

The menopause support gap 2026: addressing *muscle* *and joint pain* at work

For HR, Benefits, Health and Wellbeing and Rewards leaders



FOREWORD

Musculoskeletal health — the chapter most menopause action plans *still miss*

When menopause first became a workplace conversation, the focus was rightly on the symptoms most people had been told to keep private: hot flushes, brain fog, disturbed sleep, mood changes. That conversation is now, at last, a normal part of the benefits agenda. The Employment Rights Act 2025 has created a voluntary route for large employers to publish action plans addressing menopause, with mandatory publication planned from spring 2027, subject to secondary legislation.

But the workplace conversation is still missing a large piece of what actually happens to a woman's body around menopause.

In general practice I saw the same pattern repeatedly. A woman in her late forties or early fifties would come in for what she thought was a knee, a shoulder, a stiff hip, or lower-back pain that had crept in and stayed. It rarely arrived with a menopause label attached. It rarely left with one either. In 2024, Wright and colleagues proposed the term 'musculoskeletal syndrome of menopause' to draw attention to these symptoms. In their published review in *Climacteric*, they estimate that more than 70% of women will experience musculoskeletal symptoms through the menopausal transition, and around 25% will be disabled by them. In our own VIDA data, menopausal women report more pain than the desk-work baseline, and average reported pain that was higher in post-menopause assessments than in perimenopause assessments (3.8 versus 3.4 out of 10). Hot flushes come sixth on the symptom list they report to us, behind tiredness, memory changes, sleep, concentration and mood.

The point of this whitepaper is not to reintroduce menopause. Others have done that well. It is to put musculoskeletal health back into the picture so that when your organisation writes its menopause action plan, the physical side of a menopausal employee's day at work is not the part that gets left out.



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Contents

1	Executive summary	04	7	The chapter most plans still miss	16
2	Why this whitepaper, in 2026	05	8	What a credible MSK offer should do	18
3	What menopause looks like in the VIDA data	07	9	How Vitru VIDA fits in a MAP	20
4	Where MSK sits in menopause	10	10	In summary	21
5	Movement is the most consistent lever	12	11	Glossary	22
6	What the Employment Rights Act requires	14	12	References	23



This edition puts musculoskeletal health back into the menopause conversation, drawing on Vitru Health's own VIDA platform data and the wider clinical and workplace literature.

SECTION 1

Executive *summary*

EXPERIENCE MSK SYMPTOMS

>70%

of women, through the menopausal transition (Wright et al, 2024).

LEFT DISABLED BY SYMPTOMS

~25%

of women find these symptoms disabling.

Menopause action plans are moving towards mandatory.

Employers with 250 or more employees can currently publish voluntary action plans addressing the gender pay gap and menopause. The government intends publication to become mandatory from spring 2027, subject to secondary legislation [1, 3].

Workplace menopause support should explicitly address muscle and joint pain, alongside other symptoms that can affect working life.

Most published guidance now covers policy, manager training, occupational health, symptom awareness and specialist clinical support. Musculoskeletal pain, one of the most common physical symptoms women report through perimenopause and into post-menopause, is still rarely named in the MAP conversation. Wright et al (2024), writing in *Climacteric*, estimate that more than 70% of women experience musculoskeletal symptoms through the menopausal transition and around 25% are disabled by them [8].

**The practical implication for a MAP is straightforward**

A plan that overlooks musculoskeletal symptoms may miss an important part of employees' experience. Whether adding MSK support changes absence, retention or pay-gap outcomes would need separate evaluation. This whitepaper explains why, using our own VIDA data, and sets out what a MAP-ready MSK provision should look like.

SECTION 2

Why menopause and musculoskeletal health deserve attention in 2026

Menopause is now one of the most active areas in workplace health. In the space of two years it has moved from an emerging conversation to a legislated, published priority, and the clinical picture of what menopause does to the body has advanced just as quickly. This edition reflects both shifts.

Three shifts sit behind this edition:

The Employment Rights Act 2025 has moved menopause from optional to published.

