"Let each person tell the truth from ~~his~~ her own experience." Florence Nightingale

THE LIVED EXPERIENCE OF MENOPAUSE FOR NURSES IN THEIR WORKPLACE

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Sue Smith

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ABSTRACT

Purpose: To investigate the lived experience of menopause for nurses in their workplace.

Background: Most women aged between 45-55 will experience some level of menopause symptoms and by the year 2025 over 1 billion women worldwide would have experienced perimenopause (Grose, 2021). How women experience menopause at work, and what can be done to support them, is particularly important for the nursing profession given its workforce demographic of older cis-women. While there is some research on the experience of menopause and how to improve it in workplaces, it is limited. This is especially so in Aotearoa New Zealand, where there is a paucity of research investigating the effects of menopause on women's health in general, and specifically, in the healthcare workforce.

Method: 35 nurses working at Te Whatu Ora Southern who had or were experiencing menopausal/ pre-menopausal symptoms were recruited, using purposive sampling, to complete an anonymous qualitative survey designed for this study. The data were analysed using reflexive thematic analysis informed by a phenomenological framework.

Findings: The analysis of the survey data produced five superordinate themes. The first of these themes “The multiplicity experience that is menopause” highlighted the multitude of symptoms that occur with menopause, and which require management within the wider context of the participants’ lives that often include gendered and life-course stresses. The second theme “Challenge to my identity” drew attention to how the menopause experience challenged the participants’ sense of self in terms of who they thought they should be and their perceived identity within their workplace. The third theme “Coat of armour” evidenced a strategy for ignoring or overriding the problem by withholding their concerns and issues and staying silent. The fourth theme “Desires for an Effective Workplace” identified the positive and negative aspects of experiencing menopause in the workplace, and what actions were more or less effective in supporting nurses with menopause at work. Finally, the fifth superordinate theme "Reaching a new stage" celebrated the identification of what can work for these women and how they can reframe this experience into a positive, particularly through knowledge and appropriate support.

Conclusions: The stigma associated with menopause shaped these nurses experiences of their workplace, along with a lack of education, sense of support available at work, and appropriate access to services when required. Findings also show the importance of recognising the life course that these women are situated, since multiple physiological, psychological and social factors interacted to affect their experiences and outcomes. The study highlighted a vulnerability related to gender roles and norms; need for improved workplace support; an individual approach to improve retention of nurses; and further research. Understanding the current inequities and the complexity associated with menopause is key to reducing the stigma and offering choice.

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LIST OF ABBREVIATIONS/ TERMS

- Oestrogen (UK/AUS/NZ term) = One of the female sex hormones needed for the menstrual cycle, bone strength, puberty and pregnancy (Healthdirect, 2022).
- Estrogen = as above (USA).
- Progesterone = an endogenous steroid hormone that is commonly produced by the adrenal cortex as well as the ovaries and the testes (Cable & Grider, 2023).
- **Hot flushes** (UK)/ hot flashes (USA) = (included in vasomotor symptoms), medical condition with sudden onset that cause intense heat and sweat in the neck, chest and face, and when the skin may turn red (Deecher & Dorries, 2007). All references to hot flashes updated to state hot flushes.
- ERT = estrogen replacement therapy = first hormone replacement therapy using female ovarian hormones, initially human then replaced by pregnant mare's urine (Lawton, 2006).
- HRT= hormone replacement therapy – used to relieve symptoms of menopause by replacing female hormones, progesterone and oestrogen or oestrogen only (NHS inform, n.d.)
- MHT= menopausal hormone therapy = most recent terminology, replacing HRT, for prescription medications to increase levels of sex hormones in the body such as progesterone and oestrogen (Health Direct, 2024).
    - HRT is now used to describe when treatment is used to replace oestrogen in non-menopause caused situations (Healthify, 2023)

CHAPTER 1 - INTRODUCTION :

MENOPAUSE - TRANSLATING THE TRANSITION

"*The disease model of menopause claimed that menopause could be accurately (and fruitfully) understood as an estrogen deficiency disease*" (Kleinman et al., 2005).

"Meno"- Greek word for month

"Pausis – Greek word for pause

The first talk of menopause was Aristotle in 384-322 BC when he mentioned that periods appeared to cease around 40 years of age (Lawton, 2006) while the French physician Charles-Pierre-Louis de Gardanne coined the term "menopause" in the 1820s (Prague, 2019). The term continues today, with Menopause used to describe the menstrual cycle ceasing and this cessation being caused through the reduction of ovarian hormones, oestrogen and progesterone (Nelson, 2008).

While Menopause is often used colloquially as the term for the whole process of menstrual cessation, it is actually referred to as "Climacteric" which includes the cessation of oestrogen hormone production, ending of the menstrual cycle and the vasomotor effects. The Greek origin of the word Climacteric is *klimakter* and means a rung in the ladder, referring to the next step in the journey as a positive move forward (Coney, 1994). Climacterium includes four stages including: premenopause which is the time between a woman's first period and the onset of perimenopause, this can include irregular periods but generally shows no hormonal changes or symptoms; perimenopause is when the physical and psychological symptoms of menopause commence with hormonal changes and is the transition phase into menopause which can typically last up to 6 years; menopause when the period ceases permanently; and post menopause is 12 months after the last period (Gregorin & Pajk, 2016). Once a woman has had no periods for 12 months she is post-menopausal (Lawton, 2006).

The reduction in the hormones, oestrogen and progesterone, once produced by women's ovaries, is what triggers menopause with some women stopping their periods abruptly and others having irregular periods for years (Goodyear, 2018). It is these lower levels of hormones that can create health issues that may impact on a woman's day to day life. For example, When perimenopause/ menopause occurs women can experience increased cholesterol levels which heightens the risk of heart disease (Cherney, 2023).

Approximately 1% of women will experience premature menopause where the period ceases before they turn 40 years old and an additional 6% due to surgery or treatment such as chemotherapy (AMS, 2022). Due to the suddenness of surgically induced menopause the symptoms can often be longer lasting and more severe leaving women at risk of heart disease, stroke, or sexual dysfunction for example (Dear, 2023a).

Over 1 million women in New Zealand are in the 35-65 age bracket leaving a large portion of the population affected by menopause (Dear, 2023a). In 2020 there were 657 million women aged 45-69 worldwide (EMAS, 2023) with over 1 billion women worldwide expected to experience menopause by the year 2025 (Pellegrino, 2022). Menopausal onset tends to happen around the age of 44-56, although there are variations in reports for the average age of menopause in New Zealand. Health Navigator (2023) has the average age range for menopause in New Zealand between 45-55 years, which is the same average internationally. Whereas the Women's Health Action states New Zealand statistics showing menopause occurring anytime between 42-56 years with the average age in New Zealand being 51.5 years (Womens Health Action, n.d.).

While life expectancy has risen for women across the decades so has the amount of women experiencing menopause and particularly menopause at work. In the 1900s the New Zealand life expectancy was 57 years for a Pakeha (European) woman and in 2020 it was 83.5 years of age (Stats NZ, 2021). Since 95% of women will now reach the age of 50 there are more older women making up a larger proportion of the population with more working mothers reaching menopause (Lawton, 2006).

Regardless of their onset age or length of menopause a large portion of these women are likely to experience significant symptoms and effects that can impact on their work.

Transitioning to menopause can impact on women's experiences at work. For example, the NZ Menopause survey 2023 reported that over 80% of women had a negative impact at work due to their menopause symptoms (Dear, 2023c, pp 35). Similar findings are reported elsewhere, for example, in the UK, Many of 13 million women who are currently going through peri-menopause or menopause report receiving inadequate support due to sexism and ageism even though 51% of the population will experience menopause. Most women aged between 45-55 will experience some level of menopausal symptoms, and women's lived experience of menopause is increasingly more public yet menopause is still not openly discussed, especially at work, and the negative narratives around ageing continue (Goodyear, 2018). By 2025, 1 billion women will be post-menopausal yet women are still reporting they are ill informed and not discussing their experiences (Grose, 2021). These findings highlight the importance of understanding women's experiences of menopause at work.

How women experience menopause at work, and what can be done to support them, is particularly important for the nursing profession given its workforce demographic. For example, the most recent New Zealand Nursing workforce statistics for 2018/2019 show the Nursing population is overwhelmingly female at 91% and it has an older age profile with 43% being aged 50 years and over (Te Kaunihera Tapuhi o Aotearoa/ Nursing Council of New Zealand, 2019).

SYMPTOMS

Menopause can have a wide range of symptoms varying in severity caused by hormonal changes and influenced by multiple factors including culture. A variety of physical and psychological symptoms are reported across studies on menopause with some being caused through the hormone changes and others being impacted on by other symptoms, e.g. night sweats causing fatigue. Lawton (2006) separates menopause symptoms into early and intermediate while reminding people that not all of this life stage's symptoms are menopause related with the example of thyroid disease causing hot flushes.

International research has shown that 75% of menopausal women can experience symptoms that can last up to decades for some (APPG, 2022). The New York based Female Founders Fund study showed 78% of women had some type of symptom that interfered with their day to day life and only 36% of women felt they were prepared for menopause (Pellegrino, 2022). While 58% of women in the NZ Menopause survey 2023 reported their symptoms as being severe or very severe (Dear, 2023c). With 70-80% of New Zealand women experiencing significant menopause symptoms of which 30-40% will see a doctor about (Health Navigator, 2023).

The UK NICE guidelines identifies menopause symptoms include reduced libido, hot flushes, vaginal dryness and fatigue (NICE, 2015). Zouboulis, et al. (2022) also includes headaches, breast tenderness, bone/joint/muscle pain, irritability, poor concentration and insomnia which could then lead to further neurological symptom. Early menopause symptoms include; night sweats, dry eyes, mood changes whereas intermediate symptoms included enhanced wrinkles, thinning of skin and hair and pain on intercourse (Lawton, 2006). Sievert et al. (2008) identified some specific risk factors for hot flushes such as ethnicity, smoking, anxiety and psychological stress.

The Founders Fund study identified over 30 symptoms that women can experience with some women having severe symptoms and others having none at all (Female Founders Fund, 2020). The perfect storm of insomnia during menopause could be one of the most wide-reaching effects which can be impacted on by a multitude of factors. The drop in melatonin, increase spikes in cortisol and brain chemicals orexins, that can stimulate wakefulness appear to increase in menopause (Pellegrino, 2022). These are all outcomes of sleep disturbances, then add these to general ageing issues like aching joints, sleep apnoea and some hot flushes and insomnia can have a negative effect on health through sleep deprivation and low immune (Pellegrino, 2022). Sleep deprivation could also contribute to a woman's mental health such as increasing levels of anxiety and depression which have been linked to low levels of oestrogen along with low self-esteem and anxiety attacks (Lawton, 2006). This culminating issue of sleep deprivation has ongoing physiological effects including stress on cardiovascular, weaker bones, blood sugar levels, weight gain and potential impacts on levels of dementia (Pellegrino, 2022).

Late consequences of menopause as Lawton (2006) describes them include osteoporosis and coronary heart disease both of which can kill or disable millions of women worldwide. Similarly Herbert et al. (2020) describe how oestrogen depletion contributes to increased risk of diabetes, cancer, cardiovascular disease, bone loss, muscle wasting and urogenital atrophy. The variety of symptoms from physical to psychological can be illustrated in a cross sectional qualitative study of Australian women where VSM symptoms were associated with low general and psychological well-being and depressed mood (Herbert et al., 2020). Further research would be valuable to improve on the limitations of these studies by increasing the sample size, including other cultures, multiple education levels of participants and socio-economic status along with duration of menopause. Through understanding the relationships between stress and menopausal symptoms, better management of the physical symptoms could be attained while also improving working conditions.

Furthermore the UK All Party Parliamentary Group (APPG) menopause report highlighted the risk of suicide was one of the many hidden costs of menopause with current suicide rates for women aged 45-54 having risen 6% in the last 20 years (APPG, 2022). Perimenopause has been shown to heighten the risk of mental health issues with research showing a second peak in the incidence of schizophrenia and panic disorder in women aged 45 to 50 but not amongst men (Bezzant, 2020). Women are also often treated inappropriately with anti-depressants for misdiagnosed psychiatric conditions which are actually menopausal mood related symptoms (Dear, 2023a). The need for education and improved understanding of menopausal mood related issues is increasing with more women reaching menopause age.

For instance Mosconi described how women who do have pre-existing mental health issues such as bipolar disorder may experience relapses and for those women who have suffered from PMS or post-natal depression being more at risk of developing a mood disorder at perimenopause (Bezzant, 2020). She continues to state that women are at higher risk of developing Alzheimer's than men and it is due to the loss of oestrogen through menopause as oestrogen is part of the metabolism of the protein that forms Alzheimer's plaques while we have oestrogen limited plaques are formed but once oestrogen is depleted the brain ages faster (Bezzant, 2020).

All of these symptoms are individually experienced with some differences reported across cultures. A variety of factors can have effects on how women experience menopause including cultural norms, knowledge of menopause, social factors, education, health status, stress, environmental conditions and employment (Namazi et al., 2019). As menopausal symptoms have been identified as both physical and psychological it has been suggested to treat women more holistically and to consider the complexity of these needs (Gregorin & Pajk, 2016). Cross cultural studies suggest menopause is better understood as a biopsychosocial issue.

For example studies have shown how factors can affect the experience of menopause such as the positive effect emotional intelligence and social support can have on menopause experiences and how having a positive attitude can improve the severity of menopause ((Bauld & Brown, 2009). In the US longitudinal study of menopausal symptoms, 'Study of Women's Health Across the Nation" (SWAN), smoking, being single, history of heart disease, lower education and non-employment were all found to be associated with menopause commencing earlier than normal (Chadha et al., 2016).

In conclusion the commencement age, length of menopause and severity of symptoms varies across cultures and can be affected by multiple factors. The median duration for VSM symptoms was 7.4 years as found in a multi-ethnic study in the US (Zouboulis et al., 2022). There is no definite way to predict how long the menopausal symptoms will last and for 10-20% of women it can be for up to 12 years but for most it is between 2-5 years (AMS, 2022). Menopause is a subjective experience being individual to each woman.

THESIS AIMS

Recent international occupational studies have raised the need for women to have more awareness and support from their employers, both on the impact of menopause and how it can affect their health but also how their workplace can impact on the menopausal symptoms (Hardy et al., 2018). Within this research there is a particular need to focus on understanding nurses experiences and specific demographics to then provide appropriate information, support and to reduce workforce attrition.

While international research has addressed some of the gaps in knowledge on women's experiences of menopause in the workplace, and how to improve workplaces for them, there has been limited research investigating the effects of menopause on women's health and particularly in the healthcare workforce in New Zealand. Therefore it is unknown if New Zealand Nurses have similar experiences, nor how they interpret them. This is important for the well-being of nurses, especially as the number of older workers increases in the New Zealand workforce (Blockley, 2018) and because managers cannot make assumptions about nurses needs in regard to managing menopause which will vary (University of Auckland, n.d.). This research therefore aims to fill some of that knowledge gap and gain a better understanding of the lived experience of nurses in their workplace and how they make sense of menopause.

The following literature review chapters introduce the history of understanding menopause including the medicalisation of menopause; hormone replacement therapy; contemporary understandings with influences of culture and society; menopause at work and for nurses working in New Zealand; current research and the New Zealand political landscape.

CHAPTER 2 - HISTORY

The 19th century was full of archaic and negative references to menopause including Dr Edward Tilt, who published the first full length publication about menopause in 1857 (van de Wiel, 2014), describing the change as… “*the forms of insanity are distinguished: delirium, mania, hypochondriasis, melancholia, impulsive insanity and perversion of moral instincts*” (Lawton, 2006, pp. 13–14). Although these references were typical they are scattered in the earlier 19th Century with physicians mostly unconcerned over women’s menopause with the first menopause monograph published in 1897 by Currier, then the focus changed slightly at the turn of the century to education and reassurance hoping that would diminish the need for medical intervention and prescribing (Kleinman et al., 2005).

The medicalisation of menopause, initially developed by Tilt’s earlier publications situated menopause as “*a recognizable pathology in need of medical management*,..” (van de Wiel, 2014, pp 75) and was then developed as a response to the clinicians education, commercial interests and patient demands (Sievert et al., 2008). Two key developments opened the door to this medicalisation of menopause. The development of the synthetic hormone diethylstilbesterol (DES) in 1941 and the oestrogen extract, Premarin, in 1942 (Kleinman et al., 2005). Kleinman (2005) explains that these medications were initially only prescribed in severe cases where reassurance, education and sometimes mild sedatives didn’t work. This development of medications grew over the next two decades until the once conservative view of menopause treatment turned into a more direct approach, influenced by the aggressive marketing from pharmaceutical companies to physicians of their drugs (Kleinman et al., 2005).

The 1960s saw psychotropic drugs being targeted at women to treat menopause which gained the psychiatric label “involutional melancholia” to cover the midlife depression a condition eventually found to not exist but used at the time to diagnose women with menopause as unwell (Coney, 1994). In 1962 Allan Barnes, a John Hopkins gynaecologist, confirmed that menopause was a disease and other physicians followed with agreement that this incapacitating disease needed to be treated (Kleinman et al., 2005). The biomedical model would place menopause as a disease deficiency, something that needed to be treated, a concept furthered by Dr Robert A. Wilson who in the 1960s aimed to save women from their "*living decay*" of menopause and lifted this once considered disease of the mind to a disease of the body (Coney, 1994). Dr Wilson and his wife Thelma described menopausal women to be suffering from a "*vapid cow-like feeling called a negative state*" and maintained these women were docile creatures missing out on life (Kleinman et al., 2005, p. 207). Coney describes Wilson as the "*Hugh Hefner of menopause*" for his description of mid-life women as castrated and desexed while questioning his oestrogen deficiency model as being reductionist and not taking into account the experiences of the women themselves (Coney, 1994, p. 76).

As the baby boomers hit menopause a greater need arose for control of the women's health narrative. Until then the research had been led by the biomedical model and informed by North American studies (Beasley, 1999). Coney (1994) argued that menopause was a normal stage of ageing without requirement for medical supervision. With a move to create unbiased research women who did require and chose to access these treatments would be given back that control over their healthcare. Within the disease model of health menopause is framed as a deficiency and just as diabetes was produced through an insulin deficiency so too menopause was the outcome of an oestrogen deficiency and could be cured through providing that missing element (Kleinman et al., 2005).

One of the options to curing this deficiency was the development of Hormone Replacement Therapy (HRT) which gave women that control of their health and while initially held some risks, which are still being debated, has diminished many of the debilitating symptoms of menopause for millions of women worldwide. Next I discuss the development of hormone replacement therapy.

HORMONE REPLACEMENT THERAPY

As part of the medicalisation of menopause a common medical treatment in the 19th century was to remove the woman's womb and genitalia to treat her hysteria as all women's problems were thought to come from her genitalia (Lawton, 2006). There were also attempts to treat women with hormones through the development of hormone treatment as far back as the 1800s. Ovariin was produced by Merck in 1890 and was developed from pulverised cow ovaries (Kleinman et al., 2005). In 1896 crushed human ovaries were made into compounds, raw egg purgatives and powdered donkey penis were also given to women (Lawton, 2006).

Female ovarian hormones were discovered more recently with active oestrogen compounds being extracted from pregnant women's urine in 1926 (Lawton, 2006). This earliest version had such a strong odour the urine was replaced with pregnant mare's urine and was created in Canada and named Premarin (**PRE**gnant **MA**res' u**RIN**e) (Kleinman et al., 2005). Premarin, which became the earliest Estrogen replacement therapy (ERT), was developed at a time when it was still implied that women had a deficiency to be cured (Lawton, 2006).

Around the same time as Premarin's development, Edward Dodds published his formula for a synthetic estrogen, diethylstilbestrol (DES). His plan to publish it was aimed at preventing Hitler from discovering it for his own use. He then realised it hadn't been tested appropriately and had dangers so began an awareness program and by 1941 multiple big pharma companies were controlling the narrative on the use of this drug and the FDA finally approved it for use (Kleinman et al., 2005).

Premarin was marketed as a cure of menopause and an anti-ageing solution including improving skin tone and hot flushes (Lawton, 2006; Sievert et al., 2008). Then an article published in 1975 in the USA stated that women using estrogen were five to fourteen times more at risk of developing endometrial cancer, this was rebuffed by the producers of Premarin, Ayerst, until the FDA ordered the labels to be updated to identify the risk (Kleinman et al., 2005). Several other studies and task forces emerged investigating the risks of estrogen treatment and the correlation to breast cancer rates and the use of DES; and links to breast cancer prevalence in women who used it and their offspring (Kleinman et al., 2005). This marketing then had to evolve in response to the research showing links to cancer of the womb, therefore following adjustments to include progesterone which protected the womb from cancer, the marketing was continued (Lawton, 2006).

The prescribing rates and length of treatment reduced for ERT for a while until the 1980s. Between the aggressive marketing by Ayerst pharmaceuticals and the looming baby boomers needs, the use of ERT increased even after these cancer scares. The influence of the baby boomers cohort was witnessed as they had started reaching menopause and the number of women aged 45-54 in the years between 1970-2000 increased by approximately 56% (Kleinman et al., 2005). By the late 1990s Hormone Replacement Therapy (HRT) was recommended for use by all women for the reduction of menopausal symptoms such as VSM symptoms, osteoporosis, and included recommendations that it could reduce coronary heart disease and dementia (Sievert et al., 2008). No longer referred to as ERT the terminology had been updated to reference the multiple hormones being replaced such as progesterone and estrogen. While the initial studies showed positive results with reductions in heart disease, osteoporotic fractures, cataracts and Alzheimer's, HRT was then linked to an increase in thrombosis and breast cancer (Lawton, 2006).

By the end of the 20th century HRT was being offered as a treatment for the consequence of female ageing, women started declining this medicalisation of their natural ageing process or sought alternative treatments such as cohosh or seen hot flushes as power surges (Kleinman et al., 2005). In addition to the health issues identified with HRT, a feminist discourse challenging the medicalisation started to have an impact on its use. HRT treatment is described as another way for the patriarchal society to control women's sexuality further with it being a way to keep women "feminine forever" and being derived from the influence of Dr Wilson on medical professionals (Beasley, 1999).

The deficiency disease model needed to be challenged and the need for "treatment" of all women going through menopause rather than focusing on those who actually needed it had to be debated (Coney, 1994). While HRT ‘saved” many women from debilitating symptoms it was still placing menopause as a disease or deficiency to cure and attempting to halt a natural stage of ageing. Considering the amount of issues that were raised over the years with hormone treatment and its side effects it was surprising how it continued to be marketed by the pharmaceutical companies and how it continued to be used. Exercise was actually the most commonly used treatment in the recent NZ Menopause Survey 2023 with 51% of participants citing it, whereas 31% had used HRT and 15% having never tried any treatments, suggesting the importance of not assigning a one-size-fits-all approach (Dear, 2023b). Further research was needed on the effects of HRT and its benefits for women experiencing menopausal symptoms. Next I discuss the effects of the Women’s health institute research.

WOMEN’S HEALTH INSTITUTE EFFECTS

The Women’s Health Institute (WHI) was sponsored in the 1990s by the U.S. National Institutes of Health (NIH) as a response to the fact most medical research had been undertaken with white males. It consisted of multiple clinical and observational studies into cardiovascular disease, cancers and osteoporotic fractures and was a long term national health study which concluded in 2005 with extension studies continuing annually (WHI, 2021). 161,809 women participated in the Women’s Health Initiative Clinical Trial of Estrogen Plus Progesterone clinical trial and when it began over “*six million women were taking estrogen and progestin”,* with no knowledge of the long-term risks of HRT (Kleinman et al., 2005, p. 183). Prior to the WHI results evidence from observational studies had shown 30-50% reduced risk of heart disease for women who had been taking estrogen (Kleinman et al., 2005). These observational studies did not provide the clinical evidence required to indicate long-term risk factors so the WHI clinical trial was timely.

Then in 2002 the WHI questioned the safety of HRT following their Estrogen and Progesterone (E+P) study showing increased risk of breast cancer, venous thrombosis, dementia and ischemic stroke in the women who took HRT as compared to the placebo (Kleinman et al., 2005). These results were not expected and upsetting to millions of women worldwide who had been under the impression, as had their gynaecologists, that the drug they were on was safe and lifesaving (Kleinman et al., 2005). A dramatic decline followed in HRT prescribing from 2001-2003 internationally with its use falling, for example, 40% in Australia and greater in the USA (Davis et al., 2021). In 2003 the FDA ordered a “black box’ warning on the estrogen products advising they only be used for short time periods and only for certain symptoms such as night sweats and hot flushes (Kleinman et al., 2005).

Consequently the ongoing effects of this initiative can still be seen today with both women and clinicians being tentative around HRT and this research continued to shape the use of its use internationally. In the Decisions at Menopause study (DAMeS) Sievert et al. (2008) demonstrated that in their study across 4 countries, Morocco, Spain, United States and Lebanon, all showed a change in their management of menopausal women and the prescribing of HRT following the WHI report. Herbert et al. (2020) also found that over 75% of women aged under 55 years who were experiencing VSM symptoms were not taking HRT with 28.5% of those women having severe symptoms. Menopausal Hormone Therapy (MHT) is the term currently used in contemporary studies for what was known as HRT and referred to in this document alongside HRT.

The WHI study findings were heavily debated across multiple studies and countries. A key limitation of the WHI study was the age of their participants and the fact they were asymptomatic. The study gave Conjugated Equine Estrogens (CEE) to women who were predominantly over 10 years post their last period suggesting an obvious reason why their results were so different to the previous observational studies on younger women (Cagnacci & Venier, 2019; Klaiber et al., 2005). Since then multiple studies have shown positive results using MHT and favourable effects on cardiovascular health yet the continued narrative is overshadowed by the fear of cancer from the 2002 report (Natari et al., 2021). The WHI findings of 2002 continued to shape prescription practice to this day yet recently there has been a move to revitalise MHT with more positive discourses occurring.

Menopause is a “hot topic” with recognition of the spending power of menopausal women being referenced across blogs and research worldwide (Noon, 2022a) and the growing workforce demographics for menopausal women being highlighted in research studies (NZIER, 2023). Contemporary debate has developed further following the documentary *Davina McCall: Sex, Myths and the Menopause,* which raised the need for discussion, breaking the silence and creating change for millions of women by placing celebrities in the menopausal limelight (Jermyn, 2023). This emerging discourse includes debates of structural and systemic failures that menopausal women are facing. While the solutions provided by these celebrity driven documentaries appear to be improving the awareness of menopausal issues it is thought to be influenced by the biomedicalization instead of re-imagining menopause there is a continued definition of an oestrogen deficiency disease (Jermyn, 2023; Orgad & Rottenberg, 2023).

CHAPTER 3 - CONTEMPORARY UNDERSTANDINGS

Feminists have denounced the continued medicalisation of menopause stating the drug companies and physicians have worked in tandem across the years to reconstruct menopause from a natural biological course into a condition requiring medical intervention and pharmaceuticals (Kleinman et al., 2005). This change in discourse and control of the narrative around menopause involves multiple influencing factors including: improving clinical education; changing the way society views menopause; supporting menopausal women particularly at work; understanding the biopsychosocial elements that can be involved; and access to appropriate treatment.

SOCIAL CONTEXT

The negative picture of menopause has been portrayed in the media for so long that the positive changes associated with menopause have been overshadowed. Lawton (2006) raises key points on the positive features of menopause such as no more periods, no more Pre Menstrual Syndrome (PMS), no more pain and not havening to deal with contraception. The economic advantage for lower socio-economic and rurally isolated groups was also a benefit (Jones et al., 2012). Briggs et al. (2023) highlights that as some cultures celebrate menopause as opposed to the negative connotations we see in western society it is important when developing education material to be inclusive and engage with these perspectives by creating a model that isn't a "one size fits all".

Society is evolving with some positive movements occurring internationally. Sophie, Countess of Wessex, is the first Royal to describe her brain fog experiences in public; Salma Hayek had menopause written into her recent movie role in "The Hitman's wife"; and the incontinence company Tena was able to gain a change of the phrase used in Arabic for menopause from "the age of despair" to "the age of renewal" (Pellegrino, 2022). Some of these positive advancements include the recognition of support in the workplace for menopausal women such as the legislative reviews occurring in the U.K, along with recognition of the multiple factors that can affect menopausal women such as social, cultural and psychological.

CULTURAL INFLUENCES

The construct of menopause varies considerably across history and across cultures with the westernised view that menopause is the end to menstruation being developed more recently by gynaecologists. Menopause symptoms were found to be influenced by factors including socio-economic, culture and medical history (Chadha et al., 2016). If menopause was affected solely by biological changes then all women would be having a more homogenous experience, therefore an updated approach to menopause needs to include a biocultural paradigm (Jones et al., 2012).

Cultures hold different meanings or perceptions about menopause where some will celebrate the life stage others do not therefore an awareness is needed to support all individuals (P. Briggs et al., 2023). For the Aboriginal people of Australia elders are respected and menopause is linked to gaining status (Jones et al., 2012). Herbert et al., (2020) references the contrasts in approaches from their research with white Australian women holding some negative views towards menopause compared to that of other ethnicities being more positive, demonstrating how women's experiences and beliefs about menopause are influenced by sociocultural factors.

While social and biological factors have been shown to affect menopause, such as age, smoking, stress and education, they are not sufficient to explain the total variations seen across women's experiences of menopause whereas cultural influences could be more relevant in explaining the differing needs during menopause (Jones et al., 2012). Researchers have shown variation within society and cross culturally in the incidence of symptoms, such as hot flushes, and the risk associated with heart disease suggesting the blanket HRT recommendations are not appropriate (Kleinman et al., 2005). This necessitates cross cultural qualitative and quantitative research.

Some minority groups in society are stating there are barriers to accessing services and support for menopause, specifically LGBT+ and ethnic minorities who report that they do not associate with the western model of menopause and that they have been underrepresented in research (APPG, 2022). While many studies have shown the specific symptoms and effects on women these studies can also have limitations as they are not always standardised or valid and could be affected by multiple variables such as age, ethnicity, culture, diet and environment (Nelson, 2008). Further highlighting the need for appropriate research conducted across cultures and with LGBT+ groups.

Cross cultural research to date has consistently shown differences in the reporting of symptoms highlighting the need to understand menopause as a biocultural event influenced by variables such as reproductive history and diet (Kleinman et al., 2005). Chadha et al. (2016) identified that most indigenous groups in their research commenced menopause earlier which they related to a harsher lifestyle particularly for Asia, Central and South America. This research could be extended through future studies targeting socio economic groups in western countries to identify if there was also a difference between women living in harsher environments within the same culture.

For example Chadha et al. (2016) identified only 28 published articles across 33 years 1981-2014 that included climacteric, menopause, indigenous or aboriginal. Which reflects the substantial gap in relevant research on indigenous women's experiences of menopause. The scales and measures used within this previous research has limited validity for ethnic groups and cultures as it hasn't been designed for those specific ethnicities (Chadha et al., 2016). Jones et al., (2012) also draws attention to the limited number of research studies in Australia where they were not able to reference indigenous women yet there is considerable literature on Australian women as a whole, they identified only two research studies about Indigenous women's experiences of menopause. The APPG report (2002) also identified that in the UK some cultural groups were not being represented in the research.

Several studies have shown the differences in menopausal symptom reporting across cultures with African American women reporting 80% hot flushes, 52% Japanese women reporting hot flushes and Mayan women of Mexico reporting none (Lawton et al., 2008). Nelson (2008) also described how previous research results have shown African American women reporting more vasomotor dysfunctions than white women. In the Menopause symptom profile of Māori and non-Māori women in New Zealand they identified that while there were differences across certain factors which were thought to influence menopause, such as education levels, weight and smoking status, the participants still reported the same or a similar rate of vasomotor (VSM) symptoms (Lawton et al., 2008). Therefore identifying that other factors could also be influencing women's experience of menopause such as education, access to services and socio-economic status.

