8, Full-time

“I sometimes find when stressed at work, my period may arrive later than expected. It generally comes at a time when myself and body feel more relaxed.

Analyst, Band 6, Full-time

While there was awareness and acceptance that some jobs were not possible to undertaken away from fixed workplace, many discussed the value of being able to work at home as a means of positively negotiating menstruation and work:

“Being able to work from home has been a godsend in dealing with increasingly heavy periods now I’m in my 40s, as it’s easy to change trousers etc when bleeding through.

Anonymous, Mental health condition disclosed

“Since working from home, I have been able to deal with my period a lot better, I am not under any pressure to not let it show that I’m in pain and I can get lunch, make tea and go to the bathroom with less walking.

Administrative services, Band 5, Full-time

“Every 2-4 periods are very painful for the first day or two. The pain can radiate all the way down my legs and into my feet when it’s bad, so it can be distracting when I’m working. I’m lucky though, as I have flexible working conditions and work predominantly from home, so I can manage my work around symptoms. This wouldn’t be possible if I was expected in the office every day. I would have to take sick leave instead.

Business Services, Band 6, Full-time

“Needing frequent access to the bathroom and being uncomfortable has affected my work performance. If I had not been able to work from home, I would have had to go off sick.

Admin Officer, Band 4, Full-time

For some, working in a physical fixed site meant that certain environmental conditions could make menstruation more disruptive, as could expectations surrounding workwear or work conditions:

“I find it difficult to manage my pain at work and often find myself not managing to be my normal self. I find I’m not as communicative with patients and I find that I struggle to do heavier duties. I have not taken time off work, however. I also have so many fears. I am a radiographer and can spend hours in theatre without breaks. The surgeons won’t let us out even when we are not needed. I worry about changing my sanitary pads and my tampons.

Radiographer, Band 5, Full-time

“I can occasionally have very heavy periods which makes working in hot wards uncomfortable. These can be unpredictable

Physiotherapist, Band 6, Full-time

“I am currently ‘non uniformed staff’ and wear a tunic but my own trousers. That is a good arrangement because when you have heavy periods, you want to wear dark coloured trousers as every month on the 2nd/ 3rd day of my period, the ‘super’ Tampax and sanitary towels reach saturation and because I work clinically, I can’t always leave clinic (e.g., if supervising undergraduates working on patients) to go to the toilet. In a previous post I had, they insisted I wore light coloured scrubs - unfortunately this encourages you to phone in sick on days of heavy periods because you know other people will see blood on your trousers and the embarrassment is just awful. If you could just wear your own trousers (as in my current post), it’s fine, I just know to wear black for a couple of days and I can come to work.

Medical and Dental Consultant, No Band disclosed, Full-time

This was also reflected in comments surrounding prolonged ability to endure shift work as menstruation and menopausal symptoms coalesced:

“Sweats and unable to cope with heat on the ward, no air conditioning on ward, exhaustion due to sweating and exhaustion, urine infection due to dehydration caused by heat on ward even though I drink as much as possible. A 12-hr shift in these conditions is what is making me retire 10 years early.

Staff Nurse, Band 5, Full-time

Different work-related factors were also viewed as having a compounding effect, including commuting, or travelling for work:

“Stress + COVID vaccination (required for my role) both impacted my cycle. Vaccination stopped periods for 3 months (confirmed by doctor to be the cause).

Biomedical Scientist, Band 6, Full-time

“Stress at workplace, backshifts and current problems with travel to work (Stagecoach buses being cancelled, it takes me sometimes 2 hours to get to work/home) making difficult to manage period pains and get to toilet when I need it.

Lab Assistant, Band 3, Part-time

“My role also involves having long journeys/ meeting patients often living 2 hours away. This does not fit well with having menstruation at work. This also results in anxiety in menstruation management.

Children’s Services, Band 7, Full-time

“There have been days I have dragged myself in when I was probably unfit to drive or be at work, but I have been unable to rearrange commitments.

Community Charge Nurse, Band 6, Full-time

D3. The Secondary Symptoms of Menstruation: Menstrual Suppression, Stigma and Shame in the workplace

As suggested in the previous section, part of challenge of menstrual management at work arose from a pressure that came from social and cultural perceptions of menstruation as ‘out of place’ in work. Across Bands, job areas and ages, menstrual suppression, stigma and shame were present and had an impact on the way women experience menstruation and menstrual health at work.

Suppression

Suppression relates to practices that seek to hide menstruation or menstrual symptoms. Women sought to suppress the impact of symptoms associated with their menstrual cycle in a variety of ways, the most notably being ignoring them even when symptoms felt disruptive. Over three quarters of respondents (76%) would carry on and consciously ignore menstrual symptoms at work. Pressure to suppress menstrual experiences was often linked to broader cultures surrounding work:

“I think modern day work culture has instilled a feeling of guilt about doing anything for yourself even when it’s essential (i.e., even more serious issues like taking time off when experiencing burnout or in this case changing your work habits for a couple days to avoid extra pain, discomfort etc when menstruating)[...] It’s not the pain Olympics and life is hard enough without owing everyone who raises an eyebrow an explanation.

Pharmacy, Band 4, Full-time.

Suppression also happened through a lack of discussion of menstrual health at work. Just under half (42%) of respondents had heard menstrual health being openly discussed in their workplace in the past year. This influenced their likelihood of disclosing disruptive menstrual symptoms to those in their immediate work environment:



Menstrual suppression was particularly notable when framed as a dialogue surrounding working through pain more broadly. Many felt that working environments prohibited the ability to express pain as it was viewed as an emotion not commensurate with a professional image or identity. For some, deferring one’s own health and wellbeing was also attributed to cultures within a health care setting:

“*I would be against it (menstrual leave) being made a specific category of leave, or anything else which would single it out among other causes of chronic (or recurring) ill health. Everyone should be able to take sick leave or get reasonable adjustments when they need it due to pain or other symptoms, regardless of cause, and I worry that making things specific for menstrual causes risks undermining this global principle. [...] in **my own profession (medicine) there remains a culture that we work through pain and illness, often to the detriment of our long-term health.***

Medical and Dental, No Band disclosed, Part-time

Suppression due to the practical necessities of work influenced other menstrual management practices. For example, one cardiac Physiologist (Band 7, Full-time) discussed how she ‘ran multiple packs of pill together to avoid menstruation/cramps/low mood during a busy on-call weekend’. It may also impact disproportionately on requests for time off due to not wishing to disclose to managers

“*My menstrual issues are regular, every single member of staff knows what is happening which is embarrassing. Also frequent toilet breaks are easier to take without attracting unwanted attention. [...] My manager is male; I don’t want to discuss with him. If upset stomach is mentioned, there is then a 48-hour infection control time where staff can’t be in work. That is unnecessary for this issue. Menstruation isn’t contagious, but again, I’m not telling a male manager.*

Administrative Services, Band 4, Part-time

Menstrual suppression was not a dichotomous experience (e.g. either suppressed or not suppressed), but rather conditional on certain work conditions. Employees often discussed partial disclosure whereby they would discuss how some menstrual symptoms or experiences they felt could be managed in more socially acceptable ways. For example, mentioning cramps to colleagues might be ok, but not discussing heavy bleeding: others felt working conditions enabled choice over disclosure.

“*I work from home, however, and so it feels more appropriate or acceptable to use heating pads whilst working as no one can see it (e.g., in an office). I have also been experiencing much heavier periods and this has caused me to have to keep stepping away to change tampons. Much easier when working from home :) it feels like too much of a taboo in the workplace to keep stepping away to the toilet.*

Business Services, Band 7, Full-time

Stigma

Stigma relates to a fear of being negatively ‘marked’ or marginalised in some way due to association or connection with menstruation or menstrual symptoms.

Stigmatising menstrual cultures was indicated in two ways.

First was a code of silence around disclosing menstrual leave. 26% of respondents knew of someone who had taken sick leave due to menstruation and declared menstruation as the reason. Yet 32% knew of someone who had taken leave due to menstrual health but had chosen to defer the reason to another medical complaint.

Second was a paucity of organisational avenues through which to seek support. Less than a fifth of respondents (17%) agreed that their workplace provided a way for employees to disclose ways their menstrual health impacted work. While respondents noted that their immediate work environment and colleagues often ‘*understand my worries as many of us are women*’ (Radiographer, Band 5, Full-time), there was a lack of organisational apparatus surrounding disclosure in a positive and unproblematic way.

Considering stigma in more depth, it appeared that traditional organisational cultures of stigma were rooted in menstruation not being seen as a legitimate workplace issue. This could result in practices that created potential risks in the workplace:

“*Period cramping and migraines that accompany affects me from getting my work done, I cannot concentrate and spend my day going back and forth to the office toilets. I use a hot water bottle at my desk. I shouldn’t be driving with the migraines I get due to my periods, but I don’t feel I can call in sick as its not seen as a sufficient reason to be off work.*

Administrative Services, Band 4, Part-time

Other respondents framed their menstruation at work in terms of detracting from productivity and efficiency, or as a direct result of their menstruation or symptoms, but due to fears of being ‘outed’. In particular, the stigma of menstrual blood- which may be referred to as ‘leakage freakage’ - resulted in significant personal labour to ‘hide’ any possibility of this happening:

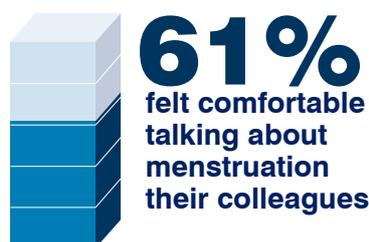
“*Horrible pain and bleeding heavily makes a busy demanding work day much harder. taking pain relief has side effects and running to the bathroom to change sanitary protection frequently is concerning (have I bled through?) as well as time consuming.*

Staff Nurse, Band 5, Full-time

“*More frequent trips to the toilet with heavy periods, having to leave to go home to change clothes due to leakage. Now bring spare clothes to work. But still time-consuming.*

Nursing and Midwifery, Band 5, Part-time

Stigma is often context dependent, and manifests differently in the relationships we have with other people. This influenced how comfortable respondents felt in talking about menstrual health within and beyond the workplace.



Talking about menstruation also differed for those who worked in male dominated working environments.

“ I sometimes have phases when my period is very, very heavy for the first few days and has led to a few ‘accidents’ (essentially blood has leaked onto my clothes). It is very difficult and embarrassing when you need to explain to a male manager that you need to end or postpone a conversation in order to sort yourself out (without explicitly explaining what is wrong).

Programme Manager, Band 7, Full-time

“ I experience headaches with my cycle, and intrusive pelvic and back pain - I have come to work before with a hot water bottle and paracetamol to ease the symptoms, however I now work in an environment (all male) where I don't feel as comfortable in making it known that I am experiencing such discomfort - the combination of headache and pelvic pain can be very distracting as there is no way to ease it until it passes, therefore my work for 2-3 days can be affected as my concentration and motivation are not at full capacity.

Nursing and Midwifery, Band 5, Full-time

While the number of respondents surveyed on menstrual health were in a workplace comprised of mainly men was relatively small (n=127), it was notable that for this group, only 17% felt comfortable talking to their line manager about menstruation and 42% felt comfortable talking to colleagues.

Other respondents also referred to a broader masculine culture as preventing disclosure and creating stigmatised environments:

“ In the NHS I would feel comfortable talking in confidence to a manager, even if they were male, because I would feel there was a support framework I (and they) could draw on. But I still wouldn't talk about it openly with colleagues - NHS IT is still fairly bloke-heavy, and blokeish. I imagine the same is true for some other areas, non-clinical AND clinical.

Administrative Services, Band 5, Full Time

“ I wouldn't want to flag up that I felt mentally less well due to menstrual cycle. I would be worried I would be seen as a “hysterical female” in a culture which generally isn't as supportive of wellbeing as it says it is. It's also, I feel, quite a personal and private issue.

Medical and Dental, Band undisclosed, Part-time

However, significant allyship in the form of supportive colleague or line managers played a vital role in offsetting what could be stigmatising environments:

“ I am the only female or person who menstruates within my team, which can be isolating, although it helps that my line manager has understanding due to his own family. I don't know who I would approach outside of my line manager, he might try to help even if he can't fully understand.