Under the ERA, employers with 250 or more workers must publish a menopause action plan alongside their gender pay gap report. Voluntary publication opened on 6 April 2026, with mandatory requirements to follow in 2027 [1, 3]. Employers with 250 or more employees can currently publish an action plan, with mandatory publication planned from spring 2027 subject to secondary legislation. It will be visible to employees, candidates and comparable across the sector. Employers can describe their chosen actions and how they intend to track progress. Anonymised engagement and outcome data may also help them evaluate their provision.

Retention pressure remains material.

The UK Government's 2024 Shattering the Silence about Menopause: 12-Month Progress Report confirms approximately four million women aged 45 to 55 in UK employment, 27% reporting negative impact on career progression, 13% considering leaving their job because of menopause, and around 1 in 10 women aged 40 to 55 who have actually left a job for this reason [4]. CIPD's Menopause in the Workplace research (October 2023, n = 2,185) found 67% of affected women reported mostly negative workplace effects and 53% had been unable to attend work due to symptoms at some point [5].

In the CIPD survey, only around one in four of female employees aged 40–60 said their employer had a menopause policy or other support measures. That is the case both in the CIPD's employee-side data and in the wider gov.uk 2024 progress report [4, 5]. The gap between demand for support and provision of it is what the Employment Rights Act 2025 is now closing by statute. Losing an experienced employee carries costs beyond recruitment. In a 2014 study covering five UK sectors and employees earning £25,000 or more, Oxford Economics estimated an average replacement cost of £30,614, including £25,181 in lost output while a new employee reached full productivity [7].

WHY THIS WHITEPAPER · THE COST LENS

A few widely-cited industry figures put a scale on this:

- 1 14 million working days a year are lost in the UK to menopause symptoms alone** (Health & Her / Censuswide, 2019, referenced in the UK Government's 2024 progress report) [4, 9].
- 2 In the UK, musculoskeletal conditions are a leading driver of sickness absence.** HSE reports 7.1 million working days lost in 2024/25 due to work-related MSK disorders, while broader all-cause MSK burden has been estimated at 23.4 million working days lost in 2022.
- 3 Musculoskeletal disorders carry a global economic cost.** A study published in 2025 estimated their macroeconomic burden at approximately US\$2.1 trillion in 2021, equivalent to 1.41% of global GDP. Low back pain alone accounted for around US\$0.9 trillion of that total.

The retained industry figures should be read alongside primary UK sources such as the gov.uk 2024 progress report and the CIPD 2023 study, which give the most defensible current UK-specific numbers.

The gap this paper is written to close

Most of the published response to that pressure has focused on policy, manager training, EAP access and specialist clinical care. All are necessary. None address MSK. That is the gap this paper is written to close.

