Health needs of middle aged population: an unaddressed link

By
Dipti Govil
Indian Institute of Health Management Research, Jaipur, India

1. Introduction:

In India, at some point after forties, a woman enters into the third phase of her life. This phase of life is generally ignored and she chooses to mourn silently. A woman is given adequate care from teen till reproduction and over the past one decade policy makers are seized with the issue of protecting the right of the elderly i.e. from pension and health welfare benefits to reproductive and sexual rights. However there exists a glaring gap in health issues for women in their forties and fifties till they cross over to the elderly. This group has been totally overlooked by the policy makers, as they cross the boundaries of reproduction and does not fall under old age.

During the middle age, physiologically, menopause is the most notable event for women. Though, menopause is a natural phenomenon but it has been listed as a *Disease* in International Classification of Diseases – 9 & 10, Disease Data Base, e-Medicine, and Medical Subject Headings. It supposedly alters the function of human body resulting in menopausal symptoms termed as 'menopausal syndrome'. Menopausal symptoms aggravate, if women undergoes hysterectomy or early menopause.

With an increased life expectancy, women in developed countries now live approximately more than one third of their life after ovarian failure (Luzuy & Campana 2004). The average life expectancy of a woman in the developed countries ranges between 80 and 85 years and in developing countries, between 60 and 70 years. The average age at menopause is approximately 50 years (WHO 1996); with a possible wide variation between developed and developing countries. In 1990, there were 467 million women aged 50 years and above (40 per cent of these women live in the developed regions while 60 per cent in the developing countries) globally. This global figure is expected to rise to 1200 million by the year 2030 where as the proportion of postmenopausal women living in the developed region is expected to decline to 24 per cent causing an alarming situation for developing countries (WHO 1996). Population of post-menopausal women ranges between 5 to 8 percent, which makes up a relatively small proportion of the population in developing countries. Whereas, in industrialized countries, it makes-up over 15 percent of the total population. By 2030, this proportion is expected to increase drastically everywhere around the world. Therefore, indicating the immense need of public health system for post-menopausal women.

In India, the age at menopause was reported between 43 to 47 years, much lower than the international average (MacMohan, 1966, Singh, et.al. 1969). Based on the literature, it may be said that almost all women living beyond age 45 years experience menopause. The proportion of women aged 45 years and above was 18.6 per cent with the absolute number of 92,201,360 (Census of India, 2001). According to Sample Registration System 2005, the average life expectancy at birth of an Indian woman was 65.8 years. The life expectancy at the age of 45 – 50 years was more than 30 years. It indicated that if the average at menopause in India is 45 years, an Indian woman will approximately survive nearly for 30 years after attaining menopause. A rise of four years in the life expectancy at birth of an Indian woman could be observed from 1970-75 to 1997-2005. This recent increase trend in life expectancy

adds to the complexity. Since ancient times, the age of 45 was considered old; today it marks the beginning of the period we call midlife-menopause.

2. Objective:
The paper attempts to understand the health status of post menopausal women with a specific focus on prevalence of non-communicable diseases and menopausal syndromes. The paper also tries to access the treatment seeking behaviour for the health problems.

3. Methodology
A community-based retrospective study was conducted on 2,600 households from 6 wards of district Moradabad in Uttar Pradesh, India under a PhD Project. Nearly 370 women with menopause were identified during the house listing. Final interviews were conducted with 247 menopausal women. Open-ended questionnaire was used for data collection.

Bi-variate, descriptive and factor analysis were used for data analysis.