Japanese women outlive western women by at least 5 years and are seen as some of the healthiest in the world which is why studies comparing menopause experiences have been prevalent in Japan (Jones et al., 2012) .Studies have shown when Japanese women move to the USA their prevalence of disease increases to a similar rate of American women yet when in Japan they are some of least symptomatic in the world suggesting the importance of environmental and cultural factors on health (Jones et al., 2012). Japanese women have the longest life expectancy in the world with less breast cancer, heart disease and chronic illness than western countries, they also had low rates of alcohol use and smoking and good exercise and diet yet when this becomes more westernised with each generation will their good health statistics reflect the change (Kleinman et al., 2005). What impacts would this westernisation of health have on their menopause symptoms.

BIO-PSYCHO-SOCIAL-CULTURAL

Evidence suggests a need to recognise transition symptoms in a broader context including both social and psychological (Brewis et al., 2017). Several studies have identified the importance of ageing on this time of a woman's life and highlighted the need to respect the effects this can have on a woman's body and psychology without always being specifically caused through menopause. Society tends to associate all things mid-life with menopause and the need to disentangle what is specifically hormone related and what is actually a social concept is key to developing a more appropriate idea of menopause (Coney, 1994). Clarity on what is menopause related and what is age related will be important moving forward when planning appropriate and evidence based holistic treatment and support for women.

The bio-psycho-social approach recognises the effects of other variables in a woman's life and the influence they can have on the transition symptoms such as caring for elderly parents, children leaving home and recognising the woman's attitude to ageing (Brewis et al., 2017). While the menopausal transition is occurring, additional factors may also stress women such as ageing, empty nest and a changing role in society (Nelson, 2008). Research needs to focus on the holistic experience of women not just their physiological symptoms.

This holistic focus will aid in reducing the continued negative effects on women's careers. Mills (2023) describes a workplace exodus occurring at the "Queenager" stage of life which is contributed to by menopause when woman cannot enjoy their full potential due to gendered ageism. The Queenager is referred to as a woman living comfortably in her midlife and as freely as she did as a teenager, living life to the full and not succumbing to gendered ideas of women in their midlife stage who often has financial freedom (NextTribe, n.d.; Noon, 2022b).This workplace exodus wasn't only affected by menopause though and occurred in conjunction with multiple life events such as divorce, teenagers mental health issues, redundancy, caring for elderly parents, bereavement and abuse which was identified in the Noon research survey where 50% of women aged over 50 had been affected by at least 5 of these major life events (Mills, 2023; Noon, 2022a).

Additionally Hoga et al. (2015) reviewed 24 worldwide studies to identify evidence of women's experiences of menopause as there had been no systematic reviews conducted on women's experience of menopause at that time. Their review also identified that menopause is a life stage affected by many other variables within a woman's life such as sociocultural, environment, family and changing roles in society which health care providers take little notice of when they should be providing dynamic ways to manage a complex issue (Hoga et al., 2015).

As detailed previously culture has a profound effect on the experience of menopause from the interpretation society places on the transition to the way women experience the symptoms. In Japan menopause is referred to as a loss of balance in the body and is understood to be caused by both physiological and cultural factors, whereas in the shamanic cultures such as Cree women they must enter menopause to reach their full healing powers joining many other cultures that believe aging women gain power (Dhanabalan et al., 2023). Recognising the bio-psycho-social-cultural effects on menopause is imperative to providing appropriate treatment. As research has shown the psychological factors such as beliefs, anxiety and self-esteem can all influence the way that women experience symptoms of menopause such as hot flushes (Hunter & Rendall, 2007).

GAP IN KNOWLEDGE AND TREATMENTS

As GP practices manage the majority of health information for women, Primary care is the first stop for most women requiring support. Without the knowledge and evidence base required to make informed decisions women are resulting in significant symptoms that can impact on their daily living. For instance a 2022 study in the UK showed the key barriers to accessing treatment for menopause were MHT misinformation, incorrect perceptions around breast cancer risks, lack of correct diagnosis and misattribution of symptoms to other issues (Barber & Charles, 2023).

There is evidence based international guidelines supporting the use of MHT whereas research is indicating that women are not being prescribed this as a treatment option. For example in Australia less than 11% of postmenopausal women aged between 40-65 years were using MHT and only 4.5% were using the local vaginal oestrogen therapy to treat vulvovaginal atrophy which affects over 50% of perimenopausal and post-menopausal women and is a cause of sexual dysfunction (Herbert et al., 2020). While some evidence previously showed a link between breast cancer and HRT for many women the risks of HRT now outweigh that cancer risk (APPG, 2022).

For instance in their qualitative study of Australian women's understanding of menopause, Herbert et al. (2020) described an overall negative view of MHT usage and lack of understanding and confidence in its benefit and safety which is highlighting a need for proactive education and support from Primary Care providers. Davis et al., (2021) produced similar results in their study on Australian health care providers views on the treatment of menopause which showed uncertainty about the use of MHT. Their participants would prefer to support complementary and alternative medicines (CAMS) which reinforced the negative attitudes of women towards MHT leaving symptomatic women at high risk of postmenopausal bone loss without treatment (Davis et al., 2021).

Carter, Davis, et al., (2021) described their recent qualitative study indicating that general practitioners were reluctant to prescribe MHT other than to women with severe symptoms and how they lack confidence in knowing what to prescribe. Where Herbert et al., (2020) showed the women in the community were reluctant to use MHT. While the fear of MHT remains, clinicians as gatekeepers need to present the community with unambiguous evidence based information so women can make informed decisions on their healthcare options (Herbert et al., 2020).

Therefore to provide appropriate support to patients and the community the identified clinical knowledge gap needs to be addressed. A 2017 survey of medical trainees in the USA reported that over 20% had no lectures on menopause in their residency with only 6.8% stating confidence in managing women experiencing menopause (Davis et al., 2021). This gap in clinical knowledge has been linked to the WHI report affecting the confidence of clinicians. The UK's APPG report also identified the gap in policy and appropriate support to women in the community highlighting issues with postcode lottery for accessing appropriate services and socioeconomic disparities along with identifying that 41% of the UK's medical schools do not have mandatory menopause education on their curriculum. Their recommendations included more research; workplace policy development; improved HRT access reducing inequities; regular check-ups for older women; improved education for the public an clinicians (APPG, 2022).

APPG recommendations included reducing the identified postcode lottery and wealth divides by introducing initiatives such as the Women's health hubs. These hubs compliment Primary Care providers and support them to provide that speciality knowledge for women's health such as menopause symptoms (APPG, 2022). Similarly Dear (2023b) also refers to the lack in specific menopause training of Doctors in New Zealand yet raises the issues of introducing post-graduate training on the already over-burdened primary care sector which could cause more issues therefore other resources and options need to be developed such as menopause specific clinics.

In their 2023 review of the APPG report P.Briggs et al. (2023) details the importance of education and stakeholder communication. The summary detailed strategies such as including the education within the school sex education curriculum and linking with the cervical screening programs to improve on the "well women's" health checks could assist in providing the education to all areas especially those groups who are not as engaged with health professionals (P. Briggs et al., 2023).

Current treatments and services for menopause tend to be aimed at white women, not designed for specific ethnicities and reliant on location for access to specialists. In New Zealand the lack of culturally specific research, increased cultural stigma for Māori and Pasifika women and increased health inequities impact on their menopause experience (Dear, 2023a). The top ten treatments in the New Zealand Menopause Survey included exercise 51%, supplements 44%, food/ diet 43% and MHT 31% (Dear, 2023b). Access to appropriate treatments will have effects on how women experience menopause and function in their daily lives including their workplaces. The next chapter discusses those experiences at work.

CHAPTER 4 - EXPERIENCING MENOPAUSE AT WORK

Industrialised countries have seen a modernisation of the workforce alongside an ageing population increase the rates of participation for middle aged and older women (Carter, Jay, et al., 2021). Of the 657 million women worldwide who are aged 45-59 around half of them contribute to the workforce through their menopausal years (Rees et al., 2021). In the UK women make up 45% of the workforce aged over 50 years old with over 60% of women from the Organization for Economic and Commercial Development (OECD) being in paid work (D'Angelo et al., 2022). Those women that are working can now be spending a third of their working life after menopause (Carter, Jay, et al., 2021). In the UK over the last 30 years the biggest increase in employment rates occurred in the 60-64 and 55-59 age ranges with similar increases occurring in Europe and Australia (Brewis et al., 2017).

Women's participation in the labour force in New Zealand has increased over the last few decades with a 39% participation rate in 1971 compared to men's 82%, growing to 60% in 2001 compared to men's participation which decreased to 74% (Mannetje, 2009). Dear (2023a) points out the importance of recognising the detrimental effects of menopause across society including effects on children, men and the economy with 47% of our New Zealand workforce being women and 842,000 women having dependent children who live at home.

Due to the increase in workplace participation a growing interest in the experience of menopause in the workplace is developing including effects of workplace stress on menopause and impact on workplace productivity (Carter, Jay, et al., 2021). For example the Fawcett report indicated 14% of women in their representative study reduced their hours and 10% of women left their job due to menopause (Fawcett, 2022). While male- dominated professions were resistant to offering support to menopausal women yet it was actually the female-dominated industries where they endured the most suffering through this silent transition and where reduction of hours would often lead to quitting their roles (NZIER, 2023).

Additionally Beck et al. identified in their survey of attitudes towards menopause in the workplace that many female participants didn't actually know their menopause status, highlighting a gap in women's health knowledge (Beck et al., 2020). This identifies the ongoing theme from many studies of the lack in knowledge for women across the world. 64% of women in the NZ Menopause Survey 2023 mention they did not understand their symptoms were menopause related highlighting the need for further education of both healthcare providers and women (Dear, 2023b). For example Steffan's 2020 study (2021) showed the participants feeling a responsibility to manage their own menopause at work by enduring the symptoms with the women self-navigating the complexity of individual and unknown symptoms.

Studies are now indicating the need for women to have more awareness and support from their employers around the impacts of menopause and how it can affect their health and also how their workplace can impact on their menopausal symptoms (Hardy et al., 2019). This can be represented with a more empathetic open workplace where the needs of the employee can be discussed without judgement or concern of creating negative age related stigma. Symptoms such as hot flushes can be influenced by workplace stressors and the reverse can occur with hot flushes exacerbating stress and increasing the chances of leaving the workforce altogether (Carter, Jay, et al., 2021). Hot flushes have been described as the most inescapable symptom of menopause with potential health and safety issues at work due to heat stress risk, effects on cognitive function and night sweats inducing sleep disturbances all contributing to workplace safety issues (Carter, Jay, et al., 2021). Between 20-40% of women are estimated to have hot flushes or night sweats (HFNS), or VSM symptoms as they are also referred to, which can have negative effects on day to day life including the workplace (Hardy et al., 2018).

These effects of menopause on the workplace do not only include menopause impacting on the ability to work but also the effects of the working environment, both psychosocial and physical, on how women experience menopause at work (Rees et al., 2021). Certain environments will exacerbate menopausal symptoms such as warm offices and stressful workplaces. A recent study on the effects of rotating shifts on nurses suggested that younger women were at risk of accelerated menopausal onset due to the effects bought on from doing night shifts (Stock et al., 2019).

Similarly the 2017 U.K. report, *The effects of menopause transition on women's economic participation in the U.K.*, identified evidence of participation and productivity being affected negatively by workplace environments contributing to the symptoms worsening (Brewis et al., 2017). Whereas D'Angelo et al. (2022) reported one third of their study, *The Impact of Menopausal Symptoms at Work*, had significant difficulties coping at work with menopause symptoms yet these results were not affected by the type of work rather by other factors such as financial stability, depression and poor health.

A Dutch study's findings from 2016 reinforced previous research into the negative impact of menopause symptoms on women's capacity to function at work with their results also showing that women suffering menopausal complaints were eight times more likely to report low work ability than women not experiencing menopause symptoms (Geukes et al., 2016). Likewise Herbert et al., (2020) Australian study also showed VSM symptoms were associated with poor self-reported work performance for women, while women with severe menopause symptoms reported reduced work productivity which causes higher rates of absence, productivity loss and indirect costs for employers (D'Angelo et al., 2022). The lack of knowledge, education and workplace support for menopause impacts on women's ability to effectively continue working through these menopausal symptoms.

Additionally a study looking at women's and men's perceptions of menopause in the workplace reported 45.8% of the women surveyed had not disclosed their menopause status at work with most stating it was private, concern their abilities would be questioned or they would be seen negatively (Beck et al., 2020). This may relate to a wider stigma, the deficit discourse intersecting with work that is designed for the male body suggesting women are negotiating a double deficit of both being female and menopausal.

There is also evidence that women experiencing menopausal symptoms at work do not attempt for promotion and are more likely to leave before retirement due to the symptoms (APPG, 2022), and women with severe menopausal symptoms had less motivation which led to reducing work, changing jobs or leaving the workforce (D'Angelo et al., 2022). The APPG report also identified issues with women's economic participation, gender pay and progression gaps (APPG, 2022). Globally in 2019 women held only 28% of management positions which has not altered considerably since 1995 (UN, 2020). As described by Mills (2023) menopause symptoms are often simply the "*straw that broke the camel's back*" for many women's careers as they are experiencing so many other life events at the same time which impact on their ability to continue in their job effectively where simple accommodations and flexibility in the workplace would make such differences for these women and yet the workplaces lose out when these women leave with all their experience and knowledge.

A political wave of support for menopause in the workplaces is developing in the UK following the APPG report and the support of the British Menopause society. Employment policy needs to focus on the inclusivity of workplaces as menopause is contributing to the gender pay gap and age equality issues (Rees et al., 2021).

In the U.K., the Government has been advised to support an employer led campaign to promote the importance of supporting employees through menopause as a key employee health issue to facilitate employee retention, progression, education, gender pay gaps and overall economic participation (APPG, 2022).

While the UK is advanced with their menopause support through creating a Women's Health Ambassador role, the development of the Government Menopause Taskforce and the NHS signing the Menopause Workplace Pledge there are still recent setbacks to the development of menopause support (GOV UK, 2022). The British Government most recently declined the taskforces request to recognise menopause as a protected characteristic under the Equality Act and to create a menopause leave policy both recommended through the Women and Equalities 2022 report (BBC, 2023). The APPG (2022) report identified that there were limited workplace policies in support of menopause and that the loss on economic participation will only grow as women are working more and later in life.

This appears the same for New Zealand with limited workplace policies existing for menopause and no cost analysis occurring on the impacts of menopause (Dear, 2023a). Therefore to ensure expertise remains in the workforce and continued diversification employers should place importance on retention of menopausal women while recognising the occupational safety issues that some symptoms can present (Carter, Jay, et al., 2021). Carter, Davis, et al. (2021) include recommendations from the European Menopause and Andropause society to review current policies such as flexible working arrangements, access to cold water, temperature controlled environments and improved workplace cultures all of which should be reflected in Australian workers current policies and rights. Options such as flexible working arrangements and working from home are options offered to many women internationally and in New Zealand giving them control and autonomy. Yet in the female-dominated industries such as nursing the nature of the work does not allow for flexible hours or remote working and when employees have to ask for help they feel embarrassed and shame (NZIER, 2023).

The New Zealand economic participation report, Silent Transition, showed that employers in general were happy to support older women and understood the value they had in the workplace, and it was more the traditionally male-dominated industries that appeared more resistant to that support (NZIER, 2023). Certain workplaces will have more of a negative effect on women during menopause. Industries with a higher percentage of female employees such as nursing, that include shift work and are physically and mentally demanding roles should investigate appropriate models of support to ensure employee retention.

NURSES AT WORK

The impact of shift work on workers bodies has been researched but there is a lack of focus into how this affect could differ in menopausal women. Stock et al. (2019) found that women under the age of 45 and doing shift work were more at risk of earlier menopause while highlighting earlier menopause is associated with cardiovascular disease, cognitive decline and osteoporosis. Analysis of the data from the Nurses' Health Study in the U.S. confirmed nurses working more than 6 years on rotating shift work had increased risk of coronary artery disease (Killien, 2004).

As the baby boomer generation reached menopause the requirement for appropriate research into the needs of women and workplaces grows. The retention of nurses becomes more important given the numbers that will be working through peri-menopause and menopause. Nurses are one of the most frequently used populations in studies particularly in the U.S. due to the Nurses' Health Study which commenced in 1976 and the Nurses' Health Study II both which were funded through the National Health Institutes to initially focus on effects of oral contraceptives in women but have also provided a plethora of data on women's health (Killien, 2004). Killien notes that while the studies were not designed to specifically look at nurses roles it has allowed knowledge into women and nurses health which due to it being a longitudinal study can review how health changes over time and what behaviours influence health (Killien, 2004).

A lack of education and support was illustrated in Cronin's et al., (2023) recent international qualitative study across six countries, including New Zealand, which explored menopausal nurses perspectives of digital health interventions. This study identified a gap in information and education for women creating a continued invisibility for those nurses reaching menopause who would then turn to the internet for support which often included misinformation indicating the need for more evidence based support and potential for digital interventions (Cronin et al., 2023). Cronin et al., (2023) identified physical and cognitive symptoms that affected nurses ability to work while experiencing limited support from medical professionals, recommending menopause education, flexible workplaces and digital and non-digital health and well-being interventions to mitigate resignations of experienced nurses.

Furthermore Gabrielle et al., (2008) found the nurses in their study of Registered Nurses aged 40-60 years in Australia, blamed their increased exhaustion on sleep disturbances which were impacted directly by the long shifts they had to work creating increased stress and decreased satisfaction at work. All of these symptoms influenced chronic health conditions such as depression, diabetes and hypertension which were all present in their participants (Gabrielle et al., 2008). Similarly Matsuzaki et al. (2014) reported in their study on Nurses in Japan that there was a higher prevalence of irritability and fatigue in the nurses than those women from studies in the general community while the nurse managers reported higher depressive symptom rates and qualitative overload (having too much to do) while those nurses not in management positions reported lower rates of job satisfaction. The importance of understanding these effects is imperative with the nursing workforce increasing in age. The following chapter discusses relevant research in New Zealand and the menopause political landscape.

CHAPTER 5 – NEW ZEALAND RESEARCH, NURSES AT WORK, CURRENT RESEARCH AND THE POLITICAL LANDSCAPE IN NEW ZEALAND

NEW ZEALAND'S CULTURAL FOCUS

Māori are the indigenous people of New Zealand with an estimated population of 892,200, 17.4% of the national population of 5 million with 50% of the Māori population identifying as female (Stats NZ, 2022). The westernised view of women has taken over New Zealand's society and the conflicting ideologies of women's position in society continue to collide with the Māori worldview of the collective which includes protection and valuing both male and females' roles (Bullivant Ngati Pikiao et al., 2022). Life expectancy for indigenous women is increasing and along with the continued rates of poorer health and well-being statistics there will be more indigenous women living through and beyond menopause who will require research that is evidence based and relevant to their individual needs rather than based on Western ideology (Bullivant Ngati Pikiao et al., 2022).

It is important to understand women's needs specific to their experiences in New Zealand. These experiences have been developed across colonisation, immigration, distinct historical understandings including the Te Tiriti o Waitangi (Treaty of Waitangi) through to the Cartwright enquiry into cervical screening (Morgan et al., 2011). Wāhine Māori frame their understanding of health and wellbeing from a place of colonisation and through having experienced the trauma of having their culture severed (Bullivant Ngati Pikiao et al., 2022).

The Western bio-medical practices are evidence based and do not consider the therapies and self-care that indigenous women often already use (Bullivant Ngati Pikiao et al., 2022). Bullivant et al.'s (2022) use of a meta ethnography method to identify a gap in research for wāhine Māori's constructions of menopause allowed for multiple understandings of the same phenomena without privileging one women's experience and through deconstructing the dominant western ideology it allowed the indigenous voice to be heard. This highlights the importance of referencing women's individual experiences. The Māori concept of menopause is framed by the reproductive journey which includes Mātauranga Māori (Māori knowledge) and to improve the health outcomes of wāhine Māori requires a commitment to including Mātauranga Māori in future health sector planning (Bullivant Ngati Pikiao et al., 2022).

Due to the discourse on women's health and menopause being dominated by Western ideology there is a lack in research on indigenous women's interpretations of health including menopause with less research regarding wāhine Māori in New Zealand (Bullivant Ngati Pikiao et al., 2022). In the first cross sectional study including vasomotor symptom data for wāhine Māori the results concluded HRT was accessed about half as much in wāhine Māori as non-Māori, which could be due to clinical pathway inequalities but this needs more research to see if it is cultural attitudes or access issues (Lawton et al., 2008).

To provide equitable healthcare for Māori and other indigenous women there needs to be a wider understanding in the mainstream services of how indigenous women construct their view of menopause (Bullivant Ngati Pikiao et al., 2022). As described in the Silent Transition report wāhine Māori are experiencing menopausal symptoms differently than non-Māori as their survey results showed significantly higher rates of recurrent urinary tract infections; joint stiffness; memory and concentration issues; and feeling fatigued (NZIER, 2023). Indicating the need for further culturally appropriate research.

RESEARCH FOR NURSES IN NEW ZEALAND

Nurses are our largest group of professionals working in healthcare and many undertake shift work, in New Zealand and worldwide the statistics show an increase in ageing nurses (Blockley, 2018). With the baby boomer generation having reached retirement age, significant numbers of nurses are retiring and there is concern of the loss of knowledge across the nursing profession and the potential for younger nurses to be placed into roles beyond their expertise (Blockley, 2018).

The number of nurses working in the South Island of New Zealand aged over 60 years of age has increased overall by 6.1% reaching 22.9% in 2018/19 (South Island Alliance, 2020).The proportion of female Doctors has also increased in New Zealand and women will outnumber men in the workforce by 2025 (Medical Council, 2019). The New Zealand Nursing council data shows that 43% of their female nurses are over the age of 50 (Te Kaunihera Tapuhi o Aotearoa/ Nursing Council of New Zealand, 2019) creating an older profile of workers than most professions and in comparison to those other professions ageing nurses are reported to have higher workload demands (Clendon & Walker, 2013). Throughout the world the nursing workforce is ageing which demands new strategies to retain these employees, such as flexible working arrangements, resources to cope with shift work and improving scheduling practices (Clendon & Walker, 2013).

With a mixture of cultures now representing nurses across New Zealand a one size fits all approach to employment and well-being support is unlikely to be appropriate for workplace policies, given that differing cultures may perceive and experience menopause differently. The March 2023 Nursing Council quarterly report showed there were 69,592 nurses currently holding an annual practising certificate (APN) and of these nurses 36% were international (Te Kaunihera Tapuhi o Aotearoa/ Nursing Council of New Zealand, 2023). While the South Island nursing workforce is predominantly New Zealand European/Pākehā (72.6%) it includes Other European (13.8%); followed by Filipino (7.5%); Indian (3.7%); Māori (4.9%); and Pacific (1.1%) (South Island Alliance, 2020). In March 2019 SouthernDHB (Te Whatu Ora Southern) recorded 5.3% Māori nurses and Filipino at 6.6% (South Island Alliance, 2020). In February 2023 Te Whatu Ora Southern had 5,719 employees, of which 77.9% were female and 30.8% of those females were aged between 40-60 years old.

The Silent Transition report identified the need for employers to communicate with their employees to try and understand their transition requirements so workplace adjustments could be developed and implemented to meet their specific industry-based needs (NZIER, 2023). New Zealand requires its own locally designed and evidenced solutions to workplace support for women experiencing menopause. Due to New Zealand's ethnic groups and specific cultures, high share of small firms and its particular mix of industries any support needs to be designed with these specific needs in mind (NZIER, 2023).

While the U.S. and U.K. have undertaken research on menopause effects in the workplace there is limited research into the experience of nurses and menopause in New Zealand. Historically occupational studies in New Zealand have prioritised male dominated industries resulting in limited data on women's roles (Mannetje, 2009). Statistics have long excluded a true reflection of women's occupations due to incorrectly recording retired women as 'housewife' on death certificates excluding their prior occupation, not recognising their unpaid caring roles and under-counting agricultural roles (Mannetje, 2009). This gap in research highlights the need for New Zealand based research on nurses' experiences of menopause that recognises their culture, specific environments and individual journeys.

A population such as New Zealand requires its own culturally specific research designed locally for our population that has not been created by androcentric knowledge developed through research on a homogenous group of white men. Feminist scholars are attempting to recreate non-androcentric sexist knowledge (often including an intersecting racial inequality) that rewrites the 'truths' previously produced through the institution of science that are not actually neutral but rather impacted by patriarchal, colonial and capitalist structures (Wigginton & Lafrance, 2019).

There is limited research for women in New Zealand and specifically for nurses at work. The impact of this lack of research for Māori and Pasifika women in particular is that many are being left untreated (Dear, 2023a). Bullivant et al. (2022) highlights the importance of recognising the impacts that colonisation and Western healthcare models have had on wāhine Māori worldviews. Therefore any research in New Zealand should include a cultural focus that encompasses a Māori worldview. Particularly in reference to menopause where western views can place menopause as an end, a trauma or loss whereas Māori traditions would see menopause as part of a journey and important in continuing the whakapapa (genealogical lines) (Bullivant et al., 2022). Dear highlights this need for specific research into particular communities within New Zealand such as Māori, Pasifika and transgender to ensure equitable outcomes, appropriate healthcare and that people are supported (Dear, 2023a).

Goodyear (2018) completed a qualitative study focusing on the experience of menopause for 11 nurses working at Christchurch hospital. This study showed the continued fear of being “outed” as menopausal employees, the lack of control of the physical changes that can occur, the associated shame attached to the stigma along with added external stressors that pressured the women.

The limited numbers of research being conducted in New Zealand all show the lack of knowledge, understanding and negative impacts on their workplace experience and the need for further culturally appropriate research to be conducted locally for the population. Cronin et al. (2023) included several New Zealand nurses in their recent international study and found there is a lack of education, knowledge and support in the workplace for nurses where they identified that the workplace is the key environment they find most difficult to manage their menopause symptoms. Similarly in the NZ Menopause survey 2023 “*84% of working women said menopause had negatively impacted their work in some way*” (Dear, 2023b, pp. 35) highlighting the urgent need to develop local research for our specific population. Importantly the Silent Transition report raised the need to include research on the factors that can impact on the menopause experience such as personal circumstances and occupation and how this can affect the workplace and economic participation (NZIER, 2023).

Contemporary international research on menopause in the workplace recommends that employers should recognise symptoms of menopause while including recognition that implementing some policies pertaining to women can isolate older women through creating prejudices around their capability at work (Carter, Davis, et al., 2021). Not all women feel comfortable discussing menopause at work so employers need to develop inclusive policies and cultures including educating managers to have appropriate discussions and providing support when needed (Rees et al., 2021).

The majority of menopause research currently available is based on reviewing the prevalence of the symptoms with a body of work comparing these symptoms across groups of women. These studies are potentially limited because the results could be affected by multiple variables such as age, ethnicity, socio-economic, culture, diet and environment. Very few studies identified these additional factors that could affect women's experiences of menopause.

CURRENT NEW ZEALAND POLITICAL LANDSCAPE

In July 2023 an official meeting took place in the Beehive (New Zealand Parliament) to commence discussions around the experience of menopause in New Zealand this included the Minister for Women and the Associate Minister for Health and the NZ Menopause Collective. With the presentation of the Make Menopause Matter NZ petition with 5583 signatures, the Menopause Matters submission and the survey report, Menopause is getting on the political agenda in New Zealand (Dear, 2023a). The national petition reiterated similar requests as the UK APPG report's recommendations by including the following:

- Mandatory menopause training for GPS and Medical students
- Workplace menopause awareness and support
- Education included in school curriculum's

During the development of this thesis the New Zealand Women's Health Strategy 2023 was also being created and was published in July 2023. The vision of pae ora- healthy futures- for all women sets the direction for improving health for all women including equitable health outcomes for wāhine Māori (Māori Women), which included 4 key priorities for change in the next 10 years;

- Priority 1: A health system that works for women
- Priority 2: Improving health care for issues specific to women

- Priority 3: Better outcomes for mothers, whānau and future generations
- Priority 4: Living well and ageing well.

(Minister of Health, 2023).

This current study aligns with several of these priorities through its aims of identifying ways that women's wellbeing can be improved both for the individual nurse and the organisation.

CHAPTER 6 - AIMS AND RATIONALE:

There is a lack of research of nurses experiences of menopause at work and particularly in New Zealand. Key contemporary studies in New Zealand include Goodyear's (2018) qualitative study which focused on the menopause experience of 11 nurses at Christchurch hospital; Dears (2023) Menopause survey on 4288 women (not explicitly focusing on nurses); Cronin et al's., (2023) research on digital interventions for nurses experiencing menopause in the workplace, including New Zealand participants; and the NZIER (2023) Silent Transition research on workplace impacts of menopause (not explicitly focusing on nurses). This lack of specific research in New Zealand for nurses menopause experiences is despite research highlighting key elements of nurses jobs making the menopause experience specific (for example, remote working not an option), as well as demographics highlighting the importance of retaining nurses in this aging, female dominated workforce. Further, locating a study in New Zealand affords the ability to explore potential, localised cultural meaning for both wāhine Māori and non-Māori women. Feminist work says there is a need to center the voice/experiences of women, suggesting to better understand nurses experiences of menopause at work indicating a qualitative study is required.

The strengths of the research to date show consistent findings of symptom prevalence such as VSM symptoms (Zouboulis et al., 2022) and effects of culture (Namazi et al., 2019) so we know that ethnicity and culture shapes experience. It also included paying attention to the fact that menopause occurs at this life stage for women which can include increased stressors (Brewis et al., 2017; Mills, 2023; Nelson, 2008) but on the other hand the research doesn't go any deeper than pointing these things out. It highlights the importance of how women interpret their experience but the research doesn't do any of this interpretation.

Menopause clearly has biological underpinnings and this current research highlights the importance of culture and meaning making for women. These are the things we know which lead us to investigating a more in depth understanding of the nurses individual experiences in their specific workplace and identify areas for improvement. Therefore, this research assumes a phenomenological approach to interpret the experiences of nurses in their workplace who are peri-menopausal or menopausal.

CHAPTER 7 - METHODS SECTION

INTRODUCTION

In the following chapter I discuss the qualitative approach I employed for this study and the philosophical assumptions that underpinned it. The methodology of the data collection is outlined along including describing the choice of qualitative surveys; followed by an overview of the design of this study. Next, I explain the process for Thematic Analysis and how it was applied to the data collected. Ethical considerations including cultural awareness of this study are then discussed, followed with the quality criteria that I used to assess this research against to ensure it has been developed to the highest standard. Finally, I reflect on the overall processes across this study.

WHY A QUALITATIVE APPROACH

Qualitative methods aim to produce valued knowledge from both the researcher and participants voices through the interpretation of meaning making while recognising it is produced in context (Riley & Chamberlain, 2022). As the purpose of this research was to understand the lived experience of menopause for nurses in their workplace, qualitative methodologies concerned with meaning making and individual experience were best suited.

Riley and Chamberlain (2022) describe how through employing a qualitative approach researchers produce valued, contextualised knowledge by interpreting the meaning making. Qualitative research can demonstrate the effects of sociocultural and linguistic context, the perspectives and settings for participants responses and how the researchers can then interpret that information, providing a key advantage of both examining and theorizing contextual effects (Yardley, 2017). The contextual effects relevant to this study included it being based in a South Island hospital with only female nurses and the wider context of New Zealand and its gender specific norms.

