Title: A mixed-methods investigation of women's health-friendly organisations as perceived by menopausal working women

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Abstract:

Objectives: To examine women's perspectives on what constitutes a women's health-friendly work culture, and to assess whether perceiving one's organisation as women's health-friendly is associated with menopausal symptom experience and work-related outcomes.

Methods: A cross-sectional mixed methods online survey collected self-reported quantitative and qualitative data from working menopausal women. Primary outcome measures included presence of menopausal symptoms (past four weeks), vasomotor symptom problem rating, job stress, and whether participants perceived their organisation as supportive of women's health (dependent variable). Two open-ended questions explored participants' views on what makes a work culture 1) friendly and 2) unfriendly to women's health.

Results: From the responses of 300 participants, over two-thirds (65.7%) perceived their organisation as supportive of women's health. These participants reported significantly lower job stress and less problematic vasomotor symptoms compared to those who did not. No significant association was found between menopausal symptom presence. Thematic analysis of qualitative responses revealed two overarching themes capturing shared perceptions of women's health-friendly and unfriendly work cultures. Theme 1 focused on the *people at work*: *awareness and understanding* of women's health, *attitudes towards women and work*, and their *talking about women's health at work*. Theme 2 addressed more structural factors of *organisational arrangements and provisions*: *flexibility in work arrangements*, *resources and support*, and the *physical work environment*.

Conclusions: This study provides novel insights into how women perceive a health-friendly work culture and the potential relevance to menopausal experiences and work. The findings have clear implications for policy and practice, warranting further attention and investigation.

Key words: women's health-friendly work culture, menopause, mixed methods, UK

Highlights:

- Women who view their workplace as women's health-friendly (WHF) have less job stress and less problematic menopausal symptoms
- Perceptions of a WHF work culture are influenced by the people within the organisation and the provisions and resources on women's health
- A WHF workforce understands, holds inclusive attitudes, and communicates openly about women's health
- A WHF workplace offers supportive organisational infrastructures, such as flexible working arrangements, facilities, and fit-for-purpose physical environments

1. Introduction

Menopause and women's health is becoming increasingly recognised as an important occupational health issue. Defined as the last menstrual period, the menopause is a natural process typically occurring between 45 and 55 years [1], although can occur earlier or be induced through surgery or cancer-drug treatments [2]. Associated symptoms with hormonal changes typically last four to five years [3]. Although highly variable within and across individuals, many women experience changes in menstruation (e.g., irregular periods, 'flooding'), vasomotor symptoms (e.g., hot flushes, night sweats), physical symptoms (e.g., aches and pains), and psychological changes (e.g., difficulties with memory and concentration, sometimes referred to as 'brain fog') that can impact their quality of life [4], including work. These may not be problematic for all women, however, managing symptoms in the work context can be being particularly challenging [5-7]. Some women reporting concerns around their performance at work, and the impact of menopause attributed symptoms may have on their work-life balance and careers [8-11].

The biopsychosocial model of health recognises that the experience of women's health and the menopause is the interplay between physical symptoms, individual beliefs, and the social and cultural context in which health is experienced [12-14]. Previous research has shown that stigma, embarrassment, and lack of awareness about women's health and the menopause can deter women from seeking support or discussing health concerns in the workplace [15]. Women also report finding menopause symptom management at work more difficult due to perceived stigmas, embarrassment, limited access to information, and the general silence surrounding the topic both from other women and employers [16,17]. As a result, women have called for employers to foster a "positive culture around women's health" to help normalise discussion and support (p.40) [18]. Such supportive cultures have the potential to

foster openness, reduce stigma, and encourage help-seeking behaviours, while unsupportive environments may reinforce silence and exclusion [19].

Organisational culture is generally understood as the shared values, beliefs and norms [20] reflecting "'*the way people think around here*' and '*the way things are done around here*'" (p.2) [21] and functions as a social control mechanism that influences employee behaviour and collective organisational outcomes [22]. However, its role in menopause and women's health at work remains under-explored. Furthermore, there is limited quantitative evidence demonstrating whether working in a women's health-friendly organisation is actually associated with better health or work outcomes making it difficult to assess the impact of such organisational efforts or to inform evidence-based policy and intervention design. This paper contributes to these gaps by answering the following research questions:

RQ1. Do women working in a women's health-friendly organisation have different experiences of (a) menopausal symptoms and (b) their work, compared to women working in organisation that are not women's health friendly?

