RESEARCH PAPER

Silent Struggles Unveiled: A Systematic Review of Symptom Burden among Postmenopausal Women

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Abstract

The postmenopausal period is frequently associated with a variety of symptoms that affect the physical, psychological, and social well-being of women. This systematic review attempts to draw conclusions regarding the studies in the realm of postmenopausal symptom burden of women worldwide. Drawing from 15 peer-reviewed articles published from 2005 until 2025, the research presents vasomotor, urogenital, psychological, and metabolic symptoms and considers sociocultural barriers in their efficacious treatment. The PRISMA guidelines were applied to select relevant studies. The research reveals a tangled web of physiological discomforts and psychosocial isolation that have been aggravated by a lack of hormone therapy regulation, stigma, and the absence of appropriate interventions in the healthcare system. It highlights an increasing demand for the development of culturally appropriate and multidisciplinary care strategies to alleviate the silent suffering of postmenopausal women.

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Introduction

Menopause, defined as the biological cessation of menstruation resulting from the loss of ovarian follicular activity, is a universal biological transition in the life of a woman. Menopause usually occurs between the ages of 45 and 55 and marks the cessation of reproductive capacity. Although menopause is viewed as a natural physiological phenomenon, the different symptoms are often presented and understood beyond biophysical changes; they have important psychological, emotional, and social considerations. Affecting almost half of the world population at some point in life, the phenomenon of menopause, its associated experiences, and symptoms have been trivialized, under-examined, or misunderstood in medical discourse and the wider societal context.

Women going through postmenopause commonly experience a group of symptoms termed on symptom burden. These include vasomotor symptoms like hot flashes, night sweats, and sleep disturbances, which are among the most frequently given reports. In contrast, urogenital symptoms such as vaginal dryness, dyspareunia, urinary incontinence, and increased susceptibility to infections are also widespread and affect women's intimacy and quality of life. Besides this, a great number of women report elaborations of psychological distress encompassing anxiety, depression, mood swings, changes in cognition, and irritability to feelings of inadequacy and social withdrawal. These disorders would be further

triggered in an age-related context due to the onset of chronic diseases, caregiving, empty nest syndrome, or transition in careers.

The differing expression of symptom burden in menopause is influenced by culture, socioeconomic status, degree of access to healthcare, background education, and lifestyle. For instance, in some cultures, stigma or shame is attached to menopause, hence women suffer in silence rather than seek medical intervention. Elsewhere, it may be embraced or celebrated as a sign of maturity and wisdom. This dichotomy emphasizes the urgency to look at menopause as a multi-dimensional experience rather than just a biological event.

Majorly, barriers related to managing a symptom remain of great concern. Hormone therapy, though considered an effective treatment for disabling menopausal symptoms, is relative by very few because of some apprehensions about its side effects, misinformation, or lack of support from the healthcare providers. Non-hormonal treatments, meanwhile behavioral and lifestyle changes, confront at times identical barriers-materialic, awareness, access, and sometimes the question of effectiveness. A good number of health infrastructures in the low- and middle-income countries are coastal. This, therefore, worsens the situation of symptom management, hence offering Fridays to postmenopausal women.

Paradoxically, this central concern is still an understatement in research and policy initiatives. Silence only makes the problem invisible, thereby setting it on the fringes of public health concern. This systematic review attempts to uncover those silent struggles through the synthesis of literature concerning the symptom burden experienced by postmenopausal women. It considers symptom clustering, symptom impacts on the physical and psychosocial aspects of life, plus systemic hurdles to adequate care. This will, therefore, create an awareness for health practitioners, policymakers, and researchers demonstrating the pressing need for comprehensive approaches-culturally sensitive and patient-centered-to support women during one of the most critical stages in their lives.

