

RESEARCH ARTICLE

Menopausal Experiences and Perceptions of Nursing Professionals at Base Hospital Nikawaratiya: A Qualitative Study

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Abstract

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Menopause is a universal biological transition characterised by declining reproductive hormone production that significantly impacts women's physical, psychological, and social well-being. This study explored the lived experiences of menopause among middle-aged nursing officers. A qualitative phenomenological study was conducted from April to June 2021 at Base Hospital Nikaweratiya, Sri Lanka, following ethical approval from the Ethics Review Committee, Dept of Health Services, Provincial Council of the Northwestern Province (ERC No: ERC/NWP/2020/12). Nursing officers aged 40-60 years who had undergone natural menopause were recruited through purposive sampling. Semi-structured face-to-face interviews were conducted using an interview guide. Data saturation was achieved after eight interviews. Interviews were transcribed, and data were analysed using thematic analysis. Four major themes emerged: (1) struggling with uncontrollable physical changes, (2) navigating emotional turbulence, (3) challenges in work and family, and (4) strategies for managing menopausal symptoms. All participants reported hot flushes, excessive sweating, along with burning sensations, vaginal dryness, and joint pain as physical symptoms. Psychological experiences included anger, anxiety, and sleep disturbances; however, most participants showed resilience and adaptation over time. Menopause created challenges affecting daily activities, family relationships, sexual health, and workplace performance, with nurses struggling to manage symptoms while fulfilling professional responsibilities. Coping strategies included spiritual practices, meditation, dietary modifications, and lifestyle adjustments. Although nurses were aware of hormone replacement therapy, its use was low due to concerns about side effects and a preference for natural approaches. These findings highlight the need for menopause-friendly workplace policies, including flexible hours, supportive environments, and confidential support services.

Keywords: *menopause, nursing personnel, experiences, perceptions, qualitative research*

1 | Introduction

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Menopause is defined as the permanent cessation of menstruation, clinically diagnosed after 12 consecutive months of amenorrhea unless due to other physiological or biological causes, typically at the age of 45-55 years (World Health Organisation, 2022). Natural menopause represents the biological marker for the loss of reproductive potential because of ageing with reduced ovarian function and estrogen secretion (Peacock et al., 2023). Menopausal transition or perimenopause is the period before the last menstrual period, characterised by endocrine alterations and the emergence of perimenopausal symptoms. Postmenopausal refers to all years following the last menstrual period (Ortmann et al., 2020).

The average global age at natural menopause is 51 years, with tremendous heterogeneity (40-58 years) influenced by genetic, environmental, and lifestyle factors (Agrawal et al., 2025). Menopausal transition is characterised by diverse metabolic, somatic, and emotional alterations due to declining estrogen levels, having a substantial effect on the quality of women's lives (Hulteen et al., 2023). The most common vasomotor symptoms are hot flushes and night sweats; genitourinary symptoms including vaginal dryness and urinary dysfunction; and psychological symptoms including mood changes, anxiety, and sleep disturbances (Crowe et al., 2025).

International research shows that nurses experience significant physical and emotional challenges during menopause while continuing their professional duties. A qualitative study among women's health nurses identified severe fatigue resulting from poor sleep as the most unbearable symptom, directly compromising their capacity to provide optimal patient care (Vanderzalm et al., 2023). Nurses reported increased anxiety about patient safety, memory lapses, and the quality of care they provided. Fatigue led them to double-check their work, take longer to complete tasks, and sometimes step away from patient care when symptoms were severe. Similarly, a Finnish study of 3,487 registered nurses aged 45 and older reported that 76% experienced general fatigue, 67% experienced sleep problems, and 81.7% reported hot flushes at their peak intensity (Heta et al., 2025). Even though many nurses have these symptoms, menopause is still a taboo topic in healthcare. Nurses get little support from managers or workplace health services while dealing with memory problems and mood changes.

Cross-cultural research further explains the universal nature of these challenges. A qualitative study involving 48 nurses from six countries documented consistent experiences of embarrassment and emotional distress related to menopausal symptoms, particularly hot flushes, during patient interactions (Cronin et al., 2023). Nurses expressed concerns about making errors due to fatigue and cognitive changes, with many feelings compelled to "just get on with it" along with their symptoms. Some even considered reducing their working hours or leaving the profession entirely. A longitudinal study in Japan identified cognitive and memory problems as particularly prevalent among nurses aged 50-

54, affecting 81.7% of participants, with menopause, shift work, and severe hot flushes strongly associated with these cognitive difficulties (Hayashi et al., 2022). Research from the same cohort demonstrated that shift work, particularly night shifts, exacerbated menopausal symptoms, including increased daytime sleepiness, particularly among individuals aged 60 and older (Terauchi et al., 2024). A Chinese research study among 424 middle-aged nurses established that menopausal symptoms and spiritual well-being significantly influenced sleep quality across all menopausal stages, with severe symptoms and lower spiritual growth correlating with poorer sleep and diminished work performance (Bai & Cheng, 2021).

The workplace environment itself presents additional obstacles for nurses managing menopausal symptoms. Inflexible temperature control, lack of private spaces for symptom management, and rigid work schedules compound the difficulties posed by forgetfulness and concentration problems (Cronin et al., 2023; Vanderzalm et al., 2023). Australian research in mental health settings revealed that hot flushes proved especially disruptive during patient care, sometimes forcing nurses to remove protective equipment or pause their work. Nurses expressed concern about visible sweating in front of patients and potential professional repercussions of disclosing symptoms to colleagues or managers. Unexpectedly, even with their health knowledge, many nurses felt unprepared for menopause. Studies from Australia and New Zealand showed a substantial gap between what they knew and what they experienced, leading to additional stress and self-doubt.