Administrative Services, Band 5, Full-time

What was notable was that even though over two thirds (69%) of employees felt that most people feel embarrassed or ashamed discussing menstrual health in the workplace, respondents themselves felt they were equipped to talk about menstrual health of others. 95% of respondents felt that they were confident in talking to a colleague about their menstrual health in relation to work.

One reason for this may be that those choosing to complete the survey who were more 'menstrual confident' than the general population. However, there was also suggestions that in workplace with positive structural and culture

elements, employees were happy to be more open about menstrual health at work. In particular, a number of respondents discussed how positive local atmosphere and work cultures countered broader menstrual stigma:

“With the NHS culture for me personally I feel I can approach either senior member to openly express my difficulties on any given day, I can confidently say I will be understood and given the option to apply suggested methods to help manage any issue which arises.

Admin Coordinator, Band 4, Part-time

Stigma is particularly powerful when connected to body-based work experiences since it is often related to ‘bodily signs designed to expose something unusual and bad about the moral status’ of the individual. In other words, stigma connects menstrual health experiences with morally discrediting ideas about bodies at work. In doing so, it lays the groundwork for prejudice not through material practices (such as policies and procedures), but through an imagined attachment to a denigrated experience – menstruation and the ‘problematic worker’.

The power of menstrual stigma meant that respondent discussed heightened vigilance in their work as something women in all jobs experienced:

“I don’t think there is any women who confidently get up after sitting for a while and doesn’t think am I leaking?

Nursing and Midwifery, Band 5, Full-time

“Been in so much pain, it’s often difficult to concentrate at work. Having very heavy periods make me feel so uncomfortable and paranoid when at work.

Dental Nurse, Band 5, Full-time.

Respondents themselves were also hyperaware to their menstrual needs resulting in them being framed as being ‘difficult’ or ‘malingering’, particularly in the context of inflexible workplace cultures where even minor adjustments potentiated layers of management approval and earned the ire of some colleagues and management as being unreliable, unprofessional and ‘not a team player’.

In considering solutions to help address the burden of menstrual stigma, respondents often called on examples they felt had worked in current or previous workplaces. These often revolved around an ability to be flexible where possible, especially when symptoms were embarrassing:

“Destigmatise needing last minute modifications to accommodate menstrual symptoms. For instance, for a couple of days a month, I have clotty bleeding that floods when I stand up. Working from home on those days would be very helpful - even if I’d previously agreed to go into work for a specific reason.

Administrative Services, Band 6, Full-time

Others discussed how stigma could either be challenged or reproduced around discussions of fairness. Framing menstrual health as a right was viewed as reducing stigma, whereas perceptions around un/fairness and menstrual health at work may create obstacles for allyship. This could be particularly complex around discussions of menstrual leave. 13% of respondents felt that leave provision specifically for menstrual health could be perceived as unfair for others in the workplace, although this was less (10%) for those in lower job bands (1-4). It was notable that there was relatively little difference between generations (primarily Gen X and Millennial) in terms of perceptions of fairness of menstrual leave.

Shame

Shame is often associated with stigma. However, stigma can be the general fear of being associated with a particular quality, situation or person that is considered highly undesirable. Shame, on the other hand, is understood here as the emotion that results from an actual experience. Both are powerful and negative emotional experiences that can control social behaviour and sanctions.

38% of respondents reported having had a menstrual related workplace experience that left them feeling embarrassed. This increased to 47% for those with a disability:

“I was working on a covid positive ward about a year ago and I was asked to change into scrubs, which I did. My period came on unexpectedly and stained the scrubs, and a male nurse told me it was “nasty” and to actually throw the scrubs away rather than put them in a red laundry bag. Sometimes when I am on my period, I sweat more than usual, and this has been commented on several times by my line manager. I have tried to manage this and even looked for medication over the counter to help but so far, I have not been able to find anything. This makes me feel embarrassed, but I feel like I can’t talk to my line manager about it as she just wants it fixed.

Nursing and Midwifery, Band 2 Casual/fixed term

“I have taken 2 episodes of absence in the past 12 months as a result [of menstruation]. This has been mostly due to the concern that I would bleed through during shift which would result in embarrassment and also due to the pain which I experience.

Administrative Services, Band 5, Full-time)

As suggested in the above examples, shame operated on two levels. First, the primary shame took place when confronted with their menstruation or menstrual symptoms in a workplace context. Menstruation and menstrual-related symptoms were viewed as an illegitimate workplace concern and for those experiencing a menstrual-related condition such as endometriosis, they felt that in the workplace ‘it’s a chronic condition but it doesn’t feel like a valid one (Nursing and Midwifery, Band 7, Casual/Fixed term). This impacted respondents’ likelihood of taking medical leave and their propensity to disclose their menstrual symptoms in the workplace.

However, an internalised secondary shame was also mentioned around ‘allowing’ their bodies and menstrual experience to be impacted by work:

“Having started a new job in Spring my menstrual cycle has been all over the place. I honestly can’t say if this is down to my own personal situation, the stress of working/ single parenting or just my age and approaching the years of menopause. I wouldn’t say it is fully impacted by work but certainly that works plays a part. I do thankfully work in a supporting team in public health however I would feel embarrassed/ ashamed to mention or put down that my work affects my menstrual health and vice versa.

Allied Health Professional, Band 4, Part-time

Bureaucratic processes surrounding menstrual-related experiences compounded the existing angst respondents shared about their bodies. The below excerpt vividly illustrates how organisational processes can exacerbate the shame around a common menstrual-experience – a ‘leak’:

“I experience flooding for the first two to three days of my period and have to take a change of clothes to work. Also had to request a new chair due to this and found it quite embarrassing when estates required full details about why I wished a specifically wipeable chair and not fabric.

Strategic Development, Band 6, Full-time

D4. Intersectional Experiences of Menstrual Health and Work

Intersectionality is concerned with different axes of power operating in ways that generate disadvantage or marginalization at a cultural or structural level. It often considers the impact of two or more identifying categories (such as gender, age, ethnicity, or disability) coming together to produce a negating experience that is more than the sum of the composite parts.

We recognise the lack of research that explores the intersectional nature of menopause with other health conditions or other social experiences, such as minority membership (e.g., sexuality or ethnicity). The sample sizes surrounding ethnicity, gender identity and sexual orientation were too small to provide a statistically meaningful analysis, and more qualitative-based research is required to explore intersectional experiences in more depth.

However, the extant dataset enabled us to identify how those self-reporting a disability faced specific barriers and challenges surrounding menstrual health and work.

Menstrual health-seeking encounters – which were identified as challenging for the general population – were further complicated by the presence of a disability or concomitant health condition. These manifested in three ways.

First, by impacting diagnostic pathways. That is, overlapping symptoms and difficulties in advocating for oneself within a bureaucratic medical system delayed diagnosis or resulted in negative externalities, such as inappropriate treatments and pain. For example, diagnostic pathways for menstrual conditions were hampered by conditions such as neurodiversity that made poor communication channels have disproportionate effects for some neurodiverse women:

“*I'd been waiting and fighting to get understood, taken seriously then diagnosed and seen, especially being ND (neurodiverse), I struggle to communicate my own problems.*

Administrative Services, Band 5, Full-time

“*I recently had a gynaecological appointment that was miscommunicated on what procedure that was being carried out. I was told I was getting my cervix tested, but instead had a straw inserted through my cervix, causing me intense pain and I nearly passed out when it finished. If this had been communicated properly, I would have prepared myself for it mentally and emotionally.*

Administrative Services, Band 4, Full-time

Second, disability and concomitant health conditions were reported as limiting and complicating treatment options for menstrual health conditions. For instance, mental health could influence their menstrual health-seeking encounters:

“*The contraceptive pill I was eventually prescribed (Yasmin) was amazing and addressed all the issues I'd experienced around severe PMS symptoms (including psychological symptoms/pain/heavy periods – which were probably exacerbated by the fact that I am high functioning autistic, although at the time I was undiagnosed). However, the specialist PMS clinic I had been attending stopped running and the NHS board decided without any consultation with those of us who were affected that women would no longer receive Yasmin as it was more expensive than other contraceptive options - although I had previously tried other options which had actually made things worse. [...] No other support around my symptoms was offered, and I ended up needing to take time off sick due to the impact on my mental health.*

Administrative Services, Band 5, Full-time

I have sought advice re: painful and heavy periods. I have also been off with mental health issues and brought it up with my GP that I thought I was peri-menopausal and the GP was quite dismissive and did not offer any further tests.

Management, Band 5, Part-time

Third, concomitant health conditions created a catch-22 situation from a menstrual health perspective. That is, the dual pathologies were perceived as exacerbating one another and created medical binds:

It took a very long time for me to be diagnosed with endometriosis. I was put on the OCP to 'control' my periods at 12 but this was not successful. [...] I was unable to conceive but was told by my GP that I was too depressed to be referred for fertility treatment on several occasions throughout my late 20s and early 30s despite my infertility being the reason I was depressed! I persisted and I was finally diagnosed with endometriosis and has laparoscopy and diathermy at the age of 36 following difficulty conceiving and miscarriage. [...] I am now 42 and currently on my 5th cycle of private IVF in an attempt to conceive but have been told it is very unlikely to be successful. [...] Periods have honestly ruined my life and despite being a medic myself I have unfortunately always felt that the medical profession did not care in the slightest.

Education, Band 8, Full-time

The additional complexity of concomitant health conditions meant an ethos of positive partnership between individuals, their healthcare providers, and workplace was even more important for employees.

Some respondents who had diagnosed menstrual-related conditions alongside other health conditions were more likely to express concerns about the longer-term viability of work and the consequences this would have on their current and future financial security. The compounding impacts of the effort and labour in working through multiple intersecting health experiences was viewed by some as career limiting. However, they often suggested that line managers and colleague support could prolong workforce engagement:

He [my line manager] does hope that I'll be in the office full-time in the future, though this [my health experiences] will likely cause me to leave the team and workplace completely, location-based work being dyspraxic, autistic, with visual issues, C-PTSD and endometriosis is mentally and physically tiring without travel and interaction on shared spaces. It's a shame because I love my job.

Administrative Services, Band 5, Full-time

Others recognised how a combination of positive healthcare and a supportive line manager had enabled long term engagement in the labour force. One respondent, who had experience menstrual symptoms and was now heading towards menopause, discussed their line manager as playing a key role, alongside other stakeholders:

Both my GP and the Sexual Health Service have been very supportive and understanding of my peri-menopausal symptoms, which have become much more apparent in recent months, and have resulted in me also asking for medication for anxiety, which has increased significantly due to low mood as a result of stress at work and family bereavement, and my obsessive-compulsive habits increasing unreasonable, as I try to handle the effects of the peri-menopause. Although my line manager has mainly been supportive of my health and wellbeing, I am not convinced that this condition and the impact it can have on someone, is fully understood by line managers and what they can do to support their staff.

Administrative Services, Band 4, Part-time

The study specifically measured intent to exit the organisation within the next 12 months due to menstrual symptoms – the proportion of individuals with a disability who were likely to leave (9%) was more than double that of those without a disability (4%). Individuals with a disability (18%) were also more likely to be change their hours and formal working conditions in the next year due to menstrual symptoms when compared with those without a disability (14%). This suggests that more attention needs to be paid to individuals experiencing intersectional experience as they are precipitating costly turnover decisions.

The implications of managing intersectional health conditions were particularly marked for those with a physical disability. The workplace had a clear role to play in terms of providing practical supports, particularly for employees required to work on-site. For those with disabilities and concomitant health conditions, accessibility and adequacy of facilities for managing menstruation could be an issue:

“To have menstrual products available in disabled toilets (as I am a disabled person) as currently they are only in able-bodied female toilets.

Allied Health Professional, Band 6, Full-time

“I’ve often struggled to access a suitable toilet to deal with my menstrual health needs, as there are only two sets of toilets, plus one disabled one on my floor at work. As I now have mobility issues, I’ve not only had to put up with pain from my period, but extra fatigue from having to walk further to access a suitable loo.

