WOMEN'S WR REPORT

EVIDENCE-BASED INSIGHTS ABOUT WOMEN AT WORK

WOMEN'S REPORT 2024

Paper 1: Menopause and the modern working woman

by Dr Antonella Silver

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Menopause and the modern working woman

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In today's society, where there is a strong desire to combat the effects of ageing through various anti-ageing products and treatments, women are still faced with the inevitable and natural process of menopause. This stage of life is often unfamiliar to women, as it is not openly discussed by previous generations, and even some medical professionals shy away from the subject. It is disheartening to hear stories like that of Halle Berry,[1] a well-known celebrity, who had difficulty obtaining a proper diagnosis and support for her menopausal symptoms. This raises questions about why menopause is stigmatised and relegated to secretive conversations, rather than being openly discussed. It is important to explore the impact of menopause on the modern working woman, as menopause impacts about one-third of a woman's life.[2]

WHAT IS MENOPAUSE?

Menopause is a natural biological process that marks the end of a woman's reproductive years, typically occurring in the late 40s and early 50s, although the timing varies amongst women; the average age is between 48 and 52 years of age. Menopause is the 12-month period after the final menstrual period, although it is often diagnosed retrospectively, as it is uncertain whether another period will follow. Menstrual cycles may become irregular, and abnormal uterine bleeding occurs, such as a longer or a shorter menstrual cycle. Women may experience unpredictable menstrual periods (skipping a cycle or having two periods close together), and may suffer heavier or prolonged bleeding or intermenstrual or breakthrough bleeding, due to fluctuating follicle stimulating hormone (FSH) levels. After one year without menses, a women is considered post-menopausal until the end of her life. In some women, menopause can occur prematurely — before the age of 45. Early menopause is associated with smoking, familial tendency, nulliparity, epilepsy, childhood cancers, and chemo- or radiotherapy in adults, while later menopause is associated with obesity, multiparity, and higher cognitive scores during adolescence.[3,4,5]

THE EFFECTS OF MENOPAUSE

During menopause, oestrogen levels drop, and the impact thereof on individuals varies. About 75% of women experience hot flushes and night sweats, which could vary in intensity. Hot flushes usually start in the face with a feeling of heat and tingling, which then spreads over the chest and arms. These flushes are associated with perspiration that persists for a few minutes. In one-third of women, these may be so severe that they have a significant impact on quality of life. Hot flushes usually start about two years before the last menstrual period, and peak a year after the final one. This is usually transient, lasting only two to three years, but, in about 25% of women, may last more than five years. In a minority of women, these hot flushes may be lifelong. These episodes may, in turn, lead to insomnia and obstructive sleep apnoea.[6]

Subjective cognitive decline, coupled with slower learning and reduced verbal recall, is one of the most frequent complaints of women undergoing menopausal transition, with a 44% to 62% prevalence estimated in population-based studies. This is ascribed to lower oestrogen, which plays an important role in the neurobiology of cognitive processing

1 *Forbes, A. (2024, May 3). "I'm in menopause, okay?" Halle Berry backs bill to bring more services to women's health. USA Today. https://www.usatoday.com/story/entertainment/celebrities/2024/05/03/halle-berry-menopause-bill/73560451007/*
2 *Greendale, G.A., Lee, N.P., & Arriola, E.R. (1999). The menopause. Lancet, 353(9152): 571-580. DOI: 10.1016/S0140-6736(98)05352-5*
3 *Harlow, B.L. & Signorello, L.B. (2000). Factors associated with early menopause. Maturitas, 35(1): 3-9. DOI: 10.1016/s0378-5122(00)00092-x*
4 *Akahoshi, M., Soda, M., Nakashima, E., Tominaga, T., Ichimaru, S, Seto, S., & Yano, K. (2002). The effects of body mass index on age at menopause. International Journal of Obesity and Related Metabolic Disorders, 26(7): 961-968. DOI: 10.1038/sj.ijo.0802039*
5 *Morimoto S. & Atsushiro, I. (2023). Late age at menopause positively associated with obesity-mediated hypertension. Hypertension Research, 46(5): 1163-1164. DOI: 10.1038/s41440-023-01237-7*
6 *McKinlay, S.M., Brambilla, D.J., & Posner, J.G. (1992). The normal menopause transition. Maturitas, 14(2): 103-115. DOI: 10.1016/0378-5122(92)90003-m*

and neuronal function. However, the Women's Health Initiative's memory study showed that these changes affect only about 4.5% of the perimenopausal population, with cognitive functioning normalising in the post-menopausal period. Several studies have reported that prolonged oestrogen exposure results in better cognitive outcomes during and after menopause.[7]