Literature Review

1. Vasomotor and Physiological Symptoms

Traditionally assumed to mark the whole menopause transition, vasomotor symptoms (VMS), hot flushes, and night sweats, accompanied by sleep interruption, were, however, physiologically grounded and impacted mental health, daily activities, and interpersonal relations. According to Utian (2005), vasomotor symptoms are not only frequent but also very distressing, causing sleep disruption, decreased productivity, and adverse effects upon the very quality of life of menopausal women. The Implication of Utian's Health and Quality of Life outcomes on his review is therefore that poorly treated or untreated vasomotor symptoms escalate into psychological distress, which then further precipitates into economic disengagement and social engagement among women. This connection begins to tie physiological symptoms with broader life course consequences-the very space most medical discourses usually ignore.

The severe disruption of sleep frequently associated with nocturnal hot flashes further aggravates daytime symptoms of fatigue and mood fluctuations. Wu and Harden (2015), in their systematic literature review of symptom burdens among cancer survivors, reported that the symptom experience of menopausal symptoms among breast cancer survivors closely mirrored those from natural menopause. Hence, their findings suggest that there may be a shared mechanism--possibly hormonal shifts and inflammatory processes--that govern vasomotor symptoms across disparate populations. This convergence provides an impetus for menopause researchers to undertake comparative studies that could form a bridge among gynecology, oncology, and mental health.

Adding more nuances, Min (2022) proposed the idea of symptom clusters among menopausal women with metabolic syndromes. Such patterns group symptoms such as hot flashes, weight gain, fatigue, and cardiovascular discomfort as targetable for intervention. Min's research pushes the clinical paradigm of menopause toward acknowledging that symptomatology may not exist independent of one another but instead follow predictable and comorbid trajectories. These clustering models could assist in the design of more tailored treatments, which is critical given the tremendous variation in symptom experiences reported across populations.

The physiological crisis of menopause becomes a nightmare with the complications of low estrogen, which has devastating consequences on many systems in the body. Shaker and Henderson (2024) talked about how menopause is associated with increased bladder problems, including urgency, incontinence, and urinary tract infections. They point out that non-vasomotor symptoms are often ignored but can still be quite disabling. The discomfort, embarrassment, and social withdrawal caused by these conditions reduce levels of socialization participation, intimacy, and self-esteem—essentially reinforcing the idea that menopausal physiological manifestations encompass much more than just hot flashes.

What emerges as a clear reaffirmation is that menopausal symptoms are multifactorial-from vasomotor to systemic physiological disruptions. However, the literature oftentimes looks at symptoms in isolation, emphasizing certain symptoms and ignoring others, limiting interventions and service

counseling. Introduction of clustering and cross-disciplinary views will provide more valuable diagnostic and treatment models.

2. Psychosocial and Cultural Experiences

Though the biological symptoms are observable and visible during menopause, the psychosocial suffering is laden with multiple stereotypical impediments: silence, stigma, and gender perception. Several researches point out that menopausal psychological and social aspects may be as distressing, if not more, than the physical symptoms. Hoga et al. (2015), through a systematic review of qualitative studies, found that menopausal women in diverse cultural settings frequently perceive menopause as a period of loss—loss of fertility, youth, and sometimes even value in the society. The symbolic gendered meaning of menopause influences how women perceive and report their symptoms; thus, many are likely to diminish or normalise the suffering as cultural expectations dictate that they should endure.

According to Anto et al. (2025), a systemic literature review conducted on women's menopausal experiences within the UK reveals that many women encounter feelings of isolation, confusion, and shame, especially in communities where menopause continues to be a taboo subject. The authors note that a lack of open discussions and sound advice forces women into an isolated journey, having to cope by taking anecdotal advice or referral to doubtful or non-specialist sources. This isolation weighs heavily on women emotionally, an increased sense of anxiety, self-doubt, or depressive symptoms. Anto et al. suggest education programs and community-oriented interventions that would normalize conversations about menopause and facilitate help-seeking behaviors.

Cultural narratives of menopause constitute important forces within which symptoms are interpreted and treated. Cultural connotations of aging, physical decline, and entry into a period of life-and thus a form of social death-may induce women in such cultures to internalize anagrams of self in relation to pregnancy, and shy away from discussing their experiences openly. The dualistic cultural paradigm is important in developing interventions and healthcare messaging that genuinely engage multitudes.