Management approaches to menopause vary considerably across populations and professional groups. Hormone Replacement Therapy (HRT), utilizing estrogen alone or combined estrogen-progesterone formulations, effectively alleviates vasomotor symptoms and provides osteoporosis protection. However, its utilisation differs substantially due to concerns about side effects and preferences for natural management (Cameron et al., 2024). Research among nursing populations reveals notably low HRT utilisation and limited comprehensive knowledge even among healthcare professionals. The Japan Nurses' Health Study found that approximately 8.5% of nurses used HRT over 10 years, with higher uptake among those with stronger endocrinological knowledge, suggesting that professional familiarity influences treatment decisions (Yasui et al., 2023). Similarly, a Kuala Lumpur community survey discovered that 83.4% of women had never used HRT, with significant associations between low menopause and HRT knowledge and negative attitudes toward hormone therapy (Gan et al., 2024). These findings demonstrate that menopausal experiences and perceptions are shaped not only by biological factors but also by socioeconomic determinants, education level, physical and emotional health status, cultural context, and individual attitudes and expectations (Peate et al., 2024; Thapa & Yang, 2022).

In Sri Lanka, research specifically examining menopausal experiences among healthcare workers remains limited. A community-based study in the Bope Poddala area of the Galle District found that among 184 pre-menopausal and 1,666 post-menopausal women, the most prevalent symptoms were physical and mental exhaustion (49.5%), joint and muscular discomfort (48.5%), and irritability (41.3%) (Rathnayake et al., 2019). Post-menopausal women showed significantly lower quality of life scores, particularly in physical functioning, role performance due to physical and emotional health, and comfort domains. Another Sri Lankan qualitative study in the Boralesgamuwa area found that women primarily managed symptoms through self-care practices, including the use of local herbs and religious activities (Ilankoon et al., 2021).

The gap in understanding how Sri Lankan nursing personnel experience and perceive menopause within their professional context necessitates focused investigation. Given that nurses constitute a population that may be "busier than general women," exploring their unique management strategies and adaptation mechanisms is particularly relevant to workplace health policy and support system development. This phenomenological study aimed to explore menopausal experiences among middle-aged nursing officers and to examine their perceptions about menopause management within their professional healthcare environment.

2 | Methods

This study adopted a qualitative, phenomenological design to explore the lived experiences and perceptions of menopause among middle-aged female nursing officers. The phenomenological design was selected because it allows for an in-depth understanding of personal experiences and the meanings attached to menopause, enabling researchers to capture the essence of participants' lived experiences from their own perspectives (Neubauer et al., 2019; Cypress, 2022).

Setting

The study was conducted at the Base Hospital Nikaweratiya, a Type B hospital in the Northwestern Province of Sri Lanka. The hospital consists of two medical wards, two surgical wards, a gynecology ward, pre-and post-maternal wards, a pediatric ward, an intensive care unit, a dialysis unit, an accident and emergency unit, clinics, and two respiratory units. Approximately, 149 nursing officers were employed at the hospital, including seven male nurses, working on a 24-hour basis.

Population

The target population comprised of female nursing officers aged 40-60 years working in the Base Hospital, Nikaweratiya who had undergone natural menopause according to the following inclusion and exclusion criteria. To be included, study participants had to be postmenopausal (i.e., not menstruating for at least 12 months), aged 40-60 years, and willing to participate in the study without any influence from the research team. Nurses were excluded if they were currently using hormone replacement therapy (HRT) as hormone supplements can alter or suppress natural menopausal symptoms, making it difficult to understand their actual experiences (Hardy et al., 2021). Nurses who had undergone hysterectomy or ovary removal before natural menopause, or had severe medical or psychiatric conditions that could affect their menopausal symptoms were also excluded from the study. However, women who had stopped using HRT at least six months before the study were included, as this time gap reduces hormone effects while allowing discussion of past HRT use and views.

Sampling Technique

Purposive sampling was used to select participants who could provide clear, detailed, and meaningful information about their menopause experiences. This approach is well-suited to phenomenological research because it focuses on individuals who have directly experienced the phenomenon and can describe it meaningfully (Campbell et al., 2020; Moser & Korstjens, 2022). By intentionally selecting information-rich participants, the study gathered in-depth, reflective insights that revealed the key features and meanings of the menopausal experience (Ahmad et al., 2025; Palinkas et al., 2024).

Data Collection

Data collection tool. Data was collected through semi-structured, face-to-face interviews guided by a pre-formulated interviewer guide. Participant recruitment and data collection continued until data saturation was achieved, at which point, no new themes or insights emerged from the interviews (Hennink & Kaiser, 2022; Vasileiou et al., 2018). The interview guide was systematically developed through a three-step process: (1) a comprehensive review of national and international literature on menopausal experiences among women and healthcare workers to identify relevant thematic domains; (2) alignment with the study objectives and conceptual framework to ensure content relevance; and (3) consultation with the research supervisor and two subject experts in nursing and women's health to refine the structure and appropriateness of questions (DeJonckheere & Vaughn, 2019; Kallio et al., 2016).

The interview guide consisted of both socio-demographic and open-ended questions designed to explore participants' experiences and perceptions of menopause. Probing questions such as "What...?", "How...?", and "Can you describe...?" were used to elicit rich, detailed responses. The interview guide was divided into three sections: Section A - Socio-demographic information, Section B - Experience-related questions, and Section C - Perception-related questions.

To enhance content validity, the drafted interview guide was reviewed by a panel of three experts in nursing research, qualitative methodology, and women's health. Each expert independently assessed the guide for the clarity, relevance, and comprehensiveness of its items (Aminase et al., 2019; Polit & Yang, 2016). Their feedback was used to refine wording, sequencing, and conceptual coverage of the questions.

A preliminary trial of the interview guide was conducted with two post-menopausal nursing officers who were not included in the final sample. The purpose of this preliminary trial was to assess the clarity, comprehensibility, appropriateness of the questions, the logical flow, and the time required for the interview (Dikko, 2016). Feedback from the preliminary trial indicated opportunities to simplify language and improve question sequencing to enhance participant understanding and facilitate natural conversation flow. The interview guide was then revised based on this feedback, ensuring that questions were clearly worded, culturally appropriate, and logically organized before being used for the primary data collection phase.

