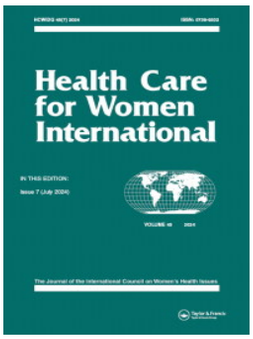

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How does women's health matter? A qualitative study on women's health issues in relation to work participation. Experiences and perspectives from nurses and managers in a Norwegian hospital

Marianne Gjellestad[a], Heidi Enehaug[b], Kristin Haraldstad[c], Vegard Nilsen[d] and Migle Helmersen[a]

[a]Department of Nutrition and Public Health, University of Agder, Kristiansand, Norway; [b]Work Research Institute, Oslo Metropolitan University, Akershus, Norway; [c]Department of Health and Nursing Science, University of Agder, Kristiansand, Norway; [d]Department of Public Health, Agder County Municipality, Arendal, Norway

ABSTRACT

In this article, we explore associations between women's health and participation in working life, work ability and sickness absence. Through interviews with nurses and hospital managers, we identified three main occupational barriers connected to biological and physiological sex differences: considerations on women's health, work organization and work environment as conditions for health, and equality and expectations in society. We find that individual experiences, job systems, and societal attitudes affect each other negatively, and that systemic problems tend to be individualized. The lack of recognition of women's health affects work participation, work ability and sickness absence in women, representing a challenge to female occupational health, as well as to gender equality and public health in general.

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Background

Working life is a primary area of improvement for gender equality, living conditions and public health in developed countries. The UN Sustainability Development Goals target women's participation in working life specifically at two points: Gender Equality (5) and Decent Work and Economic Growth (8) (United Nations, 2022). Using Norway as an example, there is still substantial gender segregation in the labor market. Women generally participate less in employed work, they work more part-time, and they have higher rates of sickness absence than men (Petersen et al., 2022). A substantial welfare system known as "The Nordic Model" defines Norway's inclusive approach to the occupational setting. An important factor in this

CONTACT Marianne Gjellestad marianne.gjellestad@uia.no, marianne.gjellestad@agderfk.no Department of Nutrition and Public Health, University of Agder, Kristiansand, Norway.

approach is the inclusion of persons with reduced work ability in the workforce despite their health challenges (Petersen et al., 2022). In 2022, rates for sickness absence in Norway were still increasing (5.4%), and gender differences persist, as evident in the 7.0% sickness absence rate for women and the 4.1% rate for men (Aldridge, 2023). National and international studies identify a multitude of factors that contribute to the gender difference in sickness absence, including the combination of paid work, domestic work and other responsibilities, differences in health exposure due to different types of jobs, vulnerability, and possibly also general health (Hellevik et al., 2019; Løset et al., 2018; Mastekaasa, 2014; 2016). Until recently, research on women's sickness absence has focused on structural and cultural causes. However, women and men also have different biology and physiology, and they experience different health challenges (Schei & Bakketeig, 2007). Women's health and the biological differences between women and men have been poorly investigated in association with working life; therefore, more knowledge is needed on how female physiology impacts occupational health (Ministry of Health and Care Services, 2023b; Ose et al., 2014).

Women's health

Women's health can be defined as "diseases and ailments that only women have, diseases that affect more women than men, that affect very many women or that have different consequences for women than for men" (Ministry of Health and Care Services, 2023a). Female biology involves physiological and psychosomatic changes and variations, both within the menstrual cycle and through the different stages of age (Maltau et al., 2015; NFOG, 2022). Although these changes are due to normal physiological processes, they dispose for ailments and diseases that affect only women. Recent literature on women's health and working life shows that conditions such as pre-menstrual syndrome (PMS), dysmenorrhea, endometriosis, and menopause can affect work ability and sickness absence (Grandey et al., 2020; Hardy et al., 2019; Hardy & Hunter, 2021; Lacovides et al., 2015; Millear & Gervais, 2016; Sperschneider et al., 2019), but there is a lack of knowledge on prevalence, how barriers are experienced and how the complexity of women's health can affect women's work participation (Gjellestad et al., 2023; Ministry of Health and Care Services, 2023b). Pregnancy has been identified as the major cause for gender difference in sickness absence, explaining 20% of the difference in Norway (Nossen, 2019). National studies on reproduction and work have focused on risk assessment and facilitation of the work environment for pregnant employees (Strand, 2001; Wergeland, 1999), with later research showing that it can be difficult for pregnant women to get necessary facilitation at the

workplace, and that women struggle with credibility in the process of securing sick notes from general practitioners (GPs) (Fredriksen et al., 2014). International studies have shown that it can be difficult to get facilitation to continue breastfeeding when women return to work after maternity leave, according to guidelines and legislations (Burns & Triandafilidis, 2019; Scott et al., 2020). Infertility treatment has also been found to have a clear negative impact on work ability and sickness absence (Courbiere et al., 2020; Payne et al., 2019). In general, women's diseases are more often chronic and complex, i.e. conditions with pain or exhaustion (Lunde et al., 2022).