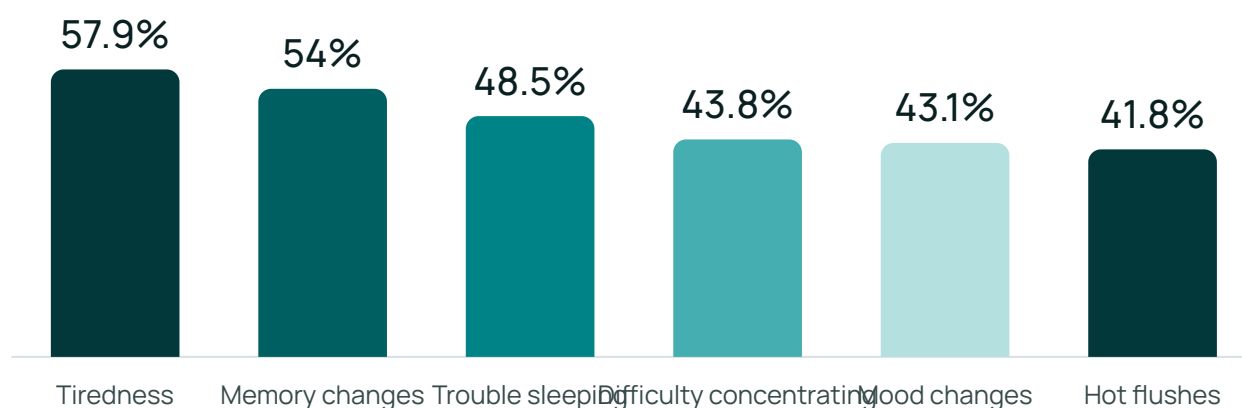
SECTION 3

What menopause actually looks like in the *VIDA* data

Vitruue's VIDA platform has now completed more than 17,000 wellbeing assessments across UK desk-based workforces. A recent 2026 extract of 763 menopause-specific assessments, alongside the wider dataset, lets us describe what women report to us rather than what the public narrative assumes. Three findings from that extract are worth sitting with.

3.1 The symptoms most reported are cognitive and fatigue-based, not vasomotor

Percentage of menopause assessments reporting each symptom, n = 763. Multiple symptoms could be selected.



Hot flushes are the sixth-most-reported symptom in this sample. That does not make them unimportant, but it does say something about how public discussion of menopause has narrowed the picture. In these assessments, tiredness, memory changes, trouble sleeping and difficulty concentrating were each reported more frequently. For leaders, this is a reason to listen broadly and build support around the range of symptoms employees report.

WHAT THE VIDA DATA SHOWS · CONTINUED

3.2 Average pain was higher after menopause than during perimenopause

Stage	Avg. symptom count	Avg. max pain (0–10)
Perimenopause	4.2	3.4
Post-menopause	3.3	3.8

Fewer symptoms do not necessarily mean less pain. In this sample, post-menopause assessments recorded an average symptom count around 21% lower than perimenopause assessments (3.3 versus 4.2), while average maximum pain was around 12% higher (3.8 versus 3.4). For employers, these findings suggest that musculoskeletal support should remain available after the menopausal transition, even when other symptoms ease.

3.3 Lower back is the number-one pain site in each of the five assessment groups

Ranked by percentage of assessments in each life stage reporting pain there.

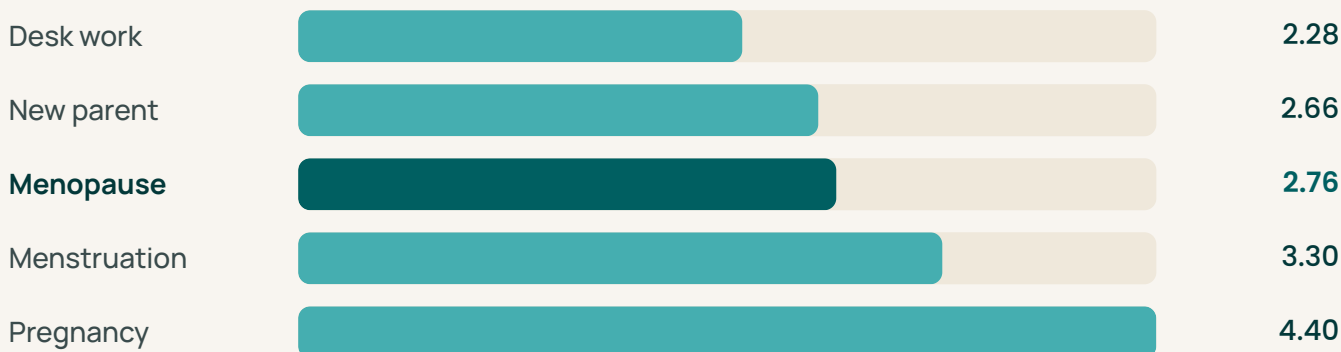
Life stage	#1 pain site	Prevalence
Desk work (baseline)	Lower back	25.0%
Menstruation	Lower back	31.9%
Pregnancy	Lower back	51.9%
New parent	Lower back	30.9%
Menopause	Lower back	23.3%

Lower-back pain was commonly reported across the groups examined, but these data do not explain its causes. For employers, the practical priority is to understand each employee's pain and how it affects daily activities and work, so menopause support can respond to individual needs.

