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RESEARCH ARTICLE
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SURVEY REPORT ON KNOWLEDGE AND AWARENESS OF PATIENTS ABOUT POST MENOPAUSE AND ITS COMPLICATIONS

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Abstract:
A woman's menstrual periods have permanently stopped at the stage after menopause, which is usually caused by aging naturally. Numerous health issues, including osteoporosis, an increased risk of heart disease, vaginal and urinary issues, and metabolic changes including weight gain, can be brought on by a drop in estrogen at this time. Regular checkups, lifestyle changes, and medical treatments are necessary to address these problems and maintain overall health. The lived experiences of postmenopausal women, a subject that has gotten little attention, are illuminated by this study, which makes it noteworthy. The survey found that women are not well-informed about this important stage of life. In addition to the reported lack of education of their healthcare personnel, women may remain unnoticed and unsupported. We must ensure that all medical staff has received menopause education so that women can learn how to manage their symptoms and general health. In recent years, this has been dealt with. For example, the training provided by the British Menopause Society. Women who experience severe symptoms may need to be referred to menopause specialists. Nonetheless, the menopause shouldn't be depicted negatively or with excessive medication. Women should hope that the years after menopause will be enjoyable and fruitful.

Keywords: *Survey, post menopause, follicle depletion, diagnosis and treatment.*

1. Introduction:

To start the menopause, a natural biological process that typically occurs between the ages of 45 and 55, marks the end of a woman's reproductive years. It is defined by a 12-month consecutive cessation of menstrual cycles, primarily due to a decrease in the manufacture of ovarian hormones, particularly estrogen and progesterone.1 One Although menopause is a normal part of aging, the physical, emotional, and psychological symptoms that accompany it can have a significant influence on a woman's quality of life. And mental health conditions can significantly affect a woman's quality of life. Understanding the physiological changes and potential challenges connected with menopause is essential for managing and improving women's well-being during this transitional time. Menopause is a common transition that all women go through as they age. 2 the

period of a woman's life when she moves from the reproductive to the non-reproductive stages is known as menopause. The natural menopause, or the permanent cessation of menstruation, occurs after the end of a woman's last menstrual cycle. Both secondary menopause and natural menopause are intrinsic. Typical adverse effects include mood swings, sleep problems, urogenital atrophy, vasomotor symptoms (such as hot flashes and night sweats), and an increased risk of cardiovascular disease and osteoporosis. Understanding the physiological changes and potential challenges connected with menopause is essential for managing and improving women's well-being during this transitional time. Examples of medical interference that can trigger the succeeding events early include bilateral ophorectomy (surgical menopause) or iatrogenic excision of the ovary and its function by radiation, chemotherapy, or gonadotropin-releasing hormone analog medication.3 premature ovarian failure that is induced without surgery may be either temporary or permanent.

1.1. Menopause: When Does It Happen?

Although menopause is a common occurrence among women, timing of the final menstrual period and the beginning and duration of the menopausal transition vary. The menopause, or the end of menstruation, has the additional effects of increasing circulating concentrations of follicle-stimulating hormone (FSH), decreasing inhibit, which inhibits the release of FSH, and decreasing ovarian production of oestradiol, the most physiologically active form of oestrogen. Women may experience ovarian follicular atresia at menopausal age that is milder than the overall Oocyst count being reduced; However from a crest of 5 million follicles in mid-gestation and 2 million at delivery, the number of follicles has dropped to roughly 1000 by the time they reach menopause. The amount of follicles that migrate to the gonadal ridge during gestation, their ability to undergo mitosis until mid-gestation, and the rate of follicular atresia all affect the age at which major follicle depletion occurs. The frequency, kind, and timing of menstrual bleeding may alter as circulating estrogen levels fall throughout the menstrual transition. Menstrual irregularities are more common in women over 40. These irregularities might result in bleeding without ovulation, after a short luteal phase, or after a deficient luteal phase. Cycles that lead to decreased luteal phase oestrogen and progesterone production may be caused by insufficient FSH [or insufficient FSH response of the follicle] in the follicular phase. Excessive bleeding may result from progesterone's inability to inhibit oestrogen synthesis, including hyper-estrogenicity, which is brought on by the lack of a corpus luteum.4, 5