While focusing on the current research aims, a qualitative methodology was seen as being most suitable to understand the phenomena especially considering most literature to date had identified prevalence and effects on that phenomena but not how women interpret their experience.

EPISTEMOLOGY

This research takes a phenomenological approach which is underpinned by a critical realist epistemology where the experiences, reality and meanings of the participants are reported while acknowledging the way the participants are making meaning of those experiences and how the social context can affect this (Braun & Clarke, 2006).

In this study the knowledge is developed by creating insights into people's interpretations of their experiences while recognising social contexts having influence on the individual's interpretation of their experience.

METHODOLOGY

Phenomenological research is aimed at producing knowledge around the experience of the participants including feelings and thoughts as opposed to making claims about what caused those feelings (Willig, 2013). The focus of this research is to understand the experience and the interpretation of that experience. Hursserl formulated transcendental phenomenology in the early twentieth century which was interested in the experience people have of the world at certain times and in certain contexts as opposed to abstract statements. The philosopher Heidegger, a student of Hursserl, developed phenomenological thought further to include hermeneutic phenomenology which, when applied to psychological research embraces the way the researcher interprets the data as an integral part of the analysis (Willig, 2013). By recognising my influence on the research this reflective process embedded me as the researcher with the communication, analysis and interpretation process between the participants and myself the researcher.

The key aim of phenomenology is to identify and understand the participants' lived experience and is an idiographic approach focusing on individual experiences using purposive and homogenous sampling, for example, nurses at one workplace. The object of this study is not 'menopause' but rather how the nurse's experienced of menopause at that moment in time and then how the researcher attempts to interpret their responses creating an engagement between researcher and participant accounts (Riley & Chamberlain, 2022). It is important to understand the participants views, how they have come to understand the phenomenon in this way and how they try to make sense of it, while being transparent with assumptions this theoretical framework makes about the nature of the data being collected and how this affects the method used (Braun & Clarke, 2006).

Phenomenological knowledge is concerned with how the participant experiences the world with the texture and quality of that experience rather than if their interpretation is correct or an accurate reflection of what has really occurred (Willig, 2013). Recognising the importance of the hermeneutic version of phenomenology including an awareness of what I as the researcher brought to the analysis and rather than bracketing or removing that prior knowledge I embraced it and made it explicit (Hein & Austin, 2001; Willig, 2013). I chose a phenomenological approach as it is concerned with the experiential world of the participant and has the assumption there isn't just one world to be studied rather there can be as many worlds as there are individuals all experiencing one event differently (Willig, 2013). Which gives me the opportunity to delve into the richness and texture of each individual nurse's story on how they each experienced the same or similar situations in their workplace, while recognising that they could have varying interpretations of that situation.

Qualitative Surveys

Qualitative surveys use open ended questions to produce responses from the participants. The questions aim to gain information about the participants experiences, their own narratives and opinions. Qualitative surveys can also include some quantitative questions to ascertain demographics such as age and nationality. There are multiple methods for surveys such as telephone and face to face while the online option suited this study best as it maintained anonymity and ease of access for the participants. A qualitative survey is not trying to determine prevalence or frequency but rather diversity of a topic of interest in a population (Jansen, 2010).

A key advantage of qualitative surveys is the flexibility to address a broad range of questions including meaning-making practices, people's views and material practices (Braun et al., 2021). Qualitative surveys can offer the advantage of wide-angle lens approach through the variety of voices delivering an array of experiences (Braun et al., 2021). While qualitative surveys have provided for this wider-angle approach covering larger geographic areas they have been criticised for not providing depth in the data particularly in comparison to interviews; Braun and Clarke (2021) disagree with this sentiment finding qualitative surveys can be rich in detail particularly when it involves disclosure of private information. Given the topic of discussion was something personal the choice of an anonymous qualitative open survey was an ideal option.

STUDY DESIGN

Survey Design and Questions

The survey included quantitative data allowing a combination of qualitative and quantitative questions to create a rich understanding. The demographic questions were followed by the survey questions. The qualitative survey was developed following informed consultation with staff along with existing research literature. As the phenomenological approach is interested in a dialogical approach of interpretation between participant and researcher the research design needed to be structured around gaining in depth exploration of the participant's sense making of their experiences (Riley

& Chamberlain, 2022). The questions were designed to illicit accounts of the participants experiences with menopause in their workplace. What they did, how they felt, what was discussed and with who, what happened and what they would have liked to happen. Inclusion of some key questions around social support; life stressors; impacts of living in Aotearoa could all support the data to tell their story given these factors were all identified in the current research as having an impact on how women experience menopause internationally.

These questions were developed based on what the literature review identified. This previous research highlighted these issues but did not include how people made sense of them. Therefore the survey questions were created to invite the respondents to provide their lived experience of the issues. This allowed the responses to map onto the aim of developing the literature with a focus on their experiences. The survey questions were tested by 8 nurses and reviewed with stakeholders with feedback used to update the accessibility of the survey form.

The survey included two types of data being collected where the participants were asked open ended questions on 3 key menopause issues where they could describe their experiences. This was followed with questions to gain an overall understanding of the participants experiences. The participants were asked three questions about their overall experiences. First, they were asked to rate it and explain why giving reasons for their rating. Second, they were asked what their life circumstances were like including stressors and responsibilities and if that shaped their experience of menopause. Thirdly they were asked what access to social support they had and what that looked like for them (refer to appendix iv).

The participants were also asked what else they would like to see improved in their workplace so this could be used to inform the report for the workplace. Qualitative online surveys allow access to the wider geographically dispersed population, such as Te Whatu Ora Southern's staff which covers Otago and Southland, gaining richer insight into the topic with more sensitive data collection due to anonymity (Braun et al., 2021).

Having a mixture of demographic and open questions in the survey allowed for the participants to share their stories and interpretations of their experiences. The aim was to show the nurses individual experiences and what affected them specifically in their workplace and identify areas of improvement. Therefore, I needed to collect qualitative data rather than specific numbers or measurements of their menopause symptoms. By using a qualitative survey the participants could use their own words creating a complex and rich account filled with their subjective practices and experiences instead of choosing pre-determined responses as in tick boxes in a quantitative tool (Hardy et al., 2019).

The participants were greeted with information pages on the webpage explaining the research and their rights where they could consent and continue with the survey questions. They would then proceed with the survey online in their own time. It took them approximately 45 minutes to complete. All participants could withdraw from the survey while completing it as long as they hadn't submitted the survey. I had planned to close the survey at the end of July 2023 after 1 month but due to requests from Nursing managers to allow more time for participation I was able to keep it open until the end of August, allowing the participants numbers to double in the second month.

Sampling method and criteria

A purposive sampling method was employed to ensure the correct individuals within the population were identified. This included developing a specific inclusion criterion:

- Identify as a female
- Be between the age of 40-60 years
- Be currently employed at Te Whatu Ora Southern as a nurse

- Identify as perimenopausal or menopausal
- Feel comfortable sharing some of the experiences they have had to date with menopause in their workplace.

In conversations with my supervisor, it was decided to keep the sample to one workplace, Te Whatu Ora Southern. This allowed me to contextualise the findings within one type of workplace which was hospitals rather than the community-based nurses whose environments are different. This also allowed me to manage the sample size of the study.

Recruitment process

Recruitment opened once the ethical approval had been granted. An advertisement was posted on the workplace noticeboards detailing the survey criteria. The researcher also networked with nursing teams, Nurse managers, educators, and relevant staff to share the project information with potential participants. This type of sampling can be useful when trying to find a smaller group of specific participants who might know of each other's experiences (Naderifar et al., 2017). This sampling is beneficial as it is a quick sampling source and can access specific target populations. Awareness of the criticisms and limitations was recognised by utilising a tightly identified criteria to gain access to a specific and potentially inaccessible population also fitting into the purposive sampling technique.

I attempted to ensure all areas of Te Whatu Ora Southern were informed of the research so everybody who was willing and met the criteria could participate. Due to the limited time left after waiting for an extended period for the ethics approval I could not do as much face to face relationship building which could have supported a more culturally appropriate model of recruitment. The survey was then left open for two months.

The flyers developed were shared across the organisation and had a direct link and a QR code link for mobile phones.

Survey Participants

37 participants responded to the survey. Three responses were removed as they did not complete the questions required for analysis leaving 34 participants in total. The age range was from 40-60 years of age with the majority of participants falling in the 40-49 age group. The ethnicity was predominantly New Zealand/ Pakeha with 82% see Table 1.

Several of the "others" identified their specific ethnicity as per below yet given the importance of anonymity in a small workplace I have chosen to exclude their specific ethnicity when describing in depth analysis later in the data ensuring good rigour by updating the process to protect the participants anonymity.

Table 1 DEMOGRAPHICS OF PARTICIPANTS

Age	40-49 (n-12)	50-54 (n-12)	55-60 (n-10)
	n %	n %	n %
Ethnicity			
NZ European/ Pakeha	8 (66.67)1	10 (83.33)	10 (100)
NZ Māori	(8.33)	- -	- -
Other (English, South African)	3 (25)	2 (16.67)	- -

1 NZ Māori participant identified - removed them from this demographic data to de-identify their age range for anonymity.

A large sample in the survey can allow for a wider range of experiences and explore more commonalities and differences. As Braun and Clarke (2021) discuss addressing the questions and the richness of the dataset are more important considerations than reaching a specific sample number (2021). The sample size was acceptable for this study as it was more important to gain depth of data than large numbers of participants.

DATA ANALYSIS

Principals of Thematic Analysis

Thematic Analysis (T.A.) can be used for phenomenologically informed research that focuses on the individual using an open survey to gather participants individual responses. Being theoretically flexible T.A. can take on the theoretical assumptions when being used in a particular study (Braun & Clarke, 2021a). My aim was to locate the data that is the actual lived experience of the participants then analyse this while trying to understand their experience through their eyes.

A reflexive T.A. method was best suited to explore recurring patterns in the participants' experiences and their sense making. Underpinned with a phenomenological epistemology approach to study the participants' subjective experiences. Braun and Clarke T.A. is appropriate when the data source is something other than interviews, such as surveys, that gather in-depth accounts of personal experience and when the sample is relatively larger than N = 10 (Braun & Clarke, 2021a).

The risk of the easy-to-use reputation of T.A. along with its lack of a theoretical base can have the outcome of researchers doing research without identifying a theoretical or epistemological standpoint (Willig, 2013). By clearly identifying the phenomenological approach and its connection with the research question this minimises the limitation. Another limitation identified for T.A. is using a deductive approach when utilising codes identified through theory and existing research which could reduce opportunity to identify new ideas from the data therefore not meeting the ethos of qualitative research (Willig, 2013). Therefore, an inductive approach was chosen for this study and detailed elsewhere in this chapter in the Data Analysis section.

In summary, this research employed an epistemological standpoint informed by phenomenology. Given Thematic Analysis' ability to review patterns in meaning and be utilised across multiple theoretical backgrounds it was an appropriate approach taken with this study. Its use as a methodological approach aligned well with the overall aim of the current research; to understand the lived experience of menopause for nurses in their workplace.

Thematic analysis is an umbrella term for a family of qualitative methods with an approach that recognizes multiple orientations to coding, such as deductive and inductive; developing latent and semantic meanings from the data; processes of coding and a type of theme development; with a level of flexibility to which theory will frame the research (Braun & Clarke, 2021a). Taking a Phenomenological approach allowed for recognition of the participants individual meaning making within their experiences.

Braun and Clarke (2006) described T.A. as a method aimed at uncovering themes that have some degree of meaning or patterned response. While T.A. has been referred to in social sciences since the early 20th century including being used interchangeably with content analysis across both qualitative and quantitative research it wasn't until the 1990s that it began being published as a qualitative technique (Terry et al., 2017). Braun and Clarke contend that *reflexive* thematic analysis needs to be positioned within qualitative research that is conducted in an interpretivist paradigm referred to as a Big Q orientation (Campbell et al., 2021). The difference between Big Q and little q can be described with the analogy of Big Q being a sculptor working with the raw materials and their skills to develop the sculpture through an analysis process that is creative whereas small q would be a more technical analysis process sifting through soil to find already existing buried treasure (Terry et al., 2017).

The current study aligns more closely with a Big Q orientation utilising certain qualitative sensibility skills such as an interest in meaning and process as opposed to cause and effect; developing an understanding that can be complex and contradictory; and tolerating uncertainty (Braun & Clarke, 2022). The participants own descriptions (words) are providing access to their reality while the researcher then interprets these realities (Terry et al., 2017). By taking an experiential orientation I could capture people's perspectives of their experiences by looking at people's lives, their meanings, and realities without making claims on the social construction of those meanings. This is underpinned by the theoretical assumption that reality is reflected in language while focusing on what people think, feel and do (Terry et al., 2017). The aim was to gain an understanding of the participants lived experience from their perspective and how they were interpreting their world. Hence why the questions involved what they experienced, what they were doing, who they spoke to, why and why not. Terry et al, describes a 6 phase non-linear approach to Braun and Clarke's reflexive T.A. which can be recursive and iterative moving around the phases (Terry et al., 2017).

As I used multiple versions of the data such as both electronic and printed, I discovered I almost approached each version as a new story with a new view on the experience that was being described. I developed further interpretations of the data, and the analysis grew. Phenomenological research is interested in the participants experience, in this case of menopause, therefore the data needed to share something about the meaning of the nurses' experience while paying attention to how the participants foreground their experiences and being concerned with how they experience themselves within context of their story (Willig, 2013). The participants discussed being tired, feeling aged, not being themselves giving examples of the fear of being stupid within the workplace. When developing the themes, I chose the most appropriate extracts that represented that theme and created an interpretation that would best describe how they were experiencing their journey. Upon creating the analysis stage, I was finding a lot of links between what I was reading in my data, the interpretations I was making and the existing literature. This allowed me to connect the experiences to current research.

Process of Thematic Analysis

1. Familiarization with the data

Familiarisation has been described as immersion in the dataset through in-depth engagement and repeated reading, observing initial patterns and locating meaning, asking questions and being analytical while making notes of the first insights ensuring the whole dataset is read before any coding commences (Braun & Clarke, 2006; Terry et al., 2017).

This phase could begin while the data collection took place. Willig (2013) describes how important it is to note down the initial ideas and relationship to the research question while familiarising with the data before coding starts as these ideas can influence how a researcher choses code. Through this process I then became more familiar with the data by reading the survey responses and making notes paying attention to certain experiences that participants highlighted.

Following initial immersion with the data I began asking myself questions such as "how is this person making sense of what they're sharing with me? Why are they making sense in this way? What assumptions are they making? How would I feel in this situation?" So I could start to critically engage with the data as guided by Braun and Clarke (2022).

I saved the survey responses into an excel spreadsheet where I could filter, sort and make comments. While reading the individual survey responses I commenced summarising the key patterns I was interpreting along with adding notes (comments) in the margin to the key points that were appearing to match with potential codes. I noticed a contradiction in statements occurring from this familiarisation stage with participants firstly not wanting to share their experience with others as it plays into the stereotype- old, deranged woman but then also wanting support and communication. The idea of ‘risk” and vulnerability” shone through particularly in a workplace setting.

2. *Generate codes*

I went from the familiarisation stage to generating codes to use. Coding is the identification of segments in the data that have meaning relevant to the research question and the systematic creation of meaningful labels for these segments (Terry et al., 2017). The inductive process of analysis allowed for the data and my interaction with that data to inform the creation of the codes while respecting the fact that I will have bought my own perspectives, knowledge and background to my meaning making yet by employing reflexive T.A. I managed this process (Braun & Clarke, 2022). The analytical process was grounded in the experience of the women and their meaning making, not pre-determined by theory or research as with a deductive approach (Braun & Clarke, 2021b; Terry et al., 2017). While continuing the reflexive process I constantly asked myself is the code I have just developed coming from the extract or coming from what I think they should be saying, what influences are my pre-conceived ideas having on this code development?

The level at which the codes were identified involved the semantic (explicit) level. This level was most appropriate for this study as it looked at the explicit meaning then progressed beyond a descriptive process into an interpretation to theorize significance of identified patterns whereas a latent level would have delved into the assumptions beyond the meaning taking on a more constructionist paradigm (Braun & Clarke, 2006).

Some segments might have had no code at all as they held no relevance to the research questions while others might have two codes (Terry et al., 2017). While coding, I paid attention to contradictions in the data (Braun & Clarke, 2006) and there were many with participants having opposite opinions to each other but also to their own examples.

I also identified miscellaneous pieces of data that were not fitting initially within any code at that point. These were reviewed at each stage with assistance from my supervisor to develop their meaning and position. I started with a colour coding system for allocating the codes and had a document with the key that eventually became the Codes and theme table.

Braun and Clarke described coding as a part of analysis where the data is organised into meaningful groups, less broad than themes, and the importance of linking the coding process to the epistemological and theoretical underpinnings, phenomenology (Braun & Clarke, 2006). By developing this process below with an individual approach for coding then theme development this was our way of keeping true to the phenomenological approach and focusing on the individual participant's journey. By moving beyond the textbook version of reflexive T.A. I was very nervous as this was all new to me, but it actually helped for me to embed a more in-depth understanding of the phenomenological approach and why I was doing it this way, to focus on the individual response.

The specific process I employed was to code the individual participant’s survey responses into a coding transcript highlighting both descriptive and interpretive codes, key words and extracts. Since this was a phenomenologically informed study, I coded 6 participants initially with the aim to keep their individual experience as the focus. Instead of following Braun and Clarkes Thematic Analysis guide to review the whole dataset and develop code clusters/ candidate themes I instead developed individual code transcripts in word documents. Once the first six Theme tables and Master Table were created, as per the next step, I then moved to the next group of participants and coded their responses individually and followed the steps below.

An additional step I developed within my code generation phase was to create a matrix for social support/ stress versus self-described overall experience rating. How the women rated their overall experience against how they rated their social support and levels of stress. This was to see if there was a relationship there as described in the research. I would develop this further in the analysis stage.

3. *Generating Initial themes*

Themes should capture the relevant meanings contained in the codes and patterns across the codes (Willig, 2013). Braun & Clarke (2006) clarify that themes do not emerge from the data but rather they are identified by the researcher through their active role in the study. Following the need to keep an individual focus on the participants responses once I had the individual code transcripts for the first 6 participants, I then developed their individual Theme tables with subordinate and superordinate themes, sub themes and extracts which are patterns of shared meaning.

While Braun and Clarke (2022) describe developing clustered patterning across the dataset as this research was phenomenologically informed the patterns were developed at an individual level first for each participant then reviewed across the dataset. This allowed for the individual experience to be the focus and for codes to be clustered into candidate themes, still following the Braun and Clarke guidelines for T.A. with development of the phases to suit the research question and keeping the analysis true to the individual experience. I then developed a Master table incorporating the first 6 participants Theme Tables.

I then proceeded to review the next group of participants and identify their codes and develop their themes. If that data fitted within the current codes and themes the examples were added to the Master table. If there was data that showed new codes and/or themes these were then also added. This Master table was developed as an ongoing fluid process as the data was being analysed. This allowed me to continue being true to each individual participants survey data while also managing many responses. This was completed while adhering to key components of initial theme development detailed by Braun and Clarke (2022) including:

- Does this initial theme capture something meaningful?
- Does it have a central idea that combines the codes and data together while being coherent?
- Are there obvious boundaries?

An important reflection occurred to me within this stage where I understood the information I was develping on this subject included the survey responses, my own research through attending events such as the Australasian Menopause conference and from discussions with fellow Te Whatu Ora employees interested in sharing their stories directly with me. I had to be aware of where my interpretations were emerging from and what was influencing me.

I was left with one code in the end that didn't fit within any of the current themes at that point- "Cultural differences in behaviour". This code was eventually included within a theme once these were reviewed within the next stage and realigned. I then started allocating the individual codes across the themes into the Codes and Theme table document, in the next phase I developed this further.

4. *Developing and reviewing themes*

In this stage, the themes are reviewed to confirm if any can be further integrated into higher order themes, removed, or if further codes are identified (Willig, 2013). Starting with the Master table I reviewed all the initial themes using the steps below while asking is the theme coherent; does it have boundaries; convey something important; is there enough evidence in the data (Braun & Clarke, 2022):

- Level 1 - Review at level of coding – by reviewing all the extracts related to each key theme and confirming do they actually form a pattern. Are the code clusters relevant to this theme and to the research question.
- Level 2 – Similar to level 1 but in relation to the whole data set. Then review the entire data set and see if the themes do reflect the whole data set.

There are two key steps to this level to ensure the themes are truly reflecting the data set accurately and second to review and include any data initially missed in the earlier coding steps, as coding is ongoing (Braun & Clarke, 2006). Through the individualised process that I employed I was automatically completing this process. Having created the themes at an individual level and reviewed the extracts to see if the code clusters were cohering. I reviewed the data set individually and as a whole to confirm if the themes were reflective of the data. This helped to refine the themes and where certain codes fitted best therefore, I found some movement was required of codes as the themes became clearer to me. When I moved a code across, I did wonder should those two themes then become one, are they sharing too much in common and should they be combined. At that point I didn’t combine any themes as I felt they were coherent and producing different illustrations.

When I read further, I realised I had misunderstood the message being described by a participant and then reviewed my initial code. Sometimes this was within a survey and sometimes it was several surveys later before adding more experiences into the data that I realised what participants were trying to describe in their stories. Hence the importance TA being iterative.

Through focusing on both the individual themes and codes for each participant I was able to keep their experience alive. This provided a set of themes that were distinctive to these coded data extracts. I felt that each theme was telling something individual. I then moved back to the overall data set to review the themes.

5. *Refining, defining and naming themes*

Then I continued to refine the Code and Theme table document including superordinate and subordinate themes and allocated all of the codes across the themes this was used to create the mind map.

   a. For each of the identified themes, I constructed a detailed analysis beyond that of just a description or paraphrase of the data. This produced the 'essence' of the theme describing what is interesting and why and consisted of the analysis of each theme explaining how that fitted within the overall story particularly in relation to the research question (Braun & Clarke, 2006). It described what the theme was about; the central concept of each theme; the boundary; what contribution to the overall analysis does this theme provide; and included the subthemes (Braun & Clarke, 2022). These definitions sometimes developed over the analysis of the data as my understanding of what the participants were describing grew. I also added in two additional themes halfway through this development of as I realised the codes were more suited to these new patterns. "Choices…" was key when I started reading more extracts whose codes were about choice such as medication, healthy living. "Normalising…" became apparent when I discovered many responses were positive and the women were coping. Finally, the "What healthcare should look like" theme emerged which was small in extracts but quite distinct in the patterns that created it. These themes all developed after I had developed the first Master table.

The final review of the themes occurred with my supervisor where we refined the amount of superordinate and subordinate themes. Combining some of the codes under certain themes in a different manner while expanding on the current themes. The superordinate themes were minimised, and more subordinate themes were expanded on. This required some re-coding of extracts and examples to then fit with the overall data. I found this step in the process made it much easier to describe the themes and realised I had already mapped out my descriptions and extracts.

6. Writing Up

Themes are described as the ultimate analytic purpose of the T.A. process (Braun & Clarke, 2022) which Willig (2013) agrees in identifying the aim of the analysis as being to answer the research question through developing insights that could thematize the meanings people attribute to phenomena.

The aim was to produce a coherent argument in relation to the research question through developing an analytic narrative about the themes and how the data provides evidence of those themes individually and across them using data extracts that support the story (Braun & Clarke, 2006). Campbell described this narrative needs to be a compelling argument that doesn't just describe the data but rather addresses the research question (Campbell et al., 2021). While using both my narrative and the illustrations from the data extracts it was important to provide the distinctions of each theme and their scope while linking them back to the research question (Braun & Clarke, 2006). Phenomenological research is interested in the participants experience of menopause, therefore the data needed to share something about the meaning of the nurses' experience (Willig, 2013).

I presented my data and interpretations in my analysis section to keep those clearly defined, while connecting these interpretations to the literature. I then explored further in the discussion section how the analysis supported, developed or challenged existing knowledge. For each superordinate and subordinate theme I included the number of respondents who were coded into that theme for example “Fear of getting worse/ unknown” (n5).

ETHICAL CONSIDERATIONS

The following section outlines the key ethical considerations and how I applied them to this research. This included strategies put in place should any issues occur.

Consent and Participant autonomy

Participants could withdraw before commencing the study or during the survey. Survey participants remained anonymous and were given the option to opt in or out of having their data included in the full data set that will be available, upon request, for researchers to view if the Researcher publishes the study. If a participant was known to the researcher (work colleague) the researcher emphasised it was their choice to take part.

Right to withdraw

All participants were advised the survey was anonymous. If they chose not to submit their survey questions this would not be included. Once they submitted their responses this was then included in the survey data.

Privacy and confidentiality

All online qualitative survey responses collected in this research would remain stored securely on the Researchers Massey OneDrive. The survey was online and accessible without identifying each participant.

- Example of the 1 participant who identified their country of origin- I removed this from my analysis discussion- this is an example of rigour and ethical consideration around confidentiality as I changed the process to protect their anonymity.

Participant Discomfort

Given the sensitivity of this topic and the potential to share difficult workplace situations all participants were reminded that they could decide to withdraw while doing the survey and before submitting or not to respond to certain questions. Useful support information was included on the information sheet within the online survey along with the workplace counselling service.

Participant and researcher safety

Participant

As this is sharing sensitive information the participants were ensured privacy and respect. Participants were given information about consent as noted above, they were also guided on how to withdraw. They were advised they had the right to decline questions.

Researcher

This was a low-risk project. The researcher had many years working in healthcare settings, all of the data may be sensitive but it was unlikely to be distressing for them, but should they have experienced distress they would speak with their supervisor immediately.

Cultural Considerations

While Māori females were not the key focus of this project, they may have been participants or found the study outcomes relevant, consideration was given to participation and tikanga.

In recognition of the limited studies (see literature review chapter) and the need to create a survey that would be attractive and relevant to Māori participants I contacted the Māori Health Unit at Te Whatu Ora Southern but was unable to gain support due to limited resources. I therefore participated in cultural consultation with Massey University staff to discuss potential recruitment and analysis issues. I undertook the cultural consultation, to identify how to enhance my recruitment practices for Māori but as local staff were busy and ethics delayed my ability to build relationships as much as I'd like. However, I sought to create equal opportunities for Māori to participate through using te reo on the recruitment posters and relationship building with staff as outlined above.

Cultural consultation was sought through the Centre for Indigenous Psychologies, Massey University. The aim was to provide the safeguards required to ensure the research was conducted in a manner that demonstrated the respect for the Te Tiriti o Waitangi principles of protection, participation and partnership. All ethnicities were welcomed. When the findings were analysed by ethnicity and/or when any of the participants described their ethnicity informed their experiences at work the Researcher wrote this up to value their individual experiences in a way that was not generalizable to their ethnicity.

Ethical approval

An ethics application was submitted to Massey University Human Ethics Committee on 22/2/2023. Along with the literature on ethics for research methods, several institutional policies informed this application: The Massey University Code of Ethical Conduct for Research and Teaching involving Human Participants (Massey University, 2017) and Te Ara Tika: Guidelines for Māori research ethics (The Pūtaiora Writing Group, 2010), NEAC Guidelines (2019). After required amendments were made, a full ethics approval was granted on 15th June 2023 by the Human Ethics (Southern A) Committee. A summary of the main ethical considerations of this study are discussed later in this chapter.

If the participants wanted to contribute their stories and experiences to the study but didn’t want this data publicly available to other researchers, they could opt out. Then that way I could save their data in the anonymized dataset and keep those participants separate who did not wish to have their full data available. Their data could still be used to inform the study.

MEETING QUALITY CRITERIA

Ethical considerations have already been discussed above. To achieve rigour in my research I applied a systematic approach to using T.A. following the 15-point checklist of criteria for good thematic analysis from Braun and Clarke (2006) (see appendix i) and the principles of qualitative research as detailed by Yardley to ensure value and quality while using a phenomenology approach (2017). The four principles described by Yardley regularly used to measure value and quality in qualitative research are sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance (Yardley, 2000).

Qualitative analysis must show sensitivity to the data by considering the participants attached meanings (Yardley, 2017). This criterion was applied by completing a relevant literature review; using an open-ended survey; including data extracts with participants own words; and treating participants with empathy and focusing on the nature of the experience.

Commitment and rigour can be achieved through collecting appropriate data, showing the expertise and skills in the methods used, providing an in-depth engagement with the topic and completing a detailed analysis (Yardley, 2017). The coding process within T.A. ensured systematic engagement with the data and a robust analysis which produces themes ensuring rigour in the research (Braun & Clarke, 2022). This criterion was met through personal experience being a peri-menopausal woman working in healthcare with many years' experience of working in women's health. The criterion was developed to ensure the homogenous group was targeted to gain the correct data, appropriate sample size and enough data to answer the research question. Using the steps outlined by Braun and Clarke for T.A. I completed a thorough data analysis to find the patterns across the themes developed from the experiences shared by participants.

The processes and methods utilised in this research were clearly detailed to show how my interpretation was developed from the data and why, including participant recruitment, data collection and analysis meeting the transparency criteria (Yardley, 2017). Using the data extracts in the analysis to show how the decisions were developed and recognising my role as the researcher and how my ideals, knowledge and beliefs can impact on how I interact and interpret the data. I used a reflective journal that showed how I made some of these decisions and what in my own beliefs could have impacted on those decisions.

All research needs to generate knowledge that is useful (Yardley, 2017) and have the potential to make a difference (Yardley, 2000). I believe this research is important to not only the nurses involved but for all health care workers and women in workplaces. This research presents employers with positive improvements that could provide continued support to nurses in their workplaces. This study provided a platform for the participants to share their experiences and their journeys. Those that approached me were genuinely excited and engaged with the positive opportunity it could provide to them and the workplace.

REFLEXIVITY

"Reflexivity is never final and complete but an ongoing process of reflection" (Braun & Clarke, 2022, p. 15).

The researcher can influence the research process in qualitative research both as a thinker (epistemological reflexivity) and as a person (personal reflexivity) therefore it is important to acknowledge not just our biases but how the researcher 's reactions to the data and research context can influence our understandings and insights (Willig, 2013). This included recognising the information I analysed from the survey responses was my interpretation influenced by my knowledge, my experiences, and my biases.

The practice of anonymity was also raised while creating the survey as the managers wanted to know who answered for their overall numbers from each region but as I kept it anonymous this was not possible. This explores the competitiveness we often see in departments across organisations.

I was disappointed I was unable to include a focus group within this research due to the ethics approval wait time reducing the time left to complete the research. This meant I felt disconnected from the group. I went to the nursing team meetings to discuss the research with key nurse managers, but I didn't feel the staff on the floor were connected. I was then rushed in July to get the survey questions distributed and to collect data. Which reduced the excitement that had been attached to finally 'doing' research.

In such a large workplace I also found it difficult to talk to such a wide range of potential participants due to shifts, rosters, illness, non-engagement, and limited opportunities to market the research due to limited resources and constraints on the teams. While completing the thesis I was employed as a Quality Improvement Facilitator for Te Whatu Ora, Southern. This role included working with teams across the organisation on projects and investigating ways to improve processes and systems while engaging with multi-disciplinary teams. While I could not complete this research as part of my role as a Quality Improvement Facilitator, although it would be benefitting the organisation and my own development, the Nursing Management team were very supportive. Also, I realised by being an anonymous survey I had no way of getting feedback on the process from the participants other than those who approached me. I should have included this in the survey questions.

Using T.A. with phenomenology as the theoretical base was ideal as each of the participants responses was unique and rich with detail. Giving me insight into their world and the way they experienced it. T.A. allowed for me to look at this level of detail. I found T.A. ideal for my novice skill level of qualitative research, there was easy to find and understand guides and support available.

