

## Menopause Knowledge and Attitudes of English-Speaking Caribbean Women: Implications for Health Education

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### Abstract

Seventy-four 36-60 year old English-speaking Caribbean women living in the New York metropolitan area were surveyed to determine their knowledge and attitudes towards menopause, and to identify implications for health education practice. A 33-item questionnaire was distributed by the researcher and her trained research assistant at three sites. Sixty-three (85%) of the seventy four women surveyed returned useable questionnaires. Respondents lacked comprehensive understanding of the meaning of the term menopause and information about the risks of heart disease associated with menopause. In general, menopause health information was limited. The majority said they did not seek medical attention when symptoms were present. Among those who did seek care and those for whom treatment was prescribed, non-compliance was high, even with the support of a significant other. There was little correlation between the reported level of education and knowledge of health risks associated with menopause. Although limited in its generalizability, this study identifies the need for further research. It suggests the tailoring of health promotion and disease prevention strategies as well as identifying "efficacy-based" prevention strategies that focus on the needs of English-speaking Caribbean women.

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By the year 2020, there will be approximately 45.9 million menopausal women in the United States, more than at any other time in history (Miles & Malik, 1994). 3.7 million of these women will be African-American. Menopause, as part of the cycle of reproductive aging is universal, but the expectations and experiences of those who are menopausal vary across cultures. Hence, the need to compile data on the knowledge and attitudes of women from different cultures.

We know that culture plays a large part in the use of preventive services (Hines, 1993) yet is often overlooked when planning menopause care. Demographers tend to include Caribbean women under the rubric of African-American or Blacks (U. S. Census Bureau, 2000).

### Statement of the Problem

Menopause has been associated with heart disease, the largest single killer of women in the United States (CDC, Cardiovascular Health,

1996-2000). Among African American females, aged 35-74 years, the mortality rate is known to be higher than for the general population. Coronary heart disease is a major cause of mortality and morbidity in the African American population (Pham, Freeman & Grisso, 1996).

Both research and experience suggest that a large proportion of women from the English-speaking Caribbean are similarly at risk for heart disease, due to a lack of exposure to information and lack of access to the healthcare necessary to reduce risk factors. As virtually no literature address the interests and needs of Caribbean women, demographers have applied data relating to African Americans or Blacks to define or describe problems involving this group (Saunders-Phillips, 1996; U.S. Census data, 2001). This inclusionary definition carries the implicit yet unlikely assumption of a rather homogeneous African American population, without recognizing cultural differences between and among different groups.

The physiological fact of menopause may be universal, but how women experience menopause differs by ethnicity, culture, and socio-economic status. Given the definitions of low income and poverty in the Department of Health and Human Services guidelines, many women from the English-speaking Caribbean are low-income. Like many other immigrants, they are attempting to improve their economic position with little thought to preventive health strategies. Studies of low-income perimenopausal African-American women have concluded that there are culturally based expectations for disease risk. Utian & Schiff (1994) suggested the need for "efficacy based prevention strategies" to meet the needs of a diverse group of menopausal women.

Self-efficacy has been defined as the beliefs individuals hold about personal capabilities to exercise control over their own level of functioning and over events that affect their lives. A strong personal efficacy belief enhances motivation and performance. High levels of motivation enhance self-efficacy beliefs and therefore strengthen the commitment for achieving goals. Those with high levels of motivation are less likely to become frustrated when threatened by personal difficulties and are motivated to take action rather than feel threatened. Those who do not exercise self-efficacy are less likely to master challenges and to achieve their goals. (Bandura, 1993). Thus building strong efficacy beliefs is one of the primary objectives if menopausal women are to take actions that will improve their health enhancing practices. Self-efficacy imparts thought, beliefs, feelings and behavior through the individual's cognitive, motivational, affective and selective processes (Bandura, 1993).