Data Collection Procedure

Data were collected from April to June 2021 by a team of four undergraduate nursing students. Eligible participants were identified through systematic screening against inclusion and exclusion criteria; 15 potential participants were initially identified. Individual information sessions were conducted with each eligible nurse to explain the study's purpose, procedures, voluntary nature, potential benefits, and assurances of confidentiality and anonymity (Saunders et al., 2019). Information sheets were provided in Sinhala (participants' native language) and included comprehensive study details, researchers' contact information, and the supervisor's contact information for any queries or concerns. Those who expressed interest were scheduled for individual consent sessions where written informed consent was obtained, with ten nurses initially agreeing to participate. Interviews were scheduled at participants' convenience, primarily during their break times or after duty hours, with careful attention to selecting private, quiet locations, typically the nursing rest room or quarters, to ensure confidentiality and minimize interruptions (Lobe et al., 2020). At the end of the study, each consenting participant received an educational leaflet and a short awareness session on menopause and hormone replacement therapy (HRT). This was done for the purpose of knowledge dissemination and participant's benefit. It was not an intervention or part of data collection.

The research team conducted semi-structured face-to-face interviews, each lasting approximately 30 to 60 minutes, consistent with the recommended interview duration for in-depth qualitative inquiry (Sim et al., 2018). Participants were encouraged to share their experiences freely in response to each question. During the interviews, one team member interviewed while another observed and documented nonverbal cues, such as body language, facial expressions, and gestures, to provide contextual depth to the verbal data (Archibald et al., 2019). All interviews were audio-recorded with participants' permission to ensure accurate capture of their narratives for subsequent transcription and analysis.

Each interview session followed a structured format beginning with a 5-minute warm-up conversation to establish rapport, 5 minutes for demographic data collection, 30-50 minutes for the main interview using the interview guide with open-ended questions and probing techniques, 5-10 minutes allowing participants to add any additional thoughts or clarifications and concluding with expressions of appreciation for participation (Kallio et al., 2016). Interview techniques emphasised active listening without interruption and the use of open-ended questions. Data collection continued

until data saturation was achieved, the point at which no new themes or information emerged from subsequent interviews (Hennink & Kaiser, 2022). After conducting eight interviews, the research team observed a repetition of themes and a lack of new information.

Ethical Considerations

Ethical approval was obtained from the Ethics Review Committee of Provincial Health Services, Northwestern Province, Sri Lanka (ERC No. ERC/NWP/2020/12). Permission was also obtained from the Medical Superintendent and Special Grade Nursing Officer of the hospital. Written informed consent was obtained from all participants before data collection, and all information was collected anonymously (Saunders et al., 2019; Bromley et al., 2015). Participants were permitted to leave the study at any time if necessary. The privacy and confidentiality of participants and their information were safeguarded at every stage of the research study (Orb et al., 2001; Sanjari et al., 2014).

Data Analysis

Audio recordings were transcribed verbatim after each interview. Transcription was initiated within 24-48 hours of each interview to maintain accuracy and facilitate accurate analysis (Halcomb & Davidson, 2006; Azevedo et al., 2017). All four researchers independently reviewed the transcripts for accuracy and completeness. Data analysis was conducted collaboratively by the four members of the study team. Braun and Clarke's (2019, 2021) reflexive thematic analysis approach was utilised, which is particularly suited to phenomenological inquiry as it allows for in-depth exploration of participants' lived experiences, such as how they understand, explain, or make sense of what they have lived through. The analysis was conducted in the participants' native language (Sinhala) to preserve the accuracy and nuances of their experiences, with only the final illustrative quotes translated into English for reporting. The research team engaged in regular discussions throughout the analysis process to ensure that interpretations remained grounded in the data and accurately reflected participants' perspectives (Nowell et al., 2017).

Trustworthiness of the study was ensured using Lincoln and Guba's (1985) four criteria: credibility, dependability, confirmability, and transferability (Enworo, 2023), which remain fundamental standards establishing rigour in qualitative research (Korstjens & Moser, 2018; Rose & Johnson, 2020). Credibility was strengthened by spending sufficient time with participants during 30-60-minute interviews, discussing findings with the research team and supervisor, and checking interpretations with two participants to ensure their experiences were accurately represented (Birt et al., 2016; Stahl & King, 2020). Dependability was supported by maintaining a clear record of all study decisions, conducting a preliminary review of the interview guide, and audio-recording and transcribing all interviews in Sinhala to ensure accuracy. Confirmability was ensured by reflecting on potential researcher bias, involving multiple team members in data analysis, and using direct quotations to demonstrate that the findings derive from the participants' words (Cypress, 2017; Connelly, 2016). Transferability was enhanced by providing detailed descriptions of the study setting, participant characteristics, data collection, and findings, so that others can judge whether the results may apply to similar healthcare environments (Stahl & King, 2020; Korstjens & Moser, 2018; Rose & Johnson, 2024).