RQ2. What are working menopausal women's perceptions of a women's health-friendly work culture?

2. Method

An online survey, hosted on the platform Qualtrics, gathered quantitative and qualitative (a concurrent mixed methods design) [23] self-report data from females experiencing or had recently experienced their menopause and its transition whilst in employment within the UK. Females aged 18–65 in the UK were recruited through study adverts posted on social media (Twitter, Facebook, LinkedIn), personal and professional networks of the research team, and the study funder (Wellbeing of Women). Information about the study was provided to participants on the first page and consent by ticking a consent box was required before

proceeding with the survey. Participants were asked to share demographic information, including age, ethnicity, disability status, their job and employing organisation (see Table 1). Participants were also asked to provide data on their menopausal experience, which included the type of menopause they have, any menstrual changes and when they had the last menstrual period to determine their menopausal status, as well as their menopausal symptoms presence, and specifically, vasomotor symptom presence and associated problem-ratings (mean score of 3 items taken from Hot Flush Rating Scale [24], 10 point scale ranging from 1 "*Not at all a problem*" to 10 "*Very much a problem*"; α=0.91). A single item collected data on participants' current level of job stress [25] and a dichotomous item asked participants to indicate perceptions of working in a women's health-friendly organisation. Lastly, two open-ended questions then asked participants to share views and describe a women's health-friendly and unfriendly work culture.

For the quantitative analyses, chi square analyses were conducted on menopause symptom presence and the outcome variable (i.e. working in a women's health-friendly organisation). Point-biserial correlations were conducted on job stress and the vasomotor symptom problem rating to assess the associations with the outcome variable. The statistical software package SPSS (version 28) was used for the quantitative analyses, using a probability level of 0.05 (two-tailed). For the qualitative data, an inductive thematic analysis performed, guided by Braun and Clarke's (2006) [26] six-step process. Two of the researchers (CH, AG) performed initial explicit level coding and thematic development, independently, before holding discussions to discuss their preliminary analyses. Themes were found to be very similar. Discrepancies were discussed and a final set of themes and incumbent codes were generated. Inter-rater reliability was checked by a third experienced researcher (ET); 100 coded extracts (around 50% of the data) were assigned to the themes and a kappa of 0.85 indicated a strong level of inter-rater agreement [27]. The software package NVivo (version 12) was used to

support the qualitative analyses. Information about the positionality of the research team can be found in Supplementary file 1.

3. Results

Three-hundred females in the UK provided usable data (see Table 1). They were, on average, in their early fifties, white, without any disabilities, working full-time, in non-manual, large organisations within public, government of university sectors. The majority were experiencing a natural menopause, with around half in their post-menopause stage, experiencing menopausal symptoms in the past 4 weeks, including around half vasomotor symptoms specifically (i.e. hot flushes/night sweats). Over two-thirds (68.0%) were experiencing moderate to severe levels of job stress. Just over one third did not perceive themselves to work in a women's health-friendly organisation.

Table 1

Sample demographics (N=300)

Variable	N (%)
Age in years	M = 51.31 (SD 5.33)
	Range = 19-65
Menopause type:	
Natural	263 (87.7%)
Surgically-induced	28 (9.3%)
Chemically-induced	9 (3.0%)
Menopause status:	
Post (no menstruation for 12 months)	147 (49%)
Early peri (menstrual changes in last 6 months)	90 (30.0%)
Late peri (menstrual changes in last 6-12 months)	57 (19.0%)
No change in menstrual cycles / regular periods	6 (2.0%)
Menopause symptom (any) in past 4 weeks[a]:	
Yes	258 (86.0%)

