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Exploring the barriers and facilitators to ageing women's workplace well-being: A systematic mapping review using the socio-ecological model

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Abstract

There is an imperative globally to respond to the challenge of a growing population of women in work who are living and working for longer, but have disproportionate impacts on their well-being in their older years compared to men. However, there is a paucity of evidence regarding the impact of various well-being issues related to women in this context. This review explores the barriers and facilitators to the workplace well-being of women over 40 years old. A systematic mapping review was conducted that yielded 956 results with 39 included papers using terms: barriers and facilitators to well-being, work and older women. The review highlights how the well-being of ageing

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women is shaped by dynamic interactions amongst work, family, health, and environment. These findings underscore the value of the Socio-Ecological Model in identifying gaps and informing multi-level, intersectional interventions that reflect the lived realities of ageing women.

Keywords: well-being, workplace, women, ageing, menopause

Introduction

Women are working for longer globally, with labour force participation reaching record levels at 67% in 2024, and the largest increases are seen amongst those aged 55–64 (Organisation for Economic Cooperation and Development [OECD] 2024). Despite this trend, significant gender gaps in employment and well-being persist across Europe (Eurostat 2024). Whilst the gap across Europe between men and women in employment aged between 55 and 64 years old has decreased from 14.5% (2017) to 12.1% (2023), there are still significant gaps and large variations across Europe between men and women's employment overall (Eurostat 2024). Despite the growing number of women working later in life, there is a paucity of knowledge regarding the general well-being of women, as well as the health discourses surrounding women's workplace well-being (Payne & Doyal 2010; Rowson et al. 2023).

Research on older women's health at work has largely centred on menopause, reflecting its impact on productivity, sickness absence, and workforce retention (Bryson et al. 2022; Evandrou et al. 2021). Several reviews exploring this topic highlighted that evidence of interventions to support women in work experiencing menopausal symptoms and their impact on workability is sparse (Atkinson et al. 2021; Dennis & Hobson 2023; Hardy et al. 2018b; Jack et al. 2016), although there is evidence of increasing research interest in the United Kingdom (UK) and increasing public awareness around this topic (Beck & Brewis 2024). Nevertheless, Grandey et al. (2020) highlighted a workplace taboo in women's health issues across the life course, referred to as the three M's: menstruation, maternity, and menopause. Ryan and Gattrell (2024) highlight women in middle and older ages

often are faced with the assumption that their capacity will deteriorate, thus facing ageism. Whilst menopause is an important factor, women's workplace well-being encompasses a broader set of health and social determinants. This review therefore adopts a wider lens, examining barriers and facilitators to well-being across the life course and intersections of gender, age, and work. Addressing this gap is critical given persistent structural inequalities and the lack of Human Resource Management (HRM) and occupational health strategies tailored to older women.

The need to explore ageing women's well-being at work across Europe is highlighted because of the lack of focus on HRM and occupational health practices that underpin health-related well-being as well as occupational well-being. This, as demonstrated, has significance across the life course in respect of the health needs of women. Gendered structural inequalities globally remain a significant issue, exacerbated by the pandemic, and deep-rooted in societal norms, highlighting the significance of this review. It has been highlighted that there is a gap in the literature around the barriers and facilitators to the well-being of ageing, working women, as well as the exploration of intersectional elements to gendered ageing across the life course (see e.g. Ní Léime & Ogg 2019). Therefore, there is a clear need to identify a broad spectrum of barriers which women over 40 years old may encounter and how best to support them. The review therefore explores the following research question:

> What are the barriers and facilitators to the workplace well-being of women over 40 years old?

Determinants of Ageing Women's Workplace Well-Being

Globally, there are several structural inequalities impacting the well-being of women across the life course. These include the gender gaps in employment, pay, pension, care and health care. The gender pension gap for the OECD countries, consisting of 38 countries globally, including countries across Europe, Japan, South Korea, New Zealand, Australia, Israel, the United States, Mexico and Chile, stands at an average

of 26% (OECD 2025). However, there is a mixed picture, whereby Germany, France and the United Kingdom demonstrate higher than average gender pension gaps, whilst women in Finland, Hungary, and Denmark demonstrate lower than average gender pension gaps. Additionally, employment and well-being data also vary by gender across countries (OECD 2024). As an example of this global trend, focussing on UK data, according to the latest Office for National Statistics (ONS 2022) labour market data, 15.66 million women aged 16 and over were employed from October to December 2022, which represents a rise of 108,000 from the year before. However, women's employment was down to 72.3% from a record high of 72.7% in 2019 compared to the male employment rate of 79.0%. These trends are mirrored across Europe, whereby there are clear labour market differences by gender, although variable by country (OECD 2024), the prevalence of unpaid work is crucial to understanding the health risks faced by women.

The latest global data shows an imbalance in caregiving and unpaid labour roles by gender, whereby, on average, men take on less of a burden, and women spend less time on leisure activities outside work (Gender Equality Index [GEI] 2023), seeming to reflect differing cultural and social norms around gender roles. In Belgium, Croatia, the Czech Republic, Germany, Greece, Hungary, Italy, and Lithuania, men contribute less than 20 hours per week to caregiving responsibilities (Eurostat 2024b).

Societal structures and policies contribute to this gap. Andersen (2024) argues that recognising unpaid care as a valuable societal contribution in society and policy is key to addressing gender inequalities. There is also a clear gender health care gap impacting workplace well-being in women across Europe, whereby women are receiving substandard treatment compared to men (Criado Perez 2019; The Fawcett Society 2024). Temmerman et al. (2015) highlighted a range of gender biases whereby women were given lower-quality health care treatment than men. This included biases in clinical trials and implicit biases in how women are perceived by healthcare professionals. The Fawcett Society (2024) also argues, based on evidence gathered from women in the UK, that sexism within the health care system is creating poor health outcomes for women and could therefore be linked to

sickness absence trends seen in women, particularly beyond 50 years old (Bryson et al. 2022; Evandrou et al. 2021; OECD 2025; ONS 2022). For example, health conditions such as heart disease have been cited by the UK government as a key concern in terms of the need to raise awareness to reduce the gender health gap and associated implicit biases (Winchester 2021). In addition, medical training is gendered in that the teaching of some conditions (e.g. heart attacks, autism) concerning symptoms is based on male presentation, which can delay or prevent women from getting diagnosed and treated (see e.g. Regitz-Zagrosek & Gebhard 2023).

Menopause is a significant but not exclusive factor influencing well-being. Symptoms such as hot flushes, fatigue, and night sweats can affect productivity and lead to workforce attrition (Brewis et al. 2017; CIPD 2023). Despite growing awareness and research interest in the UK (Beck & Brewis 2024), evidence on effective workplace interventions remains limited (Atkinson et al. 2021; Hardy et al. 2018a). Beyond menopause, women face ageism and assumptions about declining capacity (Ryan & Gattrell 2024). Broader determinants, including occupational status, education, and socioeconomic factors, interact with physiological changes, underscoring the need for a holistic approach (Throsby & Roberts 2024).

To capture these complex interactions, this review draws on the Socio-Ecological Model (SEM) (McLeroy et al. 1988; Rimer & Glanz 2005), which considers individual, social, and policy-level influences on well-being. Mapping these determinants across SEM layers reflects the dynamic interplay of factors over time, aligning with Bronfenbrenner's ecological systems theory (1979).

Occupational Well-Being

There is a vast HRM, occupational psychology and occupational health literature that can be drawn upon when considering the well-being of ageing women. Firstly, in respect of HRM, well-being is increasingly seen as important for organisational performance; hence, the need for organisations to invest in the well-being of their employees (see e.g. Guest 2024). One key stage of life that can be associated with health issues for women is the menopause. The European Menopause and Andropause Society

argue that workplace policies should promote greater inclusivity, reduce stigma, and create better working conditions (Rees et al. 2021). However, the debate around the focus of such policies seems to point to a need for a more holistic focus of healthy ageing, rather than singling out the menopause. It has been argued that specific policies aimed at menopause could stigmatise older women, with the implication that all people experience difficult symptoms that require workplace adjustment, when the picture is far more complex (Carter et al. 2021). Similarly, with HRM practices that support well-being, researchers have emphasised quality of working life perspectives and a more holistic well-being orientation to HRM practices (Guest 2024), which relates to occupational health practices.

Secondly, in respect of occupational health, Ilmarinen (2012) advocates for improving the physical work environment (reduce physical loads, rehabilitative adaptations lighting, noise levels and thermal environment), flexible working alongside addressing work patterns (e.g. shift work where extended recovery periods should be offered to 45–50+ year olds, and exposure to long shifts minimised) in response to occupational health challenges that come with ageing. Finally, a range of workplace factors facilitating occupational well-being over time have been highlighted such as the "Vitamin Analogy" by Warr (2007, 2011). This highlights various vitamins for well-being at work, including autonomy or opportunity for personal control; perception of significance amongst others and interestingly, "equity," has also been highlighted as important for well-being.

The SEM (McLeroy et al. 1988; Rimer & Glanz 2005) has been proposed to address the converging factors impacting workplace health because it emphasises individual health and recognises that it is impacted by multiple spheres of influence, including the work place, family, community, and the broader political environment (Baron et al. 2014). In Rimer and Glanz's (2005) adaptation of the model, there are five layers representing five distinct areas: (1) individual (intrapersonal): for example, well-being knowledge, attitudes, well-being behaviour, self-beliefs, self-efficacy and traits; (2) interpersonal: consisting of formal and informal social networks or support systems, for example, family support, workplace and wider support systems that impact on well-being providing social identity, support, and role definition;

(3) institutional factors (community level): for example, well-being policies, and informal structures constraining or promoting well-being; (4) community factors (community level): such as wider social networks impacting on well-being and norms/standards existing as formal or informal amongst individuals, groups, and organisations; and (5) public policy factors (community level): consisting of local and national government policies and laws that regulate or support well-being actions and practices.

Methods

Review Typology

A systematic mapping review process using the SEM (McLeroy et al. 1988; Rimer & Glanz 2005) was adopted to identify the key barriers and facilitators to ageing women's workplace well-being, to chart and categorise existing literature and identify the main themes and gaps (Rimer & Glanz 2005; Slater & Briggs 2024). The systematic review process was guided by the framework suggested by Arksey and O'Malley (2005) and used by Edwards and Brettle (2016).