THE VIDA DATA IN CONTEXT

Where menopause pain *sits*

Menopause pain profile in context. Averaged max pain across five life-stage assessments (0–10 scale):



Menopause sits above the desk-work baseline and above new parenthood – and it sits at a career stage where absence and attrition are most expensive to the organisation.

SECTION 4

Where MSK sits in menopause, and why it *gets missed*

The clinical link between menopause and musculoskeletal pain is well-established and, since 2024, has a named clinical concept: the musculoskeletal syndrome of menopause, proposed by Wright and colleagues in Climacteric [8]. Their review argues for treating the cluster of arthralgia, muscle loss, bone-density decline and progressing osteoarthritis around menopause as a single, recognisable syndrome rather than as isolated complaints. They estimate more than 70% of women will experience these musculoskeletal symptoms through the menopausal transition, and around 25% will be disabled by them.

Bone health deserves a place in every workplace menopause strategy. Bone-density loss after menopause increases osteoporosis risk. The links with joint pain and osteoarthritis are more complex, making it important for employers to recognise different MSK needs and help employees access appropriate support. The result shows up as:

- **Joint stiffness**, most commonly in knees, hips and hands, from reduced synovial lubrication.
- **Muscle loss**, at a faster rate than in the pre-menopausal years, which increases strain and pain sensitivity.
- **Increased risk of osteoporosis and osteoarthritis**, from bone thinning and joint inflammation.
- **A lower threshold for chronic pain to become embedded**, particularly in the lower back, neck and hips women are already using intensively at desk work.

Clinicians have long recognised musculoskeletal symptoms around menopause, although the proposed umbrella concept and its underlying mechanisms remain under study. For employers, the practical question is how to give MSK health a clearer place in menopause support. Three considerations can help.

WHERE MSK SITS · THREE CONSIDERATIONS

MSK does not present as a menopause symptom.

A woman with a sore knee books a GP appointment for a sore knee. She rarely connects it to hormonal change, and neither does the manager she quietly stops joining for the office run.

Menopause support pathways were built around specialist consultations.

HRT, GP or specialist advice, and access to therapy all have a place in menopause care. Workplace MSK support can build on that care by addressing pain, physical function and the demands of the working day, helping employers turn their menopause offer into practical, everyday support.

MSK sits under a different budget in most organisations.

Menopause tends to sit with reward, benefits or D&I. MSK sits with health and safety, PMI or DSE compliance. That structural separation is a large part of why menopause action plans do not include MSK provision by default. Nobody is doing anything wrong. The org chart is doing what org charts do.

The consequence for employees

The physical side of menopause is often the least supported. A woman gets a helpline number, a manager training deck and a policy document. She does not get anything that addresses the lower-back and joint pain that is actually making it harder for her to sit at her desk for a full day.

SECTION 5

Movement is the most consistent *lever* we see

The data highlight a link between activity and pain. In an extract of 16,292 assessments, higher self-reported exercise frequency was associated with lower reported pain among women and men.

Average maximum pain

By exercise frequency (0–10 scale).

Frequency	Female	Male
Never	3.49	2.60
1× / week	3.07	2.36
2× / week	2.68	2.04
3+ × / week	2.35	1.68

Share reporting high pain

Reporting ≥ 7 / 10.

Frequency	Female	Male
Never	21%	11%
1× / week	15%	10%
2× / week	11%	7%
3+ × / week	9%	5%



~1/3 lower reported pain

Employees who reported exercising three or more times a week had approximately one-third lower average maximum pain than those reporting no exercise. Three points fall out of this that matter for a menopause plan.

MOVEMENT IS THE MOST CONSISTENT LEVER · CONTINUED

The pain-reduction effect is real and substantial.

More frequent exercise is linked to lower reported pain. Employees who reported exercising three or more times a week had approximately one-third lower average maximum pain than those reporting no exercise. For employers, this adds context to the case for accessible activity opportunities within a broader MSK offer.

Make it easier to get started.

Among women, the largest difference in average reported pain was between those who reported never exercising and those exercising once a week. Men showed a different pattern, with the largest difference between twice and three or more times weekly. These associations do not prove that exercise reduces pain, but they offer a useful starting point for workplace support: accessible opportunities for employees with different activity levels.