Work and work environment

Women have increasingly entered the workforce since the institutionalization of care tasks in the 1970s (Petersen et al., 2022). Today, professions such as nurses, kindergarten teachers and service-sector jobs are dominated by female employees; these sectors also feature persistently high sickness absence. Systematic work with health, safety and environment (HSE) was developed for industrial, male-dominated workplaces (Ose & Busch, 2020). In the last decade, the focus has shifted from physical safety and security to involve more typical challenges in the traditionally female occupations, such as violence and threats, role conflicts, and relational and emotional demands (Hagen & Jensen, 2022). The consequences of exposure to relational and emotional demands in the work environment were investigated by Hochschild, (2012), who found that women in the service sector have to suppress their own emotions to adjust to professional expectations. When employees experience a discrepancy between expectations and their own feelings at work, for instance, smiling and caring when tired or angry, they experience emotional work or emotional labor. This was found to be a source of psychological symptoms such as depression or exhaustion (Hochschild, 2012), a finding also confirmed by later research (Indregard et al., 2018).

The balance between demands from the work environment and the control experienced by the employee is described in the Demand-Control Model by Karasek and Theorell (Karasek, 1979; Karasek & Theorell, 1990). The model has two parameters: job demands, illustrating the work's demands on the employee, and job decision latitude, indicating the individual's decision authority in the work setting, including the possibility to select which skills to use for solving various tasks. High demands and high decision latitude indicate an active job, leading to mastery. High demands and low latitude indicate high strain, leading to stress. Later, a factor of support was added to the theory, emphasizing the importance of social support in the work setting (Karasek & Theorell, 1990). The

model was initially developed without a gender dimension, but the authors pointed out that professions engaging many women often have high demands and low latitude, resulting in high strain. The nursing profession is on top of the scale indicating high job strain in Norwegian occupational research (STAMI, 2019) and is a profession with persistently high sickness absence and dropout rates (Ministry of Health and Care Services, 2023a). It is debatable whether and how the Demand-Control model can be used to explain mechanisms in sickness absence (Allebeck & Mastekaasa, 2004) and the suggested gender differences in job strain due to the variations in career choices (Karasek & Theorell, 1990) still leave much of the gender difference in sickness absence unexplained (Nossen, 2019); therefore, we add an investigation of potential increased strain due to women's biological or physiological conditions to the model.

Research aim

Women's lower participation in working life and higher sickness absence has mainly been investigated as being caused by structural and cultural factors, emphasizing that women and men have different professions and different responsibilities at home (Mastekaasa, 2016). However, biological and physiological differences between women and men have also been suggested to impact gender differences in work participation and sickness absence, but this has been poorly investigated (Mastekaasa, 2016; Ministry of Health and Care Services, 2023b; Ose et al., 2014). The objective of this study is to explore the potential burden of female physiology in the context of work and to investigate possible associations between women's health, work ability and sickness absence in a hospital setting. We ask two research questions:

RQ 1: How do nurses experience women's health in relation to work participation?
RQ 2: How do nurses and hospital managers experience potential barriers for work ability related to women's health?

Method

Study design

To explore women's lived experiences and the associations between women's health and working life in depth, we adopted a qualitative, inductive approach. The study's main material consists of in-depth interviews with 10 female nurses. Further, to reveal potentially contradictory experiences, we examine the nurses' interviews together with findings from a focus group with managers in the same hospital organization. We aim to

investigate experiences in the context of social constructionism, emphasizing the mutual influence between the participants, the researchers, and the world they live in (Alvesson & Sköldberg, 2018). The study was planned and conducted by a team of researchers with different backgrounds: a nurse-midwife with additional experience from human resources/HSE and public health, a sociologist, a nurse with a degree in psychology, and two medical doctors with specializations in community medicine and occupational medicine. The different preconceptions and reflections on reflexivity were used to increase understanding and develop an open approach to the field.

Data collection

Our study site is a hospital organization run in three different geographical locations in a southern region of Norway. The recruitment of nurses was done though the nurses' union; a union representative shared information about the study to all female members and issued an open invitation to participate. We aimed to interview women both with and without subjective health issues. To identify variations, we selected the participants into two groups: five nurses who defined themselves as healthy and five who faced challenges related to women's health. The first five to sign up to each group were recruited for interviews. Their age ranged from 29 years of age to 63 years of age (average 49.2 years of age). The majority had more than 10 years of work experience. See Table 1 for a description of the nurses.

We developed an interview guide based on areas of women's health together with selected aspects of women's life known to influence work participation: family situation, stress and coping, work environment, and management (Hagen & Jensen, 2022; Karasek & Theorell, 1990; Petersen et al., 2022). Interviews were conducted by the first author between February and May 2022. The conversations lasted for 60–90 min and took

Table 1. Nurses interviewed in the study.

Nurses	Age	Nursing Seniority	Living Situation	Children	Subjective Health Status at Recruitment
Nurse 1	41–55	10+	Partner/spouse	Yes	Healthy
Nurse 2	56–67	10+	Partner/spouse	Yes	Challenged
Nurse 3	56–67	10+	Partner/spouse	Yes	Challenged
Nurse 4	25–40	2–10	Partner/spouse	No	Challenged
Nurse 5	25–40	2–10	Partner/spouse	Yes	Healthy
Nurse 6	41–55	10+	Single resident	No	Challenged
Nurse 7	41–55	10+	Single resident	Yes	Healthy
Nurse 8	56–67	10+	Partner/spouse	Yes	Healthy
Nurse 9	41–55	10+	Partner/spouse	Yes	Healthy
Nurse 10	41–55	10+	Partner/spouse	Yes	Challenged

Table 2. Managers participating in the focus group interview.

Managers	Management Seniority	Position and Span of Control
Manager 1	10+	Unit manager, 56 persons
Manager 2	10+	Unit manager, 100 persons
Manager 3	0–2	Unit manager, 30 persons
Manager 4	10+	Head of department
Manager 5	10+	Head of department
Manager 6	2–10	Head of department
Manager 7	10+	Unit manager, 80 persons
Manager 8	10+	Unit manager, 60 persons

place at meeting facilities at the hospitals, at the county house, at a local library, and at the university.