Search Strategy

An initial scoping strategy was carried out using MEDLINE via Ovid to check the specificity and precision of the search strategy.

The search strategy was constructed around the three main concepts: barriers and facilitators to well-being, work, and older women. The search terms were (old* or ageing or ageing or mature) and (work* or employ*) and (women* or female*) and (well-being or well-being or "well being" or "mental health") and (barrier or facilitator or limitation or benefit).

The following electronic databases were searched by the research team in March and May 2023: PsychINFO, PsychEXTRA, MEDLINE, MEDLINE(R) Epub Ahead of Print via Ovid and CINHAL. The search was run again in September 2025. To supplement this, further electronic and hand searching was carried out between May 2023 and November 2024 in PsychINFO, PsychEXTRA, MEDLINE, MEDLINE(R) Epub Ahead of Print via Ovid and CINHAL and the journals *Maturitas*, *European Journal*

Table 1. Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Studies that have a key focus on ageing women (aged 40 years old and over) and the barriers and facilitators to their workplace well-being	Studies that look at women under 40 years old only. Studies conducted in the workplace with women but without a clear focus on barriers or facilitators (or both) to well-being.
Studies that are work-related	Studies that are not work-related
Must be primary research that both collected and analysed data	Papers using secondary methods, such as literature reviews
Carried out since 2013, globally	Studies carried out prior to 2013

of Ageing, *International Journal of Aging and Human Development and Ageing and Society*, which yielded $n = 5$ papers and are noted in the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) diagram in the hand searching total. In addition, articles were scanned in 2024 for any other further citations that met the inclusion criteria (see Table 1), which yielded $n = 3$ included papers and are also noted in the PRISMA diagram in the hand searching total.

Study Selection, Data Extraction and Analysis

All citations were downloaded, and duplicates were removed. Initially, the titles and abstracts were screened against the inclusion and exclusion criteria to identify relevant studies by CEE and ES, and a proportion (35%) was double-checked by CEE, ES and LA. Following this, the full texts were obtained for those papers marked as included and unsure, and these were screened to obtain the final included list by CEE and ES. See the PRISMA flow diagram in Figure 1 for details. The data extraction and charting of the data process was informed by the procedure proposed by Osei-Kwasi et al. (2016). Four authors (CEE, ES, CF, GB) charted a sample of the included papers into factors relating to barriers and facilitators to ageing women's workplace well-being, which were themed into clusters and overarching factors (see Table 2 for a tabulation of barriers and facilitators alongside their factors). As the main aim of

Figure 1. PRISMA chart of systematic search and identification of studies via databases

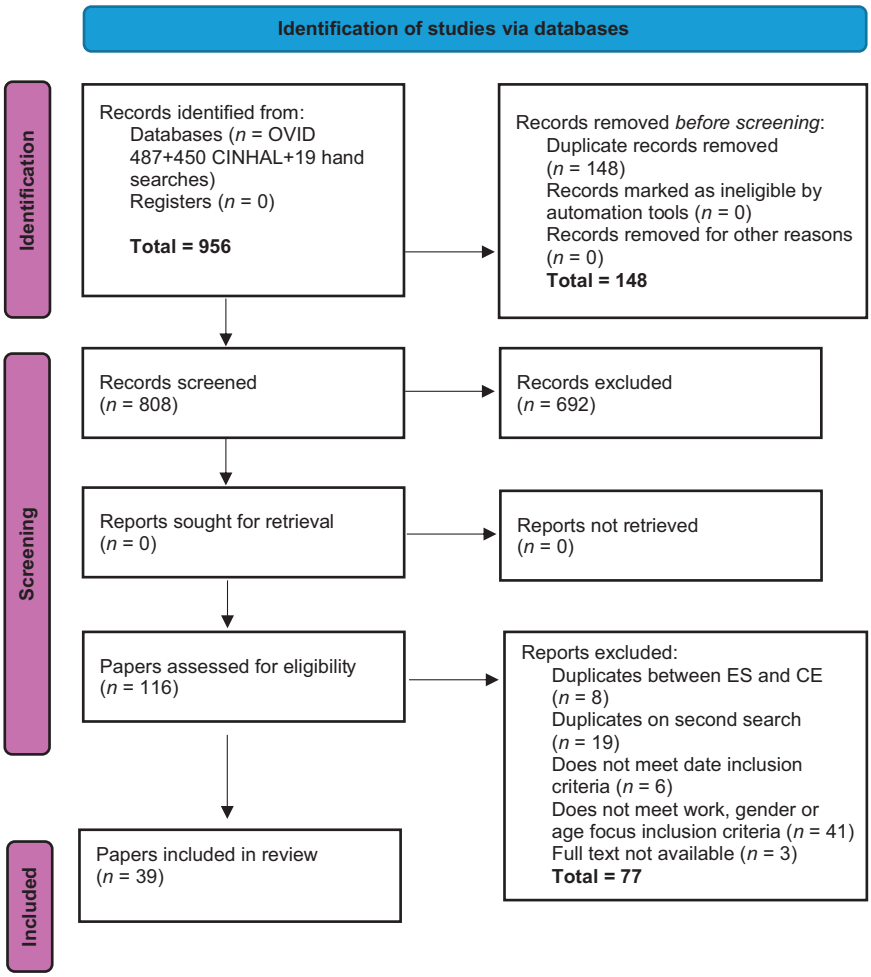


Table 2. Factors by socio-ecological model layer and barriers/facilitators

SEM Layer	1) Individual (intrapersonal)	2) Interpersonal	3) Community (i)	4) Community (ii)	5) Policy
	Factors				
Barriers	Negative impacts of the menopause on well-being	A lack of awareness amongst managers of the lifelong needs of ageing women	A lack of awareness amongst managers of the lifelong needs of ageing women	Lack of an open and positive organisational culture	
	Physical activity in women may be hindered by work	Discrimination as a barrier to well-being	Workplace discrimination	Ageing and intersectionality: discrimination negatively impacts women's workplace well-being	
	Identity and menopause self-perceptions, knowledge as a barrier to well-being	A lack of Menopause Support and Line Management (negatively) Impacts on Well-being	Impact of job role on well-being and management of long-term conditions		

(*Continued*)

Table 2. (*Continued*)

SEM Layer	1) Individual (intrapersonal) Factors	2) Interpersonal	3) Community (i)	4) Community (ii)	5) Policy
Facilitators	Identity and Menopause self-perceptions, knowledge as a facilitator to well-being	Menopause Support and Line Management Impacts on Well-being	Workplace policies to support the menopause	Having an open and positive organisational menopause culture	Policy to support active ageing/ policy to support physical activity programme
	Work as a Facilitator and Barrier to Women's Well-being	Line managers need to be aware of the need to support the lifelong caring needs of ageing women	Gender-sensitive life course well-being policies with a positive focus		Policies to support lifelong well-being in women: flexible working and family-friendly working practices
	Physical activity interventions positively impact well-being	Menopause self-perceptions and self-efficacy as a driver of well-being	Workplace policies to support the lifelong caring needs of ageing women		Public policy to make lower-paid roles more equitable and rewarding

(*Continued*)

Table 2. (*Continued*)

SEM Layer	1) Individual (intrapersonal)	2) Interpersonal	3) Community (i)	4) Community (ii)	5) Policy
	Factors				
	Interventions to support working carers on an individual level: improving perceived control, optimism and coping		Physical activity is included in the well-being policy to support women, particularly in sedentary roles Implement sustainable strategies for women across the life course in roles that are physically challenging with age Women were more likely to need to work because of financial necessity		

SEM: Socio-Ecological Model.

this mapping review was to assess the evidence with respect to the barriers and facilitators to ageing women's workplace well-being on a broad basis, it was decided to include all factors reported in the papers. Finally, for purposes of rigour, another author (LA) then cross-checked the study characteristics and a sample of the mapping and data extraction across the reviewers. All papers were scored using Critical Appraisal Skills Programme (CASP) quality appraisal checklists (CASP 2024), and each respective score can be found in the study characteristics table (Table 3). The appraisal was distributed evenly between the authorship team, and full scoring sheets were shared amongst the team for rigour. These checklists allow the reviewers to assess the study design, data collection methods, and the appropriateness of these with respect to the results and conclusions as well as potential bias. In addition, 16% of the quality appraisals were cross-checked by CE and ES for consistency and there was 100% agreement with the scoring.

There were two stages to the analysis of the papers: (1) all barriers and facilitators to women's workplace well-being factors were identified, extracted, and coded and (2) the factors were then sorted and mapped onto the SEM layers. Interactional effects across the layers were additionally coded (e.g. biopsychosocial factors over time) with each member of the authorship team taking a sample in a data-driven approach.

Rationale for Inclusion/Exclusion Criteria

Given the average age of onset of the perimenopause, 40 years and over was chosen to explore the well-being of ageing women in work. The inclusion of studies since 2013 is based on the harmonisation of pensionable age in Western countries, globally impacting on ageing women in work, and the implementation of the GEI (2023) in the EU. The systematic review was limited to 2013–2024 to reflect such changing measures and policy focus regarding the ageing workforce across Europe and globally.

