



Review

# Support Mechanisms for Women during Menopause: Perspectives from Social and Professional Structures

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**Abstract:** Approximately one billion women globally have undergone menopause, occurring at an age of around 51 years and typically between ages 45 and 54. As life expectancy increases, women are projected to spend at least one-third of their lives in postmenopause, emphasising the growing importance of menopause as a critical public health issue. In this context, this paper aims to offer updated insights into the increasing societal and political interest in menopause. It underscores the impact of support mechanisms encompassing familial, workplace, medical, technological, and government support on women's attitudes and experiences around menopause. Furthermore, the study aims to identify key gaps in research, practice, or legislation concerning support systems for menopausal women and provide recommendations for enhancing familial, workplace, medical, technological, and government support.

**Keywords:** menopause; partner support; workplace support; government policies



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## 1. Introduction

Menopause, a natural phase in a woman's life, is intricately linked to psychosocial events of midlife and the ageing process [1]. As defined by the World Health Organization (WHO), menopause is characterised by the permanent cessation of menstrual cycles for a continuous 12-month period [2]. However, symptoms may occur before the cessation of menses, and the transition from the reproductive period to menopause is called perimenopause [3].

Not all women experience symptoms prior to or during menopause, but about one-third of them do. The symptoms associated with menopause can be highly distressing, significantly impacting various aspects of women's lives, including personal, social, and professional domains. Perimenopause is marked by a range of major symptoms, encompassing central nervous system (CNS) related issues such as vasomotor symptoms, sleep disturbances, anxiety, depression, migraine, and changes in cognitive performance. Additionally, there may be notable changes in weight and metabolism, cardiovascular functions, and urogenital symptoms, including vaginal dryness, dyspareunia, vulvar itching and burning, dysuria, increased urinary frequency and urgency, and recurrent lower urinary tract infections. Sexual dysfunction, a decline in sexual desire, and musculoskeletal symptoms, including bone health decline and changes in body composition, are also common [3].

Reduced oestrogen production by the ovaries is the primary cause of menopausal symptoms [4]. Yet, focusing solely on hormonal changes and viewing menopause through a purely biomedical lens can obscure its broader context, overlooking its significance as a 'change of life' intertwined with multiple other stressors [5]. For instance, many women shoulder household responsibilities while holding jobs, handle financial commitments to grown children, and provide caregiving duties for elderly parents. They describe finding themselves "sandwiched" between these roles, leading to possible conflicts in their public and private lives [6–8].

Menopause is, therefore, shaped by both social construction and biology. Thus, it becomes crucial to understand it not merely from a biophysical perspective but also within the broader social context of women's lives. In this context, this review aims to discuss the following support mechanisms available for menopausal women: (1) family support, (2) support from friends and support groups, (3) workplace support, (4) medical support, (5) technological support, and (6) government support. In doing so, it will aim to answer the following research questions:

1. How does each of the support systems identified influence women's experience surrounding menopause?
2. How can pre-, peri-, or postmenopausal women be better supported by the support systems identified?
3. What are the key gaps in research, practice, or legislation relating to the identified support systems?

## 2. Methodology

The following databases were searched for relevant literature from between January 1990 and December 2023: Google Scholar (Google Inc., Mountain View, CA, USA), PubMed (National Library of Medicine, Bethesda, MD, USA), ISI Web of Science (Thomson Reuters, New York, NY, USA), Science Direct (Elsevier, Amsterdam, The Netherlands), and Scopus (Elsevier), as well as search engines such as Google, Yahoo, and Bing.

The search keywords included "menopause", "menopausal", "post-menopause", "post-menopausal", "pre-menopause", "pre-menopausal", "perimenopause", "perimenopausal", "family", "partner", "children", "friend/s", "support group", "workplace", "medic\*", "doctor", "general practitioner", "family doctor", "healthcare provider", "technolog\*", "government", "policy", "support", and "help". Using "OR" and "AND", the keywords were combined and entered in the search box of the databases as follows: (menopause OR menopausal OR post-menopause OR post-menopausal OR pre-menopause OR pre-menopausal) AND (family OR partner OR children OR friend\* OR support group OR workplace OR medic\* OR doctor OR general practitioner OR family doctor OR healthcare provider OR technolog\* OR government OR policy) AND (support OR help).

The selected publications were further evaluated based on the following inclusion/exclusion criteria: articles were selected if they included relevant data; additional articles were discovered through snowballing, which involved examining the references of selected articles, and were incorporated when they contributed to contextualising our findings; studies that were not available in English or as full text were excluded. Moreover, relevant online surveys, government policies, or other relevant information identified by search engines were also included in the study.

## 3. Results and Discussion

### 3.1. Family Support

Several studies indicate that higher family support plays a crucial role in mitigating menopausal symptoms [7,9,10]. The perceived levels of support, however, vary cross-culturally due to differences in familial circumstances. For instance, Mosuo women, residing in large households that consist of several generations from the mother's side in southwestern China, primarily receive support from their blood relatives. In contrast, Han Chinese women, living with husbands and/or parents-in-law, seek more support from female neighbours. This results in Mosuo women perceiving greater family support but lesser support from friends compared to Han Chinese women [9].

Table 1 summarises the key findings related to family support around menopause found in the literature. Most of the research tools adopted the Menopause Rating Scale (MRS) or self-designed questionnaires to assess various aspects, including climacteric knowledge encompassing common symptoms, male spouses' attitudes towards their wives' menopause, and knowledge of healthcare. Additionally, a few studies employed the Multi-dimensional Scale of Perceived Social Support (MSPSS), Attitudes Towards Menopause

Scale (ATMS), and the Menopause Attitude Scale (MAS) to measure husbands’ attitudes toward female menopause.

**Table 1.** Key findings related to family support for women in the pre-, peri-, and postmenopausal stages in various studies.