Nursing and Midwifery, Band 5, Full-time

A number of people discussed the increase in reusable menstrual products, and how this required facilities to support this decision.

“I, and a lot of women I know, have started using menstrual cups in place of tampons or pads. Having a sink in each cubicle rather than shared handwashing facilities would allow for more privacy when washing and replacing these.

Administrative Services, Band 4, Full-time (partial/ sight loss/blindness)

Others suggested that workplaces could benefit from having an advocate that would help to proactively negotiate how symptoms could be collaboratively managed with the organisation:

“I have never taken leave due to PMS related symptoms but my working shift is always so, so challenging emotionally. It would be great if these days got to be half days or something - but I realise this is maybe too much to expect especially in the public sector. Maybe having a menstrual health practitioner or representative of some sort that people could confidentially consult within the organisation, to see if there are ways of managing symptoms better in the workplace/get some tips or support, other.

Job not disclosed, Band 5, Part-time, ADHD

D5. Sustainable Workplaces and Positive Menstrual Health

This study was interested in exploring how the relationship between menstrual and menstrual health and work impact people’s perceptions surrounding the sustainability of their workplace or labour market participation. This included an exploration of the different physical aspects of the job environment that could support menstrual health.

The survey was undertaken at a time when there were significant numbers of unfilled positions within the NHS across the UK, as well as a shortage of nurses³⁷ and other healthcare professionals globally. These are situated within broader demographic trends that subsequently require organisations to provide working conditions and inclusive workplaces that allow people to meaningfully and positively participate in the labour market for longer.

³⁷https://www.icn.ch/system/files/2023-03/ICN_Recover-to-Rebuild_report_EN.pdf

There were several practical aspects that could make managing menstrual practices challenging. This included the limitations of time and space to attend to menstrual needs. While there was a general feeling that there were usually adequate facilities in fixed workplaces (such as hospitals, clinics or offices) to attend to menstrual needs, others working in the community or having to travel often had to ‘make’ do’ with relying on public facilities:

“Heat pack on abdomen is good and understanding by colleagues my workplace hospital environment is good but have difficulties finding public facilities early am during commuting time for frequent emergencies. Have been refused at large 24hr supermarkets as toilets don’t open until 8am. Also, Health Centre don’t open until 8:30 in the main, it’s difficult if the first meeting of the day is there & you have a long commute before. This all adds to the anxiety of the commute

Physiotherapist, Band 7, Full-time.

[suggestion of] Access to NHS sites e.g. GP surgeries to access toilets when out on visits rather than supermarket toilets.

Nursing and Midwifery, Band 6, Part-time.

Finding time to attend to menstruation while working was a challenge, with 32% of respondents suggesting they could find time to attend to menstruation at work. This varied dramatically depending on band: while 80% of respondents in band 8 or above felt they could find time to attend to their menstrual needs at work, only 16% of those in bands 1-4 felt the same.



77%

Felt they had adequate workplace facilities to attend to their menstrual needs



32%

Cannot regularly find time to attend to their menstruation at work

The consequence of this for menstrual health was a series of offsetting and accommodating practices adopted by employees. It was clear was many employees invested significant effort into ensuring they could work through menstruation and menstrual symptoms. This included keeping medication or hot water bottles at work and strategically and creatively planning ways to quickly go to the toilet without disrupting the flow of patients or their colleagues:

“I have been fortunate to have good line managers who I could confide in and would help me problem solve or ease guilt around needing reasonable adjustments due to my endo. [...] I work in the community. I have to be very creative about where and when I go to the toilet and factor this into my day. It adds an extra layer of thinking in a job that already has a lot of logistics to consider. e.g., travel time between home visits etc. I also have anxiety around being ‘caught out’ and leaving a big pool of blood on someone’s sofa.

Allied Health Professional, Band 6, Part-time

Others discussed changing the period products they used in direct response to work conditions such as wearing double menstrual protection:

“I am a midwife and regularly in all day clinics which are overbooked. I am not getting time to go to the bathroom to change my tampon often enough so have changed to pads. I feel this is safer for my health.

Midwife, Band 6, Full-time

“*Period pain, heavy periods. Having to plan my day around toilet stops etc (I work in the community and can be out of the office almost all day between patient’s homes.)*

Nursing and Midwifery, Band 5, Full-time

At the same time, there was evidence that some respondents were channelling their resources – physical, psychological, emotional and financial – into working through menstrual symptoms at the cost of other aspects of their life.

“*Feeling completely exhausted during PMS and first few days of my period makes working so much harder and unable to do much in the evenings during this time.*

Clinical Scientist, Band 7, Full-time

“*Due to work demands, I find it difficult to take care of myself when I need it most during menstruation.*

Medical Secretary, Band 3, Full-time

This ability to use leisure time to offset the impact of work, if done over a period of years, can deplete an individual over time. In other words, the opportunity costs of inadequate menstrual support in the workplace could place employees at risk of burnout and creates an environment for dissatisfaction and disengagement over the course of a working life.

These offsetting practices constitute a form of menstrual labour related to inflexible working conditions, environments or cultures. They constitute the backdrop for greater turnover intent, particularly for those respondents who felt their work had disrupted their menstrual health. In particular, they were more likely to leave **both** their **organisation** and the **workforce** altogether.

Around 5% of the total sample intended to leave their workplaces in the next 12 months as a result of their menstrual symptoms. However, for that 5%, experiencing disruption to their menstrual health because of work was important in making this decision.

Of those who intended to leave their current job in the next 12 months, 63% experienced disruption to their menstrual health because of their work. This compared with only 26% of those who intended to stay. This was consistent amongst those intending to leave the workforce entirely in the next 12 months. Here, 60% experienced disruption to their menstrual health because of their work, compared with only 26% experiencing disruption out of those intending to stay in the workforce.

Other factors could influence the decision to leave work. For example, those who has disruptive menstrual symptoms but reported having autonomy in their work were more than twice as likely to stay as those who didn’t have autonomy in their jobs.

Shift work also played a significant role in those wished to leave. Of those expressing an intention to leave, over a third (37%) were shift workers. Similarly, of those experiencing disruptive menstrual cycle who looking to change their working conditions in the 12 months, around a quarter (26%) were shift workers.

D6. MAPLE: Moving Towards Period Positive Practices At Work

While there was no evidence that disruptive symptoms significantly impacted attendance or productivity at work for the vast majority of respondents, continuing to rely on private offsetting measures is untenable when planning for a sustainable healthcare workforce.

Evidence of 'what worked' for respondents suggested that supportive and positive experiences can be crafted with minor workplace accommodations. Such changes may not necessarily incur significant expense and also signal a cultural willingness to be positive and supportive around women's experiences.

Responses can be summarised as suggesting five key practices to create period positive workplace identified. These are: **M**icroleave, **A**llyship, **P**hysical environment, **L**ine Management, and **E**ducation and awareness.

Microleave

Flexibility to manage the episodic nature of menstruation and menstrual symptoms is fundamental to improving employee experiences of menstrual health at work. In particular, trusting employees with the autonomy to manage workspace and time. Minor accommodations around time or 'microleave' (as little as five to ten minutes) can provide the difference between a day's productivity or a full day's absence.



Microleave is a means through which intense, unexpected and ephemeral symptoms can be managed and allows employees to 'job craft' without being in contravention of strict absence policies (i.e., a full day of sick leave or leave that requires prior notice and approvals).

'Microleave' is particularly salient for shift workers, but presents an opportunity for all employees that:

- Provides a way to manage acute symptomatic presentation that commonly occurs during menstruation, e.g., pain medication during intense sudden cramping or taking a brief respite break to manage a 'leak'.
- Establishes trust in employees experience of menstrual health and the associated symptoms.
- Enables employees to be present and maximise their work capacity and productivity

Respondents advocated for this practice by suggesting only a small amount of time was often needed; for example, to access pain relief or have a short break for the most intense moments of symptoms. For those who reported face disruption to their work because of menstruation, small accommodations though flexibility around start times could also make the difference between working or having to call in sick for a full shift or working day.

“Having free sanitary products is helpful as well as being able to symptom manage without this impacting your work security. I don't think annual leave or sick leave should be applied to periods and their symptoms; this feels almost punitive. Some creative thinking is needed health science services.

Anonymous, Band 7, Full-time

“Having to start a bit later due to period cramps in the morning and waiting for painkillers to kick in.

Human Resource, Band 5, Full-time

“Working from home has helped a great deal. I also work flexi time which helps if I feel I can't work on I can stop early and make up my time. Manager, Band 8A, Full-time

“Allow colleagues to have 'soft' work days if period is really troublesome, whereby you can delegate certain tasks or have an office day.

Nursing and Midwifery, Band 5, Part-time

Microleave was also seen as providing a solution to those who may contravene absence policies due to having to take off a full day of sick leave or prevent taking a full day of leave when the episodic nature of symptoms did not require this:

“*I have a very supportive manager and I have the option of working from home, this has made a big difference to me as I can deal with everything period related a lot better from home. I don't have to go off and hide in the loos if I want to cry for no reason, I can sit with a hot water bottle and in comfortable clothes and I don't have the stress of commuting to and from the office, it makes a massive difference to me.*

Administrative Services, Band 4, Full-time, Long-Term illness

“*Having less strict NHS policies as after 3 times of missing from work staff is being formally reviewed to manage absences. This is something I am trying to avoid so I have been too scared to ask for a sick leave due to period pain. It is to be able to save up the 3 sick leaves a year, in case I would need to use it for actual sickness / illness.*

Childrens Services, Band 7, Full-time

Part of this was surrounding trusting employees experience of menstruation and associated pain that enabled women to be present and work to a capacity they were possible of achieving:

“*My workplace has been extremely supportive when it comes to my menstrual health. They have never questioned me when I have had to take time off work due to endometriosis pain flares. Days when I have had high pain days but are workable (or high pain days when due to staffing I can't go home) they have allocated me lighter workload or given me students to work with so I don't push myself too far.*

Nursing and Midwifery, Band 5, Full-time

Allyship

Creating a positive and person-centred environment on the work floor through constructive conversations is key to challenging stigma and enabling work to carry on 'as usual'.

Specifically, allyship is most effective and supportive when it:

- Focuses on practical solutions directed at supporting the individual through their specific concern, e.g., acquiring medication, taking a micro-break, adjusting the schedule of work.
- Sensitive of negative stereotypes around reproductive health in the workplace, e.g. avoiding bias and judgement (e.g. halo / horn effect where women are either stereotypes as 'angelic', infallible and never complaining, or as grumpy, awkward and with problematic bodies)
- Trust is reinforced through supportive and private feedback, e.g. 'I appreciate you coming to me with this and your attempts to minimise disruption to team'.

Our findings revealed that trust was diminished when conversations with line managers and team colleagues involved:

- Questioning – excessive questioning felt invasive and was seen to imply that individuals were untrustworthy or 'faking' their condition.
- High bureaucratic burden – this was a strong deterrent to taking leave of any duration and created an atmosphere of suspicion and gave the impression of a surveillance culture, for example, the need to present a medical certificate for even a few hours' or half day's absence.
- Unhelpful sociocultural stereotypes – individuals were motivated to be professional and often already felt guilty for disrupting the flow of work. Unhelpful stereotypes such as the 'difficult woman', the 'malingering employee' or the 'emotional female' only prompted individuals to feel shame around their health situation and deterred them from seeking help from their workplace.

“ I have experienced a mixture of positive and negative reactions around menstruation in the workplace. It all depended on the time and place of the conversation. Example: a colleague asked for help when she noticed a blood spot on her clothes and she came straight to me knowing that I carry pretty much a full pharmacy around with me. I helped her and we went right back to work, no questions asked. My line manager and I have open and honest conversations.

Public Health, Band 5, Full-time

“ I have had support from colleagues (my team) due to menstrual issues at work, I had massive PV bleed at work and they ended up with an additional patient because of it - this really changed the way people viewed by issues. They had always been supportive but never really got how my periods were affecting everything. There were comments about the number of times I went to the loo etc but as soon as I mentioned I was on my period they generally rallied round and helped me. To the point they would interrupt a meeting or consult to allow me to go to the loo and change protection. As a group of women, we were all good at supporting each other and adapting workload etc to support each other whether menstruating or pregnant. Not all our colleagues beyond the team were as tolerant.