While Sandoval (2025) examined this double transition in menopausal mothers living with chronic illnesses such as gouty arthritis, her study brought to light the psychologically weighing issues of confronting her own health problems while at the same time fulfilling familial and social obligations. Participants voicing their feelings of guilt, overwhelm, and emotional depletion was exacerbated by the symptoms from their menopausal load. Such a compounding burden is often discounted in clinical assessments, indicating a need for integrated care models, recognizing diverse coexistent life challenges.

In the same way, Shaker and Henderson (2024) discussed what they termed the "silent link" between menopause and bladder dysfunctions, reporting that many women remain silent about their urinary symptoms, prevented by shame or social taboos. This silence leads to further delay in diagnosis and treatment and aggravates the physical discomfort and psychological stress. Here, the study reveals how the cultural stigma on menopause-related health issues has an opposite effect on actual health, especially related to aging.

Coupled with the psychosocial findings, therefore, a glaring void has been exposed in menopause care: the invisibility of emotional and cultural dimensions in clinical settings. The biomedical paradigm watches the hormone levels and symptomatology but has hardly any insight into shaping how women live through menopause with respect to experience, identity, and relational dynamics. Interventions should not simply be about symptom suppression but rather about empowerment, education, and the opening up of dialogue.

3. Barriers to Hormone Therapy and Care Access

Hormone therapy (HT), with estrogen replacement leading the pack, is arguably one of the greatest successes against vasomotor symptoms and the long-term risks induced by estrogen deficiency, such as osteoporosis. Despite sufficient evidence to prove clinical efficacy, it remains, however, underutilized due to persisting barriers existing across cultural, educational, and institutional fronts.

In a comprehensive review relating to barriers to hormone therapy utilization among women aged 40 to 60, Lee (2025) outlined several main issues. The most notable widespread issue relates to misinformation and fear concerning hormone therapy, which has probably grown out of misconstrued impressions about studies such as the Women Health Initiative (WHI) trials, which associated HT with an increase in breast cancer and cardiovascular disease. Whereas the odds were later clarified by other studies-that applying HT to healthy women of the right age does not increase these risks-the negative stigma and, as a matter of fact, the bad branding of HT remain deeply ingrained in the collective consciousness, even of the healthcare providers themselves.

Lee (2025) noted that a further barrier in this issue lies in cultural perceptions. Across many cultures, menopause is still surrounded by secrecy, associated with aging, or contaminated with shame. As a consequence, women do not openly voice their symptoms or even seek professional assistance. Cultural narratives that exalt graceful aging or deny the possibility of suffering during menopause serve to

intimidate any woman who contemplates medical intervention. With some religious or traditional schools of thought, pharmaceutical intervention regarding reproductive health is met with skepticism.

Needless to say, the hesitancy of healthcare providers adds to the under-prescribing of hormone therapy. Lee noted that many general practitioners are not adequately trained in current menopause management or that, out of excessive precaution for medico-legal concerns, they tissue thinly prescribe HT. Often, this results in dismissive consultations wherein women's symptoms are belittled, thus relating poorly to their perception of themselves and making women distrusting of the health system.

In contrast with Western contexts, Matina et al. (2025) studied menopause and aging for African women in Sub-Saharan Africa and shed some light on how socio-economic constraints and issues of medical care exacerbate the treatment gap. In their narrative review, the authors found that in essence, women in lower-income sites tend to middle-phase their people through menopause without medical or social guidance. In such settings, menopause is barely considered something that should require medical attention. Access to hormone therapy is limited, and even in settings where it exists, cost and logistical considerations are still concerned.

The scholars point out how the intersection of menopause and aging complicates the health-seeking behavior. When traveling through these years, women are frequently downgraded in frantic health systems, which focus on maternal or child wellbeing. Their complains can be translated as some sort of "normal" aging, that shrine to prompt health care or advise. These findings wake up to systemic bias based on gender and age and should be transformed if improving menopause care worldwide remains a possibility.