Country	Sample Size	Age (Years)	Study Design/Data Collection Method	Findings *	Ref.
North America, Asia, Australia, Europe	Middle-aged immigrant women who were in a natural menopausal transition. The total sample size of the 11 qualitative, 19 qualitative, and 7 mixed-method studies were 430, 6786, and 789, respectively	45–65	Scoping review including 11 (30%) qualitative studies, 19 (51%) quantitative studies, and 7 (19%) mixed-method studies	<ul style="list-style-type: none"> <li>• Marriage positively influenced immigrant women’s menopausal transition, reducing loneliness and increasing happiness.</li> <li>• Adult children supported immigrant women, offering financial assistance and aiding in adjusting to a new society.</li> <li>• Limited resources led some women to neglect their health while fulfilling familial responsibilities.</li> </ul>	[11]
China	732 perimenopausal women	40–60	Cross-sectional study/demographics, MRS, 10-item Connor–Davidson Resilience Scale, and Perceived Social Support Scale	<ul style="list-style-type: none"> <li>• Family support (<math>\beta = 0.169</math> to <math>0.240</math>, <math>p &lt; 0.001</math>) and resilience (<math>\beta = 0.140</math> to <math>0.202</math>, <math>p &lt; 0.001</math>) were negatively associated with the total and subscale scores of MRS.</li> <li>• Women with higher</li> <li>• family support had fewer menopausal symptoms.</li> </ul>	[7]
China	54 Mosuo women and 52 Han Chinese women	40–60	Cross-sectional study/demographics, MRS, Self-Esteem Scale, and Perceived Social Support Scale	<ul style="list-style-type: none"> <li>• Compared with Han Chinese women, Mosuo women reported higher perceived support from family.</li> <li>• Predictive variables for the severity of menopausal symptoms were: perceived support from family (<math>\beta = 0.210</math>, <math>p = 0.017</math>); self-esteem (<math>\beta = 0.320</math>, <math>p &lt; 0.001</math>); previous history of premenstrual syndrome (<math>\beta = 0.293</math>, <math>p &lt; 0.001</math>); number of family members (<math>\beta = 0.229</math>, <math>p = 0.003</math>); and family income (<math>\beta = 0.173</math>, <math>p = 0.028</math>).</li> </ul>	[9]
USA	169 couples with perimenopausal women	38–60	Cross-sectional study/demographics, menstrual status, MCS, and MAS	<ul style="list-style-type: none"> <li>• Husbands had little knowledge about their wives’ menstrual statuses.</li> <li>• Wives’ attitudes toward perimenopause were positively correlated to husbands’ attitudes (<math>r = 0.22</math>, <math>p &lt; 0.01</math>) and negatively correlated to husbands’ perceptions of the frequency of menopausal symptoms (<math>r = -0.17</math>, <math>p &lt; 0.05</math>).</li> <li>• Husbands’ attitudes were</li> <li>• negatively correlated with wives’ self-reported symptoms (<math>r = -0.19</math>, <math>p &lt; 0.05</math>) and husbands’ perceptions of wives’ symptoms (<math>r = -0.22</math>, <math>p &lt; 0.01</math>).</li> </ul>	[10]
Turkey	93 women	45–60	Cross-sectional study/self-designed questionnaire, MSPSS, and ATMS	<ul style="list-style-type: none"> <li>• ATMS mean score was <math>36.31 \pm 7.75</math> (range 18–56), family subscale mean score was <math>21.61 \pm 4.43</math> (range 4–28), and significant other subscale mean score was <math>14.91 \pm 6.32</math> (range 4–26) of MSPSS.</li> <li>• Family support (<math>20.93 \pm 4.75</math>), significant other support (<math>13.66 \pm 5.98</math>), and total MSPSS score means (<math>52.25 \pm 11.71</math>) of women who had negative attitudes towards menopause were lower than women with positive attitude, and differences were statistically significant (respectively, <math>p = 0.037</math>, <math>p = 0.000</math>, and <math>p = 0.001</math>).</li> <li>• Positively significant correlations were found between total MSPSS scores (<math>r = 0.443</math>), family support subscale (<math>r = 0.404</math>), significant other support (<math>r = 0.285</math>), and ATMS scores.</li> </ul>	[12]

Table 1. Cont.

Country	Sample Size	Age (Years)	Study Design/Data Collection Method	Findings *	Ref.
Turkey	60 couples	Mean age ± SD women: 50.20 ± 5.15; men: 53.70 ± 5.40	Cross-sectional study/demographics, MRS, ATMS, BDI, and BAI	<ul style="list-style-type: none"> <li>Both the women and their spouses had a positive attitude towards menopause.</li> <li>There were no significant differences in BDI scores between the women and their spouses.</li> <li>BAI scores were more likely to be higher in women than their spouses (<math>p &lt; 0.0001</math>).</li> <li>MRS scores were significantly positively correlated with the BAI and BDI scores of the women.</li> <li>ATMS scores in men were significantly and negatively correlated with the total MRS score (<math>r = -0.03, p = 0.02</math>), somatic symptoms (<math>r = -0.27, p = 0.05</math>), and urogenital symptoms (<math>r = -0.32, p = 0.018</math>).</li> </ul>	[13]
India	100 couples	N/A	Cross-sectional study/MENQOL Brief Cope Questionnaire, and Personal Health Questionnaire to diagnose and grade depression	<ul style="list-style-type: none"> <li>“Acceptance” is the most used strategy by both partners, while males also use “religion” and “positive reframing” as coping strategies.</li> <li>Husbands struggled to understand and accept the menopausal transition, viewing it as unworthy of significant attention.</li> </ul>	[14]
USA	61 menopausal women	38–60	Mixed methods/focus groups (8 women) and individual in-depth interviews (53 women)	<ul style="list-style-type: none"> <li>52% reported negative attitudes from partners, emphasising problematic symptoms and urging medical treatment.</li> <li>13% reported positive oversight by partners, providing emotional support, active listening, and understanding.</li> </ul>	[15]
USA	96 men married to pre-, peri-, and postmenopausal women	44–71	Mixed methods/interviews	<ul style="list-style-type: none"> <li>32.3% of husbands reported not providing special support during their wives’ perimenopause.</li> <li>57% offered emotional support, being sensitive and active listeners.</li> <li>Knowledge about menopause: one-third knew specific facts like menstrual cessation (35.6%) and oestrogen drop (34.5%); 27.6% knew little or nothing about menopause.</li> </ul>	[16]
UK	2650 women with menopause symptoms (currently or within previous 10 years) and 350 partners	45–65	Mixed-methods/online questionnaires (Survey 1, 2015, n = 1000; Survey 2, 2016, n = 1000; Survey 3, 2017, women n = 650 and partners n = 350) and descriptive statistics	<ul style="list-style-type: none"> <li>Survey 3:                             <ul style="list-style-type: none"> <li>22% of women and 28% of partners had frequent arguments due to partner’s lack of understanding of menopause.</li> <li>23% of women reported feeling isolated from their family.</li> <li>73% of partners expressed a willingness to provide support, but 38% lacked clarity on how to do so.</li> <li>11% believed they were better parents before undergoing menopause.</li> </ul> </li> <li>Survey 2: 36% of women reported menopausal symptoms affecting social life.</li> </ul>	[17]
UK	1525 women	48–54	Mixed-methods/health symptoms, menopause, and change in life circumstances questionnaires	<ul style="list-style-type: none"> <li>60–90% of women in all menopausal transition categories reported either a stable or improving personal life across various ages.</li> <li>Women with four or more children perceived an improvement in their psychosomatic status (nervous and emotional state, self-confidence, work life, ability to make decisions, and ability to concentrate).</li> </ul>	[18]

Table 1. Cont.