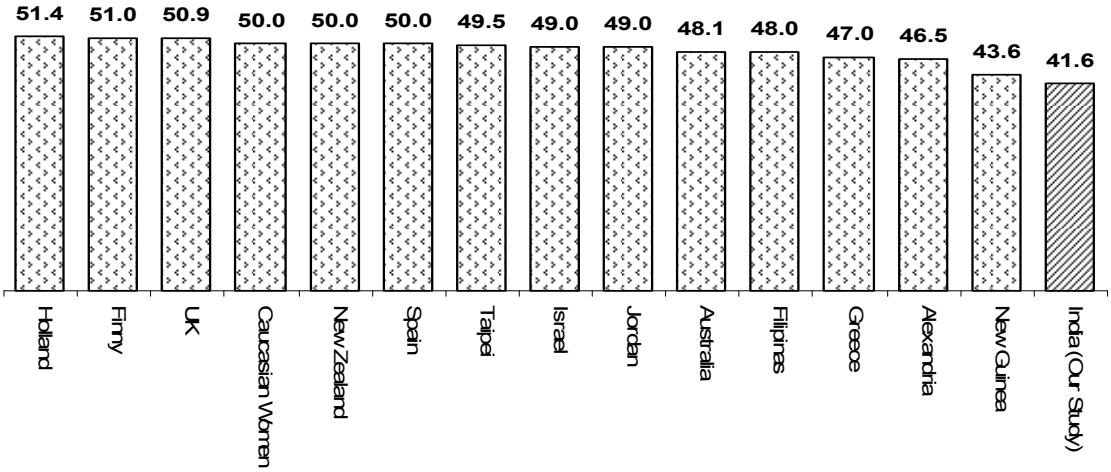
The definition of menopause considered in the present study is "the permanent cessation of menstruation resulting from either the loss of ovarian failure or removal of uterus. Particularly, the defined sets of definition in the study are follows:

Natural Menopause: The permanent cessation of menstruation resulting from the loss of ovarian follicular activity followed by 12 months of consecutive amenorrhea (WHO).
Early Menopause: The permanent cessation of menstruation before the age of 40 years.
Normal Menopause: Menopause occurred after the age 40 years.
Hysterectomy: The cessation of menstruation followed by either surgical removal of uterus or bilateral orphectomy.

3.1. The Sample:
In the sample of 247 menopausal women, a majority (206, 83 percent) attained menopause spontaneously (natural menopause); while only a small number of women (41, 17 percent) did experience menopause after undergoing hysterectomy. The median chronological age in the sample of natural menopausal women was 48 years with a mean of 47 years. For hysterectomized women, median chronological age was 47 years with a mean of 44.6 years.

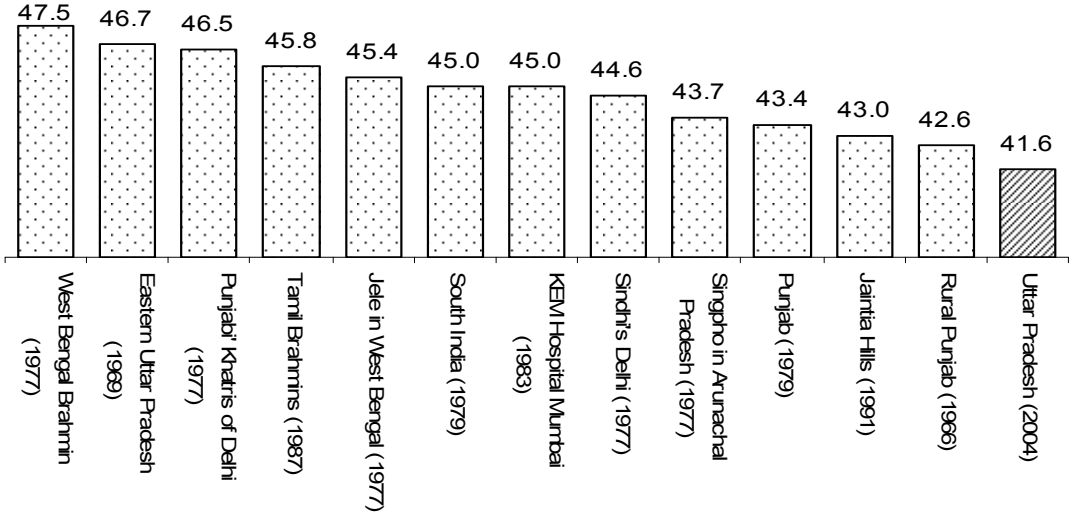
4. Results
4.1. Age at Menopause:
In the present study the mean age at menopause is 41.6 years, which is the least not only among international studies but also among Indian studies (Figure 1 & 2). Worldwide age at natural menopause ranges between 45 and 55 years with a mean age of incidence of 51 years worldwide (Brambilla & McKinlay 1989). Population in developed countries demonstrated comparatively later age at menopause than population in the developing countries. The age at menopause among Japanese, Chinese, and Hawaiian women is found to be between 49 to 50 years (Goodman 1985). The same varied between 47 to 52 years among women in various countries (Figure 1).