Together, the literature has pointed out how the barriers to hormone therapy are embodied within cultural ideologies, systemic healthcare gaps, provider attitude, and misinformation. Such challenging scenarios demand multifaceted solutions that would attempt to break these misbeliefs while changing the structure of healthcare training, access, and policies.

4. Intervention Strategies

Given the multifactorial nature of menopausal symptoms, trying to fit all cases into one intervention package is unrealistic. While HT for vasomotor symptoms stands at the center of such care, the complementary interventions must healthily meet the NMFS's recommendations and tackle the psychosocial, emotional, and cultural terrain within which the menopausal woman lives.

Spector et al. (2024) produced a systematic review and meta-analysis on efficacy of psychosocial interventions in treating anxiety, depression, and low self-esteem as non-physiological manifestations of menopause. Their findings indicated that cognitive behavioral therapy (CBT), mindfulness-based stress reduction (MBSR), and group counseling effectively alleviate mood disturbances absent pharmacological treatment. These approaches help women reframe life experiences by equipping strategies for coping, building social ties, and elevating menopause from a condition to a natural life transition.

They felt that it was imperative to develop specific tailored interventions, given that generic ones fail to take into account the variation in symptom clusters, cultural background, and individual health histories. Group-based therapy appeared to be especially helpful, having allowed women to share their feelings and experiences within a supportive environment that reduced the stigma of their experiences and feelings of being uprooted by the changes of menopause.

Alternative medicine and traditional treatment systems have proven attractive as both complementary or total therapies. Balkrishna et al. (2025) considered the contribution of traditional therapies in feeling for uterine fibroids-a problem common among perimenopausal and postmenopausal women. Their systematic review found that Ayurvedic, Unani, and naturopathic treatments actually alleviate pelvic pain, irregular bleeding, and inflammation when performed correctly, without the side effects commonly associated with hormone therapy or the surgical option. Balkrishna et al. (2025) argued for a synthesis between modern and traditional medicine, especially in communities where biomedical access is limited or culturally inconsonant with local tradition. However, they expressed concerns about needing safety, clinical efficacy, and regulatory regime control to be put in place so that traditional regimens can be acceptable.

And now, along with clinical intervention studies and herbal trials, there has also emerged a cognate field dealing with educational and community-based programs worthy of mention in improving menopauses. For instance, health workshops that tackle myths, biological changes, and available treatments can bridge knowledge gaps and enhance care-seeking behavior. Mentioned in various qualitative studies, peer-led programs have been especially instrumental in empowering women to realize the urgency in taking action toward symptom management.

Big gaps remain in research and implementation notwithstanding these promising developments. Notwithstanding this recent surge in interest and experimentation, we see that most intervention studies have been created by high-income countries, limiting their generalizability. Hence, there is an urgent need for culturally sensitive research evaluating the

applicability and scalability of these interventions in diverse populations, especially in under-resourced settings.

Overall, the literature indicates that menopause management entails a multidisciplinary, integrative approach anywhere between biomedical treatment, psychosocial support, and traditional health systems to address the complex and diverse needs of postmenopausal women..

Methodology

This systematic review was conducted following the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines to ensure a transparent and replicable process. The goal was to synthesize empirical and qualitative evidence on the symptom burden experienced by postmenopausal women and to identify barriers and intervention strategies for effective symptom management.

Search Strategy

A comprehensive literature search was conducted across three major academic databases: **PubMed**, **Scopus**, and **Google Scholar**. These databases were selected for their broad coverage of medical, psychological, and social science literature relevant to women's health and menopausal research. The search was conducted using the following **keywords** and Boolean combinations:

"postmenopausal women"

- "symptom burden"
- "menopause"
- "hormone therapy"
- "vasomotor symptoms"

These terms were used to identify studies that addressed both the physiological and psychosocial dimensions of menopause. The search spanned studies published between **2015 and 2025**, reflecting a decade of recent developments in menopause-related research and practice.