Country	Sample Size	Age (Years)	Study Design/Data Collection Method	Findings *	Ref.
Australia	50 partners of women with diagnoses of breast cancer, and self-reported menopause status	40–51	Mixed-methods/paper and online questionnaires, demographics, partners' perceptions of menopause, and menopausal therapies	<ul style="list-style-type: none"> <li>44% reported difficulties discussing menopause with family and partners.</li> <li>All partners expressed enjoyment in assisting their breast cancer partners during menopause.</li> <li>87% believed their support was desired.</li> <li>69% found their support effective in relieving menopausal symptoms.</li> <li>33% perceived reluctance in female partners to discuss menopause and 13% reluctance to receive support.</li> </ul>	[19]
Brazil	20 men who have lived with women experiencing natural menopause for a minimum of 5 years	40–63	Qualitative study/interviews	<ul style="list-style-type: none"> <li>Men lacked knowledge about menopause, viewing it as a transitory phase without significant impact on well-being.</li> <li>Over time, men recognised the intensity of menopausal symptoms and developed strategies for emotional support and adjustments in marital relations.</li> </ul>	[20]
Qatar	56 Qatari and 87 non-Qatari (from seven neighbouring countries) pre-, peri-, and postmenopausal women	40–60	Qualitative study/semi-structured focus groups	<ul style="list-style-type: none"> <li>Participants emphasised that Arab women benefit from robust familial support during menopause.</li> <li>Supportive husbands play a crucial role in shaping women's positive experiences and perceptions during menopause.</li> <li>Other female family members were considered less significant than husbands in supporting women during menopause, as women often gained insights into menopausal experiences from sisters or mothers, retrospectively.</li> </ul>	[21]
USA	158 women of Hispanic, Navajo, and non-Hispanic white heritage with both natural and surgically induced menopause	34–71	Qualitative study/focus groups	<ul style="list-style-type: none"> <li>Attributes regarding family support:                             <ul style="list-style-type: none"> <li>Navajo women: traditional **—listen to elders; transitional—less contact with elders; modern—isolation from family.</li> <li>Hispanic women: traditional—surrounded by family; transitional—some family nearby; modern—little family.</li> <li>Non-Hispanic women: traditional—stay-at-home wife, near other family members; transitional—employed outside the home, often isolated from other family members; modern—employed outside the home, often isolated from other family members.</li> </ul> </li> </ul>	[22]
Canada	19 pre-, peri-, and postmenopausal women who have used or are using complementary therapy	41–62	Qualitative study/focus group	<ul style="list-style-type: none"> <li>Women relied on mothers, sisters, friends, and colleagues for crucial support and information during menopause.</li> <li>These sources shared personal experiences and provided advice.</li> </ul>	[23]

USA = United States of America; ATMS = Attitudes Towards Menopause Scale; MAS = Menopause Attitude Scale; MSPSS = Multidimensional Scale of Perceived Social Support; MCS = Menopausal Symptoms Checklist; MRS = Menopause Rating Scale; QOL = quality of life; MENQOL = menopause-specific quality of life; BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory. \* Main findings are reported as relevant to the main theme of this review. \*\* Women whose lifestyle closely resembled that of a prior generation were categorised as traditional, while those with a lifestyle more detached from their cultural roots were classified as modern. The transitional category included the remaining participants in the study.

### 3.1.1. Partner Support

The partner emerges as the pivotal and closest figure capable of providing crucial support to a woman facing the challenges of menopause. Several cross-sectional studies

provide evidence that men's perceptions and attitudes toward their wives' menopausal transition influence their wives' experiences and attitudes. A cross-sectional study conducted in the US involving 169 married heterosexual couples found that wives' attitudes were more closely (and negatively) linked to husbands' perceptions than their self-reported symptoms. The attitudes of husbands toward menopause showed a significant positive correlation with their wives' attitudes, but exhibited a significant negative correlation with their wives' menopausal symptoms and their own perceptions of the severity of their wives' menopausal symptoms [10]. Similarly, positive significant correlations were found by Erbil and Gümüşay (2018) between the support of a significant other and the total MSPSS scores and the ATMS scores of women, respectively [12].

Another cross-sectional study indicated that men's ATMS scores were negatively correlated with women's total scores for menopausal symptoms, physical symptoms, and genitourinary symptoms [13]. Additionally, a scoping review by Zou et al. (2021) reported that changes in men's attitudes during and after menopause, such as perceiving wives as non-sexual or less attractive, contributed to issues like domestic violence and divorce and diminished perceived support during the menopausal transition [11].

Emotional support from spouses plays a significant role in mitigating depression and anxiety during menopause [24]. In a study conducted in the UK, most spouses (73%) expressed a desire to help their partner through menopause, but 38% felt helpless in providing support [17]. Some men reported confusion about coping strategies and emotional support [25], and some spouses thought that non-intervention was the best support strategy, especially when their wives were experiencing emotional fluctuations [15,20].

Their partner's absence of information about menopause, coupled with women's reluctance to share their experiences, negatively impacts the emotional support available from husbands [16,19]. In total, 22% of the women and 28% of their partners surveyed in a mixed-methods study conducted in the UK reported frequent arguments due to the partner's lack of understanding of menopause since its onset. Additionally, almost a quarter of women (23%) reported experiencing a sense of isolation from their families [19].

Changes in sexual function during menopause and vasomotor symptoms, such as hot flashes and night sweats, impact sleeping arrangements. While these may seem trivial in a specific moment, they contribute to the perception that women's bodily changes are "abnormal". They also hinder intimate relations, with male partners physically distancing themselves from women and their bodies [15].

Interestingly, while the term 'menopause' carries a negative connotation (in Arabic, it translates to 'the age of despair'), many women viewed this stage positively if they perceived their husbands as being supportive. The partner was seen as the most significant factor influencing women's experiences around menopause in a qualitative study conducted in Qatar [21].

### 3.1.2. Support from Other Family Members

Women—mothers and sisters—emerged as crucial sources of support and information. They served as guides, sharing personal stories and providing advice on diverse approaches to different aspects of menopause [23]. However, some expressed a desire for more comprehensive information, and believed that their support networks had equipped them better for this significant life stage [22].