1.2. Epidemiology

In the United States, an estimated 1.3 million women go through menopause each year. Menopause typically begins between the ages of 45 and 56. However, about 5% of women have an early natural menopause between the ages of 40 and 45. Additionally, 1% of women suffer from primary ovarian insufficiency, which is defined as a complete cessation of menstruation before the age of 40 as a result of ongoing ovarian failure. Black and Hispanic women are more likely to undergo early and premature menopause than white women. The incidence of premature menopause is 1.4% for Black and Hispanic women and 1% for white women. In a similar vein, the incidence of early menopause is 2.9% for white women and 3.7% to 4.1% for Black and Hispanic women. However, race does not seem to play a part in the differences in a patient's menopausal timing when confounding factors are considered. But at the population level, it could have a role. Additionally, compared to women of other races, Black women regularly have more problematic vasomotor menopause symptoms. Eighty percent of Black women experience vasomotor symptoms, which typically endure for 10.1 years. Sixty-five percent of white women experience vasomotor symptoms, with a median duration of 6.5 years.6

1.3. Etiology

As women age, the number of ovarian follicles decreases due to ovulation and atresia. The granulosa cells of the ovary are deteriorating as the main source of inhibit B and oestradiol. Anti-mullerian hormone (AMH), another hormone secreted by the ovary's granulosa cells, likewise

decreases in levels. Follicle- stimulating hormone (FSH) and luteinizing hormone (LH) synthesis increases gonadotropin is not inhibited by estrogen and inhibit A and B. Additionally, the hypothalamic-pituitary-ovarian axis is disrupted by this decrease in estrogen levels. As a result, endometrial growth is unsuccessful, which may cause irregular periods or even the end of menstruation. During the premenopausal phase, a shortened follicular phase is frequently the initial monthly symptom. Menstruation becomes more frequent as a result. After then, the menstrual cycle usually gets longer. An ovulatory cycle might cause unusual uterine bleeding during premenopausal. Eventually, menstruation ends. Because testosterone levels don't change significantly in the early stages of menopause, a relative increase in the ratio of testosterone to oestrogen can elicit symptoms of excess androgens.
Bilateral ophorectomy is one surgical treatment that may induce menopause. Menopause can also be brought on by endometriosis, radiation therapy, prolonged illnesses like HIV/AIDS, cancer chemotherapy, especially with alkylating medications, and other treatments including antiestrogenic chemicals. This article's focus will be on natural menopause.7

1.4. Pathophysiology

For elderly women, menopause is a normal physiological process. The quantity of primary ovarian follicles rapidly declines throughout this period, leaving insufficient numbers to respond to FSH's actions. Thus, there is no LH surge and no ovulation, which results in a reduction in oestrogen production and the cessation of menstruation. LH and FSH levels rise unchecked for years after menopause starts. Since the adrenal glands can still convert modest amounts of testosterone into oestrogen, some people may not have any symptoms other than the end of their menstruation.6, 7, 8, 9 Even though more than 80% of women have menopausal symptoms, women's experiences with these changes differ greatly. Numerous situations can impact the physiological processes of menopause. Body mass index, socioeconomic status, health conditions, physical activity, diet, smoking, ethnicity, and overall gynecologic health are some of these. Its etiology is centered on changes in the hypothalamic-pituitary- ovarian (HPO) axis brought on by ovarian age.

1. Follicle Depletion in the Ovaries women has a certain number of ovarian follicles at birth, and as they age, their number and quality diminish. Follicle-stimulating hormone, or FSH, eventually causes the remaining follicles to lose their capacity to react.
2. A Decline in Estrogen production: As follicle counts drop, the ovaries release less inhibit B and estrogens. Reduced estrogens lead to the end of the menstrual cycle. Growth of tissues (bone, skin, and vaginal mucosa) that react to oestrogen.
3. Elevated gonadotropin levels: Reduced negative reaction to estrogen and inhibin B sources: an increase in FSH and luteinizing hormone (LH) levels. Compared to LH, FSH rises more dramatically. Follicle- stimulating hormone, or FSH, eventually causes the remaining ovarian follicles to lose their ability to respond. Women have a certain number of ovarian follicles at birth, and as they age, both their number and quality decline.
4. A Reduction in the Production of Estrogen: The ovaries produce less estrogen and inhibin B when the number of follicles declines. The menstrual cycle ends as a result of decreased estrogen. Development of tissues like skin, bone, and vaginal mucosa that respond to estrogen.
5. Elevated levels of gonadotropin: A less adverse response from inhibin B and estrogen sources is indicated by higher levels of luteinizing hormone (LH) and FSH. The rise in FSH is greater than that of LH.