Table 3. Study characteristics of included studies

ID	Author and date	Link to the study	Country	Study population	Design	Participants	Study main outcome in relation to barriers and facilitators to well-being	Well-being focus	Gender focus	Age focus (years)	CASP score
1	Geukes et al. (2023)	https://www.sciencedirect.com/science/article/pii/S037851222300364X	The Netherlands	Netherlands municipal department female employees	Quantitative-quasi-experimental-cohort study	Intervention: *N* = 47 (29 follow up), Control: *N* = 33 (25 follow up)	After 12 weeks, the intervention group showed significantly higher self-efficacy to manage symptoms than the control (mean 6.52 vs. 5.84; adjusted difference 0.75, 95% CI 0.03–1.46, $p = 0.040$).	Menopause and holistic women's well-being	Female only	Age 40–67	M
2	Nawrocka et al. (2019)	https://www.dovepress.com/article/download/49648	Poland	Women in white-collar roles	Cross-sectional (survey)	*N* = 348 (30–49 years: 32%, 50–65 years: 58%; 66–75 years: 34%)	Meeting physical activity guidelines improved work ability and reduced musculoskeletal issues in workers aged 50–64, with significantly better work ability in active women aged 30–49; both activity intensity and workability declined with age ($p = 0.000$)	Physical activity and work ability	Female only	Age 30–75	M/H
3	Rowson and Gonzalez-White (2019)	https://www.tandfonline.com/doi/full/10.1080/03601277.2019.1611223	Saudi Arabia and in the United Arab Emirates	Mature (40+) single Filipina flight attendants	Qualitative (interviews)	*N* = 5	Maintaining the 3 As: Appearance, Attendance, and Attitude was seen as harder with age, with women using Selection, Optimisation, and Compensation strategies like comparing themselves positively to younger colleagues, staying active, resting, and attending health checks	Selection, Optimisation and Compensation Theory strategies used to mitigate ageing and impacts on work ability	Female only	Age 42–54	L/M
4	Kwak et al. (2014)	https://e-jmm.org/DOIx.php?id=10.6118/jmm.2014.20.3.118	South Korea	Perimenopausal and menopausal women in either professional or non-professional roles working in Seoul University hospitals	Cross-sectional (survey)	*N* = 189	A significant correlation was demonstrated between menopausal attitude and symptom management ($r = 0.221$, $p < 0.001$)	Menopause and menopause, knowledge, attitude and symptom management	Female only	Age 40–59	L

(*Continued*)

Table 3. (*Continued*)

ID	Author and date	Link to the study	Country	Study population	Design	Participants	Study main outcome in relation to barriers and facilitators to well-being	Well-being focus	Gender focus	Age focus (years)	CASP score
5	Geukes et al. (2016)	https://www.sciencedirect.com/science/article/pii/S0378512216301013?via%3Dihub	The Netherlands	Employed first-time attendees of a menopause clinic aged 44–60 years and a reference group of non-symptomatic women	Cross-sectional (survey)	*N* = 60 compared to a reference group of non-symptomatic women: *n* = 205	The odds for reporting lower work ability were 8x higher if suffering from menopausal symptoms ($p > 0.001$)	Menopause symptoms and work ability	Female only	Age 44–60	H
6	Hardy et al. (2018)	https://www.emerald.com/insight/content/doi/10.1108/ijwhm-03-2018-0035/full/html?ref=oseterics.com	United Kingdom	Working women (menopause transition or post menopause)	Qualitative (interviews)	*N* = 15	Barriers to menopause conversations included male-dominated environments, distant relationships, and fear of stigma, whilst facilitators involved open cultures and the need for dialogue; discussions focused on advice for both women and their colleagues	The factors that support or hinder workplace conversations about the menopause	Female only	Age 45–60	M/H
7	Hardy et al. (2018)	https://link.springer.com/article/10.1186/s40695-018-0036-z	United Kingdom	Working women (within a family court and probation staff) and a subsample of peri- and post-menopausal women	Cross-sectional (survey)	*N* = 216, Subsample: *n* = 168	Menopausal status wasn't linked to work outcomes overall, but job stress, demand, control, and support were; hot flush and night sweats (HFNS) indicators weren't significant, though workplace HFNS problem ratings predicted intention to leave after adjusting for age	Menopausal status and work stress and relationship with job performance, turnover intention and intention to leave the workforce	Female only	Age 45–65	M

(*Continued*)

Table 3. (*Continued*)

ID	Author and date	Link to the study	Country	Study population	Design	Participants	Study main outcome in relation to barriers and facilitators to well-being	Well-being focus	Gender focus	Age focus (years)	CASP score
8	Griffiths et al. (2013)	https://www.sciencedirect.com/science/article/pii/S0378512213002235	United Kingdom	Women in professional, managerial and administrative (non-manual) occupations	Cross-sectional (survey)	*N* = 896	Three symptoms: low confidence, poor concentration, and memory issues were especially challenging at work, with women using a range of coping strategies, including psychological, social, and health-related approaches	Menopause symptoms and work ability	Female only	44–55 years old	M
9	LaBond et al. (2022)	https://www.tandfonline.com/doi/full/10.1080/09581596.2020.1846684	Australia	Mature age (55+) Australian bus drivers	Qualitative (semi-structured interviews)	*N* = 19 (32% female)	Poor health limits labour participation and time, creating unequal experiences for blue-collar workers nearing retirement and making it harder to meet the policy goal of working until age 67	Type of work affects time, health and financial aspects of working in later life	Both female and male	Age 55–71	L/M
10	Tomczyk et al. (2021)	https://pubmed.ncbi.nlm.nih.gov/34649542/	Germany	2018 wave of the German Socio-Economic Panel	Cross-sectional (survey)	*N* = 30,152 (52% female)	Most time was spent on work (4.6 h/day), followed by leisure (1.77 h), childcare (1.60 h), and housework (1.55 h); men worked more, did less care and housework, and reported higher affective and domain-specific life satisfaction, with more full-time roles and higher education	Women tend to spend more time on care, childcare, errands and housework, affecting well-being outcomes	Both female and male	Age 18–100	M

(*Continued*)

Table 3. (*Continued*)

ID	Author and date	Link to the study	Country	Study population	Design	Participants	Study main outcome in relation to barriers and facilitators to well-being	Well-being focus	Gender focus	Age focus (years)	CASP score
11	Whiley et al. (2021)	https://onlinelibrary.wiley.com/doi/full/10.1111/gwao.12946	United Kingdom	Working women with experience of menopause	Qualitative (interviews)	*N* = 6	Themes found as follows: menopause as dirty – physically (leaky bodies), emotionally (uncontrollable emotions), morally (less of a woman/feminine ageing) and socially (stigma/taboo) dirty	Shame and stigma around menopause affect work participation	Female only	Age 40 and over	M/H
12	Riach and Jack 2021	https://pubmed.ncbi.nlm.nih.gov/34682537/	Australia	Menopausal women working in the higher education and healthcare sectors	Cross-sectional, qualitative (survey)	Higher education: *N* = 839, health care: *N* = 1092	Three key themes described the intersectional experience of menopause at work: (1) menopause as a "slippery inequality" overlapping with age, gender, and other forms of discrimination; (2) the extra labour required to manage symptoms, especially in inflexible workplaces; and (3) how service-oriented roles in HE and healthcare contribute to poor experiences by prioritising others over self	Menopause implications for work – a reciprocal relationship which adds to existing inequalities around gender/age, etc., in workplace	Female only	Age 40 and over	M/H
13	Meng et al. 2024	https://doi.org/10.1007/s10433-024-00821-1	Denmark	Workers (across the job function categories "Office work," "work with people," and "work in the field of production") aged 50+	Cross-sectional survey design, part of a larger cohort study	*N* = 10,798 workers; "Office work" (47% female), "work with people," (67% female) and "work in the field of production" (16% female)	SOC strategies, especially optimisation and compensation, were most effective for older employees in people-focused roles, with collective use linked to improved work ability and well-being, particularly amongst women	Selection, Optimisation and Compensation Theory strategies used to mitigate ageing and impacts on work ability	Both female and male	Age 50 and over	M

(*Continued*)

Table 3. (*Continued*)

ID	Author and date	Link to the study	Country	Study population	Design	Participants	Study main outcome in relation to barriers and facilitators to well-being	Well-being focus	Gender focus	Age focus (years)	CASP score
14	Templeman et al. 2024	https://journals.sagepub.com/doi/10.1177/00914150231208680	United States of America	Black/African American and White working caregivers	Cross-sectional survey design	*N* = 299 (61% female), Black/African American: *n* = 49 (74% female), White: *n* = 250 (58% female)	Primary caregiving stress alone didn't predict well-being; other role strains mattered. Black working carers reported greater internal resources (e.g. perceived control, spiritual coping) but less external support than White carers	Primary caregiver stressors, secondary workplace strains and well-being	Both female and male	Mean age was over 50	H
15	Arpino and Bellani (2022)	https://www.frontiersin.org/journals/sociology/articles/10.3389/fsoc.2021.806099/full	20 European Countries and Israel	Survey of Health, Ageing and Retirement in Europe data, individuals aged 50 and over and their partners	Longitudinal survey	The total sample varied across the outcome variables from *N* = 51,906 (life satisfaction, 56% female) to *N* = 61,914 (EURO-D, 53% female)	Grandmothers providing childcare reported better quality of life and fewer depressive symptoms than those who didn't, but these benefits disappeared when combined with paid work	Quality of Life and Depressive Symptoms in the context of the grandmother role combined with employment	Both female and male	Age 50 and over	H
16	Steffan (2020)	https://onlinelibrary.wiley.com/doi/10.1111/gwao.12539?msockid=3e978392882f6c112146973 8891f6def	United Kingdom	Working women from Edinburgh	Qualitative study: (interviews)	*N* = 21	Menopause identity talk revealed two themes: neoliberal endurance versus self-depreciation, with participants expressing fear and reduced confidence because of uncertainty about how they were perceived	Menopause identity talk and impacts on workplace well-being	Female only	Age 47–62	M/H

(*Continued*)

Table 3. (*Continued*)