The recruitment of eight hospital managers to the focus group was conducted through the hospital's organization. The organizational director shared information about the study and issued an open invitation to participate. Eight managers, all of whom were women, signed up. Five were working as unit managers with direct personnel responsibility for 30 to 100 nurses. The other three managers were department heads with overall responsibility for several units. Managerial experience in the group varied from one year to 31 years (average 12 years). See Table 2 for a description of the managers. The focus group interview was conducted in May 2022 at the county house by the first and last authors, and it lasted for 120 min. An interview guide was adapted from the interviews with the nurses.

All interviews were recorded and transcribed verbatim by the first author.

Analysis

For a systematic analysis process we used the six steps (1–6) described in the reflexive thematic analysis process developed by Braun & Clarke (Braun & Clarke, 2006, 2022). The ten interviews with nurses were analyzed first as the study's main material. In the first step, familiarization of the data (1), the material was read repeatedly by the first author, and key terms were identified. The familiarization step revealed that descriptions of women's health and subjective complaints did not differ much between "healthy" and "challenged" nurses, so the two groups were analyzed together. We created 158 empirical codes based on identified meaning units in the text (2). The codes were merged into 140, and then divided into 16 groups with subgroups. Further, codes were grouped into five main areas as initial themes (3). Based on the research questions, we renewed themes from the coded material (4) and synthesized them into three main themes with subthemes (5). Themes and sub-themes are presented in Table 3. NVivo software was used in the process to ensure a systematic structure and overview of the material. Coding and analysis were conducted by the first author and discussed by all the authors for

Table 3. Themes and sub-themes in the analysis.

Themes	Sub-themes
Considerations on women's health	Areas of women's health
	Complexity and lack of recognition
Work organization and work environment as conditions for health	Coping
	Organizational work environment
	Physical work environment
	Psychosocial work environment
Equality and expectations in society	Gender differences in terms of working life
	Women taking more responsibility in the home

each step. The focus group with managers was analyzed based on codes and themes developed from the nurses' analysis to reveal potential contradictory perceptions in the material. Finally, the report was produced for textual presentation (6).

Ethical considerations

This study was planned and conducted according to the principals of the World Medical Association Declaration of Helsinki (2014). It was approved by the ethical committee at the Faculty for Health and Sport Sciences, University of Agder, Norway and SIKT- Norwegian Agency for Shared Services in Education and Research (SIKT ref. 798255). Informed consent was collected, and further assurances of confidentiality were given to the study participants at the onset of the interview. The participants were numbered (see Tables 1 and 2), and all interviews were deidentified during transcription. In the Findings section, the results are illustrated by informant group and number with adherent quotations. The participants were informed that the hospital's occupational health service could be provided at the informants' request if needed after the interview.

Findings

We identified three main themes from the informants' shared experiences: 1) considerations on women's health, 2) work organization and work environment as conditions for health, and 3) equality and expectations in society. The three themes with subthemes are listed in Table 3.

The nurses had various subjective perceptions of the term women's health. In addition to their self-perceptions, they shared reflections from their participation in work life and society in general. They all had personal experiences with menstruation at work, eight had gone through one or more pregnancies, two had been treated for infertility, one had a birth injury, and eight were now in the age for potential menopausal symptoms. Additionally, seven of the ten nurses had personal experience with different

chronic conditions causing pain or exhaustion. Their experiences of how health issues affected their work ability varied, and for some of them it caused sickness absence.

Considerations on women's health

Complexity and lack of recognition

When asked about women's health as a term, the nurses' replies mostly referred to the organizational work environment, rather than to health issues; they described their own personal limitations as challenges related to the organization of work. Reflections on quality of life and on the individual responsibility for managing their own overall life situations were also frequently mentioned themes. The managers also identified issues related to work organization and work environment in response to the concept of women's health. Second, they addressed the women's overall life situation, including responsibility for their children, family, and household. By the managers, women's health was described as the women's individual capability to cope with the overall situation.

The nurses expressed distance between their own experiences of women's health and how it was regarded in society. When asked "How do you feel about the term women's health?", and "what does the term mean to you?" at the start of the interview, the nurses described a complex and poorly recognized field:

> Women's health is… it is so many things. It is all that we stand for, from when we are teenagers until we get old. It is about women being de-prioritized when it comes to health, like it is not seen as very serious when it concerns women (…) We can have babies, we can breastfeed—there are lot of positive things as well. But my first thought when you say women's health is that we often are de-prioritized, and I think that's terrible. (Nurse 5)

> And I also think about all these women's diseases, that the diagnosis is worthless, you become worthless, society regards you as worthless. (Nurse 7)

All the nurses faced health challenges related to women's health, including the informants who were recruited as "healthy" participants. Several of these informants initially talked about their good health. However, as the interviews proceeded, they shared stories that revealed a variety of challenges, including PMS, dysmenorrhea, infertility, sleep problems, headache and musculoskeletal disorders. Some also described problems with keeping up at work simply because they were getting older. The ailments led to reduced work capacity and also affected their leisure time. Several of them had taken sick leaves over the course of their careers, either with defined diagnoses or because of more diffused symptoms.