❖ Signs and symptoms

Because of the continued low hormone levels, symptoms may appear or linger even after menopause has officially finished.
1. Symptoms of Vasomotor Hot flashes: Abrupt flushing, perspiration, and warmth, particularly in the upper body. Hot flashes that interfere with sleep are known as night sweats.
2. Symptoms of Genitourinary Dryness and atrophy of the vagina: Low estrogen causes the vaginal

walls to thin and dry out, which can make intercourse uncomfortable or painful. Painful sexual activity (dyspareunia).Urinary urgency or frequency: Usually brought on by the urethral and bladder linings becoming thinner. Elevated risk of UTIs (urinary tract infections).

3. Issues with Sexual Function Diminished libido: Diminished desire for sexual activity. Difficulty reaching an orgasm or arousal.

4. Cognitive and Psychological Shifts Mood fluctuations. Irritability. Anxiety or depression. "Brain fog" or memory loss. Poor sleep quality or insomnia.

5. Modifications to the Body weight growth, particularly in the abdominal area. Wrinkles and thinning of the skin, Hair loss or thinning, Muscle and joint ache.

1.5. Treatment

When a woman has not had a menstrual cycle for 12 months in a row, she is said to have reached post menopause, which is the end of her reproductive years. The significant drop in oestrogen and progesterone levels at this point frequently results in a number of problems. Below is a summary of typical issues and how to address them: Typical Postmenopausal Complication.

1. Vasomotor symptoms: nocturnal sweats and hot flashes.
2. Problems with the vagina and the urinary system: dryness, atrophy, painful sex, infections, or incontinence.
3. Bone loss: Higher risk of fractures due to osteoporosis.
4. Cardiovascular disease: Reduced oestrogen increases risk.
5. Mood swings and cognitive problems: anxiety, depression, and memory impairments.
6. Weight gain and metabolic alterations: elevated belly fat, insulin resistance.
7. Sexual dysfunction: discomfort during intercourse and low libido.10,11

❖ **Optional Treatment:**

1. Hormone Replacement Therapy (HRT): Symptoms include preventing osteoporosis, vaginal dryness, and intense hot flashes. Types: Women without uteruses can receive estrogen treatment (ET). For women with uteruses, combined oestrogen-progestin therapy (prevents endometrial cancer). Risks: Not appropriate for everyone; slight increase in blood clots, stroke, and breast cancer.
2. Drugs that are not hormonal: SSRIs (including paroxetine), SNRIs, gabapentin, and clonidine are effective treatments for hot flashes. Denosumab, bisphosphonates, and selective oestrogen receptor modulators (SERMs) such as raloxifene are used to treat osteoporosis. Local oestrogen creams or rings, lubricants, and vaginal moisturizers can all help with vaginal problems.
3. Changes in Lifestyle: Diet: 800–1000 IU/day of vitamin D and 1200 mg/day of calcium. Exercise: Resistance and weight-bearing activities to improve cardiovascular fitness and bone health. Reduce alcohol intake and stop smoking to reduce your chances of heart disease and osteoporosis. Controlling weight lowers the incidence of joint problems and metabolic syndrome.
4. Psychological Support: CBT or counseling for anxiety, depression, or mood swings. Dealing with emotional shifts can also be facilitated by support groups.
5. Alternative Medicine: Plant-based substances called phytoestrogens, such as soy isoflavones, have a moderately positive effect on hot flashes. Some women may benefit from acupuncture if they have mood swings or hot flashes. Herbal cures: (such as red clover and black cohosh)—use with caution, as there is little proof and potential interactions. The symptoms, risk factors, and general health of the individual all influence postmenopausal medicine. A list of often recommended drugs and treatments for postmenopausal women is provided below:

1.6. Medication

1. HRT, or hormone replacement therapy goal: Prevents bone loss and relieves symptoms lik e vaginal dryness, hot flashes, and night sweats. Types: Treatment with just estrogen (for women without a uterus) Oestrogen-progestin combination therapy (for uterine women) Forms include pills, patches, gels, sprays, lotions, and vaginal rings. Risks: May raise the risk of heart disease, breast cancer, stroke, and blood clots, particularly if taken for an extended period of time.