ID	Author and date	Link to the study	Country	Study population	Design	Participants	Study main outcome in relation to barriers and facilitators to well-being	Well-being focus	Gender focus	Age focus (years)	CASP score
17	Verburgh et al. (2020)	https://pubmed.ncbi.nlm.nih.gov/32899848/	Netherlands	Women working in lower-paid roles in the Amsterdam University Medical Center during menopause and midlife.	Mixed-method convergent semi-structured interviews, surveys pre and post-intervention	Survey: *N* = 56, Interviews: *n* = 12	Quantitative data showed significant improvement in menopausal symptoms after the Work-Life Programme (WLP), whilst qualitative findings revealed it fostered mental empowerment and positive changes in behaviour, health, well-being, and workplace experience	Menopause symptom management and well-being	Female only	Age 45–60	M
18	Rutanen et al. (2014)	https://pubmed.ncbi.nlm.nih.gov/23324726/	Finland	Women with menopausal symptoms	A randomised control trial.	*N* = 89 (intervention group: *n* = 45, control group: *n* = 44)	The 6-month physical exercise intervention trialled women with menopausal symptoms significantly increased work ability both in the short term and long term	Physical activity and its impacts on work ability and work strain	Female only	Age 47–62	M
19	Sang et al. (2021)	https://www.mdpi.com/1660-4601/18/4/1951	United Kingdom	Individuals working (or having previously worked) in higher education including those completing a PhD	Qualitative: (open-ended survey)	*N* = 627 (99% identified as cisgender women, 1%, 8 identified as queer, agender, non-binary, or as men)	Higher education employees' "blood work" was found to be composed of barriers related to the management of painful, leaking bodies, as well as access to facilities, stigma, and difficulties with balancing workload	Barriers associated with "blood work"	99% female	Age 20–65	M

(*Continued*)

Table 3. (*Continued*)

ID	Author and date	Link to the study	Country	Study population	Design	Participants	Study main outcome in relation to barriers and facilitators to well-being	Well-being focus	Gender focus	Age focus (years)	CASP score
20	Carmichael et al. 2014	https://www.tandfonline.com/doi/full/10.1080/17430437.2014.919261	United Kingdom	British Household Panel Survey data (BHPS, 1991–2008), key stakeholders and older women (50+)	Mixed methods (secondary data & interviews)	BHPS: *N* = 193,103 (54% female), Interviews: *n* = 36 (100% female)	Age has less impact on physical activity when other factors are considered. Whilst employment can limit activity and retirement doesn't always increase it, barriers like psychological factors, caregiving, cost, and environment persist. Health and social connection remain key motivators, especially for retirees	Paid work and participation in exercise and leisure-time physical activity	Both female and male	Age 20 and over	M
21	Lacey et al. (2016)	https://pubmed.ncbi.nlm.nih.gov/27069516/	United Kingdom	Medical Research Council (MRC) National Study of Health and Development	Longitudinal survey design	*N* = 1725	The study found that women with weaker ties to paid work had lower life satisfaction, and so did those who did not have children, when compared to women with combined strong ties to paid work with marriage and parenthood	Work and family experiences influence on subjective well-being	Both female and male	Age 60–64	M/H
22	Handley et al. (2021)	https://pubmed.ncbi.nlm.nih.gov/33971829/	Australia	The sample drawn from the Australian Rural Mental Health Study aged 45 years old, with differing employment/retirement circumstances.	Mixed longitudinal research design	*N* = 2013	Retired participants reported better mental health, relationship satisfaction, and life satisfaction than employed individuals. Chronic illness and adverse life events significantly affected health outcomes, and those not in the workforce rated all six well-being measures lower than employed or retired groups. Women also reported stronger social relationships than men	Physical health, daily functioning, financial position, mental health, interpersonal relationships, and life satisfaction were analysed in relation to employment status (employed vs. retired)	Both female and male	Age 45 and over	M

(*Continued*)

Table 3. (*Continued*)

ID	Author and date	Link to the study	Country	Study population	Design	Participants	Study main outcome in relation to barriers and facilitators to well-being	Well-being focus	Gender focus	Age focus (years)	CASP score
23	Li et al. 2022	https://pubmed.ncbi.nlm.nih.gov/35124984/	Canada	2012 wave of the Canada General Social Survey (employed and family caregivers aged 15–64 years old)	Cross-sectional survey design	*N* = 2426 (59% female, 54% aged 45–64 years old)	Women employed as caregivers reported significantly poorer mental health, higher caregiver stress, more weekly caregiving hours, greater employment adjustments, and more family-to-work conflict than men in similar roles	Caring responsibilities' impact on mental health outcomes	Both female and male	Age 15–64	M
24	Cronin et al. (2023)	https://pubmed.ncbi.nlm.nih.gov/37700454/	England, Finland, Denmark, New Zealand, Australia, and the United States of America	Female nurses in a healthcare setting	Qualitative (focus groups and interviews)	*N* = 48	Peer support and access to relevant information, especially on symptom management, were key needs, with women valuing resources like leaflets and guidebooks. There was a feeling a sense of "invisibility" whilst going through the menopause	Menopause and digital health interventions	Female only	Age 45 and over	M/H
25	Caputo et al. (2020)	https://link.springer.com/article/10.1007/s13524-019-00839-6	United States of America	Data from the National Longitudinal Survey of Mature Women	Longitudinal survey	*N* = 2781	Workplace discrimination could be a contributory factor in developing depressive symptoms and functional limitations	Discrimination in the workplace impacts well-being	Female only	Age 30–64	H
26	Comolli et al. 2022	https://pubmed.ncbi.nlm.nih.gov/35619744/	Switzerland	Swiss Household Panel (SHP)	Longitudinal, survey	*N* = 1885 (53% female)	Women with full-time work and a later "traditional" family (children in their late twenties) tend to have better long-term financial and overall well-being outcomes, compared to those with earlier transitions or different work-family patterns	Explores how employment-family trajectories impactwell-being	Both female and male	Age 20–50	M/H

(*Continued*)

Table 3. (*Continued*)

ID	Author and date	Link to the study	Country	Study population	Design	Participants	Study main outcome in relation to barriers and facilitators to well-being	Well-being focus	Gender focus	Age focus (years)	CASP score
27	Harnois and Bastos (2018)	https://pubmed.ncbi.nlm.nih.gov/29608325/	United States of America	The study draws on the General Social Surveys	Cross-sectional survey design	*N* = 3724 (50.4% female)	Age and gender-based discrimination negatively affected women's mental and physical health, with multiple forms of perceived discrimination linked to poorer well-being outcomes	Discrimination impacts on mental and physical health	Both female and male	Age 18–60+	M/H
28	Hickey et al. (2017)	https://www.tandfonline.com/doi/full/10.1080/0167482X.2017.1327520	Australia	Women working in three hospitals in metropolitan Australia	Cross-sectional survey design	*N* = 1092	Postmenopausal women reported better mental health and lower intention to leave than pre- and peri-menopausal women. Whilst symptoms didn't generally impair work ability, most lacked manager support and wanted organisational changes like temperature control, flexible hours, remote work, and menopause-related resources	Menopausal symptoms at premenopausal, perimenopausal and postmenopausal stages and impact on work and workplace well-being	Female only	Age 40 and over	M
29	Gartoulla et al. (2016)	https://www.sciencedirect.com/science/article/pii/S0378512216300184?via%3Dihub	Australia	Women were recruited from an established database based on the Australian electoral roll	Cross-sectional survey design	*N* = 1263	The study provides evidence of an association suggesting a relationship between VMS and women's well-being, as well as an association between VMS and self-reported work ability in women at midlife	Well-being impacts of vasomotor (hot flushes and night sweats) symptoms (VMS) and impacts on workability	Female only	Age 40–65	H

(*Continued*)

Table 3. (*Continued*)

ID	Author and date	Link to the study	Country	Study population	Design	Participants	Study main outcome in relation to barriers and facilitators to well-being	Well-being focus	Gender focus	Age focus (years)	CASP score
30	Atkinson et al. (2025)	https://www.sciencedirect.com/science/article/pii/S0378512224002822	United Kingdom	Female workers from the human resource (HR) Information Systems of three large urban UK police forces	Mixed-methods, cross-sectional survey	*N* = 1684; Qualitative data (open comment boxes): *N* = 345)	The study found that menopause symptoms negatively affected job satisfaction. Women with negative attitudes toward age and menopause, especially those peri- and post-menopausal, reported lower satisfaction, whilst those with positive, open attitudes reported higher satisfaction. Workplace factors like shift work and gender balance also significantly influenced job satisfaction during menopausal transition	Menopause attitudes and experience impact on well-being	Female only	Age 40+	M
31	Gottardello and Steffan (2024)	https://www.sciencedirect.com/science/article/pii/S0378512224002020?pes=vor&utm_source=scopus&getft_integrator=scopus	United Kingdom & United States of America	Working individuals, identifying as neurodivergent and having experienced menopause symptoms	Qualitative design (semi-structured interviews, cross-sectional	*N* = 43	The study demonstrated that neurodivergence combined with going through the menopause can make psychological symptoms worse and negatively impact their experience of engagement with work (particularly social aspects). This was connected to feelings of being out of control from their usual routine	Neurodivergence impact on well-being through menopause	*Not reported*	Age 40+	M

(*Continued*)

Table 3. (*Continued*)

ID	Author and date	Link to the study	Country	Study population	Design	Participants	Study main outcome in relation to barriers and facilitators to well-being	Well-being focus	Gender focus	Age focus (years)	CASP score
32	Akinleye et al. (2024)	https://link.springer.com/article/10.1007/s10900-023-01247-z	United States of America	Primary care clinicians in New York State	Survey design- respective cohort study	*N* = 3627 (*n* = 808 38% female)	Newly acquired burnout in primary care clinicians was associated with being a woman, a clinician age younger than 56 years old and having adult dependents. Authors argue that adopting policies aimed at creating more flexible working patterns would mitigate burnout	Burnout associated with Covid 19 impacts women with caring responsibilities	Both female and male	46 years old plus including those under 45 (47%)	M
33	Obeidat et al. (2024)	https://www.sciencedirect.com/science/article/pii/S0022437524001087#t0015	United States of America	The General Social Survey (GSS) was used and the sample were workers from a range of sectors	Survey design-longitudinal	*N* = 5914 (*n* = 3060 51.74% female)	The odds of having back pain in males were 0.90 lower than the estimated odds in females. Authors recommend employers consider gender when exploring flexible work arrangements, tailored training programs, and ergonomic improvements	Worker well-being is measured through various workplace variables, including job satisfaction, and back pain in work	Both females and males	18 years+	H

(*Continued*)

Table 3. (*Continued*)