No	42 (14.0%)
Vasomotor symptoms in past 4 weeks[b]:	
Yes	179 (59.7%)
No	121 (40.3%)
Vasomotor problem rating[c] (n=179)	M = 5.20 (SD 2.28)
	Range = 1-10
Ethnicity:	
White	273 (91%)
Mixed	4 (1.3%)
Asian	10 (3.3%)
Black	2 (0.7%)
Other	6 (2.0%)
Prefer not to say	5 (1.7%)
Registered disability status:	
No	266 (88.7%)
Yes	22 (7.3%)
Unsure	7 (2.3%)
Prefer not to say	5 (1.7%)
Working hours:	
Full-time	225 (75.0%)
Part-time	72 (24.0%)
Casual / ad hoc	3 (1.0%)
Type of employment:	
Non-manual	273 (91.3%)
Manual	27 (9.0%)
Work sector:	
Public / Government / University	184 (61.3%)
Private	87 (29.0%)
Charity / Not-for-profit	29 (9.7%)
Organisation size:	
Large (>250 employees)	247 (82.3%)
Medium (51-249 employees)	25 (8.3%)
Small (11-50 employees)	19 (6.3%)

Micro (<10 employees)	9 (3.0%)
Job stress:	M = 2.82 (SD 0.77)
	Range 1-4
Not stressed	12 (4.0%)
Mildly stressed	84 (28.0%)
Moderately stressed	150 (50.0%)
Extremely stressed	54 (18.0%)
Work in a women's health-friendly organisation:	
Yes	197 (65.7%)
No	103 (34.3%)

[a]Question item "Have you experienced menopausal symptoms over the last 4 weeks?"

[b]Question item "Are you currently having hot flushes and/or night sweats (i.e. in the past 4 weeks?)"

[c]Problem rating is the average score of these three question items: "Please select a number on the scale (1-10) to indicate how your flushes/sweats have been during the past 4 weeks: To what extent do you regard your flushes/sweats as a problem?; How distressed do you feel about your hot flushes?; How much do your hot flushes interfere with your daily routine?"

3.1 Main quantitative analyses

No statistically significant differences were found between those that perceive themselves to work in a women's health-friendly organisation compared to those that do not in relation to the presence of vasomotor symptoms (X^2 (1, N=300) = 0.40, p>.05) or any attributed menopausal symptom (X^2 (1, N=300) = 0.2, p>.05) in the past 4 weeks. However, participants experiencing vasomotor symptoms reported statistically significantly less problematic vasomotor symptoms if they perceived themselves to work in a women's health-friendly organisation compared to those that do not (r^{pb}=-.19, p<.05, n=179). Participants perceiving themselves to work in women's health-friendly organisation also reported statistically significantly lower job stress than those that do not (r^{pb}=-.12, p<.05, N=300).

3.2 Main qualitative analyses

Two hundred and fifteen participants responded to one or both open-ended questions about women's health-friendly work culture (WHF-WC). Qualitative analysis identified two interconnected overarching themes: (1) people at work and (2) organisational arrangements and provisions. Each theme comprised three sub-themes, summarised in Table 2 and detailed below.

3.2.1 Theme 1: People at work

Participants identified the people within the workplace as central to shaping a women's health-friendly culture. Key factors included their *awareness and understanding of women's health*, *attitudes towards women and work*, and the degree of *talking about women's health* at work.

3.2.1.1 Awareness and understanding

Participants consistently emphasised that a women's health-friendly work culture (WHF-WC) depends on a workforce that is aware of, educated about, and understands women's health issues and their potential impact at work. A WHF organisation was described as one where the "*whole workforce [is] educated*" with particular emphasis on line managers and those in leadership roles being informed about the diverse ways women's health may affect employees. As one participant put it, it is important that people at work "*be informed but don't assume*".

Participants also highlighted the importance of recognising and accepting differences between male and female workers. Cultures that dismissed or ignored these differences were perceived as less supportive, whereas WHF cultures acknowledged and respected them. An "*understanding workplace*" was characterised by staff who were sympathetic and sensitive to women's health needs. In contrast, workplaces where people have a *"lack of awareness"* or knowledge of these issues were not viewed as WHF.