Figure 1. Mean age at menopause International Comparison



Mean age at menopause in the present study is not only the least among international studies but it is the least among Indian studies. However, in India, the proportion of women in menopause/hysterectomy in the age group 30-49 is the largest (17 %) in South Asian countries (Nepal:14%; Bangladesh:11%; Indonesia:10%; Pakistan:9%; Srilanka:9%; Thailand:8%).

Figure 2. Age at Menopause: National Comparison.



4.2. General Health Status and Perceived Health Status:

In order to assess the overall health status of women, 28 item General Health Questionnaire (GHQ) has been used. The questionnaire focuses on the hinterland between psychological sickness and health. It concerns itself with two major classes of phenomena: namely, 1) the inability to carry out one's normal 'healthy' functions, and 2) the appearance of new phenomena of a distressing nature (Goldberg & Blackwell, 1970; Wing et al. 1977).

Perceived health status of women has been evaluated by querying about the opening question (Have you recently been feeling good and perfectly well in health) of the General Health Questionnaire. Replies to this question were standardized as, "good, better, worse and much worse". Half the respondents reported their health to be 'worse' compared to other half of

women expressing their health to be 'better than earlier' or 'the same as usual' respectively. The question has been cross tabulated with type of menopause. Virtually an equivalent proportion of women with early and normal menopause affirmed their health status to be 'worse' or comparatively 'much worse' than before. Imbalance in the health status among natural menopausal and hysterectomized women was found to be quite marked. A majority of respondents under the hysterectomized category avowed themselves to develop 'worse' health, while this proportion plunged among women who attained natural menopause.

Table 1. Percent of ever married women aged 27-52 years by Perceived Health Status according to Type of menopause.

	Perceived Health Status				Number of women
	Better	***Same***	***Worse***	***Much worse***	
Type of menopause					
Early menopause	16.1	39.3	35.7	8.9	56
Late menopause	22.7	31.3	38.7	7.3	150
Natural menopause +	20.9	33.5	37.9	7.8	206
Hysterectomy	12.2	19.5	53.7	14.6	41
Total	19.4	31.2	40.5	8.9	247

Significant level Chi-square : + p<.10

More than half of the women were assessed with the high score on General Health Index in the sample indicating that perceived health status corresponds with the General Health Index. Distribution of the four subscales illustrates the highest prevalence of somatic symptoms among the respondents (Table 2).

Table 2. Percent of ever married women aged 27-52 years by General Mental Health Index (High Score) according to Type of menopause.

Characteristics	**Somatic complaints**	**Anxiety and Insomnia**	**Social Dysfunction**	**Severe Depression**	**General Health**	**N**
Type of menopause						
Early	53.6	62.5	26.8	41.1	55.4	56
Normal	54.0	50.0	26.0	36.7	48.0	150
Natural Menopause	53.9***	53.4	26.2*	37.9	50.0**	206
Hysterectomy	90.2	63.4	43.9	41.5	73.2	41
Total	59.9	55.1	29.1	38.5	53.8	247

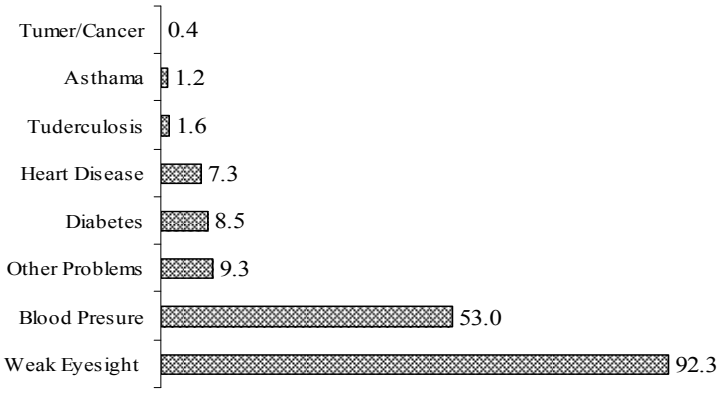
Significant level Chi-square : ** p<.001; * p<.05

Allocation of the general health score by the type of menopause specified that hysterectomy provoked the chances of being in poor health status. The hysterectomy sample was scaled on the advanced side for every scale. The differences for somatic complaints and social dysfunction were statistically prominent. High score on general health can be seen among early menopausal women compared to normal. Subsequently, for subscale, a higher proportion of women with early menopause were found to have more complaints as against that of normal menopausal women, though the emerging differences are not significant.