Oestrogen stimulates the vaginal epithelium to stay healthy, elastic, and moist, which is why menopause may cause vaginal atrophy, with resultant sexual problems. Weight change, particularly weight gain, is common during this period. There is also a redistribution of body fat, specifically an increase in abdominal fat, predisposing women to the risk of developing insulin resistance, with a subsequent increase in the risk of cardiovascular disease. Oestrogen is cardioprotective; it lowers blood pressure, which is one of the reasons why women have less cardiac disease compared to men. Intimal thickness — the thickness of the innermost layer of the blood vessel wall in the arteries — becomes increased, and salt sensitivity becomes more pronounced. The lack of oestrogen shifts blood lipids towards a more negative profile.

Bone health is also negatively impacted, with bone loss starting during perimenopause and increasing after the final menstrual period. On average, between 1% and 3% of bone is lost annually, increasing the risk of fractures. Muscle mass deteriorates with age in both men and women, but is more common amongst women. This decrease in muscle mass adds to the risk of falls and fractures. The risk of osteoarthritis increases greatly after the final menstrual period, leading to deterioration of the spine and knees. The skin's thickness, elasticity, hydration, and collagen are reduced, leading to wrinkling. Facial terminal hair increases, while hair on the body and scalp reduces.[8]

In addition, menopause and its transition phases present a period of heightened vulnerability with regard to women's mental health, especially when they coincide with other stressors, such as adult children leaving the family home or elderly parents requiring care. Menopause may also affect a woman's relationship with her partner, as the associated hormonal changes may lead to mood swings, decreased libido, and physical discomfort. Depression, irritability, fatigue, loss of interest, poor concentration, and agitation are common in the perimenopausal transition and early menopause.

DEMOGRAPHICS AND MENOPAUSE

Not all women experience menopause the same; there are differences amongst cultures. Menopause tends to be earlier in African, Asian, and Middle Eastern populations, and later in American and European populations. Flushing is more common in African, Hispanic, and European women, and less common in Japanese and Chinese women. African women are more prone to the cardiovascular complications of menopause, even when data are corrected for the increased prevalence of obesity amongst African women. Skin changes are more pronounced in white women when compared to black women, probably due to darker skins being better able to withstand the effects of photoaging — premature ageing of the skin through long-term exposure to ultraviolet radiation from the sun.

Osteoporotic fractures (fractures that occur in individuals with osteoporosis or low bone density), specifically hip, spinal, and wrist fractures, are most common in Scandinavian, European, and Mediterranean women, and less common amongst women in Africa. Women with an anxious predisposition tend to suffer worse hot flushes. Obese women have a longer menopausal transition and experience worse hot flushes, which may be because fatty tissue acts as an insulator, trapping heat in the body and generating additional heat.

7 *Conde, D.M., Verdade, R.C., Valadares, A.L.R., Mella, L.F.B., Pedro, A.O., & Costa-Paiva, L. (2021). Menopause and cognitive impairment. World Journal of Psychiatry, 11(8):412-428. 7*

8 *Neer, R.M. (2022). Bone loss across the menopausal transition. Annals of the New York Academy of Science, 1992:66-71. DOI: 10.1111/j.1749-6632.2009.05233.x*

Hot flushes are significantly more increased in HIV-positive women, independent of their CD4 count (also known as 'T cells', which are white blood cells that fight infection). HIV infection causes immune system dysfunction, leading to chronic inflammation and immune system dysregulation. The chronic inflammation, in turn, can exacerbate the menopausal symptoms, including hot flushes.