Table 2

Themes, sub-themes and example quotes from qualitative analysis

Themes	**Sub-themes**	**Example quotes of friendly and unfriendly women's health-friendly work cultures**
People at work	Awareness and understanding	Friendly: *"Be 'quietly' sensitive to the physical needs and comfort of women", "trying to understand that it is the same women but she has just changed a bit"*
		Unfriendly: *"Uneducated naïve colleagues", "Ignoring it", "dismissive"*
	Attitudes towards women and work	Friendly: *"Not being treated differently...in a negative way", "A culture that respects women all women and understands health issues"*
		Unfriendly: *"Intolerant", "Where 'women's problems' are trivialised and mocked", "thinking that you should just get on with it because its life."*
	Talking about women's health	Friendly: *"where people can openly discuss without embarrassment", "Being able to talk about personal issues in confidence and without judgment"*
		Unfriendly: *"Snipe and nasty remarks about women", "preferring to ignore it as it's too embarrassing to talk about it", "Sarcastic comments"*
Organisational arrangements and provisions	Flexibility in the work arrangements	Friendly: *"Access to flexibility at work so you [women] can be at your best", "Allows anyone to request adjustments not just women without needing to provide medical reasons"*
		Unfriendly: *"Inflexible working patterns and spaces", "Emphasis on working long hours", "Doing things the same way because that's how we've always done it."*
	Resources and support	Friendly: *"Support groups as applicable", "Networking that allows feedback and change upward to senior leaders and organisational directors", "Values*

	are embedded in the appraisal system"
Physical work environment	Unfriendly: *"No provision", "No support for health / symptoms", "lack of training and awareness across the organisation"* Friendly: *"Inclusive and fit for purpose office space design", "breakout areas where you feel comfortable taking 5 minutes away to try and get yourself back", "Clean bathrooms"* Unfriendly: *"Unclean toilets and facilities", "not adaptive to individual needs - noise/temperature/location"*

3.2.1.2 Attitudes towards women and work

Perceptions and attitudes toward women and their health were central to how participants judged a workplace as WHF. A WHF culture was described as one where women's health is taken seriously, not "*trivialised*", stigmatised, or treated as a "*taboo*". As one participant noted: "*Take it seriously - it's not a joke or something to be ridiculed; it's real and a natural part of life*."

Visible inclusivity and respect for women were key indicators of WHF workplaces. This included gender equity in leadership roles, an absence of a gender pay gap, and the normalisation of conversations about women's health. In such environments, women's needs were acknowledged without judgement, and their wellbeing was treated as a legitimate concern. In contrast, workplaces where women were expected to "*just get on with it*" or where their health issues were dismissed were seen as intolerant and unsupportive. As one participant reflected: "*I work with a number of senior staff who are women… so I don't think you should undermine this by implying that we are all victims of our biology.*"

WHF workplaces were also described as "*person-friendly*" or "*health-friendly*," where kindness, collegiality, and empathy were prioritised over competition. All staff, their roles, and their needs are respected. Importantly, WHF cultures were marked by a willingness to understand and learn about others' health experiences, including those specific to women. Such "*positive*", "*inclusive*" and empathic attitudes would foster environments where employees feel comfortable, motivated, and valued.

3.2.1.3 Talking about women's health

Communication about women's health at work - how it is discussed, how people respond, and whether staff feel safe to speak - was viewed as a key feature of a WHF work culture. Participants described WHF workplaces as those where women's health is openly

acknowledged and discussed, rather than silenced or ignored. A lack of dialogue was seen as indicative of an unfriendly culture: "*A culture where women's issues are not talked about*."

Open conversations, underpinned by active listening and respectful communication, were considered essential to reducing stigma and normalising women's health issues. Both verbal and non-verbal cues were noted as important in creating an atmosphere where such discussions could occur without embarrassment: "*Where people can openly discuss without embarrassment.*"

Feeling safe and supported when raising health concerns with colleagues or managers was a defining aspect of a WHF work culture. Participants valued environments where they could speak "*in confidence and without judgment*," and where managers adopted open-door policies to encourage dialogue. Cultures where women's health was treated as legitimate and non-taboo were contrasted with those where negative comments, mocking, "*insults*", or inappropriate jokes occurred, which undermined trust and psychological safety and would prevent women's talking about their health at work.

3.2.2 Theme 2: Organisational arrangements and provisions

This theme relates to how workplace structures, policies, and environments support - or fail to support - women's health. Key factors included *flexibility in work arrangements*, the availability of *resources and support*, and the suitability of the *physical work environment*.