Areas of women's health

Hormonal changes

Menstruation was not considered relevant in the occupational setting but something you had to deal with privately, even when at work. Nevertheless, some of the nurses reflected on how pain and heavy bleeding affected their working day. One described how having her period while carrying out work tasks and focusing on patients could lead to difficult situations and role conflicts:

> No one cares whether you have your period that day or need time to go to the restroom at all. The last time I had my period I bled through my pants three times during the shift (…). You have tampons and pads and the whole package, to make sure you can last for as long as possible. And then you are there, helping a stroke patient who cannot use his own feet and maybe weighs 120 kilos. You stand there with a full team of four people to help him walk a few steps, and then you feel it dripping, and you have no, you have no possibility of letting go of the patient. (Nurse 5)

The use of non-prescription painkillers was considered common. The nurses had contradictory views on whether menstrual pain was considered a legal reason for sickness absence, or for leaving work.

Menopause was a more frequently addressed theme among women at the workplaces, according to the nurses. It was considered a normal condition, though, and some were joking about sweating and opening the windows. Others were more bothered and described how it could influence both private and professional life:

> It is like you get less power, less courage, less resilience. You cannot handle as much as you used to. And what has been hard earlier in life, if the backpack gets heavy enough, you put it down when you reach menopause (laughs). So many women get problems. And I believe that this is something that health authorities and people in general do not want to talk about too much. Because this is something they hope people will not focus too much on. It is a huge health challenge for many of us. But then of course, there is less support (…) One thing is the hot flashes, but many also get more emotionally unstable. (Nurse 3)

Two nurses had been prescribed inadequate treatment for menopausal symptoms by their GPs. Symptoms such as poor sleep, depression, and exhaustion made it difficult to function at work, and the lack of recognition from their GP's added to the burden. Eventually, both were placed on sick leave. One of them finally consulted a doctor at her own hospital ward to get help, the other one changed GP for a second opinion. They both returned to work after a short period of hormonal treatment.

The managers also had experiences concerning female ailments and diseases that could be associated with work ability and sickness absence among the employees. Pain and heavy bleeding were recognized as

common issues related to menstruation, but they supposed most of the employees did not have problems at work while having their period. Menopause, on the other hand, was considered more problematic. The managers acknowledged that being around the age of 50 made nurses vulnerable, and that headache and sleeping problems were common. They also explained how employees' hormonal disturbances could influence the work environment through a bad atmosphere, inviolability, and personal conflicts. Still, women's health in general did not receive much attention at the workplace, or in society at all, according to the managers. One of them stated that women's issues tended to be neglected and misunderstood:

> I absolutely find it timely to talk about menstruation. We talk way too little about women's stuff. And menopause (…) and hormones. Because we are supposed to be so… strong. We are supposed to be as good as men; we are not allowed to feel pain, and we are not to talk about it. If you have a problem, you just have to work out more, lose weight or maybe change your lifestyle. (Manager 5)

Pregnancy and reproduction

Working while pregnant was described as an individual situation by both nurses and managers, depending on the woman's conditions and her work tasks. Two of the nurses had been pregnant recently and had been followed up with a midwife from the hospital's occupational health unit. This midwife routinely talked with the nurses and their manager about individual facilitation, and the pregnant employees were offered not to work night shifts. However, the nurses found it hard to work during pregnancy. The majority were on sick leave– either fully or partly– before maternity leave started because of their physical condition in combination with work tasks, family situation, or the totality.

> It wasn't long before it was too hard to work. It… I tried coming to work; my pelvis ached, the floors were hard, and I was walking so much every day. There are a lot of painful positions, we often stand bent over patients. I tried graded sick leave for a while, but it is very difficult to work that out at a hospital. You can be there 50% of the time, to work two and a half days a week, but to be there and work with reduced capacity, on a full day, and in that way work 50%—that does not function in my job. (Nurse 5)

The managers considered facilitation for pregnant employees, and they explained how they could keep pregnant nurses longer if they cared for them in the occupational setting. The routine of having a midwife come from the hospital's occupational health unit was considered helpful, provided that the midwife had an encouraging approach to make the women stay at work as long as possible. However, they had to organize tasks in balance with the budget, and giving to someone was equivalent to taking

from someone else. Thus, the hospital was limited in how many they could facilitate for at a time, and this was a concern in the managers' group. The nurses found it difficult to work with the reduced capacity because of work load and time pressure. If the necessary facilitation and support was difficult to obtain, it was easier to get a sick note from the GP.

There was extensive concern about returning to work after maternity leave. Several of the nurses described the feeling of leaving the babies too early, and of handling the time-squeeze. Those who were still breastfeeding found it difficult or impossible to get the required time to breastfeed or pump at work because of work organization and scarce resources. According to the managers, time off to breastfeed was sometimes debated; for most women, it was presumably unproblematic, but some were "demanding their rights". Facilitation included the flexibility to breastfeed or pump at work or late attendance for the morning shift, depending on the individual's needs. However, there was no reduction in workload because no extra personal resources were deployed:

> So, we are not able to facilitate for them to breastfeed and at the same time make them feel up to speed when they are late for work (laughs); we are not able to do that. (Manager 8)

Two of the nurses had undergone infertility treatment during their careers. The experience was difficult for them in several ways. Hormone treatment made them vulnerable, and they constantly worried about their situations. One of them had been open with her leader but kept it secret among the colleagues. She tried to stay at work partly because she knew she did not have the right to file for a sick leave related to this treatment. At one point, when she needed time off, the doctor used the diagnosis "COVID-19". The other nurse was open about her situation and received social support from her colleagues. Both nurses were concerned about being exposed to stress through the treatment process, and they felt it unfair that there were no legal adjustments for taking time to rest and heal:

> What should be the reason for your sick leave? (…) You have no other days to rest, to get back on your feet… You can ask for a sick note, but then it will be because of psychological issues (…), something I do not always find appropriate. This is about my body being full of medicines – huge amounts of medicines – and then it should be possible for me to, for that reason, to get a sick note. I have asked the occupational health service if I could use a self-certification, but I was told that I could not. (Nurse 4)

Chronic and complex disorders

Chronic pain due to musculoskeletal conditions or headaches was a common problem for seven of the 10 nurses. They did not necessarily see it as a women's health issue, a disease, or a health issue at all.

