

**WOMEN'S REPRODUCTIVE HEALTH IN THE WORKPLACE**

**A thesis submitted in fulfilment of the  
requirements for the degree of**

**MASTER OF ARTS IN ORGANISATIONAL PSYCHOLOGY**



**BY**

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**January 2026**

## ABSTRACT

Reproductive health issues such as Menopause and Premenstrual Syndrome (PMS) or Premenstrual Dysphoric Disorder (PMDD) affect women's personal and occupational lives. Despite this, there remains a lack of targeted policies and interventions in various organisational context, including in South Africa. This oversight is also reflected in the dearth of literature or research examining the impact of and women's experiences with these issues within South African workplaces. Thus, using a qualitative research approach, this study explored the lived experiences and perceptions of women affected by PMS and Menopause within the South African workplace context. Using Liberal feminism and Empowerment theory, this study advocates for the reproductive health rights or justice and institutional support of women's unique health needs, while Goffman's Stigma theory sheds light on the psychosocial dynamics of silence and discrimination associated with women's reproductive health in the workplace. Through semi-structured interviews with women representing the population of interest, the analysis revealed that the physical, emotional, and cognitive difficulties of these issues significantly affect women's overall quality of life. Despite this, workplace support remains inadequate, perpetuated by stigma, and gendered norms that pressure women to suffer in silence. The study highlights the urgency of policy reforms within our workplaces, empowering affected women through structural accommodations, and challenges the normalisation of gendered health stigma, trivialisation, and discrimination. Conclusively, the findings contribute to broader discussions on gender equity and occupational health and wellbeing, calling organisations to recognise women's reproductive health issues, including PMS and menopause, as legitimate workplace concerns and equity issues.

**Keywords:** PMS, menopause, reproductive health, experiences and perceptions, workplace stigma, workplace support, reproductive justice, qualitative research.

## **ACKNOWLEDGEMENTS**

Completing this research has been a deeply enriching journey, one that would not have been possible without the support, guidance, and encouragement of many individuals. First and foremost, all glory and honour to Almighty God whose grace, wisdom, and strength, sustained me throughout this research journey. It is His divine guidance that I found the perseverance, clarity, and inspiration to complete this work. Further, I extend my deepest gratitude to my research supervisors Dr Trust Kabungaidze and Dr Tinashe Harry, for their invaluable mentorship, insightful feedback, and constant motivation. Their expertise, patience, and dedication were essential in shaping this work, and I am truly grateful for their unwavering belief in my potential.

I would also like to express my sincere appreciation to my colleagues and fellow researchers for their assistance, thoughtful suggestions, and encouragement through this research process. Thank you for the stimulating discussions, collaborative spirits, and camaraderie that kept me motivated during challenging times. Their perspectives greatly enriched the quality and depth of this research, and their insights and encouragement were invaluable. My heartfelt thanks also go to Rhodes University and the Psychology Department for providing the academic environment, resources, and opportunities that made this research possible and enriched my personal growth.

A special acknowledgement goes to my family and friends, whose unconditional love, patience, and encouragement sustained me throughout this journey. Their belief in me, even during moments of self-doubt, was my greatest source of strength. I would also like to express my heartfelt thanks to all the participants who generously shared their time and experiences, making this research possible and meaningful. Lastly, I would also like to express my deepest gratitude to the National Research Foundation – German Academic Exchange Service (NRF-DAAD) for their generous financial support, this funding was instrumental in enabling my research and providing much needed resources.

This research is a culmination of collective effort, and I am forever indebted to all who played a part in its realisation.

## **DEDICATION**

I dedicate this research to my dearest mother – Bukiwe Yekani. With all love, I dedicate this work to you – the foundation of my strength, the source of my courage, and the light that guides me through every challenge. Your endless sacrifices, unwavering faith in me, and unconditional love are my greatest motivation. You taught me resilience in hardship, kindness in struggle, and the power of perseverance. Even when the path is uncertain, your prayers and encouragement carry me forward. This achievement is as yours as it is mine. Thank you for believing in me long before I believed in myself. I hope this work makes you as proud as I am to call you, my mother.

## TABLE OF CONTENTS

|   |           |
|---|-----------|
| ABSTRACT  | i         |
| ACKNOWLEDGEMENTS  | ii        |
| DEDICATION  | iii       |
| TABLE OF CONTENTS   | iv        |
| <b>CHAPTER 1 – INTRODUCTION TO THE STUDY</b>                    | <b>1</b>  |
| 1.1 INTRODUCTION AND BACKGROUND                                 | 1         |
| 1.2 DEMARCATION OF THE STUDY                                    | 3         |
| 1.2.1 Geographical Demarcation                                  | 3         |
| 1.2.2 Size and Type of Organisations                            | 3         |
| 1.2.3 Units of Analysis   | 4         |
| 1.3 DEFINITIONS OF KEY CONCEPTS                                 | 4         |
| 1.3.1 Premenstrual Syndrome                                     | 4         |
| 1.3.2 Menopause   | 4         |
| 1.3.3 Reproductive Health                                       | 4         |
| 1.3.4 Diagnostic and Statistical Manual of Mental Disorders     | 4         |
| 1.4 PROBLEM STATEMENT   | 4         |
| 1.5 RESEARCH QUESTIONS  | 6         |
| 1.6 AIMS AND OBJECTIVES   | 6         |
| 1.7 SIGNIFICANCE OF STUDY                                       | 6         |
| 1.8 CONCLUDING REMARKS  | 7         |
| <b>CHAPTER 2 – LITERATURE REVIEW AND THEORETICAL FRAMEWORKS</b> | <b>8</b>  |
| 2.1 INTRODUCTION  | 8         |
| 2.2 LITERATURE REVIEW   | 8         |
| 2.2.1 Premenstrual Syndrome (PMS)                               | 8         |
| 2.2.1.1 PMS in the Workplace                                    | 9         |
| 2.2.2 Menopause   | 14        |
| 2.2.2.1 Menopause in the Workplace                              | 16        |
| 2.3 RATIONALE OF THE STUDY                                      | 21        |
| 2.4 THEORETICAL FRAMEWORKS                                      | 22        |
| 2.4.1 Feminism  | 23        |
| 2.4.1.1 Liberal Feminism in the Workplace                       | 24        |
| 2.4.2 Empowerment Theory and Women’s Agency                     | 26        |
| 2.4.3 Stigma Theory and Spoiled Identity                        | 28        |
| 2.4.4 A Complementary Framework: Integrating the Theories       | 31        |
| 2.5 CONCLUDING REMARKS  | 32        |
| <b>CHAPTER 3 – RESEARCH METHODOLOGY</b>                         | <b>33</b> |
| 3.1 INTRODUCTION  | 33        |
| 3.2 RESEARCH PARADIGM   | 33        |
| 3.3 RESEARCH APPROACH   | 34        |
| 3.4 RESEARCH DESIGN   | 34        |

|   |            |
|---|------------|
| 3.5 POPULATION AND SAMPLING PROCEDURE       | 35         |
| 3.6 DATA COLLECTION                         | 37         |
| 3.7 DATA ANALYSIS                           | 37         |
| 3.8 SOUNDNESS OF THE STUDY                  | 39         |
| 3.9 ETHICAL CONSIDERATIONS                  | 40         |
| 3.10 CONCLUDING REMARKS                     | 41         |
| <b>CHAPTER 4 – RESEARCH FINDINGS</b>        | <b>42</b>  |
| 4.1 INTRODUCTION                            | 42         |
| 4.2 REFLECTION ON THE DATA ANALYSIS PROCESS | 42         |
| 4.3 SUMMARY OF FINDINGS                     | 42         |
| 4.4 PRESENTATION OF PMS FINDINGS            | 44         |
| 4.5 PRESENTATION OF MENOPAUSE FINDINGS      | 69         |
| 4.6 CONCLUDING REMARKS                      | 90         |
| <b>CHAPTER 5 – DISCUSSIONS</b>              | <b>91</b>  |
| 5.1 INTRODUCTION                            | 91         |
| 5.2 DISCUSSION OF FINDINGS                  | 91         |
| 5.3 CONCLUDING REMARKS                      | 123        |
| <b>CHAPTER 6 – SUMMARY AND CONCLUSIONS</b>  | <b>124</b> |
| 6.1 INTRODUCTION                            | 124        |
| 6.2 SUMMARY OF DISCUSSIONS                  | 124        |
| 6.3 IMPLICATIONS OF THE STUDY               | 125        |
| 6.4 RECOMMENDATIONS FOR ACTION              | 126        |
| 6.5 LIMITATIONS OF THE STUDY                | 126        |
| 6.6 CONCLUDING REMARKS                      | 127        |
| 6.7 LIST OF REFERENCES                      | 128        |
| 6.8 APPENDICES                              | 148        |
| Appendix A                                  | 148        |
| Appendix B                                  | 149        |
| Appendix C                                  | 150        |
| Appendix D                                  | 153        |
| Appendix E                                  | 156        |
| <b>LIST OF TABLES AND FIGURES</b>           |            |
| Table 4.1                                   | 43         |
| Table 4.2                                   | 45         |
| Table 4.3                                   | 70         |
| Figure 5.1                                  | 92         |
| Figure 5.2                                  | 96         |
| Figure 5.3                                  | 103        |
| Figure 5.4                                  | 113        |
| Figure 5.5                                  | 117        |

## CHAPTER 1

### INTRODUCTION TO THE STUDY

#### 1.1 INTRODUCTION AND BACKGROUND

Reproductive health challenges – including menopause, premenstrual syndrome (PMS), premenstrual dysphoric disorder (PMDD) – have long impacted women's quality of life, with extensive research underscoring their somatic, affective, and cognitive burdens (Biyiklar & Balcioglu, 2025). Although considered normal transitions in women's lives, research shows that these conditions have far-reaching consequences for organisations as well, including increased absenteeism, presenteeism, and decreased productivity and performance (Hickey et al., 2017 & 2024; Ponzio et al., 2022; Hardy & Hunter, 2021). This is predominantly due to the incapacitating nature of these issues on many women, significantly impacting their overall quality of life and consequently hindering their capacity for optimal performance, productivity, professional presence and engagement.

In response to these challenges, some countries have made substantial progress in acknowledging and addressing the impacts of reproductive health in the workplace. For instance, over the past decade, reproductive health interventions have been implemented in high-income countries, such as France, Spain, Japan, Taiwan, and Indonesia to name a few (Carrefour, 2023; The Global Woman Leader, 2023). These interventions include, but not limited, flexible work arrangements (e.g., remote work, flexible hours, and menstrual leaves), ergonomic workspaces (e.g., ergonomic chairs, heat packs, private rest areas, in-house sanitary kits), and mental health support programs (e.g., access to counselling, stress management, employee support groups) (Van Barneveld et al., 2022).

Despite the advancements in both literature and practice, women's reproductive health challenges remain overlooked and unaddressed in various organisational contexts and agendas, particularly in the South African work context where limited attention is given to addressing or circumventing the impacts of these challenges on women. Many South African organisations lack policies and interventions dedicated to supporting women navigating reproductive health challenges. Ngoepe-Ntsoane highlights this oversight, noting that many South African workplaces continue to rely on generic leave provisions, with a lack of research and policies directed specifically

towards reproductive health. The biological processes unique to women are often excluded and considered personal or private matters within professional or organisational settings (Izadi et al., 2024; Biyiklar & Balcioglu, 2025). This oversight not only perpetuates systemic silence and hostile workplace environments for working women but also undermines their overall wellbeing.

The persistent neglect of reproductive health issues in South African workplaces can be attributed to several factors including a lack of awareness about the significant impact of related issues on women as well as the enduring male dominance and patriarchal norms within South African workplaces. In South Africa, the employment rate for men has always been higher than women for many years (e.g., 2014-2024). For instance, recent data from Statistics South Africa (2025) reflects this disparity in employment. Approximately 35.6% of women were actively employed in the South African labour market in the first quarter of 2025, compared to 45.3% of men.

While these figures reflect the broader South African employment rate, they reveal a notable 9.7% disparity. This enduring disparity in employment may not only perpetuate the marginalisation of women's health needs but also heighten their vulnerability to unsupportive workplace environments where their unique health needs may remain undervalued and neglected, particularly in male-dominated workplaces. Furthermore, these figures (i.e., 35.6% of actively employed women) also underscore the substantial representation of women in the country's labour market, which in turn raises concerns about the significant proportion of women who may be currently experiencing or vulnerable to reproductive health challenges in their workplaces.

Despite this growing representation of women in the country's labour market, research examining the impact of women's reproductive health issues within the South African work context remains remarkably scarce. Consequently, this presents a significant knowledge gap regarding the impact of these issues on women's overall quality of life. Understanding the reproductive health needs of working women in South Africa is important for improving both their personal and occupational wellbeing and empowerment. To address this research gap, the present study investigated the lived experiences and perceptions of working women affected by reproductive health issues in South African workplaces, with particular focus on PMS and menopause – reasons to be provided in the subsequent section.

## **1.2 DEMARCATION OF THE STUDY**

The purpose of demarcating any study is to enhance its focus and manageability from a research standpoint (Holman & Wilholt, 2022). Therefore, the exclusion of other reproductive health challenges does not diminish their importance or the feasibility of research. Instead, demarcation was important to ensure that the research's scope remains manageable within a single study. Without demarcation, this would have been difficult to achieve.

With that said, the researcher acknowledges that there are several reproductive health issues, other than the ones under investigation, that have a multifaceted impact on both the personal and occupational aspects of women's lives (e.g., endometriosis, abortion, pregnancy). However, to ensure the research remains feasible and maintains depth, and considering the innate limitations, the study narrowed its focus to PMS and menopause. This deliberate narrowing of the study's focus to these specific key issues within the broader spectrum of reproductive health was to ensure a more comprehensive and meaningful analysis. These reasons led to this targeted investigation rather than a broader, protracted or extended study.

### **1.2.1 Geographical Demarcation**

In research, geographic demarcation refers to the process of establishing or setting clear boundaries between geographic areas or regions and is commonly used to delineate areas for research purposes. In the present study, data collection was geographically demarcated within the broader South African context, with the sample or participants emerging mainly from provinces such as the Eastern Cape, Kwa-Zulu Natal, Western Cape, and Gauteng.

### **1.2.2 Size and Type of Organisations**

The study was conducted with participants across a diverse range of organisations, encompassing various industries such as Education, Banking and Finance, Retail, Public Healthcare, Financial Technology, and Municipality. These organisations also differed in size. The rationale for not focusing on a specific industry was intentional, aiming to provide a broader perspective that enhances the transferability of findings across varied industries. This approach facilitated an in-depth identification and understanding of these issues, uncovering their patterns and trends across diverse

organisational settings, thereby strengthening the foundation for developing practical and robust recommendations that can be applicable to diverse workplaces.

### **1.2.3 Units of Analysis**

The study was limited to working women affected by the reproductive health issues under investigation, drawn from various organisations and industries within the designated study area.

## **1.3 DEFINITION OF KEY CONCEPTS**

This section provides the reader with an understanding of the key concepts or factors discussed throughout the study. All the important terms are defined subsequently.

**1.3.1 Premenstrual Syndrome** - Premenstrual Syndrome (PMS) is a common cyclical disorder affecting females of reproductive age, characterised by a range of distressing physical, behavioural, and psychological symptoms that typically emerge in the days preceding menstruation (Citil & Kaya, 2021; Sanchez et al., 2023).

**1.3.2 Menopause** - Menopause is generally described as a normal period in women's lives that is marked by the cessation of fertility due to oocyte depletion and loss of gonadal steroids, with wide hormonal fluctuations, leading to physical and psychological implications (Santoro et al., 2021).

**1.3.3 Reproductive Health** – Reproductive health “is a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes” (World Health Organisation, 2023).

**1.3.4 Diagnostic and Statistical Manual of Mental Disorders (DSM- 5-TR)** - The DSM is a comprehensive classification system and diagnostic manual that provides a standardised criterion for the classification and diagnosis of various mental health disorders. This manual is published by the American Psychiatric Association and the DSM-5-TR being the latest version, as released in March 2022.

## **1.4 PROBLEM STATEMENT**

Existing research notes that reproductive health issues not only curtail the professional lives of women but also diminish their overall wellbeing and sense of empowerment (Grandey et al., 2020). Research also maintains that the lack of organisational

consideration and support for these issues perpetuates gendered inequalities in broader society (Kessler, 2023). While gender parity in labour force participation is growing across many countries, including South Africa, existing workplace norms continue to reflect the needs of a 'disembodied, genderless worker' – one historically shaped around men's bodies and life courses (Izadi et al., 2024). Consequently, the needs and experiences of women and people with reproductive health needs are often ignored and marginalised.

Undoubtedly, post-1994 South African workplaces have made significant strides in addressing gender concerns. However, there has been less exploration of reproductive health challenges in our workplaces, even though these deemed inclusive structures still present difficulties for women, particularly those experiencing PMS and menopause and other reproductive health issues. Furthermore, despite the existence of various health and well-being legislations (e.g., *Section 27 of the Constitution, Employment Equity Act, Occupational Health and Safety Act, Employment Equity Act*) aimed at promoting employee wellness and equality in South Africa, there remains a predominant lack of policies and interventions specifically addressing women's unique health concerns in the workplace, including their reproductive health challenges or concerns (Sibande & Roomaney, 2021; Ngoepe-Ntsoane, 2024).

In addition, this oversight is also reflected in the scarcity of evidence-based research studies on these issues within this setting (Ngoepe-Ntsoane, 2024), as many originate from international countries (e.g., Hardy et al., 2018; Hardy & Hunter, 2021; Ponzo et al., 2022; Okamoto et al., 2024). Overall, this suggests a contextual gap, therefore, limiting the transferability or generalisability of findings from international research studies to this context. As a result, this study addresses this gap, by expanding research efforts to include the underrepresented geographical context of South Africa, thereby ensuring a more comprehensive understanding of the phenomena under investigation. Furthermore, existing research primarily employs other methodologies (e.g., Ponzo et al., 2022; Geukes et al., 2023; Loukzadeh et al., 2024; Okamoto et al., 2024) resulting in a limited number of studies that utilise qualitative methods. Thus, this suggests a methodological limitation and the present study addresses this by adopting a qualitative methodology.

## **1.5 RESEARCH QUESTIONS**

The study's primary research question is *“What are the lived experiences and perceptions of women affected by reproductive health issues in the workplace?”*

The following sub-questions will be addressed to ensure that the research aims and objectives are achieved.

- What are the lived experiences and perceptions of women affected by PMS and menopause in the workplace?
- How do these experiences and perceptions impact women's personal and professional lives?
- How do women manage PMS and menopause-related challenges?
- What organisational measures can be implemented to support and empower women facing these challenges in the workplace?

## **1.6 AIMS AND OBJECTIVES**

In line with the research question(s), this section outlines the objectives of the present study, which are:

- To have an in-depth understanding of the lived experiences and perceptions of women affected by PMS and menopause in the workplace.
- To examine the impact of these experiences in working women's overall quality of life.
- To explore strategies that women employ to manage PMS and menopause-related challenges.
- To provide workplace recommendations that may be helpful in supporting and empowering women affected by these issues.

## **1.7 SIGNIFICANCE OF THE STUDY**

The present study plays a crucial role in dismantling the prevailing silence surrounding reproductive health issues in the workplace, particularly in South Africa. By examining the impact of these issues on women, this research serves as a catalyst for organisational change, promoting the recognition and accommodation of women's unique health needs. Furthermore, it addresses the gender inequalities exacerbated by the neglect of reproductive health issues in workplace policies and agendas. It also

contributes to the empowerment of women by advocating for inclusive workplace environments that acknowledge reproductive health issues like menopause and PMS as legitimate concerns. Given the demonstrable impact of these issues on occupational functioning, this study provides empirical support for implementing support structures that would benefit the overall personal and occupational quality of life of women. At large, this study contributes towards South Africa's Sustainability Development Goals (SDG), specifically SDGs 3, 5, 8, and 10 (SGD Report, 2024). Aligned with SDG 3, this study promotes health and wellbeing by equipping employers with the knowledge to accommodate women and promote their overall wellbeing in the workplace. This empowerment of women reinforces gender equality – core principles of SDGs 5 and 10. Concurrently, this not only enhances women's inclusion but also advances SDG 8's core principles of full and productive employment and decent work. Additionally, this study also contributes towards the National Development Plan (2030), that looks to eliminate poverty and reduce gender inequality by the year 2030 through economic growth and inclusion (SDG Report, 2024).

Overall, this study holds substantial value to multiple stakeholders, including policymakers, gender activist, and various bodies committed to promoting inclusion and overall wellness in the workplace. By providing research grounded insights, this study informs the development of targeted workplace policies and programs to address the reproductive health challenges in the work context. Critically, considering the dearth of South African-specific research on these issues, this study assumes a critical role in challenging the existing status quo, therefore, driving transformative change or structural reforms that recognise related issues as a critical dimension of workplace inclusion.

## **1.8 CONCLUDING REMARKS**

This chapter presented the study's foundation, research problem, objectives, and significance of examining women's experiences and perceptions of reproductive health issues (i.e., PMS & Menopause) in the workplace context. By framing these important elements, the chapter sets the stage for a deeper exploration of the subject under investigation. The subsequent chapter builds upon this foundation through a comprehensive literature review and theoretical framework, further contextualising the study within existing scholarly discourse.

## **CHAPTER 2**

### **LITERATURE REVIEW AND THEORETICAL FRAMEWORKS**

#### **2.1 INTRODUCTION**

The previous chapter introduced the study, emphasising the importance of recognising and acknowledging reproductive health issues as legitimate concerns to women's overall quality of life. It also underscored the research problem, its questions and objectives. Ultimately, it highlighted the significance for related research within the South African context given the dearth of studies in this area within this setting.

The current chapter provides a comprehensive background and review of existing literature on the reproductive health issues under consideration, namely premenstrual syndrome (PMS) and menopause, within the workplace. It connects the study to the broader scholarly dialogue on the studied phenomena, framing its importance and relevance. In essence, this chapter informs the reader of what is known about the subject and what remain known or unexplored, thereby establishing a rationale for further research or investigation. Additionally, the chapter outlines the theoretical frameworks that inform or guide the research.

#### **2.2 LITERATURE REVIEW**

##### **2.2.1 Premenstrual syndrome (PMS)**

Premenstrual Syndrome (PMS) is a common cyclical disorder affecting female of reproductive age, characterised by a range of distressing physical, behavioural, and psychological symptoms that typically emerge in the days preceding menstruation (Sanchez et al., 2023). While the exact aetiology of PMS remains unclear, research suggests a strong association with hormonal fluctuations – particularly in oestrogen, progesterone, and serotonin during the luteal phase of the menstrual cycle (Citil & Kaya, 2021; Jose et al., 2021). The fluctuations of these hormones during the luteal phase of the menstrual cycle are believed to trigger PMS-related symptoms (Citil & Kaya, 2021).

PMS often encompasses a wide range of behavioural and psychological symptoms including withdrawal, lack of interest, depression, tearfulness, anxiety, stress, anger outbursts, irritability, frustration, diminished psychological resilience and so on (Hardy

& Hardie, 2017; Jose et al., 2021; Mahmood et al. 2022; Sireesha et al., 2023). Physical symptoms such as headaches, abdominal pain, bloating, fatigue, joint and muscle pain, nausea, breast tenderness, insomnia, and lower-back pain are common (Hardy & Hunter, 2021; Jose et al., 2021; Mahmood et al., 2022; Sireesha et al., 2023). Research further underscores that the hormonal fluctuations associated with PMS can significantly impair cognitive functioning, contributing to brain or cognitive fog (e.g., forgetfulness and lack of concentration) which is often exacerbated by the interplay of physical and emotional symptoms (Jose et al., 2021; Hayward et al., 2024). PMS is a prevalent concern among women of reproductive age, with approximately 50 - 95% experiencing at least two or three these symptoms during the luteal phase of each menstrual cycle (Dasikan, 2020; Jose et al., 2021; Mahmood et al., 2022).

At the more severe end of the spectrum lies Premenstrual Dysphoric Disorder (PMDD), a clinically recognised mental disorder distinct from typical Premenstrual Syndrome (PMS) (Hardy & Hunter, 2021). PMDD is characterised by significantly severe psychological and physical symptoms than PMS, affecting approximately 3-8% of women of reproductive age (American Psychiatric Association, 2022, Ponzio et al., 2022). Although PMDD shares some symptomatic overlap with PMS, it is distinguished by the intensity of emotional and psychological disturbances, with researching framing it as a debilitating mental health condition (Ponzio et al., 2022). Both PMS and PMDD are individualised experiences, with symptom severity, frequency, and duration varying across individuals and menstrual cycles (Hardy & Hunter, 2021). This variability is influenced by factors such as cultural norms, environment, diet, age and biological differences (Mahmood et al., 2022; Park et al., 2023).

### **2.2.1.1 PMS in the Workplace**

A growing body of literature underscores the importance of addressing PMS in the work context provided its significant impact on women's personal and occupational lives. Studies by Schoep et al. (2019), Grandey et al. (2020), Ponzio et al. (2022), Park et al. (2023), Okamoto et al. (2024), Loukzadeh et al. (2024) demonstrate that PMS-related symptoms including physical manifestations (e.g., headaches, muscle pain, abdominal cramps, bloating) and emotional implications (e.g., irritability, mood swings, anger, anxiety) substantially impair women's overall job performance and productivity.

These findings are corroborated by earlier studies (Borenstein et al., 2004; Heinemann et al.; 2010; Kahyaoglu & Mestogullari, 2016; Hardy & Hardie, 2017) which also reveal marked declines in women's work productivity and performance during PMS. The consistency of these findings across various studies highlights PMS's substantial repercussions on essential work outcomes. This is unsurprising, given that hormonal fluctuations during PMS are frequently associated with impaired concentration, attention to detail, and other executive functions essential to work productivity and performance (Victor et al., 2019; Schoep et al., 2019; Grandey et al., 2020; Jose et al., 2021; Dilbaz & Aksan, 2021). Collectively, these findings underscore the interplay of PMS symptoms in creating a cyclical impact that significantly undermines workplace productivity and performance.

Studies by Hardy and Hunter (2021), Ponzo et al. (2022), Hemmegan et al. (2022), and Okamoto et al. (2024), indicate that menstrual-related mood disturbances, physical symptoms, including difficulties in cognitive function, significantly contribute to increased absenteeism and presenteeism, which further diminishes work productivity or performance. These findings are corroborated earlier research including Kahyaoglu and Mestogullari (2016) and Victor et al. (2019) whose respective studies similarly highlight the detrimental impacts of related PMS symptoms on critical work outcomes, including absenteeism, presenteeism, and overall productivity. The consistency of these findings across different studies not only reinforces the robustness and reliability of the observed associations but also underscores the pervasive impact of menstrual health on women's professional lives.

Research also indicates that PMS symptoms, particular emotional distress, significantly impair women's Interpersonal or social relations. Park et al. (2023) found that PMS often disrupts social interactions, with many women experiencing difficulties engaging with colleagues, partners, and their broader environment due to challenges in regulating emotions such as frustration, anger, mood swings, and hopelessness. Furthermore, Mahmood et al. (2022) notes that PMS exacerbates stress or tension, anxiety, and susceptibility to conflict, contributing to social maladjustment and diminished work productivity. These findings are supported by earlier studies by Rapkin and Winer (2009) Tkachenko et al. (2010), Victor et al. (2019) which similarly highlight the adverse effects of PMS-related emotional dysregulation on social adjustment and interpersonal relationships. Overall, these studies underscore the

pervasive social implications of PMS, extending beyond individual symptoms to disrupt professional and social dynamics.

The challenges of emotional regulation during PMS are often compounded by feelings of self-blame and guilt (Park et al., 2023). In response, many women often withdraw and isolate themselves in the workplace to prevent impulsive or harsh interactions with colleagues or partners (Park et al., 2023). This pattern of behaviour is consistent with the findings of Victor et al. (2019), who identified a significant relationship between PMS and social avoidance or isolation. While this is seemingly protective short-term, it may inadvertently perpetuate a cycle of isolation that can exacerbate feelings of loneliness and other depressive symptoms. Collectively, these findings highlight that PMS not only disrupts functions critical for job performance or productivity but also has tangible consequences on women's emotional wellbeing, hence the negative impacts on their social domain. Therefore, these findings underscore the need to address the emotional impact of PMS in the workplace, fostering a more supportive and positive social environment for women.

The comprehensive spectrum of PMS symptoms is a risk factor to heightened occupational stress, with women expressing reduced psychological resilience and a diminished sense of control over job demands (Hardy & Hunter, 2021; Loukzadeh et al., 2024). The relationship between PMS and occupational stress well-documented in literature. Studies by Hannani et al. (2019), Chen et al. (2022), and Al-Hmaid et al. (2024), Wang et al. (2024) consistently demonstrate that PMS symptoms often exacerbate occupational stress, while occupational stress in turn intensify PMS manifestations. Earlier studies also indicate this dynamic, revealing how occupational stress may exacerbate PMS symptoms and vice versa (Deuster et al., 1999; Hourani et al., 2004; Jahromi et al., 2011; Kahyaoglu & Mestogullari, 2016). This cyclical dynamic often leads to adverse work outcomes, including increased absenteeism and reduced work productivity, and impaired job performance. Therefore, this underscores the urgent need for workplace interventions that address both PMS and work-related stress as interconnected health and productivity issues.

The overall impact of PMS on working women often reduces their job satisfaction, motivation, overall happiness, exacerbates work-life imbalance, and dissatisfaction with their work environment (Kahyaoglu & Mestogullari, 2016). This is supported by

Park et al. (2023) and Al-Hmaid et al. (2024), whose studies further emphasise the substantial negative impact of PMS on multiple dimensions of women's quality of life. As a result, some women experiencing severe PMS-related challenges often report heightened turnover intentions in the workplace, particularly in the absence of institutional support (Hardy & Hardie, 2017; Hardy & Hunter, 2021; Browne, 2023). The symptoms of PMS, coupled with the work-related difficulties they create often prompt women to consider leaving their jobs or exiting the workforce entirely (Griffiths et al., 2021; Carneiro, 2024). These findings demonstrate how women experiencing severe reproductive health issues are often forced to choose between maintaining their health and sustaining their careers as their challenges are trivialised. Therefore, this highlights a critical workplace equity issue given the lack of accommodations or support for related issues in various organisational settings.

