

This section of the textbook addresses various issues to consider when counseling women about health issues related to menopause. Managing patients should involve addressing their concerns based on scientific evidence while also being respectful and considering their individual priorities.

Social and cultural aspects of care

Health status and health outcomes are determined by many factors in addition to the physical factors. They include education, income, social status, housing, employment, health services, community support, spirituality, personal health practices, and the physical environment.

Differences between middle-class Caucasian women and women of other social and cultural backgrounds have implications for the way they experience menopause and for their future health and well-being. Risk factors, morbidity and mortality patterns, and access to health care differ among these groups. However, there are few data on these differences as they relate to menopause, because much of the current body of health information is based on Caucasian, relatively healthy, middle-class women.

United States. From the 2000 census, there were approximately 40 million postmenopausal women in the United States. This includes more than 3.5 million African-American, 1 to 2 million Hispanic, and 1 million Asian women. In 2000, almost 10% of the US population was foreign born. Nearly 15% are estimated to speak a foreign language at home. Millions of American-born residents follow the traditions and beliefs of other cultures. The census also reported that about one in three US residents was multiethnic, multiracial, or multicultural; by mid-century, about 47% of the population will be nonwhite. Thus, it is likely that most practitioners in the United States will care for women of many races and cultures.

In the United States, rates of diabetes mellitus (DM), hypertension, and obesity are much higher among African-American, Hispanic-American, and American-Indian women than among Caucasian-American women. African-American women are reported to have a 50% higher prevalence of hypertension, and it develops at an earlier age. When treated for hypertension, African-American women have significantly greater risk reductions in fatal and nonfatal cardiovascular events and in all-cause mortality.

Osteoporosis rates are higher among Caucasian-American women than African Americans. This is most likely because of higher bone mineral densities (BMDs) in African-American women associated with fewer hip fractures (5.6% vs 15.3% for Caucasian Americans). African-American and Asian-American women have higher rates of lactose intolerance than do Caucasian-American women. African-American women have lower rates of endometrial cancer

(1.5% vs 2.6%) and breast cancer (7.3% vs 10.2%), although each of these cancers is more likely to be fatal.

Many immigrant groups present special challenges with disease risks different from those in the United States.

Canada. Canadian healthcare professionals face similar social and cultural challenges in meeting the needs of an increasingly diverse population. Currently, the growth rate of the immigrant population is approximately three times that of the Canadian-born population. Sources of immigration to Canada have also shifted recently. There are increasing numbers of immigrants from Asia, Central and South America, the Middle East, and Africa. Although there is a lack of ethnos-specific national data, some analyses suggest that recent immigrant women report better health and are less likely to engage in risky health behaviors, such as smoking and regular alcohol consumption, than Canadian-born women. Unfortunately, immigrant women are more likely to report poor health and higher morbidity than Canadian-born women over time.

Canadian Aboriginal women represent about 3% of the total population of Canadian women. However, they face multiple health burdens, including poor health status, poverty, violence, and substance abuse. Health practices of Aboriginal women are very different from those of the general Canadian female population. They are twice as likely to smoke and to have alcohol dependence. They are at higher risk for chronic diseases (eg, cardiovascular disease [CVD], DM, arthritis, cervical cancer, human immunodeficiency virus [HIV], and acquired immune deficiency syndrome [AIDS]) and have higher death rates for heart disease and stroke. Their life expectancy is 5 years lower than the national average for Canadian women.

The Canadian Women's Health Surveillance Report identified other vulnerable groups. Single mothers were more likely than partnered women to be poor and to experience higher rates of distress, personal and chronic stress, violence, and emotional abuse. Incarcerated women were at higher risk of exposure to HIV/AIDS, antibiotic-resistant tuberculosis, hepatitis C infections, and sexually transmitted infections. Rural women had significantly higher rates of mortality than urban women.

Ethnicity and menopause. With respect to menopause, variations exist across racial and ethnic groups in the frequency and severity of menopause-related symptoms, and attitudes toward menopause, use of menopausal hormone therapy (HT), and the healthcare system.

The Study of Women's Health Across the Nation (SWAN) is a 10-year longitudinal trial of several ethnic groups of US women—including African Americans, Caucasian Americans, Chinese Americans, Japanese Americans, and Hispanic Americans—designed to examine group differences with respect to the transition to menopause.