ID	Author and date	Link to the study	Country	Study population	Design	Participants	Study main outcome in relation to barriers and facilitators to well-being	Well-being focus	Gender focus	Age focus (years)	CASP score
34	Casolari et al. (2024)	https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-023-10465-z	Italy	Healthcare professionals, including physicians, nurses and administrative staff, working at the University Hospital of Modena	Survey design-cross sectional	*N* = 443 (*n* = 363 82% female)	The study found that work ability declines with age, particularly amongst women with comorbidities, high Body Mass Index (BMI), at least one child under 5 or a dependent adult, poor work-life balance, and those doing over 20 hours of housework weekly. Conversely, work ability improves with relationship-oriented leadership, autonomy in decision-making, and skill match. The authors argue that women face greater difficulty balancing life and work, which negatively affects their work ability	Work ability and job-related drivers including alongside socio-demographic factors including childcare and other caring responsibilities	Both females and males	35 years +	M
35	Edge and Bacci (2024)	https://cipp.ug.edu.pl/-You-feel-a-little-bit-invisible-really-a-thematic-analysis-exploring-self-perceptions,192988,0,2.html	United Kingdom	Women aged 60 and over in various roles, with a focus on lower-paid and part-time roles	Interviews-qualitative	*N* = 19	Themes across the dataset focused on self-perceptions of workplace identity in women over 60. These included positive and negative influences on age-positive identity, experiences of invisibility or exclusion, and not identifying as "old." Positive self-beliefs involved promoting age-positive norms, rejecting age as a barrier, and challenging stereotypes in the workplace	Self-perceptions of ageing and identity as positive and negative drivers to well-being	Female only	60 years plus	M/H

(*Continued*)

Table 3. (*Continued*)

ID	Author and date	Link to the study	Country	Study population	Design	Participants	Study main outcome in relation to barriers and facilitators to well-being	Well-being focus	Gender focus	Age focus (years)	CASP score
36	Sedani et al. (2024)	https://pmc.ncbi.nlm.nih.gov/articles/PMC10686843/	United States of America	Orthopaedic surgeons	Cross-sectional survey	*N* = 1625 (*n* = 169 9.6% female)	The study found that female orthopaedic surgeons experience significantly higher rates of social isolation and burnout, affecting workplace well-being. Discrimination, including microaggressions, was identified as a key factor, with authors urging workplaces to take action to reduce these behaviours.	Musculoskeletal and related injuries and psychological and emotional burnout.	Both females and males.	Average age M was 50 years old.	
37	Freak-Poli et al. (2025)	https://pubmed.ncbi.nlm.nih.gov/39608049/	Australia	The study used annual data from the Household, Income and Labour Dynamics in Australia	Longitudinal cohort study-survey	*N* = 9216 (*n* = 798 widowed-28.9% female)	Low social isolation and high social support did not prevent increased loneliness after widowhood. For women, older age weakened the link between bereavement and loneliness, whilst being born in a non-English-speaking country, poverty, employment or volunteering, and having a long-term mental health condition strengthened it.	Social isolation and widowhood impact on social health in those employed and not employed.	Both females and males.	Over 55 years old	M

(*Continued*)

Table 3. (*Continued*)

ID	Author and date	Link to the study	Country	Study population	Design	Participants	Study main outcome in relation to barriers and facilitators to well-being	Well-being focus	Gender focus	Age focus (years)	CASP score
38	Cho (2025)	https://journals.sagepub.com/doi/full/10.1177/01640275251353217	South Korea		Longitudinal cohort study-survey	*N* = 10,254 (% female unavailable)	Findings reveal a positive association between working status and subjective well-being for men, but not for women	Subjective well-being and working status	Both females and males	60–75 years old.	M
39	Wang and Ge (2025)	https://www.dovepress.com/empirical-analysis-of-the-impact-of-employment-on-the-elderly-mental-h-peer-reviewed-fulltext-article-PRBM#:~:text=This%20study%20aimed%20to%20investigate%20the%20impact%20of,social%20significance%20of%20employment%20as%20a%20status%20passage	China	The study used three waves (2015, 2018, and 2020) of the China Health and Retirement Longitudinal Study (CHARLS)	Longitudinal cohort study-survey	*Not reported*	The study shows employment supports positive status passage for older Chinese adults in multicultural settings, with a significant reduction in depressive symptoms ($\beta = -0.3945$, $p < 0.01$) and improved mental health. However, older men benefited more than women as a result of cultural and structural factors	Work impacts on mental ill health	Both females and males.	60–75 years old.	M/H

CASP: Critical Appraisal Skills Programme; CI: confidence interval; SOC: selection, optimisation and compensation.

Results

The key characteristics of the 39 studies representing a total of N = 341,088 participants included in the review are presented in Table 3. Firstly, in terms of layers of the SEM and corresponding factors of the mapping review, there were (n = 23) studies mapped onto the individual-level layer and (n = 16) onto the interpersonal-level layer. With institutional factors (community level) being the second largest layer, mapping 19 studies, whilst community factors (community level) mapped ten studies and public policy factors (community level) nine (some mapped onto multiple factors, see Table 2). Overall, the largest proportion of studies was conducted in the UK and across Europe (n = 23), of which nine were conducted within the UK, which was the largest proportion of studies conducted within a single country across the whole sample of papers. 35 studies were conducted within a single country whilst four were conducted across multiple countries, highlighting a gap in cross-national research. Most studies (n = 20) focussed exclusively on women (including one study that distinguished between cisgender women making up 99% of the sample and 1% being gender minorities), whilst 18 included both men and women, and one did not specify a gender, but the presumption is that the gender focus was women.

In terms of age, most studies (n = 29) had some exclusive focus on women with an age cut off at 40 years and over (e.g. 40, 45, 50 years old plus, etc.), but others (n = 10) used a broader or life course approach with these studies including participants aged 15 years, 18 years, 20 years, 30 years to 65 years old plus.

Regarding methods, there was a mix of approaches with the majority situated in the quantitative paradigm (n = 24), 11 in the qualitative paradigm, and four mixed-methods studies.

Table 2 shows the barriers and facilitators to well-being by SEM layer, and their associated factors, and Table 4 highlights the studies mapped by factor and the number of factors and studies by SEM layer. Figures 2 and 3 illustrate the barriers and facilitators to ageing women's workplace well-being mapped on to the socio-ecological model (SEM).

Table 4. Factors and studies mapped on to layers of the socio ecological model

Layer of the socio-ecological model	**1) Individual (intrapersonal) factors** e.g. Well-being knowledge, attitudes, well-being behaviour, self-beliefs, self-efficacy and traits	Studies mapped onto factor	**2) Interpersonal factors** comprises formal and informal social networks/ support systems, e.g. family support, workplace and wider support systems that impact well-being, providing social identity, support, and role definition	Studies mapped onto factor	**3) Community level (i) Institutional factors** e.g. policies, practices, and informal structures constraining or promoting well-being	Studies mapped on to Factor	**4) Community level (ii) community factors-** e.g. wider social networks and norms/standards existing as formal or informal amongst individuals, groups, and organisations	Studies mapped onto factor	**5) Community Level (iii) Public Policy Factors,** e.g. Local and national government well-being policies and laws that regulate or support healthy actions and practices	Studies mapped on to Factor
Number of factors	*n* = 6	-	*n* = 7	-	*n* = 7	-	*n* = 2	-	*n* = 3	-
Number of studies	*n* = 22	-	*n* = 16	-	*n* = 19	-	*n* = 10	-	*n* = 9	-
Factors	Identity and menopause self-perceptions, knowledge as a barrier and facilitator to well-being	Atkinson et al. 2025; Comolli et al. 2021; Edge & Bacci 2024; Gartoulla et al. 2016; Geukes et al. 2023; Gottardello & Steffan 2024; Hardy et al. 2018a; Kwak et al. 2014; Riach & Jack 2021; Steffan 2020	Menopause support (e.g. workplace adjustments, use of assistive technologies, digital apps) and line management training positively impact well-being (and lack of impacts negatively)	Atkinson et al. 2025; Cronin et al. 2023; Geukes et al. 2023; Gottardello & Steffan 2024; Griffiths et al. 2013; Kwak et al. 2014; Riach & Jack 2021	Gender sensitive life course well-being policies with a positive focus	Akinleye et al. 2024; Hickey et al. 2017; Geukes et al. 2023; Gottardello & Steffan 2024; Obeidat et al. 2024; Sang et al. 2021	Having an open and positive organisational Menopause Culture, inclusive of intersections	Cronin et al. 2023; Gottardello & Steffan 2024; Hardy et al. 2018a; Hickey et al. 2017; Whiley et al. 2023	Public policy to support Active Ageing/Policy to support physical activity programmes	Carmichael et al. 2014; Handley et al. 2021; Nawrocka et al. 2019

(*Continued*)

Table 4. (*Continued*)

Layer of the socio-ecological model	**1) Individual (intrapersonal) factors** e.g. Well-being knowledge, attitudes, well-being behaviour, self-beliefs, self-efficacy and traits	Studies mapped onto factor	**2) Interpersonal factors** comprises formal and informal social networks/ support systems, e.g. family support, workplace and wider support systems that impact well-being, providing social identity, support, and role definition	Studies mapped onto factor	**3) Community level (i) Institutional factors** e.g. policies, practices, and informal structures constraining or promoting well-being	Studies mapped on to Factor	**4) Community level (ii) community factors**- e.g. wider social networks and norms/standards existing as formal or informal amongst individuals, groups, and organisations	Studies mapped onto factor	**5) Community Level (iii) Public Policy Factors,** e.g. Local and national government well-being policies and laws that regulate or support healthy actions and practices	Studies mapped on to Factor
	Physical activity interventions positively impact well-being	Nawrocka et al. 2019: Rutanen et al. 2014	Physical activity interventions positively impact well-being	Nawrocka et al. 2019	Physical activity included in well-being policy to support women particularly in sedentary roles	Nawrocka et al. 2019	Gendered ageing and intersectionality: discrimination (including self-stigma and stereotyping) negatively impacts women's workplace well-being	Caputo et al. 2020; Edge & Bacci 2024; Freak-Poli et al. 2025; Harnois & Bastos 2018; Sedani et al. 2024	Public policies to support lifelong well-being in women: flexible working and family-friendly working practices	Akinleye et al. 2024; Casolari et al. 2024; Lacey et al. 2016; Li et al. 2022
	Physical activity in women may be hindered by work	Carmichael et al. 2014	Positive self-beliefs mitigate negative stereotypes: workplace interpersonal culture	Edge & Bacci 2024; Rowson & Gonzalez-White 2019	Implement sustainable strategies for women across the life course in roles that are physically challenging with age	Rowson & Gonzalez-White 2019	-	-	Public policy to make lower-paid roles more equitable and rewarding	Hoven et al. 2015; LaBond et al. 2022