The gender gap in pain does not close with exercise.

At every activity level, women report 30 to 40% more pain than men. Women who exercise three or more times a week (2.35) still report more pain than men who exercise twice a week (2.04). More activity, lower reported pain. The gender gap remains. It does not remove it. Higher self-reported exercise frequency was associated with lower average pain, but women reported higher average pain than men at every exercise frequency. That is a reasonable expectation to set for any physical-support intervention in a menopause plan: it will help, and it will not fully equalise.

In a separate extract of 15,582 assessments, women were less likely than men to report exercising three or more times weekly in every age band, including those aged 50 and over. These data do not establish the reasons for the difference. For employers, the opportunity is to understand what makes participation difficult and shape support around those needs. Short sessions during the working day and flexible ways to take part are options to explore with employees.

SECTION 6

What the Employment Rights Act *now* requires

The ERA has changed what a menopause offer has to demonstrate, not just what it has to contain. In outline [1, 2, 3]:

- The Employment Rights Act 2025 became law on 18 December 2025 and phases in through 2026 and 2027.
- Employers with 250 or more workers will be required to publish a menopause action plan (MAP) alongside their gender pay gap data.
- The government intends action-plan publication to become mandatory from spring 2027, subject to secondary legislation.
- Plans are published on the gender pay gap service, where they will be publicly visible and comparable across employers.
- Plans set out the steps the organisation is taking to reduce its gender pay gap, support employees experiencing menopause, and improve wider workplace gender equality.
- Government guidance for the menopause element names, among other example actions: manager training, occupational health advice, menopause support groups and networks, menopause risk assessments, and policy review [3].

MSK health belongs in the wider menopause risk picture

Government guidance includes menopause risk assessment as one possible action, covering factors such as temperature, facilities, working arrangements and ergonomic furniture. For HR leaders, MSK assessments can add insight into physical work factors and employees' support needs, contributing to a broader review of the working environment.

WHAT THE EMPLOYMENT RIGHTS ACT REQUIRES · IMPLICATIONS

Two implications for benefits leaders.

1

Generalist wellbeing tools that were adequate when menopause was a voluntary conversation are not automatically adequate for a published, comparable plan. The plan has to demonstrate specific, measurable action. Anonymised uptake and outcome data can help employers understand who they are reaching, where gaps remain and whether support is making a difference.

2

The plan will be read alongside every other MAP in the sector. That comparison is where organisations that treated menopause as a policy statement will look thin against organisations that treated it as a clinical and operational programme.



A published, comparable plan rewards employers who can show specific, measurable action on the physical side of menopause – not only policy and signposting.

SECTION 7

The chapter most menopause action plans *still miss*

Read across the current wave of menopause action plan guidance from the specialist providers – Peppy, Fertifa, Menopause Friendly UK, the major benefits consultancies – and a clear consensus is forming on what a credible MAP looks like. It typically covers:

- 1 A written menopause policy and periodic review
- 2 Line manager training on menopause conversations
- 3 Specialist clinical access: menopause GP, gynaecologist, HRT
- 4 Occupational health referral pathways
- 5 EAP-based emotional and psychological support
- 6 Peer support networks and internal awareness campaigns
- 7 Workplace adjustments: temperature, breaks, uniforms, flexible working

All of that is correct. All of it should be in a plan. And nearly none of it addresses the physical, day-to-day musculoskeletal pain that Wright and colleagues have now framed as a defining syndrome of the menopausal transition.

Read the shortlist again with that lens. There is a specialist for hormones. There is a policy for time off. There is a manager trained to have a supportive conversation. There is nobody whose job is to help a menopausal employee's stiff hip, sore lower back or aching shoulders. The physical symptom that VIDA data shows is the most consistent physical change across every women's health life stage is the one the plan is silent on.