TREATMENT OPTIONS

It is important to note that menopause is not a state of disease, but rather a natural phase in a women's life that can be accompanied by uncomfortable symptoms. It has a negative impact on systems that can affect longevity through the risk factors discussed above. If not managed effectively and in a timely manner, it could lead to severe health consequences. Management of this phase consists of both medical and lifestyle management.

LIFESTYLE CHANGES

Optimal exercise, according to the World Health Organization (WHO), consists of 150 minutes of moderate-intensity exercise per week. Menopausal women who follow an active lifestyle enjoy numerous advantages. Physical activity helps to improve metabolic profile, cognition, and quality of life. Exercise also helps to improve balance and muscle strength, reducing the risk of falls and fractures. Exercise improves cardiovascular health, and significantly reduces the risk of cardiovascular incidents, strokes, and breast- and colon cancer. A loss of a mere 10% body mass in overweight individuals improves insulin resistance.

"Menopausal women should follow a healthy diet and limit their alcohol consumption to 20 g (two glasses of wine) per day. As part of the lifestyle changes, weight-bearing exercise is important to improve bone density. However, women should be aware that a low body mass index (BMI) is associated with poor bone mineral density."

Management of hot flushes consists of lifestyle management and pharmacological intervention (discussed below). Lifestyle interventions that have shown to be effective are measures such as weight control, regular exercise, slow diaphragmatic breathing, lighter clothing made of breathable fabrics, drinking cold liquids, and avoiding triggers such as alcohol and spicy foods.

MEDICAL MANAGEMENT

While an oestrogen deficiency is the reason for menopausal symptoms, not all women can be given oestrogen through hormone replacement therapy (HRT; also known as menopausal hormone treatment or MHT). There are two main types of HRT, namely oestrogen-based and tibolone (a type of therapy that contains a synthetic hormone). Oestrogen cannot be given to women who still have a uterus, unless opposed with progestogen, to protect the endometrium (uterine lining) from hyperplasia and malignancy. Oestrogen used for menopausal therapy varies, but conjugated oestrogen and oestradiol are the most widely used preparations. These can be administered orally or transdermally (via a skin patch) for systemic treatment, or vaginally for the genito-urinary syndrome of menopause (vaginal and vulvar dryness).

Another option is tibolone, a synthetic drug that is metabolised to different metabolites that have estrogenic, progestogenic, and androgenic actions. Tibolone inhibits the enzyme sulfatase in the breast, so that the inactive oestrogen sulfates are dominant in the breast. Only when the sulfate group is removed do the oestrogens in the breast become active. Unlike oestrogen, it is not necessary to oppose tibolone with progestogen, as one of the metabolites has a progestogenic effect. Tibolone does not stimulate the endometrium to undergo hyperplasia (enlargement as an initial stage of cancer), but does stimulate bone formation, and is therefore an effective treatment for osteoporosis. Tibolone may, therefore, be the safer alternative for patients with increased risk factors related to certain cancers. However, tibolone is associated with increased facial hair. The appropriate treatment therefore varies from woman to woman.

Oestrogen deficiency causes increased bone demineralisation, leading to an increased risk of osteoporotic fractures when falling and compression fractures of the vertebrae. Bone mineral density is influenced by genetics; it peaks during youth and decreases with age, and the process is accelerated by menopause. HRT reduces fracture risk in both osteoporotic and

non-osteoporotic women. HRT is the therapy of choice amongst women aged 50 and 60 years with an increased risk of fractures. Tibolone is also effective in preventing both vertebral and non-vertebral fractures.

Daily calcium supplementation should be used to supplement a deficient dietary intake of calcium, i.e., less than 1 200 mg elemental calcium per day. However, excessive calcium intake may lead to cardiovascular disease, renal calculi, and constipation. Vitamin D intake should be about 800 IU daily, depending on serum vitamin levels. Bisphosphonates, a group of drugs that are potent inhibitors of bone resorption (when bone tissue and minerals are broken down and calcium is released into the bloodstream), are often used to enhance bone density. While they are effective in preventing fractures, they are not without safety concerns.