Administrative Services, Band 6, Full-time

Physical Environment

The facilities available in a workplace environment had an impact on how sustainable work was when menstruating. Several respondents discussed toilets as being critical to their experience of menstruation at work. This was reflected in terms of intentions to leave: where those who signalled a greater intention to leave were less likely to be in workplace with good access to adequate facilities where they could attend to their menstrual needs (68% compared with 77% overall.)

Findings suggest that access was not just about having a toilet nearby providing the chance to have ‘proper clean’ (Midwife, Band 6, Part-time) but the condition and provision within that toilet. The conditions of spaces to change, such as toilets, was often mentioned. Some respondents suggested that the facilities were not mindful of the female-dominant workforce in most NHS workplaces:

“ Bleeding through menstrual products, changing clothes is compounded by not being able to just go to a toilet during work due to work commitments.

Nursing and Midwifery, Band 7, Full-time

“ Sanitary bins are too few and usually full which is a problem. Not enough toilets are available for the quantity of women who use them.

Secretary, Band 4, Full-time

“ Availability of toilets is problematic at times, there simply are not enough. Dignity is an issue as often the paper bags for disposal are not available, there are no separate bins to put them in either so they go in the same bin as paper towels which are often very full. In mixed sex single toilets, there is often urine on the seat and floor from men using them meaning you have to clean up before using them.

Occupational Therapist, Band 7, Full-time

Practical aspects such as free menstrual places that were appropriate for different levels of bleeding and always available were also seen as a positive practice. Free sanitary produces also a powerful material ‘signal’ of acknowledging menstruating employees as well as supporting those unable to buy products due to financial of shift work restraints:

“My workplace is brilliant. There are free sanitary items available in all toilets and if I needed to take a few minutes to sit down/get some water etc then that would be completely fine.

Support services, Band undisclosed, Part-time

“Access to free menstrual products for staff who need them (cost of living crisis).

Administrative Services, Band 3, Full-time

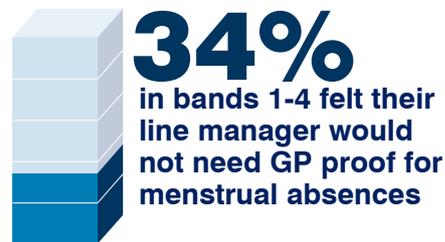
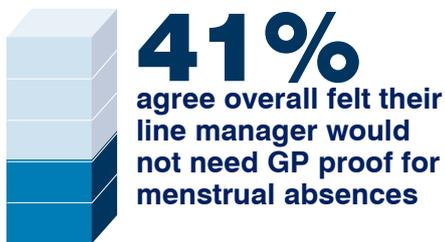
“Since the provision of menstrual products in the NHS workplace myself and other staff have been eternally grateful as this has meant that staff can access these products without having to ask around staff for a pad or tampon. it has saved myself embarrassment and especially on the odd occasion when I have not been able to purchase the products before work.

Nursing and Midwifery, Band 5, Full-time

Line management

Line Management and direct supervisor relations were seen as fundamental to viewing menstrual health as either problematic or an area that could be positively discussed and worked through in the workplace. Part of the reason for this was that line managers were often in positions where they were required to manage tasks such as assess performance and absences, or manage day to day workflows and tasks. They were therefore seen as having a challenge in balancing the demands placed on them within the large bureaucratic structure of the public sector, while also managing any discretion they had in a consistent manner.

The challenges in this emerge when discussing the various responses surrounding the need for ‘evidence’ or menstrual experiences in relation to work. Evidence of proof from GP’s when they took time off for menstrual symptoms differed across bands.



There were several examples of positive line management support where respondents had been offered flexibility in the tasks they undertook or how they worked in a flexible manner:

I often experience pain and the pain medication can make me feel groggy so I try to avoid when at work and use a tens machine or hot water bottle under my desk instead. Also affects my sleep pattern and mood, making me very emotional which can be undermining at work when dealing with important or sensitive issues. However, I have a very supportive line manager and this makes a huge difference in being able to work flexibly. I’m grateful I have a non-clinical, non-patient facing role where I can do this.

Project Manager, Band 6, Full-time

Education and Awareness

Workplace education and awareness around menstruation was seen to be a positive step, with an emphasis on line management training, as well as training for all colleagues.



Agree that workplace have a role to play in educating line managers about menstrual health



Agree that workplaces have a role to play in educating staff about menstrual health

One anonymous respondent who had endometriosis, suggested that awareness was fundamental to them continuing work, suggesting a need for *'more understanding of menstrual health and endometriosis. more support with both, phased returns after being off sick would help'*.

Others mentioned how education of the variety of experience and different symptoms could ensure that they were acknowledged without menstruation being viewed as stopping employees from doing a good job.

“ I feel that the work place would be able to make a difference by allowing and understanding the issues around periods. The severe heaviness is degrading and having management that could understand would be very useful.

Health Visiting Assistant Practitioner, Band 4, Part-time

Respondents also discussed how this could involve drawing on expertise within their workplaces to provide short session of 'lunchtime learnings' that people could access.

“ Offer help and advice from experts, have someone to talk to. Education of the subject so symptoms are understood and not made a joke of.

Administrative Services, Band 6, Casual/fixed term

Communicating the availability of education and awareness could also help in combatting stigma surrounding menstruation and work:

“ I think menstrual health is a topic that is generally not discussed formally at my workplace and therefore I think being more open would definitely help. If there was an opportunity to discuss these things then it would not be so taboo and things could be done to help.

Clinical Technologist, Band 6, Part-time

“ To cultivate an attitude of understanding periods and period pain and always being open to appreciate that people are different and they are affected differently by it. In an ideal world I hope all managers (male and female) stay open and flexible in working with the affected employee to find a course of action that best fits the person in pain with no consequences such as reduced pain. An employer that is understanding and supportive of their staff wellbeing will retain staff more and will have people who feel valued and who want to give more.

Administrative Services, Band 6, Full-time

In short, the MAPLE framework underpinned workplaces that fostered compassionate leadership, inclusive cultures and an environment where all employees can make a positive and production contribution, summed up by one respondent's experiences as upholding an ethos of:

“*Flexibility and kindness. An employee being able to work flexibly in order to respond to their experiences. Sometimes I know that sitting in agony for an hour will produce relatively little work. Whereas meeting my need to relieve pain and soothe, results in more productivity overall.*”

Allied Health Professional, Band 6, Full-time

E. Findings 3: Menopause and Work

E1: Menopause and Work

Respondents who had went through menopause or were currently in menopausal transition emphasised the fluctuating nature of symptoms. Over three quarters (78%) of respondents reported feeling that menopausal symptoms changed over time, suggesting that workplace policies need to be responsive to these changes to enable a highly experienced workforce to continue working through this period.

The diversity of employee's menopause was matched by the variety of responses around how it was experienced at work. 37% of respondents felt menopause could be managed without support from their workplace, which was consistent across job band and job roles.

Menopause often occurred at a busy time in a respondent's life and as such, an individual's resources may be stretched across multiple and often competing demands for their time and energy in work and social lives. At the same time, there was evidence that their previous experiences of working through adverse life and work circumstances made menopausal employees a resilient cohort within the workplace. This was helped by having a community of colleagues around them having similar experiences:

“ Workplace has been really supportive, especially as there are many of the team who have menopause symptoms. We can take some time to regroup, work from home & have been provided with fans. Potentially one example of something that would be of benefit is to have more shower facilities to allow staff to freshen up if hot flushes are particularly bad as wearing a uniform with sweat patches and feeling 'grubby' is not beneficial to our mental health and confidence.

Lead Practice Educator, Band 8, Full-time

“ I work with many women roughly the same age as me, so we are all going through similar experiences. Everyone is comfortable sharing experiences and ways in which they cope with symptoms, which goes a long way to helping, when you realise you are by no means the only person going through the experience. For me personally, just having an understanding that what I am experiencing is a normal, inevitable process, which is time limited, is enough for me to keep going.

Nursing & Midwifery Team Manager, Band 7, Full-time

In general, respondents did not feel that managing menopausal health at work was more or less disruptive in healthcare compared to other sectors. However, the nature of job demands may have an impact. For example, respondents in nursing and midwifery positions were more likely to view menopausal symptoms as more disruptive to their work (35%) compared to those doing other jobs within NHS Scotland (25%). At the same time, and more so than in experiences of menstrual health, respondents emphasised the presence of a visible community and allyship around menopause. This was particularly relevant when employees discussed finding solutions to help balance menopause while working:

“ I feel there is not a lot of support in general for menopausal women that is accessible to a certain degree. I am currently aware, there is a support group started by a gyn consultant at U.H.W site in monthly meeting in the evening, which is fantastic! However, I'm not from that region and don't drive. Maybe if it was held virtually as well? Most of my own knowledge I've had to learn from some support sites. Very little public health awareness in my opinion.

Nursing and Midwifery, Band 2, Part-time.

Across the sample, there were disparities over the presence and awareness of current policies that explicitly supported menopause, perhaps reflecting the different approaches and visibility of menopause policies and practices in different boards across NHS Scotland. At the time of the survey, 40% of respondents were aware that their workplace had policies that mentioned menopause. The majority of respondents (89%) also felt there was a need for specific menopause policies and practices and that menopause should be explicitly referred to in several general workplace policies. Menopause education was also seen as important, with similar perceptions across work hours (full or part-time), job band and job roles about its importance:



E2. The Bi-Directional Relationship Between Menopause and Work

The relationship between menopause and work experience was interwoven where symptoms could be impacted by different aspects of work, and work could be impacted by symptoms. Respondents often described an ‘unvirtuous cycle’, whereby certain aspect of their job could exacerbate menopause symptoms, that in turn negatively impacted their experience of work. These mainly circulated around stress and anxiety, and the physical demands of particular tasks:

“Higher workload resulting in less time to manage flushes. Physical strain exacerbating joint pain. Difficult to concentrate due to extra demands at work.

Nursing and Midwifery, 6, Full-time

Menopause impacting work

For those experiencing or having experience menopause, 76% felt that their menopause had disrupted their work in some way over the past 12 months. This increased to 93% for nursing and midwifery staff.

Some employees discussed ‘frustration at not being able to manage same workload as before’ (Allied Health Professional, 7, Full-time) although many others suggested this was a cumulative effect due to workloads becoming excessive rather than their own performance being unreasonable or very different to earlier in their lives.

Those experiencing symptoms highlighted the diversity of symptoms associated with menopause that could disrupt work. These include well-documented symptoms such as heart discomfort, anxiety, brain fog, psychical and mental exhaustion, and sleep problems. 78% of respondents who reported these as disruptive symptoms also suggested they happened frequently.

However, respondents also subverted some other assumptions around ‘common’ menopausal symptoms. For example, out of those reporting disruptive symptoms, 17% had never had a hot flush and a further 19% has only experienced them between 1 and 5 times a year. Similarly, 13% had never experienced joint discomfort at work.

Others discussed the psychological effect of menopause on how it impacted on their feelings about their performance at work, even when there was no evidence that others around them or their line manager had raised concerns:

“Loss of self-confidence and anxiety have made me feel anxious about being able to do my job and reacting to issues occurring at work when I would normally brush them off.

Anonymous

Several strategies were used by respondents to manage disruption to their work. Similar to those responding to the menstrual health survey, an overwhelming majority of employees (75%) carried on working and sought to ignore it. Over 1 in 5 (21%) changed what they ate or drank to try and manage symptoms:

“ I do not drink for the whole day once I leave home after 1 cup of coffee at 7am when I am out working in the community until I return home at 6pm. Even doing this I will need to use supermarket toilets approximately 4 or 5 times and with urgency, If I drink any fluid then I would need to use the toilet more often than that. I usually have a really bad headache when I get home but better that fear of incontinence.

Nursing and Midwifery, Band 7, Full-time

A number of employees also referred to work as a one of the main reasons for choosing to take medication during menopausal transition:

“ I have gone onto HRT in order to try and keep working,

Medical and Dental Consultant, Band Undisclosed Part-time

Work impacting Menopause

There was consensus that the workplace had an important role in supporting menopausal transition of employee. 73% agreed organisations can make a significant difference to their experience of menopause at work. However, agreement decreased for those in Bands 1-4 (68%).