THE CHAPTER MOST PLANS STILL MISS · CONTINUED

This is not a criticism of the current market. Menopause specialist providers built for hormonal and psychological care, and they should keep doing that. MSK falls into a different budget line, a different provider category and a different regulatory framework, sitting under DSE and HSE rather than benefits. The org chart is doing what org charts do.

The result, though, is that the physical layer of menopause support is where most MAPs will have their weakest section, and it will be the hardest section to defend when a published plan is read alongside every other plan in the sector.

The rest of this whitepaper is about what to do about it.

SECTION 8

What a credible MSK-in-menopause offer *should do*

Drawing on both the ERA guidance and our clinical experience across UK employers, we would test any menopause offer against four questions.

1 Does it cover perimenopause as well as post-menopause?

Symptoms and pain can affect working life before someone recognises them as menopause-related. Support should be available during perimenopause as well as after menopause, without requiring a formal diagnosis. For employers, that means responding to the difficulties employees report and helping them access appropriate support early. Existing legal duties may apply depending on individual circumstances. Provision that only activates post-diagnosis leaves the largest cohort unsupported: women in their forties who do not yet call it menopause but are already changing how they sit, move and sleep.

2 Does it address the physical, not just the informational?

A menopause helpline is a signposting service. It is not, in itself, an intervention for lower-back pain that has been present for eighteen months. A credible offer should include a route into structured, personalised movement and pain-management support that a woman can use at her desk, in her own time, without booking a clinician.

WHAT A CREDIBLE MSK OFFER SHOULD DO · CONTINUED

3

Can it be evidenced with anonymised outcome data?

A strong menopause action plan makes progress visible. Government guidance asks employers to explain how they will track their chosen actions. For your MSK offer, that means asking useful questions: who is using the support, what do employees think of it, and how are their pain and everyday comfort changing? Looking across roles and locations can also reveal gaps in reach. Anonymised data can help you understand what is working and where to improve, without needing to publish the underlying datasets.

4

Is it consistent across the workforce?

Access to support should not depend on who manages you or where you work. A clear, consistent route helps your menopause offer reach employees across roles and locations, with options that work for shift-based teams as well as those at London HQ.

Easiest to underestimate, hardest to retrofit

MSK is the piece of this that is easiest to underestimate and hardest to retrofit once a plan is public. It is also the piece for which the underlying evidence, in our data and the wider literature, is most consistent.

SECTION 9

How Vitruue VIDA *fits* inside a menopause action plan

VIDA is a workspace assessment and pain-reduction platform. It was built for desk-based workforces, and it is used at scale for DSE compliance in the UK and Ireland. What matters for a menopause action plan is what it does with the data it collects.

Assessment

VIDA runs each employee through a clinically-validated workspace assessment (webcam-based posture check, workspace layout, pain and symptom capture). For menopausal employees, that includes a symptom module covering the areas listed in Section 3.1.

Pain Coach

Employees with reported pain move into VIDA Pain Coach, a personalised exercise and management programme delivered through short videos and stretches that can be done at a desk or from home. This is the "second-session-is-easier" surface described in Section 5. Vitruue's State of MSK 2026 outcome study shows that regular Pain Coach users reduce their pain by at least 34% [10].

Analytics

The employer dashboard brings together engagement, symptom prevalence, setup scores and pain trends across the workforce. Where sample sizes and privacy safeguards allow, aggregated measures for employees experiencing menopause can help employers evaluate support and describe progress in their menopause action plan.

Consistency

VIDA is used at scale (up to 10,000 assessments in a single deployment), which means the same standard of provision reaches every employee, wherever they work.

None of that is a substitute for specialist menopause clinical care. It is designed to sit alongside it, and to close the MSK gap that specialist care alone does not address at scale.

SECTION 10

In *summary*

The market has moved on menopause faster than most benefits teams expected. The ERA has created a route for large employers to publish menopause-related action plans, with mandatory publication planned from spring 2027 subject to secondary legislation.

The next place the market needs to move is on the physical side of what menopause does to a working woman. Musculoskeletal pain is one of the most consistent physical changes through perimenopause and into post-menopause. It is also one of the least represented in the current menopause action plan discourse.