The overall review of the data used a semantic analysis approach being data driven which directed the reading process, therefore a smaller sample was beneficial as this reading is time consuming but important for the rest of the analysis (Braun & Clarke, 2006). Still drowning but still attached to a flotation device.

I would describe the familiarisation stage age as a feeling of drowning while still attached to my unicorn floaties. I commenced stage with fear of the data, concerned I wouldn't know what I was analysing, or that no themes would eventually develop. My fear subsided but was replaced with a new concern of exactly how much information was now available in front of me.

While part of me feels women should be identifying their issues and asking for help at work I then felt torn as I understood having had my own health issues and not wanting to admit to them for fear of vulnerability, black listing and career pathway damage. This is a real occurrence for women who have a difficult time working their way through organisations and particuarly into management without being identified as "vulnerable" or "incompetent" due to menopause symptoms.

By the coding stage I was developing the codes in multiple environments such as office, home, swimming pool (side line- no floaties required) and children's sporting events. With my sound cancelling headphones and most often on the laptop electronic version I reviewed the examples and found sometimes that change in environment gave me a different insight, that the environment itself altered my perception of that data.

By the time I was refining, defining and naming themes I felt comfortable starting the next stage while floating on my unicorn flotation device feeling almost in control, "look mum no hands!".

I commenced a journal early in the research process and made notes as I went. Finding there was more, almost daily, entries around the data collection time. It then became quiet as I commenced the analysis and utilised all my brain power to concentrate on this stage. There was a huge amount of change and stressors in my life throughout this year of doing my thesis and upon reflection it was incredible that I completed it and with such joy. This joy was also contributed to by my supervisor and their continued support to me and my flotation devices while drowning most of the year. Professor Riley was patient and responsive and found a way to engage with my level of understanding.

Reflecting on my assumptions of how certain factors will influence participants responses e.g. socio economic, ethnicity, role at work it was interesting to see how I developed that within the analysis itself. I felt I developed more empathy than judgement for the participants. Being in the role that I am in, Quality Improvement, I worried I would try and think of ways to "fix" the workplace issues for them rather than start by sharing their stories. In the end the improvement report I developed for the workplace might contribute to helping with some of those situations raised.

As the aim of phenomenological research is to look at the world through the participants eyes, to step into the participants shoes and understand their experience my role as a researcher was to be empathetic, unconditional, showing positive regard resembling a person-centred counsellors approach through not questioning the validity of their discourse (Willig, 2013). This reminded me of my undergraduate papers particularly in counselling and took me back to when I first began my degree and the reason I started studying psychology, I did like to listen to people's stories.

My own journey with menopause had only just begun when I started this research. I had an inkling this might be starting before I began the thesis topic but wasn't focused on it. When I was reading some responses, they were starting to reflect some of my own experiences with menopause as I was beginning to experience the same symptoms. I was careful not to inflict my own judgements onto the survey responses when analysing. I do think it gave me more empathy to recognise some of the symptoms the participants were describing and making that “part of the club” head nod many, many, times. Some nurses who knew me began talking through their shared experiences with me which gave me ideas around future improvements for the workplace and counselling support options. I had hoped they’d noted these experiences down in their survey responses and asked them to talk to their managers or seek support.

While the menopause symptoms I had started to experience did aid me in developing empathy I was concerned how the potential cognitive symptoms could affect me. Having already sustained a traumatic brain injury and suffering from continued retention and fatigue issues it did make it difficult. I had to keep reviewing what I had just read and found myself asking “where did that thought come from? is it mine or did I read it?”. I was very concerned I’d miss including a reference. I went back to the previously provided support from the rehabilitation providers and powered through.

CHAPTER 8 - ANALYSIS

The survey contained open questions as described in the Methods section, along with questions to help understand their overall menopause experience. They were asked if they had additional stressors and responsibilities that shaped their experience of menopause. Examples of stressors included caring for elderly parents, financial burdens, mental health struggles, moving countries and death of spouse. They were also asked if they had effective social support and where they received that from such as family, friends, and social groups. There was a variety of examples such as positive social support through family through to no social support and feeling isolated. The following analysis includes further discussion around additional stressors and social support.

Figure 1 shows the results for the participants overall experience of menopause. These results show a general distribution across the experiences with most being in the middle with a score of 7/10. There were some outliers in the data where some of these examples included rating a negative experience such as 3/10 then describing how things had become positive once they had started HRT treatment.

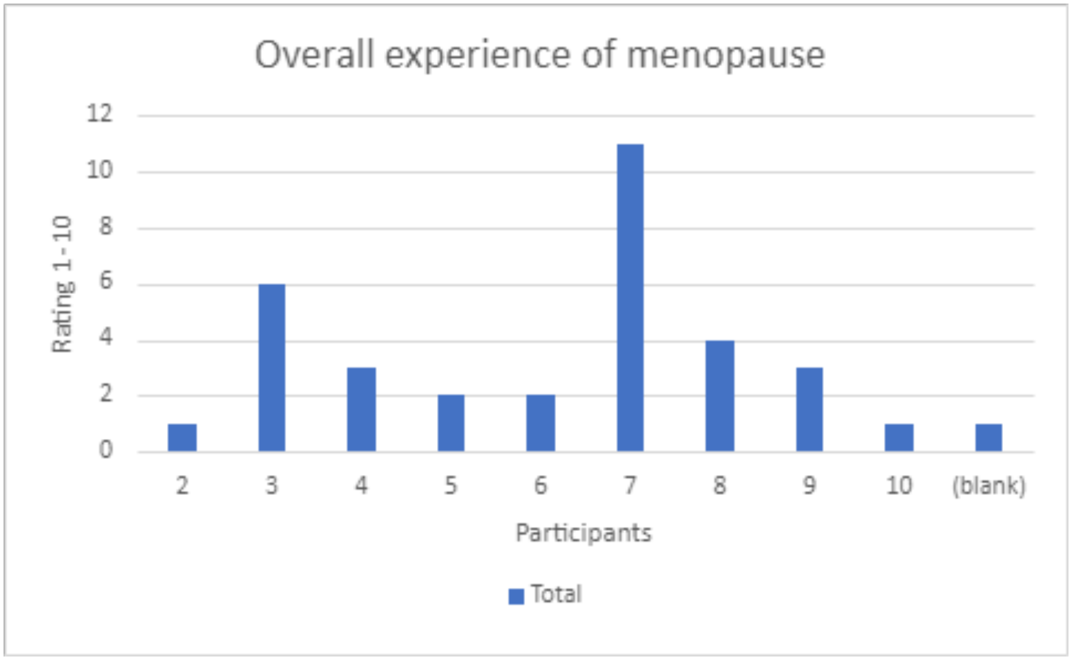

Figure 1: PARTICIPANTS OVERALL EXPERIENCE OF MENOPAUSE

Table 3 includes an interpretation of the responses to the survey questions around their overall experiences and what that meant for them including what social support they had in their lives. This table is based on this interpretation and if the participants explicitly stated positive or negative, or if they stated they had severe symptoms as opposed to no symptoms.

Table 3 SOCIAL SUPPORT AND STRESSORS

OVERALL EXPERIENCES	social support, stressors, symptoms	Social support, severe symptoms, stressors	No social support, stressors	Challenging workplace issues	No social support, symptoms, isolated	No Social support, symptoms, managing
POSITIVE	8				1	3
NEGATIVE	2	7	8	3	1	

The analysis produced Five superordinate themes that described participants' experiences of menopause in their workplace. The first of these themes "negotiating the complexity" highlighted the multitude of symptoms that occur with menopause, and which require management within the wider context of the participants' lives that often include gendered and life-course stresses. The second theme "Challenge to my identity" drew attention to how the menopause experience challenged the participants' sense of self in terms of who they think they should be and their perceived identity within their workplace. The third theme "Coat of armour" evidenced a strategy for ignoring or overriding the problem by withholding their concerns and issues and staying silent. The fourth theme "Effective Workplace" identifies the positive and negative aspects of experiencing menopause in the workplace, and what actions were more or less effective in supporting nurses with menopause at work. Finally, the fifth superordinate theme "Reaching a new stage" celebrates the identification of what can work for these women and how they can reframe this experience into a positive, particularly through knowledge and the appropriate support.

Each of the superordinate themes had several subthemes, summarised in Table 2.

Table 2 SUPERORDINATE AND SUBORDINATE THEMES

SUPERORDINATE THEMES	SUBORDINATE THEMES
The multiplicity experience that is menopause	Struggling with multiple symptoms Fear of getting worse/unknown Occurring in wider context Social & health care support is often limited
Challenge to identity	Challenge to identity - self Challenge to identity - work
Coat of armor	Just get on with it Kiwis don't Not anyone's business Negotiating stigma through silence
Desires for an Effective workplace	Unsuccessful, working practices and management Reducing stigma/acceptance

	Making it work at work In wider context of good health care
Reaching a new stage	Identifying strategies that worked for them A new positive stage Having the knowledge Having the support & appropriate health care

Superordinate Theme 1: The multiplicity experience that is menopause (n37)

The common theme identified by most participants was the range of symptoms that were experienced, that in turn could have wide reaching effects on these participants lives and their work experiences. The subordinate themes within this superordinate theme included: Struggling with multiple symptoms, fear of them getting worse or being unknown, and occurring in the wider context which often made managing symptoms difficult due to existing care duties outside of their work and where both social and health care support is often limited.

Subtheme: Struggling with multiple symptoms (n = 33)

The Silent Transition report indicated that the most common menopause symptoms reported in their results were: Difficulty sleeping; Feeling fatigue; Memory, brain fog or concentration issues, with night sweats and hot flushes affecting about half of the women in their survey (NZIER, 2023). These key symptoms were also reported in the present study along with participants describing struggling with a range of symptoms that impacted on their daily life, including work. This range of symptoms included irritability, depression, palpitations, weight gain and mood swings. P5 for example, described her experience related to sleep:

> *"Lack of sleep. I can average around 3hrs of sleep some nights. Emotional outbursts".* (P5, 50 years old).

This extract represents one of the many symptoms this participant describes in her responses related to her experience of menopause. She also provides evidence of what that means for her, with three hours sleep, representing less than half of what counts as a good night's sleep where less than six hours of sleep a night has been linked to adverse sleep deprivation effects (V. Briggs, 2023). Sleep is needed for emotional regulation and P5 experiences problems with that due to her sleep deprivation, describing how not gaining an appropriate amount of sleep, impacts on her waking life, in the form of "*Emotional outbursts*" (Vandekerckhove et al., 2018).

> *"Just feel my joints aren't as good as they were, but have since found out one leg is shorter than the other inner soles adjusted have made a world of difference. Keeping more active has helped. Poorer sleep quality, mild anxiety at times . Hot flushes have essentially gone. Migraines which I only had every few months have gone".* (P10, 56 years).

P10 describes the multitude of issues she must negotiate including joint pain, sleep disturbances. anxiety and headaches. While finding some relief through walking she states her "...*joints aren't as good as they were*..." and along with the lack of sleep quality and anxiety she just isn't herself anymore.

P5 states these emotional outbursts are not her normal behaviour, and become themselves a symptom of menopause impacting on her experience in the workplace, as she explained in another survey response:

> *"Sleepless nights. Brainfog. Emotional overthinking and anger outbursts that aren't normal for me. Feeling more aged".* (P5, 50 years old).

P5 goes on to describe a range of different experiences such as the brain fog and sleepless nights and how this isn't normal for her which again adds to her struggle. These are examples of multiple symptoms which are complex and being experienced by the participants as difficult. This complexity involves interacting symptoms such as brain fog, changes in cognition, emotions, feeling aged and sleeplessness which can then in turn affect emotional outbursts. They are not part of her identity as P5 states it isn't normal for her, so the outcome is often feeling more aged and incapable at work and not herself (see "Challenge to identity- self" section below for further analysis on how multiple symptoms effect participants sense of self). P5 gives us examples of multiple symptoms that were experienced as complex and difficult to manage, a pattern that was a shared one across the data set.

In these, and other examples the Participants reported multiple symptoms, that were not readily identified making it difficult to recognise and therefore to manage. These difficulties were part of the struggle these participants were experiencing both in their day-to-day life and within the workplace. They reported the feeling of things not being normal or 'quite right' while having a constant struggle with a variety of symptoms.

For other participants the symptoms were more generalised and not easy to identify such as the sense of not being sharp, a feeling that things weren't right such as for example P4 explained:

> *"My memory is not as sharp as it once was but no specific examples sorry. Sometimes I just forget the word I am looking for".* (P4, 48 years old).

In this example P4 talks about a generalised sense of not being as sharp as she once was. Here she states she can't identify specific examples but there is still a general feeling that things aren't quite right. Several participants identified this isn't their 'normal" and they didn't feel right. Her specific symptoms were relevant being poor memory and word forgetting. Sometimes these symptoms were not initially identified as being related to menopause, leaving women with little knowledge on how to manage them or gain control over their lives.

Perhaps the most invasive and difficult symptom to manage when it occurs at work is a hot flush which is a temperature dysfunction due to hormonal changes (Deecher & Dorries, 2007). As described in this study the effects of hot flushes can be inescapable and considered a potential safety risk then in the workplace .While across the literature more women tended to report experiencing sleep disturbances and/or brain fog, hot flushes can have a debilitating affect while occurring in the workplace (Carter, Jay, et al., 2021). Most participants had some experience of this vasomotor symptom and described their challenges in the workplace in particular.

> *"I was having terrible hot flushes where I had to carry around tissues to mop up face, it was hard wearing masks as well. They could happen at any time and the most horrible place is in a meeting. I am now on HRT and have minimal flushes".* (P18, 55 years old).

P18 describes the extreme example of her experience with hot flushes, having to mop her face which was made more challenging with mask wearing in the workplace. P18 explains how difficult the symptom can be when it occurs with no warning and in the most inappropriate environments such as meetings where it can be difficult to mask the occurrence or leave the environment to reduce embarrassment and manage the symptom.

> *"Yes all the time! One example is when I was scrubbed in theatre (happens frequently). It is very uncomfortable but you have to push through and try to ignore it. Obviously the patient comes first along with the procedure."* (P32, 50 years old).

P32 shares her experience at work when fully donned in the theatre uniform (gown, mask) they have experienced hot flushes on a regular basis leaving them uncomfortable. They've learnt to push through this symptom given the environment they're in and the priority for them being the patients' well-being.

> *"…talking with a family , discussing breast feeding and then an overwhelming rush of heat surges thru your body and you become sweaty and clammy - and*

> *my face perspired , I felt like the family might of thought I had had a big night out".* (P37, 54 years old).

P37 remembered an incident when working with a family and her concern that the visual symptoms she was exhibiting during a hot flush would make them think something was wrong with her. This participant had expert knowledge, which relates to women's bodies (breast feeding) and she was sharing this with the participant as the expert yet simultaneously her body was going through uncontrollable changes which then position her as not the expert professionally. She makes comment that the family might of thought she was out for a big night. This represents that she thinks the family could perceive her as not professional coming into work hungover and not providing a good health service. She is experiencing both an overwhelming embodied experience and anxiety over the fact the patient could be perceiving her as not providing a good standard of healthcare. The social conditioning and stigma attached to menopause created this situation where she didn't feel she could simply state that she was having a hot flush, especially in the context where she was talking about other natural body processes such as breast feeding, an empowered act for a woman (Dehghani et al., 2023). Hot flushes in particular are described by the participants as being the most debilitating while occurring in the workplace.

> *"I developed arthritis and aching joints.*
> *I got "hangry" I generally became more irritable and became less of a people pleaser. I became less tolerant of men and their poor excuses in general. I developed cystic acne. I have significant signs of osteopaenia. my blood pressure has increased and my overall ability to manage stress is reduced. I have put on 18kg in a short period of time despite eating nutritiously. I had panic attacks in the early phase and took antidepressants because I became suicidal overnight (my life was great but I became suicidal)"* (P35, 52 years old).

This participant detailed more extreme examples they had to manage with both physical symptoms and sudden suicidal ideation. This occurred amongst a lack of health professional support and diagnosis and no support within the workplace detailed in

“Social & health care support is often limited” and “Unsuccessful, working practices and management” subthemes. She felt isolated and alone especially when being overwhelmed with the suddenness of the symptoms and the lack of clarity from her GP due to her age- not being in the normal menopausal range.

The first subtheme identified the complexity of interacting symptoms that were experienced individually by each participant. These symptoms were often not recognised or diagnosed making them difficult to treat or find knowledge on management. Hot flushes were raised as a key symptom affecting participants in their workplace.

Subtheme: Fear of getting worse/unknown (n=5)

While experiencing a potential range of symptoms such as described above, from brain fog to irritability to joint pain to hot flushes, the participants were also dealing with the fear of them getting worse and not knowing where to get the appropriate help. So that there was the added fearful anticipation of what the future might hold. As P22 (43 years) said:

> *“I think that I only have mild symptoms and there is worse to come yet”.* (P22, 43 years old).

P22 identifies the potential for her symptoms to worsen. The participants are describing this variety of symptoms but with little support and not knowing what to expect. Knowing what the symptoms relate to doesn’t appear to alleviate the anxiety completely due to the future orientation that it is going to get worse and the lack of knowledge of what to actually expect.

The fear of these worsening and unpredictable symptoms for the participants included how it could impact on the workplace.

> *“I have not done anything that might jeopardize patient care, but I do worry that as I get more into menopause that I could”.* (P23, 45 years old).

The concern P23 raises around what could occur if her symptoms worsened and within her role of patient care is a workplace health and safety issue that should be addressed and supported, yet the participants noted their fear and vulnerability within the workplace if they asked for help. This could manifest as a small worry in the back of her mind every day, so that, while she hasn't harmed a patient that potential risk is shaping her daily experience at work concerned that future mistake just might occur.

As P15 details the hope that her symptoms will pass easily yet without knowledge of how the symptoms develop she also has minimal idea on what to expect. As menopause is made up of multiple symptoms which may or may not occur and which becomes idiosyncratic for each woman giving them their own experience it is adding to its complexity. These women can't have any sense of certainty of what's going to happen to them. Therefore, this adds to their stressors.

> *"have heard that these symptoms can pass or resolve for some women and I am hoping that this will be the case for me, too. I wonder if supplements or vitamins will help*". (P15, 49 years old).

P15 continues with the theme of the unknown for her experience where she is reliant on other women's experiences and yet this might not be what occurs for her as menopause is individual. This example talks about how vitamins and supplements could be beneficial but there is no real knowledge of this or idea of where she could go for advice, leaving her unsupported. For these participants it isn't just their bodies that are unpredictable and causing stress but it's the lack of knowledge of how they can support their bodies that adds to this complex situation.

Some women must negotiate the changing needs of their body and unpredictability of menopause as described by P25. As she states below "*I guess…*" she is referencing the unknown that comes with this unpredictability. Having experienced what she thought was her last period then counting down the 12 months without a period that meets the menopause criteria she has an unexpected period leading to restarting the countdown.

> *"I feel I have experienced minimal symptoms, after 2 months I had another period -recently, so I guess I restart my countdown".* (P25, 52 years old).

P25 explains her journey of a stop-starting menopause. But it can create uncertainty and lack of control and without access to education and support these participants are left to feel unsupported and uncertain. This appears to be a combination of both the lack of education/ support and that each woman's body is different and will experience menopause uniquely.

This lack of knowledge and unpredictability adds to the fear of worsening symptoms creating stress when considering the effects on their workplace. While managing the multiple symptoms they are also managing future orientated anxiety because they don't know what is going to happen and how to manage the next symptom and how it impacts them at work.

Subtheme: Occurring in wider context (n=25)

The responses to the survey showed that participants' menopause experiences are occurring in wider context, this wider context could be lifespan, gender, age, other stresses which often intersected. Several participants talked about elderly parents, some talked about children, others talked about multiple problems. For example P19 (48 years old) described having care responsibilities for multiple generations, both her mother and father who had multiple health problems, including cancer, dementia and heart problems; an adult child with severe mental health problems, and grandchildren also needing support (DETAILS REDACTED TO PROTECT ANONYMITY); similarly P7 (55 years old), also described multiple, intergenerational, responsibilities of care; while P21 (60 years old) described her symptoms of menopause suddenly surfacing following a bereavement.

The Silent Transition report identified that 44% of their sample had unpaid care responsibilities for example elderly family or children which can impact on their ability to find paid work or focus on their paid roles due to fatigue (NZIER, 2023). The nursing profession internationally is facing an increase in their older nurses which is a growing number within their workforce who are facing impacts on their ageing bodies in an industry that is physically challenging which can sometimes include shift work, high levels of stress and where they are often taking on carer roles and unpaid duties at home (Ryan et al., 2017). As outlined in the literature, and supported in this study's participant responses, experiences of menopause are not just embodied/biological, but interact with the life course, which is deeply gendered within our society given expectations for women to take on caring roles, creating significant challenges for this cohort of women.

> "*I had my mother but she had no significant problems with her menopause and she is very stoic and was a SAHM so her solution was just stop working, your life is too stressful and your body is telling you that*". (P35, 51 years old).

P35, for example, shared her experience with her mother automatically advising her to stop work due to her menopause symptoms, which were described as severe. She described her mother as a stay-at-home mum- "SAHM" and "stoic" giving the impression there was limited support for her to manage her symptoms or to stay at work. Within our culture the idea of a stay-at-home mother is valued, as per this participant's mother's comments. While part of that more traditional role is a devaluing of the working woman where in this case the automatic response was to leave the role and stop working without discussion or recognition of the importance of that role to the participant. In this context, when nurses are struggling at work, one solution could be to interpret their bodies as no longer being fit for work.

Menopause can happen at a time when women are in the "squeezed middle" with responsibilities for older generations, while also having younger children at home. Below P35 continues with her example of her younger children to care for.

> *"I had a 10month that I was breast feeding and 4 yo child with undiagnosed neurodiversity problems, I had just moved into our new house. No financial stressors. I got a glandular fever type virus and was physically unwell for quite some time and went into menopause during it". (P35, 51 years old)*

This participant is caring for two young children requiring breastfeeding and specialised care due to neurodiversity issues. She also contracted glandular fever which added to her physical ailments and stress triggering menopause symptoms. This participant gives the sense of a woman managing multiple demands outside of her already demanding work.

The participants examples highlighted the recontextualising of the nurses as carers outside of the workplace and how this impacted on them both personally and professionally. These added stressors can include other elements too such as the wider context of their jobs including unsupportive management and potential organisational change for some.

> *"I had a change in career pathway -off the floor nursing and now into management...managing a ward and staff is busy and stressful as well as navigating the constant changes within the social environment that impact our jobs".* (P25, 52 years old).

P25 identified her job and unsupportive workplace as being the influences in the wider context creating stresses that impacted on the management/experience of her menopause.

This subtheme highlighted how participants described the experience of menopause at work as intersecting with their social context, which is often shaped by gender, norms of care that laid responsibility on these women, while for others, it was organisational change and practices that caused additional stress that they experienced as shaping their experiences of menopause.

Subtheme: Social & health care support is often limited (n6)

While these participants were negotiating their struggles related to menopause, they were often provided with minimal social support and appropriate health care support. Whether that be through family and friends or through their primary healthcare providers. This often left them to navigate this struggle alone. Bauld and Brown (2009) identified that women’s menopause symptoms can be affected by social support and that women’s own attitudes towards their menopause could influence how they experienced these symptoms with a focus on emotional intelligence impacting on their coping abilities. The findings in this study also showed the effects of positive and negative social support.

This negotiation of the complex symptoms was often achieved alone creating additional stressors for the participants to manage.

> *“I went "bat-shit" crazy for a while and then overtime I have found solutions and navigated the changes, things are a lot better now but I have pretty much had to navigate it on my own”.* (P35, 51 years old).

P35 describes how bad their situation became with little help from others making them feel isolated and incapable. While she received support from her colleagues at times through humour, she really wanted some guidance on what was happening with her cognitive deficiencies and didn’t feel she had the ability or mechanisms to seek that help. Even through all her difficult situations at work she was given no social support and had to locate any solutions by herself.

Shared negative experiences could sometimes ease that feeling of being alone and dealing with issues in isolation, like being in the club of shared misery where other women have welcomed them in.

> *“random strangers in the street were more supportive than friends and family. I only hope that I am more supportive to my sisters when they go through it”. (*P35, 51 years old).

P35 describes where they gained some support and how the lack of this in your own social circles can have a negative impact. This lack of support and added stressors was also occurring within the workplace as described below by P25;

> *“I didn't tell them about my severe symptoms because they became overwhelmed and sometimes even walked away if i started to talk about how I was actually feeling. I have a vivid image of my service manager popping in to*

> *see if I was ok when i returned to work and when i didn't act all happy and pleased about life her bum literally bounced off the seat and she left".* (P35, 52 years old).

P35 describes the isolation which was magnified with this detailed experience of management not wanting to hear about her issues or provide her with support. Having her manager actively trying to avoid her request for support. This was a person of responsibility whom she should have been able to reply upon to keep her safe in her workplace. It appeared that she felt she had to keep everything happy and positive and wasn't allowed to raise any issues at work or seem needy.

The expectation that women need to stay positive and reject negativity by keeping a pleasing disposition for both themselves and for others could be shaping some of the participants experiences in the sense that gendered expectations of women mean that you're not allowed to express difficult feelings (Calder-Dawe et al., 2021). Given how difficult menopause is, this inability to discuss difficult feelings will further make the situation harder to live with and challenging to manage without being able to acknowledge and share their experiences.

P35 was not alone, as several participants shared negative reactions that they had received from their managers leaving them feeling isolated and unsupported which would add to the complexity and stress they were already feeling.

> *"My head nurse was not supportive and questioned me and my ability to work. I would have liked some support/empathy from them as they were aware of my situation. I was very disappointed in their reaction".* (P13, 56 years old).

P13 was left feeling questioned and incapable by their manager when they sought support. They stated they needed a level of empathy and encouragement following them making the manager aware of their menopausal related needs. Left with disappointment and feeling alone they could not manage their symptoms at work very well. These findings map onto a range of study findings identified in the literature review, including the Fawcett report (2022) which identified that women were left feeling their competence was questioned, with the APPG report (2022) and the NZ Menopause survey report (Dear, 2023b) both highlighting the fact women would prefer not to identify their menopause symptoms that have a negative effect on their work as being related to menopause or seek support from workplaces that do not have menopause policies or guidelines in place.

P35 was very young to have commenced her transition and together with P13 they were not given the support or appropriate healthcare education to recognise their potential menopause symptoms leaving them isolated, undiagnosed and feeling unsupported by their managers.

The survey participants reported having to negotiate a lot of complexity related to the multiple symptoms that were experienced that were sometimes hard to identify, recognise and treat. These symptoms often weren't recognised as menopause particularly without appropriate healthcare support.

> *"Then also being told that you are too young (41yrs at the time of first symptoms) and not to over think symptoms. So then you think you just might be going crazy, cause blood tests come back in normal ranges"!* (P38, 48 years old).

Here P38 described the lack of support and control of her symptoms without appropriate diagnosis. Her initial interpretation of her symptoms is dismissed both through the GP and the scientifically proven blood tests. Her conclusion is she must be going crazy because if it's not menopause then it must be her mind. P38 was experiencing several symptoms that were not being identified as menopausal likely due to the complexity of menopause as identified in previous research (Barber & Charles, 2023). Therefore, following the dismissal from her GP she had no way to manage these multiple symptoms without a framework of understanding. Without a diagnosis, this complexity of menopausal symptoms created additional anxiety and reduced wellbeing. Through the lack of symptom recognition women are noting a reduced wellbeing including issues such as depression, loss in confidence and suicide ideation which is evident in New Zealand data such as higher reported rates of low life satisfaction (NZIER, 2023).

Some participants had even gone as far as to diagnose themselves with dementia and not surprising when the current research includes correlations with the reduction in estrogen and risks for Alzheimer's and menopause being linked to relapses in mental health issues (Bezzant, 2020). If these participants do not know enough about their menopausal symptoms and their doctor advises they don't have menopause, then it's not surprising they turn to other interpretations such as cognitive disorders.

This lack of identification or support often commenced at the primary care level when women would seek GP support with little outcome. Many participants detailed their lack of support or guidance through their health professionals. P35 continues with her examples of isolation through her GP's lack of knowledge:

> *"the GP's seemed to be very behind in the knowledge they have available to them about menopause and women's health in general. my GP had the grace to acknowledge that he didn't know much about menopause and I then made an appointment with the [private clinic] through [insurer]. I had to suggest to the GP that I go on HRT they didn't identify any of my issues as being menopausal".*
> (P35, 51 years old).

Here she identified that she was wanting support from her GP with her symptoms and struggles, while her GP acknowledged their deficit in education on menopause yet didn't take control and seek further support in her opinion. The GP's inability to identify and diagnose her symptoms left her to make her own diagnosis. While her situation was not as common, being in premature menopause, she should still have some trust in her primary healthcare professional knowing where to go for support if they didn't know the answers. The NZ menopause survey results highlights the lack in training for Doctors in New Zealand which is comparable to most international curriculums (Dear, 2023b).

The APPG recommendations in the UK included the need for change with up to 41% of the 33 Medical schools in the UK not including menopause education on their curriculum (APPG, 2022). These findings can explain, the comments from the participants around struggling to get support from their primary care providers.

This lack of healthcare knowledge was repeated in many of the participants examples including:

> *"We are lacking support services clinics for women. GP education. Huge waiting lists for gynae, unless you pay insurance cover to see them privately".* (P38, 48 years old).

P38 shares their frustration of this gap in the healthcare system of appropriate support for menopausal women. Raising the lack of clinics of which there are none in this region; lack of GP education and long wait lists at the specialty clinics. The financial inequity she has also identified details the idea that without money women will have less access to the private health system, creating further inequity for them. The inequities occurring in healthcare for women are also highlighted by examples of access to HRT medications. Comparing the differences between available HRT treatment in New Zealand versus Australia shows the lack of options that health professionals can access in New Zealand which was raised recently in discussions at the Australasian Menopause Conference (AMS, 2023).

> *"Never stop the supply of HRT, during COVID this was rationed I did think if this was a condition that men suffered from then would there have been a supply shortage?".* (P14, 59 years old).

Gender inequity is raised by P14 when during COVID the access to HRT was rationed, would this be a different outcome if this medication was required for a male specific condition. This feeling of hopelessness that the medication she needed to manage her symptoms had to be rationed while the covid pandemic occurred, heightened the stress she was already feeling. That frustration that a medication they know can support them and minimise their debilitating symptoms cannot be accessed must have been disheartening and reinforces a sense of the lack of support across the healthcare system.

This lack of appropriate social support and healthcare has detrimental effects on women's health and their experiences of menopause. Just as stress can affect a women's experience so can the lack of social support and workplace support.

Summary

The ongoing complexity of menopausal issues these participants were facing while experiencing multiple symptoms has only been made more difficult through the lack of education, support and knowledge from health professionals and from their support systems. The identified issues have added stress and fear for these participants' creating a sense of vulnerability and a lack of correct diagnosis. Which occurred within intersecting contexts of gender, age, lifespan and culture for example which could all add further stressors. Many participants were carers both in their nursing roles and within their homes as parents, carers and partners. Therefore, without the correct social and healthcare support these types of added stressors added to their complexity of struggles.

Superordinate Theme 2: Challenge to identity (n18)

This second superordinate theme identifies the struggle that participants were having with not feeling like themselves. This occurred when menopause was creating a challenge to their identity both for themselves and within the workplace. This challenge was created through physical and cognitive symptoms that created barriers for them to participate in their lives as they felt they should be capable of doing.