Much has been written about the impact of health promotion and disease prevention and the behaviors of low income women. (Saunders-Philips, 1996). Differences in the perception of health status and the value of health and healthcare providers are often mediated by income and education, as well as acculturation and cultural background. Lack of access to

knowledge and care, as well as poverty per se, may result in unhealthy behaviors.

The identified lack of knowledge about menopause in our participant population suggests the need for a more culturally focused, relevant education as a pre-requisite for developing successful preventive strategies. The purpose of this research is to determine English-speaking Caribbean women's knowledge and attitudes toward menopause as the potential basis for the development of culturally relevant health promotion interventions.

### **Significance**

This study represents a landmark venture into the area of English-speaking Caribbean women's menopausal health. It is expected to provide valuable information for determining areas of health education need, as no relevant data has so far been identified.

The study involved the administration of a questionnaire to English-speaking Caribbean women to identify their knowledge and attitudes toward menopause and the cultural issues relevant to health promotion and disease prevention. Menopause related education of all women including English-speaking Caribbean women need to be highlighted. The intention is two folded, to identify particular educational, attitudinal and cultural differences that might influence health behavior, and to rectify the paucity of menopause related information available about this population. Lack of information prevents optimal use of available preventive and medical care services and limits the effectiveness of new initiatives.

The English-speaking Caribbean culture itself comprises segments with subjectively divergent sub-cultural patterns of behavior. Internally, there are distinctive differences of race, ethnicity, parlance and religion. Bi-racial societies represent countries such as Barbados, Antigua, Jamaica, St. Lucia, Trinidad, and St. Vincent, and they differ in their cultural, political, and economic structures. According to the 2000 census, the terms Black or African-American is used for people having origins in any of the Negroid racial groups of Africa. This

description makes extracting data about those from the English-speaking Caribbean difficult and inclusive.

The sample of respondents included women from Jamaica, Barbados, Grenada, Trinidad, Guyana, St. Kitts, Tortola, St. Vincent, and Nevis. Because the majority (59%) of the respondents to this study was Jamaicans, the overview focuses on Jamaican immigrants. Emigration from Jamaica to the United States has been heavy and steady, with approximately 20,000 migrants to the U.S. annually. New York has a significant population from the Caribbean that resides in the neighborhoods of Flatbush, Canarsie and Flatlands of the Borough of Brooklyn. According to the 2000 census, one in two from Flatbush was born outside the U.S. Residents from Jamaica and Trinidad and Tobago form approximately 60% of this population. In Canarsie and Flatlands, two out of five residents are born outside of the U. S., with Jamaicans forming the largest part of the 51% of African Americans. People from the English-speaking Caribbean reside in all the boroughs of the city, but the concentration is highest in those three neighborhoods.

In the 2000 census, residents were asked to rate their state of health: approximately 17% of those living in these neighborhoods did not consider themselves to be in good health. The leading cause of death in Canarsie, Flatlands and Flatbush reflects the national trend showing heart disease as the number one killer, and the number one cause for hospitalization. Depression was found to be major cause of ill health but often it was not diagnosed, even though treatable. There is poor access to medical care. Thirteen percent of the population reported no health coverage, 22% had no personal physician and 10% needed care but did not receive it (Centers for Disease Control & Prevention, 2004). The Borough of Brooklyn identified 'Targets for Prevention' did not directly include menopause even though heart disease is one issue being targeted for other reasons.

## **Review of the Literature**

A review of the literature from 1993-2004 was conducted to identify studies providing information on menopause knowledge and attitudes. Of the studies identified, most (90%), focused on the general experience of "Black" women and/or "Afro-American" women. (Brett & Madans, 1993). No studies on menopause were found that specifically addressed the knowledge and attitudes of English-speaking Caribbean women. One study used the word 'Black' to include women who were not "African-American" but were from non-English speaking Caribbean countries (Brett & Madams).