(*Continued*)

Table 4. (*Continued*)

Layer of the socio-ecological model	**1) Individual (intrapersonal) factors** e.g. Well-being knowledge, attitudes, well-being behaviour, self-beliefs, self-efficacy and traits	Studies mapped onto factor	**2) Interpersonal factors** comprises formal and informal social networks/ support systems, e.g. family support, workplace and wider support systems that impact well-being, providing social identity, support, and role definition	Studies mapped onto factor	**3) Community level (i) Institutional factors** e.g. policies, practices, and informal structures constraining or promoting well-being	Studies mapped on to Factor	**4) Community level (ii) community factors-** e.g. wider social networks and norms/standards existing as formal or informal amongst individuals, groups, and organisations	Studies mapped onto factor	**5) Community Level (iii) Public Policy Factors,** e.g. Local and national government well-being policies and laws that regulate or support healthy actions and practices	Studies mapped on to Factor
	Negative impacts of the Menopause on well-being	Cronin et al. 2023; Gartoulla et al. 2016; Geukes et al. 2016; Griffiths et al. 2013; Hardy et al. 2018b; Hickey et al. 2017	Line managers need to be aware of the need to support the lifelong caring needs of ageing women.	Arpino & Bellani 2022; Templeman et al. 2024; Tomczyk et al. 2021	Policies to support the menopause include: a tailored approach to individual needs, workplace adjustments, encouraging a positive attitude to the Menopause (particularly in male dominated environments) and provide guidance on management of the menopause/ education on symptom management	Gartoulla et al. 2016; Geukes et al. 2023; Griffiths et al. 2013; Hardy et al. 2018a, 2018c; Hickey et al. 2017; Riach & Jack 2021; Steffan 2020; Verburgh et al. 2020	-	-	-	-

(*Continued*)

Table 4. (*Continued*)

Layer of the socio-ecological model	**1) Individual (intrapersonal) factors** e.g. Well-being knowledge, attitudes, well-being behaviour, self-beliefs, self-efficacy and traits	Studies mapped onto factor	**2) Interpersonal factors** comprises formal and informal social networks/ support systems, e.g. family support, workplace and wider support systems that impact well-being, providing social identity, support, and role definition	Studies mapped onto factor	**3) Community level (i) Institutional factors** e.g. policies, practices, and informal structures constraining or promoting well-being	Studies mapped on to Factor	**4) Community level (ii) community factors**- e.g. wider social networks and norms/standards existing as formal or informal amongst individuals, groups, and organisations	Studies mapped onto factor	**5) Community Level (iii) Public Policy Factors,** e.g. Local and national government well-being policies and laws that regulate or support healthy actions and practices	Studies mapped on to Factor
	Interventions to support working carers on an individual level: improving perceived control, optimism and coping		Night shifts' impact on menopause symptom management	Riach & Jack 2021	Impact of job role on well-being and management of long-term conditions	LaBond et al. 2022	-	-	-	-
	Work as a facilitator and barrier to women's well-being	Caputo et al. 2020; Cho 2025; Comolli et al. 2022; Handley et al. 2021; Lacey et al. 2016; Lee & Haley 2023; Templeman et al. 2024; Wang & Ge 2025	Team support to mitigate ageing women's needs (e.g. helping with more strenuous tasks) can support ageing women, particularly in people-focused roles.	Cronin et al. 2023; Meng et al. 2024	Policies to support the lifelong caring needs of ageing women.	Akinleye et al. 2024; Arpino & Bellani 2022; Casolari et al. 2024; Li et al. 2022	-	-	-	-

(*Continued*)

Table 4. (*Continued*)

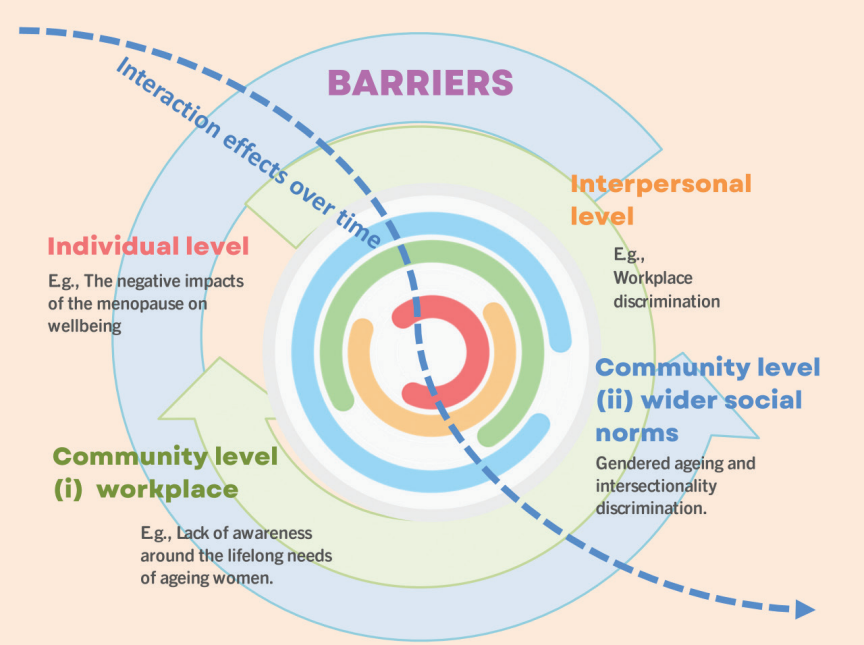
Layer of the socio-ecological model	**1) Individual (intrapersonal) factors** e.g. Well-being knowledge, attitudes, well-being behaviour, self-beliefs, self-efficacy and traits	Studies mapped onto factor	**2) Interpersonal factors** comprises formal and informal social networks/ support systems, e.g. family support, workplace and wider support systems that impact well-being, providing social identity, support, and role definition	Studies mapped onto factor	**3) Community level (i) Institutional factors** e.g. policies, practices, and informal structures constraining or promoting well-being	Studies mapped on to Factor	**4) Community level (ii) community factors**- e.g. wider social networks and norms/standards existing as formal or informal amongst individuals, groups, and organisations	Studies mapped onto factor	**5) Community Level (iii) Public Policy Factors,** e.g. Local and national government well-being policies and laws that regulate or support healthy actions and practices	Studies mapped on to Factor
-	-	-	Workplace discrimination can negatively impact a woman's mental and physical health.	Caputo et al. 2020; Sedani et al. 2024	Women were more likely to need to work because of financial necessity.	LaBond et al. 2022	-	-	-	-

Workplace Barriers to Well-Being

Individual-Level Factors

Negative impacts of the menopause on well-being were highlighted by six studies (see Table 3: 5, 7, 8, 24, 28, 29), but the authors highlighted a gap in knowledge. Severe menopausal symptoms were demonstrated to be a barrier to workability and well-being [5, 29], and it was found that there were three symptoms, which appeared to be more problematic for women at work than in their "life in general," these consisted of: lowered confidence, poor concentration, and poor memory [8]. Evidence suggests that women's subjective performance was not impacted by menopausal experience, but additional qualitative data suggest this may result from

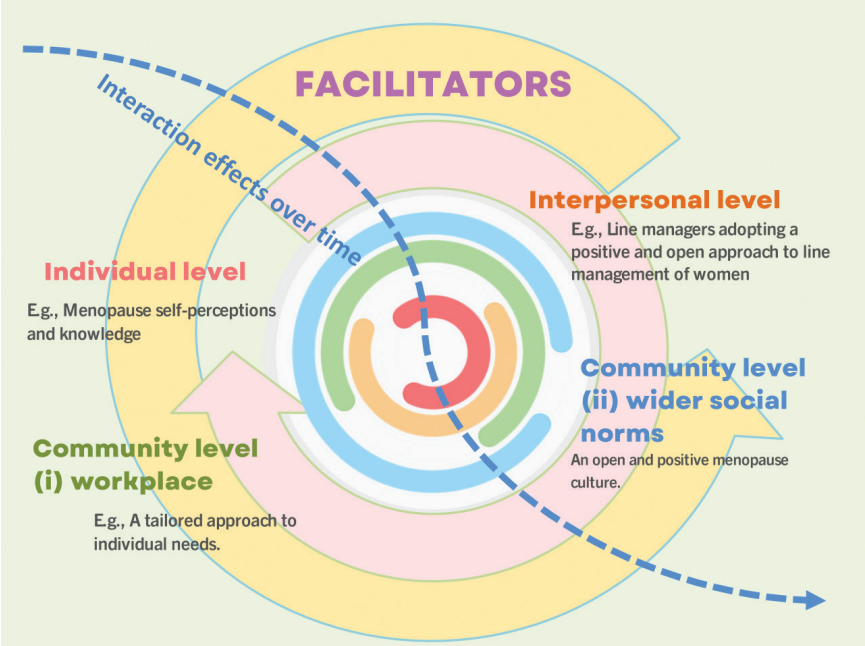
Figure 2. Barriers to ageing women's workplace well-being mapped on to the socio-ecological model (SEM)



increasing efforts [7]. Qualitative analyses indicated that hot flushes were significantly related to intention to leave and work stress was related to work outcomes, and that women experience a range of negative impacts of the menopause, including fatigue and burnout and poorer mental health [24]. Finally, it was highlighted that women vocalised being perceived differently by colleagues around the stage of menopause [12].

Another study exploring the interplay of work and participation in physical activity [20] found that employed women were less likely than men to engage in physical activity, which may be hindered by the dual burden and consequent time constraints of work and caring responsibilities. This underscores the necessity of considering individual experiences and contextual factors when considering women's participation in physical activity.