The cumulative impact of PMS extends beyond voluntary turnover (or intentions of thereof) to posing significant barriers to women's career advancement or career prospects. The negative work outcomes such as cyclical absenteeism and declines in performance or productivity associated with menstrual issues like PMS foster perceptions of incompetence or unreliability in the workplace. For instance, Hardy and Hardie (2017) and Gatrell et al. (2022) highlight how some women are even viewed unfavourable and asked to leave their jobs by employers (i.e., involuntary turnover) due to the impact of PMS on work outcomes. Therefore, the compounding impact of PMS coupled with lack of institutional awareness and support creates structural inequality and barriers that can ultimately constrain long-term career trajectories of women. Okamoto et al. (2024) supports this, noting that some women even give up promotions or quit their jobs entirely due to menstrual-related health not given consideration or attention in the workplace. Therefore, this not only systematically disadvantage women in the workplace, but could potentially limit their access to promotions, and other career development opportunities due to such biases and perceptions.

The career repercussions (e.g., loss in credibility, incompetence, unfavourable) associated with reproductive health issues often cause women to conceal their reproductive health-related challenges in the workplace context where stigmatisation and ridicule are common (Griffiths et al., 2013; Hardy & Hardie, 2017; Hardy & Hunter, 2021; Martinez-Borba et al., 2024). As a result, this often forces women to endure

significant discomforts and distress while maintaining work responsibilities, further diminishing their quality of life. According to Abbass et al. (2020) non-disclosure of reproductive health challenges is particularly prevalent among women from lower socioeconomic backgrounds, who often fear professional repercussions due to workplace biases or stigmas that tie these issues to incompetence or unreliability. These findings underscore how reproductive health issues are misunderstood and undervalued in the workplace context, necessitating institutional and policy reforms.

The underreporting or non-disclosure of PMS-related challenges in the workplace goes beyond individual concerns to systemic gendered dynamics. For instance, this dynamic is prevalent in mixed gendered settings such as the workplace, particularly when leadership or workforce is predominantly male (Borenstein et al., 2005; Johnston-Robledo & Chrisler, 2013; Robinson et al., 2017; Hardy & Hunter, 2021). This pattern often stems from the persistent taboo nature surrounding menstrual health discussions, ultimately leading to women to view related issues as inappropriate or embarrassing topics in those spaces. Hennegan et al. (2022) and Ohayi et al. (2022) supports this, highlighting how taboos (e.g., cultural) around discussions concerning reproductive and menstrual health in many societal settings hinder women in reporting or disclosing their reproductive-related challenges, leading to a sense of isolation. Compounding this reluctance is the legitimate fear of gender-based stigma, discrimination, or having their concerns dismissed or trivialised as mere hormonal fluctuations (Borenstein et al., 2005; Johnston-Robledo & Chrisler 2013; Hardy & Hunter, 2021). However, some women also express difficulty reporting or disclosing their symptoms or challenges even to female managers, noting that regardless of shared gender, some female managers can be unapproachable and unsupportive especially when they perceive their ability to manage their own symptoms as the norm (Hardy & Hunter, 2021). Another reason why some women remain hesitant to disclose or report their PMS-related challenges in the workplace is the perception that PMS is a personal concern unlikely to warrant or qualify for organisational support or accommodations (Hardy & Hunter, 2021). Consequently, women often cite alternative or unrelated health issues to justify work adjustments or leave. Broadly, the nature of non-disclosure and underreporting extends beyond PMS, to encompass other reproductive health issues like PMDD and menopause, reflecting a systemic workplace challenge where such concerns remain overlooked or unnoticed in various

organisational contexts (Hardy & Hardie, 2017; Hardy et al., 2018; Beck et al., 2020; Hickey et al., 2022).

The underreporting of PMS-related challenges in the workplace, not only leaves women to independently manage their difficulties but also perpetuate a culture of silence that hinders the development of institutional support mechanisms that could benefit both employees and organisations (Figuroa et al., 2021). This silence renders women's reproductive health an invisible issue in organisational discourse, despite its significant impacts on women's personal and occupational quality of life, perpetuating systemic neglect (Biyiklar & Balcioglu, 2025). While organisations bare responsibility to proactively create supportive environments for their employees, women's reluctance to report or disclose their reproductive health challenges at work reinforces the status quo. Therefore, this underscores the need for collective advocacy to normalise these conversations in the workplace.

### **2.2.2 Menopause**

Menopause is generally described as a normal period in women's lives that is marked by permanent cessation of fertility following the depletion of ovarian follicular activity or menstruation (Abbas et al., 2020; Davis & Baber, 2022). During this period, women encounter a loss of ovarian follicular activity which results in hormonal changes in their bodies, causing disruptive somatic, somatic, and cognitive symptoms (Davis & Baber, 2022; Koothirezhi & Ranganathan, 2023). Menopause is also an individualised experience, meaning the severity of symptoms may differ from person to person (Jack et al., 2016; Hickey et al., 2024). Factors such as individual and cultural differences, health status, and environmental or workplace conditions may influence the severity of symptoms (Namazi et al., 2019).

PMS generally resolve with the onset of menopause, a transitional phase that begins with perimenopause. Perimenopause, the initial stage of this transition, is characterised by a woman's body undergoing significant adjustments toward the cessation of reproductive capability (Himanshi & Singh, 2022). This stage is marked by the emergence of menopausal symptoms, at times accompanied by erratic and irregular periods that are accompanied by intensified PMS-related symptoms, as highlighted earlier. In some women, this transition occurs earlier than expected (before age 40) – this phenomenon is known as *early or premature perimenopause* (Mishra

et al., 2019, Himanshi & Singh, 2022). According to Himanshi and Singh (2022) perimenopause typically spans 2 to 8 years, encompassing significant physiological and psychological changes. Menopause is the point at which a woman has experienced 12 consecutive months without menstruation and PMS-induced symptoms. During this phase, the menopause-related symptoms experienced during the perimenopause phase often intensify.

The period following menopause (i.e., 12 consecutive months without menstruation and PMS-induced symptoms) is referred to as post-menopause and is often characterised by continued menopausal symptoms which gradually diminish over time (Koothirezhi & Ranganathan, 2023). Post-menopause is also characterised by an increased risk of health conditions such as osteoporosis and cardiovascular diseases due to low oestrogen levels signifying the permanent cessation of fertility (Koothirezhi & Ranganathan, 2023). Overall, this underscores the continuous nature of reproductive health challenges faced by women, transitioning from one reproductive health related or induced issue to another throughout their life span. Further to that, this highlights that those in employment navigate most of their career lives while managing the constraints and difficulties posed by related reproductive health issues.

In the context of the present study, the term “menopause” is used to describe the entire transition process to reflect the continuum of symptoms and experiences across the phases given that symptoms can begin from perimenopause and last throughout post-menopause (Roush, 2012). This approach acknowledges the overlapping nature of challenges during these phases, therefore offering a comprehensive understanding of their impact on working women’s quality of life.

Despite menopause being a normal life transition, research demonstrates that the hormonal fluctuations of menopause are often accompanied by an interplay of somatic, affective and cognitive or functional symptoms with significant disruptions in both women’s personal and occupational lives (Brewis et al., 2017; Namazi et al., 2019; Beck et al., 2020). Somatic symptoms include hot flashes, headaches, fatigue, musculoskeletal tension, night sweats, sleep disturbances, chest and head pressure, dizziness, and nausea (Moratalla-Cecilia et al., 2016; Namazi et al., 2019; Beck et al., 2020; Hickey et al., 2017 & 2024). According to the same studies, affective symptoms may encompass depression, stress, anxiety, mood swings, irritability, frustration.

Additionally, women in menopause may also experience cognitive impairments, particularly brain fog which is characterised by memory lapses, concentration difficulties, and reduced attention to detail (Brewis et al., 2017; Hickey et al., 2017 & 2024). This clearly demonstrates a significant symptom overlap across reproductive health issues, as PMS encompasses similar symptoms. Furthermore, this underscores how women continuously face reproductive health challenges throughout their lives, further deteriorating their quality of life across personal and professional domain. To gain a comprehensive understanding of the personal and occupational impacts of menopause, a review of relevant studies is provided subsequently.

### **2.2.2.1 Menopause in the Workplace**

There is extensive evidence that the experience of menopausal symptoms negatively affects women's quality of work-life. For example, Geukes et al. (2012 & 2016), Whiteley et al. (2013), Hardy et al. (2018), consistently demonstrate how somatic symptoms (e.g., hot flashes, sleep disturbances, fatigue, headaches, musculoskeletal tension or pain) and affective symptoms (e.g., mood disturbances, irritability, anxiety) of menopause collectively undermine women's work performance and productivity, and how these symptoms often lead to heightened absenteeism and presenteeism at work. More recent studies also highlight the marked impact of these symptoms on women's quality of work-life, underscoring similar impact (Grandey et al., 2020; Geukes et al., 2023; Safwan et al., 2024; Hickey et al., 2024). The hormonal fluctuations of menopause that result in marked cognitive impairments, particularly brain fog, also significantly reduces women's ability to perform their work responsibilities efficiently. Evidence of this is highlighted in research studies by Brewis et al. (2017), Beck et al. (2020), Grandey et al. (2020); Atkinson et al. (2021 & 2024), and Hickey et al. (2017 & 2024). Earlier studies by Woods and Michell (2011), Griffiths et al. (2013), and Whiteley et al. (2013) also demonstrate the persistent nature of menopausal cognitive difficulties on workplace outcomes such work productivity, performance, absenteeism, and presenteeism. Overall, these studies further underscore the interplay between symptoms, highlighting how somatic and affective symptoms frequently compound menopause-induced cognitive impairments, creating multidimensional workplace implications for menopausal women, including their overall wellbeing. The convergence of evidence across decades highlights how menopausal symptoms create unique barriers to occupational functioning for women.

Despite the overwhelming evidence underscoring how menopause affect occupational outcomes, this issue remains inadequately addressed in various organisational contexts, exposing a persistent blind spot in workplace accommodations (Brewis et al., 2017; Hill, 2020; Cronin et al., 2021). As a result, women often engage in over-compensatory behaviours such as working extended hours to make for the recurrent declines in their work performance or productivity (Hardy et al., 2017 & 2018). This is supported by Banks (2019) who also underscores that menopausal women often feel anxious about the impact of their symptoms on work performance and productivity. According to Banks (2019) this anxiety often leads to overcompensation, including working longer hours and overexertion, in efforts overcome or mask perceived shortcomings. However, while these adaptive behaviours may work, they may significantly exacerbate physical and emotional distress, leading to burnout, emotional exhaustion, and chronic fatigue and occupational stress (Griffiths et al., 2013; Hardy et al., 2018).

Research also highlights a link between occupational stress and menopause. Hardy et al. (2018) highlights that women experiencing the comprehensive spectrum of menopausal symptoms frequently report moderate to severe levels of work stress, resulting in increased absenteeism, presenteeism, and diminished work performance. This aligns with earlier research findings by Matsuzaki et al. (2014) who identified work stress as key risk factor that has an adverse impact on women's occupational well-being. Conversely, a recent study by Moffat et al. (2024) indicates that when women receive adequate reproductive health support, stress in often diminished. The relationship between occupational stress and menopause highlights the complex nature and interplay between menopausal challenges and occupational wellbeing. This also underscores how hormonal changes during menopause can directly interact with workplace demands, creating unique challenges that require targeted support.

Many research studies consistently emphasise the interplay between the workplace environment or conditions and the severity of menopausal symptoms (Griffiths et al., 2013; Jack et al., 2016; Jafari et al., 2017; Faubion et al., 2023). These studies demonstrate how physical aspects like workplace design, temperature, and ventilation, along with psychosocial factors like job autonomy, support, and work demands, shape women's menopausal experiences. According to Jack et al. (2016) and Safwan et al. (2024), when the psychosocial and physical stressors of the

workplace environment are left unaddressed, women's ability to concentrate, be productive, as well as their career decisions are often negatively impacted. Griffiths et al. (2016), Bariola et al. (2017), and Hickey et al. (2017) emphasise the importance of practical accommodations in the workplace, including several workplace adjustments, raising awareness, and supportive leadership practices to improve working conditions for menopausal women. Conclusively, these studies collectively highlight the critical need for organisations to implement a comprehensive gender-sensitive framework that addresses broader health and well-being issues of employees, including those experiencing menopause. However, it is worth noting that not all women experience work-related interruptions due to menopause symptoms; nevertheless, research indicates that for those who do, support is limited and critically needed (Steffan & Potocnik, 2023).

Jack et al. (2016) and Geukes et al. (2023) note that collegial and supervisory relations in the workplace are often affected by menopausal symptoms. Similar findings were revealed in an earlier study by Griffiths et al. (2013), demonstrating how menopausal symptoms, particularly affective symptoms such as irritability, mood swing, and anxiety often impair social relationships at work. These symptoms make it difficult for women to maintain not only professional presence and engagement, but also workplace interactions and relationships due to heightened emotional sensitivity that may lead to conflict and tension at work (Woods & Michell, 2011). As a result, women often chose to isolate or withdraw from the presence of people within and outside the workplace. Therefore, this not only diminishes team dynamics but also undermines organisational behaviour, culture, and effectiveness.

The overall spectrum of menopausal symptoms significantly impacts women's occupational wellbeing and career prospects and decisions. Hardy et al. (2018) and Verdonk et al. (2022) note that women experiencing severe menopausal symptoms report decreased work motivation, job satisfaction, and overall confidence in their competence, leading to turnover intentions. These feelings elicit thoughts of entirely leaving their jobs and careers due to negative impacts on both their personal and occupational quality of life, particularly in the absence of adequate institutional support systems (Griffiths et al., 2021). These findings align with earlier work by Jack et al. (2014 & 2016), which similarly demonstrates how menopausal challenges diminish work motivation and commitment, ultimately leading intensified turnover intentions.

Research further reveals that some women sometimes decline promotions or avoid roles or opportunities with greater responsibilities due to concerns about the impact of menopause on important workplace outcomes (Hobson & Dennis, 2023 & 2024). This reflects how reproductive health challenges influence women's career decisions, leadership aspirations, and workplace dynamics. Therefore, this underscores the importance to acknowledge and address reproductive health challenges to create workplace environments that supports the wellbeing and career prospects of women affected by related conditions.

Research reveals troubling attitudes toward menopause in the workplace and in broader society. Jack et al. (2016) and Atkinson et al. (2022) highlight that many organisations fail to recognize menopause as a legitimate workplace concern, leaving women vulnerable to ridicule or hostility when discussing or disclosing their menopausal challenges at work. Geukes et al. (2023) and Safwan et al. (2024) support this, demonstrating how some organisations exploit menopause to undermine women's standing, self-efficacy, and competence. Some organisations even use the occupational challenges of menopause against women in promotion or career advancement decisions, viewing or labelling women experiencing reproductive health difficulties as unfavourable compared to men (Gatrell et al., 2017; Safwan et al., 2024). These findings highlight a negative perception that associate menopausal status with diminished competence or incapability, which in turn perpetuates non-disclosure and underreporting of related issues in the workplace (Hickey et al., 2022).

The lack of disclosure or reporting of menopause due to workplace taboo and stigma is well-documented in existing literature. This taboo and stigma suppress open discussion or reporting of menopausal challenges in the workplace due to fear of professional repercussions associated with menopause, which further impedes organisational support (Beck et al., 2020; Schaedel & Ryder, 2022; Geukes et al., 2023; Martinez-Borba et al., 2024). Griffiths et al. (2013) emphasises that not disclosing menopause-related challenges is itself a stressor, yet women choose to suffer in silence due to persistent workplace stigma and discrimination. To corroborate this, research by Hardy et al. (2019) and Beck et al. (2020) collectively highlight key barriers to disclosure of menopausal challenges in the workplace, including fear of discrimination and stigmatisation particularly in male-dominated workplaces. Similar disclosure challenges are also highlighted in studies by Hickey et al. (2017) and Gatrell

et al. (2017). Collectively, these findings underscore how workplace stigma and systemic barriers perpetuate a culture of silence around menopause, consequently compromising the wellbeing of women and professional equity.

Menopause is not only perceived as a problematic issue, but also an embarrassing and shameful topic in the workplace (Griffiths et al., 2013; Hardy et al., 2018; Geukes et al., 2023), further creating significant barriers to open discussion or reporting. Whiley et al. (2023) extends this analysis highlighting how aging itself becomes stigmatised differently by gender, while men often retain their status as they age, women are often rendered undesirable and invisible. According to Whiley et al. (2023) menopause is often associated with a loss of femininity or theorised as 'dirty' femininity in society and in organisations, leading to women being cast out, shamed and stigmatised in these contexts. Additionally, existing literature reveals that women themselves often hold negative attitude towards menopause, due to societal culture and beliefs (Erbil, 2018). Mukuwa et al. (2015) notes that women experience personal discomfort with open discussion with male colleagues regarding reproductive health matters, highlighting perceptions that such matters are sensitive, embarrassing, and only fit for feminine discussion. Cultural and traditional norms play a significant role in shaping perceptions that discourage such conversation between men and women (Mukuwa et al., 2015). This observation would be unsurprising within the South African context which is characterised by deep rooted cultural and traditional norms that may present challenges to such dialogues.

Furthermore, many societies place high value on fertility and youthfulness, framing menopause as both loss of reproductive capacity and attractiveness (Green & Santoro, 2009; Ayers et al., 2010). As a result, these cultural narratives often make menopausal women internalise negative attitudes toward this transition. Therefore, the societal devaluation of post-reproductive age highlights the need to challenge gendered stereotypes that associate women's worth solely with fertility and youth. Overall, such attitudes lead to non-disclosure and underreporting menopausal challenges, which in turn leaves them unaddressed and overlooked in many organisational contexts (Edler, 2023). Because of the silence, some organisations may or remain unaware of the workplace challenges of menopause, thus hindering organisational support and intervention.

Existing literature underscores the critical role of effective leadership and institutional awareness in breaking the barriers associated with reproductive health challenges. Griffiths et al. (2016), Hardy et al. (2018), and Geukes et al. (2023) suggest that workplaces with open culture, and knowledgeable line managers and supervisors can foster a workplace environment that is conducive to open dialogues about menopause and other related matters. Therefore, this underscores the importance of gender sensitivity and awareness in the workplace, particularly in regions such as South Africa, where deep-seated cultural and traditional norms can influence such gender or menstrual-related conversations, ultimately hindering societal-organisational understanding and support.

### **2.3 RATIONALE OF THE STUDY**

Existing literature highlights the positive impact work can have on one's overall wellbeing. For instance, Steger (2016) highlights that meaningful work fosters self-esteem, provides one with a sense of purpose and fulfilment, and contributes their mental and emotional wellbeing by reducing psychological stress and enhancing job satisfaction. Additionally, Steger (2016) emphasises that work generally improves one's quality of life by enabling the fulfilment of personal responsibilities and offering opportunities for self-improvement. However, these benefits are often hindered or diminished for women affected by reproductive health issues, such as premenstrual syndrome (PMS) and menopause, as highlighted in the literature review. Despite the well-documented implications of these reproductive health challenges on women's personal and occupational lives, there is a significant gap in literature addressing these issues within the South African work context. Much of the current research stems from international contexts (England, America, Turkey, Iran, Germany, Canada, Britain, Brazil, Uganda, Australia, etc.), therefore, this necessitated research that captures and reflects the socio-cultural dynamics of South Africa, where a diverse workforce and society may bring distinct challenges and perspectives.

Understanding the experiences and perceptions of working women affected by reproductive health issues is also important in promoting inclusive workplace wellness policies and programs. Jack et al. (2021) emphasises that there is uneven progress in recognising the specific needs of women in the workforce, particularly those affected by related issues. Therefore, the present study contributes to the progress towards the

recognition of reproductive health needs in the South African workplace context. Furthermore, the study not only address critical social justice issues (e.g., gender inequalities) persistent in our workplaces owing to the impacts of these issues but also provides organisations evidence-based insights to the experiences and challenges women face due to reproductive health issues.

As highlighted in the literature review, reproductive health issues are historically neglected and dismissed topics in workplace discourse. Consequently, affected women often encounter normalised stigmatisation, discrimination, misunderstanding, and a lack of support in various occupational and societal settings (Izadi et al., 2024). This exacerbates women's reluctance to engage in open discussions about their challenges, further isolating them in those environments. Therefore, the present study challenges these misconceptions, raises awareness, and looks to foster environments of understanding, acceptance, and inclusivity in the workplace or society at large. By addressing this underexplored area within the South African context, the study assumes a critical role in dismantling the invisible barriers that perpetuate inequality, social injustice, and discrimination in the workplace. It paves way for greater recognition of these issues, the implementation of support structures, and the elimination of associated stigmas. Ultimately, the findings of this research may improve women's overall wellbeing and career prospects, while promoting inclusivity and equity within broader employment structures.

Overall, this study not only aspires to bridge a critical gap within existing academic literature, but also to spreads awareness and fosters transformative change or reforms by providing research-driven recommendations. By breaking the silence surrounding reproductive health challenges, it offers a platform for women empowerment, promotes equity, and addresses the persistent gender inequalities embedded within South African organisational and societal contexts.

## **2.4 THEORETICAL FRAMEWORKS**

To inform the analysis of the *lived experiences and perceptions of women affected by reproductive health issues (i.e., menopause & PMS) within the South African workplace context*, it is essential that a robust theoretical lens is applied. Therefore, this research is primarily grounded in three core theoretical perspectives – Feminism specifically Liberal feminism (Wollstonecraft, 1792; Mill, 1869), Empowerment theory

(Rappaport, 1987), and Stigma theory (Goffman, 1963). These frameworks are explored further in the subsequent sections, including how they complement one another to inform research on this topic. Individually, each framework provides diverse insights into the dimensions (e.g., personal, structural, and social) of women's experiences with the phenomena under investigation. Collectively, these frameworks provide a comprehensive basis for understanding and addressing the challenges at the intersection of work and women's reproductive health. Additional frameworks, including Reproductive Justice, and Employee Voice and Silence theory are incorporated into the discussion.

### **2.4.1 Feminism**

Feminism encompasses a wide range of political movements, ideologies, and social movements united by a common goal of defining, establishing, and achieving political, economic, personal, and social equality between genders (Raina, 2020). The foundational premise behind feminism is that women have long been given an inferior or secondary status by patriarchal structures and male-dominated social discourse, reinforced by western philosophical traditions. Therefore, at its core, feminism advocates for women's equality and justice across all sphere or aspect of life, ensuring equal access to opportunities and resources that have historically been disproportionately available to men (Raina, 2020). Studies highlight that the feminist movement may be divided in three or four waves, with each wave dealing with different aspects of the same feminist issues (Hussain, 2019; Raina, 2020).

The first wave emerged in the nineteenth and early twentieth century, advocating for women's equal rights to vote and equal representation on parliament. The second wave gained momentum in the 1960s, broadening the scope of feminism by advocating for systemic equity in legal, social, and professional spheres, including education and employment. In the 1990s there third wave emerged as a both a continuation and critical response to the perceived failures or limitations of the earlier movements, expanding the discourse to include intersectional perspectives. This phase incorporated broader gender and race issues to encompass the experiences of marginalised populations (Hussain, 2019; Raina, 2020).

Collectively, these waves gave rise to different branches of feminism that are not mutually exclusive but instead represent different perspectives and approaches within

the broader feminist movement as it evolved over time (Effiong, 2020). These branches include, but not limited to, Liberal feminism, Cultural feminism, Socialist feminism, Radical feminism, Ecofeminism, Postcolonial feminism, Intersectionality, each contributing distinct perspectives to address gender equality (Ankush, 2013; Effiong, 2020). With that said, the most relevant framework to the present study is Liberal feminism.

#### **2.4.1.1 Liberal Feminism in the Workplace**

Liberal feminism is associated with the second wave of the feminist movement, advocating for women's equality. At its core, this framework emphasises the need to dismantle discriminatory practices by pushing for equal rights through legal and political reforms within institutions and broader society to improve women's positions (e.g., status and equality). Unlike more radical approaches, Liberal feminism advocates for the integration of women into the existing social and political structures or systems, rather than completely restructuring them (Ropers-Huilman, 2003, Effiong, 2020).

This framework is underpinned by the following core principles. Firstly, it emphasises the inherent value and diverse contributions of women across various societal domains (Ansari, 2022). Secondly, it acknowledges that women have historically been an oppressed group, often subjected to limited opportunities and restricted social participation, impeding the realisation of their full potential (Ropers-Huilman, 2003; Ansari, 2022). Lastly, this framework advocates for the rights of women and aims to grant access to equal rights and representation through legislation (Ansari, 2022). Accordingly, key historic figures (e.g., Mary Wollstonecraft to Ruth Bader Ginsburg) and contemporary advocates have focussed on advocating for women's rights to equal opportunity and access to critical spheres of education, employment, and political participation, including reproductive rights, to reduce gender-based discrimination (Jones & Budig, 2008; Ankush, 2013).

In the workplace, Liberal feminism has been fundamental in advancing policy reforms that protect women's rights and wellness (Bailey, 2016). For example, feminists operating within this framework have played a critical role in banning gender-based discrimination through legislation, securing maternity protections, and advocating for equal pay to address gender wage-gaps in various organisational contexts. Further to

that, through this framework, feminists have also addressed harassment and gender-based violence of women in various spheres of society, including the workplace, redefining such acts as fundamental violations to women's rights. These advances are collectively reflected in South African legislation, including, but not limited to, Labour Relations Act, Employment Equity Act, Basic Conditions of Employment Act.

These policy and legal achievements have improved women's positions in various workplace contexts in South Africa by recognising and reframing their unique struggles as aspects of workers' rights and organisational concerns rather than personal problems. For instance, the introduction of legislation (e.g., Employment Equity Act and Basic Conditions of Employment Act) addressing gender pay-gaps and pregnancy discrimination now prohibits employers from dismissing women on basis being pregnant or paying them less based on gender (i.e., giving women an inferior or secondary status to male). Another example is the promotion or implementation of accommodations such as maternity leave as a necessary intervention so that biological differences do not translate to occupational disadvantages. Such reforms reflect or embody Liberal feminism's advocacy for gender equality or equity – ensuring that women have the same legal rights and access to opportunities that have historically been disproportionately available to men, including support or accommodations for women's unique health needs.

Clearly, this framework critiques workplace norms that reflect the needs of a normal or disembodied genderless worker. Traditionally, workplaces were designed or shaped around men's bodies and life courses, treating women's reproductive processes as deviations or weakness (Izadi et al., 2024). Feminism points out that society, including the workplace, has long advantaged the male body as the primary standard, viewing the female body as inferior or secondary standard, associating it with deficiencies, lack of control, and other stereotypes because of their reproductive bodies (Gatrell et al., 2017; Kessler, 2023). In the workplace, such biases associate women's unique biological processes with assumptions about negative organisational or work outcomes, thus resulting to organisational or institutional discrimination and stigma that perpetuate gender inequality (Kessler, 2023; Carneiro, 2024). Liberal feminism uncovers and addresses related biases through advocating for equal-opportunity policies or legislation.

Accordingly, from a Liberal feminism's standpoint, this study contests that women's overall reproductive health (i.e., including menopause and PMS) is recognised as a worker's rights and social justice issue that organisations or employers within the South African context must not overlook or trivialise but instead address. When organisations overlook or dismiss natural processes like PMS and menopause, women's professional or occupational wellness suffers, exacerbating structural inequalities. In the context of the present study, this framework therefore guided the researcher to examine organisational policies and the degree to which these structures uphold women's health rights, including reproductive rights.

In essence, using this framework, this study explored the structural factors affecting women's experiences of PMS and menopause. This involved examining organisational policies (or lack of thereof) on menstruation or PMS and menopause, and how these policies reflect broader gender norms and uphold women's reproductive health rights. Further on, by using this framework, this study examined whether there are clear support provisions or structural silence around these issues. From a Liberal feminism's standpoint, this study asked whether women feel they have equal opportunity and rights in the workplace despite their unique health needs. Conclusively, this framework offered a macro-level outlook, underscoring the importance of rights, equity, and institutional reforms in understanding and improving women's reproductive health issues (e.g., PMS and menopause) in the workplace.

#### **2.4.2 Empowerment Theory and Women's Agency**

Empowerment theory is a framework originating from community psychology, particularly the works of Rappaport (1987), representing a guiding principle for fostering social, political, economic agency. Central to Empowerment theory is self-determination, which centres on building individual and collective agency, enabling marginalised people to take control of their lives, make informed decisions, and actively shape their futures (Perkins & Zimmerman, 1995; Zimmerman, 2000). According to these scholars, empowerment theory emphasises improving wellbeing and social justice through collaborative and participatory approaches. It provides a framework for marginalised or oppressed individuals and groups to acquire both the power and resources required to exercise their rights and seize opportunities. In essence, this framework emphasises that when people have active access to

knowledge, skills, and necessary resources, not just rights, they can achieve optimal functioning and improve their standings or positions within societal domains (Perkins & Zimmerman, 1995; Murphy, 2024). Conversely, it posits that many societal issues arise from the inadequate distribution and limited access to resources (Zimmerman, 2000). Such disparities serve as significant catalysts for disempowerment within societal spaces (Perkins & Zimmerman, 1995; Rappaport, 1987).

Rappaport (1987), Perkins and Zimmerman (1995) define empowerment as a multidimensional construct and describe multiple levels of empowerment, including personal, organisational, and community empowerment. Central to personal empowerment is developing a sense of self-efficacy and critical awareness, providing one the confidence that they can shape outcomes, assert their needs, and succeed in challenging situations. Organisational empowerment involves the capacity to influence decisions affecting one's life within societal spaces (e.g., the workplace), by having a voice or say in policies or collective actions. Lastly, societal or community empowerment involves enabling structural changes to redistribute power often through education and social support networks or systems.

Empowerment is both a process and an outcome, involving the 'process' of gaining power and the state of being empowered (i.e., outcome) (Swift & Levine, 1987; Perkins & Zimmerman, 1995). Essentially, this framework does not simply imply that 'power' must be handed down to marginalised individuals or groups, rather, it requires active involvement and agency of those people in all spheres of society, including the workplace, to exercise their rights and improve their situations and positions. In the context of women, this framework would then highlight how organisations and entrenched norms of patriarchy within them render women powerless. Further to that, Empowerment theory would highlight how aiding women to recognise and address their marginalisation or oppression therefore building capacity can result to greater autonomy and health.

Empowerment and health are well-documented in research. Existing studies note that when people (e.g., women) experience powerlessness (e.g., oppression and marginalisation) in societal contexts (e.g., workplace) their overall wellness suffer (Williams et al., 2023). Therefore, empowering women through active access to knowledge, skills, and necessary resources enabling them to make informed choices

about their bodies and exercise their agency can be instrumental for achieving equity in wellness (i.e., meeting their overall health needs). In practical terms, applying an Empowerment lens to women's reproductive health means ensuring that they have the provisions to manage their reproductive bodies (e.g., menopause or PMS). Furthermore, it also means helping women build the confidence to speak openly about their reproductive health needs without fear of ridicule, shame, or embarrassment.

