

EDITORIAL

Menopause and society: the association of educational level, social status, and financial status with positive versus negative perceptions about menopause

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Menopause, the cessation of menses and ovarian function, is a physiologic, endocrinologic, and normal consequence of aging. Yet, as with all female reproductive functions, menopause is also seen and interpreted socio-culturally by the values placed by a particular society on a woman's status and worth based on her reproductive potential. The experience and interpretation of menopause is nuanced internally by each woman who goes through this transition and externally by the perceptions of her family and community. The interpretations of these experiences vary cross-culturally from a normal biological process, to transformative liberation from menses, to a state of identity loss and shame.¹

In this issue of *Menopause*, Harun et al² summarize the experience of menopause in a cohort of urban and rural women in Bangladesh. To understand the knowledge and attitudes of menopausal Bangladeshi women, they performed a 28-question interview of 160 women. They conclude that although women in Bangladesh had little understanding of the process of menopause, increased knowledge was associated with education, profession, and urban dwelling. They also identify shame and stigma associated with menopause in Bangladesh. In particular, a substantial proportion of both rural and urban women felt humiliated and 61% and 39%, respectively, of rural and urban women did not consider themselves "real women" once they lost their reproductive capacity. Additionally, 91% of women reported a deterioration of their relationships with their husbands.

Their study brings up many interesting questions. Why is there stigma to menopause in Bangladesh? Is this a universal phenomenon faced by aging women in all countries? Or does Bangladeshi society, specifically, have a negative outlook on the condition of menopause?

In Bangladesh, a South Asian country of 162 million people, 41% of the population is between 25 and 54 years of age with a median age of 27.9 years, and only 7.4% are over the age of 55 years.³ With these demographics, the population of women in menopause is much lower than in high-income countries. It may follow that menopausal women may not have a robust peer group from which to receive support and role modeling nor do they have many resources to navigate this period of their lives. Although 74% of the population is literate, literacy increases with increasing urbanization and in Bangladesh, 72% of the population live in rural areas. In Harun et al's² study, 22.5% of rural women compared to 12.5% of urban women had received no formal education. Increasing literacy brings professional opportunities that bring in income and expand women's value beyond their reproductive potential. Literacy and profession also reduces the incidence of domestic violence. In a qualitative study of 500 menopausal women in Turkey, 78.6% of the participants were not literate and 37.8% of the participants experienced domestic violence.⁴

Harun et al also uncover a 96% incidence of depression in their participants. Although the etiology of depression is complex and multifactorial, in the context of menopause, it might be related to physical changes of menopause that impair quality of life (QOL), or the psychological and social changes of self-regard and the value placed on menopausal women by their community.

In 1996, the World Health Organization developed a 26-question QOL instrument, World Health Organization Quality of Life – Biomedical Research Evaluation Form (WHOQOL-BREF) in 19 languages, which emphasizes the importance of subjective issues in health and disease.⁵ QOL is defined as individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns. Four important domains comprise the WHOQOL-BREF questionnaire: physical health, psychological, social relationships, and environment.⁵

The WHOQOL-BREF questionnaire has been used for the past two decades to evaluate health and QOL. For instance, a study from Brazil used WHOQOL-BREF to evaluate the health of older adults showed excellent sensitivity and negative predictive value for worse QOL and poor health

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outcomes.⁶ Clearly, QOL is impacted in menopause both by physical symptoms of estrogen deficiency, and changes of both self-perception and perception by society based on age. The WHOQOL-BREF instrument has been a resource to examine menopause through the four domains in several other studies, which have also linked menopause with depression, anxiety, and reduced self-esteem.^{4,7} Potentially unrelated to culture and social norms, depressive and anxiety disorders, particularly major depression, dysthymic disorder, and generalized anxiety disorder, seem to be considerable factors affecting the QOL in postmenopausal women.⁸

Across cultures, education, urban living, and profession improve QOL in menopause. A study in Poland showed a significantly better QOL for women living in urban areas, having more education, having full-time employment with economic independence, and women in a long-lasting relationship. In contrast, the strong predictors of poor QOL included self-assessment of poor living conditions, reduced financial stability, rural location, and lower education levels.⁹

The end of fertility can be perceived as the end of womanhood in the societies where women's socioeconomic existence is associated with the ability of childbearing. Socio-cultural and psychological factors play a role in this perception. In terms of shame and humiliation, other surveys have also identified shame (45% of respondents) and mental distress (95.4% of respondents) in menopause.⁴ In another survey from Turkey, 57% of women thought menopause was bad and 37% felt that they were no longer a woman.¹⁰

In Bangladesh, gender inequality in education, work opportunities, and decision-making in health care correlates with a reduction in health outcomes and QOL.¹¹ Although the majority of Bangladeshi women's lives are centered around traditional gender roles of being a wife and mother, there is an increasing discrepancy of education and income between rural and urban women.¹² Harun et al² identify one area of the rural/urban discrepancy in understanding and responding to menopause.

In conclusion, the value given to women, their role in society, and each woman's individual perception of herself give positive or negative meaning to the period of menopause. Harun et al identify three key barriers to knowledge about

menopause in Bangladesh: social stigma, access to information, and a personal feeling of shame or shyness. They also document, as do other studies, that educational level, financial stability, and urban location, which are probably a proxy of a woman's empowerment in her society, are important factors in how menopause is perceived and experienced. As more women live into the menopausal years in Bangladesh, it will be important to incorporate both educational programs and social support for these women to improve their QOL, reduce depression and anxiety, and identify important and vibrant societal roles for them.

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