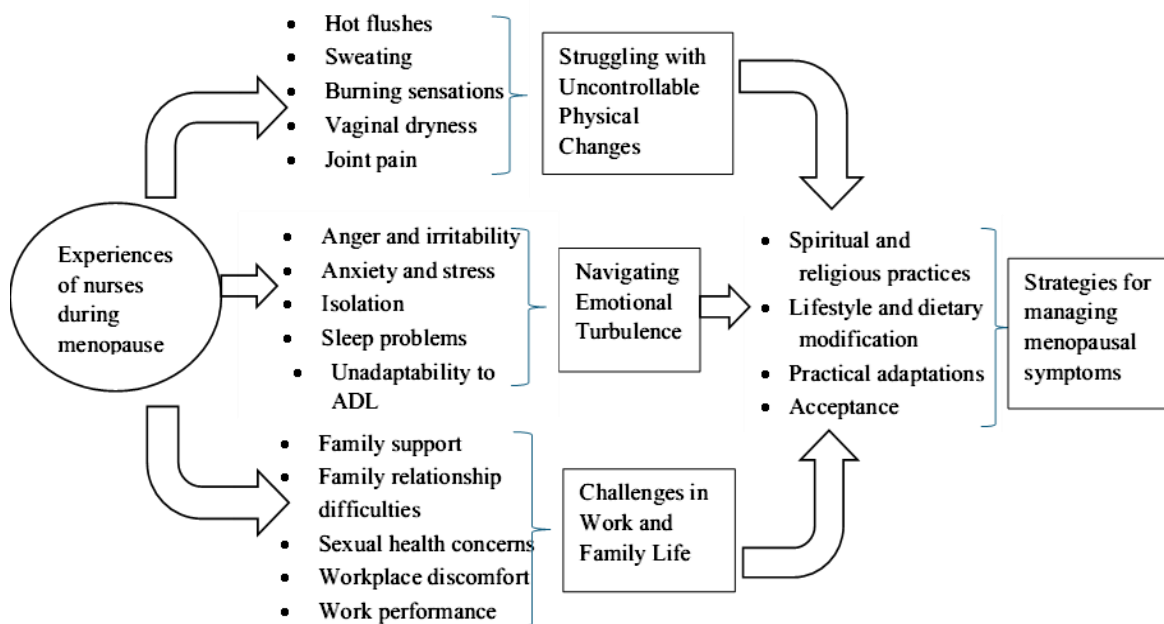
3 | Results

Eight interviews were sufficient to achieve saturation for the study. Accordingly, the sample size was eight. Table 1 presents the sociodemographic data for the study participants. Almost all of the nursing officers were married and between 40 and 56 years old. The average duration of menopause among participants ranged from 1 to 7 years post-cessation of menstruation.

Table 1. Socio-demographic Data of Nurses

Serial No	Patient Code	Age (Years)	Marital Status	Duration of Menopause (Years)
1	A	49	Married	7
2	B	44	Married	2
3	C	53	Married	5
4	D	54	Married	6
5	E	56	Married	4
6	F	55	Married	3
7	G	49	Married	5
8	H	49	Married	4

From the detailed analysis of the participants' narratives, four major themes were identified that explain the nursing officers' lived experiences of menopause. Based on the generated subthemes and the analytical process, a thematic map was developed to illustrate nurses' menopausal experiences (Figure 1).

**Figure 1. Thematic Map of Lived Experiences of Nurses on Menopause**

Theme 1: Struggling with Uncontrollable Physical Changes

All participants reported experiencing at least one physical symptom related to menopause. The most reported symptoms included hot flushes, excessive sweating, burning sensations in the feet and body, vaginal dryness, joint pain, and leg aches.

Hot Flushes and Sweating. Hot flushes were described as sudden sensations of intense heat throughout the body, often accompanied by profuse sweating. These episodes occurred both during daytime activities and at night, significantly disrupting participants' comfort and daily routines. All participants reported hot flushes and sweating, which were the most prevalent symptoms.

"After I experienced vaginal dryness, these difficulties started, and I noticed my body became wet with perspiration" (Participant A, 49 years).

"I got a feeling of high temperature (hot flushes) and some discomfort that I can't fully describe. Some ladies with us perspire heavily. They switch on the air conditioner, saying it's hot, but I feel cold" (Participant B, 44 years).

"I've been sweating much more than usual. The sweating becomes worse in hot weather, and I even sweat heavily at night now" (Participant D, 54 years).

Several participants noted that the sweating was severe enough to require frequent clothing changes and multiple showers throughout the day:

"I sweated so much that my clothes got completely wet, and I started sweating more at night... I had to wash and change three to four times a day" (Participant H, 49 years).

Burning Sensations. Many participants reported experiencing uncomfortable burning sensations, particularly in their feet and throughout their bodies. These sensations were described as intense and persistent.

"I experienced sweating, burning sensations in my body and legs, and burning sensations in my feet, just like they are emitting flames. These were the main symptoms I had" (Participant G, 49 years).

"Along with sweating, I experienced a burning sensation throughout my body, especially during work" (Participant H, 49 years).

Other Physical Symptoms. Additional physical symptoms reported by participants included vaginal dryness, joint pain, and leg aches. These symptoms often occurred together, creating increasing discomfort.

"After I experienced vaginal dryness, these difficulties started, and in the evening, I had severe leg aches" (Participant A, 49 years).

Theme 2: Navigating Emotional Turbulence

The psychological impact of menopause was a significant concern for all participants, who reported a range of negative emotional and mental changes, including anger, anxiety, stress, feelings of isolation, and sleep disturbances. However, participants differed in how they managed these challenges, with some demonstrating more positive adaptation over time.

Anger and Irritability. The majority of participants reported increased anger and irritability, often triggered by minor situations.

"I felt furious when menstruation stopped. I'm still relatively young; menopause started when I was just forty-two years old" (Participant A, 49 years).

"I get angry over small things now... it's like excessive anger compared to before" (Participant H, 49 years).

Anxiety and Isolation. Several participants described feelings of wanting to be alone and experiencing mental distress.

"I prefer to be alone sometimes; I even wonder whether I'm becoming mentally unwell. I like to be alone and don't feel like talking with my children" (Participant C, 53 years).

Sleep Disturbances. Multiple participants reported difficulty in sleeping, which contributed to their overall stress levels.

"I get angry over small things... I also have sleeping problems. I feel stressed" (Participant H, 49 years).

Unadaptability to ADL. Although participants initially experienced distressing psychological symptoms, most demonstrated positive adaptation over time. These participants developed acceptance of menopause as a natural life transition.

"I never made it into a major problem in my life. I faced it by accepting that it would end someday. I read about it in magazines, which helped me understand how to manage the discomfort" (Participant A, 49 years).