> Well, maybe not women's health issues, but I have had some musculoskeletal complaints coming and going, and periodically, I am bothered by headaches. (…) I have had a frozen shoulder in one arm, and then I was completely out of it. I have had problems with headaches and poor sleep over the last years, but it comes and goes. Now it has been very good for a period, and yes… It is hard and demanding if you sleep poorly over a long period of time. (Nurse 1)

Nurse 1 considered herself in the «healthy» group of informants. For several others, pain was something they endured and handled as best as they could. One talked about having migraine from time to time before she became afflicted with more severe health problems:

> To me, what hindered me the most was my migraine. This was earlier, when I was still okay and healthy. (Nurse 10)

When asked about this quote, and whether she did not consider migraine a disease or a problem, she answered:

> Yes, no… it is a disease, it is. Like, it affected me, but not as much as I am affected now (…). I managed to handle it, and I kept going to work – that is maybe why I haven't thought so much about it. (Nurse 10)

Several of the nurses explained how they managed to cope at work despite being exhausted at home. Conditions such as migraine, musculoskeletal disorders, and sleeping problems were also worsened by night shifts. Nevertheless, when relating to seriously ill patients and their next of kin, it was hard to justify one's own complaints.

The managers considered themselves lucky to have strong health and reflected on strategies for keeping the work-life balance. They also acknowledged the difference in type of job compared to the nurses. Many of their employees were not as privileged as themselves in terms of their health or their personal lives. However, the wide span of control, with too many employees, made it difficult to follow up on individual needs.

Work organization and work environment as conditions for health

Work organization and work environment

When the nurses spoke about their health, they all included work environment in the reflections. Many of them were clear about not recommending the profession to young people joining the workforce. Time pressure, general burden on health, and a lack of resources made it difficult to last long as a nurse, especially one with health issues. At the same time, being able to work as a nurse despite challenges was considered important. The participants experienced frustration because the salary level did not match the work effort. The continuous downsizing of the personnel working close to patients, while management resources increased in

number, was a cause of dissatisfaction. Additionally, the perceived distance between the workers and the management, and the lack of recognition of the nursing staff, made matters worse. The wards were always busy:

> I guess you feel defenseless. You felt you had no one to protect you; you had to take any patient coming in and… like there were no boundaries. You just wanted to find somewhere to hide, or to stop existing, when it was at its worst. Right? (Nurse 8)

> When I look back after all these years: rewarding profession, but incredibly exhausting. People have no idea how hard it is (…). Nurses have terrible working conditions. (Nurse 3)

Several of the nurses claimed that their health challenges had developed as a direct cause of the working conditions after long careers as nurses. Shift work was considered hard for one's health, especially night shifts and the changing of shifts from evening to daytime. Sleep was a key factor and several described age as significant; when you reached a certain age, it became difficult to sleep between the shifts, which made it all more difficult. Among the younger nurses, shift work was also considered a possible benefit that provided flexibility. Nevertheless, the younger ones also planned to specialize and advance, partly to be rid of the night work in the future.

Part-time work was problematized from different angles. All nurses who desire a full-time position should receive it, both to make a decent living but also to the benefit of the hospital:

> I believe the hospital would benefit from offering full positions to nurses, because then you would become able to function in the role sooner – you get that clinical gaze, you work a lot, and it is easier to work, and so you work more efficiently (…) It would lower your stress levels a bit as you become more confident in the role. I am absolutely sure that it would contribute to reduced sickness absence. (Nurse 2)

The managers also deemed part-time work a challenge for several reasons. The general shortage of nurses made them encourage employees to work full time. On the other hand, the challenges of filling weekend schedules made the use of smaller positions necessary. Also, they assumed some of the nurses did not have sufficient health capacity or a life situation suited for full-time work. The managers emphasized the importance of the nurses' awareness about the art of work, knowing that it could have detrimental health effects, and that 24/7 shift work was an integral part of it. They identified a mismatch between the attitudes of some of the young nurses and the demands of the hospital, and they called for better and more realistic information about working conditions during the education process. At the same time, the profession should be inclusive enough to ensure recruitment. Some of the managers stated that nurses could not be expected to have "a health made of steel" and that employers were not

in a position to make too many demands because of the shortage of personnel.

Physical work environment and ergonomics were addressed by several of the nurses. Heavy lifting and bad postures were frequent, but were considered something that followed the job.

Social support from colleagues was considered crucial for staying healthy at work, and for staying at work at all. Many of the nurses had friendships among their colleagues, and support, guidance, and interaction in the group was very important. This was described as a reason in itself for going to work, especially in periods of reduced work ability. Others emphasized the importance of debriefing with colleagues who could understand the situation, for not bringing stress and tough experiences home from work. The psychosocial work environment was described as important for professional development and for nurses to trust each other when dealing with acute situations. However, the nurses also described the negative consequences of a female-dominated environment, such as gossiping and talking, depending on the various personalities.

Coping

Coping was closely related to autonomy at work. The nurses described different sources of motivation and various ways to cope with the work situation.