4.2. General health problem

Figure 3 indicate the prevalence of self reported general health problems among the menopausal women. Poor eyesight emerged to be the most prominent problem (92 percent) among all menopausal women. However, this was as low as 25 percent before attaining menopause. Blood pressure (reported by respondent, as per doctor's verification) also prevailed amongst more than half of the women.

Figure 3. General Health Problem



The poor eyesight existed significantly on the higher side among natural menopausal women in comparison to hysterectomized ones. Hysterectomized women were prone to have blood pressure marginally on higher side in comparison to their counterparts. Eight percent of natural menopausal women suffered with heart diseases in contrast to women who underwent hysterectomy (2 percent). Amplification in the age of respondents extended the chances of suffering from the heart disease. Marginally, a higher proportion of hysterectomized women were patients of diabetes as compared to women with natural menopause.

4.2.1. T*reatment seeking*

Overall, around 63 percent of women suffered with one or other general health problem during the time of survey. Of the suffering women, a majority sought treatment for their ailments. Treatment seeking from an allopathic doctor was quite high among the respondents. Only 12 percent women visited a homeopathic doctor for consultation and treatment. Only a small proportion of the respondents visited both allopathic and homeopathic doctors simultaneously.

Figure 4.i. Proportion of women suffered from Ailments

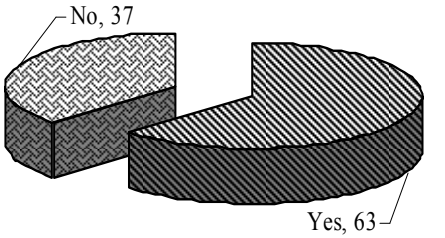
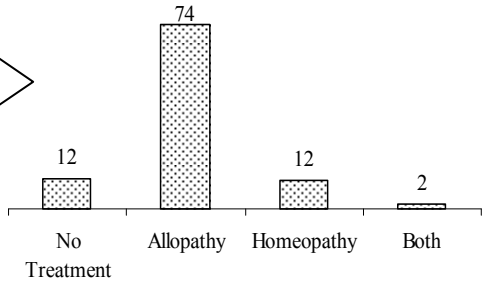


Figure 4.ii: Type of treatment taken for one or other general health problems



4.3. Menopausal Syndrome and Treatment Seeking

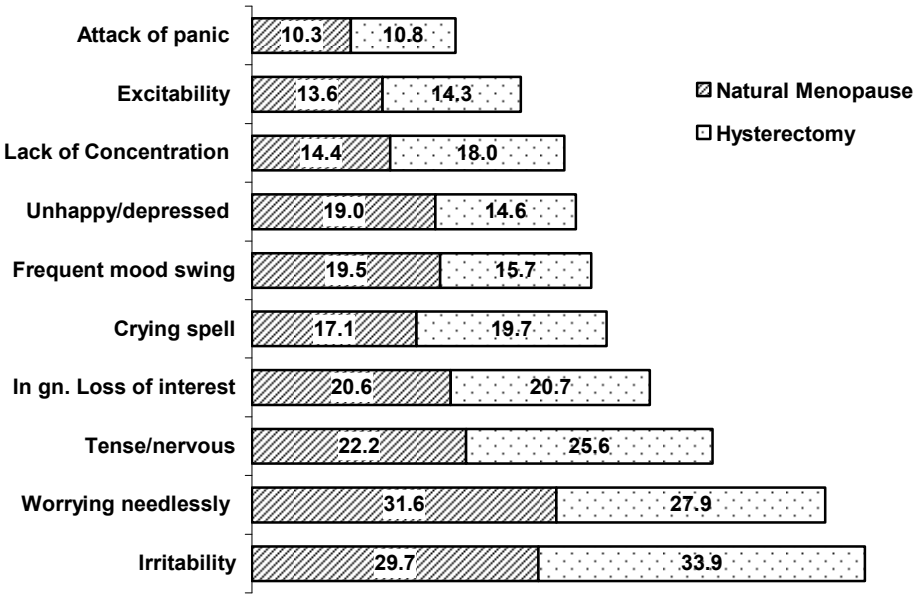
The factor analysis has been carried out with 41 symptoms to identify the underlying variables/factors that explain the pattern of correlations within a set of observed variables. Of a total of forty-one, five symptoms related to sexual dysfunctions were kept separated. Of the remaining 36 symptoms, three factors were extracted by the software with variance of 37 percent, Psychological Symptoms, Psychosomatic Symptoms, and Vasomotor and Urinary Symptoms.