"I didn't seek medications immediately. I thought the symptoms would disappear with time. Other nurses told me to see a doctor, but I explained that these are normal changes, and I don't have any severe disease" (Participant C, 53 years).

Participants who successfully navigated emotional turbulence actively employed coping techniques to manage their emotional responses:

"I practice meditation when I feel angry, which helps me calm down" (Participant E, 56 years).

"These symptoms don't last forever. They will gradually disappear in a few years" (Participant G, 49 years).

Theme 3: Challenges in Work and Family Life

Menopause significantly affected the participants' social relationships, daily activities, and workplace performance. This theme revealed both challenges and sources of support in the participants' lives. Participants' experiences within their families varied. While some received understanding and support, others faced challenges in managing family relationships during menopause. On the other hand, most participants reported that menopausal symptoms posed significant challenges to performing their nursing duties effectively. The demanding nature of nursing work, combined with physical symptoms, became particularly difficult during menopause. Participants described struggling to maintain professional standards while managing profound physical discomfort and emotional instability.

Family Support. Some participants reported receiving support and understanding from their family members, particularly husbands and children.

"My husband knows about my condition. I told him about my difficulties. My children also understand now. My two daughters are grown up, and they know what I'm going through" (Participant A, 49 years).

"Yes, I received family support at home, which helped me to manage this situation" (Participant E, 56 years).

Family Relationship Difficulties. Several participants reported significant difficulties maintaining family harmony due to increased irritability and mood changes. These participants expressed frustration at needing to suppress their emotions to preserve peace in the household, adding another layer of stress to their menopausal experience.

"I get angry easily now... but I can't express it fully because I have to maintain peace within my family" (Participant B, 44 years).

"It's difficult at home as well. I easily get fatigued when I'm doing routine housework. I experience body burning sensations and get angry. It's challenging to control the anger around my family" (Participant H, 49 years).

Sexual Health Concerns. Some participants specifically mentioned experiencing difficulties with sexual intimacy due to menopausal changes.

"There was much discomfort during sex. There are issues during intercourse because of hormonal changes and vaginal dryness" (Participant G, 49 years).

"Actually, I sweat so heavily that even my husband cannot stay close to me. The bed becomes wet with sweat at night" (Participant G, 49 years).

Physical Discomfort at Work. The most commonly reported workplace challenge was managing excessive sweating while wearing nursing uniforms during long shifts.

"When we wear uniforms, we sweat excessively. It's really uncomfortable for me when 6-hour shifts are over, I sweat so much. I feel particular discomfort when my feet and legs are sweating" (Participant H, 49 years).

"Yes, there was sweating during duty. It wasn't initially a big problem, but the sweating caused discomfort. I had to take frequent showers. I would wash even at 2:00 AM before resting during night shifts" (Participant G, 49 years).

Emotional Control at Work. Some participants described the difficulty of managing emotional symptoms while maintaining professional behaviour during patient care.

"I had to control my anger with great difficulty during my duty time. This was challenging when interacting with patients and colleagues" (Participant H, 49 years).

Impact on work performance. Despite these challenges, most participants demonstrated commitment to maintaining their professional responsibilities.

"It was challenging, but I made up my mind to focus on my nursing duties" (Participant A, 49 years).

"The leg pain was particularly problematic during duty hours when I had to stand for long periods" (Participant F, 55 years).

Theme 4: Strategies for Managing Menopausal Symptoms

Participants have utilised various strategies to manage menopausal symptoms, mainly utilising non-pharmacological approaches. These strategies reflected both individual preferences and cultural practices.

Spiritual and Religious Practices. Many participants identified spiritual and religious practices as primary sources of strength and comfort during the menopausal transition. Buddhist meditation and teachings provided not only practical techniques for managing emotional symptoms but also a philosophical framework for understanding and accepting life changes. Participants described these practices as grounding forces that helped them maintain perspective and emotional balance.

"We all are Buddhists; we should get closer to Dhamma and practice meditation. I believe Buddhism provides strong support during this transition" (Participant B, 44 years).

"I practice meditation when I feel angry. This helps me maintain emotional balance" (Participant E, 56 years).

Lifestyle and Dietary Modifications. Most participants made planned changes to their diet and lifestyle to alleviate symptoms. These modifications ranged from increasing fruit consumption and avoiding fatty foods to seeking out cooling foods and beverages that might reduce burning sensations. Participants approached dietary changes thoughtfully, often balancing symptom management with other health considerations.

"I consume more fruits now and avoid fatty foods. However, my gastritis increased during this period, so I had to be careful with my diet" (Participant C, 53 years).

"I drink and eat cold things to reduce the burning sensation. I also listen to music to relax myself, read books, and spend time with my children. These activities help me overcome the difficulties" (Participant H, 49 years).

These dietary and lifestyle modifications reflected the participants' desire to manage symptoms through natural means that they could control, rather than relying solely on medical interventions.

Practical Adaptations. Participants developed numerous practical solutions to manage the most disruptive physical symptoms, particularly excessive sweating. These adaptations included taking multiple showers throughout the day, keeping fans readily accessible, changing clothing frequently and adjusting their environments to maximize comfort. While these solutions did not eliminate symptoms, they provided some relief and allowed participants to maintain their daily activities.

"I take frequent showers to manage the sweating, sometimes three to four times daily. I always keep a fan nearby" (Multiple participants).

Acceptance and Patience. Several participants adopted the condition by viewing menopausal symptoms as temporary.

"These symptoms don't cause major problems. They will disappear after some time, and they will resolve in a few years" (Participant G, 49 years).

This perspective helped participants to tolerate difficult symptoms while maintaining their daily responsibilities and avoiding excessive focus on discomfort. The combination of spiritual practices, lifestyle modifications, practical adaptations, and acceptance reflected the participants' holistic and culturally grounded approaches to managing the menopausal transition.