Subtheme: Challenge to identity - self (n13)

The experiences of menopause described by these participants challenged their sense of identity. A feeling of discontent was echoed by the participants who were unhappy with their current situations. Their physical wellbeing, cognitive abilities and relationships with others were all being tested from what they felt were the effects of menopause. Menopause had presented challenges to the person they felt they should be both physically, mentally and in relation to others.

> *"Just not feeling like yourself. Having all these random symptoms, that change all the time. Especially when you have been a fit well person. Struggling to par take in normal family activities. Husband and kids think you are 'Crook' again and again".* (P38, 48 years old)

Above P38 describes that she doesn't feel like herself anymore and then defines what "herself" used to be such as a "fit well person". Implying that she is no longer feeling like this. She then follows this with an example that she can't participate in her "normal" family activities, positioning herself as not being normal any longer. She no longer feels like that fit and well person who could participate and she's letting down her family.

This challenge to one's sense of self was affecting her relationships with others which as described above would also add to her feelings of isolation. As P38 (48 years) detailed the perception from family that they are simply "*crook again*" isolates her from others who would normally be her support system. This created a perception she had to be capable and healthy and to be able to participate without barriers. In this extract, we see how a combination of having multiple symptoms, as described in subtheme "Struggling with multiple symptoms" and the lack of support, as described in subtheme "Social & health care support is often limited", intersect for this participant with a sense of loss of self. This loss of self exhibits the feeling that they were once part of certain activities or situations and now they're not.

> "*Anxiousness, not feeling like yourself. Wondering what the hell is wrong with you and if in fact that you are crazy".* (P38, 48 Years) old.

P38 also experienced a loss of feeling like herself stating she was feeling crazy and anxious thinking there was something wrong with herself. That feeling of loss of oneself then added to the anxiousness with continued concern something is wrong with herself and that the fault is within her. This loss of one's ability and sense of self that can be caused through the effects of menopause can create isolation and add to the stress and pain already being felt. There was a grief in how the participants felt towards losing their physical or cognitive abilities and not being able to participate in activities they once enjoyed and considered normal.

Eighty five percent of the 2023 New Zealand Menopause survey respondents identified that menopause had affected their sex life negatively and that 88% had experienced effects on their relationship with their partner (Dear, 2023b). Similarly, the participants in this study described effects on relationships which could then exacerbate their ability to cope or manage these symptoms.

> *“Maintain healthy relationships with loved ones can be challenging with labile moods”.* (P21, 60 years old).

P21 described the challenge she experienced maintaining healthy relationships when feeling cognitive/ mood issues. These “*labile moods*’ were uncontrolled irritability and heightened emotions which made it difficult to maintain healthy relationships with her family who would have normally been her social support circle. This highlighted that this is potentially a doubled problem for participants because they lose their relationships that would have been their normal social support, but that also adds to their loss of sense of previous self (who did have/was capable of having healthy relationships).

These descriptions of struggling with labile moods also link to findings in the Dear study that hormone changes can have a mental health impact, however for P21 it seemed that she had not considered HRT or received other support to manage these (Dear, 2023b). This ongoing challenge the participants felt towards their identity was maintained through lack of education, support and knowledge so they couldn’t gain a level of control. They felt isolated and alone while trying to manage the variety of symptoms. They simply wanted to feel like themselves again by being the person they felt they should be.

Subtheme: Challenge to identity - work (n8)

This challenge to their identity continued into their workplace when the participants experienced menopausal symptoms such as hot flushes and brain fog at work, they experienced these as a fundamental challenge to their professional identify and self-worth within their roles.

> *"I am a [Title of Job] with a large team and I will be in the middle of a conversation with someone that I have known for a while and I will be struggling to recall their name. It's embarrassing sometimes".* (P22, 43 years old).

P22 states her role indicating ability and a level of responsibility where she perceives the need to not be forgetting people's names. P22's example of forgetfulness was a common thread for these participants along with the embarrassment it created when in a workplace situation.

For P20 their self-worth within their team was negatively affected while struggling with symptoms in the workplace.

> *"I lived this for a good two - three years. It was horrible and made me feel that I was useless and not a useful/ well functioning member of the team".* (P20, 53 years old).

This experience left them feeling hopeless and not a well-functioning member of the team. This was a '*horrible*' experience for the participant over several years making them feel de-valued and they developed a sense of loss for the person they used to be. That self which included their identity as a team member. That membership that came under threat both personally and within their team identity because they felt useless and unable to do their job which was an important part of their identity. Even with supportive team members participants raised issues around how these additional struggles and needs would surely wear thin on others in their team after some time. These findings highlight the issues raised by Dear (2023b) with over 80% of the NZ menopause survey participants stating menopause had negatively affected their work in some way.

> *"When these things happen I feel a failure and like I'm the stupidest person in the room. I also think I have early dementia*". (P5, 50 years old).

As P5 described they felt stupid in comparison to others in the workplace and thought they had dementia given the lack of healthcare support and knowledge. She felt like a failure in her role and went to an extreme level of interpretation of her symptoms thinking she had a disease such as dementia as that was the only rational idea that could explain these symptoms. The Silent Transition report identified that most women are reluctant to ask for any type of adjustment in their workplace or to even approach management (NZIER, 2023). Perhaps one of the reasons participants were reluctant to ask for help is that they didn't want to be "outed" as stupid or mad.

Some participants could pass it off with humour, but they still felt incompetent and silly particularly when in a workplace. This humour was highlighted by P18 who described using a '*CRAFT'* book as a management strategy for the cognitive issues that she experienced.

> *"I have a lot of people stop me in the corridor and i have to have a notebook with me so that i can remember CRAFT book is what it is called (Can't remember a fucking thing)".* (P18, 55 years old).

These type of management strategies were common where the participants had notebooks, techniques for added memory aids, support for each other and codes that gave notice to their colleagues that they were struggling and needed a 'wing-woman'. Humour was a commonly used method to ease the situation and regain some dignity.

Some of the participants included examples where menopause symptoms were specifically affecting their ability, safety and self-worth within their roles creating a vicious cycle of risk, fear and loss of their professional identity. Cognitive issues in the workplace were raised and acknowledged as being a risk by these participants. As P15 (49 years) raises her concerns below;

> *"I have also confused medications which are of a similar class. This was also on an over-night shift which seems to make the symptoms worse. In the medication case I double checked with another staff member to ensure that I taken the correct medication from the cabinet before it was administered. In these cases it is quite embarrassing at best and at worst is a near-miss for medications. I worry that I will lose the respect of my peers and will seem incompetent or unsafe".*
> (P15, 49 years old).

Here P15 describes a scenario in the workplace of a near miss situation with

medication. She goes on to acknowledge the potential for a safety risk but also the fear it elicited if her peers knew, and she would be seen as incompetent. Her solution to double check is appropriate in reducing risk, but it also makes her vulnerable to looking incompetent in front of the other nurse who she's asked and that's embarrassing. Therefore, she either looked incompetent or she was being unsafe.

This challenge to her identity and the employee she used to be or should have been is important to her. What was absent in these participants descriptions of their experiences was feeling that they had the right education, knowledge or workplace support to seek help or the confidence to know that help would easily be given if they sought it. P15 described the fear of losing the respect of her team and being both unsafe with the patients but incompetent in her role and no longer able to perform her tasks as she did previously. She felt embarrassment with her loss of control and loss of identity within the workplace.

Summary

Here the participants identified the challenge that menopause symptoms can have on their sense of self. This included both the cognitive affects that went as far as leaving some thinking they had dementia. Through to the physical effects presenting a challenge to who they felt they should be. Both restricting their ability to participate in everyday life and to be a well-functioning team member. Menopause can create a vicious cycle of symptoms that can challenge a woman's sense of self both within the workplace and outside of it. These findings linked to the Fawcett report which stated 1 in 10 women in the UK had to leave their job due to menopause symptoms where 14% had to reduce their hours (Fawcett, 2022).

Superordinate Theme 3: Coat of armour (n29)

While struggling through the variety of menopausal symptoms without support they described a strategy of grin and bear it/ stiff upper lip mindset, that worked as a "coat of armour". They described this as a way to protect themselves, but this did not facilitate positive, happy coping. This stiff upper lip mindset was made clearer when reading through their entire stories to see the high levels of stress and range of negative experiences they were enduring. They were not coping, and they were identifying that they were struggling through symptoms often feeling isolated. Some of these examples had a cultural component specific to living in Aotearoa. A few examples were identified as being nobody else's business and they would cope with their menopause symptoms alone and not seek support through their employer. A key subordinate theme that was identified was where they managed to negotiate this perceived stigma through keeping silent.

Subtheme: Just get on with it (n23)

The grin and bear it attitude appeared to be a management technique and particularly in the workplace for these participants who did not want to exhibit any level of vulnerability. There was absolutely no engaging or articulating of their issues to anybody no matter what level of symptoms they were experiencing.

> *"I have <u>never</u> said anything to <u>anyone</u> about it".* (P4, 48 years old).

P4 explains they have never discussed their issues with anybody. Even when they were suffering or needing support in the workplace it was not discussed nor did they seek assistance. The fact they underlined NEVER and ANYONE highlights the fact they are readily choosing to manage alone and it was unacceptable for them to share. Yet further into her descriptions she detailed wanting to help and her underlining changed to ADVOCATE and ENCOURAGE;

> *"I am not sure why I haven't said it directly to anyone as I am a big advocate of talking about menopause and perimenopause".*
>
> And
>
> *" ...as I do encourage others to discuss menopause and perimenopause symptoms*".

She also talked about being supportive of education in the workplace. Yet her stance on *NEVER* talking to anyone contradicts this statement. Given the findings above about the challenge to their work identity, and what we know of the broader social context of stigma, in this example, we can see a sense of how it feels impossible to talk about experiences, even when intellectually you think people should, and you support other women to do so.

Here P25 raises the added stress of this internalising and how it would simply make her physical symptoms worse, yet she continued to internalise and to not seek support.

> "*I probably internalise a lot and have internal stress that manifests as spinal issues -sore shoulder, neck hips etc. Higher stress related cortisol levels which are difficult to reduce."* (P25, 52 years old).

The sharing of these symptoms or issues would put these participants in a vulnerable situation and as previously identified could make them look stupid to their peers or incompetent adding to that loss of work identity subtheme "Challenge to identity - work". Therefore, the easiest and safest management strategy was to keep silent and that added to the protective armour being set in place.

These findings identified the issues that can occur at work particularly when women do not feel safe enough to seek help and support. As described in the Fawcett report highlighted that 44% of their sample said their ability to work was affected by menopause while 26% of women took time off work due to menopausal symptoms but only 30% of those women identified in their sick note that it was due to menopausal symptoms (Fawcett, 2022). The protection of their vulnerability was developed through their continued silence building a safe place within the workplace.

P7 identified multiple reasons why they didn't need to draw attention to themselves and to just get on with their job...

> *"Part of life and busy clinic-*
>
> *Carried on without telling anyone , tight time frames for clinic time*
>
> *Don't like to draw attention to myself".* (P7, 55 years old).

The type of work being described is delivered within tight time frames and often under duress which makes P7 feel she doesn't have the time or ability to raise her own issues. The type of clinic work can't stop or slow down for her to deal with anything other than her role. Those menopause issues are seen as something that is '*part of life*" and therefore given less priority. This might also link to how we in New Zealand are known to have a tall poppy syndrome and don't always promote speaking up or speaking out (also see subtheme below "kiwis don't). These issues also intersect with her personal anxiety around not wanting to draw any attention to herself given the threat to her identity and potential for vulnerability in the workplace as described above by other participants. They feel safer to keep silent and protect themselves.

Subtheme: Kiwis don't (n3)

Several cultural behaviour differences were also raised in the responses that confirmed the stiff upper lip mindset. How New Zealand nurses were seen as getting on with it and how they do not make a fuss. While this subtheme didn't contain many examples it was of high impact in the analysis as it referenced the potential for New Zealanders to have certain behaviours directly attributed to living in this country.

P27 raised their experience that Kiwis as a nation don't make a fuss and for something like menopause, we tend to just get on with it.

> *"I think as a kiwi you don't make too much of a fuss and just get on with it. It's a part of life and its something we as women go through".* (P27, 55 years old).

Where P3 agreed that in the USA they would be much more confrontational so their responses could be different to these types of situations.

> *"people tend to be less confrontational then in the USA, so maybe, but I've lived here for a long time, so not sure about this".* (P3, 38 years old).

P13 raised the cultural component for Kiwis and the participants not discussing these types of issues in the workplace. Linking the experience of not discussing this in the workplace directly to the impact of social and cultural influences.

> *"the limited discussion about menopause in our country socially/culturally makes it not a subject also talked about freely at work".* (P13, 56 years old).

For many cultures menopause is a freely discussed topic and a celebrated stage of life such as in the traditional Māori worldview where menopause is seen as an important and valued stage for wāhine Māori reproduction journey which includes continuing the genealogical lines (whakapapa) (Bullivant Ngati Pikiao et al., 2022). Within the dominance of a white settler/ pakeha culture as P13 (56 years) indicates it isn't really a subject we discuss here in New Zealand. This contributes to the isolation and lack of support within workplaces and increased stigma attached to this stage of life for these participants.

Several international studies have reported cultural differences in the way that women report their symptoms (Fawcett, 2022) agreeing with the findings from this study that culture does affect the experience. These findings show one of the cultural elements for this study is that New Zealanders tend to put up with problems and not rocking the boat, this could be linked to historical settler identity where in the past things have been difficult and there's an expectation not to complain.

Subtheme: Not anyone's business (n2)

Continuing with the superordinate theme of the Coat of Armour some participants noted it wasn't anyone's business to know when they were having menopause symptoms. These participants may have been keeping quiet as they wanted their privacy respected, and they felt it was a normal part of life that didn't require special attention. Yet these examples were situated in a negative context and added more to the suffering in silence notion. While there were only two specific comments within this sub theme, they appeared to be important and impactful giving the impression they didn't want anybody to know within their workplace and seemed more guarded and vulnerable within the rest of their responses. These responses were important within the overall analysis to assist in answering the research question about the nurses' experience of menopause within their workplace.

> *"I don't expect help from organisation about this. Why? its a normal part of life".* (P27, 55 years old).

P27 felt their experience was private and their own and it was not for their workplace to know or support as it was simply a normal part of life. It appeared they didn't see it relevant to ask for support through their workplace. Their response is situated in the overall context of suffering from a lot of symptoms, and they rated their overall experience as 7/10 which is negative, so it didn't appear that they were managing or coping with menopause citing "*terrible*" symptoms.

As P24 agreed they did not feel their employer would or should support them.

> *"I don't feel it is my employers job to support my menopause symptoms".* (P24, 46 years old).

This participant's overall rating was also 7/10 and within the context of their overall responses they appeared to be struggling through menopause and not knowing where to go for support. This participant stated they planned their life around their periods which were becoming more erratic, almost being held prisoner by their hormones. Therefore, while they state it isn't their employer's role to help, they potentially did not know of the support that could be offered both by healthcare providers and in the workplace.

The APPG report detailed the many testimonials they received around women being questioned for their competency and ability at work in relation to menopause symptoms (APPG, 2022) where the Fawcett report showed within their participants only 22% disclosed their workplace issues in relation to menopause and only half of them being prepared to apply for a promotion and quarter considering leaving before retirement all in relation to menopause symptoms (Fawcett, 2022). The findings in this report agree with these two studies in that the women felt safer to keep quiet and that it wasn't anyone else business, particularly at work.

Subtheme: Negotiating stigma through silence (n6)

Some participants described how they tried to hide from the stigma that menopause can create and the perceived inequities through staying silent to protect themselves and their workplace reputations.

> *"I don't feel its anyone else's business what my hormonal schedule is or that I could be impaired or imbalanced by hormones. I don't want my peers to think of me as an irrelevant or silly old lady. I don't want to use menstruation/peri/menopause as an excuse though the symptoms are quite real and have big impact on my life. I also feel the "deranged woman on her period" is a stereotype and is overplayed and I don't want to contribute to this negative parody".*

P15s (49 years) example identified the important issue of raising menopause needs but also developing a gendered vulnerability or inequity if they do. Yet within the context of the rest of their responses they had extreme symptoms and negative examples within the workplace where they could have benefitted from support. There appeared more a theme of fear of seeming incompetent and vulnerable as opposed to coping and being okay to manage alone without workplace support. As described by P32 (50 years)...

> ”*Telling someone would open myself up to vulnerability and possibly make the matter worse.”* and *…" Easier to keep to yourself. Don't want to feel useless”.*

This negotiating stigma through silence did appear to stem from fear and vulnerability and the need to feel safe and useful in their workplace. Therefore, the aim was to seem competent and not useless through silence.

Summary

The stiff upper lip mindset some of these participants displayed appeared to be more in response to feeling vulnerable and in a negative context rather than feeling supported, educated, in control and in a positive place. As they were not coping well with their menopause symptoms and feeling isolated their overall menopause experience ratings were low and yet they continued to state it wasn’t anyone else’s business and it was much easier to deal with the stigma by staying silent. These participants chose this option of silence and armour through their fear of vulnerability in the workplace. This was highlighted through their perceived lack of support if they did ask for help going on previous experiences. It was also influenced by expectations to be strong and not ask for help that could be both gendered and related to our national identity and a fear of dis-preferred identity (stereotypical mad woman).

That concern for vulnerability in the workplace is highlighted again as the participants consider their best option is to grin and bear it and suffer later through the development of a “coat of armour”. This armour is essentially the silence they have maintained to protect themselves.

Superordinate Theme 4: Desires for an Effective workplace (n35)

This theme identified by the participants revolved around what would make an effective workplace and what wouldn’t. Examples were raised about what an unsuccessful workplace should not be doing to or for their employees. To be an effective workplace for employees experiencing menopause this required reduction of the stigma attached to being menopausal through education, respect and knowledge. The workplace needed to acknowledge this experience occurred to women within their workforce and was part of their life course. The workplace also needed to find solutions to make it work for their employees and strategies that supported them. Then with all this support working well the employees needed to still have access to appropriate healthcare so they could continue to work. This included the correct diagnosis and medical intervention and support if required.

Subtheme: Unsuccessful, working practices and management (n25)

The first subordinate theme highlights examples of an unsuccessful workplace and what not to do if they are aiming to be supportive of their nurses. This included examples of how not to support your staff and what is occurring in the workplace that impacts on menopause symptoms negatively and finally where menopause affects the workplace negatively.

When providing support in the workplace, the organisation would need to take into account the needs of their nurses and the patterns of work such as shift work.

> *“Yoga at a time they can’t go”.* (P22, 43 years old).

P22 gave this example where the workplace had developed the idea of yoga but not at a time that they could attend. Any type of service or group needs to be accessible at a time for those that it would provide the most benefit.

P35 described their challenging situation as being ignored and unsupported in her workplace, which made it easier for people to deal with.

> *"not really I just had to get through it. I appreciate that I had a less common experience. but they coped by ignoring me...* [details redacted to protect anonymity]*. I had to get my own more comfortable chair, I had to adapt my work space, I had to make all of my appointments to get help, I had to take time off work because I was falling behind but I'm pretty sure they would have let me keep working until I dropped at work or had a melt down. I have become much better at advocating for myself but initially I was regularly fobbed off and ignored if I had any issues".* (P35, 51 years old).

This less common experience that this participant references was experiencing early menopause, where they did not gain workplace or healthcare support, or the correct diagnosis (identified in subtheme "Social & health care support is often limited") so they suffered with symptoms and lack of understanding. With a long list of symptoms, she describes the need for somebody to offer her guidance and support with some staff just walking away when she tried to describe what was happening.

In the workplace she had a list of items that could support her menopause experience such as the chair, adapting the desk and her workspace and then sourcing appointments for support. She identified ways and issues that they could support her with but as she describes she received no support from her workplace. Continuing to work under huge stressors and as stated potentially " *until I dropped at work or had a melt down*". This gave the sense of a total lack of care or responsibility of care in the workplace.

Her feelings of loss and isolation created the impression for her that she was crazy as she was far too young to be in menopause - detailed in the subtheme "Social & health care support is often limited". This left her with panic attacks and feeling suicidal at one point along with a long list of physical symptoms - detailed in the subtheme "Struggling with multiple symptoms". This was exacerbated by the complete lack of care and support she felt she received in the workplace. She stated she eventually worked it all out herself and took time off to see naturopaths and Doctors and now openly talks to colleagues so nobody else has this type of experience.

While support identified in the workplace is key to a successful work environment P20 raised the added feeling of vulnerability and isolation from their peers if they did ask for support, which was echoed elsewhere in multiple responses.

> *"While you support each other it must get a bit wearing for the other members when the same member is off form for so long".*
>
> *"Some of the newer members of staff still look at me oddly at times and are having to readjust to my coming back up to speed and full function".* (P20, 53 years old).

The lack of overall education for people can add to a misunderstanding of why women might be behaving in a certain way or needing a certain amount of support. While that needs to be handled with diplomacy and care it is also important not to isolate women with gender related inequities and treat them differently. The Silent Transition report detailed around three quarters of their sample as having menopause issues that affected their workplace which identified a large cohort of employees potentially needing support, education, and specific policies in place to offer support if required (NZIER, 2023). This support needs to be available if, and when women need it as P20 raised her concerns that she was already being seen differently due to her menopausal symptoms therefore making her feel unable to ask for help for fear of isolation.

Identifying the added stressors that the workplace can have on staff is important particularly for nurses already suffering from menopausal symptoms. Some nurses will opt to change their roles and reduce their level of stresses or change from shift work.

> *"I changed my role at that time which was very stressful".* (P21, 60 years old).

P21 describes the level of stress associated with changing roles right at the same time as going through menopausal symptoms at work and how much this added to her struggle at work. Suffering with anxiety, anaemia through heavy bleeding and ongoing fatigue added to this participants' daily menopause struggle then a bereavement and all these symptoms resurfaced.

Added stressors can affect menopause symptoms and make them worse and then affect the workplace (Rees et al., 2021). The participants responses showed that to be an effective workplace, healthcare organisations need to recognise that menopause is part of their employee's life course. The findings showed a lack of policies to support their employees or to help reduce the stigma associated with menopause. The participants detailed that access to the appropriate healthcare services is key to continued employee support ensuring the barriers to knowledge, diagnosis and support are removed.

Subtheme: Reducing stigma/acceptance (n9)

Reducing stigma for the participants was identified as important within their workplace to gain a sense of confidence when experiencing menopause symptoms. Participants often considered open communication and acceptance as part of the solution.

> *"I can't think of specifics but there should be education and support available within the workplace".* (P13, 56 years old).

By modelling acceptable behaviour towards their employees', workplaces could develop a positive and respectful culture where these participants would feel safe.

P28 agrees with this sentiment that older women need to be recognised and that menopause is a natural time and should be respected. This shouldn't be a problem or an issue for women but rather a normal time in a women's life, all experiencing it individually.

> *"showing respect and understanding that it is a natural time and value placed on our older women".* (P28, 54 years old).

Placing "*value*' on mature women particularly in a time when western society generally lessens their worth is an important culture change in workplaces. Noting the nursing workforce in New Zealand is over 90% female and over 40% of those female employees are over the age of 50 years (Te Kaunihera Tapuhi o Aotearoa/ Nursing Council of New Zealand, 2019). Therefore, understanding this transition in a women's life would be very important for supporting a large component of healthcare workers across New Zealand.

P4 agrees this identification of menopause and acknowledgement is required to actively support the nursing workforce.

> *"I am definitely keen to see menopause and peri-menopause acknowledged more in workplaces in general".* (P4, 48 years old).

With only 1% of the Silent transition survey participants identifying their workplace as having a menopause policy most New Zealand workplaces do not recognise, support or understand the economic, health, safety and wellbeing effects of menopause which has been echoed in these findings (NZIER, 2023).

Subtheme: Making it work at work (n32)

When the workplace was identified as making it work for their employees this involved solutions so that they could continue to do their jobs well. These solutions often involved colleagues and management being supportive and using humour to minimise the embarrassment.

> *"My peers are supportive to me and assist in some physical tasks without me asking them. I have told my head nurse. so far she has been ok about it".* (P13, 56 years old).

P13 details the positive experience she has had through her peers being supportive and assisting her with the tasks that could be difficult due to physical symptoms. She also identified the support from her manager which gives her confidence and ease to carry on with the struggle but with less stress knowing she has support.

> *"People are generally nice about it although I have mainly female colleagues and it's hard to know how it would go otherwise. As I make a joke of it - people just go along with it".* (P26, 49 years old).

Whereas P26 explains her positive experience could be because she mainly has female colleagues of which she assumes they have a comradery or sisterhood of understanding. The continued use of humour brings people into the experience with ease and light-heartedness and removes the stigma.

The participants recognised that menopause occurred at an age where physical work can be difficult and implied that to be a successful workplace recognition of the specific demographic needs of their workforce is required which can include reduced physical and cognitive ability.

"Women's health is NOT a priority in some of our Hospitals when we are about 70% of the workforce". (P21, 60 years old).

P21 raises this issue and links this to the statistics for nursing (Te Whatu Ora Southern has 77% female employees) highlighting the need to have an awareness as an employer that your workforce demographic is predominantly female. Part of being an effective workplace, particularly in healthcare, is recognising where your employees are in their life course e.g. menopause transition. It is important to recognise the physical and cognitive changes as the Silent transition report details in the New Zealand Health survey data where it confirms that this age group of 45-54 years shows a significant drop in self-rated health (NZIER, 2023). P21 raises the importance of recognising who your workforce is and if over 70% are female there needs to be relevant support provided to meet their specific workplace needs.

This is part of a wider recognition of needs that is required by workplaces. With nursing this included a large component of middle-aged women and their specific needs as highlighted by P22.

> *"I think there needs to be more recognition that a lot of the nursing workforce are middle aged woman and we are tolerating symptoms of menopause and just getting on with it and caring for others".* (P22, 43 years old).

Here she identifies an issue with *"tolerating symptoms of menopause and just getting on with it..."* echoing the previous subthemes of "Just get on with it" and "Unsuccessful, working practices and management". The issue where women are continuing to care for others in all aspects of their lives with limited concern for their own needs and with detrimental effects on themselves and their own health is being raised here. Women are placing themselves under a lot of stress and the demands on them are high. Due to women reducing their hours or leaving their roles due to menopause symptoms there is a negative impact on them and their employers (Dear, 2023b).

This subordinate theme also identified potential ideas on how the workplace could do better and make improvements such as suggestions from P11:

> *"Increase in paid sick leave*
>
> *Support and interventions to assist with workload*
>
> *Fitness and health support*
>
> *Paid leave*
>
> *Change in uniform policy to accommodate flushes".* (P11, 52 years old).

The uniforms were reiterated by other participants also. Suggestions such as reviewing the material and the design to give better breathability and provide ease of use when experiencing symptoms. Access to education, fitness, advice and support could improve the experience of employees. Along with the suggestion of paid menopause sick leave instead of using their normal sick leave allowance.

Where P21 opted for the access to specific health clinics for women within the workplace to provide ease of access while at work and the ability to see Doctors with the specific knowledge of women's health.

> *"Women's Clinics- for Staff".* (P21, 60 years old).

P10, included suggestions on the shift work options for nurses knowing the effects shift work can have on their bodies particularly when experiencing menopause symptoms. Being given the choice to work these shifts or not with clinical backing could provide many women with the autonomy to look after their health especially those who are the main income earner within their household and have limited option to change their roles or reduce their hours if required.

> *"Yes I think choice to do night shifts from 55 onwards / with support of your GP".* (P10, 49 years old).

Where P25 grew these further to incorporate equitable ideas on how we define sick leave so both males and females could benefit when applicable along with the acknowledgement the nurses' uniforms were not conducive to menopausal symptoms.

> *"Maybe the availability to have "health days" off as opposed to sick leave however this applies to all staff...not just female. Its more around changing the wording regarding sick leave.*
> *Again mentioning the uniforms -would be better to have breathable stretch fabric that don't overcook staff".* (P25, 52 years old).

P33 talks below of the normalization of menopause which can be achieved through support, education, knowledge, and the right help when it's needed.

> *"it is a normal life process, some people are affected more than others, and in different ways".* (P33, 52 years old).

She also raises the point that some are affected more than others and in "*different ways*" which is important when delivering this support and education. Therefore, any workplace response needs to recognise it isn't a one size fits all.

Subtheme: In wider context of good health care (n1)

Continuing with the positive and supportive workplace theme there is no point recognising that you have women as your primary workforce and having everything above in place that makes you a supportive employer if they cannot access appropriate healthcare such as GPs that understand menopause. The workplace needs to be part of the bigger picture.

> *"As previously noted I have always had gynae issues and my care and treatment since emigrating to Aotearoa in 2009 has been exceptional".* (P26, 49 years old).

P26 identifies when she has experienced excellent healthcare that has made her menopausal symptoms easier. By having access to appropriate healthcare which includes recognition, diagnosis, treatment, and medications the participants could know what they are experiencing, how to manage it and where to gain support. Without this a successful workplace would still not be enough to improve women's experiences overall.

Summary

This theme identified what a workplace could do to be successful at supporting its employees through menopause. By describing examples of being unsuccessful the participants shared their negative experiences and highlighted what could be done to improve this. Such as creating an awareness of what affects menopause in the workplace and how to support their employees while valuing mature women. This involved reducing the stigma through education, support, and knowledge for all employees. This transition stage is occurring for many nurses and their workplace needs to acknowledge that it is part of their life course and design ways to manage, support and provide guidance when necessary. Finally access to healthcare is key to ensuring all women are given equitable choices and strategies to managing their health while still being able to maintain a successful working life.

Superordinate Theme 5: Reaching a new stage (34)

The final superordinate theme is celebrating reaching a new stage through positive experiences; finding strategies that helped them reach this positive new stage such as reframing that experience to make menopause normalized; having knowledge and education; and having the right healthcare and support to reach this new stage.

Subtheme: Identifying strategies that worked for them (n16)

As there has been multiple symptoms identified in the preceding themes that the participants have had to manage, here I identify the multiple strategies these participants developed that worked for them to manage these symptoms. These included changing workplace roles, HRT and healthy living.

P23 started to re-evaluate their workplace priorities when they realized their menopausal symptoms were making it harder to complete their daily tasks.

> *"I find that a stressful day at work can tire me out more than it once did, and that my life and work priorities are changing, so I have had to do some work sorting out what I want my life to look like in the next 5 to 10 years. Because of this I have actually changed my job to one that is less stressful and busy, because I found it was becoming draining and I no longer enjoyed it".* (P23, 45 years old).

P23 describes how her workday is now more tiring and less enjoyable and therefore she has reviewed life and work priorities over the next 5-10 years. She decided to make changes to her workplace to reduce the stress and enjoy her life and work more. This was aimed at reducing the stress and finding a role that isn't as busy so she can enjoy what she is doing in her role.

Not many people would have the ability to easily change or reduce their roles due to financial restrictions and this decision would have been made with sacrifices. Finding the strategy that worked for her was to change her role in the end to something less stressful to take care of both her physical and mental health. The idea of changing their job when it creates less stress and is enjoyable for the woman is a positive strategy if that is the end experience for them.

Other strategies included medicines such as Hormone replacement therapy, anti-depressants or natural medicines that managed the symptoms.

> *"I did have intense anxiety last year after COVID that I put down to COVID but maybe it was perimenopause - I started a low dose SSRI which has been amazing and I find I am much more relaxed about life". (*P4, 48 years old).

P4 described her positive experience with selective serotonin reuptake inhibitors (SSRI) which helped her to feel more relaxed and gain control over her symptoms and her life. P4 describes the inconsistency in diagnosis though with Covid symptoms and anxiety. This could have occurred because there are so many potential symptoms related to menopause, and women often don't know them all and they can get attributed to other issues. Now that P4 reflects back it potentially wasn't Covid but rather perimenopause.