Overall, from an Empowerment theory's standpoint, this study drew attention to women's agency and voice in navigating reproductive health challenges. It examined whether women feel empowered to disclose their health challenges, including reproductive health. Furthermore, it examined whether women feel empowered to request accommodations for related issues, and what might help them to feel more supported in the workplace. Existing research underscores how providing employees health resources and support policies can empower them and improve their personal and organisational outcomes (Okolieuwa et al., 2023). Thus, when organisations allow women to have control over reproductive health through accommodations, support policies, and other related provisions, women can then improve their health and better participate in the workplace, and broader society.

#### **2.4.3 Stigma Theory and “Spoiled Identity”**

Goffman's Stigma theory provides an insightful framework for understanding stigma and its effects on individuals. According to Goffman (1963, p.3), stigma is defined as an “attribute that is deeply discrediting”, leading to a spoiled identity, which means not fully accepted by society. This theory incorporates many contemporary attributes that are often discredited, including physical irregularities, blemishes of character, and tribal stigmas (Clair, 2018). A discrediting attribute could either be readily discernible or could be hidden but nonetheless discreditable if revealed. Furthermore, the Stigma theory underscores how individuals often manage their identity when they possess a stigmatised attribute, that is constantly navigating between being discreditable (i.e., where stigma is concealable) and being discredited (i.e., where stigma is visible). According to Goffman (1963) as cited in Clair (2018), stigma is “a general aspect of social life that complicates ever-day micro-level interactions where the stigmatised may be wary of engaging with those who do not share their stigma, and those without

a certain stigma may disparage, overcompensate for, or attempt to ignore stigmatised individuals” (p.1).

Link and Phelan (2001) expanded Goffman’s Stigma theory, conceptualising it as a co-occurrence of various components facilitated by power dynamics or differences. According to their framework, stigma occurs when differences are labelled, then stereotypes are associated with the label, leading to separation (i.e., Us vs. Them), and ultimately loss of status and discrimination. To clearly demonstrate this, consider the following example: Society identifies a human difference that is noteworthy (e.g., menopausal woman), then dominant cultural norms associate the label (i.e., being “menopausal”) with negative traits (e.g., assuming that menopausal women are less capable or unreliable because of their symptoms). Those with the label are then categorised as distinct from the norm (e.g., viewing women with related-reproductive health needs as “them” who are not fit for challenging work demands). Consequently, the labelled individuals (i.e., menopausal women) suffer discrimination and injustices such as being not trusted with bigger workplace roles or promotions due to the stigma attached to their reproductive health condition.

Link and Phelan (2001) maintain that this process is facilitated by societal and institutional power, meaning that when those in power accept and enable these stereotypes, either consciously or unconsciously, stigma is the result. This then underscores why others (e.g., men or male employees) remain advantaged or privileged while “them” are not (e.g., women needing reproductive health support or accommodations). Research highlights how reproductive health stigma often results to internalised shame, stress, withdrawal for labelled individuals, as well as other negative outcomes such as reduced performance, absenteeism, opportunities, overall wellness, and curtailed careers (Beck et al., 2020; Hardy & Hunter, 2021)

Various reproductive health issues carry significant stigma (e.g., the notion of spoiled identity) in various societal domains, including the workplace. For instance, stigma towards menstruation is a well-documented concern in research, where related issues are often perceived as dirty, sensitive, and embarrassing topics in mixed gendered contexts (e.g., at work) (Hardy and Hardie, 2017; Hennegan et al., 2022). Same applies to menopause, research shows how “menopausal” women or menopause itself is viewed as dirty femininity or loss femininity, and rendered undesirable (Whiley

et al., 2023). Consequently, such gendered stereotypes and stigma often mean that women conceal their reproductive health challenges and needs, as they are trivialised and discriminated.

Notably, stigma can be detrimental factor to disclosure or reporting of health-related challenges in the workplace and according to the Employee Voice and Silence theory such acts deprive organisations of potentially useful information (Marrison, 2014). This theory highlights the motivational factors or processes that affect whether employees will voluntarily engage or communicate information about their concerns, problems, or work-related issues to employers or colleagues. For example, in the presence of motivational factors (e.g., absence of stigma and discrimination), employees are likely to engage or communicate their work-related issues and this is referred to as an upward voice, meaning that they provide valuable information that may aid in the development of solutions or interventions. However, when this is not the case, where positive motivational factors are lacking (e.g., presence of stigma and discrimination), then important information is withheld hindering potential solutions or interventions. Therefore, stigma hinder such conversations in the workplace, perpetuating the lack of organisational or institutional support or accommodations for affected individuals.

In this study, investigating women's perceptions and experiences of reproductive health issues (i.e., PMS and menopause) within the South African context, the Stigma theory directed attention to feelings of shame, withdrawal, silence, and discomfort in relation to these issues. The researcher looked for evidence of women not reporting or disclosing their reproductive health challenges and needs in the workplace due to anticipated stigma. In Goffman's stigma theory (1963), this is referred to as "information control", where labelled individuals or individuals with a stigmatised attribute carefully manage information to avoid prejudice. This theory also helped the researcher interpret any incident of differential treatment, as well as internalised stigma within the "labelled" (i.e., women with reproductive health needs). Recognising these patterns can help frame reproductive health challenges such as PMS and menopause as legitimate workplace concerns, rather than individual or personal matters.

#### **2.4.4 A Complementary Framework: Integrating the Theories**

Each of the reviewed frameworks provide different or unique perspectives on women's perceptions and experiences with reproductive health issues in the workplace. Essentially, these frameworks are not mutually exclusive; in fact, they complement and reinforce each other to provide a more comprehensive understanding of the phenomena under investigation. Thus, by integrating Liberal feminism, Empowerment theory, and Stigma theory, the present study addresses the problem or subject under study from multiple angles and levels of analysis.

For example, by employing Liberal feminism, the study looks to confront and address discriminatory practices in the workplace, by advocating for women's rights through institutional, legal, and policy reforms (e.g., reproductive health justice or policies) aimed at improving women's positions and enabling them to reach their full potential. However, institutional and policy reforms without active empowerment can be insufficient and may lead to unsustainable change (Amartya, 1999). In the context of the present study, simply having reproductive rights does not automatically translate into women's ability to exercise them. To address this, Empowerment theory was employed, emphasising the need to not only advocate for equal rights to address inequality but also actively equip women with knowledge, skills, and resources needed to drive meaning and lasting change. Therefore, while Liberal feminism provides a structural and political lens for reforms, Empowerment theory provides a framework for practical strategies and interventions to ensure these rights are enforced in practice, thus enhancing women's agency. This not only strives for reproductive rights but also the need for organisations to actively provide access to resources and policies that women collectively identify as most impactful for both their personal and professional quality of life. Additionally, these assertions align with the Reproductive justice theory, which advocates for inclusive and equitable policies and practices in reproductive health services, education, and resources (Morison, 2023). This theory aligns with both Liberal feminism and Empowerment theory by striving to empower marginalised communities (i.e., women) and improve their workplace and socio-economic standings. However, to strengthen the analysis of gender-based inequality, the study further examined how societal stigma reinforces systemic oppression of reproductive bodies, particularly the psychosocial dynamics of silence, discrimination, and identity. Therefore, to address this, Goffman's Stigma theory was employed.

In conclusion, this complementary framework provided a basis for examining the lived experiences and perceptions of women dealing with menopause and PMS in the workplace. While Liberal feminism grounds or informs the study in principles of equality and justice, Empowerment theory keeps the focus on women's agency and the importance of enabling voice and active support. Goffman's Stigma theory on the other hand ensures that the societal pressures and prejudices that exacerbate women's experiences are recognised or acknowledged. Collectively, this complementary framework enabled the study to describe reproductive health challenges, while also highlighting women's reproductive health needs.

## **2.5 CONCLUDING REMARKS**

This chapter provided a comprehensive review of the existing literature on the reproductive health challenges under investigation - premenstrual syndrome (PMS), and menopause. It highlighted not only the detrimental effects of these issues on working women's personal and occupational lives but also underscored how the lack of adequate workplace support and non-disclosure or underreporting further perpetuates a cycle of silence and marginalisation. Consequently, a study rationale was established upon the literature review. Furthermore, the current chapter outlined the theoretical perspectives underpinning the study. Therefore, the subsequent chapter presents, in detail, the study's methodology.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

The previous chapter reviewed the current body of literature focusing on premenstrual syndrome and menopause in the context of work and further reviewed relevant theoretical frameworks that guide or inform the study. The current chapter outlines the methodology of the present study and provides reasons of its utilisation. In essence, the chapter covers the chosen research philosophy; research approach; research design; population and sampling procedures; data collection and analysis procedures. Finally, this chapter provides a section on the soundness of the study and ethical considerations.

#### **3.2 RESEARCH PARADIGM**

A paradigm is a lens through which a researcher perceives or interprets certain issues, as defined by Kamal (2019). Kelly et al. (2018) further notes that a paradigm forms a foundation for the pursuit of understanding in a study, therefore shaping the researcher's approach. Extending on this, Iofrida et al. (2018) explains that a research paradigm consists of the researcher's ideas about the nature of reality, the relationship between the observer and the subject under investigation, and the methodology employed to generate or acquire knowledge or understanding.

There are various research paradigms that are scholarly recognised, including positivism, interpretivism, and pragmatism. Accordingly, the present study adopted interpretivism as a research paradigm. In this paradigm, knowledge is considered as inherently subjective, characterised by multiple interpretations rather than a singular, objective truth determined through measurement processes or experimentation (Hammersley, 2013). Interpretivism, therefore, is a research paradigm that attempts to understand the in-depth subjective experiences and perceptions of individuals through different social contexts and cultures (Ryan, 2018). It posits that knowledge, or truth is constructed or shaped by subjective experiences within specific social and cultural contexts. Interpretivism focuses on the richness and depth inherent in subjective experiences or reality and the complexity and contextuality of human meanings. These arguments align primarily with the aims and objectives of the present

study – as it looked to explore and better understand the subjective or lived experiences and perceptions of women affected by the reproductive health issues under investigation. Furthermore, interpretivism is applicable within the sphere of qualitative research methodologies (Yong et al., 2021). Additionally, this further aligns with the qualitative approach and procedures employed in this study. This is further corroborated in the forthcoming sections.

### **3.3 RESEARCH APPROACH**

A research approach refers to the plan and procedures devised by the researcher, providing insight into the possible methods of data collection, analysis, and interpretation (Chetty, 2016). It essentially constitutes an essential plan or strategy that guides the design and execution of a research study. It is often influenced by the nature of the study's research problem, the researcher's philosophical position, and the type of data required to address the research questions. The most recognised research approaches in scholarly inquiry include quantitative, qualitative, and mixed methods approaches. In this study, the qualitative research approach was employed.

The qualitative approach presents matters from participants' perspectives, presenting data in a descriptive manner. This approach prioritises in-depth understanding, exploration, and interpretation of participants' experiences through the dynamic interaction with the researcher (Maher et al., 2018). Cresswell and Cresswell (2018) note that the qualitative approach involves the use of subjective data collection methods such as interviews, participant observations, and focus groups to uncover participants lived experiences and meanings. This approach aligns with interpretivism, which further supports the emphasis on subjective experiences or realities and the complexity and contextuality of individual meanings. Therefore, the employment of an interpretivist lens in the present study necessitated the employment of a qualitative research approach. Further to that, the employment of a qualitative research approach in the present study, therefore necessitated the employment of qualitative research methods – See further elaboration in the subsequent sections.

### **3.4 RESEARCH DESIGN**

McCombes (2019) describes a research design as the overall strategy or analytical approach that is employed to integrate various components of a study to effectively address the research questions. A research design serves as a blueprint or a

framework that determines how data will be collected and analysed (McCombes, 2019). This ensures that a study's methods align with its objectives, are appropriate and feasible in answering its research questions. Therefore, to provide a richer understanding of women's experiences and perceptions regarding the reproductive health issues under investigation, Phenomenology was employed as a research design. According to Gill (2020), phenomenology refers to the study of phenomena, and this could be anything that appears to an individual's conscious or lived experience. This research design is often employed to understand the depth and meaning of subjective experiences from the viewpoints of those who have lived or experienced a certain phenomenon (Lester, 1999; Alesa, 2017). In support, Creswell (2014) asserts that phenomenology is used in many qualitative research studies to investigate or interpret the lived experiences of individuals who have experienced a common phenomenon.

In the context of the present study, phenomenology therefore allowed for an in-depth exploration of how PMS and menopause impact both the personal and professional quality of life of women, shedding light into women's experiences and perceptions. This enabled the researcher to uncover the important structures and meanings of women's experiences and perceptions, providing a rich understanding of these issues. Furthermore, phenomenology does not only align with the research aims and objectives but also allows for the employment of various qualitative data collection methods, including interviews, observations, focus groups, field notes (Creswell, 2014). Therefore, given that the present study employs a qualitative research methodology, this research design was rendered appropriate.

### **3.5 POPULATION AND SAMPLING PROCEDURES**

In qualitative terms, the research population represents the larger target group of interest, comprising of individuals who share a specific lived experience (Creswell, 2014; Kabir, 2016). From within this broader population, a sample from which data is collected is purposively selected using a specific sampling method (Shukla, 2020). Central to this approach is the principle that the participants, or sample, must have direct, lived experience of the phenomenon under investigation. This ensures that the sample reflects the shared characteristics and commonalities that define the larger target group and authentically represents its voices and experiences so that research

insights can be meaningfully transferred to deepen understanding (Kabir, 2016; Cresswell, 2014).

To ensure the inclusion of participants who met the inclusion criteria and represented the broader population of interest, purposive sampling was primarily employed. Purposive sampling is a non-probability sampling technique in which participants are selected because they share characteristics that are essential to the study's objectives (Kabir, 2016). This is an approach where the researcher selects or chooses a sample based on certain criteria. The broader, target population for the current study are working women in or beyond their reproductive age. The study's sample, thus comprised of women within reproductive age and beyond, either currently employed or have employment experience across various sectors and companies within the South African context. To participate, these women were required to be in their reproductive age, thus experiencing PMS, or beyond their reproductive age, thus undergoing menopause. Participant recruitment encompassed advertising on various social media platforms like Facebook, LinkedIn, WhatsApp, and Posters (See *Appendix B for the recruitment poster*).

However, given that the researcher is male and the present study examines predominantly female phenomena that are often considered sensitive, embarrassing or uncomfortable to discuss in mixed-gendered contexts, the researcher anticipated challenges in participant recruitment. Therefore, to proactively address this potential barrier, a complementary sampling method was employed. Purposive sampling was therefore further complemented with Snowball sampling through leveraging the networks of initial participants. For example, after interviewing the participants obtained through purposive sampling, the researcher then asked them to kindly refer colleagues or peers who meet and represent the population of interest or simply meet the study criteria. According to Alase (2017), snowball sampling is based on "soliciting the advice and help of the participants who have already agreed to participate in the research project to help 'put in good words' to attract other participants to join in the research project" (p.13).

This complementary approach was time-efficient and increased access to hard-to-reach participants who meet and represent the population of interest, particularly with menopause. The overall study population or sample ranged from 18 to 65 years of

age. The sample size per condition was determined by data saturation. Data saturation refers to the point in the research data collection process where no new information is coming out of the data analysis (Saunders et al., 2018). This redundancy indicates to the researcher that data collection may come to an end as no new information is being discovered. Saturation of the data was reached with a sample size of nine (9) participants for the PMS cohort and eight (8) participants for the menopause cohort.

### **3.6 DATA COLLECTION METHOD**

Kerkmeijer et al. (2016) defines data collection as a systematic process of gathering information, or in research terms 'data', from various sources to address the study's research questions and/or objectives. The current study adopted a qualitative research approach and design; therefore, data was collected using one-on-one semi-structured interviews. Kabir (2016) describes semi-structured interviews as a method of data collection that employs a blend of closed-and-open-ended questions, that are further supplemented by probing to gather more in-depth information essential to a research study. This method of data collection aligns with the employed research approach and design, allowing for further exploration of participants' insights and experiences.

The interviews were conducted either face-to-face or online using platforms such as Zoom and Microsoft Teams, based on the convenience and preference of participants. Offering various platforms for the data collection process offered flexibility, ensuring that participants could select the interview platform that best suited their preferences. The interviews were conducted in English and IsiXhosa and tape-recorded. The duration of interviews was approximately 30 to 45 minutes (*See Appendix D for the interview guide*).

### **3.7 DATA ANALYSIS PROCEDURES**

Data analysis, as described by scholars such as Creswell and Creswell (2018) and Jennings et al. (2018) is an essential step in the research process. According to these scholars, it involves presenting the collected data in a comprehensive and understandable manner, allowing the researcher to derive meaningful interpretations.

Following data collection, the researcher transcribed the audio-recorded data and then verified the quality of the transcriptions by comparing them to the recorded data. Given satisfactory correspondence between the two, the researcher then proceeded to data

analysis. The transcribed data was manually analysed (i.e., analysis was done without using automated software) using thematic analysis following the guidelines suggested by Braun and Clarke (2016). Thematic Analysis is a five-step method encompassing familiarising self with the data, creating preliminary codes, identifying themes, reviewing the identified themes, and precisely defining and labelling each theme (Braun & Clarke, 2016). The researcher strictly followed these steps throughout this process for each transcript. The flexibility of thematic analysis in addressing diverse research questions and accommodating various data collection methods, rendered it well-suited for the study. Braun and Clarke (2016) note that thematic analysis serves the purpose of identifying patterns within and across data in relation to participants lived experiences, perspectives, behaviour and practices. This assertion further validates the applicability of thematic analysis in addressing the research questions and achieving the objectives of the study.

Precisely, Deductive thematic analysis was primarily employed to analyse the data. Deductive Thematic Analysis takes a top-down approach and is theory-driven in nature. This form of thematic analysis tends to rather provide a more detailed analysis some aspects of the data, than provide a detailed analysis of the overall data. Therefore, the researcher tries to fit the process of coding within a pre-existing coding frame aligning with their theoretical underpinnings, assumptions, or analytic preconceived notions regarding the studied phenomenon (Braun and Clarke, 2016). According to Braun and Clarke (2016) in qualitative research, data is never analysed in an "epistemological vacuum"; complete detachment from one's theoretical and epistemological commitments is unattainable, and the researcher acknowledged this. Further to that, given that the researcher had prior knowledge about the studied phenomena, he acknowledged that the study's objectives or the specific interview questions posed during data collection were formed in a manner that the themes derived bear a strong relationship with those elements.

Albeit the latter, the researcher remained receptive to unexpected themes or findings that may somehow challenge their theoretical and epistemological assumptions. This means that the researcher was, to some degree, open to letting the data speak for itself, thereby generating some data-driven findings – a major element of Inductive thematic analysis (Braun and Clarke, 2016). According to Braun and Clarke (2016) Inductive thematic analysis is particularly valuable when navigating unexplored

terrains. Given limited research on the areas under investigation within the South African context, this hybrid approach therefore proved suitable. Additionally, considering that South Africa is a culturally and traditionally diverse context, this allowed for an exploration of potential context-specific findings that could offer a richer understanding within this unique setting.

### **3.8 SOUNDNESS OF THE STUDY**

Maintaining neutrality and consistency in data collection and analysis processes is crucial for the credibility, transferability, dependability, confirmability, and authenticity of qualitative research (Abidin et al., 2024, Ahmed, 2024). This further ensures that the researcher's personal biases and preconceptions in relation to the study's topic are minimised to ensure the study's soundness (Creswell, 2014). In this study, the following strategies were employed to ensure these qualities:

A detailed protocol delineating the processes of data collection and analysis was devised and rigorously adhered to throughout these procedures. A standardised set of interview questions were used during data collection to prompt discussion among participants. These questions were designed to elicit relevant information related to the research questions and were accompanied by follow-up questions to gather more information (Patton, 2015). A few pilot tests of the data collection procedure or interview protocol were conducted to assess its effectiveness, feasibility, coherence, and potential to yield high-quality data (Patton, 2015). In essence, this included selecting a small representative sample of participants and implementing the data collection procedure as planned. This process facilitated the identification of several challenges in the protocol, including issues with the clarity of questions, its flow and structure, probing techniques, logistical shortcomings regarding data collection equipment and the researcher's preparedness to carry out this process. The pilot tests ultimately confirmed the researcher's preparedness and the appropriateness of the approach to yield high-quality data. Therefore, this provided an opportunity to make refinements in the process before its actual application or utilisation, which in turn enhances dependability and confirmability of findings (Abidin et al., 2024; Patton, 2015).

Peer debriefing, involved seeking feedback from colleagues or experts in the field who are not directly involved in the study through engaging in discussions and

presentations to gain diverse perspectives, identify potential biases, and ensure that data collection and interpretation remained objective, consistent, and trustworthy (Abidin et al., 2024; Creswell, 2014). Ensuring the applicability or transferability of research findings to various contexts of the population of interest is essential (Abidin et al., 2024; Patton, 2015). In pursuit of this goal, purposive sampling was primarily employed, deliberately including women from diverse backgrounds and employment sectors to enhance these important aspects of qualitative research. Member checking was also employed, which involved sharing the research findings or analysis with interested participants to verify the confirmability, credibility, and authenticity of their experiences and insights as captured in the data (Abidin et al., 2024; Creswell, 2014).

### **3.9 ETHICAL CONSIDERATIONS**

In research, ethical consideration is upholding research integrity, protecting human rights and fostering collaborative partnerships between research and society or participants (Bhandari, 2022). This encompasses obtaining informed consent and ensuring voluntary participation, maintaining confidentiality and anonymity, and practicing honesty and integrity throughout the data collection, analysis, and dissemination phases (Neufeld et al., 2019, Bhandari, 2022). In line with this, the following ethical standards were adhered to throughout the study.

Firstly, following the study's proposal, the study was granted ethical approval by the Higher Degrees Committee of Rhodes University (*see Appendix A for the ethical approval or clearance*). Prior the commencement of data collection of the study, participants were informed about the study's procedures, goals, potential benefits, risks, and confidentiality measures. Accordingly, this ensured that participants were fully informed before making an informed decision whether to participate or not. A consent form was issued to indicate this (*See Appendix C for the consent form*). Secondly, the researcher clarified to participants that their participation is anonymous. And so, their identities were kept confidential and anonymous throughout the data collection and analysis processes. Instead of using identifying information, unique codes or identifiers were assigned to participants to track and analyse their responses.

The researcher further highlighted that data will solely be used for research purposes and not for any other purposes without participants' explicit consent. Additionally, to further ensure that confidentiality is maintained all physical data was stored in a

designated, restricted-access location and digital data was encrypted in a secure cloud storage provider. The researcher assured participants that all these were accessible only to the authorised researcher and supervisors.

Lastly, given the employed method of data collection, participants were susceptible to experiencing discomfort or stress due to the predetermined sensitive nature of the topics discussed. Consequently, the researcher prioritised establishing rapport and fostering a comfortable, trusting environment throughout the process assuring participants that the study was a safe space, free from judgement. Additionally, recognising the potential discomfort associated with the presence of a male researcher, a female research assistant (i.e., a PhD student) was included when needed to relieve any concerns.

Overall, the study ensured the wellbeing and rights of the participants were upheld, concurrently maintaining the integrity and credibility of the study. Adhering to ethical conduct ensures that meaningful and trustworthy insights are constructed, thereby benefiting the study and the broader society.

### **3.10 CONCLUDING REMARKS**

This chapter described the methodology employed to conduct the present study. It touched on the employed research paradigm, research approach, research design, data collection and analysis procedures. The subsequent chapter presents the findings of the study.

## CHAPTER 4

### RESEARCH FINDINGS

#### 4.1 INTRODUCTION

The previous chapter described the methodology employed to carry out the present study. It touched on the employed research paradigm, research approach, research design, sampling and sampling methods, data collection and analysis procedures, and the ways to improve trustworthiness of the study. The current chapter focuses on the presentation of findings derived from the data pertaining to the reproductive health issues under investigation.

#### 4.2 REFLECTION ON THE DATA ANALYSIS PROCESS

It should be recalled that Deductive thematic analysis was primarily employed to analyse the data. Deductive thematic analysis takes a top-down approach, and it is theory-driven in nature. This form of thematic analysis tends to rather provide a more detailed analysis of some aspects of the data, than utterly letting the data speak for itself. This means that the researcher tries to fit the process of coding within a coding frame aligning with their theoretical or analytic preconceived notions regarding the studied phenomenon (Braun and Clarke, 2016). Therefore, the themes or patterns emerging from this type of qualitative analysis are strongly linked to the theoretical underpinnings of the researcher. However, the researcher remained receptive to unexpected insights or findings.

#### 4.3 SUMMARY OF FINDINGS

Using Deductive thematic analysis, five overarching themes accompanied by relevant sub-themes emerged from the data pertaining to the reproductive health issues under investigation: **Theme 1: Symptoms and experiences**. This theme focuses on the physical, emotional, cognitive or functional symptoms experienced by women during PMS and menopause. **Theme 2: Impact on professional and personal life**. The second theme addresses how PMS and menopause-related challenges or symptoms affect the professional and personal lives of women. **Theme 3: Coping mechanisms or strategies**. This theme explores the various coping strategies employed by women to manage their challenges within and outside the workplace setting. **Theme 4: Disclosure and reporting**. The fourth theme examines the extent to which women

disclose or report their PMS and menopause-related challenges in the workplace, including the factors that influence their decisions. **Theme 5: Organisational support.** The final theme relates to the extent of organisational support available to support women experiencing these difficulties, including probable solutions. [Table 4.1](#) provides a concise summary of the main themes and their corresponding subthemes.

**Table 4.1:** Summary of findings table

| <b>Themes</b>                                   | <b>Sub-themes</b>   |
|---|---|
| <b>Symptoms and experiences</b>                 | Physical discomforts (somatic)<br>Emotional distress (affective)<br>Cognitive & functional difficulties   |
| <b>Impact on professional and personal life</b> | Work & career-related challenges<br>Personal & social challenges  |
| <b>Coping strategies or mechanisms</b>          | Physical management of symptoms<br>Behavioural adaptations &<br>Psychological coping  |
| <b>Disclosure and reporting</b>                 | Comfort & advocacy<br>Reluctance & stigmatisation<br>Gender dynamics in communication   |
| <b>Organisational support</b>                   | Inclusive vs Minimal & reactive support<br>Absence of formal support mechanisms<br>Need for female leadership & advocacy<br>Practical recommendations at work<br>Education & Awareness<br>Disclosure & reporting vs intervention availability |

#### **4.4 PRESENTATION OF PMS FINDINGS**

The study's sample comprised of nine (9) women, recruited through purposive and snowball sampling, who participated in the interviews focused on Premenstrual Syndrome (PMS). These were women within their reproductive age, with an average age of 26 years. At the time of data collection, almost all participants were actively employed, though one was, at the time, unemployed, but had prior work experience. The sample represents individuals from different racial backgrounds, including Black and Coloured individuals, with most working regularly with colleagues of both genders and of variety of ages. Detailed sample characteristics are presented in detail in [Table 4.2](#).

**Table 4.2:** PMS Sample characteristics

| <b>Participant</b> | <b>Age</b> | <b>Race</b> | <b>Diagnosis</b> | <b>Position</b>           | <b>Industry</b>      | <b>Employment status</b>                  |
|--------------------|------------|-------------|------------------|---------------------------|----------------------|---|
| <b>1</b>           | 25         | Black       | PMS              | Teacher                   | Education            | Full-time                                 |
| <b>2</b>           | 24         | Black       | PMS              | Teacher                   | Education            | Contract                                  |
| <b>3</b>           | 24         | Black       | PMS              | Sales Assistant           | Retail               | Contract                                  |
| <b>4</b>           | 26         | Black       | PMS              | Student Assistant         | Education            | Contract                                  |
| <b>5</b>           | 32         | Coloured    | PMS              | Administrative Assistance | Finance              | Full-time                                 |
| <b>6</b>           | 28         | Black       | PMS              | Financial Management      | Finance              | Unemployed at the time of data collection |
| <b>7</b>           | 27         | Black       | PMS              | Human Resources           | Healthcare           | Contract                                  |
| <b>8</b>           | 25         | Black       | PMS              | Accounts Manager          | Financial Technology | Full-time                                 |
| <b>9</b>           | 26         | Black       | PMS              | Teacher                   | Education            | Full-time                                 |

## **Theme 1: Symptoms and experiences of PMS**

The study's first objective was to gain a better understanding of the symptoms that women experience during PMS. This objective is addressed by this theme, focusing to the variety of physical, emotional, cognitive and functional challenges or symptoms encountered by women during PMS. From this main theme, three sub-themes emerged strongly, including *physical discomforts*, *emotional distress*, and *cognitive and functional challenges*. Each sub-theme is explained in detail subsequently, highlighting the specific experiences shared by participants. To enrich the analysis, direct extracts from the participants' narratives are provided, illustrating these experiences in their own words. This does not only add depth to the analysis but also offers a comprehensive understanding of the impact that PMS have on various aspects of women's lives.

### **Sub-theme: Physical discomforts**

Many participants consistently reported PMS-related physical symptoms such as headaches, abdominal cramps, fatigue, and bloating. A subset described disturbances in sleep, nausea or vomiting, heavy menstrual flows, and prolonged fatigue persisting a few days post-PMS, while fewer noted lower-back pain, skin breakouts, hot flashes, and tenderness of breasts. Despite variability in intensity, many participants emphasised these symptoms as severe and disruptive enough to cause significant discomfort, impacting daily functioning. The following extracts are some of the responses that support the sub-theme – only consider relevant factors as emphasised above.

#### **Participant 1:**

*"I would have really weird mood swings; I would have very bad period pains – abdominal cramps...and I would experience some hot flashes also. But the most prevalent challenge are the menstrual cramps"*

#### **Participant 2:**

*"...but it is usually anger, mood swings, that slight temper, frustration, tiredness..."*

**Participant 3:**

*“It’s cramps that lead to vomiting; it is a very severe pain as result when I am going to vomit there is a sharp pain that I cannot take...I usually get lower abdominal pain that sometimes go through during my period”*

**Participant 4:**

*“Symptoms are tenderness of breast, headache...vomiting...cravings for weird combinations of food, cramps, irritability, a lot of anxiety as well as the sleep fragmentation...Post syndrome symptoms I normally get fatigued, drained all the time and after my period that is when I sleep a lot...”*

*“Another symptom is nausea so if you are mobilising to much it gets worse”*

**Participant 5:**

*“I experience severe mood swings, bloating, headaches, abdominal cramps, and intense fatigue. On a scale from 1 to 10, I’d rate them around 7.”*

**Participant 6:**

*“Anxiety of course, headaches, insomnia because I would be stressing and I would struggle to sleep sometimes...I would also get really painful lower back pains like my lower back would hurt...Maybe that could be because I sit for a long time and or the chair that was never comfortable, but I don’t know if that was one of the symptoms but I would say anxiety, headaches, insomnia, lower back pains.”*

**Participant 7:**

*“I mostly experience, abdominal cramps, as well as mood swings, and...severe headaches”*

**Participant 8:**

*“The symptoms that I experience the most are physical, including bloating, headaches, abdominal cramps, fatigue, skin breakouts not like acne but my skin just breaks out, and I really get heavy menstrual flow. For me it’s more physical than psychological but I also get really moody, so mood swing”*

**Participant 9:**

*“The symptoms that I experience most of the time are bloating and mostly mood swings...and sometime abdominal cramps”*

**Sub-theme: Emotional distress**

Participants consistently reported intense emotional symptoms associated with PMS, including irritability, mood swings, and a sense frustration, which many described as frequent and overwhelming. Some noted heightened emotional sensitivity or depressive feelings and marked anxiety during this period. According to participants

these emotional disturbances can be intense and substantially impact overall mood and interactions with others. The following extracts are some of the responses that support the sub-theme – only consider relevant factors as underscored above.