It is important to note that women between the ages of 50 to 60 years should be started on menopausal hormone therapy, as this is the window of opportunity for cardioprotective treatment. Women who are 10 years past their final menstrual period do not get the same cardiovascular protection from menopausal hormone therapy. Oestrogens increase the risk of venous thromboembolic events (VTE), and the risk is higher in women with a family history of VTE. Other factors that increase the risk are obesity, advanced age, arthritis, and surgery. When oestrogen is administered transdermally, the risk of VTE is much lower, and hardly increases. However, oestrogen therapy is contraindicated in women who have had a previous thrombotic event.

WHAT IS THE RISK OF DEVELOPING CANCER WHEN ON HRT?

Women using combination hormone therapy (oestrogen and progestogen) have a small increased risk of developing breast cancer (one in 1 000), and this risk disappears after cessation of use. However, HRT for breast cancer survivors remains controversial, with various trials yielding conflicting data.

"When combination therapy is used in women with a uterus, there is no increased risk of developing endometrial cancer. The absolute risk of developing ovarian cancer when using HRT is very low. Combination therapy reduces the risk of colorectal cancer, and oestrogen-only treatment has no effect on the incidence of colorectal cancer."

SUPPORTING WOMEN GOING THROUGH MENOPAUSE

Menopausal women represent the fastest-growing demographic in the workplace. Managers should thus be aware of the symptoms of menopause, and they should increase awareness while building relationships of openness and trust with these women, to ensure transparent communication and support. Employee assistance programmes should include access to support- and information services.

CONCLUSION

Menopause can significantly affect a woman's health and overall quality of life. It is thus vital that organisations effectively manage and provide appropriate support to women during this transition. Women need to be informed of and take ownership of lifestyle factors that play an important role in the severity of menopause. Early medical management is critical, including screening for potential complications associated with menopause.

An open and honest discussion about menopause is vital in reducing stigmas and creating a supportive environment. By openly talking about menopause, individuals feel more comfortable seeking support and assistance. It also enables colleagues who are not experiencing menopause to develop empathy and understanding towards their co-workers who are going through this transition, thereby fostering a more inclusive and supportive workplace environment.

About the author

MENOPAUSE AND THE MODERN WORKING WOMAN

Every year, we are privileged to have some of the foremost experts in their fields contribute to the Women's Report. Their insights, research, and thoughts on topics provide fresh perspectives on the advancement of gender equality at work. Experts come from the ranks of practitioners and researchers, and topics span women at work and the spill-over of perspectives on gender, at home and in society, on paid work.

DR ANTONELLA SILVER

Dr Antonella Silver is a University of Pretoria-trained obstetrician and gynaecologist currently sub-specialising in maternal–foetal medicine at the University of Pretoria and serving as a consultant at Steve Biko Academic Hospital. Dr Silver's unwavering commitment to improving maternal health is truly inspiring.

She has played a pivotal role in implementing innovative and effective maternity care practices at MRC, where she emphasised the importance of respectful and compassionate care for expectant mothers. Her dedication to ensuring the well-being of both mothers and their unborn babies is commendable. Passionate about women's health, Dr Silver focuses on addressing the often-neglected extremes of age. She tirelessly advocates for the well-being of elderly women burdened by malignancies, providing them with the support and guidance they need during challenging times. Additionally, she is deeply invested in the welfare of adolescent girls who face pressures and uncertainties in premarital relationships, striving to provide them with comprehensive contraceptive care and support.

Message from the Editor

Welcome to the 2024 edition of the Women's Report!

While it is true that men and women both face the stresses and challenges that accompany life's upheavals, the impact on them, as well as their subsequent responses, differ.

"For millennia, medicine has functioned on the assumption that male bodies can represent humanity as a whole.[1]"

This year's Women's Report promotes gender-sensitive information sharing about women's health concerns such as toxic stress, cancer, menopause, and pregnancy in the workplace. In *Women and Stress in the Workplace*, Renata Schoeman explains the effects of good and bad stress — eustress and distress. Mia Barnard, in *Supporting Women Employees with Breast Cancer*, provides a heartrending glimpse into the world of a woman battling to overcome breast cancer.

In *Working while Pregnant*, Salome Maswime paints a picture of what it takes to balance two worlds, while, in *Menopause and the Modern Working Woman*, Antonella Silver addresses the intricacies of navigating menopause. I hope you will find these articles both insightful and helpful.

Enjoy the 2024 edition of the Women's Report!