While P21 also had a strengthening experience through using anti-anxiety medication:

> *"I was commenced on small dose of anti-anxiety which help me to maintain health relationships with my family".* (P21, 60 years old).

Being able to maintain these *healthy relationships with family* is important as described previously particularly when needing social support in times of stress. Other medications were also mentioned as being positive strategies to manage menopausal symptoms such as the use of HRT. Both P8 and P39 gained full control over their hot flush symptoms which were described as so bad they carried tissues with them to wipe away the sweat. P8 describes her overall experience as reducing from a 9/10 (negative) to a 1/10 (positive) following the use of HRT.

> *"Now on HRT with patches and had reduced them to nearly nil".* (P8, 55 years old).
>
> *"Hence HRT was my choice. Never had a hot flush since".* (P39, 53 years old).

Having experienced such debilitating symptoms that affected daily life these two participants now regained that control and ability to function in their roles while being diagnosed correctly and receiving appropriate treatment.

Other participants took the natural remedy pathway with successful strategies being developed through diet and vitamins such as magnesium. This provided support for these participants to reduce the symptoms and also gain control back over their lives.

> *“” used to have hot flushes but since decreasing caffeine these are now manageable that I don't even notice I'm having them.”* (P19, 48 years old).
>
> *“Adapted lifestyle reduce caffeine etc., I take Magnesium at night and it helps me settle”. (*P21, 60 years old).
>
> *“I still get some residual symptoms- and some of the symptom control has helped and magnesium so I can have a good night sleep”.* (P21, 60 years old).
>
> *“ I may have experienced this a number of years ago, however at the time I wasn't aware that I might have been in the peri stage, so I started looking at diet and exercise as ways to manage the brain fog”.* (P25, 52 years old).

All three participants felt they had managed their symptoms through diet changes, exercise, or alternative medicines such as magnesium that aids in sleep. Having the knowledge and guidance on what natural remedy options they could attempt gave these participants opportunity for change and to reduce their symptoms sometimes with minimal changes to their diet.

Finally, some participants opted for lifestyle changes to develop management strategies.

> *“love getting into <u>outdoors</u>-climbing a hill and feeling of the <u>challenge”.</u>*

P7 (55 years) talks of being in the outdoors and the positive effects of this challenge through physical activity and the mental wellbeing that would induce. Women need to have options to access the type of strategy that suits them with such a variety of symptoms and a variety of responses to management strategies.

While P6 described being single as a positive as she was able to move to the “cool side of the bed” to manage hot flushes and night sweats. She could control her night-time environment without impacting on somebody else by throwing the blankets off and opening the window. This wouldn’t always be as simple for women living with significant others.

> *“Sleeping alone is a bonus. I can move to the cool side of the bed, strip off blankets, and leave windows wide open”. (*P6, 57 years old).

Identifying the strategies that work for them was key for these participants, in a context, where menopause is an individual/idiosyncratic experience. Having the education and ability to access the right support allows for choices and control. Control is what appeared to be missing in many of the participants examples of their menopause experiences until they found that strategy that worked specifically for them.

Subtheme: A new positive stage (n12)

The new positive stage explores being positive about menopause, accepting and managing menopause through constructing it as a time for change.

> *“I seem to have come out of this state now and have almost returned to normal function*”. (P20, 53 years old).

P20 celebrates the fact they have reached the other side of this menopause journey and are back at “normal function”. What that “normal” is for this participant could be different to others where some participants will accept “new normal” others will search for regaining that previous self. This participant lived with multiple cognitive issues that impacted on her daily life such as fatigue and memory loss where she felt at work that her team were carrying her during her menopause. Therefore, coming out the other end would have been a welcomed stage in her life to regain that feeling of independence and value back in her team. While dealing with multiple issues in her workplace due to her symptoms she didn’t know what to do or where to go for support. This new stage of coming out of the “brain fog’ was welcomed with tears and happiness once she realized how much it had been affecting her negatively.

Where P27 agrees that being over the “worst of it” is great and not havening to take HRT is something they were happy to have achieved. Identifying the end of their period as being a positive and not a negative is also important and potentially made more difficult because it is not a common thought in western culture (P. Briggs et al., 2023).P27 describes not having her period as a time of freedom potentially due to the costs and not havening to think of contraception.

> *“I think I am over the worst of it. Some people I know got HRT but I never considered that. /I am really pleased to not have a period anymore that is freedom!”.* (P27, 55 years old).

Whereas P28 had such a difficult time with menstruation she happily welcomed menopause as a time of celebration and freedom from the burden that her period had provided her.

> *“But, no regrets, and my menopause has been so welcome that I tolerate the symptoms with gratitude! After being a slim person all of my life, I now have 'middle age spread', but it could also be 'carb belly' because I love potatoes. I've gone up a few sizes in my underwear and I have to try things on, but these are not problems. Life is a series of changes and I'm going with (out) the flow. Auntie Flo, surfing the Crimson Tide, having the Painters in, Off PE week or On The Blob”.* (P28, 54 years old).

Here she celebrates her stages and the physical changes that are occurring in menopause with light-heartedness and humour. These changes are recognized as being a part of life and something she needs to accept and not turn into problems. She discussed being open, talking about symptoms, being respectful and valuing older women was the key things needed for managing menopause in the workplace successfully. She also described the importance for this generation to talk both within their workplace to support each other with menopause symptoms but also with their daughters about their periods and how to manage.

This new positive stage is recognised as being an individual experience which all women will interpret differently. Given the variety of variables that can impact on each woman's experience of menopause such as psychosocial, environmental, workplace, cognitive, physical, education and socio-economic to name a few then each interpretation and outcome will be different.

This stage of change can help women identify what they need at this point in their life and re-evaluating their priorities.

> *"…and has made me look at what I want from life and what I am willing to sacrifice (such as my well-being for work)".* (P23, 45 years old).

Here P23 stipulates that their experience of menopause which was negative at times helped them to decide what is worth their energy and what isn't. In an environment such as the workplace the effects were becoming negative, and she could identify that her well-being wasn't being taken care of. Her descriptions of how a tiring day at work tired her out more than it used to and gave her reason to re-evaluate her priorities were the catalyst for her making some decisions and changes in her life.

Part of this new experience includes reframing the experience as something normal, positive and manageable. They were learning to celebrate their bodies.

> *"Positives were also emphasised; hot flushes and a warmer body temperature meant you did not experience the cold as severely and no menstrual periods provided additional freedom (no more being caught without products)".* (P6, 57 years old).

P6 explains a novel idea on how to celebrate how her body produces hot flushes and allows her to keep warm. She also identifies the freedom of not having a period and the cost of products. While P27 looked forward to the end of menopause she also noted not knowing exactly when that last flush would be or when the move into "middle age" will occur was identified as being a loss. She celebrated the fact her body had carried her son which wouldn't have been possible without all of these biological processes such as her period.

> *"I look forward to the last flush but I won't know it's my last. A bit like my last period. I didn't know that was my last. In a way it is also a bit of a loss because you are moving into middle age. I am thankful my body was able to carry my son".* (P27, 55 years old).

Even after having experienced intense symptoms for over 10 years, she was thankful for this stage in her life while identifying it as a loss. Combining the joy at this stage of what her body has achieved over her life to the transition stage finishing with a sense of loss and change.

Subtheme: Having the knowledge (n15)

As many of the previous examples have shown most women do not always recognize their symptoms as being menopause related and neither do their healthcare providers. Technology can aid with delivering education, along with shared experiences across women but education is key in producing knowledge. By recognising their symptoms, the participants can potentially manage these and move through the transition stages more easily and with confidence and experience a good menopause by being informed.

> *"Because I knew what it was, no drama".* (P9, 49 years old).

P9 talks about being at ease with the knowledge of what she was experiencing and it not being a drama. This knowledge creates power and control for the participant. Even when she might not be able to stop the symptoms or improve them the knowledge of what is happening can produce this confidence. Having the knowledge to know what is happening to your body is key and then including access to and knowledge of the appropriate support.

> *"I found great support/relief when I fell over a podcast on menopause. It talked about this, and I felt that I was not losing my mind, but it was a part of menopause".* (P13, 56 years old).

Here P13 details one of the sources of education that they found which aided in their knowledge production and helped them to not feel they were '*losing their mind*'.

Knowing that her symptoms were part of menopause created a sense of acceptance and control. There is a wealth of appropriate education tools online that can support women to gain knowledge around menopause.

To create this knowledge takes appropriate and accessible education which is done in a way that it is not adding to gender inequities. As detailed below by P15:

> *"again, education. But how to do so in a way that it will not be made fun of".* (P15, 49 years old).

Education, workplace support and services are all required to manage menopause successfully. Yet this needs to be delivered in a way that doesn't add to isolation and gender-based inequities for women in the workplace making them feel targeted. While ensuring there are policies in place, education, awareness and management support this needs to be delivered in a way that empowers and engages rather than targets and isolates employees.

Sometimes this education comes in the form of books or websites and one book particularly recommended by respondents in particular being a well-known New Zealand book, Pelligrino's *Don't Sweat it* as described by P17 below.

> *"Have resources like the book "Don't sweat it" available to staff. It would help women understand menopause".* (P17, 48 years old).

P17 references this book and the need to have them and others available to staff to aid in their education. Considering these participants are working in a hospital having healthcare information readily available shouldn't be too difficult to manage.

Subtheme: Having the support & appropriate health care (n26)

Again, the differences between women's symptoms and how they experienced them would affect how they needed to then be supported. Some participants needed to talk to others such as a counsellor to gain knowledge and assurance. While others needed medical intervention such as medications. The need to understand that all women experience their symptoms differently and how this can be affected by many variables such as culture, social support, and stress is important when designing an appropriate response. The support and healthcare then need to be accessible to those participants. Those participants who had good social support systems tended to experience their situations more positively, even when their descriptions of symptoms appeared negative. These participants described having equitable access to healthcare and managing rather than struggling with menopause.

Talking with others and having shared experiences were described as key to keeping positive and feeling supported and not isolated. Examples included these types of positive social support situations that helped the participants to manage their symptoms. P4 and P5 both described their supportive families including being accessed through technology…

> *"I am grateful I have a very supportive husband who shares life with me". (*P4, 48 years old).

> *"Friends, religion and wider family via Skype".* (P5, 50 years old).

Where P18 and P 38 included their friends and family within their support.

> *"fantastic family support*
> *excellent friend support".* (P18, 55 years old).

> *"My mother.*
> *Most of my friends are younger than me so haven't had symptoms. But were supportive and a listening ear".* (P38, 48 years old).

Positive social support can help women manage menopause symptoms and stress in general. Whether if that social support comes from family, friends, or community groups. Having support is key to feeling connected. Keeping active, being involved in groups, feeling part of a community, and giving back to that community were also identified by P39 as being key to her effective social support system.

> *"I have extremely effective social support. Very involved in my local church, a connect group during the week and a women's 40s plus social group meeting*

> *approx once a month to do 'crazy' things, which I usually arrange. Plus I run a tramping group taking a group of good friends (up to 16 at a time) on great walks or other adventures twice a year. I also go to Uganda every second year being involved with an organization that supports orphaned and abandoned babies and children. This I live for". (*P39, 53 years old).

While this participant described severe symptoms occurring up to 15 times a day in her survey response, the supportive environment that she worked in aided her positive outlook even with additional family stressors. Social support can affect how women experience menopause and is known to affect both psychological and physical well-being where low social support can lead to illness and stress (Bauld & Brown, 2009).

Accessing shared experiences with others can also help in reducing that feeling of isolation as described in the next few examples where P6 identified having older sisters which helped her to gain in knowledge and support while their discussions normalized what could be discussed around menopause.

> *"I had older sisters to talk to where menopause and the symptoms were normalised".* (P6, 57 years old).

Where P3, P8 and P22 all had experiences with their friends and other women that provided them with support and guidance around HRT and symptoms ensuring they didn't feel alone in their own journey.

> *"Friends that talk openly about symptoms and HRT, made me realize early on there was no point in suffering". (P*3, 48 years old).
>
> *"often some women will say welcome to the club"!* (P8, 55 years old).
>
> *"I have friends of the same age so that helps to share the misery of peri-menopause".* (P22, 43 years old).

Even when they were sharing a "misery' it was still a shared experience and helping to turn it into a positive one. Discussions and communication aided in normalizing their experience.

In some situations, the participants required a little more than sharing with their family and peers such as counselling or specialists.

> *"did mention it to a councilor, as I was also dealing with grief.*
> *Was advised to be very careful and forgiving with myself. To par things back to the basics - nutrition, exercise, sleep".* (P20, 53 years old).

P20 talks of the importance of being kind to oneself especially when experiencing grief as trauma can affect menopausal symptoms also. Learning to focus on the things that are important to her such as nutrition and sleep so she can ensure optimal health while experiencing trauma and menopause symptoms. Stress can affect women's experience of menopause and impact on their symptoms. Early menopause has been associated with trauma such as posttraumatic stress disorder (PTSD) which is linked to dysregulated biological processes that could alter menopausal timing through reproductive system changes (Nishimi et al., 2022).

Finally, some participants required medical intervention and did find appropriate services in places such as the Oxford clinic in Christchurch.

> *"I went to a women's clinic in CHC and they were wonderful in providing some advice about symptom control".* (P21, 60 years old).

P21 describes her experience with this clinic and how they supported her with education and knowledge around symptom control. Having options for management of her symptoms gave back control and autonomy to this participant. She also discussed below the benefits of having access to a specialised service that could reduce the stress on a working woman who is also the main income earner in a household. If these symptoms can be debilitating enough that they can affect the earning capacity, then that stress can be increased.

> *"I think we need a 'health passport' that provides a women's clinic or a GP with an interest to provide support women who are trying to work full time, raising a family and when you are the main income provider-you need control or appropriate symptom management that has a interest and does not think that you are mad...". (*P21, 60 years old).

Where P26 described all of the gynaecological services she received since moving here from the UK have been exceptional. Having a lifetime of experience with gynaecological issues her comparison to overseas experience was positive for the New Zealand services.

> *"As previously noted I have always had gynae issues and my care and treatment since emigrating to Aotearoa in 2009 has been exceptional."* (P26, 49 years old).

Where P6 below also identified the benefit and importance of accessing preventative healthcare such as the annual GP visit they had attended overseas.

> *"I lived overseas where an annual GP visit is part of your health care and relevant life topics are discussed. Having regular access to preventative health in NZ may have provided additional resources for managing symptoms rather than struggling through". (P6, 57 years old).*

Preventative healthcare where women could access regular services is an idea being promoted in the UK as part of the regular cervical screening program. They are aiming to have menopause hubs where women access the specialists and gain knowledge before they reach menopause age. Therefore, increasing knowledge and reducing the effects on women, HealthCare, and workplaces (APPG, 2022). The idea of having access to healthcare information and guidance is discussed by P6 rather than leaving women to "struggle through" their symptoms unaided, uneducated and without support.

Celebrating and the normalization of menopause through confident management of their symptoms was how these participants created a positive experience. This was achieved through education, knowledge and effective strategies which included HRT and medication. Finally, the access to appropriate healthcare, support in their workplace and social support systems aided them to reach this new stage of management.

Summary

When these participants identified reaching a new stage, they were describing a positive experience that normalized menopause and sometimes re-evaluated their priorities based on their new needs. This included strategies that they had developed or discovered that helped them reach this positive new stage such as medicines, healthy living, and ways of dealing with menopause symptoms. Some participants even celebrated their bodies and looked forward to the menopause transition. An important lesson included that recognition was part of a good menopause because with the right education these women were able to recognize what was happening to their bodies and manage it. The right knowledge came in many forms with education through resources, health professionals, shared experiences, and social support systems. To reduce isolation, fear, and vulnerability, having access to the right support such as social or healthcare at the right time made a difference to these women's experiences. Education, knowledge, choices, and control were key to a positive experience along with good social support.

CHAPTER 9 - DISCUSSION

Through examining the lived experience of 38 nurses who had menopause symptoms while working at Te Whatu Ora Southern, this study produced an awareness of the lived experience of menopause at work addressing the key aims of this study. This study contributes to an emerging body of work being developed in New Zealand around menopause. To the best of our knowledge this study is the second of its kind to specifically look at the lived experience of nurses in New Zealand in a specific workplace. The aims of this study were:

- To gain a better understanding of the lived experience of nurses in their workplace (Te Whatu Ora Southern) and how they make sense of menopause.
- To explore the similarities and differences in these women's experiences.
- To identify ways that the women's wellbeing can be improved upon both for the individual nurse and the organisation.

The main findings address all of these aims and are summarized in this chapter and compared to previous research. Followed by the implications, strengths, limitations, and ideas for future research. Finishing with a comment about reflexivity and a concluding statement. The following identified themes have highlighted ways that a workplace can support their nurses who are experiencing menopause symptoms.

SUMMARY OF MAIN FINDINGS

The first superordinate theme identified the range of symptoms experienced with menopause and the struggle these created for the women in the study. This complexity of symptoms was exacerbated through lack of education, support and knowledge for these participants from their health professionals, workplaces and the community they worked and lived within. These struggles occurred within intersecting contexts of age, lifespan, work, gender, and culture where these participants were often working as unpaid carers in their homes and under variable amounts of stress which could impact on their physical and mental wellbeing. These findings addressed aims 1 and 2 of this study to gain a better understanding of the lived experience of nurses in their workplace and to identify improvements in the workplace. Participants spoke of limited education which created a vulnerability that left them with a lack of control over their own bodies and therefore their own lives.

In the second superordinate theme, participants described how difficult menopause symptoms radically undermined their sense of self, both at home and work. A challenge to their self and workplace identity had been created through the experiences with menopause which made it difficult for them to participate in their daily life or their workplace. The symptoms of menopause were presenting a challenge to these participants in how they felt they should be performing or participating in life. This included both cognitive and physical issues. They stated it restricted their ability to be a well performing team member and to participate in their everyday life with their family and friends. This addresses aim 1 of the study to understand how the nurses are making sense of their lived experiences in their workplace through the experiences they detailed in their responses.

The third superordinate theme described a strategy of keeping silent while trying to negotiate the stigma related to menopause. The participants continued to struggle through the variety of symptoms and developed management techniques such as wearing a “Coat of Armour’ to protect themselves from perceived vulnerability in the workplace and in their lives. Although they described not coping and experiencing negative situations, they continued to maintain this suffering in silence to keep their image protected of being competent and not appearing vulnerable. This added to their isolation, lack of education and ability to access suitable support. This was sometimes exacerbated through workplace environments such as fast paced clinics that left staff unable to remove themselves easily when experiencing vasomotor symptoms. This theme assists in addressing aims 1 and 2 of the study understanding the workplace experience and the similarities and differences that participants raised.

The fourth theme expanded on what the workplace could and should be providing these employees and how they experienced this. This included identifying the stigma related to menopause and removing it through education, workplace support and sharing of knowledge across team members. To be an effective workplace, participants stated that their organization needed to acknowledge who their workforce included and what their needs were such as having a large component of women who might be experiencing the menopause transition and understanding the economic effects on the workplace of not supporting these employees. Recognising menopause was part of their employee's life course. Which included a key component of having access to appropriate healthcare that would provide interventions and support employees to be able to participate in their workplace. This theme addressed all aims of the study aims from understanding their experience, the similarities and differences and ways to improve their organization.

The final theme was a celebration of reaching a new stage through positive experiences. The participants found strategies that aided them to manage their symptoms and were able to reframe their menopause to being a normalized experience. These strategies included education, knowledge and support which entailed healthcare access, workplace support, social support systems and shared experiences. From here, the participants were able to feel empowered, in control and more positive in general about their menopause transition. This helped to reduce the fear, isolation and vulnerability that had been created and gave them back control. The final theme addressed aims 2 and 3 through identifying differences and similarities in management techniques and identified ways a workplace can improve their environment and management for their employees.

HOW DOES THIS RELATE TO CURRENT RESEARCH?

The findings in this study support previous findings that menopause creates a stigma within the workplace (Brewis et al., 2017); that menopause negatively impacts the workplace for women (Dear, 2023b); and that most employers do not provide appropriate interventions to support women (Fawcett, 2022). This study showed examples of participants struggling with their roles or leaving positions due to menopause symptoms rather than seeking help. Fawcett (2022) identified similar findings of at least 10% of the menopausal women surveyed leaving their jobs due to menopause symptoms. Fawcett (2022) also found the stigma related to menopause often stopped their participants from sharing their status at work where 41% of women had seen menopause treated as a joke in the workplace.

The participants in this study had a range of responses from "*why would they share*" to they had shared but had been ignored creating mistrust and vulnerability often with a gendered inequality. The current findings supported previous research highlighting the stigma attached to menopause which is why women do not report their menopause symptoms at work or ask for help due to being questioned as being incompetent (Fawcett, 2022). Several participants in this study indicated their choice to manage their symptoms alone and not to ask for support raising the "*within-person contradictions of resilience/vulnerability"* described by Steffan (2021, p. 209) where their participants were hiding the negative effects of their menopause symptoms at work and suffering in silence similar to the internal identity conflict raised by some participants in this study.

Several participants commented that they didn't share due to fear of being treated differently with some having negative responses from colleagues and managers resulting in not asking for support again. While others that did share their experiences referenced their comradery in the workplace, the humour used and the fact they were fortunate if they had a female manager who was of similar age and assumed understanding of their menopause experience. Several participants stated they hoped they would be more supportive of their younger colleagues than what they had experienced.

As identified in previous research (Fawcett, 2022) the present study also demonstrated that women were changing their roles specifically to reduce the stress and physical strain on their bodies due to the menopause symptoms they were experiencing. These physical symptoms were sometimes exacerbated by the cognitive issues and several participants made the decision to leave the roles they felt were impacting on stress levels. Dear (2023c) showed 84% of participants being affected negatively by their symptoms; with 19% taking time off work due to symptoms; 6% of their participants had to reduce their hours and 4% had to change their roles which is not surprising when only 3% of their participants identified a menopause workplace policy. The Fawcett (2022) report showed 10% of women having left work due to menopause symptoms which included bullying and not believing their symptoms were real, which was reiterated in this study with examples such as early menopause not being believed by health professionals or management leaving participants feeling alone and isolated. These issues raised address aim 3 of the study through identifying issues within the workplace and lack of understanding or support. Participants discussed specific examples of management not engaging or offering support which would have improved their workplace environment.

The current findings also supported the NZIER research which showed there is a sense of not receiving the support needed from GPs (NZIER, 2023). It was noted in the Silent Transition report that only a few women who approached their GPs for support received hormone therapy where wāhine Māori have indicated they are prescribed other medications such as sleeping pills and antidepressants at a higher rate than other women (NZIER, 2023). The findings of this current study supported the NZIER (2023) findings with the participants describing issues around getting recognition that their symptoms were menopausal related and finding appropriate treatment. Both Dear (2023c) and the APPG report (2022) identified the lack in menopause education for doctors in both the UK and New Zealand medical school curriculums and along with the ongoing effects of the WHI report this lack of education and confidence to diagnose or prescribe is affecting women's healthcare (Carter, Jay, et al., 2021; Davis et al., 2021).

This study also maps onto the results from Davis et al (2021) who raised these issues of knowledge gaps for primary care providers in their study in Australia showing the uncertainty in prescribing MHT and use of CAMS in menopause treatment which resulted in highly symptomatic women and women with bone density risk not being treated. Studies in New Zealand, Australia and the UK highlight a lack of detailed knowledge about menopause amongst healthcare professionals that negatively shapes women's experiences of seeking help for menopause symptoms. This study supports these findings, showing how these nurses described incorrect diagnoses, lack of prescribing or treatment, long specialist waitlists and a sense of postcode lottery all creating inequities in healthcare for women.

A key issue women are experiencing is not being diagnosed appropriately including the lack of understanding, information and awareness about premature menopause such as Premature Ovarian Failure (POF) and Premature Ovarian Insufficiency (POI), yet it is becoming more common with it occurring for 2 in every 100 women under 40 years of age (NZEM, 2023). In this study there were examples of participants struggling with getting diagnosed with early onset menopause due to the fact Doctors assumed they were too young to be experiencing menopause and suffering with severe symptoms particularly while at work. They sought support through their GPs and their managers but were often misdiagnosed, unsupported, or even ignored. This supports the research showing a lack of understanding about premature menopause. Health professionals and workplaces need to understand the effects of menopause on women including onset of early menopause which can create additional risks for younger women.

Similarities between this study and others detailed in the literature review showed the wide variety of symptoms that the women managed (or didn't). These symptoms can be caused through the fluctuations in hormones whose receptors are located throughout the body and brain therefore the decline in these hormones affects the cells that the hormones influence resulting in a variety of experiences for each and every woman (Dear, 2023b). As was described in this study the participants were often not aware their symptoms were connected to menopause which aligns with the NZ Menopause sample where 64% also did not know their symptoms were related to menopause (Dear, 2023b). Steffan described the fear their participants felt due to self-navigation of the unknown which challenged their sense of resilience creating a vulnerability also represented in this current study where the participants felt fear and vulnerable and that their sense of self particularly at work was challenged (Steffan, 2021).

The physical and mental health affects reported in this study are similar to those detailed in the Silent Transition report which included industry specific comparisons that showed healthcare workers had more negative physical affects due to menopause (NZIER, 2023). While the current study did not contain comparisons with other workplaces it showed evidence of the physical effects of nursing such as fatigue, aching joints and cognitive issues all impacting on everyone in different ways. The nurses in this study reported experiencing a range of symptoms, these intersected with the role of nursing which required lots of interactions, shift work, a need for memory and cognitive functioning for tasks such as medications with the implications that if a mistake was made a patient's life could be affected.

The current study reported examples of social support and its positive effect on the menopause experience which was consistent with previous research detailing a correlation between positive social support and the ability for women to manage their menopause symptoms (Arnot et al., 2021). These examples included family, work colleagues, church, sporting teams and friends. As Bauld and Brown (2009) reported in their study positive social support, high EI and positive attitudes were linked to the severity that women reported their menopause symptoms. In general, the current study showed that social support aided in making the participants feel connected, supported and engaged so they could cope with and manage their menopause symptoms, and it points to the relevance of including this in workplace awareness. This addresses aim 3 of the study how the workplace can potentially support their employees with an awareness of the impact of social support.

As described in the analysis though there were some outliers where no amount of support would change the severity of some participant's experiences and interpretation of their symptoms. This could be due to the physiological symptoms being severe, the social context such as caring for young and old dependents who may also have physiological and psychological health issues creating a pressure one person cannot manage alone. The implications include needing to reduce the expectation for women to bear care responsibilities.

This study also showed those participants who reported high stress either within their home lives or within the workplace did show negative overall menopause experiences particularly when they didn't have any social support or workplace support. This double shift that was often described of caring for family in their day-to-day life then returning to a workplace where they also cared for people was displayed in the study. The results showed that those participants who had high levels of stress and good social support were generally coping better with their menopause symptoms. This demonstrated the important role that social support played in reducing the effects of stress. As described by Arnot et al., (2021) it isn't necessarily the stressor but rather the way the woman psychologically responds to it. This suggests that support to manage stressors would be useful, but this study also suggests this alone will not be successful. This is important to understand as this stage in life can be filled with stressors for women such as death, relationship changes and children leaving home.

Overall, this study has supported previous research findings including; that menopause has a wide variety of symptoms experienced individually by each woman (Dear, 2023b); these experiences can create challenges such as the internal identity conflict causing contradictions of vulnerability versus resilience (Arnot et al., 2021); that women experience difficulty receiving appropriate diagnosis, support and prescribing of HRT in Primary Care (APPG, 2022; Carter, Jay, et al., 2021; Davis et al., 2021; Dear, 2023b; NZIER, 2023) and inequity of access for specialist services (APPG, 2022); how stressors can affect how women experience menopause symptoms (Arnot et al., 2021); and that social support can improve this interpretation and management of symptoms (Bauld & Brown, 2009). These findings also supported previous literature which identified women leaving their roles due to the physiological and cognitive issues that menopause can cause (Dear, 2023b; Fawcett, 2022). This study included several participants that had changed roles to incur less stress or identified they would like to change roles given the psychological and physical effects they were enduring.

This study's findings are ensuring relevance for nurses working in hospitals in New Zealand and has developed the literature further by showing the need to understand the social context these nurses are living within. This current research specifically identified there is a need for organisations to reduce the stigma and offer appropriate support when needed without creating further gender inequity. It also raised the issue that while social support can potentially improve how women experience their menopausal symptoms it isn't always enough dependent on the social context.

The findings also included recognition of a positive change resulting in normalizing menopause by engaging confident management of symptoms through knowledge, education and effective strategies. These strategies included medications such as CAMS and HRT, and appropriate treatment. This also included workplace support and social support systems that allowed the women to reach this new stage of management. Participants celebrated their bodies, accepted and embraced the change, with the recognition of what was occurring through knowledge and education. This was a part of life which they were coming through the other end. While placing importance on talking and sharing of this knowledge with others.

STUDY IMPLICATIONS

The findings of this study provide relevant insight into what it is like for these female nurses working at Te Whatu Ora Southern during their menopause transition stage of life. The research involved a small sample size, so these findings are not generalisable. Given the predominance of older women in the nursing profession supporting women through menopause should be a priority. The main findings are: managing multiple symptoms so that everyone's experiences are different, which is sometimes hard to have these symptoms recognised as menopause either by the women themselves, or by their healthcare professionals. They have to manage the symptoms in a wider social context that has many demands on women of this age, that profoundly challenges their sense of self, both at home and their professional identity at work, creating fear and anxiety about stigma, that was often met with a strategy of keeping silent, which while it was damaging, it was also potentially strategic in a context where asking for help did not always end up in support. The respondents also identified changes that they wanted to see in the workplace that will be raised with nursing management at Te Whatu Ora Southern. Combined the implications are:

At work needing a recognition that this is happening; early education on menopause, so they know what to expect; actions to reduce stigma; recognising staff won't ask without being supported to do so; clear guidelines for how to support nursing staff and that support services meet their needs; including flexible working, comfortable working spaces and social support. The findings provide examples of the nurse's individual experiences and how the workplace environment and life stressors can add to what is already a challenging and demanding industry, particularly for a mature workforce which is growing in number internationally and should be valued for their skill and knowledge. Some of these findings will be presented to the nursing management team at Te Whatu ora Southern and will be considered for quality improvement opportunities. Several participants raised individual issues, and some raised general issues which could be used to improve the working environment. These included examples such as needing a menopause policy in the workplace or an approach to management that was supportive, provision of education to all, access to support and uniforms that breath.

Recognition of mature nurses' expertise and contributions to the profession are important to continued retention. This also includes a recognition of the potential impact menopause can have on a predominantly female workforce and how this demanding environment could impact on their specific, individual needs. This could be where management creates an awareness of that potential vulnerability with reduced mental and physical stamina but with a key acknowledgement that this does not reduce their value to the organization (Ryan et al., 2017). Over 40% of the New Zealand nursing workforce is aged over 50 years of age therefore to reduce the attrition and retain this wealth of knowledge and skill these nurses possess, employers need to acknowledge the potential for stress that these environments can produce including shift work and introduce flexible work practices such as part-time and remote when appropriate (Clendon & Walker, 2013). To reduce the potential workforce attrition that is being seen internationally and in New Zealand for nurses, workplaces need to review their scheduling practices and increase access to flexible and part time hours (Clendon & Walker, 2013).

The Silent Transition report, showed that there were specific industry differences for experiencing symptoms and in category 1 (includes construction, manufacturing, agriculture = male-dominated) the women experienced more cognitive issues such as brain fog and depression whereas category 2 (includes healthcare, retail education = female -dominated) experienced more issues with sleeping and fatigue which raises the issue of how certain workplaces can affect our experiences of menopause potentially worsening the symptoms we are experiencing (NZIER, 2023).