Table 3. Psychological symptoms and Treatment Seeking

Psychological Symptoms	% *Suffered*	*Associated with H or M*	*Treatment Taken*		*Allopathic*
			%	N	
Attack of panic	21	17.9	0.0	0	
Crying spell	37	14.7	1.1	1	100.0
Excitability	28	4.3	0.0	0	
Frequent mood swing	35	11.5	0.0	0	
In general loss of interest	41	10.8	1.0	1	100.0
Irritability	64	14.5	1.3	2	100.0
Lack of Concentration	32	19.8	1.2	1	100.0
Tense/nervous	48	9.3	0.8	1	100.0
Unhappy/depressed	34	6.0	0.0	0	
Worrying needlessly	60	8.8	1.4	2	100.0

There are 10 symptoms, which have been identified as psychological ones (Table 3). Irritability and worrying needlessly were highly prevailed among more than 60 percent of women. Attack of panic and excitability were the least. Women did not consider any association of the symptoms with the hysterectomy or menopause. They consider that these symptoms have occurred because of increasing responsibilities of children and house. Treatment seeking for the psychological symptoms was not there. Irritability, tense/nervous, crying spell, lack of concentration, excitability, and attack of panic were highly prevailed among hysterectomized women. However worrying needlessly, frequent mood swing, unhappy/depression were the symptom, which were on the higher side among natural menopausal women (Figure 5).

Figure 5. Psychological symptoms and type of menopause



There are 16 symptoms factorized under psychosomatic symptoms. Nearly 80 percent of the women felt energy loss or tiredness all the time. Muscle and joint pain was also one of the major health problems among the respondents. Headache, heart beating quickly or strongly, weight gain, back pain, pressure in head/body and dizzy/faint feeling were the other symptoms of poor health, which prevailed among more than half of the women. It is interesting to see that the good proportion of women considered the physical symptoms

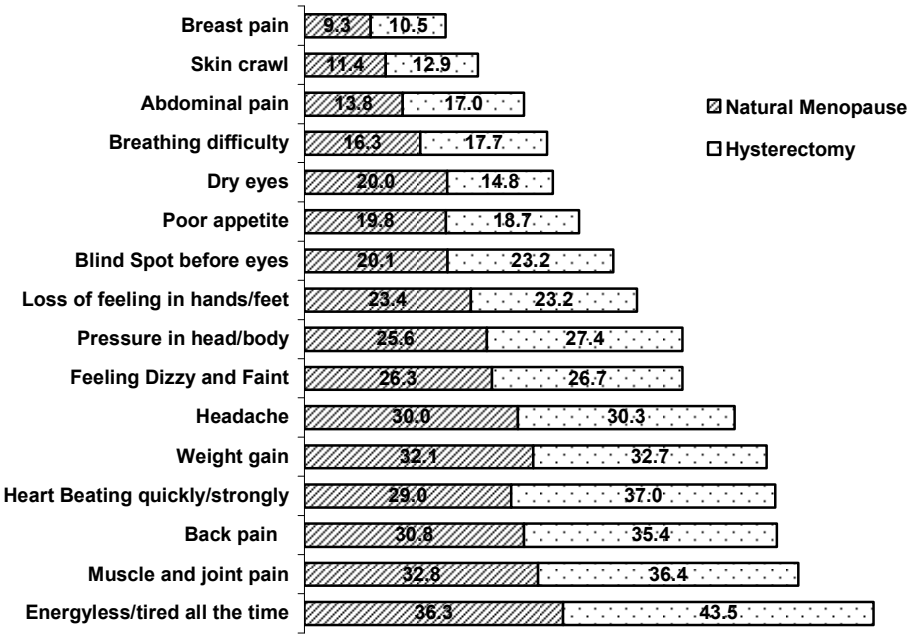
largely associate with hysterectomy or menopause. Weight gain and lack of energy or feeling tired all the time were the symptoms, for which more than 30 percent of the women considered that they were associated with menopause or hysterectomy. Treatment seeking for the symptoms associated with the physical health also existed. However, it was also interesting to see that women who had symptoms associated with blood pressure, sought treatment for those symptom. Majority of the women sought treatment from the allopathic practitioners (Table 4).