2. Drugs for Hot Flashes: That Are Not Hormonal SSRIs and SNRIs, such as paroxetine and venlafaxine originally used to treat seizures; gabapentin also helps lessen hot flashes. One blood pressure drug that may help with hot flashes is clonidine. Drugs 11, 12, and 13 1. Hormone replacement therapy (HRT) Preventing bone loss and reducing symptoms including vaginal dryness, hot flashes, and night sweats are among the advantages. Forms: Only estrogen-based therapies (for women without a uterus) Treatment with a combination of oestrogen and progestin (for uterine women) Forms include pills, patches, gels, sprays, lotions, and vaginal rings. Risks: May increase the risk of blood clots, heart disease, breast cancer, and stroke, especially if used continuously. Hot flushes while taking non-hormonal drugs. Examples of SSRIs and SNRIs are paroxetine and venlafaxine. Originally prescribed to treat seizures, gabapentin also helps reduce hot flashes.
3. Drugs for Osteoporosis For postmenopausal women who are susceptible to fractures or bone loss: Bisphosphonates, such as risedronate and alendronate the monoclonal antibody Denosumab
4. A SERM called raloxifene imitates the actions of estrogen on bone. Nowadays, calcitonin is used less frequently. Analogs of parathyroid hormones, such as teriparatide and abaloparatide.
5. Oestrogen Therapy Vaginally Regarding urinary symptoms, pain, or dryness in the vagina: Vaginal creams, pills, or rings with low dosages (like oestradiol)11,12,13
6. Additional Therapies Ospemifene: for vaginal atrophy-related unpleasant sex a vaginal insert called DHEA (Prasterone) locally transforms into oestrogen and androgens.
7. Add-ons: Vitamin D and calcium help maintain healthy bones. Black cohosh, omega-3s, and soy isoflavones are occasionally used for modest symptom alleviation (less evidence-based). Do you want recommendations based on certain health issues or symptoms, such as heart health, osteoporosis, or hot flashes?

1.7. Therapies

Hormone fluctuations and mood problems, such as irritation, depression, or worry. Managing fluctuations in libido, vaginal dryness, or self-esteem is part of sexual health and body image. Couples managing changes in intimacy can benefit from relationship counseling. Changes in identity, retirement, an empty nest, or aged parents are examples of life transitions. How to Locate a Therapist after Menopause:
Post-menopause surgeries can refer to several types of surgical procedures that might be considered or necessary after a woman has gone through menopause. Psychology Today: Search for therapists using terms such as women's concerns, menopause, or hormonal health. The North American Menopause Society (NAMS) maintains a directory of practitioners with menopause training. Telehealth platforms: You can select therapists based on their specialization using services like Better Help, Alma, or Talkspace. Some local OB-GYN clinics offer in-house counselors or recommend patients to therapists who are qualified to treat menopause issues. Procedures: Several surgical operations that may be contemplated or required after a woman has gone through menopause are referred to as post-menopause surgery. These operations may be performed for elective, preventative, or medicinal purposes. Typical post-menopausal surgeries include the following:
1. A hysterectomy: What it is: The uterus is surgically removed. Reasons for doing it after menopause: frequently brought on by endometrial hyperplasia, malignancy, pelvic organ prolapsed, uterine fibroids, or excessive bleeding. Types include total hysterectomy, which involves removing the uterus and cervix. A partial hysterectomy (Supracervical) Extreme hysterectomy (in situations of malignancy)
2. Removal of the ovaries what it is: One or both ovaries are surgically removed? Ovarian cysts, tumors, cancer risk reduction (e.g., BRCA mutation), or as part of a hysterectomy are the reasons for the procedure. Impact after menopause: If the ovaries are already dormant, the hormonal impact is reduced.
3. Surgery for Pelvic Organ Prolapsed: What it is: Repairing organs that have fallen into the vaginal canal, such as the rectum, uterus, and bladder. Why it’s carried out: Prolapsed may result from

postmenopausal pelvic floor weakness. Procedures include colporrhaphy, sacrocolpopexy, and vaginal mesh repair.
4. Endometrial ablation, which is less frequent after menopause what it is: The lining of the uterus is destroyed.
5. Types of Breast Surgery: Mastectomy and Lumpectomy (particularly for high-risk or cancerous conditions). Pertinence: The risk of breast cancer rises with age.
6. Cosmetic surgery or vaginal renewal what it is: techniques to improve the appearance, dryness, or laxity of the vagina? Why after menopause? Atrophy or pain may result from hormonal changes.
7. Bladder surgery for prolapsed, hyperactive bladder, or stress urine incontinence.12