Finally, the current study has implications across the workplace where employers should be considering these stories of isolation, vulnerability, risk and fear. If nurses and other health professionals can read these stories and understand they are not alone in this experience, that there are options for support and education if they ask. Also, that the pathways of communication and support need to be improved. That health professionals need to provide that education, that workplaces need to introduce appropriate policies so their employees can feel safe and confident when they ask for help that this will be provided, and they will not be subjected to further stigma. As shown in these results women were searching for hybrid situations through changing roles or ceasing shift work only to find without the correct support from their employer this wasn’t adequate. Each participant had their own strategies and those that were successful usually maintained their work life balance with good social support, supportive management, and knowledgeable health professionals. This silent transition needs to be a little less silent.

Health settings require more training so they can recognise and treat it better.

The current study showed the need for more primary healthcare education on menopause. Particularly for nurses if they cannot get an appropriate diagnosis, they could be at higher risk of bone density issues being on their feet and in a physical role (Davis et al., 2021). The identification of inequitable access to services needs to be addressed where all women regardless of private health insurance or location should have access to the same services (APPG, 2022). The struggle would be heavily influenced by the level of burnout and the ongoing decline in the numbers of GPs across New Zealand so while an introduction of menopause training for graduates would be welcomed by the community this might add to the level of stress on this already stressed workforce (Dear, 2023b). An option to address this gap could be the specialist menopause clinics detailed in the APPG report recommendations (APPG, 2022) and the NZ Menopause survey (Dear, 2023b).

Wider cultural change/ more services so we're not relying on women to care for the vulnerable, or at least support services to support as women who care for the vulnerable in their family; and wider social change to challenge negative discourses of menopause, by sharing positive accounts /perspectives; providing opportunities for women to get social support**.** The study findings highlight the need for improving education particularly to peri-menopausal women with a focus on addressing the menopausal-related stress, promoting relaxation and exercise, encouraging self-regulatory strategies and improving negative attitudes towards menopause (Bauld & Brown, 2009). Social support and its positive effects on the participants were identified in multiple examples which reiterates what current research has shown. Whether that be support through social networks, accessing well-being services, church, sports groups, or in the workplace accessing supportive colleagues and management. Feeling part of something like a community, having positive influences in their lives including humour within the workplace to manage challenging situations all contributed to feeling equipped to manage menopause symptoms. Social support is known to have positive effects on women’s mental and physical wellbeing including during their experiences of menopause (Bauld & Brown, 2009). This study demonstrates the need for the workplace to ensure all employees have opportunity to access the social support that can aid them in creating positive effects.

The results in Table 3 (see Analysis) showed us what we would expect based on the current literature that the more social support a participant has access to the more positive their experience is. But it also tells us these patterns aren’t completely robust where some people with social support still had negative experiences and those without social support had positive experiences. This information can help to predict some outcomes so when an organisation is developing support within the workplace being aware that social support and stresses can impact on employees is important, but it will not always be enough to make the difference.

Stress levels was another key variable where the findings identified as contributing to how women were interpreting their experiences. Examples included responsibilities placed on them such as caring for elderly parents or children but also came from the workplace and the stressors of working in healthcare and at times with limited management support or healthcare provision. Nursing can be a challenging environment and a high stress industry. Understanding who your employees are and what their needs entail will be the first step for employers to provide safe working environments while recognising the value these nurses provide and designing strategies to retain them. Knowing that women often did not ask for support for their menopause related symptoms in the workplace due to feelings of vulnerability and isolation is important in changing this culture of suffering in silence and should be addressed by workplaces and also at a national policy level (Fawcett, 2022). Employers need to ensure access to appropriate support when required such as policies, management support and education for all staff.

STRENGTHS

This study is one of only two in New Zealand that has investigated the lived experience of nurses in a specific workplace. As detailed in the introduction it is filling a gap in research both in New Zealand and internationally through looking at the lived experience for this population. These findings could be used to develop support in the workplace for these employees. While this study investigated the experiences in one organisation that organisation, Te Whatu ora Southern, is large and has as variety of nursing roles giving a breadth of experiences.

A key strength in this study was the fact I began my own journey through perimenopause at the time I commenced researching. While I did not have face to face contact with the participants where I could have built a rapport through shared experience. I still felt this assisted me to understand and interpret the survey responses with a better understanding and empathy. I was concerned on one side that I didn't have enough survey responses with only 37 in such a short space of time to have the survey open but then I looked at the level of detail and analysis required and thought that was a large amount of data to analyse. The level of detail gave me confidence in the data.

As the object of this study was to research how the nurses experienced menopause at that moment in time it was important to use an epistemological standpoint informed by phenomenology and a methodology, being Thematic Analysis, that could gather data that represented their individual stories. Reflexive Thematic Analysis focused on the individual while exploring the recurring patterns in their experiences and their sense making. The use of an open and anonymous survey gave opportunity for these participants to share in a safe environment and was evident in the richness and complexity in some of the responses where the participants shared challenging and personal examples. Due to the data collection being a survey I was also able to combine some quantitative findings to create a rich understanding of the topic and meet the aims of this study.

STUDY LIMITATIONS- FURTHER RESEARCH

This study had several limitations. The survey questions were developed with my knowledge of the topic which came from a robust literature review and years of working within women's health. I also engaged with cultural consultation through Massey University. Although I had a lot of experience that was relevant to aiding me in developing the survey questions I would have liked to develop the survey from preliminary qualitative research through the focus group. However there was a delay in the ethics application being processed, therefore I had to remove that part of the research design completely. What that meant was while I still gained rich and useful data to address the aims of the study, suggesting the survey met its criteria and usefulness I won't know if there could have been other questions that I could have asked that might have tapped into some more specific organisational or cultural understandings that exist within Te Whatu Ora Southern (SouthernDHB).

While the advertisements were shared across all nursing teams and wards I couldn't be sure the recruitment wouldn't miss potential participants who didn't attend meetings, read noticeboards or didn't have access to the workplace computers and emails. By using multiple recruitment processes the hope was all potential participants would see/hear of the advertisements. Yet being a population that doesn't easily share in their menopause journey meant it could be difficult to gain their interest or trust which might be particularly so for Māori and Pasifika nurses who were under represented in the survey respondents. Having this specific target population detailed in the selection criteria and being an anonymous process aimed to minimise their fear and create inclusion.

While these results can be attributed to this specific workplace and improvement opportunities designed they might not be transferable to other workplaces. This highlights the need to do further research in other healthcare environments such as primary care or within other industries with high amounts of female employees.

The smaller sample meant the results could not be generalised and with little time to create appropriate relationships it was difficult to engage with meaning with Māori or

Pacific nurses in this environment. Future research needs to address this gap and develop further culturally appropriate investigations into the specific meanings for Māori and Pacific women's menopause journey.

In New Zealand there has recently been a development of menopausal action such as designing policies and creating workplace programmes. This movement needs to provide appropriate and culturally specific research and evidence first before identifying what the problems are. For example support services in an organisation should be developed alongside work on reducing the stigma otherwise some staff would advocate for the service but still not access it. New Zealand has a unique cultural composition, ideas and attitudes, particular industries and high amounts of small firms all of which will require specific solutions therefore solutions here require a local flavour (NZIER, 2023).

Some key thoughts and questions from my review of the survey responses included:

- Why were there some participants who didn't respond to the main questions?
- Did they not understand what the survey was going to ask them?
- No time to do the surveys as nurses are under resourced. Reflection of their work lives also- caring for others and not taking time to look after themselves.

WHAT HAVE I LEARNT?

I was enduring some of these symptoms- lived their experience with them therefore as described earlier I had to manage my own biases and beliefs through a reflexive journal, supervision and constant reflexive self-talk when analysing the data.

The use of the focus group was planned to engage personally with the participants and get them to co-design the questions which would have benefitted the design and also engaged more appropriately with the phenomenological framework. This was frustrating it could not eventuate yet with appropriate literature review, communication and conversations with relevant people the survey was designed with the epistemology in mind hoping to elicit the individuals' experiences and interpretations.

The process has been a journey, sometimes a difficult and challenging one to develop a substantial research project to respectfully identify important, but sensitive issues then join all of this together in a comprehensible identification of patterns, while recognising variety/ variation of those experiences. While not becoming lost in this process. The challenge was to keep all individual participants story alive in the study and to attempt to meet the aims at the same time while learning to use thematic analysis in the journey.

One key lesson I learnt was that not all women want to share their story. That some are already empowered and confident with their experiences and that giving them what I believed was power and control is creating a vulnerability and fear that could create gender inequities, it must be acknowledged and respected that this is their choice.

CONCLUSION

This study addressed the identified gap in literature on nurses lived experience of menopause in New Zealand. It has shown the stigma associated with menopause particularly in the workplace; the lack of education for healthcare professionals, managers and the women experiencing menopause symptoms; and the lack of support available and appropriate access to services when required. It also highlights the importance of recognising the life course that these women are situated in and how multiple factors can affect their experiences and outcomes including menopause symptoms. The health of menopausal women can be shaped by biological, social, psychological and physical processes, including the age of menopause onset being affected by social and behavioural factors and adverse childhood events (Mishra et al., 2023). This study included acknowledgement of the gendered vulnerability in the workplace; and an expectation for females to keep positive (Calder-Dawe et al., 2021) or silent about their problems.

These findings show the need for improved workplace support for nurses experiencing menopause to improve their retention and to acknowledge the valuable asset these nurses are to our healthcare system. The complexity of symptoms and variety of ways these nurses experienced these symptoms encourages a multitude of coping strategies. Understanding this complexity and recognising the current inequities are the first steps in providing nurses with a stigma free environment that offers them support if required and that doesn’t add to gendered inequities in that workplace.

Control, power, humour and choice are key to women’s autonomy over their menopause experience.

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APPENDICES

i. Adapted 15 Point Checklist of criteria for good Thematic Analysis (TA)
ii. Advertisement
iii. Ethics approval letter
iv. Participant Information sheet; consent form; webpage- survey
v. Transcript example participant 6
vi. Transcript example participant 21
vii. Transcript example participant 35
viii. Themes table example participant 22
ix. Codes and themes Table
x. Master Table
xi. Mindmap
xii. Cultural letter

APPENDIX A: ADAPTED 15 POINT CHECKLIST OF CRITERIA FOR GOOD THEMATIC ANALYSIS (TA)

PROCESS	No.	CRITERIA	HOW THE CRITERIA WAS ACHIEVED IN THIS STUDY
Coding	2	All data has been given equal importance when coding	The entire survey response was coded for each participant
	3	Coding thorough and detailed to ensure themes are not generated from a few key examples	Coding included the entire survey responses.
	4	All extracts for each theme were collected	Extracts were identified and applied to each relevant theme.
	5	Themes are checked against all the data and each other.	Themes were checked for agreement within the data set and across the whole data.
	6	Themes are internally coherent, consistent and distinctive.	Themes were repeatedly reviewed both against the overall data and then against each other. They were updated with each review.
Analysis	7	Data have been analysed – interpreted, made sense of – rather than just paraphrased or described.	The data were made sense of and discussed in chapter 9.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.	Clear examples are given in the findings, chapter 9.
	9	Analysis tells a convincing and well-organized story about the data and topic.	The themes identified reflect the participants experience and relate to the objectives of the study, see chapter 1.

	10	A good balance between analytic narrative and illustrative extracts is provided.	Chapter 9 includes a well-balanced example of analysis and extracts highlighting key concepts.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately without rushing a phase or giving it a once-over-lightly.	Adequate time was allocated to the individual phases allowing fluidity and review to ensure analysis occurred appropriately.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.	Thematic analysis assumptions are clearly described across the methods section including the individual approach to this study, see chapter 8.
	13	There is a good fit between what you claim you do, and what you done – i.e., described method and reported analysis are consistent with the epistemological position of the analysis.	The method and analysis are consistent with the phenomenological approach underpinned by a critical realist epistemology. The knowledge was developed by creating insights into people’s interpretations of their experiences while recognising social contexts having influence on interpretations.

Kia Ora, are you a female nurse aged between 40-60 working at Te Whatu Ora Southern with experience of perimenopause or menopause?

(Te Ruahinetanga)

If so, would you be interested in completing a qualitative survey to share your menopause experiences with a Master's student from Massey University?

Who can take part in this hui?

This study welcomes female nurses currently employed with Te Whatu Ora Southern, who identify as perimenopausal or menopausal who would be happy to share their experiences of menopause in their workplace.

Participants of all cultural and ethnic backgrounds are encouraged to take part. Participants would complete an online qualitative open survey.

They would need to fit the following criteria:

1. Identify as a female
2. Be between the age of 40-60 years
3. Be currently employed at Te Whatu Ora Southern as a nurse
4. Identify as perimenopausal or menopausal
5. Feel comfortable sharing some of the experiences you have had to date with menopause in your workplace through an anonymous survey.

When and where?

For online Survey access use the QR code above or follow this link; Survey on menopause in the workplace or type in this URL address; https://massey.au1.qualtrics.com/jfe/form/SV_1GGHKEeIXnQp0km

The online survey can be completed in July 2023. The link takes you to an anonymous survey. I will not know if you use the link. This is a qualitative survey which will include open- ended questions about your experiences.

I hope that participating in the study will provide you with the opportunity to share your experiences and that you will also gain some empowerment and a sense of community through that sharing. Please keep an eye out for a bowl of thank you treats in your work area or common areas for survey participants.

The project's findings will be condensed into a summary and a link will be shared on the hospital's notice boards for you to access. These findings will also be shared with the Nursing management team at Te Whatu Ora Southern to review for any potential improvement ideas across the workplace.
If you are interested in knowing more, please contact Sue Smith.

Researcher

Sue Smith. **Phone:** [redacted]. **Email:** Suzanne.Smith.15@uni.massey.ac.nz

MUHEC APPLICATIONS- Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 1, Application OM1 23/08. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 1, email humanethics1@massey.ac.nz.

APPENDIX C: APPROVAL LETTER

MASSEY
UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

15/06/2023
Dear: Suzanne Smith

Re: Ethics Application - OM1 23/08 - Nurses lived experience of menopause at their workplace.

Thank you for the above application that was considered by the Massey University Human Ethics Committee:

Ohu Matatika 1 at their meeting held on **Tuesday, 7 March 2023**
On behalf of the Committee I am pleased to advise you that the ethics of your application are approved.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand T 06 951 6841; 06 95106840 E humanethics@massey.ac.nz; animalethics@massey.ac.nz; gtc@massey.ac.nz

The lived experience of Menopause for nurses in their workplace.

Te Ruahinetanga

Kia Ora, my name is Sue Smith, and I am a postgraduate student who is completing a Master's of Science (Psychology) with a Health Psychology endorsement at Massey University. Part of my postgraduate qualification involves doing a research project. I have worked in healthcare for a long time, and I am interested in women's health, so I have decided to do my project on this topic because I hope that I can use this project to make a difference. I'm supervised by Professor Sarah Riley who also has a long-term interest in doing research on gender and health. I am also currently employed as a Quality Improvement Facilitator at Te Whatu Ora Southern, based in Invercargill.

The aim of this project is to better understand the lived experience of nurses' experiences of menopause within their workplace. There is a lot of research that counts prevalence rates of symptoms but very little that tells us what the experience is like for that person. For example, we might know how many women experience hot flushes at work, we don't know what it's like for the person who has them. I want to know what it's *like* for you.

What the survey involves: In this survey I'm asking you to think of moments at work that stick in your mind where the experience of menopause impacted at work. To do this, I have created a qualitative survey available to nurses at Te Whatu Ora Southern. A qualitative survey asks you open questions that invite you to describe your experiences of an issue. This survey will ask questions about issues that can affect menopausal women at work. For example, one question is

“Have you experienced brain fog related to menopause at work?”, if you have, you will be prompted to give details about what those experiences are like, how you manage them, if you feel supported by others, and what could be done differently that would enhance your work life.

The survey will also ask you a few demographic questions and give you an opportunity to share additional information. It will take about 45 minutes.

How I will manage your responses/data: If you complete the survey, your name will not be recorded, this means that no one – including me - will know that you participated or what answers you give. It also means that once you have submitted your survey you will not be able to withdraw your data from the study because I won’t know which answers are yours. If you do not wish to answer certain questions, then skip to the next one.

You may want to skip a question if it’s not relevant, if it would be distressing to answer, or if you simply do not want to respond. Menopause can be a highly personal and sensitive topic. In this project, I want to make this a safe and enjoyable experience for you. You do not have to answer any questions you don’t want to.

The anonymized survey responses will be kept for five years on a secure Massey University OneDrive accessible by my supervisor, Professor Sarah Riley, which is stored there in case my project is chosen for an audit which checks veracity of research project claims. If I seek to publish this research in an academic journal, I may need to share anonymized data. You will be given the opportunity to opt in or out of this.

Who will see the study reports: I will use the survey findings to write a report for my University as part of my studies. I may also send it to an academic journal for publication, to share this information with researchers interested in this topic. I will also write a summary report that I will share with Te Whatu Ora Southern. This summary report will include your suggestions for how things might be done better to support nurses at work when experiencing menopause symptoms. Participants will not be identifiable in any of these reports.

Who can participate: This project is part of my training and I hope that you would be interested in completing this survey and sharing your experiences with me if you meet the criteria below:

- You identify as female
- You are aged between 40 and 60
- You currently work as a Nurse for Te Whatu Ora Southern
- You identify as being peri-menopausal or menopausal
- You are willing to complete the online survey.

The next page will take you into the survey.

If you have any questions or queries regarding this project, please don't hesitate to contact the following:

Researcher

Sue Smith

School of Psychology

Massey University

Wellington

New Zealand

Email: Suzanne.Smith.15@uni.massey.ac.nz

Supervisor

Professor Sarah Riley

School of Psychology

Massey University

Wellington

New Zealand

+64 4 9793621

Email: S.Riley@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 1, Application OM1 23/08. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 1, email humanethics1@massey.ac.nz.

If you feel you have been given enough information about this study and are happy to fill in the survey, please select 'Yes' in the consent question/s below and then click the '**Next**' button below.

Because this survey is anonymous, I will not know if you have participated, and this will therefore not affect my relationship with you, if I have one.

If you change your mind, you may leave the survey at any time and your data will not be included in the study.

Completion and return of the survey implies consent.

CONSENT

There are two ways in which your data might be used for the study. First, I will analyse it and write it up in my report. Second, with your permission, I may be able to share the anonymized survey responses for other researchers to look at if this research is published.

i. I confirm that I want to participate in this study, this means that the information I have given in this survey will be part of the study, but that only summaries of the survey data or short anonymised quotes will be made public should this study be published (you need to say yes to participate in the study)

☐ Yes ☐ No

ii. In addition to the above, I confirm that I am happy for larger sections of my responses to be included in a supplementary data set made publicly available should this study be published in an academic journal (this is optional, you can say no, and still participate in the study)

☐ Yes ☐ No

What is your age?

Less than 40…Older than 60…

Workplace Do you currently work at Te Whatu Ora Southern?

○ Yes (1)

○ No (2)

Ethnicity Which of the following best describes you? (This information will only be used to describe the overall sample of people who respond to the survey, I will not use this information to interpret your individual responses in the survey). Ethnicity will only be included in the analysis if you include it as important when describing your experiences in the survey that follows.

o New Zealand European/ Pākehā (1)

○ New Zealand Māori (2)

○ Pacific Islander (3)

○ Asian (4)

○ Other (5) ____

○ Prefer not to say (6)

○ Don't know (7)

MENOPAUSE AT WORK SURVEY

The survey now follows. **Thank you for agreeing to complete this survey.**

Please answer all the questions honestly. Remember that your responses are anonymous. There are no right or wrong answers to these questions.

The following survey has been informed by a literature review and previous discussions with staff at Te Whatu Ora Southern. If you have any additional suggestions or experiences, you would like to share please add these at the end.

1) Have you experienced brain fog related to menopause at work?
   Please say what it's like in general for you, and then give us the details of a specific example. What were you doing; what happened; what did you think?

   1.1. Did you tell anyone else at the time or ask for help, and if so what happened? ? What did other people around you say or do? What would you have liked them to have said and done? When responding to the questions please do not write down people's names but rather use their roles e.g. head nurse, peer, friend.

   1.2. If you didn't tell anyone why not?

   1.3. What kind of support would you like your organisation to offer you if you were to have this experience again? What was the outcome for you at work; did you seek support in any other way.

2. Have you experienced hot flushes related to menopause at work?
   Please say what it's like in general for you, and then give us the details of a specific example. What were you doing; what happened; what did you think?

   2.1. Did you tell anyone else at the time or ask for help, and if so what happened? ? What did other people around you say or do? What would you have liked them to have said and done? When responding to the questions please do not write down people's names but rather use their roles e.g. head nurse, peer, friend.

2.2. If you didn’t tell anyone why not?

2.3. **What kind of support would you like your organisation to offer you if you were to have this experience again?** What was the outcome for you at work; did you seek support in any other way.

3. Have you experienced any other symptom related to menopause while in the workplace? What was it? Please say what it’s like in general for you, and then give us the details of a specific example. What were you doing; what happened; what did you think?

3.1. **Did you tell anyone else at the time or ask for help, and if so what happened?** ? What did other people around you say or do? What would you have liked them to have said and done? When responding to the questions please do not write down people’s names but rather use their roles e.g. head nurse, peer, friend.

3.2. **If you didn’t tell anyone why not?**

3.3. **What kind of support would you like your organisation to offer you if you were to have this experience again?** What was the outcome for you at work; did you seek support in any other way.

4. Please describe your overall experience of menopause - scale 1-10.

Likert scale 1 good------10 bad

5. Please describe what that’s actually like for you e.g. 10= why/ how did that shape your experience?

6. Research shows that menopause transition occurs at a time in life when many other influences could be stressors for women- changes in career; still paying off mortgage; caring for elderly parents; dependents at home or dependents leaving home.
   Please tell us what your life circumstances are like and if that’s shaping your experience of menopause?

7. Research suggests social support makes a positive difference to women’s experience of menopause. Social support could come in all sorts of ways such as;
   - Immediate or wider family
   - Cultural identity
   - Religion
   - Friends.

Please describe if you have effective social support and where you get this from?

8. Is there anything about living in Aotearoa New Zealand that shapes your experiences of menopause at work?

9. Do you have any other improvement suggestions you would like to share for the workplace in supporting women experiencing peri-menopause or menopause?

Potential discomfort or risks to participants:

If in the process of responding to the survey you feel that you would benefit from speaking with somebody, you can find further support at the following services:

- 1737; https://1737.org.nz, free call or free text 24 hours. Brief 1:1 counselling service.
- Lifeline Aotearoa; 0800 543 354, Text 4357, https://www.lifeline.org.nz
- Vitae counseling service; Phone 0508 664 981, Employee Assistance Program- Counseling for Te Whatu Ora employees

Thank you for taking the time to fill out this survey ☺️

Please click on the '**Submit**' button to close the survey and record your responses.

Ngā mihi

Sue Smith

MUHEC APPLICATIONS

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 1, Application OM1 23/08. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 1, email humanethics1@massey.ac.nz.

APPENDIX E: TRANSCRIPT 6

Key words	Question	Transcript 6 57 years Overall= 3	descriptive codes	Interpretative/themes
	1.1			
	1.2			
	1.3			
	1.4			
Isolation PPE hot flushes difficult	2.1	I found it very hard going into isolation rooms with full PPE on. I would find I was sweating profusely behind my glasses and the face shield causing things to fog up and then having to attempt to finish the tasks at hand or leave the room to remove the PPE and "start again". The addition of face masks when having hot flushes makes things more difficult. Working in summer in wards that are not air conditioned is hard- i worked out where the fans were to cool off while the hot flushes subsided.	Healthcare is not a supportive environment	Desires for an Effective workplace - Unsuccessful working practice and management

	2.2			
manage	2.3	I felt it was something I had to manage.	Suffer in silence	Coat of armour
	2.4	My symptoms are improving so I can manage better in full PPE. /During that time, I am not sure what else could be done.	Experiencing symptoms of menopause at work Suffer in silence	Complexity - Struggling with multiple symptoms Coat of armour
	3.1			
	3.2			
	3.3			
	3.4			
Sisters normalised positives freedom	5	I had older sisters to talk to where menopause and the symptoms were normalised. Positives were also emphasised; hot flushes and a warmer body temperature meant you did not experience the cold as severely and no menstrual periods provided additional freedom (no more being caught without products). /I also had mood swings related to my period that	Shared experiences- knowledge Positive outlook	Reaching a new stage- Having the support & appropriate health care Reaching a new stage – positive stage

		were a lot worse than any of the peri-menopausal symptoms.	Managing menopause	Complexity - Struggling with multiple symptoms
	6	Sleeping alone is a bonus. I can move to the cool side of the bed, strip off blankets, and leave windows wide open.	Dealing with it	Reaching a new stage- Identifying strategies that worked for them
	7	Positive support that included older sisters and friends	Shared experiences-knowledge	Reaching a new stage - Having the support & appropriate health care
	8	I lived overseas where an annual GP visit is part of your health care and relevant life topics are discussed. Having regular access to preventative health in NZ may have provided additional resources for managing symptoms rather than struggling through.	managing rather than struggling	Reaching a new stage - Having the support & appropriate health care
	9			

APPENDIX F: TRANSCRIPT 21

Key words	Question	Transcript 21 60 years Overall= 8	descriptive codes	Interpretative/themes
Drained healthy relationships	1.1	Feeling drained when you get up to go to work Maintain healthy relationships with loved ones can be challenging with labile moods	Experiencing symptoms of menopause at work Relationships challenging	Complexity - Struggling with multiple symptoms Challenging to identity- self
advice	1.2	I went to a women's clinic in CHC and they were wonderful in providing some advice about symptom control	Equitable access to healthcare	Reaching a new stage - Having the support & appropriate health care
	1.3			
support	1.4	I think we need a 'health passport' that provides a women's clinic or a GP with an interest to provide support women who are trying to work full time,raising a family and when you are the main income provider-	Equitable access to healthcare	Reaching a new stage - Having the support & appropriate health care

		you need control or appropriate symptom management that has a interest and does not think that you are mad...		
adapted	2.1	I was commenced on small dose of anti-anxiiety which help me to maintain health relationships with my family Adapted lifestyle reduce caffeine etc., I take Magnesium at night and it helps me settle	Medication protects from symptoms	Reaching a new stage-Identifying strategies that worked for them
difference	2.2	They could see that I was unwell-Had very heavy bleeding and became anaemic corrected that with Iron and people noticed a difference in my level of being active	Medication protects from symptoms	Reaching a new stage -Identifying strategies that worked for them
	2.3			
	2.4	Women's Clinics- for Staff	Supportive team/ management make symptoms manageable	Desires for an Effective -workplace- Making it work
	3.1	It is a marathon not a sprint	Supportive team/ management make	Desires for an Effective workplace -

			symptoms manageable	Making it work at work
	3.2	Yes, eventually		
	3.3			
changed	3.4	I changed my role at that time which was very stressful	Healthcare is not a supportive environment	Desires for an Effective workplace - Unsuccessful working practice and management
	5	I still get some residual symptoms- and some of the symptom control has helped and magnesium so I can have a good night sleep	Medication protects from symptoms	Reaching a new stage - Identifying strategies that worked for them
	6	*BEREAVEMENT* – (REDACTED SPECIFICS TO ENSURE ANONYMITY) which was a shock and a lot of symptoms resurfaced	Stress affects our experience	Occurring in wider context
supportive	7	Immediate family support and very supportive husband	Social support strengthens	Reaching a new stage - Having the support & appropriate health care

	8	Women's health is NOT a priority in some of our Hospitals when we are about 70% of the workforce I took myself to CHC to attend a well structured menopause clinic which we should have in Invercargill	Health not a priority Equitable access to healthcare	Desires for an Effective workplace – Making it work Reaching a new stage - Having the support & appropriate health care
	9	Allow staff to have flexible working arrangements Provide clinics for women to attend- so they do not think that they are going out of their minds My priority was to preserve my relationship with my children- as I was on a emotional roller coaster Need Menopause Support Groups	Supportive team/management make symptoms manageble	Desires for an Effective - workplace Making it work

APPENDIX G: TRANSCRIPT 35

Key words	Question	Transcript 35 Years 51 Overall= 10	descriptive codes	descriptive codes round 2 (bringing similar codes together under one code)	Interpretative/themes
Ability loss	1.1	I had a long period of time where my brain hardly worked at all, I would stare into space for long periods of time and lose time fell behind in my paperwork. I didn't really think, I didn't really know what was happening, but I knew it wasn't right...I didn't really have the ability to do much about it and no one really noticed or just thought I had become grumpy....and avoided me. I also have ongoing loss of words. I used to be quite (oops I lost the word, moving to google to look it up) eloquent (it came back before I got to google)	Workplace is adding to cognitive issues & it's embarrassing.		Desires for an Effective workplace - Unsuccessful working practice and management

Oops functions	1.2	I usually say oops I've lost the word, I can often describe what I mean and we will come up with the word or I will look it up on google. or just carry on. I am the youngest person in my team so they know what I am going through and are supportive. the brain fog and loss of functioing was not really picked up on and I just did my best to get through the day. I could have really done with some direction.	Experiencing symptoms of menopause at work Supportive team/ management make symptoms manageable Education is power		Complexity - Struggling with multiple symptoms Desires for an Effective workplace - making it work Reaching the new stage - Having the knowledge

Supportive avoided	1.3	I didn't tell anyone about my brain fog at the time because I could hardly function. I needed someone to approach me in a supportive manner. but it was just avoided. I knew I wasn't doing my work but I was doing the best I could.	Suffer in silence		Coat of armour
Openly uncomfortable	1.4	I worked it all out myself. I had to take some time off work and see Dr's and naturopaths. I talk about it openly now as I don't want anyone else to come into this and be ignored. I know it is an uncomfortable subject but we can't ignore it forever.	Supportive team/ management make symptoms manageable Dealing with it		Desires for an Effective workplace - making it work Reaching a new stage - Identifying strategies that worked for them
panic	2.1	often in meetings or sitting talking with clients and their families, my worst ones were at night so I couldn't get any sleep. I moved my chair so I was next to a window and	Workplace is adding to cognitive issues & it's embarrassing.		Desires for an Effective workplace - UnSuccessful management is not

		wore layers and natural fibres. I would stop and be quiet for a minute while it passed. there was always a sense of panic and you would have to remind yourself that it was fine and breathe through it.	Menopause affects my everyday life negatively Healthcare is not a supportive environment		locating it in their context Challenge identity-self Desires for an Effective workplace - Unsuccessful management not situating in context
experiences	2.2	people would notice and comment have a bit of a laugh or tell stories of their own or family members experiences.	Shared experiences-knowledge		Reaching a new stage - Having the knowledge
	2.3				

	2.4				
Hangry Panic attacks	3.1	I developed arthritis and aching joints. I got "hangry" I generally became more irritable and became less of a people pleaser. I became less tolerant of men and their poor excuses in general. I developed cystic acne. I have significant signs of osteopaenia. my blood pressure has increased and my overall ability to manage stress is reduced. I have put on 18kg in a short period of time despite eating nutritiously. I had panic attacks in the early phase and took antidepressants because I became suicidal overnight (my life was great but I became suicidal)	Experiencing symptoms of menopause at work		Complexity - Struggling with multiple symptoms
Avoided intervention	3.2	I had to take some time off work. people avoided me and told me I didn't know what was happening to me and it would be alright...it wasn't at the time...it was eventually but I needed intervention	Workplace is adding to cognitive issues & it's embarrassing.		Desires for an Effective workplace - Unsuccessful management not situating in context

			Menopause affects my everyday life negatively		Challenge to identity-self
Overwhelmed bounced	3.3	I didn't tell them about my severe symptoms because they became overwhelmed and sometimes even walked away if i started to talk about how I was actually feeling. I have a vivid image of my service manager popping in to see if I was ok when i returned to work and when i didn't act all happy and pleased about life her bum literally bounced off the seat and she left	Navigating alone		Complexity - And where social & health care support is often limited
encouraging	3.4	Im not sure what they could maybe just encouraging me to look after myself and being practical	Supportive team/ management make symptoms manageable		Desires for an Effective workplace - making it work

Bat-shit crazy	5	I went "bat-shit" crazy for a while and then overtime I have found solutions and navigated the changes, things are alot better now but I have pretty much had to navigate it on my own	Navigating alone		Complexity - And where social & health care support is often limited
No stressors	6	I had a 10month that I was breast feeding and 4 yo child with undiagnosed neurodiversity problems, I had just moved into our new house. No financial stressors I got a glandular fever type virus and was physically unwell for quite some time and went into menopause during it.	Stress affects our experience		Occurring in wider context (life span, gender or other stresses) – That often linked to the wider caring role (recontextualising that nurses are carers)

STOIC Strangers supportive	7	I had my mother but she had no significant problems with her menopause and she is very stoic and was a SAHM so her solution was just stop working, your life is too stressful and your body is telling you that. the naturopath was very supportive. random strangers in the street were more supportive than friends and family. I only hope that I am more supportive to my sisters when they go through it.	Stress affects our experience Healthy living / alternative medicine can protect Shared experiences- knowledge		Occurring in wider context (life span, gender or other stresses) – That often linked to the wider caring role (recontextualising that nurses are carers) Reaching a new stage- Identifying strategies that worked for them

					Reaching a new stage- Having the knowledge
acknowledge	8	the GP's seemed to be very behind in the knowledge they have available to them about menopause and women's health in general./ my GP had the grace to acknowledge that he didn't know much about menopause and I then made an appointment with the Oxford clinic privately through Southern Cross. I had to suggest to the GP that I go on HRT they didn't identify any of my issues as being menopausal	Lacking healthcare		Complexity- Social & health care support is often limited
Melt down advocating	9	not really I just had to get through it. I appreciate that I had a less common experience. but they coped by ignoring me...(REDACTED-SPECIFIC WORKPLACE DEPARTMENT) I had to get my own more comfortable chair, I had to adapt my work space, I had to make all of my appointments to get help, I had to take time	Healthcare is not a supportive environment		Desires for an Effective workplace - UnSuccessful management is not locating it in their context

		off work because I was falling behind but I'm pretty sure they would have let me keep working until I dropped at work or had a melt down. I have become much better at advocating for myself but initially I was regularly fobbed off and ignored if I had any issues.			