**Participant 1:**

*“...I would have really weird mood swings; I would have very bad period pains – abdominal cramps...and I would experience some hot flashes also. But the most prevalent challenge are the menstrual cramps”*

**Participant 2:**

*“The symptoms are mood swings, there is that bit of anger, I do not know if its temper or what, but you get annoyed, quickly get annoyed by people...but not frequently it varies month to month it is not always the same, but it is usually anger, mood swings, that slight temper, frustration, tiredness...”*

**Participant 3:**

*“So, except for the abdominal pain, which is quite the physical side of it, I become a cry-baby, I become so emotional...I get emotionally sensitive”*

**Participant 4:**

*“Symptoms are tenderness of breast, headache...vomiting...cravings for weird combinations of food, cramps, irritability, a lot of anxiety as well as the sleep fragmentation...Post syndrome symptoms I normally get fatigued, drained all the time and after my period that is when I sleep a lot...”*

**Participant 5:**

*“I experience severe mood swings, bloating, headaches, abdominal cramps, and intense fatigue...”*

**Participant 6:**

*“I become very emotional, overly emotional, I get irritable, and I also do become depressed also. I also find myself in a state whereby I overthink a lot, and that is my most depressed state”*

*“Anxiety of course, headaches, insomnia because I would be stressing and I would struggle to sleep sometimes...”*

**Participant 7:**

*“I mostly experience, abdominal cramps, as well as mood swings, and...severe headaches”*

**Participant 8:**

*“The symptoms that I experience the most are physical, including bloating, headaches, abdominal cramps, fatigue, skin breakouts not like acne but my*

*skin just breaks out, and I really get heavy menstrual flow. For me it's more physical than psychological but I also get really moody, so mood swings yeah"*

**Participant 9:**

*"The symptoms that I experience most of the time are bloating and mostly mood swings...and sometime abdominal cramps"*

**Sub-theme: Cognitive and functional difficulties**

Participants frequently linked PMS to impair cognitive functioning, with many participants reporting reduced concentration and forgetfulness. These cognitive impairments are exacerbated by the concurrent physical and emotional symptoms, creating a compounding effect. Workplace concerns emerged as a significantly, with several participants describing difficulties to maintain focus or efficiency during PMS, leading to negative work outcomes. The following extracts are some of the responses that support the sub-theme.

**Participant 1:**

*"...I cannot do anything, I cannot focus on anything besides the pain I am feeling, so when I do get the menstrual cramps, I am practically useless for the day..."*

**Participant 2:**

*"...I slack off sometimes and there is also that small amount of memory loss/forgetfulness, I tend to forget a lot of things sometimes..."*

**Participant 3:**

*"...yes, it affects my concentration, and when you cannot concentrate you cannot be productive..."*

**Participant 4:**

*"...when you are PMS-ing your concentration levels become very low, and you train of thought becomes very slow"*

**Participant 7:**

*"...the cramps sometimes become so severe that it affects my concentration, and I have to postpone my work to the following day."*

**Participant 8:**

*"PMS really comes with a lot of difficulties, like you even struggle to concentrate at work because of the symptoms and that has a negative impact on work efficiency or performance"*

### **Participant 9:**

*“...the bloating is an uncomfortable feeling, and it affects my productivity because I focus on it and less on other things like my work”*

### **Theme 2: Impact on professional and personal life**

The study's second objective was to understand the impact that PMS has on the quality of life of working women. This theme addresses this objective, highlighting the significant impact of PMS on women's quality of professional and personal life. From this theme, two sub-themes emerged, including *work and career-related challenges* and *personal and social challenges*. Each sub-theme is explained in detail, highlighting the specific ways in which PMS affects these aspects of women's lives. To illustrate the nature of these impacts, direct extracts from participants' accounts are provided, therefore providing a deeper insight into their lived experiences.

#### **Sub-theme: Work and career-related challenges**

The interplay of physical discomfort, emotional distress, and cognitive impairment lead to substantial challenges in professional settings for many participants. Many participants reported significant difficulties in sustaining productivity and focus during PMS – leading to presenteeism, absenteeism and decreased overall effectiveness. Additionally, a subset of participants also expressed overexertion or working long hours to make up for lost time during PMS, further compounding their workplace challenges. The following extracts are some of the responses that support the sub-theme.

### **Participant 1:**

*“...I cannot do anything, I cannot focus on anything besides the pain I am feeling, so when I do get the menstrual cramps, I am practically useless for the day. I cannot really focus on anything, meaning my learners miss out on the work I was supposed to cover with them. With the mood swings, they kind of have a negative impact on the relationships in my work environment. Because I cannot just tell everyone that I my workplace that I am on my period, with the mood swings it sometimes seem to them like I am a person who breathes hot and cold – like I am moody sometimes while sometimes I am not...it makes people to not want to be around me because they never know which side, they are going to get from me...”*

### **Participant 2:**

*“...it is very challenging for me because usually before the onset of menstruation I obviously get moody and there was a time where I actually had*

*period pains and I was not able to attend work, and this was the first time I had never attended work...*

**Participant 3:**

*"...You would rather not go to work because you want to sleep, you are feeling the pain and you cannot do anything, you cannot concentrate, you are concentrating and focusing on the pain, you want to sleep. So, you would rather not go to work, if you are there you feel like I should not be here, you want to report and say I am sick because being there is not working"*

**Participant 5:**

*"The symptoms definitely affect my work-life. I sometimes have to take time off, which impacts my attendance and productivity. My colleagues notice when I'm not myself, which can strain relationships, especially when I'm irritable"*

*"Given the choice, I would prefer to take a few days off to rest and manage my symptoms. It would allow me to return to work feeling more refreshed and focused because when these symptoms hit, you are just not there, barely doing nothing. So, what is the point?"*

*"Once I'm feeling better, I usually work extra hours or take on additional tasks to make up for lost time. It's not ideal, but it helps me stay on top of my responsibilities"*

**Participant 7:**

*"As I have that sometimes I become moody and that affects how I work with my colleagues, the cramps sometimes become very severe and then I would have to take medication or sometimes leave the workplace and go home. So yes, it does affect my productivity because I would have to postpone my work to the following day".*

*"If the day is just hectic, I move my work to the next day when I feel a bit better, meaning that I would have more work responsibilities, more workload, and more hours..."*

*"No, if it were up to me, I would not even attend work during those day...because I would rather be at home like in my comfort and deal with my symptoms and then come back to work when I am feeling well"*

**Participant 8:**

*"PMS really comes with a lot of difficulties, like you even struggle to concentrate at work because of the symptoms and that has a negative impact on work efficiency or performance"*

*"If it were up to me I would choose to stay at home during PMS and not attend work because going to work while feeling discomfort just interrupts your day and the flow at work which means that you are just there physically, but your mind or brain is focusing on your symptoms and worrying about your flow and potential leaks...so yes I would rather be home but I just suck it up and attend and try to push through it.*

**Participant 9:**

*“...the bloating makes me unproductive because mostly I just want to sit down or lay down, so I am not productive when that happens”*

*“...if it was my choice, I would choose to take time off work during the PMS period, yes”*

Furthermore, most participants expressed concerns that cyclical PMS-related absenteeism and diminished productivity could negatively impact their career trajectories, as these factors risk being misconstrued as lack of commitment and inconsistency in the workplace. According to a few participants' accounts, this concern fosters a sense of ongoing anxiety and self-doubt, as they fear encountering similar challenges in future work environments. Notably, a few participants articulated explicit turnover intentions. The following extracts are some of the responses that support the sub-theme.

**Participant 1:**

*“...its already hard for us (women) to prove ourselves in the workplace, because we are not being taken seriously and it already difficult to be a woman – PMS adds to these difficulties – we are viewed vulnerable and susceptible to too many factors that are hindering us from being successful – sometimes you cannot even compete fully for things like promotion because of these issues that hinder us from performing at our optimal. So, these challenges do add to that, and we have to prove ourselves extra hard already. So, I would really say it does”*

**Participant 3:**

*“...It is only now that I realize that this is not just anything, it is deep. Because it can affect your career advancement, being recognised as an employee of the month or something like that, because you have days off, days sick and underperforming...”*

**Participant 5:**

*“Because male colleagues might see you as someone who is inconsistent or not committed to their work. And it is usually not the case, it because of the symptoms they become debilitating to the point you miss work, or even miss deadlines, or make bare minimum outputs. Because of this stigma, some women may even choose to leave their jobs or their workplace for flexible work that allows them to cope better with symptoms or challenges...”*

**Participant 6:**

*“...I still do have moments where I do feel anxious or a little bit depressed and I doubt myself because the whole experience of PMS symptoms in the workplace did make me feel like I am not smart enough and that messed me up mentally because I started doubting myself or feeling like I am not good*

*enough. So, I would say it did affect my like negatively, because I am still picking up the pieces even now..."*

**Participant 7:**

*"Yes, I think so because...as I have said sometimes, I leave the workplace and go home, sometime that may seem like I am not being productive or lacking...sometime may sometime see me as someone who has excuses, leaving the workplace, and I do not want to work and all that – meaning that they may not consider me first because me every month I want to go early or I just do not pitch up, and sometimes I am not productive at home, so I think that can affect career advancement"*

**Participant 8:**

*"Yes I think it does have an impact of our careers because if you are having these declines in work efficiency every month that may seem like we are not fit for things like promotions or other rewards and not that I am politicising this but I think it unfair for women who face severe PMS symptoms like myself because they can sometime get really incapacitating and disturbing and you get more and more fatigued and that just ruins your work-life and that can get you sidelined for important things that could improve your career"*

**Participant 9:**

*"PMS can be very severe in other people...and let's say there is an important task that one needs to do on that certain day when they are going through their symptoms and that can make them unable to those tasks and may it look like that person is unfit for the job, it's unfair because that disadvantage women in a way"*

**Sub-theme: Personal and social life challenges**

The emotional and physical symptoms of PMS frequently impact women's personal and social life, often leading to strained relationships with both colleagues and loved ones. Some participants reported regularly avoiding social interactions to prevent conflicts and misunderstandings, leading to social isolation. Workplace stigma particularly from male colleagues' lack of understanding of PMS, further complicates women's professional relationships. Some participants also reported that PMS symptoms affect their daily or social lives, often requiring them to cancel most of their extracurricular activities or other plans. The following extracts are some of the responses that support the sub-theme.

**Participant 1:**

*"...it does affect my daily activities because for example if I have somewhere to be and I am PMS-ing I might have to cancel those plans, and also sometimes*

*it does put a dent on my social life because I would also be cancelling plans that I have made with people...*

**Participant 3:**

*“Obviously you are not going to go through your normal routine...for example if you someone who goes to the gym or church you are not going to go because you are sick...If you are a person who cooks you won’t you will eat the shop or ask someone to cook for you so it is like that...so somethings will just have to stop because you unable to do whatever you usually do”*

*“You might encounter problems, sometimes you might not, some people understand that it is that time of the month so let’s just leave her alone. But some people just do not and sometimes you might get conflicts with them. Because if the person does not understand the way you are feeling because of the period you might get into conflict with them...so it is like that”*

*“I avoid social interaction as much as I can. If ever we have conversation, I try to make sure that it is short, so we do not get to point where we make other uncomfortable...So I avoid social interactions and long conversations”*

**Participant 4:**

*“It disassociates me with the social world, and I do not spend enough time with human being which the affects my relationship or friendships. But also, because PMS last for a short time, I relapse to the good me, and my friends are females, so they understand. Personally...my health deteriorates, and I became very sick...and I can’t get any work done”*

*“I think it is just trying to avoid getting into conflict with people because my mood gets really bad, and I am avoiding being on people’s bad sides. And also, it is a general feeling of not wanting to be around people and wanting to be alone. On a different case I can explain why which is linking it to the mood swings, but at the same time it is an unexplainable feeling of just not wanting to be around people with no specific reason. It is like a feeling of just it is better to be alone... I would instead say it is social fatigue, where I feel like I don’t have the energy to engage in any form of human connection or interaction because they are just going to make me feel worse or they are going to drain...that is how I can put it.”*

**Participant 5:**

*“...there is nothing I could really do with irritability and mood swing, so I most of the time choose to be alone and take time to myself to avoid strain in my workplace or personal relationships or even conflict because moods and irritability can lead to these things...”*

**Participant 7:**

*“As I have that sometimes I become moody and that affects how I work with my colleagues...”*

*“Sometimes at home people would not understand why I feel like this on certain days of the month, but then I speak with them and eventually they understand what is going. So, sometimes when they see me like with those mood swings,*

*because I not someone who is very moody, but when they see me like that, they just understand what is going on”*

**Participant 8:**

*“When I am on my period, I don’t really do anything, unless I am at work because I am always anxious and always want to be close to a bathroom to check myself because I have menorrhagia, I lose a lot of blood during my period and fatigues me so much - so my social life just gets really disturbed because I just stay indoors. Sometimes even being around people just drains you even more, and I get really moody, so I prefer to be alone mostly. So, I would say PMS disrupts my overall interactions and work efficiency”*

**Participant 9:**

*“...I work with children and closely with other people, so having mood swings around them is quite terrible because they don’t know me as that person and that person with mood swings shows up once a month, so it’s not something that they are used to and also in my workplace I feel like they don’t understand...”*

*“It does also affect my daily life, because it changes how you do things, the way you are around people, and the way you behave, be it around your partner, you friends, or the people you work with. So, everything just changes that time of the month...”*

**Theme 3: Coping strategies or mechanisms**

The study’s third objective aimed to explore and understand the coping strategies or mechanisms that women use to manage PMS-related challenges. This theme addresses this objective by examining the various strategies or mechanisms that women employ to manage or navigate both the personal and work-related challenges associated with PMS. Three prominent and interconnected sub-themes emerged from this theme: *physical management of symptoms, behavioural, and psychological coping strategies*. Each sub-theme is explained in detail, illustrating how these methods help women mitigate the impact of PMS on the across different aspects of life. To enrich the analysis, direct extracts from participants’ narratives are provided for each sub-theme, providing insight into their coping methods in their own words.

**Sub-theme: Physical management of symptoms**

Many participants rely heavily on physical strategies to manage PMS symptoms. The most common approaches include the frequent use of medication (i.e., painkillers) and hot water bottles for headaches and abdominal cramps. Very few participants noted hydration, energy supplements, sleep aids to alleviate or combat sleep disturbances

and fatigue. The following extracts are some of the responses that support the sub-theme.

**Participant 4:**

*“Some of the coping mechanisms that I apply is using medication called Nurofen which is for period pains or cramps, I usually have my painkillers with me so that my working is not affected...My job does sometimes require me to sit and so in case where I am sitting, I use a hot water bottle...and make sure that I use that to alleviate the pain. And then, when I see that I am struggling to concentrate I use energy supplements like energy drinks, bio plus...I also drink camomile tea for better sleep at night and sleeping pills...”*

**Participant 5:**

*“Most of the time I take medication to deal with the pain resulting from the cramps, and for the headache as well...”*

**Participant 6:**

*“...Like for the lower back pain I would just take some painkillers to try to make it feel better...”*

**Participant 7:**

*“...then I would have to take medication...”*

*“...As I have said, mood swings, so I would rather be quite and alone, isolating myself, and also for the cramps – having a hot water bottle around also helps with pain and keeps my body warm ...I think those my only coping mechanism I can think of right now”*

**Participant 8:**

*“I usually take medication for the abdominal cramps and headaches, make sure I stay hydrated, and obviously I use sanitary tampons for menstrual flows. I also cuddle up my hot water bottle for the cramps as well because that really helps like a lot”*

**Participant 9:**

*“With the mood swings I have not tried ways to deal with them, but with the bloating is having period patches that are available now...”*

**Sub-theme: Behavioural and psychological coping strategies**

To cope with the impact of PMS, some participants reported frequently adopting various behavioural and psychological strategies. The most reported approaches include social withdrawal to avoid interpersonal conflicts and further emotional distress, and compensatory overexertion (e.g., working additional hours preemptively) to offset productivity declines during PMS. Some participants expressed the importance of preparatory measures for anticipated workplace challenges,

including distraction from symptoms through activities like working, watching movies, or using social media. Furthermore, very few participants expressed intentions of adopting long-term management strategies such as regular exercise and meditation to better manage their symptoms and improve their overall well-being. Lastly, very few also reported frequently adjusting their environments to enhance physical comfort. Overall, this highlights the personal responsibility placed upon women to manage their symptoms privately, often without support from their employers even at work. This lack of organisational support often leaves them feeling "lost" and unsupported in their efforts to manage PMS effectively. The following extracts are some of the responses that support the sub-theme.

**Participant 1:**

*"...however, it sometimes helps to be active. And most of time I would just keep to myself and try not to annoy other people or do something to keep me busy to avoid my colleagues, so they do not have to experience the side of me that has fluctuating mood-swings"*

**Participant 2:**

*"...when the flow becomes intense it usually licks outside my pants therefore, I would have to leave work. But I do try to prepare myself adequately for situations like that, but you know how unpredictable the body is"*

**Participant 3:**

*"It depends on how severe they are during that particular time...Mine sometimes become so severe and I do not get medication I just want to sleep, to get a nap until it feels better...So I'd rather sleep, I cannot concentrate, focus, be productive so I'd rather take a nap. There is nothing that can distract me from the pain except for taking a nap...until the pain comes down yah"*

**Participant 4:**

*"...I also try to make my workspace as comfortable as possible, like control the temperature get warm as possible, adjust my working equipment and limit my movement so I cannot strain myself further..."*

*"If I was not productive enough, I always try to do much, like overwork, so that I make up for the time I was not productive, or maybe work more hours to be on track again"*

*"...keep my room temperature at optimum for better sleep"*

*"...the main objective will be not getting you work done because irritability makes you not have any interest in getting any work done. So, you distract yourself with other things that are not relevant to your work...only because you are trying to lift your mood up...when you are PMS-ing your concentration levels become very low, and you train of thought becomes very slow..."*

**Participant 5:**

*“Once I’m feeling better, I usually work extra hours or take on additional tasks to make up for lost time. It’s not ideal, but it helps me stay on top of my responsibilities”*

*“...Sometimes, when symptoms are not severe work can be a distraction but not when they are you are completely useless and just forcing it out”*

**Participant 6:**

*“...I did not exercise or meditate. I only learned about these things afterward, now that I am unemployed...things that you could do when you start feeling a certain way...”*

**Participant 7:**

*“...I move my work to the next day when I feel a bit better, meaning that I would have more work responsibilities, more workload, and more hours...”*

*“...sometimes my job allows me to do some things early beforehand and that sometimes helps a lot when I am PMS-ing, but it is also more work because you are trying to cover so much so that your work is not affected when your periods come”*

**Participant 8:**

*“...Sometimes even being around people just drains you even more, and I get really moody, so I prefer to be alone mostly...”*

*“...when I am home I simply bath, stay in bed or cuddle up my couch watch videos in my phone or watch a movie, have snacks as well, because I also crave a lot of stuff during PMS, so it quite easy to manage your symptoms outside work, and I become more relaxed and less worried about my symptoms and stuff like that...”*

**Participant 9:**

*“...It changes, sometimes you want to be alone sometimes, sometime alone but around people...”*

**Theme 4: PMS disclosure and reporting**

The study’s fourth objective looked to explore the extent to which women disclose and report their PMS challenges in the workplace, and what influences their decisions. This theme addresses this objective, highlighting the degree to which working women disclose or report their PMS challenges to in the workplace. Three interconnected sub-themes emerged strongly from the data: *comfort and advocacy, reluctance and stigmatization, and gender dynamics in communication*. Each of these themes is explained in detail, with supporting extracts from the participants’ narratives, thus providing insight into their perspectives.

### **Sub-theme: Comfort and advocacy**

A small number of participants reported feeling comfortable to openly discussing their PMS challenges with male colleagues and emphasised the importance of forcing the normalcy of conversations around the issue to foster supportive and understanding workplace environment. They stressed that such topics should no longer be treated as taboo or embarrassing. Conversely, a few participants also indicated that they do not feel the need to disclose their PMS as they have already found effective ways to manage them. The following extracts are some of the responses that support the sub-theme.

#### **Participant 1:**

*“...I definitely share my experiences with them, I do not see need or reason to why not because at the end of the day, why would we not? Because the issue is not taboo anymore and we are moving to a different era where these kinds of things need to be spoken about...and we are supposed to be transparent about this kind of information to prevent any unwanted situations... because we are just trying to change the status quo by sharing these types of things that some think they are not to be shared for the purpose of educating”*

#### **Participant 4:**

*“...But because I have been going through these symptoms for a long time now, I was able to find effective ways to deal with them, so it is not heavy on my shoulders because I am aware of what I need to do.”*

#### **Participant 7:**

*“I am very comfortable...because it is something natural and there is nothing to hide, every woman goes through that, so I am very comfortable, even with male or men...and I believe that people need to talk about these things so there can be an understanding, even in the workplace, so it not embarrassing for me”*

*“I also think it up to women to force these conversations in the workplace because we are the ones who are experiencing these things – we cannot expect men to talk about thing that they do not experience and fully understand – so it is also up to us...”*

#### **Participant 8:**

*“I also do not see the need to disclose my PMS challenges in the workplace; it’s something that I deal with myself and work around when needed...”*

### **Sub-theme: Reluctance and stigmatisation**

Despite the push for openness, many participants remain reluctant to disclose their PMS symptoms, particularly to male colleagues or employers. This reluctance is rooted in the stigma surrounding women's health issues, which creates a fear of

judgment, misunderstanding, and potential career repercussions. Cultural and societal norms that view menstruation as a sensitive or taboo topic further exacerbate this discomfort, leading to selective disclosure and a lack of necessary support from the workplace. Some women generally want to share the experiences and how they affect their quality of personal and work life, however, fear the consequences of stigma and judgement that may manifest with that. The following extracts are some of the responses that support the sub-theme.

**Participant 2:**

*“No, we choose not to talk about it because men often feel uncomfortable and disgusted when you talk about. For example, there are time where I would just mention ‘periods’ and you would hear a guy dismissing that. So, imagine, how can you speak to men about such issues when you know they are so uncomfortable and disgusted about such issues.”*

*“I think you are aware and willing to hear us, our challenges, and so on and that is what I think most women want...understanding and openness from men because we sometimes really want to be heard”*

**Participant 3:**

*“It is very uncomfortable to talk to male colleagues about that so I do not ever do that...but I can say or share anything with the female colleagues.”*

*“...sensitive and embarrassing because it is really not easy talking to a man about these things it is just uncomfortable. More like it is matters of womanhood and we should keep it like that.”*

*“...I think that is another thing that makes me not report, because it uncomfortable to talk about these issues with male, especially in detail because now I am going to tell him that I am sick because this and that...”*

**Participant 4:**

*“They become sensitive when a male figure is involved...as much as it is normal some females might feel discomfort because we don’t know how man will react towards it because they don’t have first-hand experience and that is where the sensitive comes into play.”*

**Participant 5:**

*“Not really, I feel like these things are normalised by us women and we think we can manage them, but their impact on our work is very challenging and there is also the stigma around them.”*

**Participant 8:**

*“I am really not that comfortable to talk about PMS with men because of the culture around menstruation, it is so stigmatised and how some men refer to it, it’s like you just PMS-sing it’s not a big deal you get what I mean...so there is also this bad connotation with menstruation that I don’t like...hence it really*

*difficult for me to engage in such conversations...for instance I cannot just go to a meeting full of men and just put it out there that my period cramps are killing me and messing up my day, I don't think they would understand the extent of how I am feeling..."*

**Participant 9:**

*"I'd say I am not comfortable, because I don't talk about it all, because I think it's not a conversation that can be easily started...especially with men since I work mostly with men"*

**Sub-theme: Gender dynamics in communication**

Gender dynamics significantly influence how PMS is discussed and perceived in the workplace. Many participants reported generally feeling more comfortable discussing their PMS-related challenges with female colleagues or employers, who are perceived as more empathetic and understanding. Conversely, interactions with male colleagues are often described as uncomfortable or marked with a lack of understanding, discouraging women to openly discuss these issues at work. This gendered dynamic highlights the need to bridge such communication gaps, ensuring that all employees feel supported in managing their health. The following extracts are some of the responses that support the sub-theme.

**Participant 2:**

*"...I feel like I would not report that to the male, but I would to the female. Because I feel like with him, he would not understand but the female obviously they know what we go through and easier to speak with a female regarding such issues."*

**Participant 3:**

*"I think we grew up knowing that this thing is a female thing, so it not even something that we can discuss it with a male...so it is not that easy and also what do they know about it...So I would give my supervisor an idea that I am sick, I have stomach cramps and that is it."*

**Participant 4:**

*"I am very comfortable because we (all female colleagues) are more or less the same age...and when you are the same age it easy to speak about PMS, and also our relationship is quite strong...And I do talk about my PMS symptoms with them especially if I am on duty and I need someone to lay a helping hand..."*

**Participant 5:**

*"I am very comfortable with speaking about my PMS challenges with my female colleagues because I think there is a level of understanding, and they can relate*

*to that. But with men it a bit difficult, because many of them just do not want to hear it. I think that is where the embarrassment comes from for us, and I think men also feel embarrassed with listening to women talking about periods, pads, and stuff like that.”*

**Participant 8:**

*“Oh yeah I am very comfortable to speak about PMS with women because we have the same or similar experience you know, so there is understanding, and I can freely talk with them and my team is mostly women, so we really get along also, but males no...”*

**Participant 9:**

*“Yes, I think I would be comfortable with women because it would be with people that are dealing with the same thing as me, so they would be able to understand.”*

**Theme 5: Organisational support**

The fifth objective of the study was to understand the extent to which organisations meet the needs of women facing PMS-related challenges in the workplace, including possible interventions. This theme addresses this objective by highlighting the significant gaps and barriers in organisational support, thus providing possible solutions. Many organisations were found to be lacking in this area. Six sub-themes emerged from the data: *inclusive vs minimal and reactive support, absence of formal support mechanisms, the need for female leadership and advocacy, practical recommendations at work, education and awareness, disclosure and reporting vs intervention availability*. Each theme is discussed in detail, with supporting extracts from participants accounts.

**Sub-theme: Inclusive vs Minimal and reactive support**

A few participants reported that their organisations occasionally provide minimal support for managing PMS, often reactive to unbearable challenges associated with this issue. This reactive approach highlights a lack of proactive measures and ongoing support, leaving women to manage their symptoms with little to no assistance from their employers. The following extracts are some of the responses that support the sub-theme.

**Participant 6:**

*“They (the company) did try to actually arrange counselling for me when I left or when I resigned. Because they found someone for me that I can go see but*

*to be honest, I think it was a way for them to just cover up. I felt like it was way for them to just say they tried to help so that they do not find themselves in a space whereby they did not do anything about it. I did not feel like I was truly being helped...it was like since you've resigned go through this and you will be fine..."*

**Participant 7:**

*"...but the only support is when the symptoms become like unbearable, you can be excused from work, so yeah emotional support is there..."*

**Participant 8:**

*"...for instance, there was a time where I felt like I could not handle my cramps and had really heavy flows, so I reported, and they did let me go home to rest and take care of myself properly"*

**Sub-theme: Absence of formal support mechanisms**

The analysis reveals a notable absence of formal workplace support mechanisms, policies, and resources tailored to women's reproductive health needs. Most participants expressed frustration at the absence of targeted interventions, indicating that their workplaces neither adequately acknowledge nor accommodate PMS-related challenges. This systemic oversight contributes an unsupportive work environment for affected employees. The following extracts are some of the responses that support the sub-theme.

**Participant 2:**

*"No not all, there is no intervention, there nothing...It is just they are saying we will get over it."*

**Participant 3:**

*"No, zero initiatives, nothing."*

**Participant 5:**

*"Unfortunately, there are no specific initiatives at my workplace. It's something that isn't really talked about, and there are no formal support systems in place."*

**Participant 6:**

*"Considering that this was my first job, I have had never worked in corporate before, I did not know much of procedures on when you got through this who do you talk to and what do you do, and what not..."*

**Participant 7:**

*"No, not that I can think of, or I can say no formal support initiatives, it just happens on the day when they see you are really not fine..."*

**Participant 8:**

*“No, there aren’t any initiatives specifically for that, support is kind of informal than formal...”*

**Participant 9:**

*“No, there are no policies or any interventions to address PMS”*

**Sub-theme: Need for female leadership and advocacy**

Many participants reported that organisations that have female leadership could provide more empathetic and proactive support for women experiencing PMS. According to these participants’ accounts, the presence of female leaders might foster an environment where women’s reproductive health issues are taken more seriously and addressed more effectively. The following extracts are some of the responses that support the sub-theme.

**Participant 2:**

*“it is easy to speak to a woman knowing that they would understand better than a male. It is like you as a male, you would rather speak to a male with regards to manly issues, so yeah it is like that. It is better when there is a female figure or both to make it easier for all people in the workplace. Even if it is one person of any gender, but that person should be understanding of both males and females and not lean on one side...So I think it just depends.”*

**Participant 3:**

*“...it is like that; I think organisation led by females it would be much easier to navigate such issues and talk about them...”*

**Participant 4:**

*“Organisations that are managed by females are without a doubt far better than organisations that are managed by men when it comes to catering for PMS symptoms because due to first-hand experience, they can be able to implement better interventions...”*

**Participant 5:**

*“Yah, I think female-led organisations might be more empathetic and proactive in addressing these issues. They might have a better understanding of the challenges and be more willing to implement supportive measures.”*

**Participant 7:**

*“Yes, because I think there is an understanding between women, there is a shared experience because if I got my manager who is male, they may not understand when I say I am not feeling well because of my period and all that, but if I go to a female then they can understand that”*

### **Sub-theme: Practical recommendations at work**

Several participants suggested that organisations should consider having menstrual kits with practical essentials like medications, sanitary products, hot water bottles, and many others. A subset of participants also suggested that organisations should allow for flexible work arrangements, provide menstrual rest days or leaves, and employee wellness and assistance programs, such as counselling or mental health initiatives, healthy diet awareness and exercise programs. Furthermore, a few participants highlighted the importance of comfortable workspaces. The following extracts are some of the responses that support the sub-theme.