For those respondents who were going through or had gone through menopause, 47% felt menopause had been impacted by their work. The was often centred on increasing demands of their work that prevented any space to manage symptoms effectively:

“ Unable to take a break due to unit activity

Nursing and Midwifery, Band 5, Full-time

Others discussed how physical working conditions and the environment exacerbated symptoms, with the inability to control the temperature in their workplace repeatedly mentioned:

“ The wards are far too hot. There is no air con. Then having to wear masks and full PPE makes your hot flushes even worse. You sweat and some days feel lightheaded it's so hot.

Nursing and Midwifery, Band 6, Part-time

“ Communal buildings are too hot. Although it's a long time since I started the menopause, I still have very fierce symptoms. I often think the NHS would save a fortune if the heating was turned down as well as resulting in a more comfortable working environment for all.

Administrative Services, Band 3, Part-time

“ I feel my sweats are worse at work as it's a warm environment, on the go all day and wearing a mask for 12hrs.

Clinical Support Worker, Band 3, Full-time

“ Working in an open plan office and can't control the heating system.

Administrative Services, Band 3, Full-time

Covid restrictions such as the removal of fans to prevent airborne spread of viruses, and face masks, as well as the general conditions imposed during the pandemic, were also problematic in negatively impacting menopause at work:

“It’s been difficult managing menopausal symptoms whilst working at home during the pandemic. Our organisation has been through a lot of change, and I’ve been required to adapt to different job roles, teams and projects. I’ve often felt out of my depth, consumed by anxiety, and feeling not keeping up, not functioning. I’ve felt this was my fault and generally left with feeling that I’m not good enough which adds to the anxiety and the cycle continues.

Health Improvement Manager, Band 7, Full-time

“I have been having hot flashes, and sweating extensively, due to ambient temperature, and unable to have access to fans.

Clinical Support Worker, Band, 2, Part-time

Fan was removed due to ‘Covid risk’.

Nursing and Midwifery, Band 7, Full-time

For others, a significant change of circumstances at work could also exacerbate the relationship between menopause and work due to different demands and challenges:

“I was redeployed through organisational change after 19 years in my post. The challenge of the new post and the fact of having to relearn a job was horrific. My inability to concentrate and recall things made the task at hand almost impossible and had a knock-on effect on my ability to function to the best of my ability.

Anonymous

“Lots of changes happening and lack of communication re this. Stress levels are high already, so workload and lack of communication adds to the stress.

Staff Nurse, Band 5, Full-time

Despite these impacts, respondents continued to go into work, even when this sacrificed their lives outside of work:

“Lack of sleep, but still going into work daily.

Community Nurse, Band 6, Part-time

“Some days I go to work on less than 4 hours sleep and have to bed early so I can manage to go the next day. There sometimes is no work/life balance as it is eat, sleep when I manage and then work.

Pharmacy Technician, Band 4, Full-time

E3: The Secondary Symptoms of Menopause: Stigma, Shame and Indirect Problematisation

Stigma

Many employees had recently heard menopause discussed in their workplaces, although this was often mixed between positive comments and negative dismissal or jokes. There was more evidence that menopause was being widely discussed compared to menstrual health at work. However, responses also indicated that some women experiencing menopause also felt that it is a personal matter and just suck it up (Podiatrist, Band 5, Part-time). Others also discussed how menopause was still associated with being a problematic employee or that their experience were completely dismissed:

“

It is felt generally that you are making a fuss and should just get in with it.

Anonymous

“

Unfortunately had to undergo a hysterectomy when I was 42 & for the first year I was on the lowest dose of HRT which seemed to work then I started having issues & lots of symptoms which were awful so I had to phone in sick whilst trying to get a doctor to review my dosage. I explained to my supervisor exactly why I was off sick but on returning my back to work form did not state this as the reason!!! Upon questioning it I was told it wasn't a thing & they had no code for menopause???!!! So was put down as stomach problems which I was not happy with but had no choice but to sign. I am aware of the new menopause policy but my line manager was not so unfortunately there is STILL a stigma with menopause in the NHS & it made me feel quite low, ostracised & embarrassed with my colleagues. I hope this changes in the future as unfortunately as a woman this is part of life & outwith my control. Seriously has made me rethink if I want to continue working.

Domestic Assistant, Band 2, Part-time

Peer communities appeared to be a space for support to combat stigma, 68% of respondents would tell a colleague they were disruptive menopausal symptoms, and this was consistent across most job types and pay bands. Reference to talking about menopause only between immediate close colleagues in a 'closed group' (Senior Manager, Band 8, Full-time) was common. At the same time, some felt that menopausal stigma was the result of colleagues and peers having a lack of understanding or empathy for those experiencing menopausal transition:

“

I get the feeling that the younger generation and male members of staff laugh it off as it is just an excuse.

Nursing and Midwifery, Band 6, Full-time

“

Lack of understanding from younger generation how symptoms can affect your daily working tasks, such as brain fog, hot flushes and mood swings.

Administrative Services, Band 3, Full-time

Respondents also pointed to hierarchical relations as being a barrier to discussions of menopause. 62% of all respondents would disclose having disruptive symptoms to their line manager, with this figure being slightly less (60%) for nursing and midwifery staff. Concerns about disclosure revolved around fears of other questioning an ability to do your job:

“

I do a lot of moving and handling, but scared to mention menopause in case they think you are incapable in your job.

Anonymous

“I still feel it is a subject that is slightly taboo in that I would be too embarrassed to give menopause as a reason for substandard work or for days when not slept the previous night. I would just get on with it and say nothing, but it can be difficult with the tiredness and the heat.

Allied Health Professional, Band 8, Full-time

There was also evidence of the secondary effects from more indirect practices not considering the consequence on menopause that reflected a lack of sensitivity around menopause that led to related stigma:

“We have a clear desk policy at work. When flushing my fan is not always to hand. Also I work in an open plan office environment; this doesn’t help with the social anxiety menopause has caused.

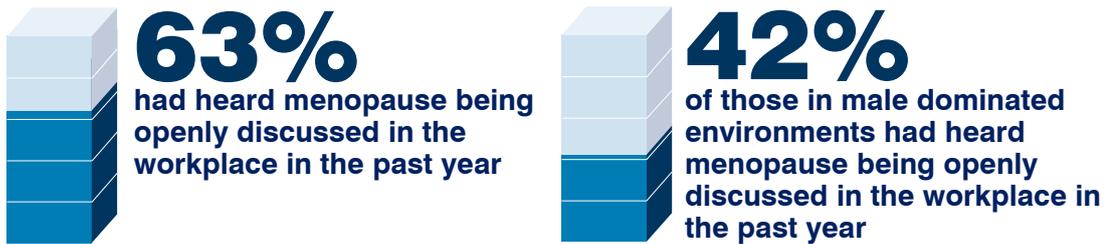
Childrens Services, Band 3, Part-time

Others discussed how the stigma surrounding menopausal symptoms could lead to shaming even when not directly attributed to a menopausal symptom:

“Stressful situations stimulated flushing leading to embarrassment and discomfort.

Nursing and Midwifery, Band 7, full/part-time undisclosed

The gender ratio of respondents’ workplace also made a significant difference to how visible menopause was as an aspect of everyday work.



Whether respondents were in a male or female dominated workplace environment did not seem to significantly impact how comfortable they felt talking about menopause with colleagues, with 69% agreeing they felt comfortable talking about menopause with colleague, those in male dominated environments, compared to 75% overall.

There was, however, evidence that male dominated workplaces impacted disclosure of menopause when taking leave. 21% knew of someone who had taken sick leave due to menopause and *not* formally declared this as the reason; this was 38% for those in male dominated workplaces.

Formal disclosure of sick leave because of menopause also differed across other job conditions. While there was relative consistency across bands and groups of those who know of those taking sick leave and disclosing this was for menopause, this was not the case for other’s not declaring, as shown below:

	Overall	Works Part-time	Bands 1-4
Know of someone in their workplace who took sick leave due to menopause and not declared it was due to menopause	21%	28%	29%

Sick leave was also framed in terms of collegiality, particularly given the staff shortages being faced:

“As nursing staff, we don’t have the ability often to take time away to gather ourselves and we put a lot of pressure on ourselves if we have to take sick leave as we know we are leaving our colleagues short staffed.

Health Visitor, Band 7, Full-time

At the same time there was mixed feelings surrounding leave designated specifically for menopause.

“I don’t think that menopause debility warrants specific dedicated time off work because this isn’t needed if the workplace can adapt to allow its employees the flexibility to work differently to manage symptoms

Senior Manager, Band 7, Full-time

Using annual leave as a strategy for menopausal symptoms was common for just over 1 in 10 respondents with 13% of respondents having taken one of more days of annual leave due to menopause. There was evidence of respondents doing this systematically as a coping strategy:

“I had a total hysterectomy at age 50 due to atypical endometrial hyperplasia with a background of endometriosis. Having suffered all my adult life, the menopausal symptoms were less problematic than the menstrual symptoms. The longer-term effects are more post-surgical than menopausal I suppose [...] Hoping to retire November 2023 so that’s keeping me going and using my annual leave to break up the week by taking a Wednesday off.

Health Services Sciences, Band 6, Full-time

“I had to take annual leave to allow me to catch up on sleep and start later in the day, shouldn’t have had to do this.

Allied Health Professional, Band 6, Part-time

Taking leave was also unlikely to help symptoms in the medium term, and in some ways could exacerbate feelings of anxiety:

“Taking time off is not always beneficial to the worry and stress of knowing you still have to come back and have to catch up on work you have missed due to being off.

Nursing and Midwifery, Band 6, Full-time

Others indicated that this stigma could also result in leaving the workforce:

“When the hot flushes were severe, I could not work efficiently, but carried on which was stressful when one came (every around 3x per hour). Felt I couldn’t show it or say to colleagues or manager. Think I would have eventually taken sick leave or left job altogether. Thankfully got HRT which helped a lot.

Clinical Research Nurse, Band 6, Part-time

Stigma also arises from the connotations that menopause has with becoming an older woman, an identity that is subject to ‘gendered ageism’; that is, the intersectional impact of sexism and age bias:

“Menopause: I expected at best not to be understood, at worse to be written off for e.g., training, advancement etc. I already get all that due to common-or-garden ageism and sexism: adding the sort of “ick factor” and downright ignorance that comes from your average IT guy in relation to gynae issues would have been too much to stand.

Administrative Services, Band 5, Full-time

Shame

Around a fifth (21%) of respondents disagreed that most people feel embarrassed or ashamed discussing menopause in the workplace, rising to a quarter of respondents from nursing and midwifery professions. However, only 8% of those in male dominated workplaces felt the same, highlighting the impact of immediate environment on perceptions of openness and acceptance surrounding menopause.

This also reflected personal experience of feeling embarrassed by their own menopause in the workplace:



For a number of respondents, being 'outed' by menopausal symptoms brought about a feeling of shame with respondents discussing the inconvenience of symptoms manifesting such as 'hot flushes at inappropriate times' (Nursing and Midwifery, Band 7 Part-time). Yet shame not only emerged from particular symptoms, but how it made respondents feel about their work identity. Some experienced a double shaming through feeling that their symptoms were inappropriate or out of order, and also that their subsequent reactions to them were out of place within a professional context.

“My brain is foggy at time and find it hard to recall people’s names, where I have placed information in shared drive folders. At times I feel really upset even though I am aware it is on reflection so out of context.

Nursing and Midwifery, Grade Undisclosed, Full-time

“I am known for performing at 110%, but now feel that I am performing below par - which affects my self-esteem and makes me anxious about the security of my job (even while being aware that is not a real risk).

Other Therapeutic, Band 8, Full-time

“On a really bad day - I get to the point where inside I am a moment away from losing it and wiping the floor with anyone who looks the wrong way or says the wrong thing (yes my rage can be this extreme!) but I am also thinking inside what are you acting like this, why bother making an issue of the menopause and end up being all sarcastic which results in me then fighting with myself (why am I doing this, who are you, stop being stupid).