APPENDIX H: THEMES TABLE EXAMPLE PARTICIPANT 22

Superordinate themes	**Subordinate themes**	**Examples/extracts**
Theme 1 Struggle and fear and vulnerability	Subtheme 1 Symptoms are multiple and interacting	Yes, I feel like I do <u>experience</u> mild brain fog.
	Subtheme 2 Fear of them getting worse	I think that I only have <u>mild</u> symptoms and there is <u>worse</u> to come yet.
Theme 2	Subtheme 1 Seems to me about not being the person they think they should be.	Symptoms interfere with work and sense of self at work (embarrassing, I'm on charge nurse (I should be better), I want to be active with my teenager but I

Challenge to identity, (& associated stress and anxiety)		can't, *millions* of bits of paper) .
	Subtheme 2 Same as above, but specifically about career prospects	I should be top of my game, I should be going up the ladder (but I'm not)
Theme 3 Desires for an effective workplace	Subtheme 1 Making it work	Successful management is acceptance, communication, education and a team effort
	Subtheme 2 UnSuccessful management is not locating it in their context	Yoga at a time they can't go **Negative correlation between work and menopause** where workplaces can affect the symptoms of menopausal symptoms through adding

		to physical and mental stress therefore making the experience worse
	Subtheme 3 Making it work – Life Course	Nurses are middle-aged women (therefore likely to have menopause) (as middle aged women) Nurses are caring in multiple ways (and have additional burdens, for example, caring for family at home)

APPENDIX I: CODES AND THEME TABLE

THEMES	SUB THEMES	CODES	CODES
Negotiating the complexity	Struggling with multiple symptoms	Experiencing symptoms at work	Struggling with multiple symptoms
		Menstruation worse than menopause	
	Fear of getting worse/unknown	Fear of them getting worse	Struggling with menopause
	Occurring in wider context (life span, gender or other stresses) – That often linked to the wider caring role (recontextualising that nurses are carers)	Caring for others	No social support creates a domino affect

		Stress affects our experience	
	Social & health care support is often limited	Navigating alone	Lacking healthcare
		Shared negative experiences	
Challenge to identity	Challenge to identity - self	Menopause affects my everyday life negatively	Relationships challenging
	Challenge to identity - work	Workplace stress can affect menopause	Symptoms affect work
		Menopause can affect the workplace negatively	
Coat of Armour	Just get on with it	Suffer in silence	
	Kiwis don't	Cultural differences in behaviour	
	Not anyone's business	My business	

	Negotiating stigma through silence	Negotiating stigma	Sharing creates vulnerability
Desires for an Effective workplace	Unsuccessful, working practices and management	Workplace is adding to cognitive issues	
		Menopause can affect the workplace negatively	
		Healthcare is not a supportive environment	Why would my workplace help
	Reducing stigma/acceptance	Create systems at work to manage cognitive issues	Reducing stigma
			Education of health professionals
	Making it work at work (solutions for the workplace to enable staff with	Supportive team/management make symptoms manageble	Health is not a priority

	menopause to still do their jobs well)		
		Use of humour	
	In wider context of good health care	Positive healthcare experiences	
Reaching a new stage	A new positive stage (and positive evaluation of it)	Constructing menopause as a time for change	Managing with menopause
		Getting on with it	Use of humour
		Positive outlook	Celebrating my body and positives
		Normalising the experience	
	Identifying strategies that worked for them (As there were multiple symptoms the women found multiple strategies	Medication protects from symptoms	Healthy living alternative medicine

	that worked for them- includes changing jobs, HRT, healthy living. In the example of a woman changing their job it highlights how it's a positive strategy- if it added stress it wouldn't be)		
		Dealing with it	
	Having the knowledge	Education is power	Technology can help support
		Recognition part of a good menopause	
		Shared experiences- knowledge	

	Having the support & appropriate health care (different needs and experiences means different types of support needed- e.g. some needed to just talk with others and gain knowledge while others needed counselling)	Equitable access to healthcare	Shared negative experiences/ shared experiences/ shared education
		Technology can help support	Social support strengthens
		Managing rather than struggling	

APPENDIX J: MASTER TABLE

Superordinate theme	Subordinate theme	Extract/ examples from transcript
Negotiating the complexity (n 37)	Struggling with Multiple symptoms (n33) DESCRIPTION [Multiple symptoms across life that are not always identified]	*My memory is not as sharp as it once was but no specific examples sorry. Sometimes I just forget the word I am looking for.* (4) *Sleepless nights. Brainfog. Emotional overthinking and anger outbursts that aren't normal for me. Feeling more aged.* (5) *Lack of sleep. I can average around 3hrs of sleep slme nights* *Emotional outbursts (5)* *Then also being told that you are too young (41yrs at the time of first symptoms) and not to over think symptoms. So then you think you just might be going crazy, cause blood tests come back in normal ranges!! (38)* *i was having terrible hot flushes where i had to carry around tissues to mop up face, it was hard wearing masks as well. They could happen at any time and the most horrible place is in a meeting. i am now on HRT and have minimal flushes (18)*

		Yes all the time! One example is when I was scrubbed in theatre (happens frequently). It is very uncomfortable but you have to push through and try to ignore it. Obviously the patient comes first along with the procedure (32) *…talking with a family , discussing breast feeding and then an overwhelming rush of heat surges thru your body and you become sweaty and clammy - and my face perspired , I felt like the family might of thought I had had a big night out (37)* *Just feel my joints aren't as good as they were, but have since found out one leg is shorter than the other inner soles adjusted have made a world of differnce. Keeping more active has helped. Poorer sleep quality, mild anxiety at times . Hot flushes have essentially gone. Migraines which I only had every few months have gone. (10)*
	Fear of getting worse/unknown (n5) DESCRIPTION (fear of the unknown – don't have information or diagnosis or an idea of what might occur as	*I think that I only have mild symptoms and there is worse to come yet.* (22) *I have not done anything that might jeopardize patient care, but I do worry that as I get more into menopause that I could. (23)* *I feel I have experienced minimal symptoms, after 2 months I had another period - recently, so I guess I restart my countdown. (25)* *have heard that these symptoms can pass or resolve for some women and I am hoping that this will be the case for me, too. I wonder if supplements or vitamins will help.* (15)

	this is so individual- but also fear of not knowing where to get help)	
	Occurring in wider context (n25) DESCRIPTION (life span, gender or other stresses) – That often linked to the wider caring role (recontextualising that nurses are carers)	*Married with 3 children in early 20s who are at varsity/working forging ahead in life. 1 currently living at home, with prospect of all being back home next year. Elderly parents with recent health issues-requiring me to go out of town to look after them. (7)* *HAVING CARE RESPONSIBILITIES FOR MULTIPLE GENERATIONS, BOTH MOTHER AND FATHER WHO HAD MULTIPLE HEALTH PROBLEMS, INCLUDING CANCER, DEMENTIA AND HEART PROBLEMS; AN ADULT CHILD WITH SEVERE MENTAL HEALTH PROBLEMS, AND GRANDCHILDREN ALSO NEEDING SUPPORT - (*REDACTED SPECIFICS TO ENSURE ANONYMITY) - *Started new role in management 3 years ago, with extreme limited previous experience. (19)* *My Dad passed away just before my symptoms started.* (13) *Majority of family overseas* *Mortgage payments* *Cancer history this caused surgical menopause.* (11) *BEREAVEMENT- (*REDACTED SPECIFICS TO ENSURE ANONYMITY) *which was a shock and a lot of symptoms resurfaced (21)*

		Life circumstances have changed quite a bit in the last two years, because my husband and I moved abroad and thats been a huge change. On top of that we recently bought a house and I changed my job, so its been a stressful couple of years (23) *I have 2 teenagers at University and 1 still at home. (4)* *Grief after the death of my mother and the responsibility of caring for a father with dementia for three years before he went into care.* *With this the move home to care for elderly parents. (20)* *I had a 10month that I was breast feeding and 4 yo child with undiagnosed neurodiversity problems, I had just moved into our new house. No financial stressors. I got a glandular fever type virus and was physically unwell for quite some time and went into menopause during it. (35)* *I guess a big one only was husband being diagnosed with ADHD 2 years ago but with his treatment has probably helped my situation and explained the previous 20 yrs! Menopause explains my wild outbursts but the deeper reason was finally discovered.* (39) *I had a change in career pathway -off the floor nursing and now into management...managing a ward and staff is busy and stressful as well as navigating the constant changes within the social environment that impact our jobs. (25)*

		I had my mother but she had no significant problems with her menopause and she is very stoic and was a SAHM so her solution was just stop working, your life is too stressful and your body is telling you that. (35)
	Social & health care support is often limited (n6) DESCRIPTION (Social support includes family, social groups, friends, church, sports- contact with others that provide support) (Healthcare is limited- due to limited access; inequitable access; limited knowledge of menopause)	*I went "bat-shit" crazy for a while and then overtime I have found solutions and navigated the changes, things are alot better now but I have pretty much had to navigate it on my own* (35) *Never stop the supply of HRT, during COVID this was rationed I did think if this was a condition that men suffered from then would there have been a supply shortage (14).* *random strangers in the street were more supportive than friends and family. I only hope that I am more supportive to my sisters when they go through it.* (35) *The key is having like minded supportive women around you. Not always possible for some I guess.* (39) *One of the only real issues is the lack of availability of a DEXA scanner as the only option is an extensive waitlist or to pay privately.* (26) *We are lacking support services / clinics for women. GP education. Huge waiting lists for gynae, unless you pay / insurance cover to see them privately.* (38) *the GP's seemed to be very behind in the knowledge they have available to them about menopause and women's health in general./*

		my GP had the grace to acknowledge that he didn't know much about menopause and I then made an appointment with the Oxford clinic privately through Southern Cross. I had to suggest to the GP that I go on HRT they didn't identify any of my issues as being menopausal (35) *My head nurse was not supportive and questioned me and my ability to work. /I would have liked some support/empathy from them as they were aware of my situation. I was very disappointed in their reaction. (13)* *I didn't tell them about my severe symptoms because they became overwhelmed and sometimes even walked away if i started to talk about how I was actually feeling. I have a vivid image of my service*

Superordinate theme	Subordinate theme	Extract/ examples from transcript
Challenge to identity (n18)	Challenge to identity - self (n13) DESCRIPTION (This isn't who I am meant to	*again, it is embarrassing. (18)* *Maintain healthy relationships with loved ones can be challenging with labile moods (21)* *Just not feeling like yourself. Having all these random symptoms, that change all the time. Especially when you have been a fit well person. Struggling to par take in normal family*

	be- challenging my idea of the self I should be)	*activities. Husband and kids think you are 'Crook' again and again. Then also being told that you are too young (41yrs at the time of first symptoms) and not to over think symptoms. So then you think you just might be going crazy, cause blood tests come back in normal ranges!! (38)*
	Challenge to identity - work (n8) DESCRIPTION (This isn't who I am meant to be- challenging my idea of the self I should be AT WORK- how these experiences stop me from contributing to my work the way I think I should)	*I have a million bits of paper on my desk with reminders on and a white board that is full of lists of things to do and <u>remember</u>.* (22) *When these things happen I feel a <u>failure</u> and like I'm the stupidest person in the room. I also think I have early dementia*. (5) *Because I don't want others to know how <u>stupid</u> I am or how <u>risky</u> I am.* (5) *I have also confused medications which are of a similar class. This was also on an over-night shift which seems to make the symptoms worse. In the medication case I double checked with another staff member to ensure that I taken the correct medication from the cabinet before it was administered. In these cases it is quite embarrassing at best and at worst is a near-miss for medications. I worry that I will lose the respect of my peers and will seem incompetent or unsafe. (15)* *struggle at times during conversations to find words especially when attempting to follow through with an human resource conversation (19)*

		i have a lot of people stop me in the corridor and i have to have a notebook with me so that i can remember *CRAFT book is what it is called (Can't remember a fucking thing)* (18) I *lived this for a good two - three years.* *It was horrible and made me feel that I was useless and not a useful/ well functioning member of the team.(20)* *I am a Charge Nurse with a large team and I will be in the middle of a conversation with someone that I have known for a while and I will be struggling to recall their name. It's embarrassing sometimes. (22)*

Superordinate theme	Subordinate theme	Extract/ examples from transcript
Coat of armour (n29)	Just get on with it (n23) DESCRIPTION (Grin and bear it- martyrdom- asking for help could open to	*…but I also generally feel that only women my age understand, and that it's not a valid excuse (perimenopause) (23)* *I probably internalise a lot and have internal stress that manifests as spinal issues -sore shoulder, neck hips etc. Higher stress related cortisol levels which are difficult to reduce. (25)* *I have never said anything to anyone about it. (4)*

	vulnerability and risk)	*I am not sure why I haven't said it directly to <u>anyone</u> as I am a big <u>advocate</u> of talking about menopause and perimenopause (4)* *...as I do <u>encourage</u> others to discuss menopause and perimenopaue symptoms (4)* *Part of life and busy clinic-* *Carried on <u>without</u> telling anyone , <u>tight time frames</u> for clinic time* *Don't like to <u>draw attention</u> to myself. (7)* *I didn't speak to anyone at work in particular about it, however where I worked was a predominantly female ward (25)* *I have never felt that I needed to specifically ask for help in these situations.* (26) (this example added here as in the context of rest of descriptions she was struggling) *Didn't feel I needed to (10)*- ask for help. *Maybe if it got <u>worse</u> then I might seek <u>help</u>. (*22)

	Kiwis don't (n3) DESCRIPTION (Cultural behaviour differences)	*I think as a kiwi you don't make too much of a fuss and just get on with it. It's a part of life and its something we as women go through. (27)* *people tend to be less confrontational then in the USA, so maybe, but I've lived here for a long time, so not sure about this (3)* *the limited discussion about menopause in our country socially/culturally makes it not a subject also talked about freely at work.* (13).
	Not anyone's business (n2) DESCRIPTION Keep this to myself (negative- not coping still but wont ask for help)	*I don't expect help from organisation about this. Why? its a normal part of life. (27)* *I don't feel it is my employers job to support my menopause symptoms (24) (*negative context*)*
	Negotiating stigma through silence (n6) DESCRIPTION	*I don't feel its anyone else's business what my hormonal schedule is or that I could be impaired or imbalanced by hormones. I don't want my peers to think of me as an irrelevant or silly old lady. I don't want to use menstruation/peri/menopause as an excuse though the symptoms are quite real and have big impact on my life. I also feel the "deranged woman on her period" is a stereotype and is overplayed and I don't want to contribute to this negative parody. (15)*

	(Trying to hide from the sigma related to menopause by keeping silent rather than risk identification; vulnerability and opening oneself up to ridicule)	*Telling someone would open myself up to vulnerability and possibly make the matter worse. (32)* *Easier to keep to yourself. Don't want to feel useless* (38) *I think there is still a bias that taking HRT is opting out or taking the easy route (14)*

Superordinate theme	Subordinate theme	Extract/ examples from transcript
Desires for an Effective work place (n35)	Unsuccessful working practices and management (n25) DESCRIPTION (Examples of how not to support your staff- what is	*Yoga at a time they can't go. (22)* *While you support each other it must get a bit wearing for the other members when the same member is off form for so long. (20)* *Some of the newer members of staff still look at me oddly at times and are having to readjust to my coming back up to speed and full function.(20)* *I changed my role at that time which was very stressful (21)*

	occurring in the workplace that impacts on menopause symptoms and where menopause affects the workplace negatively)	*not really I just had to get through it. I appreciate that I had a less common experience. but they coped by ignoring me...*(REDACTED- SPECIFIC WORKPLACE DEPARTMENT) *. I had to get my own more comfortable chair, I had to adapt my work space, I had to make all of my appointments to get help, I had to take time off work because I was falling behind but I'm pretty sure they would have let me keep working until I dropped at work or had a melt down. I have become much better at advocating for myself but initially I was regularly fobbed off and ignored if I had any issues (35)* *the uniforms are the worst. Nonbreathable fabric. I stopped wearing them, and now just wear scrubs(3)* *Work permanent nights part time* (38)
	Reducing stigma/acceptance (n9) DESCRIPTION (Through education at work, support and appropriate behaviour	*I can't think of specifics but there should be education and support available within the workplace.* (13) *showing respect and understanding that it is a natural time and value placed on our older women. (28)* *For health professionals it should be acknowledged and discussed freely*. (13)

	improving the workplace environment)	*I am definetly keen to see menopause and peri-menopause acknowledged more in workplaces in general.* (4)
	Making it work at work (n30) DESCRIPTION (solutions for the workplace to enable staff with menopause to still do their jobs well)	*Yes I think choice to do night shifts from 55 onwards / with support of your GP.* (10) *Yes, just laughed it off and fanned myself. (3)* *Increase in paid sick leave* *Support and interventions to assist with work load* *Fitness and health support* *Paid leave* *Change in uniform policy to accommodate flushes.* (11). *My peers are supportive to me and assist in some physical tasks without me asking them. I have told my head nurse. so far she has been ok about it. (13)* *Women's Clinics- for Staff (21)* *It is a marathon not a sprint (21)* *Maybe the availability to have "health days" off as opposed to sick leave however this applies to all staff...not just female. Its more around changing the wording regarding sick leave.*

		Again mentioning the uniforms -would be better to have breathable stretch fabric that don't overcook staff. (25) *People are generally nice about it although I have mainly female colleagues and it's hard to know how it would go otherwise.* *As I make a joke of it - people just go along with it. (26)* *it is a normal life process, some people are affected more than others, and in different ways* (33) *Women's health is NOT a priority in some of our Hospitals when we are about 70% of the workforce (21)* *I think there needs to be more recognition that a lot of the nursing workforce are middle aged woman and we are tolerating symptoms of menopause and just getting on with it and caring for others. (22)*
	In wider context of good health care (n1) DESCRIPTION	*As previously noted I have always had gynae issues and my care and treatment since emigrating to Aotearoa in 2009 has been exceptional* (26)

	(Without appropriate access to good healthcare we cannot have a safe and effective workplace)	

Superordinate theme	Subordinate theme	Extract/ examples from transcript
Reaching a new stage (n34)	Identifying strategies that worked for them (n16) DESCRIPTION (As there were multiple symptoms the women found multiple strategies that worked for them- includes changing jobs, HRT, healthy	*I find that a stressful day at work can tire me out more than it once did, and that my life and work priorities are changing, so I have had to do some work sorting out what I want my life to look like in the next 5 to 10 years. Because of this I have actually changed my job to one that is less stressful and busy, because I found it was becoming draining and I no longer enjoyed it. (23)* *I did have intense anxiety last year after COVID that I put down to COVID but maybe it was perimenopause - I started a low dose SSRI which has been amazing and I find I am much more relaxed about life. (4)* *I used to have hot flushes but since decreasing caffeine these are now manageable that I don't even notice I'm having them. (19)*

	living. In the example of a woman changing their job it highlights how it’s a positive strategy- if it added stress it wouldn’t be)	*Now on HRT with patches and had reduced them to nearly nil (8)* *I still get some residual symptoms- and some of the symptom control has helped and magnesium so I can have a good night sleep (21)* *I was commenced on small dose of anti-anxiiety which help me to maintain health relationships with my family (21)* *Adapted lifestyle reduce caffeine etc.,* *I take Magnesium at night and it helps me settle (21)* *Hence HRT was my choice. Never had a hot flush since.* (39) *love getting into outdoors-climbing a hill and feeling of the challenge (7)* *Sleeping alone is a bonus. I can move to the cool side of the bed, strip off blankets, and leave windows wide open.* (6) *i was fine after having a break and drink* (10) *I may have experienced this a number of years ago, however at the time I wasn't aware that I might have been in the peri stage, so I started looking at diet and exercise as ways to manage the brain fog (25)*

	A new positive stage (n12) DESCRIPTION (positive evaluation of it)	*I seem to have come out of this state now and have almost returned to normal function*. (20) *I think I am over the worst of it. Some people I know got HRT but I never considered that. /I am really pleased to not have a period anymore that is freedom! (27)* *But, no regrets, and my menopause has been so welcome that I tolerate the symptoms with gratitude!* *After being a slim person all of my life, I now have 'middle age spread', but it could also be 'carb belly' because I love potatoes. I've gone up a few sizes in my underwear and I have to try things on, but these are not problems. Life is a series of changes and I'm going with (out) the flow. Auntie Flo, surfing the Crimson Tide, having the Painters in, Off PE week or On The Blob (28)* *I dont think my memory not being as sharp as it was has had an impact on my work* (4) *…and has made me look at what I want from life and what I am willing to sacrifice (such as my well being for work).(23)*

		*<u>Positives</u> were also emphasised; hot flushes and a warmer body temperature meant you did not experience the cold as severely and no menstrual periods provided additional <u>freedom</u> (no more being caught without products).(*6) *You can look forward to being in the mountains when you are not at work!! (39)* *I look forward to the last flush but I wont know it's my last. A bit like my last period. I didn't know that was my last. In a way it is also a bit of a loss because you are moving into middle age. I am thankful my body was able to carry my son. (27)*
	Having the knowledge (n15) DESCRIPTION (Education creates knowledge and power- can manage menopause with the right education and support)	*Because I knew what it was, no drama (9)* *I found great support/relief when I fell over a podcast on menopause. It talked about this, and I felt that I was not losing my mind, but it was a part of menopause.* (13) *again, education. But how to do so in a way that it will not be made fun of(?) (15)* *Have resources like the book "Don't sweat it" available to staff. It would help women understand menopause. (17)*

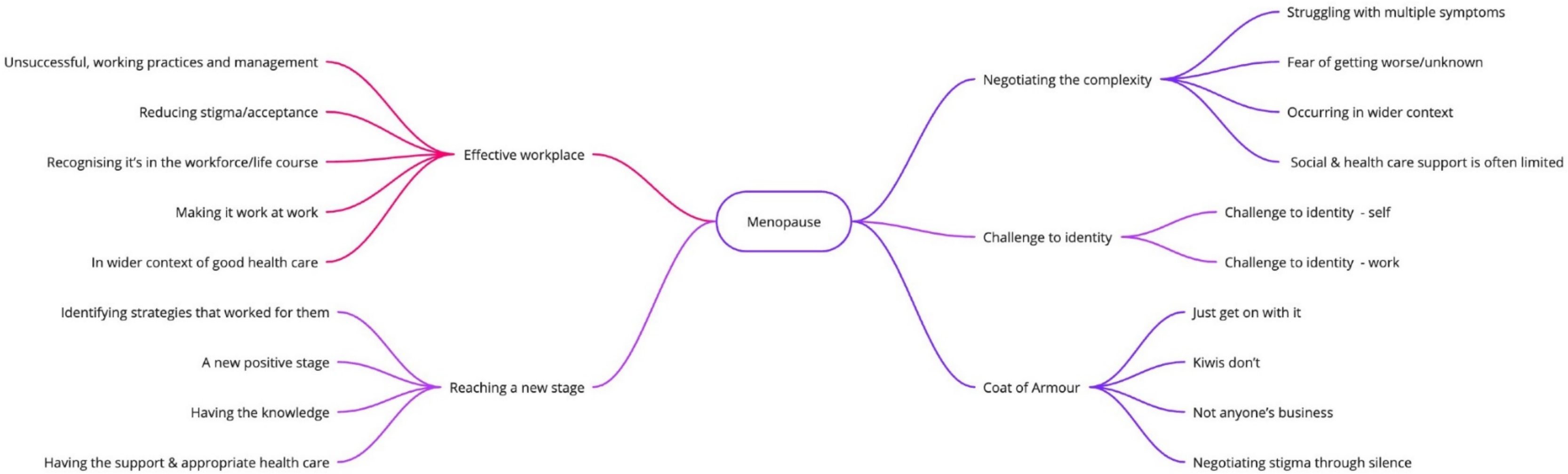
	Having the support & appropriate health care (n26) DESCRIPTION (different needs and experiences means different types of support needed- e.g. some needed to just talk with others and gain knowledge while others needed counselling)	*I am grateful I have a very supportive husband who shares life with me. (4)* *Friends, religion and wider family via Skype. (5)* *fantastic family support* *excellent friend support (18)* *The key is having like minded supportive women around you. Not always possible for some I guess.* (39) *My mother.* *Most of my friends are younger than me so haven't had symptoms. But were supportive and a listening ear. (*38) *I have extremely effective social support. Very involved in my local church, a connect group during the week and a women's 40s plus social group meeting approx once a month to do 'crazy' things, which I usually arrange. Plus I run a tramping group taking a group of good friends (up to 16 at a time) on great walks or other adventures twice a year. I also go to Uganda every second year being involved with an organization that supports orphaned and abandoned babies and children. This I live for. (39)* *I had older sisters to talk to where menopause and the symptoms were normalised.* (6)

		*Friends that talk openly about symptoms and HRT, made me realize early on there was no point in suffering.(*3) *often some women will say welcome to the club!* (8) *I have friends of the same age so that helps to share the misery of peri- menopause. (22)* *did mention it to a councilor, as I was also dealing with grief.* *Was advised to be very careful and forgiving with myself. To par things back to the basics - nutrition, exercise, sleep.* (20) *I went to a women's clinic in CHC and they were wonderful in providing some advice about symptom control* (21) *It wasn't a great problem for me -I didnt seek assistance -but talking with others of similar ages or starting their menopause journey* (34) *My mother.* *Most of my friends are younger than me so haven't had symptoms. But were supportive and a listening ear. (38)*

		I think we need a 'health passport' that provides a women's clinic or a GP with an interest to provide support women who are trying to work full time, raising a family and when you are the main income provider-you need control or appropriate symptom management that has a interest and does not think that you are mad...(21) *I lived overseas where an annual GP visit is part of your health care and relevant life topics are discussed. Having regular access to preventative health in NZ may have provided additional resources for managing symptoms rather than struggling through. (6)* *As previously noted I have always had gynae issues and my care and treatment since emigrating to Aotearoa in 2009 has been exceptional. (26).*

APPENDIX K: MINDMAP

Nurses experience of Menopause, Te Whatu Ora Southern



APPENDIX L: CULTURAL CONSULTATION LETTER

21 April 2023

To whom it may concern,

This letter is to confirm our involvement in the research project being conducted by Sue Smith as cultural consultants. We met with Sue, via zoom, on the 19th of April 2023 to discuss several key issues to consider when undertaking her research in this particular area. Sue also raised a question that was posed to her by the ethics committee and our perspective was shared.

Ngā mihi,

Aorangi & Ariana

Ariana Apiti

Tutor

Centre for Indigenous Psychologies

Massey University | Private Bag 11 222 | Palmerston North, New Zealand

email: a.apiti@massey.ac.nz

Aorangi Kora

Junior Research Officer

Centre for Indigenous Psychologies

Massey University | Private Bag 11 222 | Palmerston North, New Zealand

APPENDIX M: NTRCC LETTER

NGĀI TAHU RESEARCH CONSULTATION COMMITTEE
TE KOMITI RAKAHAU KI KĀI TAHU

Dr Bianca Dobson

Tēnā Koe Dr Dobson

The lived experience of Menopause for nurses in their workplace. We want to know what kind of support is needed in the workplace that would be effective. To do that we first have to understand the experiences of nurses. As the number of older workers increases in the New Zealand workforce, managers should not make assumptions about their needs which will vary (University of Auckland. n.d.). This research aims to address women's own experiences and explore similarities and differences. *Ngāi Tahu Research Consultation Committee (the Committee) met to discuss your research proposition.*

By way of introduction, the Committee has been established as part of the Memorandum of Understanding between Te Rūnanga o Ngāi Tahu and the University of Otago to implement the Policy for Research Consultation with Māori. The Policy provides no power of veto by Ngāi Tahu to research undertaken at the University of Otago. As such, this response is not "approval" or "mandate" for the research, rather it is a response from a Ngāi Tahu Rūnanga-appointed committee. The Committee comprises representatives from Te Rūnanga o Ōtākou, Kāti Huirapa ki Puketeraki and Te Rūnanga o Moeraki.

Within the context of the Policy for Research Consultation with Māori, the Committee bases consultation on the term defined by Justice McGechan:

"Consultation does not mean negotiation or agreement. It means: setting out a proposal not fully decided upon; adequately informing a party about relevant information upon which the proposal is based; listening to what the others have to say with an open mind (in that there is room to be persuaded against the proposal); undertaking that task in a genuine and not cosmetic manner. Reaching a decision that may or may not alter the original proposal."

The recommendations and suggestions below do not necessarily relate to ethical issues with the research or methodology. Other committees, for example the Human Ethics Committee, may provide feedback in these areas.

NTRCC Response:

We appreciate your submission. In the future, we would recommend shortening your research title. We wish you luck with your Masters.

This letter is valid for a period of 18 months until October 20th 2024. This is subject for further extension as this has taken us some time to get back to you. Please contact us if you require extra time.

Kā mihi

E.Murphy

K.Russell

T.Russell-Camp

NTRCC

The Ngāi Tahu Research Consultation Committee has membership from:

Te Rūnanga o Ōtākou Incorporated
Kāti Huirapa Rūnaka ki Puketeraki
Te Rūnanga o Moeraki

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