The coping strategies shared by the participants showed that they preferred to manage menopausal symptoms through spiritual practices, lifestyle changes, and practical methods rather than using medication. This was particularly interesting because the participants were nursing officers, who would be expected to have good access to medical care and knowledge of treatment options. To better understand why they chose non-medical approaches, they were asked about their awareness and experiences of hormone replacement therapy (HRT). Their answers showed a clear gap between what they knew and what they used. This helped explain the values, beliefs, and personal reasons behind their choice to manage menopause naturally instead of using medical treatments.

In addition to the major themes identified above, participants expressed complex perceptions of hormone replacement therapy, highlighting a clear gap between awareness and utilisation.

Perceptions Regarding Hormone Replacement Therapy (HRT)

Participants demonstrated varied levels of knowledge and experience with HRT. While awareness was generally good due to their healthcare background, the actual utilisation remained low.

Awareness and Knowledge

Many of the participants were aware of HRT as a treatment option for menopausal symptoms. This awareness arose from professional training, discussions with colleagues, participation in health education programmes, and medical consultations. Even though the participants worked in healthcare, their understanding and knowledge were somewhat general.

"Yes, I know about people who take hormone tablets. I've heard that HRT is good for preventing skin irritability and other symptoms" (Participant E, 56 years).

"Yes, I knew about HRT. I even asked a doctor about it. The doctor explained the benefits" (Participant H, 49 years).

Participants recognized HRT as an available option but did not have essentially comprehensive information about its mechanisms, potential benefits, or risks. This superficial level of awareness contrasts with their deep knowledge of nursing care and other medical treatments.

HRT Utilisation and Mixed Experiences

Only a few participants had actually used HRT, and their experiences varied considerably, ranging from significant symptom relief to discontinuation due to adverse effects. These mixed experiences influenced not only their own decisions about continued use but also shaped their perspectives on recommending HRT to others.

Positive Experience with Symptom Relief. One participant reported substantial benefits from HRT, including improved physical symptoms and overall well-being. Her experience was enhanced by receiving education about HRT through a structured programme, which helped her understand what to expect and how to evaluate its effectiveness.

Positive Experience.

"The gynaecologist prescribed tablets for me. We had attended a programme about menopause where the doctor explained HRT. I took the medication for about one year. I noticed significant improvements, and even vaginal health was normalised. Some people even commented that I looked healthier and more beautiful after taking these tablets" (Participant A, 49 years).

This participant's positive experience was notable not only for symptom relief but also for visible improvements that others noticed, suggesting a meaningful impact on quality of life and appearance.

Discontinued Use Due to Side Effects. Another participant's experience with HRT was less favourable, leading to treatment discontinuation. Despite receiving a medical recommendation for HRT due to early menopause, she developed an allergic reaction that made continued use impossible.

"After about one year of menopause, I consulted a gynaecologist who recommended hormonal treatment because menopause occurred early for me. However, I couldn't continue the medication because I developed an allergic reaction" (Participant B, 44 years).

This experience highlighted the reality that HRT, like any medical intervention, carries risks of adverse effects that may balance potential benefits for some individuals.

Reasons for Non-Utilisation of HRT

Most participants chose not to use HRT, although being aware of its availability and potential benefits. Their reasons for non-utilisation reflected deeply held beliefs about naturalness, medical intervention, and the appropriate response to life transitions. These decisions were not made carelessly; however, represented thoughtful considerations about how they wished to travel through menopause.

Preference for Natural Management. Several participants said they preferred to manage their symptoms naturally instead of using medication. They felt that menopause is a natural stage of life, not an illness, so medical treatment did not seem necessary to them.

"HRT may be beneficial, but I prefer not to use artificial treatments. I believe in managing symptoms naturally" (Participant H, 49 years).

The characterisation of HRT as "artificial" revealed participants' conceptualisation of hormonal treatment as something foreign or unnatural, contrasting with their preferred approaches involving dietary modifications, spiritual practices, and lifestyle adjustments.

Lack of Information or Recommendation. Some participants noted that they had not pursued HRT, in part, because no physician had specifically recommended it. This passive attitude toward HRT indicated reliance on medical authority. Since doctors did not recommend it, they assumed it was unnecessary or unsuitable for them.

"No, I don't use HRT. No doctor specifically recommended it to me, and I didn't seek it out" (Participant F, 55 years).

This showed that although participants made their own decisions about symptom management, they still relied on physicians for medication advice. When doctors did not suggest it, it affected their decision not to use HRT.

Belief in Self-resolution. Several participants decided not to seek medical treatment, including HRT, because they believed their symptoms would settle on their own. They saw menopause as a temporary phase, not a long-term condition that needed medical treatment.

"I didn't pursue medical treatment. I didn't even visit a gynaecologist. I believed the symptoms would resolve on their own overtime" (Participant G, 49 years).

This view showed that they accepted menopause as a natural process and felt that, although the symptoms were uncomfortable, they were not severe enough to need medical treatment.

Positive Perception for Non-Use. Interestingly, some participants who did not use HRT themselves still said it could be helpful in others with worse symptoms. This demonstrated that they understood that different people require different things.

"I would recommend visiting a gynaecologist for those experiencing severe symptoms. Hormonal treatments are available and can reduce many problems" (Participant H, 49 years). This showed that their decisions about HRT were not a complete rejection of it. Instead, they made choices based on the severity of their symptoms, their personal values, and their circumstances. They understood that natural methods worked for them, and those methods might not be enough for others with more serious symptoms.

4 | Discussion

This phenomenological study explored the lived experiences of menopause among nursing officers in Sri Lanka, revealing four interconnected themes that explain how these healthcare professionals pass through this significant life transition. Although they work in healthcare and possess medical knowledge, the participants still faced significant physical, emotional, and social challenges. These difficulties affected both their personal lives and professional performance. Their experiences are similar to what recent international studies have found; they also reflect cultural factors specific to Sri Lanka that deserve attention.