#### **Participant 1:**

*“...I also feel like they should explore the possibility of qualifying these issues to sick leaves...”*

#### **Participant 4:**

*“...enforce mental health resources, and pain killers must also be available in the workplace... Health and wellness initiatives can include exercises aimed at alleviating abdominal pain and distress so that people do not isolate themselves and engage with other people. Flexible work engagement can also be ideal during this time.”*

#### **Participant 5:**

*“...providing flexible work arrangements and offering support resources such as counselling or wellness programs could make a significant difference. But some organisations might not afford things like counselling or wellness programs, but they raise awareness on health diet, exercising, and also have the basic needs like medications, pads, hot water bottles, and also comfortable workspaces go a long way.”*

#### **Participant 6:**

*“...I think they should take their employee problems more seriously and if I am saying I am struggling and I cannot, try to hear me out that I cannot and try to find ways to help me out when I cannot do it. Because should I be in a space whereby, I am feeling pressure, and I cannot perform, and you are still adding more pressure to me like how am I going to perform if I am not well mentally. So, they should take care of people’s mental health so they can be productive...”*

#### **Participant 7:**

*“I would say things like medication should be available in the workplace for headaches and cramps, and sanitary pads because sometimes...it happens that we get periods before or after expected dates, so there should be sanitary pads available all the time”*

**Participant 8:**

*“I mean if my workplace could offer options for remote work, I would definitely be down for that because our work does not necessarily require us to be physically there, and I think if we were given that option it would really help during PMS, like really help and maybe have menstrual kit in the workplace with all the essentials like tampons or pads, medications, hot water bottles, all that stuff...”*

**Participant 9:**

*“Things like pads, certain medications, and just understanding would a good way to start.”*

**Sub-theme: Education and awareness.**

Many participants highlighted the need to normalise conversations about PMS at work to raise awareness among colleagues, especially men. They believe open discussions can address cultural barrier and stigma associated with PMS, thus creating a more inclusive and supportive work environment. Educational initiatives and awareness programs are seen as key to fostering understanding and empathy, particularly in male-dominated workplaces where PMS might be less understood or acknowledged. The following extracts are some of the responses that support the sub-theme.

**Participant 1:**

*“I think first of all they need to more open to discussing these kinds of thing and to hearing that these issues exist and what can be done to support the women because if do have a support system in our workplace that in turn will make us more productive and produce better results... make sure that women are in a comfortable work environment with the colleagues, especially with their male colleagues, that these issues are normal and accepted and therefore should not be judged as well.”*

**Participant 2:**

*“I think what they can do better is having a more understanding mindset when it comes to when during those times. For example, understanding that during those times a woman is going to be behave or act a certain way. So, I think they should have more programs that educate especially men on such issues...educate men about what women go through during these times, before and during menstruation. For it is a matter of educating and understanding about it. Once you are educated about it, you will have a better understanding about it.”*

**Participant 3:**

*“This is new, but I think that we as female could start talking about these things, our challenges, in our workplaces, with our employers, and introduce them in*

*our workspaces. Then from there we can start initiatives where we can help each other during this time of the month.”*

**Participant 4:**

*“Raising awareness especially for men, so that women are more able to work in comfortable environment...”*

**Participant 5:**

*“Raising awareness especially among men would be a starting point to create a comfortable work environment for women who experience these things...so we can talk about them without shame or feeling like we’re overstepping”*

**Participant 8:**

*“...another thing is having conversations around these issues to make sure people understand the significant impact that they can have on us, and the stigma can be addressed through that. And I think this would be very important like in organisations that are dominated by men because it could really be difficult to get around these issues in those spaces”*

**Participant 9:**

*“I think having talks about this is important, especially with males for them to understand because I feel like they do not understand it and those who do, do not understand how severe it can be”*

*“...so having more conversations about menstruation in the workplace might raise awareness and understanding, especially in men. But I think men are also not comfortable talking about these issues...so it’s not easy for women to sit men down and have such conversation but it would be very easy if men educated themselves to understand the situation that women go through with PMS”*

**Sub-theme: Disclosure and reporting vs interventions availability**

Several participants acknowledged that their reluctance and lack of openness or disclosure about PMS creates a barrier for organisations or employers to recognising their needs and providing adequate support systems. This thus creates an environment where their challenges are overlooked or not recognised as valid workplace concerns. The following extracts are some of the responses that support the sub-theme.

**Participant 3:**

*“It is only now that I realize how deep this is, so I think that we do not have these initiatives because we have taken this as a norm...and we are not open about these things...so I think we should be open and talk about them more to allow that...”*

**Participant 4:**

*“Yes, it is linked to the fact that we are not vocal enough about their challenges and symptoms.”*

*“...But I would like to conclude that all this is possible if action is taken, and women talk more about PMS challenges because interventions cannot be implemented if the vulnerable population is quite or silent...”*

**Participant 5:**

*“Yah, to a certain extent because I think that leads to them being unaware that we go through these difficulties, especially those that may be mostly led by men. This could easily be overlooked because it is not a first-hand experience to them.”*

**Participant 7:**

*“I think it contributes to the lack of awareness for organisations, because the more we quite about this thing, there more employers become unaware about it, especially males or organisations that have many male employees, so I think it is best that we talk about these issues in our workplaces, so everyone knows and understand what is going on”*

**Participant 9:**

*“Yes, I think our silence also contributes to the lack of interventions. I feel like if maybe we were more vocal about these issues there would be, but I also think that we take these things as natural, they are bound to happen so we should just go through it and deal with it as personal stuff”*

#### **4.5 PRESENTATION OF MENOPAUSE FINDINGS**

The study sample comprised of eight (8) women, recruited through purposive and snowball sampling, who participated in the interviews focused on Menopause. These were women in their menopausal phase, with an average age of approximately 57 years. At the time of data collection, all participants were actively employed within different industries, with tasks performed on site. The sample represents individuals from various racial backgrounds, including Black, White and Coloured individuals, with most working regularly with colleagues of both genders and of a variety of ages. Three participating women held managerial positions. Detailed sample characteristics are presented in detail in [Table 4.3](#).

**Table 4.3: Menopause sample characteristic**

| <b>Participant</b> | <b>Age</b> | <b>Race</b> | <b>Diagnosis</b> | <b>Position</b>           | <b>Industry</b>             | <b>Employment Status</b> |
|--------------------|------------|-------------|------------------|---------------------------|-----------------------------|--------------------------|
| 1                  | 57         | Coloured    | Menopause        | Matron                    | Education                   | Part-Time                |
| 2                  | 52         | Black       | Menopause        | Manager                   | Retail                      | Full-time                |
| 3                  | 57         | Black       | Menopause        | Director                  | Municipality -<br>Libraries | Full-time                |
| 4                  | 58         | Black       | Menopause        | Cleaner                   | Municipality                | Full-time                |
| 5                  | 55         | White       | Menopause        | SMME owner and<br>manager | Retail                      | Full-time                |
| 6                  | 52         | Black       | Menopause        | Administrator             | Municipality                | Full-time                |
| 7                  | 61         | Black       | Menopause        | Health Educator           | Public Healthcare           | Full-time                |
| 8                  | 60         | Black       | Menopause        | Registered Nurse          | Public Healthcare           | Fulltime                 |

## **Theme 1: Symptoms and experiences of Menopause**

In line with the first objective, this study looked to gain a better understanding of the symptoms that women experience during their menopausal or transition period. This is addressed by the current theme, focusing on the variety of somatic, affective, and cognitive and functional challenges encountered by women during this time of their lives. Similarly, to PMS, the following sub-themes emerged strongly from this main theme. Each sub-theme is explained in detail, highlighting the specific experiences shared by participants. To enrich the analysis, direct excerpts from the participants' narratives are provided, illustrating these experiences in their own words, adding depth to the analysis.

### **Sub-theme: Physical discomforts**

Most participants reported experiencing unpredictable somatic or vasomotor symptoms, such as hot flashes and night sweats. Occasional or irregular menstrual discomforts such as severe menstrual flows and abdominal cramps were among the most reported somatic symptoms. Less commonly reported but notable symptoms included severe headaches, skin dryness, hair loss, joint pain, and dizziness – underscoring variations in menopausal experiences. While the severity and frequency of these symptoms differ, participants described them as consistently disruptive to daily life. The following excerpts from their accounts illustrate these experiences.

#### **Participant 1:**

*“...heavy flows that happen maybe once a month, then stays away for a long time and come back again...and this do just happen in one year it takes many years. Then you get the heat, you constantly sweating, you perspire, you are always flashed whether it is wither – I could not sleep with any winter pyjamas for years I did not get cold...never sleep with blankets because you end up undressing or taking them in the middle of the night because you are having these hot flashes and you perspire. and summer is the worst... the sweating was excessive it was a lot...you get so hot...you also get headaches...you get a headache in the morning then you get a headache at night...”*

*“...I also did experience hair loss in the beginning...so I always kept my hair short, brush cut, and I did not understand because I have always had long hair, and your hair does not go back what it was...”*

**Participant 2:**

*"I do get my periods once in a while...because I used to have heavy menstruation. So, I am experiencing menopause of which sometimes I feel so hot, like I get hot flashes... my skin now was starting to be dry and I needed a lot of moisture...The most irritating one is those hot flashes where you just feel like you are hit by a heat wave... Especially if you've taken a bath you have to stay for about 15 minutes just to cool... because I sweat a lot, even at night when I'm sleeping"*

*"...when it's almost time for my menstruation... I do get pain, menstrual pains but I don't menstruate, I'll get this discomfort...but the periods don't come, they don't come every month.*

**Participant 3:**

*"I experience hot flashes, night sweats, mood swings, memory loses like I forget a lot now, and fatigue. On a scale from 1 to 10, I'd rate them around 8, especially the hot flashes and fatigue"*

*"...especially when I'm irritated just out of the blue, sometime because I did not sleep enough because I felt hot and sweaty, so the next day get very tough"*

**Participant 4:**

*"For me It's feeling so hot even when it's cold and sweating just of the blue and the joint pain and dizziness... some days, bending to pick up things it's like my knees will break..."*

**Participant 5:**

*"...and I do get some sort of achy joints and sore legs every now and then, but apart from that, it's not too bad for me"*

**Participant 6:**

*"I normally experience hot flashes and night sweats and sometimes they are worse but sometimes not that much..."*

**Participant 7:**

*"I struggled a lot with hot flashes, fatigue, and sleep problems I would wake up in the middle of the night soaking from sweat and feeling hot make you struggle to sleep also..."*

**Participant 8:**

*"The symptoms differ from person to person, I experience hot flashes, sweating, mood swings, insomnia... these were frequent except the mood swings"*

*"I experience tiredness..."*

### **Sub-theme: Emotional distress**

Most participants reported affective symptoms, with irritability and mood swings being the most common. They emphasised that the severity and frequency of these symptoms often disrupt both their occupational and personal lives. Notably, these symptoms mirror those reported by PMS participants, underscoring the persistent emotional impact of reproductive health issues across women's lives. Supporting excerpts are included below.

#### **Participant 1:**

*"...Yes, it does affect our mood, you become snappy, sometimes you feel some anger, quickly annoyed. It's a lot"*

*"...definitely, it affects how I react to things... now I think twice I think before I say anything..."*

#### **Participant 2:**

*"...it also affects out mood swings..."*

#### **Participant 3:**

*"...especially when I'm irritated just out of the blue, sometime because I did not sleep enough because I felt hot and sweaty, so the next day get very tough"*

#### **Participant 4:**

*"And the anger or moods...for example this one time I shouted at my work partner and when I did not mean to that, then I was worried after that."*

#### **Participant 5:**

*"Emotionally?... I sometimes get pissed off without realising what it is and after a while it gets to me why..."*

#### **Participant 6:**

*"...and sometimes I do get emotional, like I have anger issues, like my mood sometimes it changes out of the blue"*

#### **Participant 7:**

*"...and also, the changes in mood, as bad as it sounds, I used to get a lot moody maybe the moods are coming even today it's just a matter of time..."*

**Participant 8:**

*“...I experience hot flashes, sweating, mood swings insomnia... these were frequent except the mood swings”*

*“...and sometime felt like not talking”*

**Sub-theme: Cognitive and functional difficulties**

Most participants reported cognitive challenges such as concentration difficulties and forgetfulness. While symptom severity and frequency vary, these issues are consistently disruptive in both the personal and occupational lives of women. Further, similar impairments were reported by women experiencing PMS, underscoring how reproductive health challenges constraint women throughout their lives. Supporting excerpts are provided below.

**Participant 1:**

*“...sometimes I struggle to remember things, ad to concentrate especially when I am at work, but I work with a colleague that understands my situation because I am her mom’s age, so she reminds me and keep me updated all the time...”*

**Participant 2:**

*“...it's very difficult to work and concentrate on your pain again and work. You know it's very... difficult. But sometimes we push ourselves to do it, to do what you have to do for the day.*

**Participant 3:**

*“I experience hot flashes, night sweats, mood swings, memory loses like I forget a lot now, and fatigue. On a scale from 1 to 10, I’d rate them around 8, especially the hot flashes and fatigue”*

*“The main reasons would be like the memory issues and having a hard time concentrating...”*

**Participant 4:**

*“Yes, there is thing that happens of forgetting...I put a something here now but 2 minutes later I don’t know where it is, I look for it until I find it then I remember...”*

**Participant 5:**

*“The transition is not too difficult for me, but my memory does go sometimes which is very erratic...”*

### **Participant 7:**

*“Other problems are the lack of concentration and forgetting like you can’t think properly and these are the worst even now because the others reduce in time”*

### **Theme 2: Impact on professional and personal life**

In line with the second objective, this study also looked to understand the impact of menopausal challenges on the quality of life of working women. The current theme addresses this objective, highlighting the significant impact of menopause on women’s quality of both professional and personal life. Similarly, to PMS, the following sub-themes emerged strongly from this theme. Each sub-theme is explained in detail, highlighting the specific ways in which menopause affects these aspects of women’s lives.

#### **Sub-theme: Work and career-related challenges**

Like PMS, menopause creates significant occupational challenges for most participants due to the physical, emotional, and cognitive impacts. These participants reported difficulties maintaining work performance or productivity and professional presence (i.e., presenteeism and absenteeism) due to symptoms including hot flashes, erratic menstrual discomforts, fatigue, and memory issues. The emotional disturbances of menopause were also reported to strain workplace relationships leading to social isolation – *discussed further in the subsequent sub-theme*. The unpredictability of these symptoms makes women’s work experiences even worse, as they never know when they will occur. Supporting excerpts are provided below.

### **Participant 1:**

*“...You are at work, and you are standing then you suddenly get heavy menstruation out of nowhere – and the day just gets worse...”*

*“...It is very hard...because your body is going through all that...and when you are at work you have to perform and have this personality and all that...”*

*“To be honest it’s not something to dwell on, yah I am struggling with menopause now, but I have a job to do, and I must carry on...”*

### **Participant 2:**

*“...it does hinder when you are feeling too hot, because I work with food and I have to go out, maybe go and cool myself, sit outside and drink cold water*

*because you know, you can't be selling people food while you are sweating... It does hinder a bit because it needs me to cool down... just to try and manage them."*

*"... I would feel happier if I am not going to work during those times especially when I have hot flashes and I get some period pains discomfort...I would rather be at home..."*

### **Participant 3:**

*"The symptoms are consistent, but the intensity is sometimes different. Some days are manageable, but other days, particularly during stressful periods at work, the symptoms can become very overwhelming."*

*"...It's very tough during meetings when a hot flash hits, or when I'm dealing with fatigue during a tight deadline. The memory issues are also frustrating, worse when I'm trying to recall details during discussions or meetings"*

*"Yah symptoms affect my work life, sometimes I to take time off when the fatigue becomes too much, and that affects like my productivity and attendance..."*

*"If I had the choice, I would definitely prefer to take time off or at least have more flexibility in my work hours. It's really hard to be effective when you're dealing with hot flashes or when you are very fatigued, so being able to rest and recover would make a big difference"*

*"The main reasons would be like the memory issues and having a hard time concentrating. When I'm during these symptoms, I'm not performing at my best, and it's frustrating because I know I can do better if I felt better."*

### **Participant 4:**

*"It makes work harder. My supervisor thinks I'm slow now...I used to never miss work, but now... sometimes I have to call in sick. I can't risk fainting because I am feeling very hot, and the pain in my joints is very bad sometimes then it's hard to work"*

*"If I can stay home on the bad days? Yes. But... but I go in anyway because if I am not going to work all the time my bosses can just find someone who can work better than me"*

### **Participant 5:**

*"Yes, one thing I have realised now is forgetting a lot when I am at the shop, and that sometimes that affects the order of the business because you'd find clients call asking about their orders or I have forgotten to make stock a fair amount of times, so yes productivity is affected..."*

*"...and when I am at the shop I am required to stand and move around a lot, so having achy joints or sore legs does not help at all and things move a bit slower especially weekends when I am alone..."*

**Participant 6:**

*“Yes, I experience my symptoms during my time at work, and they affect my productivity or performance...”*

*“Yes, I would stay at home if it was my choice...”*

**Participant 7:**

*“Yes, especially lack of concentration and forgetting what to do, you start to remember things when you are reminded and of course sleeplessness causes you to feel tired at work. So, my performance is affected to a point I had to develop reminders through my phone or use coloured paper reminders on my boards”*

*“The feeling of tiredness sometimes makes me to force going to work, but now it’s getting better since I consulted”*

*“I can say it make us women put more effort in conducting ourselves at work and forces us to modify the way we work in order to perform”*

Furthermore, some participants feared that their menopause-related work challenges could potentially harm their careers. Due to work-related difficulties a few participants also reported turnover intentions. Overall, these patterns mirror the experiences reported by PMS participants, underscoring how reproductive health challenges may create occupational barriers throughout women’s lives. Below are supporting extracts from participants’ accounts.

**Participant 1:**

*“...It is very hard...sometimes I think if I did not have children, I would have left this job but because I have a responsibility, I cannot leave it...so if I did not have children, I would have left this job and maybe do something else like make my own money or something that does not put pressure or people you have to answer to...”*

**Participant 2:**

*“Most of my friends are my age, mostly they also get the discomforts so yeah it really impacts most of them negatively...and one of them recently just said she wants stop working now because the situation is bad, like almost every week going through all the menopause stuff...”*

**Participant 3:**

*“Yes, come to think of it, I think menopause can affect our careers because someone can miss out on opportunities for like given very important projects because they are struggling with symptoms that always affect the way we work...”*

*“...For example, is your bosses or employers don't understand or don't take it seriously, they can assume that a person is not capable or committed, which is not true, and I think that also affects some women's confidence and willingness to go forward with their career dreams or so, yes...”*

**Participant 4:**

*“...I am old now and sometimes I am slow and forget some work, so sometimes I am scared for my job, because maybe my bosses will say I am lazy so I must stop working so they can hire a young cleaner.”*

**Participant 5:**

*“...I think that's very possible. I stopped working a while ago before transitioning into menopause and opened my own business so I don't have first-hand experience really, but I think if I were to work my condition right now it would hinder my progress in so many ways, and I might even consider stop working. Like now if I did not have my staff and my daughter, I think I would have days where I close the shop and stay home, because some days get quite challenging”*

**Participant 6:**

*“It can make you resign or quit your job...”*

**Subtheme: Personal and social life challenges.**

Most participants reported that menopause-related emotional disturbances particularly mood swings and irritability affect both their occupational and personal lives. These symptoms often strain relationships with family, friends, and colleagues, compounding feelings of isolation. Notably, these impacts mirror those reported by PMS participants, highlighting a recurring pattern across reproductive health phases. Supporting extracts from participants' accounts are provided below.

**Participant 1:**

*“...My children are always a safe space for me when I come back from work, they never mind how upset I am, with them I could unwind, even when sometimes I snap at them...very quick to respond...”*

**Participant 2:**

*“They can affect it in a certain point, because sometimes when you're feeling uncomfortable you are not in a good space or mood to be chatting a lot or talking to your kids nicely... you just want to be alone and go through whatever you're going through...”*

**Participant 3:**

*“...My colleagues notice when I’m not at my best, which can sometimes create tension or misunderstandings, especially when I’m irritated just out of the blue, sometimes because I did not sleep enough because I was feeling hot and sweating, so the next day get very tough for me”*

**Participant 4:**

*“And the anger or moods...for example this one time I shouted at my work partner and when I did not mean to that, then I was worried after that.”*

*“When I am home, I’m tired, no energy for my family things. My child asks why I’m quiet sometimes. and I don’t know how to explain”*

**Participant 5:**

*“As I mentioned that sometimes I get pissed without knowing the source of that, my husband understands it because he always notices when I am like that and I would tell him and he would try his best to comfort me, but my biggest concern is when this happens while I am at the shop, sometimes the environment can get a little bit sour because of that”*

**Participant 6:**

*“Having this anger sometimes can make you become an enemy but it’s not that it’s the condition you are facing”*

*“It does because if feels uncomfortable you the symptoms and you are in a public space you feel like people are staring at you, so you just want to hide and left alone”*

**Participant 7:**

*“The forgetfulness gets to me, being forgetful kind of affects my personal life sometimes because I would forget things that I planned with my partner for example”*

**Participant 8:**

*“I do not experience any problems related to my work performance or attendance but when it comes to my colleagues, I sometimes distance myself to avoid talking”*

*“At first, I did not want to socialise with other people outside the workplace, I used to keep to myself indoors, but as the time goes on, I am able to...”*

**Theme 3: Coping Mechanisms**

The study’s third objective was to explore and understand the coping strategies or mechanisms that women use to manage menopause-related challenges. This theme

addresses this objective, examining the various strategies that women employ to manage both the personal and workplace challenges associated with this condition. It should be noted that some of these strategies (e.g., rest) may intersect. Similarly, to PMS, two sub-themes emerged from this theme. Each sub-theme is explained in detail with supporting extracts from participants' accounts.

### **Subtheme: Physical management of symptoms**

Most participants reported the use of practical and tangible strategies to address the physical symptoms of menopause. Commonly reported methods included the use of fans and menopause-specific medications to alleviate hot flashes, night sweats, fatigue, and painkillers for associated abdominal and joint pains. Less overarching but notable strategies that varied by individual included opening windows for cooler room temperature, wearing light clothing, and drinking cold water to minimise discomforts from hot flashes and night sweats. Additionally, constant skin moisturisation addressed the dermatological changes associated with menopause, as reported by one participant. The following extracts are some of the responses that support the sub-theme.

#### **Participant 1:**

*"...I also understand why my colleague said she is on certain pills; she has to take pills that help with oestrogen, but I cannot take those pills, they are only for people without a womb so hers was removed by her doctor..."*

#### **Participant 2:**

*"...we try to cope in general, like I said most of them (friends) are taking hormone tablets to boost their hormones...just to minimize lots of things...the sweating and the other stuff that they go through..."*

*"...I have to drink cool water and just to cool my body. I know others are taking some tablets for that, but I just drink water...just cold water so far... the dryness, I just moisturize my skin a lot... so that... I don't feel too dry..."*

*"...and I just take some pain killers just to minimize the discomfort..."*

*"...that's why sometimes if you see women having small fans in their faces it's to cool ourselves down when the hot flashes are too much..."*

#### **Participant 3:**

*"I keep a fan at my desk to help with the hot flashes..."*

*“...yes, I also take these some pills from Clicks, they are called Menopil they help with symptoms like hot flashes, sweating, and sleep sometimes...”*

**Participant 4:**

*“I carry water always and my tablets for pain...”*

**Participant 5:**

*“I did take hormonal replacement therapy (treatment) for a while, but I stopped upon realising that for me it not really a problem like some of my relatives and friends go through”*

**Participant 7:**

*“As I mentioned, I consulted using my work’s employee assisted program and I was assisted provided medications that help with everything”*

**Participant 8:**

*“...I drink a lot of fluids to hydrate myself...”*

*“To add I use a small fan to alleviate hot flashes and sweating”*

**Subtheme: Psychological and Behavioural adaptations**

Various behavioural and psychological coping strategies were reported to manage the overall symptoms of menopause. Some participants reported strategies such as taking short breaks to combat fatigue, social withdrawal, and deep breathing to manage the overwhelming emotions of menopause. Furthermore, very few participants reported working extra hard to make up for lost time. Other less commonly reported strategies included activities like knitting and reading as calming outlets for mood swings and other emotional related symptoms. Additionally, the use of planners or diaries to counteract emotional disturbances and memory challenges were also less reported. Supporting extracts are provided below.

**Participant 1:**

*“Knitting and I also read a lot of books when I am down...there is a sense of calmness...”*

*“...but I must say I work with ladies that if I am feeling like the headache is too much, I can always take a rest or lie down, they are very supportive...”*

**Participant 2:**

*“... you just want to be alone and go through whatever you're going through...”*

**Participant 3:**

*“I try to communicate openly with my colleagues once I’m feeling better. If I’ve been irritable or forgetful, I apologize and explain what’s going on...”*

*“...and I try to take short breaks to manage the fatigue. I also keep a planner or diary to help with the forgetting just to try stay as organised as possible...”*

*“...When it comes to mood swings, I focus on deep breathing and take short walks to stay calm...”*

**Participant 4:**

*“...Sometimes I sit and rest for some minutes at work”*

*“After? I just try to work, and push even if it is hard”*

*“...My child asks why I’m quiet sometimes...”*

**Participant 6:**

*“I make sure to go outside of the office to get some fresh air when I feel hot and sweating”*

**Participant 7:**

*“Mostly I managed it myself, like ensuring that things that need to be done I would deal it immediately before I forget”*

**Participant 8:**

*“I minimise the issues by avoiding people to be around me”*

*“...and energies during breaks and ensure adequate rest to combat fatigue”*

**Theme 4: Menopause disclosure and reporting**

In line with the fourth objective, this study looked to explore the extent to which women disclose or report the menopause-related challenges in the workplace, including the factors influencing their decisions to do so. This theme addresses this objective, underscoring the degree to which women disclose or report their menopause-related challenges. Like PMS, three connected sub-themes emerged strongly from the data analysis. All sub-themes are explained in detail below with supporting excerpts from participants’ accounts.

### **Sub-theme: Comfort and advocacy**

Many participants in the study reported that they are comfortable to openly engage in conversations about their menopause and related challenges with anyone, including men citing that they do take their menopause status negatively and do not tie any negative connotations to it. Some of these participants emphasise that menopause is not an embarrassing thing or something to feel less about because it is a natural transition that should be embraced. Supporting excerpts are provided below.

#### **Participant 1:**

*“Yeah, I am not fazed, I don’t see anything wrong...I do not feel anything funny about, feel less of woman, nothing no, I feel that I have come full circle...I have gone through everything as a woman”*

*“...I don’t see it as taboo, not at all...I have had friends who are male, I am from a male background and being the only girl surrounded with uncles and brothers...and my uncle would ask me questions about it like he wanted to know more he was old and wanted to have more children with his wife so who else can he ask about it other than me - so I am comfortable discussing my challenges or menopause with anyone because of the type of family, friends, and community I grew up in there is nothing taboo about it...”*

#### **Participant 2:**

*“Not for me, I don’t mind talking about it...”*

#### **Participant 5:**

*“That has never been a problem for me and my advice to other women is talk about it and tell people, because you are not the only one getting brain fog and sore legs and joints, every grown woman goes through it, it a sickness or any embarrassing it’s normal”*

#### **Participant 6:**

*“Very comfortable with anyone because if you have it and sharing with others, they can understand it and you help other women, so they won’t have the same challenges when it happens to them. So, they won’t feel embarrassed when their time comes because I shared with them”*

#### **Participant 7:**

*“Fortunately for me, I give health education to colleagues, and would talk about it easily...”*

**Participant 8:**

*"I am too comfortable to discuss my condition with my colleagues because during our training we learned some books about this both male and females"*

**Sub-theme: Reluctance and stigmatisation**

Despite some participants' comfort with engaging in conversations about menopause, some participants in this study reported that they remain reluctant to disclose or converse about their menopause issues, especially with men or mixed gendered settings, citing the cultural induced stigma that is associated with such issues in broader society leading to discomfort or reluctance to engage in those dialogues even in the workplace. The following extracts support the sub-theme.

**Participant 2:**

*"...but I do know that there are some people who are very private, who do not like to talk about it"*

*"Others its culture, others its tradition and then others are just quiet by nature...so it differs...some are just quiet and don't want to sound like they are complaining."*

**Participant 3:**

*"The stigma makes it difficult to speak up about what we're going through..."*

*"...with male colleagues, it's a different story. There's a lot of discomfort on both sides, and it's hard to know how they will react, so I tend to avoid the topic with them"*

*"...it's still a sensitive topic, and not everyone gets it"*

**Participant 4:**

*"I don't talk about it, some people laugh and joke when I sweat even during cold weather, the young women also don't understand, so I keep it inside."*

**Participant 6:**

*"People judge and you start having low self-esteem, that's why some keep quiet and don't share their problems with menopause"*

**Participant 7:**

*"I have reported my menopausal challenges, but the responses were not constructive, for example you get people who say 'take pension mos' like I don't think they understand"*

### **Sub-theme: Gender dynamics in communication**

Like PMS, gender dynamics significantly influence how menopause is discussed and seen in broader society. Very few participants reported that they are generally comfortable and open to engage or disclose their menopause and related challenges to other women, as they can relate or understand, be empathetic towards women issues. Supporting extracts are provided below.

#### **Participant 3:**

*“I’m somewhat comfortable talking about it with my female colleagues because they can relate, but with male colleagues, it’s a different story...”*

### **Theme 5: Organisational support**

In line with the final objective, the study looked to understand the extent to which organisations provide support to women experiencing menopause and provide possible solutions. This theme addresses this objective, highlighting the significant gaps and barriers to organisational support. The following subthemes emerged strongly from the data.

#### **Subtheme: Inclusive vs Minimal and reactive support**

A few participants from the menopause cohort reported that their organisations provide inclusive support as part of their employee assistance programs, including healthcare support or sick bays and rest rooms. However, there is also a few that expressed that their organisations do provide some sort of reactive and informal support menopausal challenges. Supporting extracts are provided below.