Administrative Services, Band 3, Part-time

“I would say that the menopause has impacted my work. Hot flushes, disrupted sleep, 'brain fog' lack of concentration ability, fatigue, anxiety (never been an anxious person) - all of these symptoms to name a few have negatively impacted and led to me feeling as if I am not doing my job as well as I used to.

Consultant, Band 8, Full-time

Some also felt that there had been a backlash that had emerged due to the increase presence of menopausal conversations in the popular press and by celebrities. Rather than make this a more acceptable workplace discussion, a number of respondents felt that increase media attention could mean other label them as menopausal in ways they could not control. For others, menopausal symptoms became part of more general bullying or discriminatory behaviour from others around them:

“ I hadn’t known I was in early menopause for many years. However, looking back now on HRT I can see how I wasn’t able to make myself heard. I remember meetings where colleagues rolled their eyes at me for waffling, when I was struggling to find the words. I felt gas lit, overlooked for promotion and bullied out of a job.

Art Therapist, Band Undisclosed, Part-time

“ I wish that people would not make jokes about menopausal women at work and that my colleagues were more understanding. The recent increase in attention in the media has fuelled less tolerance in the workplace. I have heard female colleagues getting angry ‘is there anyone in this workplace that is not menopausal’. I feel frequently ashamed and isolated and unable to admit I struggle with symptoms and anxiety. I don’t want to feel like a burden to others and I often feel quite isolated hiding my symptoms as best I can, but I know people notice and I frequently feel there is no dignity or compassion from colleagues. Especially for older women at work and I know there are many of us who cannot afford to go part time or retire.

Nursing and Midwifery, Band 7, Full-time

Indirect Problematisation

Part of the menopausal landscape at work was the paradoxes between menopause being signalled as an important issue and the presence of policies, but then other practices undermining positive messaging. A lot of this occurred through menopause messaging being in conflict with health and safety dictums, particularly surrounding Covid. For example, many discussed how fans has been taken away due to Covid spread, which had led to exacerbated vasomotor symptoms. Others discuss how bureaucratic layers of approval made them feel awkward or not able to access what were relatively minor accommodations:

“ My office did not have a window and I ordered a fan. This was authorised by my line manager but refused by the department who supplied the fans. we were told we could only order fans for patient areas. Occupational Health were contacted but this was never resolved.

HV Team Leader, Band 7, Full-time

Others were concerned that the increased attention towards menopause at work could problematise older women or suppress broader experiences of growing older at work:

“ It’s a natural phenomenon, don’t medicalise it, sure there are some sleeping problems, urinary incontinence, vaginal dryness --it’s called getting old. Sure, there might be some women who may need extra days here and there, just give it to them, don’t create a panic. It’s life.

Nursing and Midwifery, Band 6, Part-time

There was also a sensitivity towards ensuring menopause did not inadvertently and further problematise mid-life women at work through playing into gendered ageist stereotypes. For example, only 59% agreed that menopause specific leave was fair to other employees, and there were mixed feelings about menopausal employees being accommodated due to their symptoms. In many cases, this ambivalence emerged due to the undercurrent of gendered ageism where respondents recognised that mid-later life women were already seen as problematic:

“ Older women are frequently disrespected at work, and it seems to be acceptable to call older women abusive names or put everything down to ‘she’s menopausal’. Flippant remarks cumulatively erode people’s confidence. I often feel embarrassed and silenced ashamed to be an older woman at work and feel there is a great deal of open discrimination in the workplace

Advance Nurse Practitioner, Band 7, Full-time

E4. Intersectional experiences of menopause and work

Similar to menstrual health survey respondents, while minority ethnic respondents and those of different sexualities did not disclose unique experiences of menopause through the survey, this does not suggest the absence of different experiences, and requires future qualitative research.

Those with disabilities discussed the interrelationship between their experience of menopause at work alongside other conditions. Menopause was felt to impact different presentations and experiences of existing health conditions:

“I have Ehlers Danlos Syndrome (EDS) which is a genetic fault in collagen which causes this to be too elastic and affects any bodily system made up of collagen. [...] Menopause has exacerbated my hypermobility, my balance, which is poor due to Dyspraxia became significantly worse as joint ligaments etc. loosened further causing joint instability. I experienced Symphysis Pubis Dysfunction during two pregnancies, and it also affected me monthly during my menstrual cycle given that oestrogen tends to stabilise collagen, whilst progesterone loosens it. However, with the onset of menopause joint stability has become a permanent problem.

Allied Health Professional, Band 7, Full-time

“The brain fog and joint pain has been the worst thing at work for me. I’m in the middle of a task and I completely forget what I’m doing, or I’m speaking to someone and forget what I’m trying to say. I have osteoarthritis in my hands and feet and have constant pain, but the menopause seems to have made this worse. I work for the NHS and my role relies on my manual dexterity which has been affected. I have never taken time off as I don’t see Menopause as a sickness but something I just have to deal with and get through.

Allied Health Professional, Band 4, Full-time

Others suggested that previous conditions made them familiar with how to navigate different policies and options that also helped them to support the experience of menopause at work:

“I am already doing it as my employer supports hybrid working so I mainly work from home, but I also have other long term health conditions, so my employers have always been very supportive.

Administrative Services, Band 5, Full-time

At the same time, other respondents felt the ‘double disadvantage’ of menopause alongside existing health conditions could result in being excluded from more general conversations around menopause. There was an awareness that while menopause was becoming a more acceptable topic for workplace discussion, respondents discussed how the ‘double’ impact of menopause and their disability could be rendered problematic at work:

“In the times when my menopause was at its worst, I actively lied about it, in the same way as I actively lied about my episodes of depression - anything else would have been career suicide.

Administrative Services, Band 5, Full-time

E5. Sustainable Workplaces and Menopause

Given the need to retain healthcare professionals, we were interested in what made work more or less sustainable surrounding menopausal transition.

In terms of job demands, a repeated feature of respondent's experiences was the squeeze on time and space that prevented them feeling menopause was supported in the workplace. 32% of all respondents did not feel they could find time to attend to menopausal needs. However, this increased to 38% of staff in the job Bands 1-4, and 43% for those who were part-time. Nearly half of nursing and midwifery staff (49%) did not feel they were able to find time to attend to their menopausal needs at work. There were also disparities across availability of adequate workplace facilities.



Approximately 10% of women (in all stages of menopause) intended to leave their jobs in the next 12 months due to their menopause symptoms. It is notable that this figure is double that of the menstrual sample (5%). Respondents often resigned from permanent positions or changed their working conditions (hours or contract type) in order to gain some flexibility to manage their (menopausal) health, often at the expense of financial or job security:

“ I resigned from the NHS 5 years ago as couldn't cope with my life and body going through the menopause since the age of 45 symptoms got worse and more problematic. Got diagnosed with anxiety and depression.

Nursing and Midwifery, Band 5, Part-time

“ Leaking urine, hot flashes, fatigue, mood and concentration are some of the issues I work through. I have taken early retirement to help me cope with quality of life. I found it very difficult to do my job as the younger me. Speaking about it had been very limited in my workplace. The best option for me was to take early retirement which has impacted on my finances and status, dignity that my male Coworkers have not had to go through. I have gone back for a reduced hrs contract and find I am in invisible to my working team.

Nursing Assistant, Band 3, Part-time

“ It [menopause] led to early retirement, but I have managed to return to work on a part time basis on the nurse bank.

Anonymous

A number of respondents also discussed making significant changes to their working conditions and hours due to menopause, which carried financial consequences, as well as limiting possibilities for career development. In these situations, flexibility around secondments, changes in job role and line manager and colleague advocacy were central to remaining in the workforce:

“Working 12-hour night shifts while in surgical menopause has resulted in extreme exhaustion at times. I have been left so exhausted by working nights at times that I’ve had to take sick leave when I’ve not been able to get out of bed. I’ve subsequently left the clinical area on a secondment to a corporate area within the NHS, which is 9-5 hours and not clinical work. I’m reluctant to return to clinical practice for this reason, however, I may have no choice if my contract isn’t extended in the corporate area.

Nursing and Midwifery, Band 6, Part-time

“Work was crazy, too hot, flushes to the extreme that I couldn’t think what I was doing. I was normally a very confident organised person, and this changed. I could do stitching in an MIU (Minor Injuries Unit), but I started a tremor so had to stop. reduced my hours, my banding!! I really wanted to leave but colleagues were like NO!!! I have now taken a secondment post, or I was leaving. I loved my job as a nurse.

Staff nurse, Band 5, Part-time

Of the menopause sample (including employees at all stages of menopausal transition), intention to leave the organisation was precipitated by a perceived lack of social support (perceived managerial attitudes to menopause) within the workplace. Specifically, employees who reported the highest risk of exiting also reported:

- A concern that their manager views their menopausal symptoms as a problem
- Weak managerial support for menopause-related leave
- Fewer means to disclose the impacts of menopausal health at work

Structural support job and workplace design, including job autonomy and access to facilities), played a less significant role. Those who reported risking leaving their job appeared to do so regardless of the degree of autonomy they had in their jobs (87% of those intending to leave in the next 12 months reported they had moderate-high levels of autonomy).

However, the job environment made a difference to intention to leave, with 37% who intended to leave reporting poor access to adequate facilities.

“Access to spaces is not just about toilets- a room to go and put feet up for 30 mins would be great.

Nursing and Midwifery, Band 8, Full-time

“The functionality of the toilets in our office is very poor and can cause embarrassment due to them not flushing.

Administrative Services, Band 4, Full-time

“I work on the frontline and getting access to toilets can be detrimental sometimes when I need to go to toilet. Have been caught out a few times and now have to wear a Tena lady for a bit of confidence when working. I actually restrict my fluid intake whilst on shift as I’m scared that I will be caught out with no access to toilets.

Ambulance Services, Band 6, Full-time

In looking further at those thinking of leaving their current workplace, intention to leave was highest amongst those in late peri-menopause (11%) and lowest for those in early peri-menopause (8%). One reason for this may be a cumulative impact of symptoms that have been experienced over a longer period of time, but where menopause itself was still viewed as a long way off (given it is only known retrospectively)

A slightly smaller number of respondents (8%) wanted to leave not only their workplace but leave the workforce altogether. When considering their intent to leave the labour market altogether, we see a divergence based on menopausal stage. Here, a greater proportion of post-menopausal women (10%) reported their intention to leave the workforce altogether than peri-menopausal women (6%), particularly early peri-menopausal women (5%).

Shift work played a significant role in intention to leave both their current workplaces and leaving the labour market completely. Of those that intended to leave their job in the next 12 months, more than one-third (34%) were shift workers. Of those who signalled an intention to leave the workforce completely in the next 12 months, 27% were shift workers. This was reflective of the qualitative comments that suggest shift work exacerbated menopausal symptoms:

“After experiencing some very difficult shifts at work I started to take several days off over a few months blaming migraines instead of peri - menopausal symptoms. Eventually after several near misses driving home after nightshift, I approached my immediate line manager who was fantastic and signposted me to OHU (Occupational Health Unit). OHU were also very supportive and recommended that I refrain from working nightshifts. Unfortunately, the station manager and work force planning were not particularly supportive and wanted me to specify how long I'd need to adjust my shifts for and highlighted that it could work out worse for me as I would be allocated less days off. Feeling pressure, I agreed that I would work some nights [...] I feel forced into applying for part-time hours in order to reduce the number of nights I work.

Ambulance Services, Band 5, Full-time

“Aged 62, I was senior charge nurse in a busy department. I had planned to work until I was 65, but found because of chronic poor sleep, I was exhausted. I've reduced my hours to 15 a week, got agreement from my line manager to work two late shifts a week, so I don't have the agony of a poor night's sleep and getting out of bed at 5.30am.

Nursing and Midwifery, Band 7, Part-time

E6. Menopause Support and Best Practice: What works, and what doesn't

A range of best practices surrounding menopause support at work have already been identified in previous studies (see section H) and were echoed by respondents in this study. These included education and awareness, line manager training and the provision of uniforms within the workplace. In the following section, we discuss a number of these in more detail in relation to the particular context of healthcare workplaces.