> Really, the motivation to work, and to keep working (…) is autonomy, to feel that you have the sense of being the opposite of worthless. You have something to say, you have an impact. You are not like a hostage coming in when decisions are already made. You really get the feeling that you are seen and heard. (Nurse 8)

Some did not have this experience and expressed a feeling of being stretched and not recognized. This was hard on both health and motivation and seemed to decrease professional pride. Dealing with different types of stress was considered part of the job, and it was their own responsibility to deal with it. However, handling stress at work was also a source of motivation and coping for nurses, when managing busy and difficult situations.

The handling of one's emotions could be challenging when contacting patients and their next of kins. Some nurses described how working with very sick patients or busy shifts required the ability to put yourself aside, sometimes like wearing a mask, to appear safe and caring for others. For all of them, the job required them to suppress their own needs and emotions to a certain extent. Obtaining more experience helped with this, and it was described as a part of their professional pride and identity as a nurse.

Both nurses and managers found facilitation difficult and limited by the lack of available resources. This made the nurses vulnerable for calling in sick:

> It is a delicate balance because we cannot work at half pace here. The personnel situation is cut down to the bone, so we are dependent on the functional level of everyone. We cannot have someone here working slowly because they are not feeling well. This system is not built for that. (Nurse 9)

Having a good relationship with the manager was important both for the experience of well-being and for productivity when working with reduced health, according to the nurses. What was referred to as unclear management made the general work situation unsafe and negatively impacted health:

> You know what you are dealing with when the management is clear. If the management is murky, you don't know what you're dealing with, you don't know what's happening. Really, that uncertainty, that insecurity, it affects me. I get insecure, uncertain; it makes me tired. It exhausts my mind, not knowing. (Nurse 7)

The lack of manager availability was a source of frustration and was explained by the managers' overload of administrative tasks and wide span of control. The managers themselves described a loyalty conflict between sticking to budgets and reporting upwards while at the same time being good personnel managers.

Equality and expectations in society

Women taking more responsibility in the home

The nurses were not concerned about men and women not being equal, but rather about not having equal rights. This included perspectives on work, family, values, possibilities, and choices. Two of the nurses claimed that their male partner contributed equally at home, whereas the rest of them held the main responsibility for both the children and the household. Several had worked part-time when they had smaller children, describing this as the natural way of handling one's busy everyday life and how this affected the logistics in the family and in society:

> It is the woman who stays at home if the child is sick, and… why is it like that, really? It seems like it is a bit skewed (…) It is like an unwritten rule, like, the woman should stay home more than the man, go to the health center, all these things, take them to the dentist… But in my profession, I have always worked shifts, and then you do those things when you're free, or when working in the evenings or nights…(…) This way we have saved society for quite a lot of money, I think (laughs). All of us who work shifts, we do it in our spare time. (Nurse 1)

Women's overall life situations were pointed out as a reason why women work less and have higher rates of sickness absence: women still do more work in the house, care for children and other relatives, and balance their roles. At the end of the day, if the total burden became too heavy, work was considered the only place where you could get sickness benefits.

> I believe that women have more double roles than men. Not that the men are not helping, but I believe that we are the brain and have the logistics on most of it (…). It depends on how strong you are, but for some it can be overwhelming… I heard it myself, when I was a manager, in conversations with persons on sick leave. That they enjoy working so much, and that the job is so meaningful, but they're having a hard time at home right now, so they need a sick note. So, they are on sick leave from what is actually working, in order to take care of what is not working. (Nurse 2)

One of the older nurses described what she saw as a different attitude in the new generation of nurses. Younger women take better care of themselves, and they make other demands of their employer and of society in general. The managers also commented on this change and expressed concern about how the young nurses could manage all the various aspects of life simultaneously, such as work, family responsibilities, and personal development.

When discussing gender balance and equality, several of the nurses addressed the imbalance between women and men due to reproduction. In particular, returning to work after maternity leave was described as hard, and one of them identified how societal expectations entailed a role conflict:

> Well, you do get stressed. You think it is too early to leave your child—that feeling of guilt, that conscience of yours. And you get pushed by society, that's for sure, right, the economy, everything that society is built upon. You must work if you are part of the work force. Otherwise, you must prioritize either economy or family life (…) You are pushed back to work before you are ready for it. You are not ready to go to work when your child is six months? You need more time with your child, you are the one who has given birth to the child, not your husband. (Nurse 10)

Women were considered better than men at multi-tasking, and better at having an overview of all aspects of family life and household. At the same time, the nurses addressed the importance of women allowing their partners to take part on their own terms, and to loosen up on the controls. Several described the difficult combination of keeping up with a perfect home, with their mothers as role models, while also working full time. These demands mainly arose from their own personal expectations, they claimed, or from the expectations of other women. They pointed out the strength of supporting each other instead of comparing and judging one another. One of the informants associated expectations from society directly with women's health:

> Those… female-dominated diseases (…) I often see a common feature in them, that you go to lengths, you bend backwards. You must manage everything. The house must be perfect, the job must be perfect, the surroundings must be perfect… So, I do believe we have a certain, what I see from the people I know, who end up in those ditches, is that you push yourself too far. (Nurse 7)

Gender differences in terms of working life

Gender differences in salary, working conditions and career possibilities were considered unfair by the nurses. Several talked about male nurses who had careers as managers or advisors without higher formal qualifications. Male nurses were not expected to stay in the wards, if they ever started there, but to apply for special departments or managerial positions. Furthermore, gender differences in the work environment were described with examples: The women were tidying more because they saw the need before the men did, and they took primary responsibility for administration and extra tasks. Men and women were met with different expectations and norms, both at work and in society. Women themselves took part in maintaining this because of their high standards:

> But I think we must get over the notion that equality means that everyone should be treated equally… it's not just equal pay, it's about equal demands… and that is more difficult. Since many women tend to set higher standards for themselves, it is actually much more difficult. (Nurse 6)

The nurses described men as generally having better self-confidence, which made them more robust and able to push themselves in terms of health and work. It was also suggested that men rated their own work participation higher than women, because men and women have different careers. For several of the nurses, expectations of gender differences in health had a direct influence on their career choices. One participant, who wanted to become a police officer when she was young, was advised against this because of her health:

> There was a general practitioner at that time, when I was going to apply for the police academy, he wrote that I should not enter a profession that required heavy lifting and great strain (…) But he thought it was completely fine that I became a nurse. There, heavy lifting and great strain was not even considered a factor (Nurse 6)

Nurse 6 had worked for many years as a special nurse, with heavy lifting and physical loads in her everyday occupation. Now her work ability was reduced because of musculoskeletal disorders, resulting in periods with sickness absence.

The nurses also described a complexity affecting the female employees, when reflecting on gender differences in work ability and sickness absence:

> I guess it is the sum of our… stuff. Our health is different, it catches up on us in different ways than it does for men. And maybe we know too little about this. And if men had a woman's body, or if men's mentality had a woman's body, I wonder if it would have been a bit different. (Nurse 4)

Discussion

Lack of recognition of women's health

While exploring the term women's health in the work situation, we found it striking that the nurses did not initially recognize their female health as mainly health, but a sum of components defined by demands at work, family life, and society. We found that hormone-related ailments were largely relegated to the private sphere and not talked about in the work environment, and chronic conditions were often ignored. This aligns with earlier investigations (Grandey et al., 2020). However, the lack of focus on conditions and ailments within the field of women's health describes a lack of recognition at different levels. Nurses, managers and society all seem to downplay the meaning of women's health in this regard; the nurse describing her health (and her position) as "worthless", the managers reducing health to the individual ability of coping and the society expecting women to stretch to infinity, at the expense of their health. Many of the mentioned conditions are chronic and have diffuse symptoms. In this discussion, we question the insecurity that follows unrecognized health issues and suggest that living with unrecognized or suppressed symptoms can result in a fundamental uncertainty regarding health and work ability.

Working with unrecognized health Issues - The prize of uncertainty

Our findings show that personal health, vulnerabilities and life situation determines how the nurses cope at work. The Demand-Control Model (Karasek & Theorell, 1990) illustrates how the balance between job demands and job control defines the level of job strain in work settings. For the nurses in hospital wards, demands are high and control is low. Hence, exposure over time can cause strain to accumulate and lead to reduced work capacity or sickness absence. We suggest expanding the model to explore the nurses' job strain in new ways: job demands are experienced through an individual dimension and depend on the person's capability of coping within the given limits. Based on the experiences of the participants in our study, we ask whether health uncertainty and complexity will place an additional burden on the experience of strain in this scenario. Furthermore, if the increased experience of strain affects self-efficacy and motivation, this turns into a negative spiral. Relational and emotional work is especially relevant for nurses, as appearing safe and solid is a necessity for gaining

trust as a caregiver. The emotional labor and emotional dissonance that follow nurses' work conditions can result in burnout and sickness absence (Hochschild, 2012; Indregard et al., 2017; 2018). Several role conflicts were also described in the findings: both work-home conflict and conflicts within the work setting, between handling the busy tasks, maintaining professional integrity and taking care of one's own needs. In professions with high emotional demands, workers' presence and personality are crucial. Our hypothesis is that emotional and relational work is especially vulnerable to the uncertainty experienced from unrecognized health issues, and that the combination of uncertainty, personal constraints and emotional work in a high-strain job can result in a synergy causing reduced work ability and sickness absence. Taking the prevalence of female diseases and ailments into consideration (Lunde et al., 2022), the scope of this is extensive. Based on our analysis, two reflections can be drawn in relation to Karasek's model to reduce the nurses' job strain: first, increasing recognition and acceptance of the female health can help identify the actual problems and develop appropriate measures at the individual, organizational, and societal levels, and in this way reduce uncertainty. This requires increased knowledge of women's health as well as a culture of openness and inclusion, both identified as key terms in earlier research (Griffiths et al., 2013; Hardy et al., 2019). In the second reflection, we point out that if women's health represents this unrecognized additional burden to job strain, it potentially affects half of the work force in general, and the vast majority among nurses. Thus, it should not be an individual or personal affair, but rather a common concern to be approached jointly, and lifted as an organizational and societal matter. According to our interpretations of Karasek's model, this will ease personal experiences of uncertainty, which can reduce job strain and thus increase work ability and reduce sickness absence.

It seems contradictory that women's higher sickness absence is considered a societal challenge and has therefore been investigated in many contexts—but poorly in the context of women's health. The male body has been the norm in medical or health research (Ministry of Health and Care Services, 2023b), and systems and regulations for HSE have also developed based on challenges for male-dominated workplaces (Ose & Busch, 2020). To promote occupational health in women, systematic work with HSE must address the actual challenges in the work environment and the actual health of employees. This should be reflected in both risk assessments and measures in the work environment.