Yet, communication with children, even daughters, seems to be deficient for menopausal women and is typically met with embarrassment. None of the women included in a qualitative study conducted in New Mexico had initiated conversations about menopause with their children. However, they expressed a commitment to change this trend by initiating, or already engaging in, conversations about these topics with their daughters [22].

Conversely, findings from focus groups involving Arab women revealed that while husbands played a pivotal role in providing emotional support during menopause, the contribution of other female family members was perceived as less significant. Women

commonly acquired insights into menopausal experiences retrospectively from their sisters or mothers, which was rendered as not very helpful [21].

On a related note, for immigrant women, financial support from adult children during this phase aids their adjustment to a new society, with family social support playing a crucial role in mitigating depression linked to ethnic cultural competence. Additionally, some find joy in embracing their role as grandmothers [11].

### 3.2. Support from Friends and Support Groups

The identified studies (Table 2) used self-designed questionnaires, the Multidimensional Scale of Perceived Social Support (MSPSS), Attitudes Towards Menopause Scale (ATMS), and the Menopause Attitude Scale (MAS) to measure social support and attitudes toward menopause.

Sharing menopausal experiences with friends was crucial, especially for women who were single or had lost a spouse, to manage health challenges during and after menopause. Life changes like losing a spouse or children leaving home were noted to worsen menopause-related health problems. Despite initial reluctance, discussing these experiences with other women was seen as a valuable practice, fostering openness about health concerns and preventing more serious issues [26]. A cross-sectional study conducted in northeastern Scotland revealed that friends were perceived as the most important source of support among women experiencing menopausal symptoms. Over 90% of women considered friends to be ‘fairly’ or ‘very’ supportive in helping with their menopausal symptoms [27]. Immigrants represent another category of women who find solace and support in networking with other women in their new community, providing a sense of shared experience during the menopausal transition [11].

Furthermore, women who held negative attitudes toward menopause received less support from friends compared to women with positive attitudes, and these differences were statistically significant ( $p = 0.010$ ) [12]. Levels of friend support were also negatively and significantly correlated with the total MRS score and urogenital symptoms, but not the somatic and psychological symptoms associated with the menopause, in a cross-sectional study conducted in Saudi Arabia [28].

In addition, women’s participation in support groups was found to enhance women’s quality of life and alleviate vasomotor and psychosocial symptoms associated with menopause [29]. It can be assumed that sharing within the group contributed to a sense of normalisation and contributed to accepting the physical and psychological changes of menopause, as participants realised other women faced similar difficulties [30].

**Table 2.** Key findings related to support from friends and support groups for women in the pre-, peri-, and postmenopausal stages in various studies.

Country	Sample Size	Age (Years)	Study Design/Data Collection Method	Findings *	Ref.
Turkey	93 women	45–60	Cross-sectional study/self-designed questionnaire, MSPSS, and ATMS	<ul style="list-style-type: none"> <li>• Strong social support positively influenced attitudes.</li> <li>• Friend support of women who had negative attitudes toward menopause were lower than women with positive attitudes, and differences were statistically significant (<math>p = 0.010</math>).</li> <li>• Greater perceived social support scores correlated with factors including age below 50, higher educational attainment, employment, a perception of higher income, single marital status, residing in a province, participation in physical exercise, and maintaining positive health perceptions.</li> </ul>	[12]

Table 2. Cont.

Country	Sample Size	Age (Years)	Study Design/Data Collection Method	Findings *	Ref.
Scotland	4407 pre-, peri-, or Postmenopausal, and surgically menopausal women	45–54	Cross-sectional study/self-designed questionnaire	<ul style="list-style-type: none"> <li>• Friends were perceived to be the most supportive source of support among women with menopausal symptoms.</li> <li>• 53.0% and 41.6% of the women rated their friends as being ‘fairly’ or ‘very’ supportive, respectively.</li> </ul>	[27]
Saudi Arabia	361 women	45–65	Cross-sectional study/face-to-face interviews using a structured questionnaire including the Arabic version of MRS, the Arabic version of IPAQ, and MSPSS	<ul style="list-style-type: none"> <li>• Lack of social support, smoking, obesity, and a lack of physical activity are linked to a worsening of menopausal symptoms.</li> <li>• Social support plays a significant role in reducing menopausal symptoms and acts as a buffer to alleviate psychological distress.</li> <li>• 38%, 33%, and 29% of the women had moderate, high, and low social support on the friend subscale of MSPSS, respectively.</li> <li>• Friend support was negatively and significantly correlated with the total MRS score and the urogenital symptoms (<math>r = -0.124, p = 0.019</math>; <math>r = -0.0194</math>, and <math>p = 0.000</math>, respectively), but not with the somatic and psychological symptoms (<math>r = -0.045, p = 0.394</math>; <math>r = -0.099</math>, and <math>p = 0.059</math>, respectively).</li> </ul>	[28]
North America, Asia, Australia, Europe	Middle-aged immigrant women who were in a natural menopausal transition. The total sample size of the 11 qualitative, 19 qualitative, and 7 mixed-method studies were 430, 6786, and 789, respectively	45–65	Scoping review including 11 (30%) qualitative studies, 19 (51%) quantitative studies, and 7 (19%) mixed-method studies	<ul style="list-style-type: none"> <li>• Lack of social networks posed challenges during menopause, affecting adaptation and causing emotional distress.</li> <li>• Engaging in religious activities positively influenced the menopausal transition, providing support, coping mechanisms, and a sense of belonging.</li> </ul>	[11]
Iran	110 postmenopausal literate, Muslim, married women	Mean age support group: $53.13 \pm 5.86$ , control group: $53 \pm 6.07$	Single-blind clinical trial/demographics and MENQOL	<ul style="list-style-type: none"> <li>• Participation in support groups can improve quality of life for postmenopausal women.</li> </ul>	[29]
Sri Lanka	20 postmenopausal women	46–55	Qualitative study/individual interviews	<ul style="list-style-type: none"> <li>• Talking to friends about menopausal problems was an efficient coping strategy, especially for single or widowed women.</li> <li>• Sharing menopausal experiences with friends encouraged healthcare-seeking behaviour and increased the detection of preventable complications.</li> </ul>	[26]
Canada	25 menopausal women living in rural areas in Nova Scotia	43–69	Qualitative study/interviews in focus groups and individual sessions	<ul style="list-style-type: none"> <li>• Women identified social support, humour, and sharing experiences with female friends, relatives, and healthcare professionals as important coping strategies.</li> <li>• Women also voiced a desire for a formal group support system, which would improve their understanding of menopause and contribute to their overall well-being.</li> </ul>	[5]

Table 2. Cont.