#### **Participant 1:**

*“Anything that happens to me here they back me up...My bosses are very supportive and that is what keeps me going...”*

*“...We also have someone who is does not make us feel like they are superior to us, she is understanding and recognises our effort and experiences, make us feel important...she encourages us to take rest...and when it’s our break time we should not stress about work...”*

*“...Also, it depends on the management that you have because when I started with menopause, I worked with people who were older than me...so they were very nice...they understood what I was going through...My bosses were way older than me and I had a very nice understanding with them...so it did not affect my work relationships not at all...”*

**Participant 6:**

*“When I have a big problem at work, I report but the answer is just - Okay we hear you, no problem, take a break”*

**Participant 7:**

*“We have Employee Assistance Programs (EAPs) at work, and they support with everything we need or any problem we have”*

**Participant 8:**

*“My line supervisor is very understanding; the advice I receive from her is to take things easy and go to the rest room and rest and resume my duties when the episode is over”*

*“Yes, there is a sick bay where a primary healthcare nurse attends to any issues that affect the staff...and the environment is conducive”*

**Subtheme: Absence of formal support mechanisms**

Like PMS, some participants from the menopause cohort reported an absence of formal workplace support mechanisms, policies, and resources tailored to women's reproductive health needs. Additionally, this systemic oversight also contributes an unsupportive work environment for menopausal women. Supporting extracts are provided below.

**Participant 2:**

*“They are male dominated, and they don't really accommodate or have an idea of what women are going through...”*

**Participant 3:**

*“Unfortunately, there are no specific resources or initiatives at my workplace. It's not something that's really talked about, and so there are no like any formal support systems in place.”*

**Participant 4:**

*“There's nothing. No help, when you feel sick, they tell you to apply for a sick leave but when our days end, we cannot do anything”*

**Participant 6:**

*“Not yet, at the moment there is nothing”*

### **Subtheme: Need for female leadership and advocacy**

Some participants from the menopause cohort reported that female-led organisations or initiatives could provide better support for women experiencing menopause. Such organisations or initiatives may foster a workplace environment where women's reproductive health issues are taken more seriously and addressed more effectively due to shared experience. Some responses from participants are provided below.

#### **Participant 3:**

*"Yes, I think when women are part of or in charge of health issues at work, they will be more empathetic and hands-on in addressing things like these issues because we go through similar experiences and be more inclined to create supportive policies and initiatives."*

#### **Participant 4:**

*"Female bosses? Maybe they can care more. But our boss is not a woman"*

#### **Participant 6:**

*"Yes, a women get understand other women better, but also it depends if they are willing to listen and help"*

### **Subtheme: Practical recommendations at work**

Some participants in the menopause cohort suggested that organisations that are able should allow for flexible work arrangements or provide menopause rest days or leaves. Some suggested that employers should adopt a culture that allows for breaks during work hours. A few participants suggested wellness and assistance programs, such as mental and physical health initiatives, access to menopause healthcare, availability of equipment like fans at work, and providing comfortable workspaces. Supporting extracts are provided below.

#### **Participant 1:**

*"...First of all, I think our employers should understand that women are fragile...emotional...therefore our mental states should be protected...so I think they should have people come help us in the work environment..."*

#### **Participant 2:**

*"If women can be given certain days to through it I would really advice it and I think we also deserve that option of being to work from home when we go through these symptoms in a very comfortable place..."*

### **Participant 3:**

*“...like offering flexible work times for those that can go along that route...and providing resources like health initiative or healthcare professionals who understand and can provide help with menopause would be helpful. Even small changes, like more comfortable work environments or allowing taking breaks when needed, could make a big difference...”*

### **Participant 4:**

*“Maybe a fan in the storage room for when we feel hot and sweating...lets us take breaks and not chase us around when we are trying to calm down and rest a bit.”*

### **Participant 5**

*“My staff is still very young I don't think any of them have reached menopause, they are very young so we don't have initiatives for that even though I am menopausal myself, but if they were experiencing menopause or if I was working for some company I think I would appreciate things like being able to work from home, an understanding employer or people to talk to because I think women in those spaces go through so much emotionally and mentally because this is conditioning that can be challenging for some people so managing work while trying to manage it can be very difficult.”*

### **Participant 7:**

*“...And I believe having EAPs in the workplace help a lot so I think other organisations can try to have that as well”*

### **Participant 8:**

*“Teach or educate women about diet, and to keep regular medical visits...”*

### **Subtheme: Education and awareness**

Many participants in the menopause cohort also highlighted the need to normalise conversations about menopause in the workplace to raise awareness, thus creating a more inclusive and supportive workplace. Educational initiatives and awareness programs are seen as crucial to fostering understanding and empathy, particularly in space where women's reproductive health may be less understood or acknowledged. Supporting extracts are provided below.

### **Participant 1:**

*“...I think organisations should find out more about their employees, do research or ask them what they go through or experience...”*

*“...uplift people so that we can get together and learn about our experiences...I think that would makes us feel appreciated...”*

**Participant 2:**

*“It can involve a lot of people, it can help lots of women... so that they can be more open... so that they ... don't have to feel like shy... just for them to have that, that knowledge that is it's happening in their body, not like something that they should be ashamed of... they can openly talk about.”*

*“There should be more like awareness days... just once a year where women can talk and get more knowledge and... get to share their stories...so that from the male perspective people can be able to learn what women are going through... where there will be a talk, and men are there also just to get the feel of what women go through.”*

*“...more awareness in the workplace should be introduced. So, people can have a safe space to talk and then to express themselves.”*

**Participant 3:**

*“Maybe they can maybe start by accepting that menopause is a real issue that affects many women...promoting open discussions about women's health and just anything that is considered sensitive but affect the life of employee...”*

**Participant 4:**

*“...and have someone to understand and say we see and hear you...”*

**Participant 6:**

*“During women's month, organisations should create a platform on addressing the issue, like event specifically talking about this issue”*

**Participant 7:**

*“This topic needs to be handled with care, like don't force talks but provide an environment that is neutral and encourage participation for males as well”*

**Participant 8:**

*“In nursing we respect beliefs, religions, and cultures of individuals, so we do not force the discussions, but we educate...both females and males”*

**Subtheme: Disclosure and reporting vs intervention availability**

Some participants from the menopause cohort acknowledge that their reluctance and lack of openness or disclosure about menopause creates a barrier for organisations or employers to recognising their needs to provide adequate support systems. This

thus creates an environment where their challenges are overlooked or not recognised as valid workplace concerns. The following extract supports this sub-theme.

**Participant 3:**

*“Yes, I think so because if we don’t talk about it, people like HR or anyone responsible employee wellness won’t know it’s an issue that need to be addressed. But at the same time, it’s hard to be the one to start that conversation, especially when you don’t know how it will be received.”*

**Participant 5:**

*“That could be the case, and I think talking and telling people about it especially the ones you work with or for is very important so they can understand how menopause is an important issue to consider at work”*

**Participant 6:**

*“Yes, not sharing your problems with menopause can lead to organisations not knowing about it and understanding how women struggle with it so that is why I share my experiences”*

**4.6 CONCLUDING REMARKS**

This chapter presented the findings of the present study, pertaining to both Premenstrual syndrome and Menopause. Themes derived from data analysis were supported with excerpts from participants’ accounts. The next chapter presents discussions of the study’s findings.

## **CHAPTER 5**

### **DISCUSSIONS**

#### **5.1 INTRODUCTION**

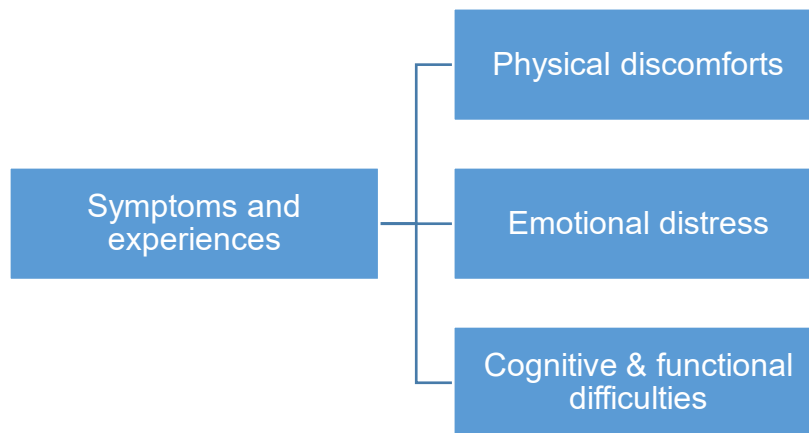
The previous chapter presented the findings of the study. It should be recalled that, using Deductive thematic analysis, five themes were drawn from the data analysis. This chapter provides discussions on the themes derived from both data sets (i.e., PMS and menopause). These discussions are supported by evidence from existing literature and by the relevant theoretical frameworks guiding the study's arguments (see Chapter 2). As a disclaimer, it should be noted that all figures in this chapter are constructed by the researcher, unless stated otherwise.

#### **5.2 DISCUSSION OF FINDINGS**

Premenstrual syndrome (PMS) tends to resolve with the onset of menopause (Newson, 2025) yet this transition itself introduces another set of challenges that have a profound impact on women's personal and professional wellbeing. This cyclical nature is highlighted in both existing literature and the findings of the present study, indicating that women often face continuous reproductive health challenges throughout their lives. Consequently, such transitions pose a significant cumulative impact on women's overall quality of life. However, despite this reality, many reproductive health issues including PMS and menopause are often dismissed as natural progressions in many workplaces and not considered legitimate workplace concerns. This neglect not only places women at a disadvantage but also undermines organisational success. By disregarding these challenges, organisations run a risk of essentially sabotaging their own progress, as per the associated implications – as to be discussed shortly.

The first objective of the study was to gain an in-depth understanding of the experiences that women incur during premenstrual syndrome (PMS) and menopause. The findings indicate that women encounter a variety of PMS and menopause-related symptoms, including physical, emotional, cognitive difficulties. However, it is important to note that both PMS and menopause are complex and individualised experiences, meaning that both the severity and the nature of their symptoms can vary significantly from one woman to another even by symptomatic episode, with some women

experiencing minimal discomfort while others endure severe physical and psychological distress (Hardy & Hunter, 2021; Hickey et al., 2024). Figure 5.1 paints a picture of the symptoms that women incur due to these reproductive health issues.



*Figure 5.1 symptoms and experiences of PMS and menopause*

The analysis underscores the debilitating physical symptoms of PMS experienced by women of reproductive age. These symptoms manifest in a variety of ways, including headaches, abdominal cramps or pain, nausea, vomiting, bloating, breast tenderness, heavy menstrual flows. Notably, lower-back pain was also reported, albeit less frequently. These findings are consistent with the work of many scholars including Hardy and Hunter (2021), Jose et al. (2021); Mahmood et al. (2022); Sireesha et al. (2023), and Sanchez et al. (2023), who identified a similar constellation of distressing physical symptoms during the symptomatic phase of PMS. In contrast, physical symptoms such as joint throbs and swelling of the lower extremities were not reported in the present study, as they were in the literature reviewed. This discrepancy may reflect contextual or demographic differences, suggesting that PMS symptomology could vary upon factors such as lifestyle, genetics, other related factors. The analysis further reveals that some women also incur significant fatigue and physical exhaustion that persists at least a few days post-PMS. This finding highlights the potential for a prolonged recovery period, raising questions about the cumulative toll PMS takes on women's physical functioning and daily activities. The post-symptomatic fatigue associated with PMS may be overlooked in standard PMS management practices, thereby a need for a more comprehensive approach to addressing both acute and residual symptoms is evidently required. In practical terms, the persistence of fatigue

beyond the typical window suggests that organisations, should they provide support in future, may need to consider extended support strategies for women.

The analysis also underscores the significant physical or somatic symptoms experienced by women in menopause, particularly the vasomotor symptoms such as hot flashes and night sweats. These symptoms are among the most reported experiences during menopause and are well-documented in existing literature (e.g., Hickey et al., 2017; Beck et al., 2020; Santoro, 2021; Hickey et al., 2024). The analysis reveals that dry skin is an issue during menopause, posing a significant challenge during certain weather conditions like hot days or summer. Dry skin is a common symptom during menopause, as the decline in oestrogen means that both collagen and oil production mechanisms that maintain skin health also slow down (Bravo et al., 2024). The analysis further reveals that hair loss is also a symptom during menopause, and this is supported by previous research showing how declines in oestrogen lead to more hair shedding (Bravo et al., 2024). For women, these changes can be distressing and can affect their self-image and perception of age. Additionally, the findings reveal that menopausal women also experience physical symptoms such as severe headaches and erratic menstrual discomforts including heavy menstrual flows and intense abdominal pain though sometime menstruation may not occur. Menstrual discomforts are particularly prevalent in the perimenopause phase of the transition, while severe headache is prevalent symptom throughout menopause (Inayat et al., 2017; Himanshi & Singh, 2022).

Similar symptoms are reported by PMS participants as per the analysis of the present study; therefore, this underscores the continuum of PMS-like symptoms through the menopausal transition phase although cause, severity, and duration may vary. A crucial insight from these findings is that menopause is not an isolated issue but part of a broader continuum of reproductive health challenges that women face, given the similarity of these symptoms with PMS. This perspective is supported by extensive research indicating that women's reproductive health issues are interconnected (Gatrell et al., 2017; Jack et al., 2021). For example, the erratic premenstrual discomforts (i.e., heavy menstrual flows and intense abdominal cramps) that some women face during perimenopause reflect an ongoing struggle that many women face throughout their lives.

The emotional toll of PMS and menopause cannot be overstated as many participants battling with these issues reported experiencing significant emotional distress. For instance, emotional symptoms such as irritability, anxiety, mood swings, and frustration were pervasive across both PMS and menopause reports. These findings align with existing research indicating that hormonal fluctuations during PMS and menopause contribute to heightened affective symptoms or emotional instability, including depression, anxiety, stress, withdrawal, anger outbursts, irritability, and frustration (Hardy & Hardie, 2017; Beck et al., 2020; Sanchez et al. 2023; Hickey et al., 2017 & 2024). The similarity in symptoms between the two conditions is striking, reinforcing the notion that hormonal fluctuations and psychological impact of these issues create a consistent lifelong challenge for many women (Hickey et al., 2017; Jack et al., 2021).

Another significant insight from these findings is that the emotional burden associated with reproductive health issues is not limited to a specific stage (i.e., reproductive age) in women's lives but persists across different life stages. Existing research suggests that both PMS and menopause are characterised by changes in progesterone and oestrogen levels, which in turn influence mood regulation (Santoro et al., 2021; Citil & Kaya, 2021). This linkage thus explains why many women experience affective dysregulations across their reproductive lifespan. Furthermore, the analysis highlights that some women are prone to severe panic attacks during their PMS symptomatic episodes. This is in line with existing research noting that severe panic attacks are frequent pre-menstruation due to hormonal fluctuations that affect certain brain chemicals leading to thereof (Nilni et al., 2012). Thus, the emotional complexity of reproductive health issues (e.g., PMS) may suggest that for certain women, they may exacerbate underlying mental health vulnerabilities.

Overall, these findings highlight that the affective symptoms of these issues can be disruptive as somatic symptoms. Therefore, this underscores the importance of integrating emotional and psychological support into PMS and menopause management practices. However, unlike PMS, where women may anticipate symptoms within a defined timeframe, menopausal symptoms occur irregularly and are less predictable, presenting a non-cyclical episodic transition that makes it difficult for women to effectively manage their symptoms (Watson, 2024). Furthermore, the overlap between the symptoms of these issues and those of other mood disorders

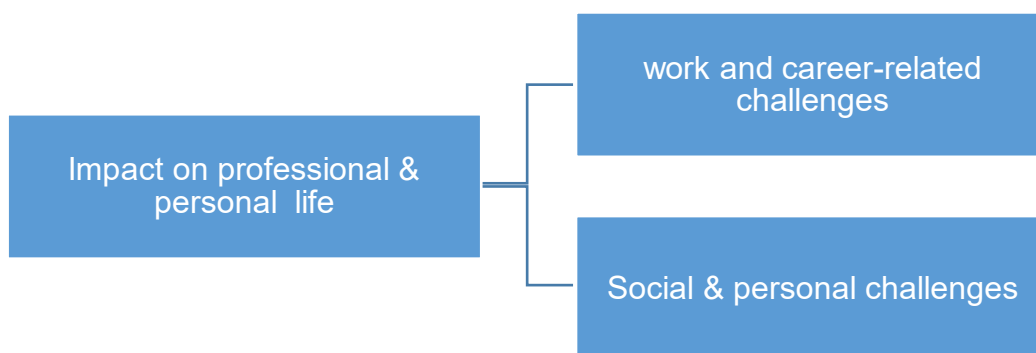
may suggest the need for a more complex, individualised approach to support, particularly for women who may be vulnerable to severe emotional dysregulation during these periods.

The severity and variability of the hormonal fluctuations that accompany these issues are striking, with many participants describing them as often severe enough to cause significant disruptions in cognitive functioning. For example, due to the hormonal fluctuations involved, both PMS and menopausal women incur cognitive challenges such as forgetfulness or memory issues and lack of concentration, or attention to detail. According to the findings, the physical discomforts (e.g., hot flashes, poor sleep, headaches, abdominal cramps, heavy menstrual flows, etc.) and emotional toll (e.g., mood swings, irritability, anxiety, etc.) accompanying these issues further exacerbate impairments in their cognitive functioning, making it even harder to concentrate or remember things. Existing research supports these findings, indicating that women experiencing the interplay PMS or menopause symptoms incur difficulties in information processing, concentration, attention to detail, and memory during their symptomatic episodes (Brewis et al., 2017; Schoep et al., 2019; Hardy & Hunter, 2021; Hickey et al., 2024). As a result, women's overall quality of life is grievously diminished in both personal and professional domains, as these issues pose a multidimensional impact on women, affecting them socially, emotionally, mentally, and functionally (Beck et al., 2020; Hardy & Hunter, 2021; Park et al., 2023). Overall, this adds another layer of complexity to PMS and menopause-related experiences going beyond physiological and emotional implications. Further on, the cognitive impact of these conditions on women is concerning in professional settings, where concentration and sustained attention are essential for productivity and performance. This is discussed further in the subsequent sections.

In addition, the analysis also reveals that the hormonal fluctuations associated with menopause and PMS lead to disruptions or fragmentations in sleep. These sleep disruptions are further exacerbated by the physical (e.g., bloating, abdominal cramps, night sweats, or hot flashes, etc.) and emotional symptoms (anxiety, stress, irritability, mood swings) that associated these issues, making it even more difficult to stay asleep or fall asleep. According to Lee et al. (2019), Beck et al. (2020), Hardy and Hunter (2021), Loukzadeh et al. (2024) poor sleep is a common symptom during PMS and menopause, and it is often exacerbated or caused by the physical discomforts and

emotional distress associated with these issues. Lack of sleep is associated with associated with several health problems including fatigue, irritability, low mood and energy, difficulties with concentration and attention to detail (Guadiana & Okashima, 2021). Therefore, this suggests that disruptions in women’s ability to maintain a restful sleep due to PMS and menopause may exacerbate already problematic emotional and cognitive difficulties, including fatigue, irritability, mood, impaired concentration and memory, thereby significantly affecting their overall daily functioning in both personal and occupational settings.

The study’s second objective was to get an in-depth understanding of the impact that these issues have on the professional and personal lives of working women. The findings indicate that these issues pose a variety of challenges for working women including workplace and career-related challenges as well as social and personal challenges. The intersection of these symptoms results in a compounded effect, diminishing not only women’s overall quality of life but also their capacity to meet societal and professional expectations. This raises essential concerns about workplace policies and support systems, as many organisations remain ill-equipped to accommodate affected women. [Figure 5.2](#) presents a picture of related impacts.



*Figure 5.2 Impact on professional and personal life.*

The analysis reveals that the physical discomfort, emotional distress, and cognitive impairment during the symptomatic episodes of these conditions create significant challenges for women’s quality of work and workplace interactions. For example, the interplay of PMS and menopausal symptoms make it very difficult for women to maintain their ability to focus, and concentration at work, therefore affecting their performance and productivity. This is most problematic in the workplace where focus or mental acuity is required. These findings are consistent with those of Brewis et al.

(2017), Hickey et al. (2017), Schoep et al. (2019), Grandey et al. (2020), Jose et al. (2021), Hardy and Hunter (2021) who similarly found that women experiencing PMS or menopause often encounter difficulties in concentration, memory, and attention to detail during their symptomatic episodes, leading to decreased job performance and productivity. According to these studies and the findings of the present study, this brain fog is predominantly exacerbated by the physical and emotional toll of these issues, which in turn further diminishes their workplace functioning. As a result, women often feel overwhelmed by the dual pressure of managing their symptoms and work responsibilities, leading to increased stress and increased risk of burnout, as per the analysis. Collectively, the present study's findings and those of existing research underscores how the overall impact of PMS and menopause intersect with the increasing demands of the workplace, where productivity and performance are greatly valued. In such environments, PMS and menopause-related cognitive impairments not only disrupt women's outputs but may also strain team dynamics, collaboration, as well as their careers (Gatrell et al., 2017).

The analysis also indicates that the physical and emotional toll of PMS and menopause result in difficulties in maintaining professional presence (i.e., presenteeism and absenteeism), with women reporting sick and, in most cases, not explicitly attributing their absence to these issues. Others, despite experiencing significant work-related challenges, choose not to report their concerns and instead attend work simply to maintain their presence, even though many participants admit that, if given the chance, they would not attend work during their symptomatic episodes. This aligns with findings by Hickey et al. (2017) and Hardy and Hunter (2021), who reported in their respective studies that PMS and menopause significantly prevented women's abilities to be fully present and meet their job demands, compelling them to take time off, sometimes leave work early, or even arrive late. Such patterns of absenteeism and presenteeism not only diminish productivity but also contribute to a cycle of underperformance and stress, further deteriorating women's wellbeing and situations within the workplace context. Evidently, both PMS and menopause-related challenges hinder women's ability to fully exercise their agency and achieve desired outcomes, such as unrestricted work attendance, performance and productivity, all of which are not only crucial for organisational effectiveness, but also for women's overall quality of life.

The pressures associated with compensating for lost time during the conditions' symptomatic episodes, particularly PMS, were evident in the study's findings. The analysis reveals that women often overexert themselves or work long hours to compensate for lost time or reduced productivity during their symptomatic phase, which further strains their physical and emotional wellbeing. This sense of needing to "catch up" adds to the already significant burden of reproductive health issues, creating a cycle of stress, fatigue, and restlessness. Studies like Hardy and Hardie (2017), and Banks (2019) similarly found in their respective studies that women dealing with these reproductive health issues bear undue burdens in the workplace, exacerbating their physical and emotional distress, ultimately impacting their overall quality of life. The cumulative effect of such burdens may have long-term consequences on women's health and wellbeing including career progression, productivity, and performance. For example, Kahyaoglu and Mestogullari (2016) and Hardy et al. (2018), respectively revealed in their studies that the negative impact of PMS and menopause on occupational wellbeing coupled with the lack of accommodations contribute to lower job satisfaction, motivation, and morale, with many women feeling disempowered by their inability to perform at their usual standards. Therefore, these findings collectively highlight the need for organisations to not minimise the importance of menstrual and menopause accommodations and recognise how absence of thereof perpetuate systemic barriers.

Furthermore, the analysis reveals that PMS and menopausal symptoms often strain relationships with colleagues and loved ones, with emotional distress playing a significant role in this regard. For example, severe emotional symptoms such as irritability, frustration, and mood swings often lead to dissociation, social withdrawal or avoidance of social interactions both within and outside the workplace. Women engage in these behaviours as mechanisms to avoid potential conflicts, recognising that the emotional distress associated with these reproductive health issues makes it difficult to regulate their emotions effectively. Owing to this isolation and disengagement is avoiding acting or behaving harshly or impulsively towards others which according to the analysis is often the case during women's symptomatic episodes. Women may be subject to pressures to conform to societal standards or expectations of maintaining semblance of normalcy during social and professional interactions and engagements, which may be particularly difficult during symptomatic

episodes, hence social withdrawal. Several studies including Tkachenko (2010), Woods and Michell (2011), Read et al. (2015), Victor et al. (2019); Mahmood et al. (2022), and Park et al. (2023), support these findings, noting that the inability to control these emotions often give rise to increased levels of anxiety, tension, and susceptibility to conflict thereby leading to strained social interactions and engagements with colleagues, partners, and their broader environment. As a result, women choose to withdraw from interpersonal interactions and engagements within and outside the workplace.

Interestingly, the analysis also indicates that the social withdrawal and dissociation associated with reproductive health issues is not only driven by emotional distress or dysregulation but sometimes stem from avoiding increased social fatigue. For instance, for some women, engaging in social interactions during their PMS symptomatic phase further exacerbates physical and emotional exhaustion. However, this hardly surprising because social interactions inherently demand emotional, physical, and cognitive labour or exertion (Sohn et al., 2018), which can be particularly more taxing during the symptomatic phase of reproductive health issues like PMS and menopause, potentially leading to increased social fatigue. This perspective adds nuance to our understanding of social withdrawal associated with related reproductive health issues because, at times, the desire for solitude is not solely due to emotional dysregulation or distress but also from the need to conserve energy and prevent compounding symptoms further. On the other hand, the analysis further reveals that some women may have “unexplainable” feelings of simply wanting to be alone during PMS and menopause. This reflects a complex layer of social withdrawal that is not purely reactive to emotional distress or pre-emptive to minimising further physical, emotional, and cognitive exhaustion. Thus, the unpredictability and variability of these feelings suggest that women may struggle to fully articulate their reasons for social withdrawal, further complicating their social experiences as this may potentially be miscomprehended or misunderstood by colleagues, friends, or loved ones. Therefore, this may add to the misunderstandings associated with reproductive health issues within social and professional environments, further perpetuating feelings of isolation, reluctance to engage socially, including lack of disclosure or reporting of challenges.

However, while social withdrawal is protective in this regard, over-reliance may present a variety of implications. Firstly, excessive social withdrawal may intensify

feelings of loneliness, detachment, and depression further deepening emotional distress (Shanker et al., 2015; Manera et al., 2022; Kim et al., 2025). Mulki and Jaramillo (2011) underscores that such feelings are negatively correlated with job satisfaction in the workplace. Secondly, irrespective of the cause, social withdrawal could also be problematic particularly in workplaces or jobs that prioritize collaboration, teamwork, or direct interactions with clients and colleagues. For example, reproductive health-induced social withdrawal may be perceived as unprofessionalism, intentional disengagement or incompetence given that related issues are often trivialised and marginalised in the workplace, as highlighted in the literature review. As a result, this may disadvantage women in the workplace, including hindering their access to career progressions like promotions. According to Marshall et al. (2007) employees often isolate themselves in the workplace when they perceive a lack of support and recognition. Therefore, proactive policies and accommodations are required to prevent the marginalisation of women's reproductive health needs and to improve work-related aspects of those affected. Importantly, this highlights the importance of fostering understanding and empathy within organisations and social environments, because the emotional dysregulation and social withdrawal associated with these issues can be misunderstood or dismissed as merely irritability or poor mood, disengagement and other connotations. Addressing these problems require open dialogue and awareness about reproductive health issues within organisations, nonetheless this is difficult due to various reasons as will be discussed in the subsequent sections.

As discussed above, the analysis reveals how PMS and menopausal symptoms, particularly emotional distress, impact women's personal lives outside the workplace, including social withdrawal and reduction in interaction and engagement with loved ones and partners. In addition to this, the analysis also reveals that the emotional and physical symptoms of these issues, particularly PMS, significantly disrupt women's daily or social activities often leading to the cancellation of commitments or plans, and a marked hindrance to complete planned extracurricular activities. Edis and Keten (2023) supports this, revealing that women dealing with reproductive health issues like PMS often postpone things or plans during their symptomatic phase. This is, however, hardly surprising, given the substantial impacts that PMS and menopause have on occupational wellbeing and other aspects of women lives, including an augmented sense of work-life imbalance and a perceived decline in the overall quality of life of

women (Kahyaoglu and Mestogullari, 2016, Park et al., 2023). Therefore, the intersection of reproductive health with personal and occupational wellbeing necessitates organisations to not engage with these issues in a fragmented or marginal manner but acknowledge them pertinent matters with workplace discourse.

The comprehensive and persistent workplace challenges that both PMS and menopause present for working women often elicit turnover intentions as per the analysis - revealing that women often possess intentions to leave their current jobs in favour of roles with greater flexibility, less demands and pressure, allowing them to manage their symptoms better. Existing literature supports this finding, highlighting how reproductive health issues often interrupts or can lead to interruptions in women's careers (Griffiths et al., 2021; Hardy & Hunter, 2021; Denis & Hobson, 2023; Biyiklar & Balcioglu, 2025). This highlights the pervasive and far-reaching consequences of these issues on women's overall workplace experiences, therefore; necessitating a growing need for workplaces to provide more adaptable working environments that cater for women's reproductive health needs.

However, the impact of these issues extends beyond work-related difficulties and turnover intentions, to deeper career-related concerns. The analysis reveals that some women have concerns that PMS and menopause could potentially hinder their career prospects due to the work difficulties these issues present in the workplace, as discussed earlier. For instance, the physical, emotional, and cognitive burdens of the PMS and menopause often lead to recurrent declines in performance and productivity, increased absenteeism and presenteeism, as indicated by the findings and existing literature. As a result, women fear this could potentially impact their professional reputation and limit their access to professional advancement or progression opportunities. The analysis highlights how the impact PMS and menopause on work outcomes may lead to assumptions that they are less capable, inefficient, or uncommitted, thereby affecting their career prospects and progression within the workplace context. In addition, the analysis further reveals that women also have concerns that the emotional disturbances of PMS and menopause (e.g., irritability, mood swings, frustration, or anxiety) could also cause employers to question their emotional intelligence. This perception could result in limited opportunities of being entrusted with essential responsibilities such as leadership roles in organisations, as emotional regulation is seen as an essential competency in related positions (Arora,

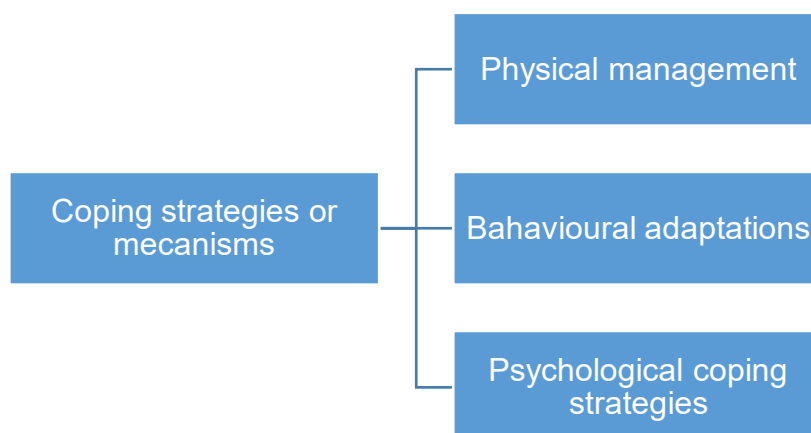
2017). As a result, this may be problematic in workplaces where emotional intelligence is highly regarded, leading to potential biases against women who may be navigating intense emotional fluctuations due to PMS and menopause. However, the overall analysis is not surprising because research demonstrates how the impact of PMS and menopause on women is often not only trivialised by employers but also perceived negatively, leading to questions about women's reliability or competence (Hardy & Hardie, 2017; Gatrell et al., 2017; Geukes et al., 2023; Safwan et al., 2024; Wang & Torbica, 2024).