The current study found that hot flushes and excessive sweating were the most troubling physical symptoms for participants, disrupting daily routines, necessitating frequent clothing changes, and severely disrupting sleep. These findings closely parallel the international research on menopausal nurses, where vasomotor symptoms consistently emerge as the most common and distressing complaints among nursing professionals (Cronin et al., 2023; Heta et al., 2025). In a Finnish study of 3,487 registered nurses aged 45 and over, hot flushes showed a peak prevalence of 81.7% in women aged 50-54 years, with many experiencing severe symptoms that significantly affected their work performance (Heta et al., 2025). The severity of symptoms experienced by participants, such as needing to shower at 2:00 AM while on night duty, extends beyond mild discomfort into significant quality-of-life impairment comparable to findings from an international qualitative study of 48 nurses across six countries (Cronin et al., 2023). That study described nurses experiencing severe hot flushes during patient care that prompted them to remove protective equipment, open doors and windows, or interrupt clinical procedures to manage symptoms.

Participants also reported burning sensations in their feet and throughout their bodies, joint pain, and vaginal dryness symptoms that occurred simultaneously and created combined discomfort. This pattern is similar to findings from the Japanese Nurses' Health Study, which showed that menopausal symptoms among nurses tend to occur in groups, such as physical, emotional, and vasomotor, rather than as single, separate symptoms (Hayashi et al., 2022). The physical demands of nursing work seemed to make menopausal symptoms worse. At the same time, these symptoms made it more difficult for nurses to perform their duties effectively. This two-way effect has been reported in studies of menopausal nurses in different countries. For example, an Australian study found that long and physically demanding shifts, emotional stress, poor temperature control at work, and inflexible schedules all increased the severity of menopausal symptoms (Cronin et al., 2023). Similarly, a cross-sectional study of 424 middle-aged Chinese nurses found that menopause syndrome severity was a significant predictor of poor sleep quality, which in turn affected nurses' work performance and overall quality of life (Bai & Cheng, 2021).

The findings of the current study indicate that nurses were particularly affected by excessive sweating while wearing uniforms during long shifts. Their work afforded little flexibility in managing symptoms, making their experience more difficult. This is similar to a Canadian qualitative study of women's health nurses, in which participants described wiping sweat from their faces while caring for patients and being careful not to lean over patients in case sweat dripped onto them (Vanderzalm et al., 2023).

Participants' psychological experiences showed a clear journey from early emotional distress to later acceptance. At first, many of the participants struggled with strong emotions such as anger, irritability, anxiety, and loneliness, which affected their sense of identity and relationships. One

participant's fear was that she was "becoming mentally unwell" highlighting how confusing and upsetting these emotional changes were. This emotional pattern is similar to findings from studies of nurses in other countries. Another study of women's health nurses conducted in Canada found that many nurses experienced strong mood swings, anxiety, and emotional instability, which they linked to poor sleep and tiredness (Vanderzalm et al., 2023). Nurses reported feeling less patient and worried that their emotional changes could affect the quality of clinical tasks. One nurse explained that lack of sleep made it hard to work safely and caused fear of making serious mistakes (Vanderzalm et al., 2023).

The six-country international study also found that menopausal nurses experienced a high level of psychological distress. Participants reported that their emotions fluctuated and were difficult to control (Cronin et al., 2023). Nurses in all countries reported problems such as poor memory, anxiety, mood swings, irritability, and low mood, which affected their confidence and performance at work. However, most participants in the current study demonstrated resilience and gradually developed acceptance of menopause as a natural, temporary life stage. This acceptance-based coping aligns with Meleis' Transitions Theory, which conceptualizes health transitions as processes involving initial disruption, gradual adjustment, and eventual achievement of new stability (Meleis, 2010). The Finnish study with 3,487 nurses similarly found that, although menopausal symptoms were prevalent and challenging, nurses employed various coping strategies and continued working despite significant discomfort; 76% reported general fatigue, and many felt unable to take sick leave (Heta et al., 2025).

A study of Japanese nurses found that memory problems and forgetfulness were common, particularly among nurses aged 50–54 years. These problems were linked to poor sleep, night shift work, severe hot flashes, and uncertainty about menopausal status (Hayashi et al., 2022). The researchers noted that these thinking and memory problems were closely linked to both physical and emotional symptoms, such as tiredness, low mood, and anxiety. This indicates that menopausal symptoms among nurses are interrelated and often co-occur, rather than occurring independently.

Further, participants found it was hard to manage their multiple roles as nurses, wives, mothers, and individuals while dealing with menopausal symptoms. This led to frustration, tiredness, and difficulty meeting both work and family responsibilities. Similar studies from other countries also show that menopause causes "role strain," affecting women's work and personal lives at the same time (Hardy et al., 2017; Cronin et al., 2023). A Canadian study found that nurses often brought their work-related fatigue home, and one nurse reported that her family was affected because she was exhausted after work (Vanderzalm et al., 2023).

Nurses in this study continued working despite significant discomfort, demonstrating strong dedication to their work. However, other research indicates that menopausal symptoms often lead nurses to reduce their hours, transition to less demanding roles, or leave nursing altogether (Hardy et al., 2017; Heta et al., 2025). A Finnish study found that many nurses considered role changes or part-time positions specifically to manage menopausal symptoms (Heta et al., 2025). Concerns about patient safety related to fatigue and cognitive changes were a significant source of distress for nurses. International research, including a Canadian study, found that nurses experiencing severe sleep problems and memory difficulties worried about making medical errors. To manage these risks, nurses reported compensatory strategies, including repeatedly checking their work, relying on written reminders, and spending more time on tasks. While these strategies helped maintain safety, they also increased workload and stress, further burdening nurses during the menopausal transition (Vanderzalm et al., 2023). Another study of nurses from six countries found that many experienced mental cloudiness and memory problems made them anxious about their work. Nurses reported that these cognitive difficulties made it harder to perform their jobs confidently, thereby increasing their stress and fear of error (Cronin et al., 2023).