Line Management

There were a number of examples where respondents had outlined line managers as providing significant support that made the difference to their choice to remain engaged in the workplace. In a majority of cases, this has involved acknowledging and recognising their symptoms as valid and using localised strategies to accommodate them. This often included guiding them in terms of healthcare support:

“I had an early menopause (40s) and it impacted on me badly in terms of fatigue and mood particularly. My manager supported me to sustain my role at work including arranging for me to see psychiatrist. My symptoms contributed to break up of my marriage and I think could have led to me leaving NHS post without support of my manager.”

Clinical Psychologist, Band 8, Full-time

“I knew something had changed. Over the next 6 months I remained off sick, I started HRT and attended counselling session which was organised through my workplace. It was during the counselling I realised that I was in the throes of peri-menopause. In the run up to returning to work, I had several informal catch ups with my line manager and agreed to identify a single person in the team that I could check in with daily on my return to work.”

Allied Health Professional, Band 4, Full-time

Respondents emphasised the importance of line management practices undertaken in ways that did not penalise other staff. However, they were also mindful that excessive workload was also a feature of their line managers jobs and that they worked under resource constraints. This could impact on how respondents engaged with their supervisors or line managers:

“I couldn't go to my line managers because am aware of their workload and the pressures they are under, so wouldn't like to lay more stress on them. I do not see my line managers as often as used to - they now work from home - and when I do see them, I do not want to be complaining about feeling of not managing.”

Pharmacy Technician, Band 6, Full-time

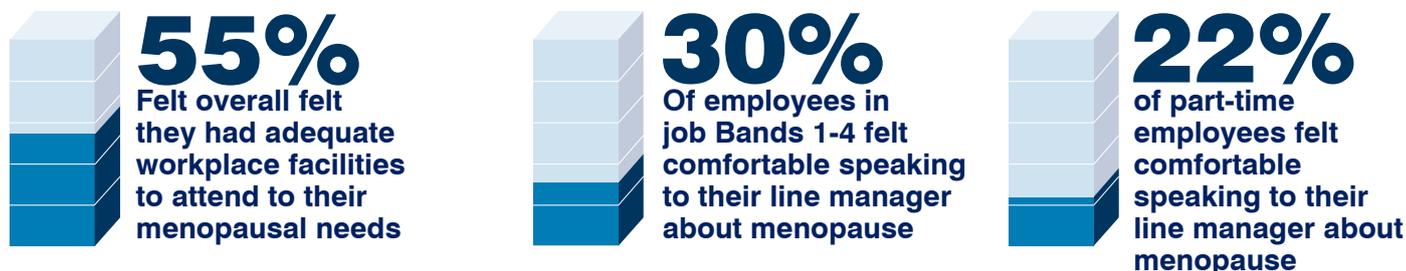
Other respondents suggested that line managers varied in their support depending on whether there was a clear practice they could follow or not:

“I felt overwhelmed at work and was not coping with my workload. When I spoke to an occupational health nurse within the organisation, she was fabulous and helped me see that maybe my symptoms were connected to the menopause. I had great support from the OH (Occupational Health) service and have now started on HRT and am starting to see improvements. My manager was very supportive of my whilst I was off sick but less so when I started back to work.”

Administrative Services, Band 7, Full-time

Those in workplaces where the gender ratios were skewed toward more men than women felt line managers would be less supportive. 34% of respondents who worked with mainly men did not feel their line manager would be supportive of someone taking leave due to menopause and over half (53%) felt their line manager would view their menopause as a problem for them (compared to 41% overall).

These findings surrounding the line manager-employee relationship highlighted how any structural ‘vulnerability’ surrounding job type or role could have an impact on discussing menopausal health concerns within the reporting relationship. While 55% overall reported feeling comfortable speaking to their line manager about menopause, this figure was significantly lower for those who worked in male dominated environments (36%). These also contrasted with those in jobs bands 1-4 or working part time.



Disclosure and Evidence

Part of challenging menopausal stigma at work involves providing clear and recognised routes for disclosure. However, there were disparities around perceptions and knowledge surrounding disclosure of menopausal symptoms, or awareness of voice mechanisms. While 23% overall agreed that their workplace provided ways for employees to disclose how their menopause impacted work, this was lower for both part-time staff (20%) and for staff in bands 1-4 (19%), suggesting that there was a need to better communicate resources to all staff across all levels and areas of the organisation to foster psychologically safe environments.

There were differing perceptions regarding the burden of evidence required to access leave due to menopause (such as medical certificate from a GP). 39% of employees felt their line managers would need medical proof to corroborate an absence or request to change their work; this varied based on job band. This figure increased to 42% of those in bands 1-4 who felt their line manager would require proof. In contrast, only 27% of those in Band 8 and above saw this as a requirement. Further, a smaller proportion of those in the upper job bands (36%) stated their line manager would view their menopause as a problem, compared to 41% in Bands 1-4.

Disclosure was seen as a challenging area to negotiate, as respondents who were both managers and employees struggled with the importance of who to disclose to, how many people were required to know, and whether there was a requirement to constantly disclose when new people moved into the job:

“I was sent to an HR person, supposedly to ‘help’ but it felt like an all-out attack on me as a person, and there were things they asked me straight off the bat that I wasn’t prepared to disclose. It took me years of counselling to be able to speak about things to them, so being asked deeply personal questions about myself and my body from an aggressive stranger that ultimately could lose me my job felt frightening and intrusive.”
Senior Manager, Band undisclosed, Part-time

“I went into countless meetings to discuss my experiences of stress with the rising pressures and how devalued and unrecognised I had become. I felt my HR(Human Resources) and line manager had no insight or compassion and instead were invalidating my experiences and dismissing my experiences of the pressures as everyone else on my band was capable of the work that I was struggling with.”
Staff Nurse, Band 5, Full-time

Education and Awareness

There was widespread consensus that everyone in the workplace should have a baseline level of understanding about menopause, including the variety of symptoms and their manifestations and implications on working in order to ‘acknowledge that menopause is not just “hot flushes”; that everyone’s journey is unique to them and they deserve to be treated with respect and compassion’ (Nursing and Midwifery, Band 6, Full-time)

Given they were employed in healthcare, some respondents suggested that there was an assumption that they already knew where they should be able to access information and advice. This was not the case for many, although there were instances where employees had been able to access advice informally due to their job:

“*My menopause has been pretty awful, but I don't think it has affected work to any great degree. Actually, my work has helped because I work in a sexual health service so lots of staff do menopause clinics and have been really happy to give me advice.*

Medical and Dental, Band undisclosed, Part-time

However, the complexity and scale of healthcare workplaces emphasised that clear signposting was just as necessary for employees in this sector as it was for the general patient population, even though they were part of the system. This was particularly important for those in medical positions who felt that there was an expectation that they should have more knowledge about menopause due to their profession and may therefore be hesitant to proactively seek or explicitly ask for information.

Agile and temporary changes

A number of respondents discussed how, as their symptoms changed, they would benefit from having time and space to 'recalibrate' to their new symptoms. In other words, temporary modes of workplace accommodation were considered valuable and provided an opportunity to return to original tasks or roles after a period of time:

“*Offer some time out of your work tasks if symptoms were causing small intermittent issues. Support this in your back to work interview.*

Administrative Assistant, Band 3, Full-time

Others discussed the importance of having freedom during the course of a working shift or working week to order to accommodate the manifestation of symptoms.

“*Understanding that I might find one day difficult concentrating but allow flexibility for me to manage this and still get my work done over the week.*

Administrative Services, Band 7, Full-time.

Respondents recognised that this was often subject to the parameters and demands of particular roles and may not always be possible. At the same time, there was also a suggestion that their line managers and workplace support could learn lessons from the recent Covid-19 Pandemic around how to enact fast and agile changes to workplace designed in order to create flexibility around menopausal practices in the workplace.

F. Discussion and Recommendations

This report has highlighted a variety of experiences and practices surrounding menstruation and menopause for NHS Scotland Employees. From our position as researchers, we do not feel that most of these features are the exclusive concern of this particular organisation and are likely to manifest in similar forms across the workforce nationally as well as hold insights relevant to international stakeholders.

Across the workplaces surveyed, there was more awareness of the experience of menopause than menstrual health as a workplace concern. For many respondents, generating awareness has multiple positive effects. It not only allowed them to share and disclose their experiences without fear of marginalisation or negative consequences, but also facilitated an ability to talk about their own needs and helped to create support and solidarity across members of the team or organisations they were based in. The overriding feature of these positive experiences suggests that workplaces with a positive attitude to women's health made for better, more inclusive and more engaged workforces for women of all ages.

At the same time, there is a caveat that some respondents still felt that the culture of their workplaces had some way to go in destigmatising menopause and menstrual health as a workplace issue. This was even more the case for menstrual health support at work, which appears to be lagging in terms of a general awareness of how employers could best support menstruation and menstrual health in their workforces. While existing menopause policies and practices might provide a blueprint that could be adapted it is also important to note that those who experience disruption to their menstrual health as a result of work – or experience work disruption due to their menstrual health – may benefit for different support mechanisms and structures given they are likely to be at different stages of their career and life.

We have already introduced one way to consider period positive workplaces through the MAPLE framework (see *Page 5*). Similarly, we have highlighted how Line Management, Disclosure and evidence, Education and awareness, and Agile and temporary changes are key to enabling menopausal positive workplaces. In support of these elements, we outline 10 recommendations to put the findings in this report into practice.

A. Engage with cultural un/learnings across the organisation and with key stakeholders surrounding menstruation and menopause

1. **Recognise under diagnosis, misdiagnosis and late diagnosis as both a public health and a labour market issue that influences participation and gendered career trajectories.** Public healthcare provision is central to an economic argument for supporting a gender inclusive workforce and gender equal economy. Respondents discussed how workplace healthcare support could both enable them to stay in work or precipitate a premature exit from their profession or even the labour force. However, employees may also be impacted through an inability to gain medical evidence that managers or workplaces require in order to support ongoing conditions or symptoms and their impact on work. Not having timely or accurate access to healthcare provision also can lead to unnecessary pain or disruption to professional lives and shape career trajectories and quality of working life.
2. **Provide networks and spaces that enable employees the opportunity for period and menopause dignity.** These spaces may not only be the exclusive locus of the immediate workplace but other physical places employees rely upon. For example, this could include large scale community awareness initiatives (similar to the 'breastfeeding friendly scheme') introducing 'menopause and period positive' ('MPP spaces'): safe access to toilet facilities for community and mobile workers. It can also include providing free menstrual products that account of different blood flows.
3. **Promote a culture change where menopause and menstrual health awareness are the responsibility for all.** This may also include identifying parts of the organisation that may not be directly connected with providing reproductive health support but responsible for policies or practices that have indirect or inadvertent consequences or place barriers to accessing support. For example, site management responsible for cooling and heating workspaces or those building to refurbishing buildings can play a vital role in facilitating a comfortable environment. Importantly, normalising discussions of reproductive health does not mean homogenising or problematising these experiences.