Women's reproductive health issues are, in general, often misunderstood in professional settings, particularly by colleagues or employers who often reduce them as 'mere' hormonal fluctuations (Robinson et al., 2017; Manion, 2019; Abbass et al., 2020; Carneiro, 2024). This, therefore, minimises their significance and undermines their legitimate need for support and accommodations. This lack of understanding and support not only perpetuates and normalises stigma and discrimination but also reduces the credibility of women who disclose their struggles with PMS and menopause. Griffins et al. (2013) supports this, noting that there is, generally, a loss in credibility associated with reproductive health issues, where related challenges are often discrediting attributes in professional settings or recognised as flaws incompatible with professional competence. This aligns with Goffman's Stigma theory (1963), which posits that stigma is not only deeply discrediting but also leads to spoiled identity. This underscores a notable gap in how reproductive health issues are understood and accommodated in the workplace, resulting to unfair career limitations for women. Furthermore, this perpetuates gendered inequalities in career progression within organisations, as women may be unfairly judged on basis of health-related challenges that are beyond their control, thereby negatively affecting their career prospects and progression within the workplace context (Thomas et al., 2024). Therefore, these findings collectively underscore the importance of fostering greater awareness and education about reproductive health issues in the workplace.

The impact of reproductive health issues, particularly PMS, on career prospects of women extends beyond those who are actively employed. For example, the analysis shows that even women who are unemployed, may possess significant anxieties about the potential challenges that PMS could present in future work environments. This anticipation of difficulty contributes to ongoing anxiety and self-doubt, as women

may worry about whether they will be able to manage the demands of their jobs while dealing with the physical, emotional, and cognitive challenges of reproductive health issues such as PMS and those encompassing similar difficulties. This highlights how these difficulties may affect women’s confidence, eliciting feelings of inadequacy or guilt among those who struggle to meet their workplace expectations during symptomatic episodes (Safwan et al., 2024). This may also impede their willingness to even pursue new opportunities thus curtailing their careers. Evidently, these insights underscore the significant role that these issues play in disrupting women’s career trajectories and workplace experiences. Therefore, by failing to address the specific needs of women dealing with reproductive health issues, not only put women at a disadvantage but organisations also run the risk of losing or missing out on valuable employees.

The third objective of the study was to explore and gain in-depth understanding of the coping strategies that women employ to manage PMS and menopause-related challenges. The findings reveal that women employ a range of methods to cope with or to manage their difficulties, including physical management, behavioural adaptations, and psychological coping strategies. Once more, it should be recalled that coping strategies may overlap. Further to that, is important to understand that PMS and menopause are individualised experiences, thus coping strategies may differ from women to women. Nonetheless, these strategies are often employed in isolation, without organisational assistance or support, placing women at a further challenging and disadvantageous position in the workplace – as will be discussed in subsequent sections. [Figure 5.3](#) illustrates these coping strategies or mechanisms.



*Figure 5.3 coping strategies or mechanisms for PMS and menopause*

To cope with or to address the symptoms or challenges associated with PMS and menopause, women employ a variety of coping strategies or mechanisms. The findings indicate a strong reliance on physical management strategies to alleviate the physical discomforts associated with these conditions. For example, analysis reveals the use of ointments to manage the dermatological implications such as dry skin that often comes with menopause. Existing research shows that the decline in oestrogen and progesterone levels during menopause significantly affects skin hydration and elasticity (Bravo et al., 2024), thus making effective skincare regimens important for managing these changes (Manson & Chlebowski, 2013; Gasser & Heidemeyer, 2021). In addition to the use of dermatological products, the analysis reveals a reliance on pharmacological (over-the-counter) medications such as pain relievers to manage physical symptoms such as abdominal cramps, lower-back-pain, and headaches associated with PMS, including menopause-induced headaches and abdominal cramps as per some menopausal participants' accounts. Ozturk et al. (2011), Read et al. (2014), Higuera (2019), Cital and Kaya, MacGregor (2023), Cieri-Hutcherson (2023), Edis and Keten (2023), also demonstrate how women rely on pharmaceutical drugs to relieve related PMS and menopausal symptom.

Hormonal treatments or medications are also used to alleviate physical discomforts symptoms such as hot flashes and night sweats as well emotional distress as per the analysis. According to Gasser and Heidemeyer (2021) and Harper-Harrison et al. (2024) hormone replacement therapy (HRT) is one of the most treatments that help women with balancing hormonal fluctuations that contribute these symptoms. Hormonal replacement therapy is known to reduce the severity and frequency of physical discomforts like hot flashes as well as improving emotional wellbeing by stabilising emotional symptoms such as mood swings and anxiety (Gasser & Heidemeyer, 2021; Cameron et al., 2024). However, according to research the use of such treatments or medications is not without risk as they are associated with potential risks of breast cancer, cardiovascular conditions, and stroke (Yazdkhastri et al., 2015; Bhole, 2015; Cameron et al., 2024). As a result, women's willingness to use HRT is diminished, leaning more to other strategies (Yazdkhastri et al., 2015). Therefore, to address menopausal symptoms, requires a comprehensive or a multifaceted approach including alternative strategies with less risky implications, thus improving the quality of life for women during this transition.

The findings also reveal the use of sleep aids and energy supplements as strategies to improve their quality of sleep and combat the fatigue that comes with PMS. By turning to these strategies, women look to manage both the mental and physical toll of poor sleep which in turn can exacerbate other PMS symptoms including mood swings, irritability, and cognitive or functional difficulties. Recent research studies demonstrate how sleep aids help with PMS-induced insomnia (Khalesi et al., 2019; Mighami et al., 2025). Furthermore, energy supplements have also been shown to be also effective in reducing the mental and physical toll of PMS among women (Ziaei et al., 2007; Whelan et al., 2009; Ebrahimi et al., 2012). Albeit not revealed in this study, research shows that sleep aids and energy supplements strategies may also work with combating the sleep disturbances and fatigue that come with menopause (Hirose et al., 2018; Rasool et al., 2019; Marks, 2022). Even earlier research supports this, noting that evidence-based sleep aids such as vitamins, magnesium supplement, and melatonin have been found to improve sleep quality in menopausal women (Bhore et al., 2015). However, in totality, the heavy reliance on pharmacological interventions or medications also raises concerns about accessibility, particularly for women from lower socioeconomic backgrounds, who may face financial or healthcare barriers. Therefore, although these interventions may be effective, access to them may be difficult due to high cost adding financial stress to women already dealing with the physical and emotional burdens reproductive health issues.

The use of non-pharmacological and practical strategies to address the physical symptoms of PMS and menopause was evident in the analysis. For example, heat therapy using hot water bottles is also employed to manage the physical symptoms such as abdominal pain associated with this PMS. This is in line with previous research, noting how hot application relieves abdominal cramps or pains associated with PMS (Eshetu et al., 2022; Yorulmaz & Karadaniz, 2021). Kwiatkowska et al. (2024) also demonstrates how various forms of heat therapy reduce abdominal and lumbar pain during PMS. Furthermore, the analysis highlights the use of fans, opening windows for ventilation, wearing light clothing, and drinking cold water are also adaptive strategies to alleviate menopausal symptoms such as hot flashes and sweating (or night sweats) within and outside the workplace setting. In addition, the analysis further reveals that temperature control (i.e., using fans and opening windows for air) helps in maintaining better sleep by reducing hot flashes, night sweats caused

by menopause, including PMS-induced sleep disturbances (albeit less reported). Evidently, these strategies are employed to counteract thermal discomforts associated with these conditions, which are also helpful for improving sleep quality. Existing research support this, noting that controlling ambient temperature reduces disruptions of hot flashes and night sweats in menopausal women, including other stress responses associated thermal discomforts, thereby improving sleep quality for affected women (Freedman, 2001; Composto et al., 2019). In the workplace, these findings underscore the need for organisations to provide access to practical accommodations that may somehow assist women in managing some of their symptoms, thus improving their overall wellbeing. Nonetheless, this requires the acceptance of reproductive health issues as legitimate health and occupational concerns within our workplaces.

In addition, the analysis reveals that some women also make minor ergonomic adaptations such as adjusting their work environments or spaces (e.g., equipment) to create a more comfortable environment to reduce physical symptoms like abdominal strain and lower-back-pain associated with PMS. Research underscores that ergonomic adaptations such as adjustable desks and lumbar-support chairs reduce physical strain and promote better posture in the workplace (Soares et al., 2020). Therefore, such adaptations can some alleviate physical discomforts such as abdominal cramping, lower-back pain, and bloating that may be exacerbated during PMS and other reproductive health issues encompassing similar symptoms, and in turn improving workplace comfort. However, these strategies reflect an important aspect of self-management where women take charge of their immediate work environments to relieve the physical discomforts of reproductive health issues while trying to maintain a degree of productivity. For example, evidence from the present study indicates that these adjustments are often informal, dependent on the individual's initiative, and employed in isolation without organisational support. Therefore, this raises questions on whether our deemed inclusive workplaces are sufficiently equipped or flexible in offering support or accommodations for affected women. Although women-led adaptations may work, institutional support is needed to scale the impact as women alone can only do much. Conclusively, these findings highlight the need for organisations to understand and educate themselves about the reproductive health needs of women. This would foster supportive and adaptable work

environments that enable women to manage their symptoms effectively and potentially flourish in their workplaces (e.g., fully exercise their agency, achieve desired outcomes without hindrance, and better their positions), as advocated by the Empowerment theory and Liberal feminism.

Women experiencing PMS disturbances sometimes prepare in advance for anticipated challenges before their symptomatic phase commence. For example, the analysis highlights how some women track their cycles and prioritize or complete demanding work in advance, anticipating work-related difficulties during their menstrual cycle. This is supported by existing research, noting that women dealing with PMS often anticipate, plan, and adjust schedules to align with cyclical productivity fluctuations (Usher & Perz, 2013). However, advance preparation can be significantly harder in strictly scheduled jobs where workers lack control over tasks or shifts therefore this may be most effective in flexible jobs. Further to that, while advance preparation can be effective with reproductive health issues that follow a consistent hormonal cycle like PMS or other menstrual issues, its utility diminishes for conditions with unpredictable and erratic symptom patterns such as menopause. Therefore, strategies such as advance preparation and planning should be carefully implemented where most appropriate, particularly for conditions that are cyclical in nature like PMS, as well as for roles with predictable or fixed workflows or flexible arrangements. As a result, the analysis reveals that some menopausal women often prioritise doing their work immediately as it comes, anticipating potential memory lapses or other related difficulties. In addition, the utility of a detailed planner or reminder to combat menopause-induced memory lapses was evident in the analysis. Therefore, these adaptive strategies highlight how women dealing with reproductive health develop cognitive or functional challenges while trying to maintain workplace productivity.

During the symptomatic phase of reproductive health issues, social withdrawal or avoidance is often a common adaptive coping strategy for women both at work and in personal settings. For instance, the analysis reveals that social withdrawal is used as a behavioural adaptation or psychological coping mechanism for PMS and menopausal symptoms. Firstly, it is employed to avoid interactions or situations that might lead to conflict or feelings of overwhelm due to emotional distress. On the other hand, social withdrawal is also used to prevent further intensification of both the physical and emotional toll of PMS and menopause. Research supports this, noting

that women sometimes use social withdrawal as an adaptive behaviour that also offer some psychological benefits to manage the challenges of reproductive health issues (Usher & Perz, 2013; Read et al., 2014; Sophia et al., 2022; Buran & Cankaya, 2023; Edis & Keten, 2023). However, while this strategy may minimise conflicts or tensions and provide temporary relief by reducing emotional, cognitive, and physical labour associated with social interactions (Sohn et al., 2018), it carries significant personal and work-related risks or implications (Manera et al., 2022; Kim et al., 2025) – as *discussed earlier*. Therefore, although social withdrawal may be an understandable adaptive behaviour, if employed excessively its long-term personal and occupational implications may outweigh short-term benefits as previously discussed.

The analysis further reveals that some women also explore behavioural strategies like exercise as long-term strategies to better manage their PMS symptoms, therefore improving their overall wellbeing. Regular physical activity, such as exercise, has been shown to reduce the intensity of PMS symptoms, like fatigue, cramps, stress, and improves the quality of sleep and mood through the release of endorphins (Cha & Nam, 2016; Eshetu et al., 2021; Sanchez et al., 2023). Although this not evident in the analysis, existing research indicates that regular exercise also reduces the intensity of menopause symptoms (Mishra et al., 2011; Bhore, 2015; Dabrowska-Galas et al., 2019), therefore, this suggests that exercise is an applicable coping strategy to women experiencing this condition. Furthermore, while exercise may be primarily a behavioural adaptation, evidence shows it does have psychological benefits (e.g., improved mood & reduced stress), thus can also serve a psychological coping strategy (Bhore, 2015; Garcia-Falgueras, 2015). However, this finding is interesting given that some women often choose to avoid physically demanding tasks during their PMS symptomatic phase, finding them physically taxing and aggravating the physical discomforts associated with these conditions – as revealed by the present study. This solidifies that reproductive health issues are indeed individualised experiences, hence the individual variability in symptoms management where physical activity (e.g., exercise) is perceived by others as beneficial to addressing physical distress but not seen the same way by others. Therefore, this underscores the importance for greater awareness and education on how to tailor physical activity interventions for reproductive health issues, taking into consideration individual differences.

Taking naps or sleeping also serves as a coping mechanism to temporarily distract women from the physical discomforts and emotional disturbances accompanying PMS. This finding aligns with existing literature highlighting that sleeping is common among women during PMS as it helps them manage associated physical and emotional discomforts (Cha & Nom, 2016; Eshetu et al., 2021; Yorulmaz & Karadaniz, 2021; Edis & Keten, 2023). This shows how women experiencing reproductive health challenges focus their energy on their physical and emotional needs by engaging in activities that makes the comfortable and relaxed. For example, short naps may offer emotional and cognitive benefits including increased alertness, improved mood, and reduced fatigue (Dutheil et al., 2021). These benefits may be particularly valuable for women experiencing sleep disturbances (i.e., poor sleep and insomnia) associated with reproductive health issues like PMS and menopause. Furthermore, napping has been found to enhance pain tolerance (Faraut et al., 2015; Krause et al., 2019), which could provide temporary relief from physical discomforts (e.g., abdominal cramps and headaches) associated with these issues. However, despite the potential benefits of naps or sleep, the hormonal fluctuations coupled with the physical discomfort and emotional distress associated with these issues can make it difficult to achieve or maintain a nap or sleep (Kravits et al., 2018; Baker & Lee, 2022).

Nonetheless, as a coping strategy, napping could present challenges in the workplace environment, as it may be interpreted as poor work ethic or low productivity by employers, because the social stigma surrounding sleeping or napping at work persists despite evidence of its benefits. Therefore, this tension between physiological needs and workplace expectations highlights broader issues in occupational health as many workplaces remain inadequately adapted to accommodate challenges related to reproductive health. Although a few progressive organisations such as Google have begun to implement health-supportive accommodations such as nap pods or rest rooms for their employees (Essounga, 2018), such accommodations remain exceptional rather than standard practices as they are still rare and not widely adopted across many organisations, particularly within the South African work context.

On the other hand, taking short breaks or rest between tasks was also evident in the analysis. Existing literature also highlights how women make it a point to take rest or break to minimise further strain to their wellbeing (Bhore, 2015; Eshetu et al., 2022; Edis & Keten, 2023). Hunter et al. (2021) also highlights how micro-breaks often

improve focus without disrupting the workflow of employees. This strategy could potentially serve as an alternative to napping given the associated stigma in the workplace setting. Therefore, organisations should enable and encourage employees affected by health-related issues to take breaks when needed, lessening associated strain and fatigue. Overall, while such interventions and accommodations align with the principles of Empowerment theory and are worth exploring within various organisational contexts, their efficacy centres on organisational willingness to deconstruct deep-rooted productivity norms that often stigmatise related actions. Therefore, this necessitates confronting perspectives that align working continuously with professional value or productivity.

Women also engage in other leisure activities to distract themselves from symptoms associated with PMS and menopause. For example, the findings reveal that engaging in activities like social media browsing, watching movies, reading, and knitting serve as a distraction from the physical and emotional symptoms of PMS and menopause. These behaviours provide temporary relief by diverting attention away from physical discomforts such as abdominal cramps and emotional disturbances such as mood swings or irritability. A study by Edis and Keten (2023) support this finding, highlighting that women dealing with reproductive health issues like PMS often engage in leisure activities such as listening to music, and watching videos or movies to make them feel relaxed and comfortable. This also aligns with positive distraction-based coping, where individuals redirect their mental energy from a stressor by thinking about or engaging in activities that induce positive emotions, therefore reducing emotional strain and stress (Waugh et al., 2020). Furthermore, there is evidence suggesting that positive distraction leads to a perceived lower pain intensity by engaging cognitive resources elsewhere (Kohl et al., 2013).

Additionally, the analysis reveals that some women may use meditation as a long-term strategy to address the emotional and cognitive difficulties that come with these issues. According to research, meditation is a well-documented strategy for managing the overall symptoms of reproductive health issues like PMS and menopause, offering both immediate relief and long-term resilience (Bhore, 2015; Portella et al., 2020; Kaur et al., 2023). For example, research has demonstrated that meditation is effective in reducing the frequency and severity of physical symptoms such as hot flashes and abdominal cramps as well as emotional symptoms such mood swings or irritability,

associated with PMS and menopause (Sung et al., 2020; Thomas et al., 2021; Jose et al., 2022; Kaur et al., 2023; Xu et al., 2024). These studies highlight that meditation also improves women's cognitive functioning through neuroplasticity and stress modulation. Further to that, meditation also improves sleep quality which is thus important for women experiencing sleep disturbances because PMS and menopause. While there is evidence confirming the efficacy of meditation in mitigating reproductive health challenges, significant barriers persist. For example, some women may not be well informed about strategies like meditation and may be thereof disproportionately excluded from such interventions. Therefore, it is important to consider such disparities when offering related support and provide training or awareness programs to better inform women about such.

However, while these coping strategies (i.e., meditation and leisure activities) may be effective in personal settings, they may face significant limitations in the workplace setting. For example, non-work activities during work times or times may be perceived as "unprofessional" in some workplaces leading to disciplinary concerns further perpetuating the biases that women already face about reproductive health struggles. Such ideologies may stem from cultural norms, organisational expectations, and implicit biases about professionalism and productivity. For example, some workplaces prioritise visible productivity or equate being busy with productivity, and non-work activities may be stigmatised (Rivera, 2015). Therefore, while these strategies may be effective, workplace constraints necessitate either the consideration of alternatives that are workplace-friendly or employers to promote understanding to support the reproductive health needs of women. Either way, this requires organisational policy changes that cater for all the health needs of employees.

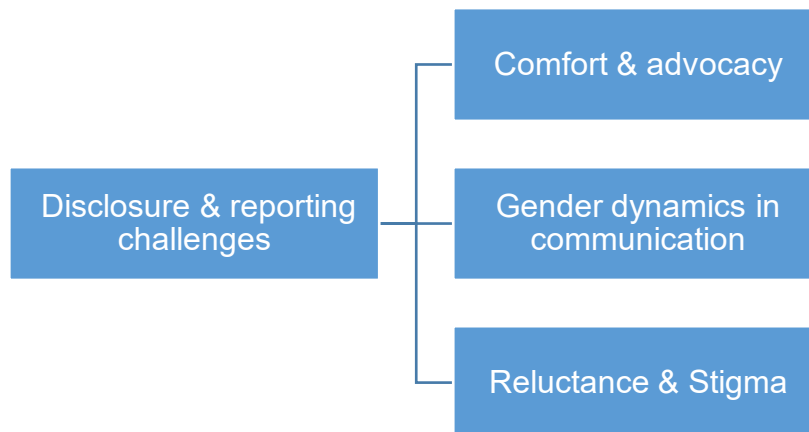
Interestingly, the analysis reveals a paradoxical relationship between work and PMS symptoms. For example, findings indicate that, for some women, when work is not extremely demanding or challenging it can serve as a distraction against the physical and emotional symptoms of PMS, given they are not debilitating. A study by Hunter et al. (2002) supports this, highlighting how some women choose to get busy to distract themselves from PMS symptoms. Research supports this, noting that cognitive tasks may temporarily override or reduce the perceived intensity of physical discomforts or pain (Kohl et al., 2013; Bushnell et al., 2013). Further to that, it is hardly surprising that less challenging activities may counteract negative emotions by inducing positive

ones, as this is supported by theories of distraction-based coping (Wolgast & Lundh, 2017; Boden & Baumeister, 1997). However, the analysis also reveals that when symptoms become more severe, this coping strategy proves ineffective, with some women describing themselves as “completely useless”, suggesting that severe symptoms render such unmanageable. The duality – work as a source of further strain and as a coping mechanism – illustrates the complex relationship women have with work during PMS and other reproductive health issues encompassing similar symptoms or difficulties, further emphasising the need for adaptive workplace policies.

Finally, the analysis reveals that heavy menstrual flows that sometimes come with menstruation and menopause (i.e., perimenopause) are one of the most difficult challenges to manage in the workplace setting. The need for frequent change of sanitary products often disrupts women’s workflow, while constant vigilance against potential leaks creates additional discomfort and stress. This aligns with existing research showing that heavy menstrual bleeding often disrupts workflow and performance and potentially leading to reduced job satisfaction (Kadir et al., 2010; Matteson & Clark, 2010; Gokyildiz et al., 2013). Further on, the anxiety of monitoring for menstrual leaks while trying to maintain composure is a well-documented challenge in studies of menstrual health (Banerjee, 2025). In the workplace, this dual burden (i.e., physical discomfort and menstrual distraction) may create a significant but often invisible barrier to workplace participation. Addressing the challenges presented by this issue requires more than individual resilience but demands systemic support. Organisations need to create inclusive workplace environments where women’s reproductive health challenges and needs are not met with stigma but accommodated. Therefore, organisations should foster practical accommodations such as accessible sanitary products for employees who may run out or not have immediate access to related products within the workplace environment. This align with the principles of Empowerment theory and to some extent those of Liberal feminism, which advocate for the provision of necessary resources to allow individuals (i.e., women) to exercise their agency, rather than being neglected or trivialised.

The researcher was also interested in exploring women’s perceptions towards the reproductive health issues under investigation. In line with this objective, the study explored the extent to which women disclose and report their PMS and menopause challenges to their colleagues and employers, and what influences their decisions in

doing so. The findings reveal a split in behaviour – indicating that some women are comfortable with openly disclosing and reporting their PMS and menopause-related challenges at work. These women emphasise need for advocacy and awareness to normalise these conversations. On the contrary, the findings reveal that some women remain reluctant, citing associated stigma and discrimination as a root cause. The findings also underscore the gender dynamics in communication involving reproductive health issues. [Figure 5.4](#) paints a picture on the latter.



*Figure 5.4 Disclosure and reporting challenges*

The analysis indicates that some women feel comfortable disclosing or discussing their PMS and menopausal challenges with everyone, including males, highlighting the value of open communication in the workplace. According to these women, normalising open conversations around these issues is crucial and they should not be considered taboo or sensitive, thus reducing stigma and foster a workplace culture of understanding and support. Therefore, openly sharing related experiences (i.e., collective advocacy) in the workplace is a significant step toward raising awareness and promoting a more supportive work environment, where women’s reproductive health issues are acknowledged rather than dismissed as mere “hormonal fluctuations”. It is also a stride towards ensuring that broader society recognises the genuine impact reproductive health issues have on women’s overall quality of life. There is a growing body of literature that also advocates workplace awareness on reproductive health issues to collapse barriers of silence and taboo or misconceptions surrounding related matters (Griffiths et al., 2016; Hardy & Hardie, 2017; Hardy & Hunter, 2021; Robinson et al., 2017; Geukes et al., 2023). These studies emphasise the need for changes in organisational culture and positive framing of women’s

reproductive health experiences, thus enabling open discussions to take place. Therefore, the normalisation of such discussions can be achieved through initiatives that allow women to voice their concerns, experiences, needs, and exercise collective advocacy in the workplace and broader society. This directly aligns with Empowerment theory's core tenet of collective agency and empowerment through active intervention.

However, openness about these challenges can sometimes be selective, depending on the comfort level with certain people. For example, the analysis reveals that PMS-related disclosure or conversations are sometimes confined to trusted individuals, particularly those with whom women share a close rapport. This not only highlights how trust and interpersonal dynamics shape women's willingness to open up about their unique health challenges but also reveals how psychological safety often enables open dialogue. In addition, the analysis also indicates that disclosure or conversations around reproductive health issues is sometimes gendered, with a clear preference for confiding in female colleagues or supervisors who are perceived as more empathetic and understanding due to shared experience, suggesting that gender dynamics sometimes impacts workplace culture. Robinson et al. (2017) and Hardy and Hunter (2021) also underscore the role played by the gender lines of managers in this regard. Therefore, this highlights how gender solidarity may collapse reproductive health misconceptions and stigma but may also perpetuate systemic silence when gender disparity (e.g., male-dominated leadership or organisations) remains unaddressed. Extensive research on gender and leadership styles indicates how diversity in leadership leads to more inclusive workplace policies (Khamesi, 2023; Shah & Dughar, 2024). Therefore, this demonstrates how representation enables inclusive policy gains within organisations.

Furthermore, the analysis reveals that this gendered dynamic is due to cultural and societal norms that view menstruation or menopause-related topics as sensitive and embarrassing, thus making women hesitant to openly disclose or report these issues in mixed-gendered settings like the workplace. Women's hesitation to report or share their challenges despite acknowledging the need for support suggests a conflict between personal needs and societal barriers. Specifically, the findings indicate that interactions with male colleagues are often marked by discomfort and misunderstanding. Studies by Schedel and Ryder (2022) and Martinez-Borba et al. (2024) supports this, noting how women's reproductive health issues remain taboo

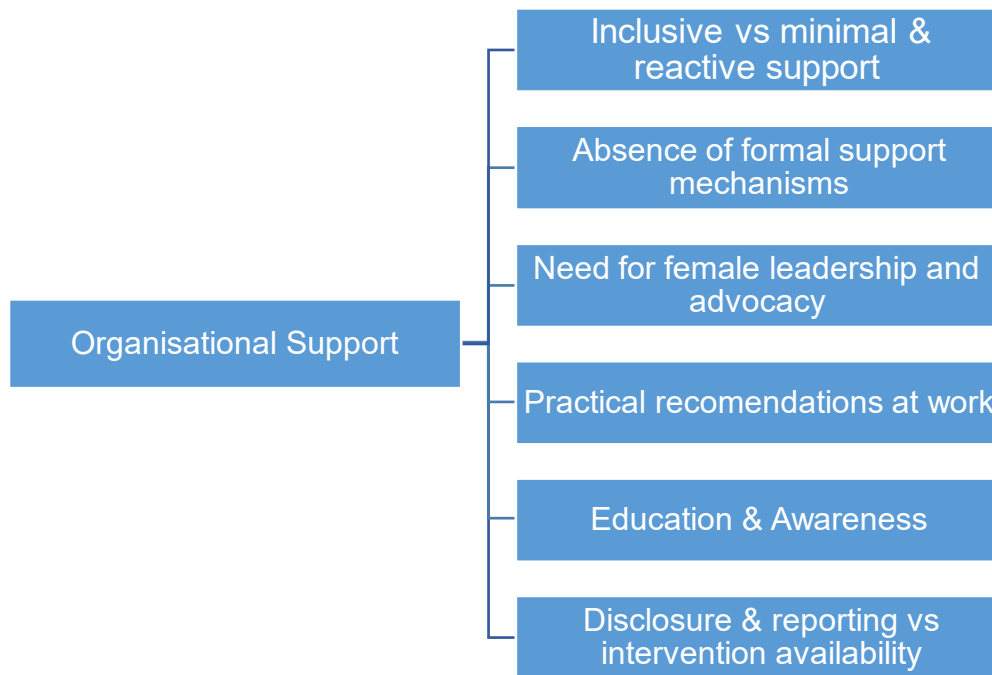
topics in workplace discourse hindering open discussions and how this exclusion results in the normalisation of discrimination and stigmatisation against women. As a result, this becomes more problematic in male-dominated or led workplaces, including underreporting of menopause and PMS work-related challenges, and a heightened potential of related discussions being trivialised or dismissed. Therefore, to address this requires intersectional solutions aimed at dismantling the culture of silence that not only marginalise women but also undermine workplace equity.

Women also internalise the perception that their reproductive health challenges or concerns are inherently tied to womanhood and are personal and sensitive matters that need not to be discussed with men. Evidently, such perceptions are rooted in the cultural and societal norms that frame menstruation and related topics as taboo or inappropriate for mixed-gendered dialogues. As a result, both PMS and menopause are often treated as personal issues by women rather than issues that could benefit from organisational support. Mukuwa et al. (2015) and Hardy and Hunter (2021) support this, noting how women normalise their reproductive health struggles in the workplace and how this contributes to the underreporting of PMS and menopause-related challenges in the workplace. Consequently, according to the Employee Voice and Silence theory this deprives many organisations of valuable information that could underscore the extent to which reproductive health issues affect women occupational wellbeing or overall wellbeing. Therefore, this stresses the importance of making reproductive health dialogues free of stigma and judgement within broader society, enabling women to share openly so that organisations can recognise their legitimate impact and need for institutional support.

On the contrary, the analysis also indicates that some women do not see the need to report or disclose their reproductive health-related challenges in the workplace, noting that they have gone through them long enough to find effective ways to manage them independently – employing the strategies discussed earlier. This perspective highlights the resilience and autonomy some women demonstrate in managing their reproductive health conditions. Therefore, despite the push for openness, the willingness to engage in such conversations is not universal, owing to related reasons. However, this raises essential questions about whether women are truly empowered in these choices or if societal expectations of self-reliance and associated stigmas discourage women from seeking external support. This is worth considering, provided

how stigma and the potential career repercussions associated with PMS and menopause are sometimes barriers to women's disclosure or reporting of these issues in the workplace. Therefore, while there is a growing movement towards open dialogues of reproductive health, it is essential to create safe spaces and foster a workplace culture of trust, where all employees feel empowered to speak about their health concerns without fear of being stigmatised in any way.