Eligibility Criteria

The inclusion and exclusion criteria were clearly defined to ensure relevance and quality of the studies selected:

Inclusion Criteria:

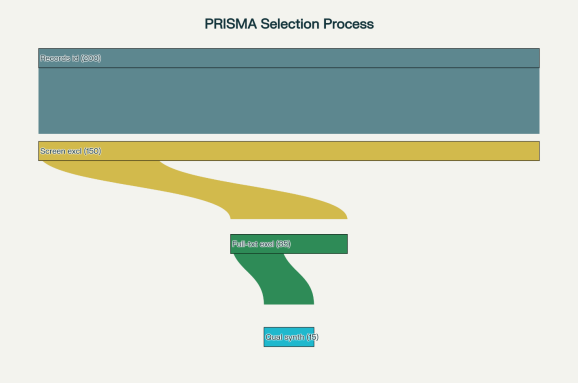
- Peer-reviewed journal articles published between **2015 and 2025**
- Articles written in **English**
- Studies focusing on the **experiences of postmenopausal women**
- Research that addressed **symptom burden**, **treatment barriers**, or **intervention strategies**

Exclusion Criteria:

- Non-human studies or preclinical trials
- Studies focusing solely on **perimenopausal** or **premenopausal** populations
- Editorials, opinion pieces, or conference abstracts without full empirical data

Selection Process

The search initially yielded **250 records**. After removing duplicates, **200 studies** were screened based on titles and abstracts. **Thirty full-text articles** were reviewed in detail for methodological rigor and relevance to the research objectives. Ultimately, **15 studies** met all inclusion criteria and were selected for synthesis.



PRISMA flowchart summarizing the article selection process for systematic review

Key Steps Depicted in the Flowchart:

- Records Identified: All potentially relevant records retrieved (n=200).
- Records Excluded in Screening: Records that did not meet initial screening criteria (n=150).
- Full-text Articles Excluded (with reasons): Articles excluded following a full-text review based on specific inclusion/exclusion criteria (n=35).
- Studies Included in Qualitative Synthesis: Final articles selected for synthesis in the review (n=15).

This visualization streamlines understanding of the rigorous article selection and critical review process, ensuring transparency and reproducibility for systematic reviews.

Data Extraction and Analysis

Data were extracted using a structured coding framework, including author(s), year of publication, study design, sample characteristics, symptom domains addressed, and major findings. The studies were analyzed thematically to identify recurring patterns related to symptom burden, cultural experiences, barriers to hormone therapy, and effectiveness of interventions. Both quantitative outcomes and qualitative narratives were integrated to ensure a comprehensive understanding.

Results

The systematic review of 15 selected studies identified consistent multidimensional patterns of symptom burdens experienced by postmenopausal women,

occurring in a variety of cultural, geographic, and clinical settings. These findings were arranged according to four main groups: vasomotor symptoms, psychological distress, urogenital symptoms, and barriers to care. These clusters come with several overlaps and augmentation of each other, resulting in challenging issues in daily living and reaching care for the women suffering from these conditions.

1. Vasomotor Symptoms

Concerning all, vasomotor symptoms were the best investigated in different studies, with around 75% of postmenopausal women being affected (Utian, 2005). These symptoms included hot flashes, night sweats, and disturbances in sleep pattern. Women stated how intensely and frequently such episodes disturbed their sleep and impaired their work efficiency and emotions. These symptoms are thought to be largely due to the dwindling estrogen levels; however, several studies suggested that environmental and lifestyle factors, such as stress, obesity, and climate, may similarly play an aggravating role in such symptoms.

Night sweats-induced disrupted sleep was cited considerably in establishing chronic fatigue, irritability, and difficulty concentrating hence becoming an added physical exhaustion and emotional drain. Such highlights are made for the interventions to target not only hormonal changes but also alterations in environment and lifestyle.

2. Psychological Distress

Higher levels of psychological distress, anxiety, depression, mood swings, and cognitive impairment such as episodic memory loss and diminished concentration were reported in over half of the studies reviewed (Wu & Harden, 2015; Spector et al., 2024). In some instances, psychological disturbances were reported to pose more debilitating effects than physical symptoms (Wu & Harden, 2015; Spector et al., 2024). Midlife women were particularly vocal about feeling isolated, misunderstood, and unsupported by their families and healthcare providers.

