The specialist authority for menopause & post reproductive health

Menopause in ethnic minority women

Why is it important to improve inclusivity and address the differences in menopause experience in ethnic minority women?

The menopause transition is a major health milestone for women. Besides the symptoms that accompany menopause, other factors such as biological, psychological, behavioural and social changes shape a woman's midlife and future health[1].

The UK is a multi-ethnic, multi-racial country and, in 2018, 13.8% of the UK population had an ethnic minority background[2]. There is however limited research evidence of menopause experiences in British ethnic minority women. A substantial portion of the information available is from overseas research, articles and blogs[18,19,20].

There are differences in biological and hormonal changes in women of different races and ethnicity. There are significant differences among women's perceptions, attitudes and expectations surrounding menopause, and this is hugely influenced by their race, culture and ethnicity[1,4].

A better understanding of these similarities and differences will improve delivery of culturally appropriate care that may help with symptoms and increase the quality of life for midlife women of all ethnicities and races[3].

Barriers to ethnic minority women seeking help[18,19,20]

People from different cultural and ethnic backgrounds may have different beliefs and attitudes, which can have an impact on their ability to seek help.

- Menopause is still a social stigma and a taboo subject in many minority communities, many communities do not talk about it openly yet[5].
- Menopause may be considered as a symbol of loss of fertility and feminity.
- There may be a general expectation for women to stay silent and not complain about their ailments.
- There may be a societal belief that "If every woman must go through menopause, then what's the big issue?"
- A lack of knowledge about menopause and HRT, and the science behind it, may exist.
- Menopause may be considered as a natural process and women may have reservations about using medical treatment for something that is a natural process.
- There may be health literacy barriers[6].
- The lack of menopause educational resources, posters and videos showing ethnic minority women may mean that these women may not be able to identify with the narrative.
- There may be language barriers and a lack of understanding by healthcare professionals of the terms used by ethnic minority women to describe their menopause symptoms.

Differences in menstrual patterns among various racial groups

- Chinese and Japanese women experience longer menstrual cycles than Caucasian women during menopause transition[1].
- Afro-Caribbean and Hispanic women have fewer ovulatory cycles in the last year before final menstrual period compared to women of other races[1].

Differences in Oestradiol changes

According to the SWAN study[1], Oestradiol begins to decrease about two years before final menstrual period and it continues to drop for two years afterwards. It then stabilises.

Chinese and Japanese women have a shorter span of Oestradiol changes and slightly lower levels than Caucasian and Afro-Caribbean women.

Differences in knowledge and attitudes towards menopause and ageing

A Pakistani university survey showed that 78% of women were unaware of menopausal symptoms and their effect on health. Most women considered it as part of the natural process of ageing and, even when having symptoms, they did not seek medical help due to a lack of awareness and poverty[6].

The traditional and conservative nature of Asian women may be a barrier for seeking help[7]. There is generally a greater acceptance of ageing in ethnic minority groups.

For instance, in Afro-Caribbean cultures, older women are respectfully called "Queen" or "Mother", implying that they embrace ageing and consider it wisdom.

Distinctive characteristics of the major UK ethnic minority groups

Women of Afro-Caribbean origin[1]

- The mean age of natural menopause is 49.6 years[8].
- Women experience a longer duration of menopause transition.
- These women have the highest prevalence and longest duration of vasomotor symptoms, and they are also more severe.
- They are more likely to experience shorter sleep duration, more frequent awakenings and less efficient sleep.
- Weight gain and mental health issues may be prominent.
- They display a smaller decline in sexual function and report a greater importance of sex.
- Even women with severe symptoms may find it difficult to come forward to seek help.

South-east Asian women (China, Japan, etc)[1]

- Women may not complain of severe vasomotor symptoms.
- Chinese and Japanese women may report a lower importance of sex and suffer more from low libido and sexual pain.
- They may suffer more from forgetfulness, joint and muscle pains.
- Chinese and Japanese women have lower bone mineral density but still have a lower risk of osteoporotic fractures than Caucasian women. This may be explained by higher composite strength indices.

South Asian women (India, Pakistan, Bangladesh, Sri Lanka, etc)

- The average age of menopause in Indian women (living in India) is 46.7 years[9]. The mean age of menopause for Pakistani women is 47.16 years[10]. This is much lower than women in western countries (51 years).
- Premature Ovarian Insufficiency (POI) needs to be carefully considered in this population. The prevalence is 1.5%, which is comparable to the rates reported internationally[11]. However, these women may have children earlier and usually their family is complete by their mid-30s, so they may not be worried about POI and they may not seek medical help. This can have implications for midlife health, such as increased risk of long-term conditions like cardiovascular disease (CVD), dementia or osteoporosis.
- Indian women may complain more of vulval and uro-gynaecological symptoms[12].
- There is a higher incidence of CVD risk factors during menopause transition such as metabolic syndrome, insulin resistance & diabetes, central obesity and hypertension[13].
- Discussions about sexual health can be quite challenging.
- Mental health is not really talked about in these communities[18].

Self-help behaviours

Ethnic minority women may often try to help themselves through various natural and complimentary interventions, before seeking medical help:

- Taking natural supplements, herbal products, Chinese medicine, etc.
- Trying to be mentally strong, focusing on relaxation and stress reduction, or getting support from family.
- Implementing lifestyle changes such as exercise and a healthier diet.

Chinese women may be more open to seeing a doctor and taking medications compared to other ethnic minority women[1].

Some ideas on how we can improve engagement and help ethnic minority women

- Offer information and advice in an open, non-judgmental way.
- Create a safe space for women to open up, absorb information and come back.
- Give evidence-based information about HRT but understand that HRT may not be easily accepted.
- Offer non-hormonal options, if appropriate.
- Provide information about midlife wellness and lifestyle changes, like diet and exercise.
- Offer information and education in a culturally sensitive manner, appropriate to the level of understanding of the woman.
- Understand the need for educational resources in multiple languages, with leaflets, posters & videos showing ethnic minority women.
- Ensure better training of healthcare professionals and the availability of interpreter services.

Conclusions and food for thought

The menopause transition in ethnic minority women remains poorly understood, with a big gap in service provision. The influence of culture, race and ethnicity on attitudes towards menopausal symptoms and treatment is very complex.

There can be significant sub-ethnic variations in symptoms within an ethnic group[14].

There is evidence that Afro-Caribbean women suffer from higher allostatic load than Caucasian women[15]. Allostatic load refers to wear and tear on the body due to repeated activation of the stress response and, thus, it may be an early subclinical indicator of future disease and mortality risk. Long term gender and racial discrimination, social and economic factors, cause chronic stress and have long term health implications[16]. Is it possible that this higher allostatic load also causes women to have more severe menopausal symptoms and a longer menopause transition?

Finally, there is the concept of acculturation. Attitudes of women towards menopausal symptoms may vary, depending on whether they are living in their country of origin, or if they have moved to a new country and environment. Attitudes and beliefs within a country, vary between traditional societies and more modern westernised societies[12,17].

There is a need for more research to understand the impact of race and ethnic differences on women's menopause transition and midlife health.

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