3.2.2.1 Flexibility in work arrangements

Flexibility in when, how, and where work is carried out was consistently identified as central to a WHF work culture. Participants described WHF workplaces as adaptable, allowing adjustments without penalty, particularly during female-related experiences that are beyond individual control. As one participant stated: *"Flexible working to support all stages of a woman's life (menstruation, pre-natal, post-natal, miscarriage, menopause)."*

Workplace flexibility included options such as remote or hybrid working, modified hours, and workload adjustments. These were seen as essential in enabling women to manage their health while remaining engaged at work. In contrast, rigid expectations and a lack of accommodation were viewed as signs of an unfriendly culture: "*Rigid work patterns*."

Participants stressed that flexibility should extend beyond task completion to include time for networking, taking breaks, and promoting work-life balance. WHF work cultures were those where line managers actively enabled reasonable adjustments and avoided placing excessive demands on staff. A "*one-size-fits-all approach*" was seen as inadequate; adaptability to individual needs was seen as essential for fostering a supportive work environment.

3.2.2.2 Resources and support

Access to appropriate resources and support was considered essential to a WHF work culture. This included supportive managers and colleagues, relevant policies, physical facilities, and accessible information. Participants valued resources such as informative materials, awareness-raising sessions, training, possibly "*mandatory*" for staff and managers, and forums for discussing women's health. Educational talks open to all staff, including men, were seen as promoting understanding and reducing stigma: *"Providing talks to people - men included - so that they understand the effects, and for women to understand they are not alone with their symptoms."*

Designated contacts, such as occupational health staff or women's health champions, were recommended. Other provisions included health insurance that covers women's health needs, wellbeing initiatives, and facilities like on-site childcare. Participants also stressed the importance of consulting both women and wider staff groups when developing resources, to ensure inclusivity and organisational relevance.

Supportive policies were also key, including appropriate recording of women's health-related absences, access to suitable equipment (e.g. gender-appropriate PPE), and targeted initiatives such as a menopause policy. Embedding WHF values into workplace systems, such as appraisals, and ensuring legal compliance further reflected a WHF approach. Workplaces where "*nothing [is] provided*," or where staff were unaware of existing support, were not seen as having a WHF work culture.

3.2.2.3 Physical work environment

A WHF work culture was also reflected in the design and functionality of the physical work environment. Participants emphasised the importance of inclusive, fit-for-purpose and adaptable spaces that support comfort, privacy, and wellbeing.

Workplaces were seen as WHF when they offered features such as break-out areas for rest, clean and private toilet and shower facilities, and temperature control at individual workstations, such as access to desk fans. One participant described the importance of "*enabling women to control the temperature at their desks*," while another emphasised the value of "*inclusive and fit-for-purpose office space design*."

In contrast, environments designed primarily around male needs, or lacking basic amenities, were viewed as unsupportive and potentially detrimental to women's ability to work. The physical environment of a WHF organisation goes beyond functionality, signalling that women's needs are considered and accommodated as part of everyday workplace design.

4. Discussion

This study makes two main contributions to the field. First, it provides empirical evidence that menopausal women who perceive their employing organisations as women's health-friendly (WHF) report fewer problematic menopausal symptoms and lower levels of job stress. Second, it identifies the specific interpersonal characteristics and organisational

attributes that influence such perceptions by working women. From this research, a WHF work culture may be defined in the following way:

> *A women's health-friendly work culture is one in which both interpersonal dynamics and organisational structures work together to create a supportive, inclusive environment that recognises and responds to women's health needs at work. It is characterised by a workforce - including managers and colleagues - who are aware of and understand the diverse ways women's health can affect work, who adopt respectful, empathetic attitudes, and who communicate openly and without judgement. Crucially, it recognises and values women as equal contributors in the workplace, while acknowledging that their health experiences may differ from men's - not as a deficit, but as a natural part of human diversity. It avoids dismissive behaviours, stigma, silence, and assumptions that women should simply cope or conceal health-related needs. At the organisational level, such a culture is supported by flexible working arrangements; accessible and relevant resources such as information, policies, and peer support; and a physical environment that is adaptable, comfortable, and fit for purpose. It also rejects rigid, one-size-fits-all practices and tokenistic measures that are unsupported in day-to-day reality. Ultimately, a women's health-friendly work culture is not just about having policies in place - it is embedded in everyday behaviours, values, and relationships that foster trust, inclusion, and wellbeing for women and all its workers.*

These findings offer novel insights this emerging concept, with important theoretical and practical implications.