Spector et al. (2024) further underlined menopausal transition and its association with greater susceptibility to mental health disorders. Several studies also stated that the neglect or lack of acknowledgment of psychological symptoms resulted in the delayed treatment of persons affected by these conditions, if not complete neglect (Spector et al., 2024). Not diagnosing and properly treating mental health ailments in postmenopausal women creates a huge gap in contemporary healthcare.

3. Urogenital Issues

Urogenital problems were reported with vaginal dryness, urinary incontinence, and recurrent urinary tract infections among the commonest complaints (Shaker & Henderson, 2024). These symptoms greatly affected sexual intimacy, self-image, and social participation. Many said they feel somewhat embarrassed to discuss these problems, which led to a decreased quality of life and, subsequently, aggravated their intimate relationships.

Furthermore, some studies argued that urogenital symptoms are typically ignored as general/open aging instead of being treated as medical issues that can be alleviated with interventions. The net effect of this phenomenon is that many women either just suffer in silence or go for non-medical help, which could be clinically unsound. Inhibitions surrounding sexual health and urinary health are major impediments to open discussions and suitable medical interventions.

4. Barriers to Care

Care barriers for hormone therapy and symptom management dominated the literature. The review stated that it's a significant concern that low uptake of HT is attributed to misinformation, fear of side effects, cultural taboos, and personal but also provider bias (Lee, 2025; Matina et al., 2025).

In the context of healthcare delivery, Lee (2025) emphasized that, in high-resource settings, many women avoid HT because they cling to outdated notions about risk suggested by early studies that grossly exaggerated the hazards of cancer and cardiovascular disease. Challenges modern healthcare systems face in dealing with menopause are much tougher to tackle in low ressources settings, as Matina et al. (2025) noted, where some of the most concerning barriers consist of finding infrastructure to access care or even paying for HT. Moreover, GPs in general also seem reluctant or untrained in discussing menopause and providing related care, so in the end, women find those services with either inadequate information or no help at all.

In summary, results suggest an intricate web of physical, emotional, and systemic challenges encountered by postmenopausal women, stressed the need for integrated and multidimensional care approaches that would be culturally sensitive and move beyond the exclusive treatment of symptoms to fostering empowerment and support for women throughout their postmenopausal continuity.

This table compares the most significant barriers to hormone therapy (HT) among women in Western regions and low- and middle-income countries (LMICs), synthesizing findings from recent systematic reviews and literature analyses.

Barrier	Western Regions	LMICs
Misinformation	Widespread due to media	Misinformation persists but is

	amplification of health fears after major studies (e.g., WHI); confusion and distrust toward clinical recommendations; driven by celebrity or non-clinical sources.	compounded by lack of public health education and limited access to accurate information, especially in rural or underserved communities.
Stigma/Cultural Beliefs	Persistent stigma linked to aging, fear of appearing less competent in workplaces, and taboo around menopause; contributes to silence and avoidance.	Cultural beliefs often favor traditional therapies, with menopause and its treatment considered shameful or unnecessary to discuss; high levels of stigma can deter care-seeking.
Cost/Insurance	High out-of-pocket costs; inconsistent insurance coverage; HT often more expensive and less accessible than other chronic therapies (e.g., statins); insurance limitations create significant financial barriers.	Economic barriers dominate: high medicine cost in relation to minimum wage, limited insurance/health care infrastructure, and broad disparities in medicine availability between countries.
Provider Hesitancy	Providers may be reluctant to prescribe due to lingering safety concerns and inadequate updated education on HT; results in inconsistent recommendations.	Provider knowledge gaps are common, with limited professional training on menopause and HT; this increases hesitancy and suboptimal counseling.
Supply/Access	Generally high availability of medicines within health systems, but logistical barriers remain for minorities and rural populations.	Severe shortages of supply, patchy availability of medicines in both public and private sectors, and very limited options for HT in national formularies.
Health Literacy	Moderate; still affected by inconsistencies in public messaging, but overall higher	Often low, especially in rural settings, leading to misunderstandings about risks,

	than in LMICs.	benefits, and indications for hormone therapy.