Country	Sample Size	Age (Years)	Study Design/Data Collection Method	Findings *	Ref.
Scotland	14 women living in the Grampian region	45–60	Qualitative study/descriptive focus group study based on a predetermined set of key questions	<ul style="list-style-type: none"> <li>• While enjoying overall strong social support, certain respondents perceived a lack of support regarding menopause. They believed that improved support networks could alleviate confusion about experienced symptoms and available management strategies.</li> <li>• A prevalent sentiment was that menopause is not openly discussed in society.</li> <li>• Women believed that engaging in discussions with other women would help normalise their menopause experiences and provide mutual support.</li> </ul>	[31]

USA = United States of America; MENQOL = menopause-specific quality of life; ATMS = Attitudes Towards Menopause Scale; MSPSS = Multidimensional Scale of Perceived Social Support; MRS = menopause rating scale; IPAQ = International Physical Activity Questionnaire. \* Main findings are reported as relevant to the main theme of this review.

### 3.3. Workplace Support

Menopausal women often encounter vasomotor, psychosocial, physical, and sexual symptoms. It has been estimated that between 20% and 40% of them experience hot flashes and night sweats, negatively impacting their vocational lives through symptoms such as discomfort, distraction, and fatigue at work [32]. Although work outcomes were not associated with menopausal status, the presence of problematic hot flashes at work was linked to the intention to stop working [33].

Psychosocial manifestations may include a diminished sense of confidence, challenges with self-identity and body image, inattention, memory loss, heightened stress levels, and an increased susceptibility to anxiety and depression. In the workplace, these symptoms can hinder a woman’s ability to perform optimally. Despite these challenges, many women refrain from seeking help, driven by factors such as embarrassment, fear of adverse reactions from others, or cultural taboos associated with the condition [34,35]. Table 3 provides an overview of the main findings concerning workplace support during menopause as documented in the literature. Most studies adopted self-designed questionnaires assessing sociodemographics, menopause symptoms, health, well-being, and aspects of work, and one study used a Health and Safety Executive’s Management Standards Indicator Tool [33].

Women consistently reported a lack of support from employers [8,17], and 26% of the women in a UK survey reported that their relationships with colleagues/employers were negatively impacted by menopausal symptoms [17]. This deficiency in support is attributed to the prevailing taboo around menopause in organisational settings, resulting in its under-recognition and neglect. A cross-sectional exploratory study among Dutch occupational physicians found that over one-third considered their knowledge about menopausal symptoms insufficient, while almost half considered their knowledge about therapeutic options insufficient. Additionally, 56% of the occupational physicians agreed that discussing menopause in the workplace is considered taboo [36]. Menopausal women themselves also experience this taboo culture, leading to the concealment of their menopausal status and symptoms from managers at work [37]. A UK study reported that almost half (47%) of employed women who took time off due to menopause-related issues chose not to disclose the real reason to their employer [17].

On the contrary, participants in a Scottish focus group study generally felt supported by their work colleagues and line managers during menopause. Colleagues offered advice, considered individual needs for the working environment’s temperature, and engaged in discussions and jokes about menopause. While some comments were deemed ageist and challenging, women appreciated the open discussion of menopause. Those who perceived

their colleagues as unsupportive believed it stemmed from their colleagues’ disinterest due to age or gender [31].

**Table 3.** Key findings related to support in the workplace for women in the pre-, peri-, and post-menopausal stages in various studies.

Country	Sample Size	Age (Years)	Study Design/Data Collection Method	Findings	Ref.
UK, USA, Australia, Japan	21,312 women	n/a (median age 50 years)	Pooled analysis using data from eight studies	<ul style="list-style-type: none"> <li>Severe menopausal symptoms are associated with reduced work ability, while treatment improves it.</li> <li>Challenging symptoms include hot flashes, poor concentration, tiredness, poor memory, feeling low/depressed, and reduced confidence.</li> <li>Taboos and limited discussions about menopause at work contribute to women’s symptom burden, potentially leading to employment changes.</li> <li>Employers recognise the need to address menopause-related challenges, fostering a workplace culture that encourages open discussions and provides support.</li> <li>Women seek information and awareness about menopause at work, prompting the creation of guidelines and training programmes.</li> </ul>	[35]
The Netherlands	267 occupational physicians (OPs)	≥30	Cross-sectional study/self-designed online survey, descriptive statistics, and post hoc logistic multivariate analyses	<ul style="list-style-type: none"> <li>Most OPs recognise menopause’s role in presenteeism (86.5%) and sickness absence (91.4%).</li> <li>48% view bothersome menopausal symptoms as ‘not sick’ but part of a normal physiological process.</li> <li>Over 56% find it challenging to assess the link between menopausal symptoms and work ability.</li> <li>63% struggle to report menopause as a diagnosis in sick leave certifications, and over 56% see discussing menopause at work as taboo.</li> <li>Positive attitudes and greater confidence among OPs are associated with higher rates of diagnosing menopause in sick leave certification.</li> <li>Dutch Ops express a positive attitude toward menopause but note a lack of knowledge and a taboo culture, emphasizing the need for education and guidelines.</li> </ul>	[36]
UK	216 pre-, peri- and postmenopausal women	45–60	Mixed methods/self-designed online survey, Health and Safety Executive’s Management Standards Indicator Tool, Hot Flush Rating Scale, and statistical analysis	<ul style="list-style-type: none"> <li>Work outcomes were primarily predicted by elements of the working environment, specifically role clarity and work stress.</li> <li>Menopausal status did not show a significant association with work outcomes, but experiencing troublesome hot flushes at work was linked to the intention to leave the labour force.</li> </ul>	[33]
UK	2650 women with menopause symptoms (currently or within previous 10 years) and 350 partners	45–65	Mixed-methods/online questionnaires (Survey 1, 2015, n = 1000; Survey 2, 2016, n = 1000; Survey 3, 2017, women n = 650 and partners n = 350) and descriptive statistics	<ul style="list-style-type: none"> <li>In all surveys, women reported a negative impact of menopause on their work life.</li> <li>Survey 2: 43% of working women believed menopause symptoms affected their work life, impacting confidence (51%), performance (44%), relationships with colleagues/employer (26%), and sick leave (17%).</li> <li>In Survey 3: women reported missing an average of 3.27 workdays annually due to menopause symptoms; 47% of employed women who took time off due to menopause did not disclose the real reason to their employer.</li> </ul>	[17]

Table 3. Cont.