The results support previous research highlighting what menopausal women want from their workplaces to feel better supported and more comfortable disclosing their menopause [15,18]. While earlier studies may not have explicitly investigated organisational culture specifically, our study builds on and reframes that body of work, helping define what a women's health-friendly work culture looks like in practice. By identifying both interpersonal and structural features, it offers more detailed practical guidance for organisations to recognise and strengthen such cultures.

These findings also contribute to the biopsychosocial understanding of menopause by showing how workplace norms and practices influence how symptoms are experienced, managed, and interpreted. Rather than viewing menopause as purely a medical or individual issue, this study highlights the important role of organisational and social factors in shaping symptom burden and stress at work. The workplace, in this view, is a meaningful context through which menopause is lived. Women with more problematic symptoms may face situations that could challenge their views about their organisation; whereas women with less problematic symptoms may have lower levels of need for support. Organisations' 'friendliness' and supportive environment may in turn help women to have less stress and less problematic symptoms.

Notable strengths and limitation of this study should be considered. A key strength of this research is the large sample providing both quantitative and qualitative data. However, the cross-sectional design prevents causal inference; longitudinal studies are needed to examine how working in a WHF culture influences health and work outcomes over time. The sample was also relatively homogenous, comprising mainly white, non-disabled women from the public sector. Future research should aim to include more diverse populations to test whether findings hold across different demographic and occupational contexts. Exploring perspectives from other key stakeholders, such as line managers, policymakers, and HR professionals

would also offer a more comprehensive understanding of how these organisations and cultures are created and sustained. Finally, future work may focus on intervention development and the creation of a validated tool to quantitatively assess women's health-friendly workplace culture.

5. Conclusion

This study sheds light on an under-explored aspect of women's health at work by examining the concept of a women's health-friendly organisation and work culture. The findings show that, when perceived by menopausal women, working in such organisations and cultures is associated with fewer problematic menopausal symptoms and reduced job stress. In addition to offering empirical support of the workplace's influence on health experiences, the study provides practical insight into the specific organisational and interpersonal elements that contribute to this type of work culture.

As national and international calls grow for more inclusive and responsive workplaces [28-32] – particularly those that are "friendly" towards menopause and women's health more broadly - these findings underscore the importance of moving beyond policy statements toward meaningful cultural change. Supporting women's health at work requires not only physical and structural provisions, but also everyday practices and personal relationships that foster trust, inclusivity and support.

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Contributors

CH participated in the conception and design of the study; performed the data collection, the analysis and interpretation of the data; and contributed to the writing of the paper.

AG participated in the conception and design of the study; performed the analysis and interpretation of the data; and contributed to the writing of the paper.

ET participated in the conception and design of the study; contributed to the analysis and interpretation of the data; and contributed to the writing of the paper.

MSH participated in the conception and design of the study; contributed to the interpretation of the data; and contributed to the writing of the paper.

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Appendices (Supplementary files)

Supplementary File 1

Researchers' positionality information

Personal characteristics of the researchers and relationship with respondents[a]: credentials/qualifications, occupation, gender, training/experience	
C Hardy (CH)	BSc MSc PhD CPsychol SFHEA AFBPsS, Chartered Psychologist in occupational psychology, Senior Lecturer in organisational health and wellbeing, woman, mixed methods research training in work psychology with experience and expertise in menopause and work research; no relationships with respondents
A Griffiths	BA MSc PGCE PhD CPsychol AFBPsS FAcSS FFOM (Hon), Emeritus Professor of occupational health psychology, woman, mixed methods research training in organisational and health psychology with experience and expertise in women's health and menopause research; no relationships with respondents
E Thorne (ET)	BSc MSc, Researcher, woman, mixed methods research training in health and work psychology with experience in menopause and work research; no relationships with respondents
M.S Hunter	BA DClinPsych PhD CPsychol FBPS, Emeritus Professor of clinical health psychology, woman, mixed methods research training in clinical and health psychology with experience and expertise in women's health and menopause research; no relationships with respondents

[a]Survey data was anonymous