Table 4. Psychosomatic symptoms and treatment seeking

Psychosomatic Symptoms	*% Suffered*	*Associated with H or M*	*Treatment Taken*		*Allopathic*
			%	N	
Abdominal pain	31	21.7	20.5	17	64.7
Back pain	66	14.0	10.4	17	64.7
Blind Spot before eyes	43	23.1	15.7	17	94.1
Breast pain	20	18.9	20.8	11	100.0
Breathing difficulty	34	16.5	24.7	21	90.5
Dry eyes	35	17.2	13.8	12	100.0
Energy less/tired all the time	80	34.3	8.1	16	81.3
Feeling Dizzy and Faint	53	16.2	43.0	58	84.5
Headache	60	17.4	25.7	38	89.5
Heart Beating quickly/strongly	66	29.7	14.5	24	95.8
Loss of feeling in hands/feet	47	20.7	19.0	22	77.3
Muscle and joint pain	69	26.6	28.9	50	80.0
Poor appetite	39	12.5	7.3	7	100.0
Pressure in head/body	53	18.8	29.5	39	87.2
Skin crawl	24	16.1	3.2	2	100.0
Weight gain	65	38.5	1.2	2	100.0

Figure 6 represents the adjusted figure for the psychosomatic symptoms by type of menopause. For all the symptoms, hysterectomized women suffered in greater proportion as compared to natural menopausal women.

Figure 6. Psychosomatic symptoms and type of menopause



Eight symptoms were classified as vasomotor and urinary symptoms. Forty seven percent of women suffered with hot flashes after hysterectomy or menopause. Hot flashes was highly prevalent among hysterectomized women as compared to natural menopausal women. Similar is true with the sweating at night. Urinary symptoms were also prevailed on a large scale among menopausal women. Except, hot flushes, incontinence, frequent and painful passage of urine, very few women considered the other symptoms associated with the hysterectomy. Treatment seeking was higher for the symptoms associated with urination as compared to vasomotor (Table 5).

Table 5. Vasomotor and Urinary symptoms and Treatment Seeking

Vasomotor and Urinary symptoms	*% Suffered*	*Associated with H or M*	*Treatment Taken*		*Allopathic*
			%	N	
Abnormal vaginal discharge	23	18.5	19.4	21	71.4
Burning sensation during urination	31	16.1	20.7	18	66.7
Frequent and painful passage of urine	40	21.9	15.2	16	62.5
Hot flashes	47	24.8	5.9	7	71.4
Incontinence	36	21.7	8.7	8	25.0
Sweating at night	38	16.8	4.2	4	75.0
Vaginal itching or discomfort	24	19.7	17.1	13	69.2

Urinary symptoms were slightly on the higher side among hysterectomized women as compared to menopausal women (Figure 7).