Country	Sample Size	Age (Years)	Study Design/Data Collection Method	Findings	Ref.
UK	11 women	n/a	Qualitative study/semi-structured interviews	<ul style="list-style-type: none"> <li>Menopausal symptoms mainly affected women's workplace roles, while the dual responsibilities of wife/mother and worker added to self-esteem challenges and conflicts in their public and private roles.</li> <li>Participants faced challenges managing menopause at work with minimal employer support.</li> </ul>	[8]
Scotland	14 women living in the Grampian region	45–60	Qualitative study/descriptive focus group study	<ul style="list-style-type: none"> <li>Women with physical symptoms felt their personal and professional lives were negatively affected (e.g., embarrassment at work, inability to sleep).</li> <li>Most found support from colleagues and managers who offered advice, accommodated needs, and discussed menopause openly.</li> <li>Some, who perceived their colleagues as unsupportive, cited age or gender biases as barriers to discussing menopause.</li> </ul>	[31]
UK	896 women in different stages of the menopausal transition	45–55	Qualitative study online questionnaire	<ul style="list-style-type: none"> <li>Problematic symptoms at work include hot flushes, poor concentration, tiredness, poor memory, feeling low/depressed, and lowered confidence.</li> <li>53.2% of respondents could not control the temperature in their usual working environment.</li> <li>Only 29.6% could negotiate their working hours.</li> <li>24.9% discussed their menopausal symptoms with their line manager.</li> </ul>	[37]

UK = United Kingdom; USA = United States of America.

### 3.4. Medical Support

Key findings identified in the literature related to medical support for women in the pre-, peri-, and postmenopausal stages are presented in Table 4. The studies vary in quality, and most of the sources cited are mixed-methods or qualitative studies.

Women expressed mixed opinions about the support provided by family doctors during menopause. While most sought help for menopausal symptoms, views varied on the adequacy of support. Some preferred addressing specific symptoms with their doctors rather than seeking general menopausal support. Those approaching their GP with psychological issues felt upset over unsupportiveness, attributing it to the doctors' perceived lack of interest in menopause and inadequate emotional handling [31]. A cross-sectional study involving more than 4000 women revealed that most (84.8%) thought that their GP was fairly or very supportive, yet one-third (34%) expressed a desire for increased support regarding menopausal symptoms from their GP or practice nurse, and over 40% of women spoke to their GP or a health professional about menopause [27].

A qualitative study conducted in Australia highlighted a perceived lack of support from family doctors for menopause, citing reasons such as a perceived "lack of care", limited consultation time, dismissal of women's opinions, and a negative attitude toward women in this life stage [38]. Similarly, 50% of the surveyed women in a German study expressed feeling only moderately to poorly/very poorly informed about treatment options. The heightened demand for information may also stem from the ongoing discourse surrounding the (breast) cancer risk associated with HRT [39].

In a qualitative study set in the UK, participants expressed a preference for communication that conveys risks and benefits to facilitate informed and personalised choices, leading to shared decision making regarding the use of HRT. The majority emphasised the need for unbiased, truthful, and summarised information, personalised to their individual

circumstances, while others preferred a more directive approach. Barriers to effective communication included time constraints, GP attitudes, and communication issues in primary care consultations [40].

A community-based survey in Idaho, USA, involving 665 women revealed that healthcare providers often fail to provide sufficient helpful information about menopause, as 49% of them left their doctor consultations with unanswered questions about menopause [41].

Overall, 31–65% [42] and 47% [43] of the women would have preferred their physicians to initiate the conversation about treatment or symptoms and give more information on the topic, respectively. These studies indicate that women are reluctant to discuss intimate symptoms such as vaginal atrophy with healthcare professionals.

**Table 4.** Key findings related to medical support for women in the pre-, peri-, and postmenopausal stages in various studies.

Country	Sample Size	Age (Years)	Study Design/Data Collection Method	Findings	Ref.
Scotland	4407 pre-, peri-, or postmenopausal, and surgically menopausal women	45–54	Cross-sectional study/self-designed questionnaire; MSPSS; Short Form-12 Health Survey, version 2; Hospital Anxiety and Depression Scale; and ATMS	<ul style="list-style-type: none"> <li>52% sought information from their GP or practice nurse.</li> <li>84.8% thought that their GP was fairly or very supportive.</li> </ul>	[27]
Germany	1000 women (qualitative survey) and 82,619 women (quantitative study)	35–70	Mixed methods/qualitative survey and descriptive statistics	<ul style="list-style-type: none"> <li>37% felt that their gynaecologist provided mediocre or poor/very poor advice on menopause.</li> <li>50% felt moderately or poorly/very poorly informed with regard to treatment options.</li> </ul>	[39]
USA	665 women	21–77	Mixed methods/questionnaires including checklist, multiple-choice and open-ended questions, and descriptive statistics	<ul style="list-style-type: none"> <li>68% discussed menopause with healthcare providers, of which 37% discussed HRT, 33% general symptoms, 13% responded “other things”, and 12% treatments other than HRT.</li> <li>49% said their questions about menopause were not answered. Topics that women wanted better information about were HRT (36%) and general questions about menopause (22%).</li> </ul>	[41]
USA	1341 women	45 or older	Mixed methods/online survey and descriptive statistics	<ul style="list-style-type: none"> <li>44% discussed their vaginal symptoms with a healthcare professional.</li> <li>31–65% of the women would have preferred their physicians to initiate the conversation and give more information on this topic.</li> </ul>	[42]
USA	3046 postmenopausal women with vulvar and vaginal atrophy	45–75	Mixed methods/online survey and descriptive statistics	<ul style="list-style-type: none"> <li>47% said they expected HCPs to initiate the conversation. However, where conversations took place, the HCP initiated them only 13% of the time.</li> <li>Women who discussed symptoms with an HCP were twice as likely to treat them than those who did not.</li> </ul>	[43]
Scotland	14 women living in the Grampian region	45–60	Qualitative study/descriptive focus group study based on a predetermined set of key questions	<ul style="list-style-type: none"> <li>Amongst the HRT users, approximately half of the women felt that they had to persuade their family doctor to prescribe it.</li> <li>Some women felt more comfortable consulting their GP with a specific symptom rather than to obtain more general support for the menopause.</li> <li>Some women who approached their GP with psychological problems felt angry that their doctors were unsupportive.</li> </ul>	[31]

Table 4. Cont.