In all the studies reviewed the issue of diversity and other important factors necessary to provide guidelines for recognizing and addressing differences among cultural groups, were lacking or absent. Several studies made comparisons of menopause knowledge and attitudes along racial lines, for example, race was correlated with hormone replacement therapy (HRT) use. Black women were less likely to use HRT than white women (Brett & Madans, 1997). Low income Blacks were also compared with low income than Latino women (Saunders-Philips, 1996). When seeking to identify sources of information, African Americans were found to be ten times more likely than Latinos to rank family first as their source for menopause related information. Neither income nor education was found to significantly correlate with information source (Pham et al., 1997).

Often menopause is symptomatic for women. The respondents preferred dietary modifications, herbs and vitamins to treat menopausal symptoms. Many viewed the symptoms of menopause as "normal" and "something all women go through." They believed that the symptoms would pass without treatment and are not unduly perturbed by menopausal discomforts (Kaufert, Boggs, Ettinger, Fugate-Woods, & Utian, 1998).

Barriers to seeking treatment for symptoms of menopause included the un-sympathetic nature of men in general (including male physicians) (Pham et al., 1997). Some of the more recent

approaches to managing menopause do not reach African Americans and most English-speaking Caribbean women. Barriers of income and education continue to leave some women frustrated by the seemingly lack of and conflicting information encountered. African American women appear to under-estimate the risk of cardio-vascular disease and osteoporosis, putting greater emphasis on cancer when making health decisions (Pham et al., 1997). Some African American women are suspicious of pharmacological treatment and may prefer non-pharmacological treatment. Helping women feel comfortable with uncertainty but still able to progress based on the best available information, is most essential (Holmes-Rovner, Padonu, Kroll et al., 1996; Maslow, 1994).

Due to the lack of research about menopausal women from the English-speaking Caribbean, it is uncertain whether the findings for "African-American," "Black" or "Caribbean women" can be generalized to this group. This study is a first step in addressing the need to gather culture data on these women, as a basis for providing relevant and appropriate menopause related health promotion and disease prevention strategies. It is hoped that this exploratory research will trigger additional research.

### **Method**

A sample of seventy four English-speaking Caribbean women in New York City between the ages of 35-64 years, volunteered to complete a menopause knowledge and attitude questionnaire. Data were collected from a total of seventy-four females based on age 35 years and older and who declared their perimenopause status. Each volunteer was given verbal explanation of the questionnaire with anonymity emphasized. A consent form was signed by each volunteer and was placed in a sealed envelop in their presence. The questionnaire was then distributed and assistance given as requested. Data were collected at three sites, an urban Community College, a center for Caribbean women, and a local Protestant Church in the Borough of Brooklyn. Data collection took six months.

### **Instrument**

The instrument used in this study was the Assessment of the Menopause Knowledge and Attitudes of English-Speaking Caribbean Women: Implication for Health Education Questionnaire. The questionnaire was in the form of a checklist determined by pre-test to take no more than thirty minutes to complete. Nine of the thirty-three questions focused on knowledge about menopause. Volunteers were asked to select the one of the seven definitions that most accurately defined menopause. Questions were also asked about menopause status, sources of knowledge about menopause and its health risks, visits to a healthcare provider in response to menopause symptoms and whether treatment, prescriptions and discussions of health risks was part their encounter with the health care provider.

Seven questions addressed the volunteer attitudes toward menopause, seeking medical services for their symptoms, and reasons for compliance or non-compliance with provider instructions or therapy. Questions addressing the expected benefits from the use of alternative therapies such as herbs, vitamins, dietary modifications and home remedies were also asked. Nine questions focused on partner perception and support. Women who indicated that they did not carry out the prescribed treatment or remedies were asked to check their reasons for not doing so. Demographic questions related to island of origin, marital status, education, income and menopause status completed the questionnaire. The questionnaire was distributed and collected upon completion by the investigator and a trained assistant who were present at each site to assist the respondents. The data were analyzed using SPSS descriptive statistics.