Figure 3. Facilitators to ageing women's workplace well-being mapped on to the socio-ecological model (SEM)



Interpersonal and Community-Level Factors

A qualitative study conducted in six countries (England, Finland, Denmark, New Zealand, Australia, and the USA) identified that some male line managers and younger colleagues can be perceived as unsympathetic to menopausal symptoms such as hot flushes [24]. A key theme discussed was that women considered that colleagues lacked understanding and felt this was because they had not experienced the menopause themselves. Further UK qualitative studies evidenced that managers' perceptions of ageing women can impact well-being and menopausal experience and that line management may benefit from training around having effective conversations with women [30, 31] Further evidence drawing upon international data added how digital interventions, including apps for connecting with others about the menopause, were reported to reduce isolation, in addition to being useful for being able to track symptoms [24]. In terms of lack of support with the menopause, ineffective or absent line management training was shown to negatively impact well-being and conversations about support for symptom management. It was found that employees were not comfortable disclosing difficulties with menopausal symptoms to line managers, making it more difficult to get the support needed [8]. Finally, a UK qualitative study highlighted how distant relationships with managers act as a barrier to having conversations, whilst it was advised that unhelpful body language, inappropriate humour and dismissive responses hinder positive conversations [6]. Male-dominated environments, distant working relationships, fear of a negative response and embarrassment were highlighted as barriers to conversations as well as impacting negatively on work experience through the menopause transition [6, 31]. Similarly, other evidence from women suggested that having an open and positive organisational menopause culture was vital, based on perceptions that menopause at work was perceived as "dirty," and therefore a barrier to well-being, affecting women's ability to navigate work whilst experiencing menopause [11].

Regarding caring responsibilities and the life course needs of ageing women, there were several studies found [14, 15, 10]. For instance, the benefits of grandparenthood were cancelled out by working, with women in Europe highlighting concerns about the potential role overload facing

working grandmothers [15]. Further in support of this, a further quantitative study highlighted that line managers need to be aware of the lifelong caring needs of ageing women, whereby women demonstrated a tendency to spend more time on care and unpaid labour than men and had lower levels of well-being [10].

Two longitudinal studies found firstly that discrimination (e.g. because of race, religion, sex, age, marital status, nationality, disability) in the workplace can result in depressive symptoms and functional limitations in women's midlife [25] and secondly, being from a non-English speaking country has impacts on women in work in later life, strengthening the bereavement-loneliness relationship [37]. In addition, other evidence from women highlights that the menopause in work combines with other inequalities, creates more work, and aspects of the workplace (e.g. night-shifts) can exacerbate these inequalities [12]. In terms of the factor work as a barrier to well-being, two studies, one in China and another in South Korea, found evidence to show that women had impaired benefits to their well-being from work in older years [38, 39].

In a large cross-sectional study, perceptions of gender discrimination amongst women were shown to at least partially explain the gap between working men's and women's mental health, whereby women suffer more perceived discrimination in work, and this impacts self-reported health and well-being [27]. There was also a link with gender and age, whereby age and gender-based discrimination were shown to be potentially detrimental for mental health in ageing women. The study underscores the importance of intersectionality in respect of workplace discrimination, and further reviewed studies supported this in respect of the negative impact of the intersections on well-being in women [36, 37].

Workplace Facilitators to Well-Being

Individual-Level Factors

Thirteen studies were mapped onto this factor (see Table 3: 1, 4, 7, 8, 12, 16, 21, 22, 25, 26, 30, 31, 35). Firstly, a study in the Netherlands explored self-efficacy interventions aimed at enhancing menopause knowledge

and symptom management through a gender-sensitive, multifaceted, holistic workshop as a facilitator to well-being [1]. Secondly, a study in South Korea found that enhanced menopause attitude and knowledge were associated with better management of the symptoms of menopause [4]. In terms of evidence of a need to change negative perceptions and the internalised stigma associated with the menopause, the importance of women's self-perceptions in avoiding negative consequences was highlighted [8]. It was also found in a cross-sectional study that women experiencing hot flushes were more likely to show an intention to leave, suggesting that the knowledge of menopausal symptom management and self-help for symptom management is important for women in work experiencing menopause [7]. Qualitative evidence in the UK demonstrated that individual women themselves should engage in positive "menopause identity talk" and try to avoid anti-ageing discourses of women, whereby ageing is seen as deviating from the "male ideal worker norms," which centre around youth and attractiveness in contrast to women's gendered and ageing bodies [16]. Whereas other qualitative evidence showed that neurodivergent individuals going through menopause reported exacerbating psychological symptoms impacting their experience of engagement with work (particularly social aspects) that were connected to feelings of being out of control from their usual routine [31]. The authors suggest measures to increase an individual's own sense of control of these symptoms, such as educational interventions, which might be beneficial at the individual level. Finally, in quantitative evidence, it was found that in women experiencing the menopause transition, negative attitudes towards the menopause are (positively) correlated with more troublesome experiences of symptoms and lower job satisfaction, whilst positive attitudes were related to higher levels of job satisfaction [30].

Another facilitator that relates to the menopause given the age of the study participants but was not always explicitly linked to the menopause was physical activity interventions positively impacting well-being (n = 2). One study focussed on workability, specifically in symptomatic menopausal women. It found that a 6-month physical activity intervention positively impacted workability but not the physical or mental strain they experienced at work [18]. Another study found that women were

more likely to have improved work ability and reduced musculoskeletal health issues, and this was particularly so in the 50–64 years group [2].

Seven studies [14, 21, 22, 25, 26, 30, 38] were mapped onto the factor: work as a facilitator to women's well-being. It was highlighted that there were benefits of a combination of strong ties to work and family life when compared to those with no children or weak ties to work [21]. Similarly, establishing a full-time career coupled with a family is suggested to be a facilitator of well-being in women across the life course [26]. It was found that being a healthy, active member of the workforce with stable social support is linked positively to self-reported health and well-being [22]. The importance of consistent mid-life work and its impacts on better mental health outcomes was also reinforced. Researchers added that a negative attitude towards one's job role was also associated with symptoms of depression and reduced functionality, highlighting the nuance around the type of work and the value placed on it by the employee [25]. Finally, women balancing unpaid care with paid work reported varying well-being depending on available resources, with higher perceived control, optimism, and spiritual coping linked to better outcomes, highlighting the importance of work quality and support beyond employment alone [14].

Interpersonal Factors

The importance of line managers' awareness of, and the need to support, the lifelong caring needs of ageing women was highlighted at the interpersonal level of the SEM. This is a clear consideration which needs to be considered by line managers when supporting older women in work, as supported by evidence of caring roles negatively impacting on ageing women's workplace well-being, as highlighted in the barriers to well-being [10, 14, 15].

In terms of interpersonal workplace culture, positive self-beliefs that mitigate negative stereotypes were highlighted [3, 35]. Collective workplace responsibility was emphasised in supporting ageing women, including help with strenuous tasks and adjustments like assistive technologies, especially in people-focused roles [13]. The need to implement work-based physical activity programmes as part of wider well-being interpersonal support systems for older women in the workplace was also highlighted [2].

Community-Level Factors

Research highlighted that interventions aimed at enhancing the well-being of women going through the menopause can have a positive impact on women during midlife [14]. Management of women experiencing the menopause must appreciate differing structures and demands between individuals, and therefore, human resources policies need to reflect these multifaceted experiences [16]. The employers' role was emphasised in making workplace adjustments and having a positive attitude towards the issue; offering guidance on management of menopause and education around symptom management and treatment was highlighted as beneficial [5]. Evidence points to a reorganisation of work to accommodate the menopause as needed and fostering a workplace environment where women want to disclose the menopause by choice and not just to access support [12]. Additionally, evidence suggests that support systems should address the intersectional experiences of women helping women develop techniques to improve emotional regulation, which can be challenged by both menopause and neurodivergent conditions [31]. The authors recommend minimising work conditions that might exacerbate vasomotor symptoms (HFNS), such as an overheated workspace, which might increase women's well-being and enhance their work ability [29].

Having a solution-focused approach, accepting and understanding and using appropriate humour were recommended for colleagues and line managers who might have such conversations [6]. In a different study by the same authors [7], efforts to retain women in the workforce were highlighted could focus on providing support to women experiencing problematic HFNS at work and adapting the work environment to improve the experience and women's ability to cope with symptoms. The impact of a multifaceted intervention was highlighted, and authors suggested that creating gender-sensitive well-being policies that avoid stigmatising the menopause whilst recognising the challenges for women at different stages in life can improve the well-being of ageing women and improve work performance [1]. They argue that changes at an organisational culture level are recommended, including the positive framings of women's contributions to the workforce. Workplaces, others recommend, should promote "healthy ageing" through an educational campaign with a positive focus and that the menopause should not be singled out but included

as part of a holistic health programme [28]. Findings from a large qualitative survey of women in academia suggest employers should shift responsibility from women, who often work through menstrual challenges, to adapting workplace culture and environments, especially in male-dominated settings where stigma persists [19]. Women emphasised that a "like me" culture, open policies, and supportive communities can foster positive conversations around menopause, countering feelings of invisibility and stigma [6, 24, 28]. An understanding of the intersectional impacts of the menopause in neurodivergent groups is suggested in qualitative research exploring this population [31].

There was evidence of a trend whereby women have worse mental health outcomes compared to men when they require some adjustment to their working patterns to compensate for needing to fulfil their caregiving responsibilities [23]. Authors suggest workplace support could therefore mitigate the negative effects requiring employment adjustment on mental health either, directly or indirectly, through family–work conflict. They argue that women require more workplace support to manage caregiving and role conflicts than men. Related to the life course, one study mapped onto lifelong caring needs, whereby findings highlighted a concern about the potential role overload facing working grandmothers, which has line management implications for supporting older women in work [15].

In respect of physical activity, one study provided evidence that a well-being policy to support women, particularly in sedentary roles, could be beneficial [2]. They recommended creating and implementing work-based physical activity programmes (based on WHO recommendations) for ageing women, based on their findings that it enhances the ability to work in ageing women. Qualitative evidence from mature women in the airline industry highlights the need for sustainable strategies that adapt physically demanding roles to better suit women's capabilities as they age [5].