Anita

Research Chair - Women at Work
Professor: Leadership and Organisational Behaviour

1 *Criado Perez, C. (2019). Invisible women: Data bias in a world designed for men. Harry N Abrams Publishers.*

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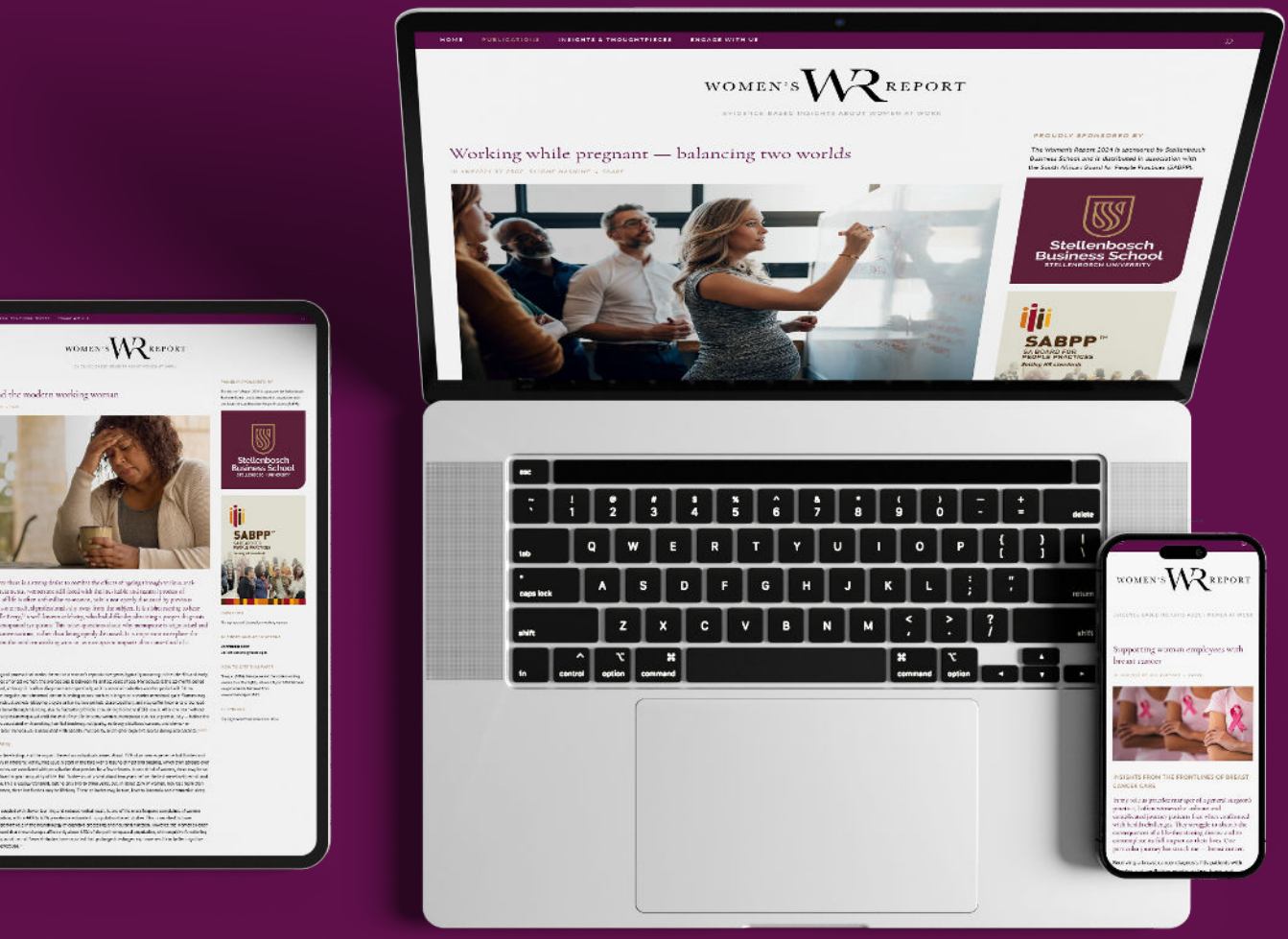

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