Vitruue's data suggests three things worth including in any refreshed plan:

- 1 Treat perimenopause as the start of the support window, not menopause.
- 2 Put MSK provision alongside specialist clinical care, not underneath it.
- 3 Build the plan on data you can publish, not intent you cannot evidence.

If you would like to walk through what a MAP-ready MSK layer looks like in practice, our team is happy to. Details are in the closing panel.

SECTION 11

Glossary

DSE (Display Screen Equipment)

The UK regulatory framework governing workstation risk for desk-based workers. Menopause risk assessment sits adjacent to DSE assessment in most organisations.

Gender pay gap service

The public UK Government service on which employers publish their gender pay gap data and, from 2026, their menopause action plans.

MAP (Menopause Action Plan)

A currently voluntary published plan for employers with 250 or more employees. Government guidance calls for at least one action on the gender pay gap and one supporting employees experiencing menopause, with at least two actions new or in progress.

Menopause

The end of a woman's reproductive years, defined by 12 consecutive months without a period, typically between ages 45 and 55.

Perimenopause

The transitional period before menopause, when symptoms may begin. Workplace support can start at this stage; applicable legal protections depend on individual circumstances under existing law.

Presenteeism

Being at work but not fully productive, usually because of unmanaged ill-health or pain.

ERA (Employment Rights Act 2025)

UK legislation enabling action-plan requirements for large employers. Publication is currently voluntary; mandatory publication is planned from spring 2027, subject to secondary legislation.

HRT (Hormone Replacement Therapy)

Prescription treatment used to replace declining hormones during menopause.

MSK (Musculoskeletal)

The system in the body that supports weight and movement, including bones, muscles, tendons, ligaments and soft tissues. One of the most common physical symptom areas in menopause.

Oestrogen

A hormone important for bone and muscle health. Hormonal changes around menopause may contribute to musculoskeletal symptoms, but pain can have multiple causes and the precise mechanisms remain under study.

Post-menopause

The phase after menopause. In VIDA data, pain scores are higher in post-menopause than in perimenopause even though symptom counts fall.

Workplace ergonomics

The setup and adjustment of the working environment to reduce physical strain. A common area of adjustment for menopausal employees experiencing joint pain or fatigue.

SECTION 12

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A note on sources and vintage

Sources in this whitepaper fall into three tiers, deliberately distinguished:

- 1 Primary and current (2024–2026).** The Employment Rights Act 2025, gov.uk guidance and progress reporting, Acas and NHS Employers guidance, Wright et al 2024 on the musculoskeletal syndrome of menopause, and Vitru's own 2025–2026 VIDA data.
- 2 Best-available UK workplace baseline (2022–2023).** The CIPD October 2023 report (n = 2,185) remains the most widely cited employee-side UK dataset. The Fawcett Society (April 2022) originated the "1 in 10 have left a job" finding, which the UK Government's 2024 progress report subsequently reaffirmed.
- 3 Retained industry figures with age labels.** The 14 million working days lost figure (Health & Her, Censuswide 2019) is validated by the gov.uk 2024 report. The 44 million working days combined MSK + menopause figure, the US\$1.69 trillion global productivity loss figure, and the £30,614 Oxford Economics replacement cost (2014) are retained from the 2023 edition of this whitepaper with their original citation dates on display. Where fresher, primary UK figures were available (as with the 14 million days figure), they are cross-referenced.

Where a figure carries a date older than the ERA legislation, we surface the date in the text so no reader treats it as current-vintage.

THE NEXT STEP

Make MSK health part of your *menopause support*

Turn your menopause commitments into practical support for musculoskeletal health. Vitruue VIDA combines personalised MSK assessments and tailored support to help employees manage pain and feel more comfortable at work. For HR, workforce insights help identify where support is needed, prioritise action and track progress.

VIDA helps you make MSK support a measurable part of your menopause action plan, responding to employees' needs through perimenopause and beyond.

Assessment

Pain Coach

Analytics



Book a VIDA demo to see what it looks like for your team.

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SCAN TO
BOOK A DEMO