The current study revealed that participants' sexual health issues affected their relationships; however, they discussed them cautiously due to cultural discomfort. Similarly, international nursing

studies have found that menopausal nurses experience changes in sexual health but often cannot talk about them openly because of workplace culture and stigma (Cronin et al., 2023; Heta et al., 2025). Supporting the above findings, a Finnish study found that menopause remains a taboo topic even within healthcare organisations, with perceived divides between genders and generations limiting open discussion (Heta et al., 2025).

Family support emerged as an important coping strategy in this study; this finding aligns with international research indicating that support from family and peers helps nurses manage menopause (Cronin et al., 2023; Heta et al., 2025). However, a study conducted in six countries found inconsistent support for nurses at work. While some workplaces were helpful, others were not. Many nurses felt that their concerns about menopause were ignored or not taken seriously, especially by younger colleagues or males. This made it harder for them to cope at work, as they did not feel understood or supported (Cronin et al., 2023).

Further, the findings highlighted that many participants preferred managing menopause with cultural and spiritual practices rather than medical treatments. Even with healthcare training, they chose Buddhist meditation, diet changes, and lifestyle adjustments, seeing menopause as a natural stage of life. Similar patterns have been observed among nurses internationally, although cultural practices vary. For example, the Japan Nurses' Health Study found that nurses often used diet, exercise, and environmental modifications to manage symptoms before seeking medical treatment. (Hayashi et al., 2022).

A key finding was that although participants were aware of hormone replacement therapy (HRT), very few actually used it. Most knew about HRT from their professional training; however, their understanding was limited. This gap between knowledge and use has been seen internationally as well. For example, the Japan Nurses' Health Study found that only 8.5% of 4,886 nurses used HRT over 10 years. HRT use was more likely among nurses who had used oral contraceptives, experienced severe menstrual or menopausal symptoms, or worked as public health nurses or midwives rather than as registered nurses. The study concluded that nurses with greater knowledge of hormones and less reluctance to consult a physician were more likely to use HRT; however, overall use remained low, even among this medically knowledgeable group (Yasui et al., 2023). Similarly, a Canadian study found that even with professional knowledge, nurses struggled to get proper menopause care for themselves (Vanderzalm et al., 2023). Some tried HRT but stopped because it did not help, caused side effects, or they were unsure about starting it (Vanderzalm et al., 2023).

Several factors can explain the observed gap. First, participants viewed menopause as a natural life transition rather than a medical condition, consistent with findings in Asian nursing populations (Bai & Cheng, 2021; Hayashi et al., 2022). Second, they viewed HRT as "an artificial treatment" and preferred natural approaches despite their medical training, consistent with the six-country nursing study (Cronin et al., 2023). Third, participants waited for their doctors to suggest HRT and interpreted no advice as support for not using it. This passive approach is notable because healthcare professionals typically guide patients, suggesting that medical knowledge does not always lead to self-advocacy. Fourth, worries about medication risks and side effects influenced decisions, with awareness shaped by professional expertise and negative peer experiences (Cronin et al., 2023; Heta et al., 2025).

Limitations

This study has some limitations that should be considered when interpreting the findings. The study included nurses from a specific work setting; therefore, the findings may not be applicable to all healthcare contexts. The data were based on participants' self-reported accounts, which may have been influenced by recall bias or a desire to present themselves positively. Cultural beliefs and workplace practices may also have shaped participants' responses, meaning the findings may not

reflect the experiences of nurses in different settings. Despite these limitations, the study offers valuable insights into nurses' experiences of menopause and how they manage their symptoms.

5 | Conclusions

This phenomenological study provides valuable insights into the multifaceted experiences of menopause among middle-aged nursing officers at Base Hospital Nikaweratiya, Sri Lanka. The findings reveal that menopause significantly impacts nursing professionals across physical, psychological, and socioeconomic domains, with all participants experiencing universal symptoms such as hot flushes and excessive sweating, alongside psychological challenges including anxiety, stress, and emotional volatility. These symptoms create complex challenges that extend beyond personal health into professional spheres, where nurses must maintain high standards of patient care while managing difficulties such as controlling emotions during duty hours and managing excessive sweating in uniforms.

The study shows positive trends in participants' adaptability and resilience despite these difficulties. Nursing officers used a variety of coping mechanisms, from meditation and spiritual practices to lifestyle changes, and they generally had positive attitudes regarding their menopausal transition. They also showed philosophical acceptance of their condition. They have conflicting opinions about hormone replacement therapy, which is reflected in their cultural values that support non-pharmacological management techniques as well as their awareness of the treatment, but limited use because of side effects and preference for natural methods.

These findings highlight the vital need for workplace support systems that recognise menopause as a valid occupational health concern from the standpoint of healthcare policy. To preserve employee productivity and job satisfaction, healthcare organisations should adopt menopause-friendly policies, such as flexible scheduling, environmental adjustments, and private support services. Consistent with the qualitative design of the study, data were generated from an in-depth exploration of experiences within a single healthcare setting, allowing rich, contextualised insights rather than statistical generalisation. This study, though focused on a specific setting, contributes insightful information to the limited literature on menopausal experiences among Sri Lankan healthcare workers and emphasises the need for comprehensive, multidisciplinary approaches to menopause in order to support women during this vital life transition while preserving both personal well-being and professional excellence.

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Author Contributions

WAPANA: Conceptualization, methodology, data curation, formal analysis

BMUMJ: Conceptualization, methodology, data curation, formal analysis

PDK: Conceptualization, methodology, data curation, formal analysis

BMBCB: Conceptualization, methodology, data curation, formal analysis.

KIDFS: Data analysis and interpretation, initial draft of the manuscript, critically revised the manuscript

KGPKM: Conceptualization, methodology, supervision, critically revised the manuscript

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