Figure 7. Vasomotor and Urinary symptoms by type of menopause

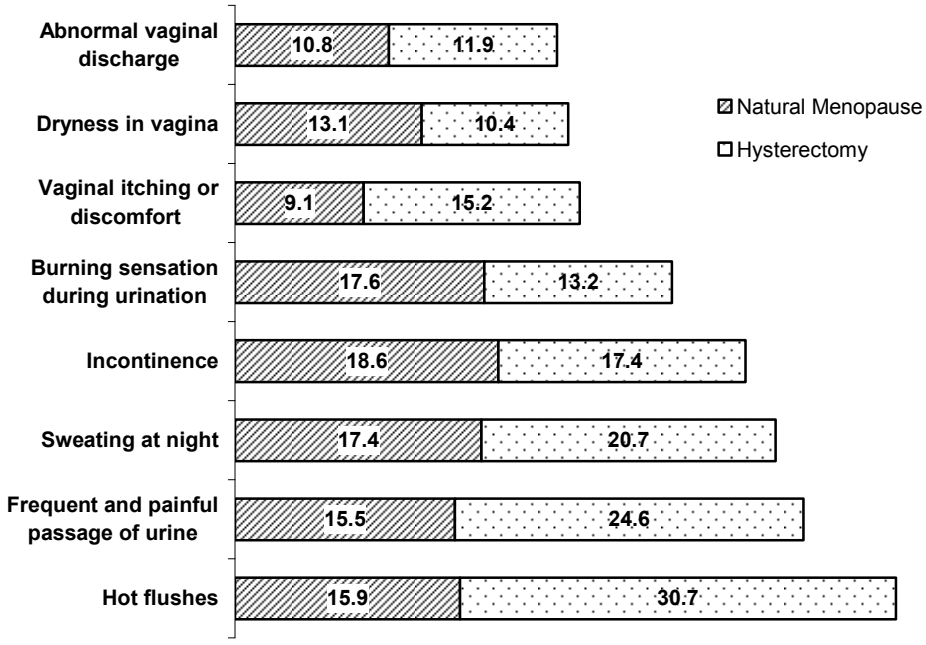


Table 6 presents the mean score for every index according to the type of menopause. On average, all menopausal groups reported the same mean number of psychological symptoms. Analyzing minutely, women with early menopause suffered with greater number of psychological symptoms compared to normal menopausal women. It was similar among women with hysterectomy who suffered slightly more than natural menopausal women. This

was true in the case of all the indices. Specifically, an average of 14 psychosomatic symptoms was reported by hysterectomized women compared to natural menopausal women where the reporting mean was 12. Nearly similar results emerged in case of early (14 symptoms) and normal (12 symptoms) menopausal women. Here the difference was statistically significant. Women with vasomotor and urinary symptoms hysterectomy and natural menopausal women showed noteworthy difference in the mean value.

Table 6. Mean of group of each sub-scale of the short scale

Factors	***Natural Menopause***						***Hysterectomy***	
	Early		***Normal***		***Total***			
	Mean	***SD***	***Mean***	***SD***	***Mean***	***SD***	***Mean***	***SD***
Psychological symptoms	4.9	3.4	4.4 *	3.1	4.5	3.2	4.7	2.7
Psychosomatic symptoms	13.8	6.7	11.6	6.5	12.2	6.6	13.9 *	5.2
Vasomotor and urinary symptoms	2.7	1.9	2.5	1.9	2.5	1.9	3.2	1.6
Significant Level on *t*-test : *p <0.05								

Conclusion

Menopause poses a big challenge during middle ages and to the healthy aging of a woman. Majority of the women suffer with one or another symptoms associated with menopause or aging. To be truly healthy an Individual needs not to be only healthy on the physical level but the psychological level too. Quite a large proportion of women suffered with symptoms associated with psychology. Blood Pressure is prevailed among more than 50 percent of women. More than half of the women are having problem associated with weight gain, pressure in head/body, muscle and joint pain, energy less/tired all the time, feeling dizzy and faint, headache, heart beating quickly/strongly, back pain, worrying needlessly and irritability are the symptoms. Whereas majority of the women consider that the symptoms are the result of their growing age instead of menopause or hysterectomy. Therefore there exists the negligent attitude of women towards their health and the nil treatment seeking for the same. It is surprising to see that treatment seeking for the symptoms associated with blood pressure and diabetes (such as burning sensation during urination, frequent and painful passage of urine, breathing difficulty, energy less/tired all the time, feeling dizzy and faint, heart beating quickly/strongly, and headache) is comparative on the higher side as compared to other symptoms. Women do not prefer to seek treatment for the psychological symptoms.

Women, with a bulk of morbidities during middle ages and without any treatment, moves to fourth phase of their life (oldies). During their old ages, they may not be as healthy as they should be and as the policy talks about - health aging. A multidisciplinary approach towards studying menopause related problems needs to be adopted. The health care needs that women require and the diseases, to which they are susceptible, vary with the stages of life. On the other hand women seem utterly negligent of their health. They usually turn to medical services when it is too late and their health problems have become chronic or irreversible. A lack of interpersonal communication between doctor and the patient also exists in the system.

With the increase in life expectancy, population in the elder ages is escalating. Along with, various concerns associated with the health of elderly people are emerging. Therefore it is time to shift the focus of public health to address the emerging health issues of middle aged women and to fill the know-do gap. Strong emphasis needs to be laid to improve medical

facilities to impart better services in accordance with changing need of women and to fill the know-do gap. There is a need to improve the understanding of health of menopausal women and to develop health promotion for women and methods to prevent symptoms of menopause and in the end enlist themselves as sick in health. Therefore, indicating the urgent need of managing health of middle aged women.

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