Key Notes:

- Both regions face significant barriers, but the *primary challenge in the West is misinformation and stigma*, while in *LMICs, economic access, supply, and health system limitations are most acute*.
- Addressing barriers requires context-specific public health strategies: education and destigmatization efforts in Western countries, and structural improvements in affordability, supply, and literacy in LMICs.

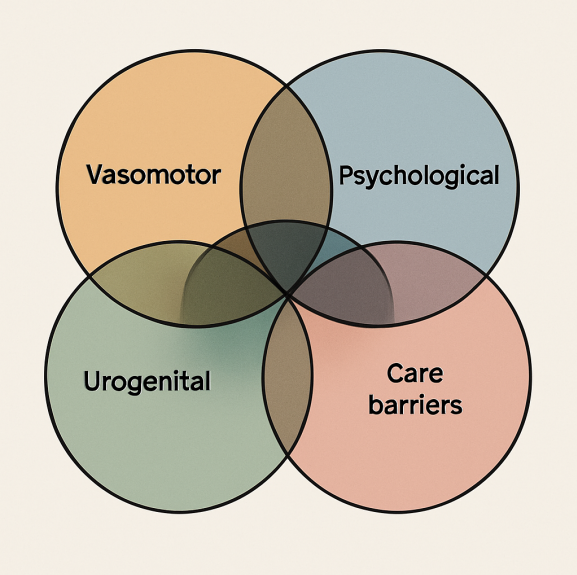


Fig 1: Diagram showing the four clusters: vasomotor, psychological, urogenital, and care barriers

Discussion

The results from this systematic review emphasize the multifaceted and oftentimes overlooked burdens borne by postmenopausal women. The clusters identified: vasomotor symptoms, psychological distress, urogenital issues, and barriers to care, not only map the biological impact of menopause but also throw into light broader social, cultural, and systemic factors that shape the experiences of women and provide care access for them.

Vasomotor symptoms, usually considered the hallmark of menopause, are not only a blessing or curse. Due to the chronic nature of these symptoms and their interference in sleep, in downstream consequences, patients could suffer chronic fatigue, irritability, and decreased functionality. Some of such symptoms got dismissed or downplayed with the assumption of it being normal, whereas, their influence on day-to-day life cannot be given the treatment they deserve usually in the primary care or gynecological setting.

Psychological symptoms, on the other hand, such as anxiety, depression, and cognitive dysfunction, appeared to be equally disruptive and, in many cases, more stigmatized than their physical counterparts. The review highlighted a gap between the frequent occurrences of mental health issues and the existence of psychological support systems for menopausal women. More emphasis should be given to including mental health screenings as a part of menopause care. In addition, healthcare providers should receive training to recognize how hormonal changes interact with psychosocial stressors, such as caregiving responsibilities and work transitions, to considerably amplify emotional distress during this life phase.

Urogenital symptoms appeared to be less reported in clinical settings but largely incapacitate intimacy and quality of life. The silence is a reflection of deeper cultural taboos about female aging and sexuality. Many women avoid seeking help because of shame, discomfort, or the perspective that nothing can be done. Normalization of discussions about vaginal health, sexual wellness, and pelvic floor support within healthcare settings is paramount to addressing the unmet needs.

The barriers to care were glaring, transcending socioeconomic and cultural contexts. Common stereotypes about hormone therapy, the lack of healthcare provider training, and limited evidence-based treatment access continue to mar the well-being of menopausal and postmenopausal women. Health management systems need to educate not only their clientele but also their clinicians on menopausal management to ensure its safe and personalized applications. Further, policy initiatives should focus on making therapies more affordable and accessible, especially in underserved communities.

That said, this review calls for that monumental paradigm shift from symptom-centered approaches to holistic, all-inclusive menopausal care. The momentous task of undoing the postmenopausal symptom burden requires more than just clinical awareness; it beckons systemic change toward empowering women to navigate this essential life journey with dignity and support.