### **Findings**

There were 63 usable questionnaires for analysis. Seventy four women volunteered to participate in the study. Of these volunteers, eleven questionnaires were not included in the data analysis because: 1) six participants had either had surgically induced menopause or did not feel comfortable giving information even though they were told that the questionnaire was

anonymous, 2) three participants were not from an English-speaking Caribbean country, 3) two participants had agreed to complete the questionnaire but their appointment at the Women's Center took much longer than expected and so they declined completion of the questionnaire.

**Demographics**

Thirty-seven (59%) of the volunteers identified themselves as Jamaicans and the other twenty four (38%) came from other English-speaking Caribbean islands. The reported average annual income was \$20,000. Twenty four women

(38%) reported being currently married. Sixteen women (25%) reported four years of college education, and only 5% of the respondents had not completed high school.

All volunteers were above 30 years of age and below 60, from an English-speaking Caribbean country, and had had no surgical reproductive intervention. The final sample consisted of 63 menopausal and peri-menopausal respondents (see Table 1). Knowledge of the nature of menopause was mediocre, and definitions varied widely (see Table 2).

Table 1  
Menopause status of English-speaking Caribbean women (N=63)

| Menopause Status | N  | Percentage |
|------------------|----|------------|
| Menopausal       | 48 | 76         |
| Post-menopausal  | 4  | 6          |
| Peri-menopausal  | 6  | 10         |
| Not menopausal   | 5  | 8          |

Table 2  
Percentage of English-speaking Caribbean women knowing the definition of menopause by (N=63)

| Definition   | Percentage |
|--|------------|
| When menstruation (periods) stops                                    | 32         |
| When the body stops making estrogen                                  | 20         |
| When hot flashes begin   | 18         |
| When the ovaries stop functioning                                    | 18         |
| When you reach age 35 and above without having a period for one year | 5          |
| When you reach the age of 50 years                                   | 4          |

Presenting symptoms reported included hot flashes, weight gain, difficulties or discomfort during intercourse, mood swings, heart palpitations and memory loss. Although participants reported seeking advice from physicians and gynecologists, only n=11, (17%) reported being given a physical examination (see Table 3).

Different treatment options were discussed with health care providers, although more than half of

the volunteers (52%) neither sought treatment nor complied with prescribed treatment. Fourteen (22%) indicated that as a health measure recommended by the health care provider they had stopped smoking and were eating healthier and taking vitamin supplements. Fifty-one of the sixty-three volunteers (81%) recognized osteoporosis as a major health risk associated with menopause, and 43% associated menopause with depression. Sixteen (25%)

recognized cardio-vascular disease as an associated risk.

All respondents claiming a “significant other” n=14, (22%) reported receiving encouragement to talk about their menopause symptoms and to visit a healthcare provider for treatment. Twenty five (40%) reported that treatment was prescribed for menopause related symptoms but only twelve (19%) indicated that they followed the prescribed treatment. For those who complied with the prescribed treatment the reported benefit was the relief of symptoms. Nineteen (30%) indicated that any treatment, including home remedies, went against “nature.”

In contrast to the African American and Caucasian women interviewed by Pham, Freeman, and Grisso (1997) who chose family members as the most frequently chosen source of menopause information, the main source of menopause information for the respondents in this study was books n=26, (41%) Physicians as health care providers were the second most frequently chosen resource n=15, (24%). Only two respondents used the Internet as a source of information, even though 56% of the volunteers were college educated. Neither the church nor television was a significant source of information.