B Provide structural mechanisms that facilitate best practice and timely support in the workplace

4. **Enable rapid-response processes for low cost, high-impact solutions.** For a majority of respondents, support for menopause and menstrual health can be low cost but highly impactful. This report identifies a number of economically efficient mechanisms that played an important role in supporting disruptive reproductive health experiences at work. They include the availability of analgesics to alleviate pain in workplace environments, which may be problematic where drugs are subject to tight control for patient safety, and uniform adaptation (including colour) when available as a legitimate support for thermal regulation.
5. **Provide clear guidance and processes that enables organisational stakeholders support to recognise when menstrual or menopausal symptoms may relate to legislative obligations.** There was a lack of clarity and concern around how to treat differential experiences of symptoms, particularly in lieu of definitive or timely medical diagnosis. Increasingly, managers may also be confused as to the legislative duties that relate to menopause, including the parameters under which enduring and significant menstrual or menopausal experiences are protected under existing Equalities legislation. While support for all symptoms should be considered, providing managers with clear guidelines will enable organisations to enforce best practice while remaining legally compliant and give line managers the confidence in their everyday practice.
6. **Add menopause and menstrual considerations to inclusivity audits of new and existing policies to minimise any secondary or indirect disadvantage.** Examples such as uniforms (fabric and colour), equipment such as the fabric or material used on seats, and no fans due to Covid risk were all discussed as well-intentioned practices that nonetheless had a profound impact on experiences around menstruation or menopause. Counterbalancing risk assessments with inclusion criteria is important to ensure that any negative consequences can be mitigated.
7. **Establishing flexible and employee-centric approaches around menstrual health and menopause.** It was noted that flexibility could take place in many forms, with formal (leave) policies not always the most welcomed organisational response. For example, there was a preference for 'microleave' in the form of approved minutes or half-hours that could prevent more longer instances of absence.

c. Commit to embedding menstrual and menopausal best practice as an ongoing endeavour

8. **Provide exemplars for line managers surrounding possible localised changes available in a variety of healthcare settings.** While it was clear there was a wide variety of job demands across the sample, the ability for line managers to provide either full or interim solutions had a positive impact on employee engagement. Such examples exists across the Boards and finding ways to advocate for best practice while inspiring initiative at a team level is a positive step towards bedding in best practice.
9. **Incorporate anti-stigma education in menopause and menstruation awareness initiatives.** This study highlights the importance of building stigma-free organisational environments that proactively support employees' menstrual health and menopausal transition. Often experiences of menstruation only became 'disruptive' due to stigma and cultural bias in the workplace. Policies and practices should not only look at support for symptoms but undertake anti-stigma education. Anti-stigma education goes beyond ideas of unconscious bias and addresses the dangers of problematising women's reproductive health in the workplace. This not only includes education and awareness around menstrual health, menopause, but how to facilitate a broader cultural acceptance of changing bodies across the working life course. Programmes of education should be resources on an ongoing basis surrounding the relationship between work and reproductive health. This should draw on evidence-based practice focused on institutional change, rather than relying on individual practices to offset structural limitations.
10. **Provide effective ways to collate and communicate best practices across the organisations.** This may include repositories of previous practice submitted by managers or employees from across the organisation. This localised knowledge sharing is vital – findings from our study illustrate that it was employees themselves who came up with practicable and collegial solutions that enabled them to continue participating meaningfully in work.

G. Conclusion

The diversity of experiences employees shared in this survey suggests that for most employees, working through menopause and menstruation is both desirable and possible, even when symptoms are bothersome, when workplaces have an inclusive culture, flexibility that assumes recognition and trust in professionals to complete their jobs, and time and space to self-manage symptoms in order to continue working. There is also evidence that when employee's health is supported by affirming and timely healthcare encounters, it has a transformational and positive impact on their economic lives.

Employees are not asking for accommodations that radically change how the NHS as an employer operates and they demonstrated a keen awareness to the demands of their job roles and desire to serve those in their care to the highest possible degree. At the same time, these demands should not put employees health at risk: to do so not only compromises short term wellbeing but negatively exacerbates what are already intense and stressful careers. Enabling people to do their jobs while supporting their own menstrual and menopause dignity at work is a vital aspect of advancing women's health in the workplace and ensuring that current and future generations of NHS employees have long, productive and healthy working lives.

It is unsurprising that in a large and complex organisation such as NHS Scotland, experiences are wide ranging. It highlights that while some employees have denigrating or negative encounters, for others, the benefit of supportive line managers, inclusive teams and flexible cultures make menstruation and menopause part of their working life in ways that is for the most part unproblematic. Identifying areas where best practice exists, and how it can be scaled across different areas of the workforce in ways that are sensitive to the complexity of different job roles and working environments is vital. And if successful in doing so, Scotland's health service has the opportunity to be a world leading employer in supporting women's health over the working life course.

H. Further Reading and Resources

(i) Bibliography

Atkinson, C., Beck, V., Brewis, J., Davies, A., & Duberley, J. (2021). Menopause and the workplace: New directions in HRM research and HR practice. *Human Resource Management Journal*, 31(1), 49-64.

Beck, V., Brewis, J., & Davies, A. (2020). The remains of the taboo: experiences, attitudes, and knowledge about menopause in the workplace. *Climacteric*, 23(2), 158-164.

Bildhauer, B., Røstvik, C. M., & Vostral, S. L. (2022). Briefing paper: assessing the Period Products (Free Provision) (Scotland) Act 2021 as model menstruation legislation. *Open Library of Humanities*.

Bobel, C., Winkler, I. T., Fahs, B., Hasson, K. A., Kissling, E. A., & Roberts, T. A. (2020). *The Palgrave Handbook of Critical Menstruation Studies*. Open Access.

Butler, C. (2020). Managing the menopause through 'abjection work': When boobs can become embarrassingly useful, again. *Work, Employment and Society*, 34(4), 696-712.

Converso, D., Viotti, S., Sottimano, I., Loera, B., Molinengo, G., & Guidetti, G. (2019). The relationship between menopausal symptoms and burnout. A cross-sectional study among nurses. *BMC Women's Health*, 19(1), 1-12.

Erchull, M. J. (2013). Distancing through objectification? Depictions of women's bodies in menstrual product advertisements. *Sex Roles*, 68, 32-40.

Faubion, S. S., Enders, F., Hedges, M. S., Chaudhry, R., Kling, J. M., Shufelt, C. L., ... & Kapoor, E. (2023). Impact of menopause symptoms on women in the workplace. In *Mayo Clinic Proceedings*. Elsevier.

Grandey, A. A., Gabriel, A. S., & King, E. B. (2020). Tackling taboo topics: A review of the three Ms in working women's lives. *Journal of Management*, 46(1), 7-35.

Griffiths, A., MacLennan, S. J., & Hassard, J. (2013). Menopause and work: an electronic survey of employees' attitudes in the UK. *Maturitas*, 76(2), 155-159.

Hardy, C., Griffiths, A., Thorne, E., & Hunter, M. (2018). Tackling the taboo: talking menopause-related problems at work. *International Journal of Workplace Health Management*, 12(1), 28-38.

Hardy, C., Thorne, E., Griffiths, A., & Hunter, M. S. (2018). Work outcomes in midlife women: the impact of menopause, work stress and working environment. *Women's Midlife Health*, 4(1), 1-8.

Jack, G., Riach, K., & Bariola, E. (2019). Temporality and gendered agency: Menopausal subjectivities in women's work. *Human Relations*, 72(1), 122-143.

Jack, G., Riach, K., Bariola, E., Pitts, M., Schapper, J., & Sarrel, P. (2016). Menopause in the workplace: what employers should be doing. *Maturitas*, 85, 88-95.

King, S. (2021). Menstrual leave: Good intention, poor solution. In Hazzard, J & Torres, L. (eds.) *Aligning perspectives in gender mainstreaming: Gender, Health, Safety, and Wellbeing*, 151-176.

Nash, M. (2022). Breaking the silence around blood: managing menstruation during remote Antarctic fieldwork. *Gender, Place & Culture*, 1-21.

O'Hara, R., Rowe, H., & Fisher, J. (2019). Self-management in condition-specific health: a systematic review of the evidence among women diagnosed with endometriosis. *BMC Women's Health*, 19(1), 1-19.

- Owen, L. (2022). Stigma, sustainability, and capitals: A case study on the menstrual cup. *Gender, Work & Organization*, 29(4), 1095-1112.
- Quental, C., Rojas Gaviria, P., & del Bucchia, C. (2023). The dialectic of (menopause) zest: Breaking the mold of organizational irrelevance. *Gender, Work & Organization*.
- Riach, K., & Jack, G. (2021). Women's health in/and work: menopause as an intersectional experience. *International Journal of Environmental Research and Public Health*, 18(20), 10793.
- Rush, G., & Misajon, R. (2018). Examining subjective wellbeing and health-related quality of life in women with endometriosis. *Health Care For Women International*, 39(3), 303-321. <https://doi.org/10.1080/07399332.2017.1397671>
- Sang, K., Remnant, J., Calvard, T., & Myhill, K. (2021). Blood work: Managing menstruation, menopause and gynaecological health conditions in the workplace. *International Journal of Environmental Research and Public Health*, 18(4), 1951.
- Seear, K. (2009). The third shift: health, work and expertise among women with endometriosis. *Health Sociology Review*, 18(2), 194-206.
- Steffan, B. (2021). Managing menopause at work: The contradictory nature of identity talk. *Gender, Work & Organization*, 28(1), 195-214.
- Steffan, B., & Potočnik, K. (2022). Thinking outside Pandora's Box: Revealing differential effects of coping with physical and psychological menopause symptoms at work. *Human Relations*, 76(8), 1137-1313.
- Tomlinson, M. K. (2023). "Periods Don't Stop for Pandemics": The Implications of COVID-19 for Online and Offline Menstrual Activism in Great Britain. *Women's Health in Communciation*, 1-23.
- Ussher, J., & Perz, J. (2013). PMS as a gendered illness linked to the construction and relational experience of hetero-femininity. *Sex Roles*, 68, 132-150.
- Willman, A., & King, K. (2023). Serving through the perimenopause: Experiences of women in the UK armed forces. *Maturitas*. 169,35-39

(ii) Existing UK reports or guides about menstrual health or menopause at work

- Bloody Good Research: Periods and menstrual wellbeing in the workplace - the case for change https://www.bloodygoodemployers.com/_files/ugd/23197e_6d1376d003ad445bbd16b8ff1fac0eea.pdf
- British Standards Institute BS 30416, *Menstruation, menstrual health and menopause in the workplace* <https://www.bsigroup.com/en-GB/standards/understanding-menopause-and-menstrual-health/>
- CIPD Menopause at Work: *A Guide for People Managers* <https://www.cipd.org/uk/topics/menopause/>
- EMAS Menopause in the Workplace <https://emas-online.org/menopause-in-the-workplace/>
- Endometriosis UK An employer's guide to managing endometriosis at work <https://www.endometriosis-uk.org/sites/default/files/files/Employers-Guide.pdf>
- Fawcett Society Menopause in the Workplace <https://www.fawcettsociety.org.uk/Handlers/Download.ashx?IDMF=9672cf45-5f13-4b69-8882-1e5e643ac8a6>
- Menopause Information Pack Online (MIPO) <https://www.menopauseatwork.org/>
- Trade Union Congress *The Menopause in the Workplace: A guides for trade unionists* <https://www.tuc.org.uk/sites/default/files/Menopause%20toolkit%20Eng%20FINAL.pdf>

Appendix 1: Further Details of Job Band within NHS Scotland

Job Bands are the way pay is organised in NHS Scotland. A general (though not exhaustive) guide for the purposes of reading this report would be as follows: Band 1 is now a closed Band; Band 2-4 is generally support workers and administrative staff; and 5 is generally where qualified staff are positioned such as nurses, midwives and paramedics; Band 6-7 is more experienced staff; Band 8 generally includes some level of management responsibility. Further example can be found in the table below.

Pay Band	Example of Occupations in Band
Band 1	This is a closed band. The lowest band NHS Boards now recruit to is Band 2.
Band 2	Domestic, porters, ancillary staff, admin workers
Band 3	Clinical Support Staff, Administration staff, emergency care assistant, trainee clinical coder, estates officer and occupational therapy support worker.
Band 4	Assistant practitioner, audio visual technician, pharmacy technician, dental nurse and theatre support worker.
Band 5	Staff nurse, operating department practitioner (ODP), podiatrist, learning disability nurse, therapeutic radiographer and ICT test analyst
Band 6	School nurse, experienced paramedic, health records manager, clinical psychology trainee and biomedical scientist.
Band 7	Communications manager, estates manager, high intensity therapist and advanced speech and language therapist.
Band 8A	Consultant prosthetist/orthotist, dental laboratory manager, project and programme management, modern matron (nursing) and nurse consultant (mental health nursing).
Band 8B	Strategic management, head of education and training, clinical physiology service manager and head orthoptist.
Band 8C	Head of human resources, consultant clinical scientist (molecular genetics/cytogenetics) and consultant paramedic.
Band 8D	Consultant psychologist (8c-8d), estates manager, chief nurse and chief finance manager.
Band 9	Podiatric consultant (surgery), chief finance manager and director of estates and facilities.

Appendix 2: Acknowledgements

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