Country	Sample Size	Age (Years)	Study Design/Data Collection Method	Findings	Ref.
UK	40 women known patients of two general practices in Cambridge	50–55	Qualitative study/focus groups and semi-structured interviews	<ul style="list-style-type: none"> <li>Some participants felt that doctors gave them adequate information, while others felt that they lacked knowledge.</li> <li>Most participants discussed their desire for personalised care and individualised risk information.</li> <li>Barriers to optimal risk communication regarding the use of HRT included GP's attitudes and heavy workload.</li> </ul>	[40]
Australia	70 women	45–70	Qualitative study/descriptive focus groups and interviews	<ul style="list-style-type: none"> <li>One third consulted a doctor on a menopause-related issue.</li> <li>Women's reactions were mostly negative when they reported their experiences with HCPs.</li> <li>Due to time limitations, many women left their HCP's office without obtaining the information they were seeking.</li> </ul>	[38]

USA = United States of America; HCP = healthcare provider; GP = general practitioner; MSPSS = Multidimensional Scale of Perceived Social Support; ATMS = Attitude Towards Menopause Scale.

### 3.5. Technological Support

The use of digital health technologies to facilitate the provision of health services, including primary health interventions, has witnessed a significant upswing over the last two decades. Digital health technologies, encompassing virtual consultations, telehealth interventions, and participation in online support communities, offer a crucial avenue for women to access information about menopause [34].

Based on interviews and focus group discussions, an effective mobile health (mHealth) application for menopausal women's wellness should feature a user-friendly mobile platform for recording menstrual cycles. It should also help users determine their current menopausal stage and provide personalised health information, social support through a social networking service (SNS) format, food and exercise recommendations, collaboration with health professionals for information quality, and involvement of family members in supporting women's health management [44].

Efforts are being made to mitigate the medicalisation of menopause by designing systems for menopausal women's overall well-being rather than a specific physiological or psychosocial symptom [45]. Moreover, a participatory design study in the Western US (2015–2017) explored menopause technologies, revealing their potential beyond tracking to predict and prevent symptoms. The designs included the use of tracked data to foresee burdensome experiences and provide interventions or behavioural guidance. As predictive analytics advance, researchers suggest incorporating diverse data types such as location (e.g., at work) to offer intelligent recommendations for self-care during challenging episodes [46].

### 3.6. Government and Policy Support

Guidelines published by the UK National Institute for Health and Care Excellence (NICE) in 2015 [47] marked a fundamental shift in approach towards high-quality and informative menopause management. Founded on evidence-based principles, these guidelines sought to improve the consistency of support and information provided to women, including those with premature ovarian insufficiency or at a high risk of developing breast cancer.

At the time of writing, the National Institute for Health and Care Excellence (NICE) had recently published a new guideline for menopause management and diagnosis [47]. The revised guideline introduces new recommendations for addressing genitourinary symptoms like dryness, painful intercourse, and vaginal discomfort or irritation. It also suggests offering a selection of vaginal oestrogen options, such as cream, gel, tablet, pessary,

or ring, to individuals registered female at birth, including women, trans men, and non-binary individuals, even if they are on systemic hormone replacement therapy (HRT). The guideline emphasises the importance of continuing treatment for as long as necessary to alleviate symptoms.

The draft updated guideline on menopause also highlights that cognitive behavioural therapy (CBT) has the potential to help women manage menopausal symptoms, including hot flushes, night sweats, depressive symptoms, and sleep-related issues [47]. CBT, initially designed for anxiety and depression, has been adapted recently to address menopausal symptoms, such as VMS and sleep problems [48].

Additionally, the British Standard released in May 2023 offers guidance through the “Menstruation, menstrual health and menopause in the workplace—Guide” to develop supportive policies and practices for employees’ menstrual and peri/menopausal health. Its recommendations include using neutral language and establishing inclusive policies, events, and support networks. In addition, specific training related to menstrual and peri/menopausal health for managers is encouraged to combat stigma and promote inclusivity [49].

Workplace policies surrounding menopause and menstrual health were also recently implemented by NHS Scotland [50], as well as two supporting guides: the Line Managers Guide and the Workplace Adjustments Guide [51]. These resources aim to help line managers support employees affected by menstrual health or menopause symptoms and facilitate adjustments to accommodate their needs in the workplace. While the Menopause and Menstrual Health Workplace Policy is designed specifically for NHS Scotland staff, the accompanying guides are intended for broader use across various employment sectors.

Additional guidance on how employers and line managers can optimally assist menopausal women can be found in various studies, commissioned reports, and guidance leaflets created for specific (UK-based) trade unions, national union congresses, and national employee associations ([52] and citations therein). Employers can support menopausal women by implementing various measures. These include modifications to the physical working environment, such as providing easy access to desk fans or allowing greater control over workplace temperatures for women experiencing hot flushes. Additionally, ensuring clean and user-friendly sanitation facilities, offering cool drinking water, and providing access to different or more open workspaces for those in confined or hot areas are crucial. Employers should also focus on health promotion initiatives, delivering comprehensive information and support, organising awareness sessions, conducting sensitivity training for managers, and cultivating a positive cultural atmosphere that caters to the needs of menopausal women in the workplace [52].

## 4. Key Gaps and Recommendations

### 4.1. Family Support

Research on menopause in homosexual couples is notably limited, with only a few studies considering partner support or the impact of the menopause transition on relationships within this demographic. In a study involving 61 women from the United States, only four identified as homosexual. Among the lesbian participants, one individual attributed her partner’s lack of support to the partner’s younger age [15]. Therefore, further exploration is crucial to understand the nuances of the relationship between sexual orientation and partner interactions during the menopausal transition.

There is a gap in the current methodologies used to assess men’s perceptions and attitudes toward menopause. While some studies have used scales such as the ATMS and MAS to evaluate male attitudes, these scales were originally developed for women and primarily focus on women’s perspectives of menopause. To address this gap, there is a need to create a comprehensive survey instrument specifically tailored to assess men’s attitudes toward menopause. Such a tool should include questions regarding the extent of men’s involvement in their partner’s treatment-seeking behaviours and lifestyle adjustments. Additionally, the questionnaire could explore other supportive actions taken by men in

response to their partner's menopausal symptoms, initiating discussions on treatment options, comfort levels in engaging in such conversations, and the nature and tone of these discussions.

Both women and their partners lack crucial information about menopause, which may hinder inter-couple communication and shape their attitudes toward this phase of life. Therefore, we suggest the implementation of educational programmes for both men and women. Such a programme was proven successful in a study of 82 postmenopausal women from Israel who participated in a 10-week psycho-educational programme. Following the program, participants reported a decrease in the severity of physiological symptoms such as hot flashes, night sweats, fatigue, and insomnia. The programme also led to a parallel reduction in perceived social and psychological symptoms, including impatience, rejection of intimacy, and feelings of uncertainty, depression, and anxiety [30]. Furthermore, a clinical trial in Iran implemented an educational programme for men about the impact of menopausal transition on their spouses. Post-training, the majority of men exhibited more positive attitudes, actively addressing menopause through joint exercise, active listening, emotional support, relaxation techniques, and increased shared activities [53].