The study's final objective was to understand the extent to which organisations provide or meet the needs of women facing PMS and menopause-related challenges in the workplace and provide probable solutions. The analysis reveals that some organisations offer means of support that are inclusive of reproductive health, while some offer minimal and reactive support typically only after significant implications. Conversely, the analysis also reveals that some organisations still lack formal support mechanisms, highlighting the need for female leadership and advocacy to foster organisational support. The findings also underscore the importance of flexible work arrangements in accommodating reproductive health challenges in the workplace. Additionally, they stress the importance of promoting education and raising awareness in the workplace and the broader social context to dismantle associated stigma, thus creating inclusive and supportive environments. Importantly, the analysis also reveals that women recognise that their lack of disclosure or advocacy about these issues contributes to the lack of intervention availability in the workplace, despite the factors that often hinder reporting, disclosure, or discussions. [Figure 5.5](#) illustrates these findings.



*Figure 5.5 Organisational Support*

According to the analysis, some organisations do offer means of support that accommodate or are inclusive of menopause health-related challenges. Particularly, this includes employee assistance programs that allows women to access healthcare for any health-related issue they are facing, including reproductive health. These findings show how some organisations regard the unique factors that influence women’s everyday experiences within the workplace instead of considering them as personal issues. The implementation of interventions or policies that are sensitive to reproductive health is of paramount importance not solely for the individual employee and the organisation, but also in the context of societal transformation (Hammond & Moretti, 2024). On the other hand, the analysis also indicates that while some organisations do provide support to women severely affected by PMS and menopause, this support is often minimal and reactive in nature. Rather than offering ongoing, proactive assistance, some organisations tend to intervene only after significant events, such as employee resignations to unbearable experiences or challenges or when they become too severe to ignore. By this point, women’s wellbeing and workplace experiences have already been significantly impacted. This reactive approach points out an important gap in workplace policies and practices concerning reproductive health, leaving affected women to navigate their challenges with little assistance from their employers or organisations.

In some, if not many, organisations or workplaces, there is an absolute absence of accommodations or support as indicated by the analysis. This not only reflects a systemic failure to equal opportunity to all spheres of employment (e.g., inclusive workplace health policies and intervention) as advocated by Liberal feminism but also demonstrates how the absence of formal support perpetuates structural or systemic gendered inequalities in the workplace. For example, this negligence (i.e., absence of inclusive workplace health policies and interventions addressing women's unique needs) continues to disadvantage women professionally, manifesting in challenges such as reduced performance, limited opportunities for promotion, and hindered career advancement. Ultimately, this undermines the advocacy for equal rights and access to critical spheres of employment, as advocated by Liberal feminism. Further on, this not only violates women's reproductive rights, but also serves as a significant barrier to women's ability to fully fulfil their personal and professional needs as well as the realisation of their full potential, undermining Empowerment theory's core tenet of agency.

In totality, the absence of support or accommodations, including the minimal and reactive approach fails to recognize the day-to-day struggles women face during their symptomatic phases. It also fails to recognize the potential for formal or continuous, and preventative support in easing the impact of PMS and menopause on women's professional and personal lives. Many studies have demonstrated how proactive organisational support for health-related challenges fosters job satisfaction and productivity (Marshall, 2020; Kessler, 2023; Pena et al., 2024). Therefore, these findings highlight the need for organisations to not only shift from a reactive approach but to take more proactive stance implementing supportive policies that acknowledge and accommodate the challenges posed by these issues before escalating to more severe implications. Consequently, such measures can empower, address the unique health needs of women and better their positions in the context of work, as advocated by both Liberal feminism and Empowerment theory.

Interestingly, the analysis indicates that women's reluctance and lack of openness in disclosing reproductive health challenges also creates a significant barrier for organisations or employers to recognise their needs. These findings highlight a need among women themselves to also advocate for and force these conversations in the workplace, particularly those that are male-dominated or led. Such amplification of

women's voice will not only advocate for their individual rights but also emerge as an important catalyst for structural transformations and institutional policy adjustments within the workplace (Grandey et al., 2020). In essence, this will not only increase the visibility of their experiences with reproductive health but also transform their individual experiences to collective narratives that can reform institutional attention and policy agendas. Research indicates that reforms in organisational policy are largely influenced by employee demands and collective advocacy initiatives (Moffat et al., 2024). For example, Thomas et al. (2024) notes how in countries like South Korea and Japan menstruation leave has been legally authorised for many years; however, its actual execution was predominantly propelled by organised demands of female employees. Therefore, despite the associated stigma and discriminations, women's silence or lack of advocacy also perpetuates a culture where reproductive health issues are not recognised as valid workplace concerns, remaining largely invisible to employers. This is supported by the Employee Voice and Silence theory which notes that employees' lack of disclosure about their concerns, problems, or work-related issues deprive organisations of valuable information that may aid or foster solutions or interventions (Marrison, 2014). Such situations are problematic, not only to organisations as discussed earlier, but also place the burden on women to cope without accommodations, reinforcing gendered inequalities within organisational policies and support systems. Therefore, these findings highlight the importance of women to also take proactive to challenge organisational norms that disregard their reproductive bodies or needs.

To explore possible interventions for PMS and menopause in the workplace, a women-centred approach was employed. The analysis reveals that representation of women in organisations' leadership or workplace health initiatives could provide or enable more empathetic and proactive support for women experiencing PMS and menopause. Such workplaces or environments, where women are part of leadership or in decision-making positions, might be more attuned to related challenges due to shared experience, leading to a more supportive organisational or workplace culture. There is existing research demonstrating how leadership diversity, particularly the presence of female leadership, can positively influence inclusive organisational policies regarding the concerns of employees (Offermann & Foley, 2020; Baczor, 2022). This is particularly important in the South African context, where many

workplaces are characterised by a history of male dominance and patriarchy, limiting awareness and consideration of the unique challenges faced by women. Research supports this, emphasising how the enduring legacy of these structures still creates gender disparities in South African workplaces, particularly in decision-making and leadership roles (Musetsho et al., 2021; Ncube, 2023), which further contributes to the lack of policies addressing the specific health needs of women. This directly undermines both Liberal feminist's goal of equal opportunity and Empowerment theory's emphasis on institutional agency, resulting in organisational cultures that treat women's unique workplace needs as individual burdens rather than collective responsibilities.

The analysis further highlights a clear need for flexible work arrangements to better accommodate the challenges associated with PMS and menopause. Flexibility in the workplace such as the option to work from home, flexible work hours, or take time off when necessary, allows employees to balance their health needs without compromising their work demands (Ray & Pana-Cryan, 2021). Therefore, able organisations should consider offering flexible work arrangements for women experiencing reproductive health difficulties thus improving their work-life balance. This would, in turn, allow women to manage symptoms or difficulties more effectively without compromising their job performance and their overall wellbeing due to behaviours such as overexertion as result of lost time. There is existing research supporting the idea that flexible work arrangements contribute positively to employee wellbeing, especially those battling health-related ailments or conditions (Shanker, 2022; Kessler, 2023). This aligns with the principles of Empowerment theory by enabling women to exercise their agency and achieve desired outcomes without hindrance or further strain. However, many organisations may be reluctant to fully implement such policies due to concerns about productivity loss or doubts over whether such requests for flexibility are valid enough to warrant accommodations, given the misunderstandings associated with reproductive health issues.

To address such concerns or doubts, the analysis reveals alternative gender-sensitive approaches. At work, women recommend practical support measures, such as providing access to medications for both PMS and menopause symptoms, hot water bottles for adnominal pain relief, in-house sanitary products, air conditioning equipment (e.g., fans) to alleviate hot flashes, and creating more comfortable and

ergonomically designed workspaces to ease discomforts like abdominal cramps and fatigue. These suggestions align with a growing body of literature advocating for health-focused workplace accommodations that address specific health needs of employees (Hardy & Hardie, 2017; Hunter et al., 2017; Hunter, 2019; Hardy & Hunter, 2021; Howe et al., 2023; Chalada, 2025). Research also confirms that providing tailored accommodations to employees' health needs not only improves their health and wellbeing outcomes but also improves overall job satisfaction, productivity, employee retention or commitment to the organisation (Marshall, 2020; Pena et al., 2024; Chang, 2024). These initiatives not only cater to the practical requirements of female employees but also resonate with feminism's advocacy for systemic reforms that promote gender inclusive practices. Furthermore, when biological disparities are actively addressed in the workplace, individuals' (e.g., women) agency over their wellbeing and work is improved - a core principle of the Empowerment theory.

In addition, the importance of comprehensive employee wellness and assistance programs that address reproductive health was evident in the analysis. These initiatives could include mental health support, counselling, and education on lifestyle modifications such as nutrition and exercise. The findings of the present study together with existing research underscore the emotional and physical impact of PMS and menopause. Therefore, counselling and mental health services could support women in managing the emotional toll of these issues, helping to reduce stress and providing a safe space to discuss their challenges without stigma. Kessler (2023) supports this, noting how access to healthcare services and the establishment of psychological support systems represent strategies that can improve not only women's productivity but their wellbeing as well. Furthermore, healthier lifestyle choices such as physical exercise and healthy nutrition have been shown to improve physical health and mood stability (Siminiuc & Turcanu, 2023; Erdelyi et al., 2024). By providing such initiatives, organisations embody Empowerment theory's core tenet of "empowerment" allowing women to exercise not only their rights but their agency as well. However, it is worth noting that not all organisations may afford comprehensive wellness and assistance programs, thus such organisations may opt for alternative methods as previously discussed.

Although the above-mentioned accommodations could prove beneficial for both women and their organisations, they do not address the stigmas and

misunderstandings associated with reproductive health issues, therefore, them alone would not contribute to a more equitable workplace environment for women. In this regard, the analysis reveals the importance of educational and awareness initiatives to promote understanding and empathy, especially in male-dominated workplace environments where women's reproductive health needs might be less understood or acknowledged. Such initiatives are essential to reduce misconceptions, which often trivialise or dismiss reproductive health challenges as minor rather than legitimate health concerns (Atkinson et al., 2021; Hardy & Hunter, 2021; Geukes et al., 2023). Nonetheless, the need for such education in our workplaces underscores broader systemic challenges in South African workplace cultures, where reproductive health issues are often excluded from workplace discourse. Furthermore, the analysis reveals a need for men to also make it a responsibility to educate themselves about these issues. According to Wegner et al. (1998), men who understand women's reproductive health issues are better positioned in supporting and understanding women reproductive needs. This suggest moving beyond expecting women or organisations to solely shoulder the burden of education, but men themselves must take proactive responsibility for their own education about related issues. Therefore, this shift from passive awareness and sympathy to active learning and understanding may represent an important step in creating inclusive workplace environments where women's health needs are not marginalised but understood and catered for.

Overall, the analysis suggests that such educational initiatives (i.e., organisational and active learning) may be important for sustained normalisation of conversations about menstrual and menopausal health in the workplace, ensuring that they become embedded in workplace culture, particularly in male-dominated organisations. Existing research supports this, underscoring how open dialogues about health-related issues in the workplace foster a culture of understanding and empathy (Geist-Martin & Scarduzio, 2011). However, while open dialogues about workplace health challenges may help, their impact remains limited without enforceable policies towards stigma, discrimination, or ridicule of any kind. True change requires concrete measures to dismantle workplace cultures that permit such. In this regard, organisations need to invest in structural interventions or policies with clear accountability mechanisms, anonymous reporting systems for health-related bias, and regular assessment to root out exclusionary practices within the workplace. Conclusively, these initiatives could

lead to a cultural shift within organisations, fostering understanding and support for women experiencing reproductive health challenges.

### **5.3 CONCLUDING REMARKS**

This chapter discussed the findings of the study. These discussions were supported by relevant literature and theories. The following chapter summarises these discussions, presents the conclusions made from them, offer recommendations and finally highlights the limitations of the study.

## CHAPTER 6

### SUMMARY AND CONCLUSIONS

#### 6.1 INTRODUCTION

The previous chapter discussed the findings of the study. This chapter presents conclusions based on those findings. Specifically, it provides a summary of key discussions, outlines the study's implications, offers recommendations, and thereafter acknowledges its limitations. Finally, it includes a reference list of all cited sources and concludes with the appendices.

#### 6.2 SUMMARY OF DISCUSSIONS

It should be recalled that the study looked explore and better understand the lived experiences and perceptions of women affected by reproductive health issues in the South African workplace context, specifically focusing on menopause and PMS. While gender issues have been addressed within the South African context, it is evident that there has been less exploration of several women's reproductive health challenges and how our deemed inclusive workplaces post-1994 still present difficulties for women, particularly those battling related issues - as indicated by the findings of the present study.

It is irrefutable that women do need some form of support to help them navigate their reproductive health challenges without further burdens or concerns in the workplace. As previously indicated, not all working women require support, but for those who do, organisational support and accommodations should be provided. However, this is not the case in many organisations, as our workplaces often devalue or pay little attention to women's unique needs or of those with reproductive bodies. The lack of interventions or accommodations for these issues in many organisational settings within the South African context, reflect an assumption that reproductive health is not an organisational responsibility but is solely an individual one, leading to band-aid individual strategies because of systemic neglect.

The lack of interventions or support for these issues within the South African workplaces perpetuates gender inequality. Women as a historically oppressed group with limited exposure to opportunities are still subjected to disadvantageous positions in the workplace as the impact or challenges of these issues restrict them against fully

exercising participation and obtaining their full potential in this domain and in broader society. This study, therefore, challenges the marginalisation of women's reproductive health needs and views this as a reflection of broader gender inequality given the broader impact or challenges these issues present for working women. The study reveals that the stigma and discrimination associated with reproductive health issues within our workplace structures and norms devalue women's experiences, particularly those relating to their bodies, leading to underreporting or lack of disclosure of related concerns, which in turn hinder organisational support even further. Therefore, this study, by employing Liberal feminism, Empowerment theory, including Reproductive justice theory, advocates that such discriminatory practices and norms are not only dismantled, but women must also be empowered in terms of active interventions, thus bettering their positions in society, including the workplace.

### **6.3 IMPLICATIONS OF THE STUDY**

This study carries significant implications for various stakeholders by addressing the systemic neglect of women's reproductive health issues in the workplace context. To better women's positions or experiences in the workplace, policymakers can advocate for the integration of reproductive health issues into labour laws or legislation, including wellness programs, as advocated by the country's Sustainable Development Goals (SDG 5 & 8). These findings support the need for workplace guidelines that recognize related issues as legitimate considerations to employee wellness (e.g., SGD 3).

Practically, organisations can also use the findings to redesign workplace policies, ensuring that women's reproductive health needs are accommodated, contributing towards SGD 3. Within the social domain, this study breaks the silence around related issues, thus empowering women to advocate for their unique reproductive health concerns, therefore reducing associated stigma. Most importantly, this study promotes structural reforms that align with South Africa's efforts to reduce poverty, gender inequality, and those that promote workplace inclusion (e.g., SDG 1, 5, & 10).

Theoretically, given the dearth of knowledge or research on these issues within the South African context, this study provides first-hand evidence linking PMS and menopause to occupational functioning, filling a knowledge gap in South African workplace studies. This study also challenges existing organisational policies that

overlook gender-specific concerns within this context, contributing to the reproductive justice and feminist perspectives.

#### **6.4 RECOMMENDATIONS FOR ACTION**

Based on the findings, the study proposes that employers and organisations implement workplace accommodations or support systems (e.g., proper ergonomic adjustments, in-house sanitary kits, flexible work arrangements, healthcare access, or any other reproductive health sensitive accommodations) for women experiencing reproductive health challenges. Organisations should also conduct awareness trainings or workshops in the workplace to educate staff and management on the impact of these issues and other related conditions to promote understanding and consideration.

Advocacy groups should use the findings to foster organisational accountability and policy reforms within those spaces. Relevant bodies should create platforms for women share their experiences, therefore fostering collective action. Recommendation also goes to policymakers to use these findings to develop South African workplace guidelines or regulations mandating reproductive health support or accommodations.

Finally, to address the study's limitations, future research should expand to account for contextual differences inherent within different organisational environments because such factors may influence the experiences of reproductive health issues in the workplace. Further to that, future research should also have adequate representation of women from other racial backgrounds to properly scale the transferability of findings within the South African context.

#### **6.5 LIMITATIONS OF THE STUDY**

According to Miles (2019) limitations in research are “constraint of your study based the research methodology and design” (p.2) – these are constraints the researcher cannot control. In essence, limitations are methodological challenges or weaknesses that most of the time are out of the researcher's control but may influence research findings (Miles, 2019). As a result, measures must be put in place to address these weaknesses so that results are credible despite limitations.

One limitation of this study is the involvement of a male researcher investigating reproductive health experiences of female participants. Existing literature underscores that cross-gender research or discussions in this domain often inhibit disclosure due to female's discomfort discussing menstrual and menopause-related challenge with males (Hardy et al., 2018; Hardy & Hunter, 2021). Therefore, this dynamic could compromise the richness and authenticity of research data. To mitigate this, the researcher implemented multiple safeguards such as building rapport and trust with participants, emphasising confidentiality and anonymity, as well as demonstrating sympathy and sensitivity towards participants' experiences. Furthermore, to ensure participants' comfort and quality of data, the study implemented an adaptive approach – when participants expressed discomfort in discussing their reproductive health challenges with a male researcher, a female research assistant (i.e., PhD student) was present during the interviews. This gender-sensitive protocol created a comfortable environment for open dialogue, built trust by leveraging shared experiences, therefore maintaining methodological consistency. Another limitation worth considering was the lack of representation of white and coloured women in the study. Adequate representation of other racial groups is important given that research maintains that experiences of reproductive health issues can be influenced by various factors. Thereby, this is a limitation worth addressing in future research.

## **6.6 CONCLUDING REMARKS**

This chapter has summarised the study's key insights, highlighted its implications, recommendations for future directions, and its limitations. Thank you.

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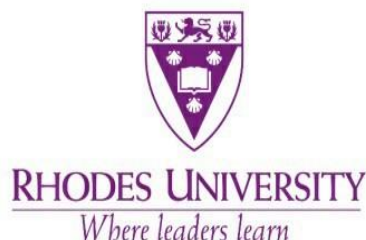
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## 6.8 APPENDICES

### Appendix A: Ethical Clearance



**Rhodes University Human Research Ethics Committee**  
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02 September 2024

Dr Trust Kabungaidze

Email: [T.Kabungaidze@ru.ac.za](mailto:T.Kabungaidze@ru.ac.za)

Review Reference: 2024-4950-9037

Dear Dr Kabungaidze,

**Re: Human ethics renewal application:** Women's health issues in the workplace.

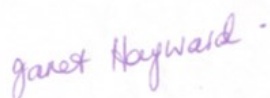
Researcher: Dr Trust Kabungaidze

This letter confirms that the above Annual Report has been reviewed and **APPROVED** by the Rhodes University Human Research Ethics Committee (RU-HREC). Your Approval number is: 2024-4950-9037

Approval has been granted for 1 year. An annual progress report will be required in order to renew approval for an additional period.

Please ensure that the Human Research Ethics Committee is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators. Please also ensure that a brief report is submitted to the ethics committee on the completion of the research. The purpose of this report is to indicate whether the research was conducted successfully, if any aspects could not be completed, or if any problems arose that the Human Research Ethics Committee should be aware of. If a thesis or dissertation arising from this research is submitted to the library's electronic theses and dissertations (ETD) repository, please notify the committee of the date of submission and/or any reference or cataloguing number allocated.

Sincerely,



**Dr Janet Hayward**

**Chair: Rhodes University Human Research Ethics Committee, RU-HREC**

cc: Ethics Coordinator

## Appendix B: Recruitment Poster

# Women's Reproductive Health matter!

You are invited to participate in a ground-breaking research project "Women's Reproductive Health in the Workplace" approved by the Rhodes' Psychology Department's Research Project and Ethics Committee, Humanities Higher Degrees Committee, and Human Subjects Research Ethics Committee (**Project's Approval number: 2024-4950-9037**).



## About the Project

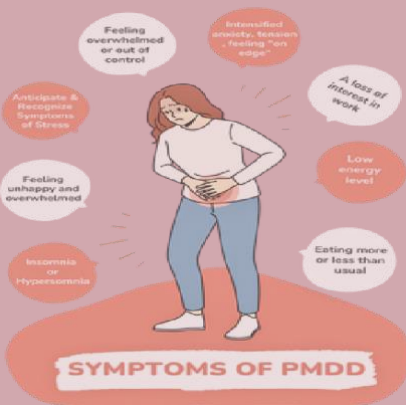
The research project aims to explore and better understand the lived experiences of women affected by either Premenstrual Syndrome, Premenstrual Dysphoric Disorder, or Menopause in the context of work. We believe that the insights and knowledge of working women (above the age of 18) will be invaluable in advancing our understanding in this area.

## Why participate?

Most importantly, your participation will not only contribute to the advancement of knowledge within the field of Industrial Organisational Psychology, but also in broader society. This project aims to address the challenges and dynamics of reproductive health issues faced by women in the workplace, therefore promoting inclusive and supportive health and well-being policies and programs within those spaces. Lastly, the project is to address the gender inequalities persistent in the workplace by shedding light on the impacts of reproductive health issues on women's abilities and career advancement. Therefore, by participating in this research project, you will serve as a tremendous force in the fight for women's empowerment and improvement of their position in the workplace and in broader society.

## Nature of Participation

One-on-one semi-structured interviews will be conducted, face-to-face in the Psychology Department or a location preferred by the prospective participant or alternatively online in platforms such as Zoom, Microsoft Teams, Google Meet, etc. based on your convenience and preference. Confidentiality and anonymity will be maintained throughout the project. The participant holds the right to withdraw from the project at any given time – free and consensual participation is paramount to the project.



## How to get involved?

Contact the researcher Athenkosi Yekani by email at [athenkosiyekani@yahoo.com](mailto:athenkosiyekani@yahoo.com) or by WhatsApp or Call at 0711296270 OR the Research supervisors, Dr Tinashe Harry at [tinasheh@mandela.ac.za](mailto:tinasheh@mandela.ac.za) or Dr Trust Kabungaidze at [t.kabungaidze@ru.ac.za](mailto:t.kabungaidze@ru.ac.za)



Your involvement will make a significant impact on the success of this research project. Being quiet about the impact of these issues is to maintain the status quo.

Should you require clarity or more information about the project please contact the aforementioned individuals.

Thank you for your consideration!

## Appendix C: Consent Form

### PARTICIPANT INFORMED CONSENT DECLARATION

(To be signed by research participants)

Research Project Title: Women's Reproductive Health in the Workplace.

*Athenkosi Yekani (g19y5852)* from the Department of Psychology, Rhodes University, has requested my permission to participate in the above-mentioned research project.

The nature and the purpose of the research project and of this informed consent declaration have been explained to me in a language that I understand.

I am aware that:

1. The purpose of the research project is to explore and better understand the lived experiences and perceptions of women affected by Reproductive health issues in the workplace.
2. Rhodes University has given ethical clearance to this research project (**Ethics Approval Number: 2024-4950-9037**) and I have seen/may request to see the clearance certificate by contacting the Ethics Coordinator (ethics-committee@ru.ac.za).
3. By participating in this research project, I will be contributing towards:
  - Addressing the prevailing silence surrounding women's reproductive health issues in the workplace.
  - Recognising the specific needs of women affected by these issues within the African and/or South African organisational contexts.
  - Addressing the gender inequalities inherent in our workplaces due to reproductive health issues, thus fostering the empowerment and inclusion of women.
  - Promoting the provision of adequate support for women affected by reproductive health issues in the workplace to exercise their agency and meet their needs (e.g., optimal occupational functioning, satisfaction, career advancement, etc.)
  - Promoting the improvement or development of workplace interventions and policies aimed at improving reproductive health and wellbeing in the workplace.
  - Filling a gap in existing literature within the African and/or South African context, considering that the current body of studies within this research area originates from international contexts
4. I will participate in the project by participating in a one-on-one semi-structured interview, either face-to-face or online via platforms such as Zoom, Microsoft Teams, Skype, based on my convenience and preferences. In this interview I will be asked questions related to my experiences and perceptions of the following the reproductive health issues, either-or: Menopause and Premenstrual Syndrome.

5. My participation is entirely voluntary and should I at any stage wish to withdraw from participating further, I may do so without any negative consequences.
6. I will not be compensated for participating in the research, but my out-of-pocket expenses will be reimbursed.
7. The following risks are associated with my participation: This research project is associated with the risk of discomfort or stress during data collection. However, this will be alleviated by creating rapport and a comfortable, trusting environment for participants throughout the process. The presence of a male researcher may be another potential issue to cause discomfort due to gender differences, to address this a female research assistant will be present.
8. The Researcher intends to publish the research results in the form of academic journals or disseminate findings through publications in edited books. However, confidentiality and anonymity of records will be maintained, and my name and identity will not be revealed to anyone who has not been involved in conducting the research, *unless I indicate to the contrary/recognize that as a public figure, my identity will inevitably be/become known in which case I agree to and accept the loss of confidentiality.*
9. In terms of the Protection of Personal Information Act, it remains my right to request the Researcher to provide me with a detailed explanation of exactly how confidentiality and anonymity will be achieved. I may request to know how my personal information will be stored securely, for how long it will be stored, and whether it is likely to be used again in further research.
10. In terms of the Protection of Personal Information Act, I possess the right to receive feedback about this research. This will take the form of an email or an information pack, *unless I elect not to receive feedback.*
11. Any further questions that I might have regarding the research, or my participation will be answered by the researcher, Athenkosi Yekani at [g19y5852@campus.ru.ac.za](mailto:g19y5852@campus.ru.ac.za); or the supervisors, Dr. Trust Kabungaidze at [t.kabungaidze@ru.ac.za](mailto:t.kabungaidze@ru.ac.za) or Dr. Tinashe Harry at [Tinashe.Harry@mandela.ac.za](mailto:Tinashe.Harry@mandela.ac.za)
12. By signing this informed consent declaration, I am not waiving any legal claims, rights or remedies.
13. A copy of this informed consent declaration will be given to me, and the original will be kept on record.

I, ....., have read the above information / confirm that the above information has been explained to me in a language that

I understand, and I am aware of this document's contents. I have asked all the questions that I wished to ask and these have been answered to my satisfaction. I fully understand what is expected of me during the research.

I have not been pressurised in any way and I voluntarily agree to participate in the above-mentioned project.

I **agree/disagree** (SELECT APPLICABLE) to the Researcher's request to take photographs and/or videos of me as part of this research project, recognising that agreement here is likely to raise the risk of compromising my anonymity and that steps will be taken to ensure this does not happen if my approval is granted.

I **agree/disagree** to the Researcher's request to voice record my comments and opinions during interviews, the purpose of which is to ensure the accurate recording of my views. Furthermore, I have the right to request a copy of interview transcriptions to confirm that my opinions are accurately recorded.

.....

**Participants signature**

.....

**Date**

## APPENDIX D: Interview Guide

### Opening - Introduction and Consent

#### Demographic Information?

1. Can you please start by stating your age, your employment status (Full-time, Part-time, Contractual), and the industry (Healthcare, Technology, Education, Finance, Manufacturing, Retail, etc) you work in?

#### Type of condition and Severity of symptoms?

2. You are participating under which condition PMS/Menopause? - Can you please tell me/us about the kind of symptoms you normally experience?
3. How frequent do you normally experience these symptoms? Is it the same symptoms every month or they're inconsistent and differ in severity?

#### Work-related Impact?

4. Have you experienced these challenges or symptoms during your time at work or in a time where you had to attend work? (Yes/No)

*Follow up: Can you specify the type challenges you had or normally experience in the workplace? (e.g., Emotional, Physical, Cognitive).*

5. What impact do or did they have in your work-life? (e.g., *interpersonal relations with colleagues, performance, attendance, etc.*)

*Follow up? E.g., so how do you address these issues to ensure that you minimise impact?*

*Follow up? If it were up to you, would you rather or not attend work doing this time? And why is that the case?*

6. What Impact do you think PMS or Menopause can on the careers working women?

## **Coping Mechanism?**

7. What coping mechanisms do you employ to manage the condition or challenges at work?

## **Disclosure?**

8. Have you ever reported your challenges to your manager/supervisor/director? (Yes/No)

***Follow up:** If no, can you provide a reason on why you never did that?*

***Follow up:** If yes, what kind of response(s) did you get when reported your concerns?*

9. How comfortable are you with having open discussions about your condition in the workplace, including male colleagues?

***Follow up:** Why, can you expand or give a reason?*

***Follow up:** Because SA is a very traditional and cultural space, and these factors can be a barrier hindering such discussions. So, do you think it is also up to women to force these conversations and discussions to break such traditional and cultural misconceptions or taboos?*

***Follow up:** do you think that initiatives or organisations with female leadership can be better equipped in understanding and possibly addressing these kind issues?*

## **Personal Impact**

10. How does PMS or Menopause affect your personal life (**e.g., relationships with other people, daily activities, and your overall well-being**) as a person outside the workplace?

## **Workplace Support**

11. In your workplace, are there any workplace support mechanisms, initiatives, or resources that are available for women experiencing Condition -related challenges?

***Follow up:** If there are, how satisfied are you with them?*

***Follow up: If there aren't any, what do you think is the cause of that?***

12. How can organisations create more inclusive and supporting environment for women dealing with PMS or Menopause - *What can they do better?*

### **Closing**

Is there anything else you'd like to share regarding your experiences or suggestions for improving women's reproductive health in the workplace?

## Appendix E: Recordings – Permission & Release Form

**Rhodes University — Department of Psychology**

# USE OF TAPE RECORDINGS FOR RESEARCH PURPOSES PERMISSION AND RELEASE FORM

|                                |  |           |     |
|--------------------------------|--|-----------|-----|
| Name of participant            |  |           |     |
| Participant's contacts details | Email address:<br>Phone number:              |           |     |
| Name of researcher             | Athenkosi Yekani                             |           |     |
| Level of research              | Honours                                      | Masters ✓ | PhD |
| Brief title of project         | Women's Reproductive Health in the Workplace |           |     |
| Name of supervisor             | Dr. Trust Kabungaidze and Dr. Tinashe Harry  |           |     |

### DECLARATION

*(Please initial/tick blocks next to the relevant statements)*

|    |  |  |  |
|----|--|--|--|
| 1. | The nature of the research and the nature of my participation have been explained to me.   | verbally                               |  |
|    |  | in writing                             |  |
| 2. | I agree to be interviewed and to allow recordings to be made of the interview.   | audiotape                              |  |
|    |  | videotape                              |  |
| 3. | I agree to _____ and to allow recordings to be made.   | audiotape                              |  |
|    |  | videotape                              |  |
| 4. | The tape recordings may be transcribed   | without conditions                     |  |
|    |  | only by the researcher                 |  |
|    |  | by one or more nominated third parties |  |
| 5. | I have been informed by the researcher that the tape recordings will be erased once the study is complete and the report has been written.<br><br>OR<br>I give permission for the tape recordings to be retained after the study and for them to be utilised for the following purposes and under the following conditions |  |  |
|    |  |  |  |

Signature of participant: \_\_\_\_\_ Date: \_\_\_\_

Witnessed by researcher: \_\_\_\_\_ Date: \_\_\_\_