Table 3  
Percentage of English-speaking Caribbean women experiencing symptoms of menopause (N=63)

| Menopause Symptoms Experiencing Now                 | Percentage |
|---|------------|
| Hot flashes   | 33         |
| Vaginal dryness                                     | 11         |
| Painful intercourse                                 | 6          |
| Difficulty concentrating                            | 11         |
| Depression  | 11         |
| Headache  | 11         |
| Memory loss   | 13         |
| Feeling as if insects are crawling all over my skin | 6          |
| Lower backache                                      | 13         |
| Sweating during the night (night sweats)            | 11         |
| Urinary problems                                    | 5          |
| Weight gain   | 20         |
| Mood swings   | 19         |
| Heart palpitations                                  | 13         |
| Irregular menstruation                              | 7          |
| Other   | 9          |

**Discussion**

This study is a first step in identifying the knowledge of and attitudes toward menopause held by English-speaking Caribbean women. Informed decisions cannot be made without knowledge, and the replies to the questionnaire clearly indicate a lack of such knowledge. Awareness of risk factors is critical to any approach to health promotion and disease

prevention. Similar to African Americans, the English-speaking Caribbean women in this study lack awareness of some of the life threatening risks of menopause.

There was a clear underestimation of such menopause related risk factors as cardio-vascular disease and cancer (see Table 4). In previous research studies, the underestimation of

cardiovascular risks of “Blacks” or “African American” women has been noted. The same results were found for English-speaking Caribbean women. As race and ethnicity are important variables, English-speaking Caribbean women like their counterparts of African descent, are more likely to develop hypertension at an earlier age than Whites, and are 1.5 times more likely to die from heart disease as estimated by the Centers for Disease Control and Prevention (National Center for health statistics,

2004). At the American Stroke Association annual conference on cardiovascular disease epidemiology and prevention, Carol Derby (2003) suggested the need for sustained efforts to modify risk factors resulting from a high cholesterol levels should include decreasing the accumulation of fat in the abdomen, reducing hypertension prior to menopause as a way of modifying the need for more drastic measures in the post menopausal period.

Table 4  
Menopause associated risks in English-speaking Caribbean women (N=63)

| <b>Risk</b>   | <b>N</b> | <b>Percentage</b> |
|---------------|----------|-------------------|
| Heart disease | 16       | 26                |
| Breast cancer | 12       | 20                |
| Osteoporosis  | 31       | 50                |
| Diabetes      | 4        | 7                 |
| Memory loss   | 12       | 20                |
| Depression    | 26       | 43                |

Causes of secondary amenorrhea include anxiety, drastic weight reduction, obesity, and endocrine disorders such as under- or over-functioning thyroid disease. Even with this knowledge, physicians do not routinely evaluate thyroid function in menopausal women. Drugs prescribed for other conditions can also cause the cessation of menstruation for example the psychiatric drug phenothiazide, and narcotics. As already mentioned, weight gain can result in amenorrhea, because excess fat interferes with the menstrual cycle.

Depression during menopause that women in this study said was a symptom of menopause is an area about which there is still controversy. Studies have linked estrogen deficit with depression. Women, who are prescribed estrogen, report an enhanced sense of self. Some experts suggest that the estrogen mood elevating effect is due to the hormone’s ability to reduce hot flashes and night sweats allowing for more REM sleep (Shaver, et al., 1988). Others say that

depression during menopause has more to do life events than with hormones, so treatment or therapy is unnecessary.

The focus of health promotion and disease prevention should include “self efficacy” and the legitimizing of symptoms by educating women in the use of non-prescriptive alternatives if they are unwilling to seek medical care.

Thirty three percent of the respondents in the study identified hot flashes as a symptom they were experiencing at the time the questionnaire was completed. Most researchers report that women will experience this symptom at some time during menopause and for some menopausal women hot flashes can be debilitating. The mechanism of hot flashes is not clearly understood but is thought to be controlled by the hypothalamus in the brain. The rate of estrogen withdrawal changes the “hypothalamic set point”, resulting in temperature changes. Others suggest hot flashes

are due to a surge in the Gonadotropin Releasing Hormone (GnRH) in the brain that directly controls the heat regulating center of the body. This mechanism creates changes in blood vessels causing them to expand rapidly in an attempt to reduce vasodilatation. Still others say that an alteration in brain glucose availability act as the trigger for hot flashes (Dormire, 2003). Hot flashes is said to deplete the body of Vitamin B, magnesium and potassium. A randomized controlled trial using the dietary supplement red clover blossom and a placebo in a double blind study with symptomatic menopausal women, found at the end of a two week intervention period, no clinically important effect from the treatment of their hot flashes or for any other menopausal symptoms (Tice et al., 2003).