Based on their evidence, recommendations were made to ensure policy supported people to participate in physical activity as they age. This can be done by promoting active ageing, addressing accessibility to physical activities, and incorporating social aspects into physical activity programmes [20]. Others recommend that policy promotion of active ageing is key, and this includes being a healthy and active member of the

workforce and having stable social support because this was shown to contribute positively to self-reported health and well-being [22]. Others recommended, based on their evidence, provision of mandatory physical activity programmes for ageing women suggested in the workplace would need to be supported by legislation [2].

It was suggested that interventions should be implemented for women who have working and caregiving responsibilities as well as social education programmes to highlight the importance of sharing caregiving responsibility, promoting more positive caregiving images of men and as affordable childcare and flexible working are likely to improve well-being later into the life course [21, 22, 32, 33, 34].

The Interactions across Layers of the SEM

Factors including job role, insecure housing, caregiving responsibilities, and long-term family trajectories have been evidenced to interact across the layers over time, thereby impacting work ability and well-being [5, 6, 10, 32, 33]. For instance, Carmichael et al. (2014) found that employed women were less likely than men to engage in physical activity, which may be hindered by the dual burden and consequent time constraints of work and caring responsibilities.

Women in physically demanding or lower-paid roles can face greater barriers to meeting physical activity recommendations, linking workplace and policy-level inequities to health outcomes. Lower pay appears to result in poorer overall health status, resulting in pressure to need to work into later life, whilst simultaneously finding it more difficult to do so [9]. Cultural and organisational norms, such as a sense of "invisibility" felt as an ageing woman, silence around menopause, stigma, and neoliberal discourses of endurance, further shape internalised beliefs about ageing and coping behaviours [6, 35]. These beliefs have contributed to the menopause being described as a "slippery inequality," adding to pre-existing workplace inequalities surrounding gender and age [12].

Other research reviewed shows that whilst work may limit physical activity, retirement often introduces new challenges, such as reduced motivation, financial constraints, and increased caregiving [20] and that long-term well-being is best supported by strong ties to both paid work

and family [21]. However, the benefits of work for women in later life have been shown to be limited by cultural and structural factors, or in fact, do not appear in respect of subjective well-being, or are cancelled out, because of the burden of caring responsibilities in women [15, 38, 39].

The long-term impact of toxic work environments was demonstrated [25], where discrimination leads to chronic stress and elevated risks of depression and physical limitations: an effect described as "stress embedding." Further studies highlight discrimination towards women and by further layers of intersectionality (e.g. by immigration status) added to this [14, 27, 36, 37]. The burden of dual roles is also significant, whereby women balancing paid employment and caregiving have been shown to experience heightened psychological strain, especially without workplace support like flexible hours [23]. This is further supported by the inequity between males and females highlighted; men are said to spend more time at work and less time on care, childcare, and housework, with higher levels of self-reported well-being and higher levels of workability [10, 34].

Menopause adds further complexity, particularly in high-pressure sectors like nursing, where nurses often feel invisible and embarrassed discussing symptoms, with workplace culture contributing to isolation [24]. Peer support and discreet tools (e.g. mobile apps) are essential for managing symptoms without stigma. This stigma often stemmed from the menopause being deemed a taboo subject, impacting a woman's ability to navigate work. Finally, the complex interaction between menopause being considered socially "dirty," coupled with shame, stigma and impact on the ability to successfully carry out their role was highlighted [11].

Discussion

The key factors identified as barriers and facilitators to ageing women's workplace well-being were, firstly, individual-level factors including self-perceptions, positive self-beliefs and efficacy around well-being, such as around menopausal symptoms. These were cited as facilitators to well-being, but also barriers in respect of negative self-perceptions around ageing and the menopause, such as invisibility and self-perceptions of how others perceive women of menopausal age.

The taboo of the menopause in work is well documented (Grandey et al. 2020), and the negative impact on women in terms of career trajectory is also apparent, as also evidenced in the review by Cronin et al. (2023). Considering the gender paradox (see e.g. Miller et al. 2021), whereby stress accumulations impact women more negatively over the life course than men, impacting health, the public health case for interventions at a workplace and public policy level is compelling. Coupled with the fact that women's labour force participation is increasing (OECD 2024; ONS 2022), the need to support women in work is also increasing.

Secondly, a range of interpersonal factors included a positive and proactive approach to line management and having a positive workplace interpersonal culture, which was shown to impact positively on self-beliefs of women around their well-being [5], whilst discrimination of women on an interpersonal level was cited as a barrier to well-being and health [25]. These factors all feature in Warr's (2007, 2011) vitamin analogy for occupational well-being, but the vitamin "equity" seems to be most salient to the findings of this review on the interpersonal level because women's inequity has been consistently highlighted in the workplace. Across Europe and globally, gender disparities have been highlighted in respect of several gender gaps, but the gender care gap is key to consider here in respect of reducing further the gender employment gap and in respect of line management and the need for flexibility (GEI 2023).

This review highlights that workplace discourses and interventions around women's well-being should be non-stigmatising and implemented as part of a broader gender-sensitive well-being policy. This mirrors previous arguments of researchers and the position statement of the European Menopause and Andropause Society, who highlight that specific menopause policies might be stigmatising and that policies should seek to promote greater inclusivity (Carter et al. 2021; Rees et al. 2021). Studies highlighted across the methodologies through longitudinal, cross-sectional and various qualitative evidence that much more can be done to support women's lifelong well-being through, for example, holistic well-being workshops aimed at increasing self-efficacy and workability to improve menopause symptom management and to promote healthy ageing [1, 28]. Furthermore, the findings highlight that workplace well-being of women can be improved by reducing interpersonal-level

barriers to discussing the menopause, such as awareness raising with line managers and having a supportive and open workplace culture that challenges masculine ideal worker norms [16]. This supports previous findings suggesting a workplace taboo around the Three M's and a need to promote a healthier workplace culture (Grandey et al. 2020). It was highlighted that roles that women tend to adopt (lower-paid and unskilled roles) and the gender pension and pay gap make women's necessity to work for longer for financial reasons more pronounced than men [12]. This supports previous findings that show women are more likely than men to extend their working life (Finch 2014), and highlights gaps still present, identified in previous reviews (Edge et al. 2017; Ní Léime & Ogg 2019).

In terms of wider social norms in the workplace, having an open and positive organisational menopause culture was most cited, although this layer had the least studies mapped highlighting a need for further evidence. Only two factors and five studies were mapped on to this level of the SEM, focussing on wider social networks and norms/standards existing as formal or informal amongst individuals, groups, and organisations. This highlights a clear gap in research around social norms in the workplace that impact on women's health and well-being, that is, the taboo of The Three M's (Grandey et al. 2020). There is a clear need for social psychology research in this area because inequity in the workplace affects women's opportunity for progression, and valued social position or perception of significance is seen as a key "vitamin" for positive workplace well-being, as is equity (Warr 2007, 2011). Furthermore, promoting a positive workplace culture has been recommended for supporting women in work going through the menopause (Jack et al. 2016). Interestingly, Manzi et al. (2021) explored stereotype threat in women aged 50 and over and showed that ageism and gender stereotype threat represent a double jeopardy for women in the workplace: if the stereotype threat is not present, perceived workplace performance increases.

At a public policy level, policies to support lifelong well-being in women – flexible working and family-friendly working practices, active ageing policies and policies to make lower-paid roles more equitable and rewarding – were identified as supportive factors for women's workplace well-being. The findings evidenced how interventions aimed at promoting active ageing and physical activity were also a key driver to support

ageing women's well-being. Flexible working arrangements to support well-being and particularly women's lifelong juggling of care were also seen as a key factor that could support women in the workplace [23, 21, 32]. However, this sits in tandem with recent evidence from the UK that shows that women are less likely than men to work hybrid (ONS 2024), and evidence whereby women were also shown to be more likely to occupy lower-paid roles with less opportunity for autonomy (OECD 2023). Finally, public policy to make lower-paid roles more equitable and rewarding was also highlighted, echoing the patterns of work women tend to adopt and the need for more women to stay engaged and healthy in the workforce [9].

Women are more likely than men to experience mental health impacts of gender-based discrimination in work, which is exacerbated in combination with age and other characteristics associated with inequality [27, 36, 37]. Riach and Jack (2021) highlight the menopause inequality that women face in work. This combines with other factors which contribute to women's inequality in the workplace, such as part-time employment, shift work, and roles with disproportionate emotional labour. They also highlight that a reorganisation of work to accommodate the menopause is required to create a supportive workplace environment for women. This mirrors both Ilmarinen (2012) and Warr's (2011) arguments, whereby both advocate for working practices that make workplaces equitable through providing workplace support, workplace adjustments and flexible working arrangements that enable positive drivers to well-being to flourish in the workplace (e.g. workplace autonomy, job control and clarity). Ilmarinen (2012) also highlights the importance of giving breaks to older women working in shift work, and recent evidence shows that shift work is bad for health (O'Halloran & Thomas 2024).

Conclusion

The workplace is a key area for public health intervention, and this paper offers a new insight into the barriers and facilitating factors to workplace well-being with a global focus on women and gender ageing across the life course in the workplace. Both occupational health and HRM research should explore ways to support women's well-being across the life course

across a range of factors. These include the menopause, inequity, discrimination and negative impacts of stereotypes, positive social norms and self-beliefs related to women's well-being, facilitated by a positive workplace culture, and finally, flexible working, physical and practical adaptations to make roles sustainable across the life course. However, there are also cultural and community-level considerations with respect to the social norms and stereotypes surrounding gendered ageing in the workplace and therefore, cross-national and intersectional research is required.

There is a range of methodological gaps highlighted in this systematic review, namely a lack of focus on (1) the life course accumulations impacting women's well-being, (2) mixed methods approaches and (3) qualitative research adopting an intersectional approach. As highlighted, there is a paucity of studies exploring the impacts of the menopause on work, and on interventions in the workplace to support women at an organisational level rather than at the level of the individual, whilst impacting on individual self-efficacy to manage well-being. Therefore, future research should explore the interplay of culture, intersectionality, and gender equity (including non-binary perspectives).

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