Contradictory perceptions

The managers described a role conflict between balancing the budget and reporting upwards while at the same time providing compassionate

leadership for their employees. The large span of control creates an inevitable distance to the employees. Being squeezed by the tight resource situation, the management focuses on ensuring day-to-day operations. However, the quotes of managers not taking care of the tasks when giving time to breastfeed is an example of different understandings and inconsistent enforcements of the regulations, showing how statutory arrangements and facilitation are random and dependent on the awareness of the individual manager. These challenges are confirmed by international research (Scott et al., 2020), suggesting the importance of developing policies and growing culture. The managers who signed up for our focus group were exclusively women. They all had their own personal strategies for coping with work and for work–life balance, and they were generally in good health. A possible selection in recruitment to management can result in managers with good health who do not feel the same uncertainty as their employees. The description of women's health as an ability to cope with the individual situation also indicates a distance from the health of the employees. At the same time, the managers clearly stated that women's health should be put higher on the agenda. Our findings show a potential for increasing knowledge and aligning the perspectives of workers and management. The nurses' experiences of autonomy and empowerment's influence on motivation also underline the importance of the employees' perspective, when developing guidelines and growing culture.

Coping was considered important for both informant groups. Even though we address the importance of the term in this article, we acknowledge that coping and self-efficacy at work hold a multitude of factors (Mittelmark & Bauer, 2022) which is outside the scope of this study and is recommended for later research.

A paradox of facilitation

Both our informant groups described a gap between individual needs and possibilities for facilitation, due to the lack of resources. This made working with reduced work ability difficult, and some explained that it was easier to get a sick note from the doctor and temporarily leave the position when pregnant. A leader's capability to facilitate for pregnant employees depends on personal approaches, official procedures and available resources (Abderhalden-Zellweger et al., 2021). In our findings, the difficulty with facilitating pregnancy or reduced work ability due to other causes is reinforced by managers' large span of control, as the high number of employees makes it difficult to take individual needs into account. The lack of support results in unused working capacity among the nurses on sick leave: The work organization makes it difficult for them to work on their own terms

because being at work means taking on the employee role as is. The managers take part in the problem, attempting to manage the ward with the resources available. This results in a paradox: Managers and workplaces cannot accommodate the facilitation needed to keep the capacity at work because of lack of resources. The result is that the nurses cannot use the capacity they might have; this way, the employer loses even more resources. The shortage of nurses is also expected to increase in the near future. The development of systems to better utilize nurses' residual capacity, allowing the employees to attend working life more according to their health, is a possible way to prevent dropout and address the shortage of nurses.

Inequalities in occupational health maintained by societal expectations

Analyzing the findings of this study, we see how a synergy of lack of recognition of women's health at different levels weakens women's work participation. Participation in working life is linked to socio-economic factors affecting social inequalities and living conditions, and in our study, societal attitudes appear to be both a cause and a consequence of the lower status of women's health. The proportion of female workers has increased in parallel with the institutionalization and professionalization of health and care (Petersen et al., 2022). The traditional ideal of the nursing profession as a calling has been replaced by academic competence, which is expected to entail responsibility and authority. Still, autonomy and status for the care tasks are low, and this is visible in nurses' working conditions, salaries and reputation. Our findings suggest that workers and managers are cultivated into the situation, and that the devaluation is also accepted by society. Both nurses and managers seem to accept poor working conditions, and the general understanding includes examples such as marginal staffing and work schedules with permanent exemptions from the established regulations (Working Environment Act, 2023). The nurse who was advised against becoming a police officer because of her health, but studied to be a special nurse instead, exemplifies a medical and societal gender bias and a lack of understanding of how good health is necessary in the nursing profession.

Women deal with expectations from different angles. They are expected to work full-time but also take primary responsibility for the home. This study cannot define any causal relationships between the burden of double roles and women's higher sickness absence, but our findings question the lack of recognition of women's total work load. We also question whether women's reproductive tasks, including childbearing and breastfeeding, should be valued higher as genuine and actual work in the contemporary discussion of gender equality.

Methodological considerations

This study was designed with a broad approach to the term women's health; hence, it does not provide new knowledge on how different specific health conditions affect work participation. 10 in-depth interviews supplemented by a focus group of eight managers is also a limited selection, but we considered sufficient information power was achieved with our informants (Malterud et al., 2016). The current study is also part of a larger research project that includes a second selection of female employees/managers from high schools' and general practitioners' (GPs') perspectives on the same topic. The recruitment strategy, with open invitations to both nurses and managers, probably resulted in participants with an initial personal interest in women's health, and therefore also with a possible higher awareness of the field than the average nurse/manager. With the lack of awareness of women's health as a main finding, this is remarkable. Using the nurses' union for recruitment can also possibly have impacted the selection through recruiting nurses with awareness and engagement. However, most of the nurses at this hospital are union members, and thus it is not expected to characterize the selection. This study concerns women with female biology regarding hormones and sex organs, and the extended gender-identity debate is not addressed.

Concluding remarks

This study suggests that lack of recognition of women's health affects work participation, work ability and sickness absence in women. With an extension of Karasek and Theorell's Demand-Control Model (Karasek & Theorell, 1990) we propose that uncertainty regarding personal health can entail additional burden to work strain, resulting in reduced work ability and increased sickness absence. We also see how different perspectives and conflicting interests are maintained by a lack of resources and managers' large span of control. The lack of recognition of women's health challenges female occupational health, as well as gender equality and public health in general. We find a synergy of different levels: the individual experiences, the job systems, and the societal attitudes, with the three affecting each other negatively and resulting in an individualization of system problems.

It is a societal responsibility to develop a working life where employees can last over time. The international shortage of nurses represents an additional challenge to the situation described in this article, but it also emphasizes the topic's importance. The findings of our study show a missing factor in the HSE-systematics for the female-dominated workplaces, not addressing important conditions affecting female health. It also highlights the importance of bringing different perspectives together to identify

various views and potential barriers at different levels when policies are developed.

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ORCID

Marianne Gjellestad http://orcid.org/0000-0002-6961-2174

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