In spite of the yet unclear understanding of the physiology of menopause, women including English-speaking Caribbean women are part of the 75% of menopausal women who experience debilitating symptoms and need pertinent information on how to address their situation.

### **Conclusion**

In contrast with “African American” or “Black” women in other studies, the English-speaking Caribbean women in this preliminary study have incomplete and inaccurate information about menopause, a lack of resources for obtaining relevant information and a resistance to seeking and complying with recommended treatments. There is a need for health educators to seek out and/or develop ways of keeping these women informed, as they do not seem to have a reference point for menopause information. A lack of knowledge about menopause, and lifetime risks of heart disease, would suggest that English-speaking Caribbean women irrespective of education need better information sources for decision making about what they can do to prevent disease and promote their own well being.

### **Recommendations**

There is an urgent need to inform English-speaking Caribbean women about the risk of heart disease and the contributions of poor nutrition to disease in a culturally sensitive

manner so that they can be assisted to take measures to reduce a major preventable cause of morbidity that arise during menopause. For all women, estrogen declines with menopause and is an added factor in increasing the risk for heart disease. However, some phyto-estrogen rich foods once present in the diet of the English-speaking Caribbean population should be encouraged. These food sources include sweet potatoes, pumpkins and soy products that are not only rich in phyto-estrogens but have the added benefits of fiber-rich carbohydrates, that contribute to the reduction of LDL cholesterol and cardio-vascular disease. Excess sodium in the diet has also been associated with an increased risk of morbidity and mortality from hypertension. Traditional foods of the English-speaking Caribbean population favor high sodium content. The promotion of exercise, a low fat diet, and low salt are vital to the prevention of hypertension and heart disease. Given the limited identified resources for menopause information, places most commonly frequented by English-speaking Caribbean women, such as places of worship, need to be cultivated as resource centers for information. Therefore, a liaison with leaders of faith-based communities is probably one of the most efficient ways of reaching this population of women, who are without the necessary information to make informed decisions. There is a need for health educators to seek out and develop other ways of keeping English-speaking Caribbean women informed, as they do not seem to have culturally sensitive resources about menopause.

### **Limitations of the Study**

The results from this study cannot be generalized to the larger population of menopausal women. The participant volunteers in the study were from the English-speaking Caribbean and have cultural differences that impact their health behavior and perception about menopause. The volunteers who completed the questionnaires reported a relatively high level of education and therefore differ in health behavior and perception from the women who did not volunteer. Socio-economic status was not found to be strongly related to health behavior.

Even though the study was of English-speaking Caribbean menopausal women, the results predominantly reflect Jamaicans. Further study is required that will reflect the knowledge and attitude of the other islands represented across all education and social levels.

### Summary

This study is the first step in identifying the knowledge and attitude of English-speaking Caribbean women about menopause. These findings cannot be generalized as previously indicated as they only reflect the response of the volunteer women who completed the Menopause Knowledge and Attitude of English-Speaking Caribbean Women questionnaire. However, despite limitations, this study does provide preliminary data that may be lacking, can complement findings from other studies and used to enhance education that can be offered to women from the English-speaking Caribbean.

Awareness of risk factors is critical to any approach to disease prevention. Strategies targeted at this population should therefore include the use of phyto-estrogen rich foods as a strategy easy to adopt. Further research is needed to identify culturally based expectations of disease risks and efficacy prevention strategies that will more closely reflect the identified needs of English-speaking Caribbean women.

Although limited in its generalizability, this study identifies the need for further study and for health promotion and disease prevention strategies tailored to English-speaking Caribbean women. Thus its heuristic value is inestimable. Further research is also needed to identify "efficacy-based" prevention strategies that focus solely on the needs of English-speaking Caribbean women.

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