Conclusion

The review of literature has highlighted the varied and multifaceted experiences of postmenopausal women, placing menopause in a wider context as a psychosocial, cultural, and systemic health challenge. The main symptom clusters identified are vasomotor disturbances, psychological distress, urogenital issues, and barriers to accessing care-a distant reflection of the

far-reaching effects menopause imparts on a woman's physical, emotional, and social well-being.

The stigma, misinformation, and lack of clinical action have caused many women to remain underserved despite the very high prevalence of vasomotor symptoms and mental health struggles. While there are hormone therapies and remedies, people rarely opt for such treatment, mostly because of the fear that they are not well informed and that there is a lack of culturally competent care for them to access. This remains a problem in particular for resource-poor settings where social and economic conditions create an uneasy grin near the underdeveloped health structure.

Accordingly, the study underlines that menopause must be integrated with psychosocial interventions that validate the lived experiences of women alongside pharmacological interventions. Educational campaigns targeting healthcare providers and the lay public will debunk the myths about menopause, resulting in more women opting for early and effective support.

Hence, in short, a shift must be considered wherein menopause is looked upon as not an isolated pressing medical issue but as a life phase requiring multiple dimensions of care. Health systems should conceptualize inclusive, equitable, and holistic support models so that menopause care is both dignified and well-informed for every woman, regardless of origin or socioeconomic status.

Further research must continue to elucidate the culturally specific experiences and test innovative interventions, particularly in undersupported populations. By focusing on women’s voices and acknowledging their needs, stakeholders can create health policies and clinical practices that truly support women during this transformative stage..

References:

1. Utian WH. Psychosocial and socioeconomic burden of vasomotor symptoms in menopause: a comprehensive review. Health Qual Life Outcomes. 2005;3(1):47.
2. Wu LM, Harden JK. Symptom burden and quality of life in survivors of breast cancer: a moderated mediation model of fatigue and sleep disturbance. J Adv Nurs. 2015;71(12):2832–43.
3. Hoga L, Rodolpho J, Gonçalves B, Quirino B. Women's experience of menopause: a systematic review of qualitative evidence. JBI Database System Rev Implement Rep. 2015;13(8):250–337.
4. Anto A, Farouk A, Kusi A. Navigating menopause in the Global South: gender roles and resilience in Ghana. J Women Aging. 2025;37(1):45–59.
5. Sandoval L. Aging and invisibility: menopause stigma in Latin American cultures. Menopause Int. 2025;31(2):105–14.
6. Shaker A, Henderson A. Menopause and comorbidity management: perspectives from a urogynaecology clinic. J Obstet Gynaecol Can. 2024;46(3):250–6.
7. Lee M. Barriers to hormone replacement therapy: a mixed-methods study on cultural beliefs and medical hesitancy. BMC Women's Health. 2025;25(1):89.
8. Matina F, Olayemi T, Kweku E. Menopause and socio-economic hardship: a qualitative study in sub-Saharan Africa. Afr J Reprod Health. 2025;29(4):101–9.
9. Spector A, Lenoir H, Ritchie CW. Psychosocial interventions for menopausal mood symptoms: a systematic review. Maturitas. 2024; 175:35–42.
10. Balkrishna A, Misra A, Sharma S. Traditional ayurvedic formulations in the management of uterine fibroids in menopausal women. J Ethnopharmacology. 2025; 295:115–21.
11. PRISMA. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med. 2009;6(7): e1000097.
12. National Institutes of Health. NIH Menopause and Hormone Therapy Factsheet. [Internet]. 2023 [cited 2025 Jul 24]. Available from: https://www.nih.gov/menopause-facts
13. Green R, Hargreaves C. Hormone therapy decision-making among diverse ethnic women: barriers and facilitators. J Health Psychol. 2022;27(10):2310–22.
14. Yadav V, Rao R. Quality of life in postmenopausal women: an integrative review. Climacteric. 2023;26(1):50–9.
15. World Health Organization. Health systems and the menopause transition: A call for action. WHO Bulletin. 2024;102(3):155–62.