#### *4.2. Support from Friends and Support Groups*

Some women reported experiencing a lack of support regarding menopause despite having good overall social support. While engaging in discussions around menopause, they tended to keep them light-hearted. Barriers to seeking help included societal views portraying menopause as a joke or taboo, fear of crying, and concerns about being perceived as attention-seeking when discussing symptoms [31]. Therefore, there is a need for improved support networks to address confusion about menopausal symptoms. One solution could be the organisation of, and participation in, support groups. Support groups were found to help modify attitudes through socio-emotional processing and help improve mental health and quality of life in postmenopausal women [29].

#### *4.3. Workplace Support*

There is a significant gap in workplace support and awareness regarding menopausal issues, underscoring the need for more comprehensive policies and initiatives to address the challenges women face during this life stage. This may be due to factors such as stigma, embarrassment, the silence of other women about their experiences, or a lack of information available on the topic [17].

Discussing menopause in the workplace is considered taboo by some women [35,36], and a lack of acknowledgement has resulted in a dearth of support systems and policies tailored to addressing the unique challenges women may face in the workplace during this life stage. Breaking the silence on menopause is crucial for fostering a more inclusive and supportive work environment for women experiencing this natural phase of life [54].

This underscores the need to widen the debate on an update to the legal framework to bring it in line with contemporary perspectives. However, the complexity of the matter arises from the potential consequences of framing menopause as a protected characteristic, as this may inadvertently contribute to stigmatisation and impact women's career trajectories [55].

Recommendations for measures that should be implemented in the workplace to provide support for women facing psychosocial symptoms of menopause include [34,35]:

1. Regular depression screening in older women, acknowledging unique menopausal symptoms.
2. Implementation of workplace adjustments, including natural fibre uniforms, comfortable temperatures, access to cold drinking water, facilities for changing and washing, and toilets.
3. Developing evidence-based guides for women-centric menopause symptom management, with online resources, psycho-education, counselling, and information on therapies, along with referral pathways.

4. Fostering an open, inclusive, and supportive culture regarding menopause within the workplace.
5. Allowing women to disclose their menopausal symptoms while avoiding the assumption that every woman wishes to discuss them openly.
6. Particularly for roles involving customer interaction or public-facing responsibilities, permitting breaks to manage symptoms such as severe hot flashes.

#### 4.4. Medical Support

Effective menopause care requires a healthcare professional workforce capable of understanding and addressing the diverse needs of menopausal women [56]. Moreover, women have expressed a receptiveness to healthcare professionals taking the initiative during consultations [42,43].

Healthcare providers could also initiate and organise educational programmes and group meetings for menopausal women and their families. Group meetings provide an ideal setting for women to come together, discuss symptoms, learn from each other, and share management strategies, reducing the burden on general practices for individual counselling appointments.

Furthermore, participating in educational programmes has proven effective in improving understanding of menopause and alleviating menopausal symptoms. Women in the UK who engaged in a menopause educational programme demonstrated better knowledge and health habits compared to the control group. A significant portion (75%) reported that the programme assisted them emotionally in coping with menopause, while an even higher percentage (87%) indicated that it helped them manage the practical aspects of menopause. In contrast, the control group attributed more symptoms to menopause, reported more sexual problems, and had a higher prevalence of hormone replacement therapy [57].

There is also an agenda dissonance and a potential gap in communication regarding menopausal symptoms between women and their healthcare providers during consultations. A group of Hispanic women, for instance, expected doctors to provide appropriate and complete care during one visit. Providers considered follow-up visits as integral to the treatment plan and were frustrated with the lack of continuity in care [58]. Other criticisms included the limited time doctors allocate for appointments and a reliance on HRT as the only treatment option [8].

#### 4.5. Technological Support

Subjects undergoing menopause expressed a need for inclusive and stigma-free online health resources. However, healthcare providers have raised concerns about the reliability of online content on menopause. Therefore, it is essential to promote health data literacy and help women identify reliable sources for accurate information that complement their discussions with healthcare professionals [46]. Moreover, efforts are being made for the development of mobile applications able to offer intelligent recommendations for self-care during challenging episodes [46]. But there remains a gap in translating those efforts into the design of tangible technological interventions.

Furthermore, mental health practitioners should actively evaluate and recommend appropriate digital therapeutics to ensure safety and efficacy [59], given the increasing adoption of digital mental health strategies, particularly among financially comfortable, employed, and well-educated middle-aged women. These strategies have shown clinically effective outcomes in addressing mild to moderate depression and anxiety [60].

#### 4.6. Government and Policy Support

Many governments lack health policies and funding for incorporating menopause-related diagnosis, counselling, and treatment into their standard offerings. Provision of menopause-related policies and guidelines is especially challenging in settings where there are other competing and pressing health funding priorities. It is hoped that more govern-

ments will incorporate menopause-related services and guidelines into their healthcare frameworks following the ones already implemented in the UK.

## 5. Conclusions

Menopause does not unfold in a social vacuum. Rather, it is a complex experience shaped by various social determinants of health, encompassing cultural elements, lifestyles, family support, education, employment, economic standing, and marital status.

High social support (among other factors, such as quitting smoking and losing weight) was correlated with reduced severity of psychological and urogenital symptoms and improved attitude towards menopause. Similarly, family support has been linked to a decreased severity of menopausal symptoms.

Promoting education, both for women and their partners, has been linked to a positive impact on quality of life during menopause. We propose the promotion of menopause-related education programmes, with a call for the active involvement of partners in supporting women's menopausal health. This involves efficient communication, interaction, and sufficient knowledge and emotional support.

Despite the increasing availability of resources, menopause remains a taboo topic, with nearly half of the global population feeling uncomfortable discussing it with family and friends. For this reason, we highlight the importance of initiation and participation in support groups that discuss menopause-related issues. These groups play a crucial role in fostering a sense of normalisation as participants come to realise that other women have faced similar difficulties. This may be especially important for women who are single or have lost a spouse.

Several studies underscore the importance of access for both women and their partners to education and simplified content. Therefore, we stress the use of non-specialised, stigma-free language by healthcare professionals and other sources of information, including online platforms.

Furthermore, the studies identified in the literature vary in quality, which raises concerns about potential research bias and the representativeness of findings for broader populations. There is a need for more methodologically robust research on the matter, including larger samples and a more diverse representation of trans and gender-diverse individuals. Addressing these gaps is crucial for a more comprehensive understanding of menopause and ensuring effective support systems.

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