2. Materials and Methods

1. Research Design: 100 postmenopausal women completed a questionnaire.
2. Participants/Materials: Women 40–65 years old are eligible to participate, depending on the study's particular topic. 12 months or more without a menstrual cycle (technically post-menopausal). An ethnicity or age range, if applicable. Not having a history of certain illnesses that could affect the study, such as cancer or serious heart problems. Individuals who have undergone surgical menopause (such as a hysterectomy or ophorectomy) are excluded. Results may be impacted by women taking specific drugs (such as corticosteroids or hormonal treatments).
3. Information Gathering Techniques:
A. Surveys and Questionnaires: Participants may be asked to answer questions concerning lifestyle, sleep, emotional health, level of menopausal symptoms, and overall well-being. Examples: The Menopause Rating Scale (MRS), the Greene Climacteric Scale, or other validated surveys focused on post-menopausal symptoms like hot flashes, mood disturbances, or vaginal dryness
B. Clinical Evaluations: Physical examinations routine examinations to track cardiovascular risk, bone health, and general health (e.g., bone mineral density testing). Blood tests: Measurements of cholesterol, hormones (such as FSH and oestradiol), and other indicators to monitor physiological changes during menopause. Tests for urinary incontinence: Evaluation via surveys or close observation.
C. Imaging Research: Bone Densitometry (DEXA scan): To assess osteoporosis risk and bone mineral density. Cardiovascular screening includes blood pressure checks, ECGs, and other evaluations of cardiovascular health.
D. Interventions, Hormonal or Non-Hormonal: If there are therapies in the study, participants could be placed in one of the following groups: Hormone Replacement Therapy (HRT): A carefully regulated course of either oestrogen and progesterone or just oestrogen to treat menopausal symptoms. Non-hormonal therapies, such as SNRIs, SSRIs, or lifestyle modifications (exercise regimens, dietary adjustments).
E. Evaluations of the mind: Mental Health Scales: Screening for mood disturbances or mental health changes, including depression or anxiety scales (e.g., Beck Depression Inventory, Hamilton Anxiety Scale).
4. Techniques for Data Analysis: Statistical Instruments: descriptive statistics (mean age, BMI, etc.) to provide an overview of participant characteristics. ANOVA, chi-squared tests, or paired t-tests can be used to examine group differences (e.g., HRT vs. non-HRT). Regression analysis is used to evaluate how different factors, such as age, BMI, and lifestyle, affect postmenopausal symptoms. Program: Statistical software such as SAS, R, or SPSS can be used for data analysis.
5. Moral Points to Remember: All volunteers must voluntarily consent to participate in the study after being fully informed of its goals, methods, risks, and rewards. Ensuring that all participant data is examined and safely kept is known as confidentiality.
6. Study Completion: Follow-up Duration: The amount of time (e.g., six months, a year, etc.) that participants will be monitored following the intervention or evaluation.

3. Questionnaire:

1) At what; age did you start experiencing menopause symptoms?

----------Years
2) What symptoms have you been experiencing related to menopause.....
3) Are you experiencing vaginal dryness?
a) Yes b) No c) May be
4) Do you have frequent urination?
a) Yes b) No c) May be
5) Have you noticed weight gain or changes in metabolism since menopause?
a) Yes b) No c) May be
6) Are you having trouble sleeping?
a) Yes b) No c) May be
7) Have you experienced mood swings, anxiety or depression?
a) Yes b) No c) May be
8) Do you feel more fatigued or having low energy as compared to before menopause?
a) Yes b) No c) May be
9) Have you noticed any changes in your menstrual cycle recently?
a) Yes b) No c) May be
10) Do you have night sweats?
a) Yes b) No c) May be
11) Do you have any concern about your blood pressure?
a) Yes b) No c) May be
12) Do you experience pain during intercourse?
a) Yes b) No c) May be
13) Do you have any issue with urinary incontinence?
a) Yes b) No c) May be

4. Result and Discussion:

1. At what age did you start experiencing menopause symptoms?

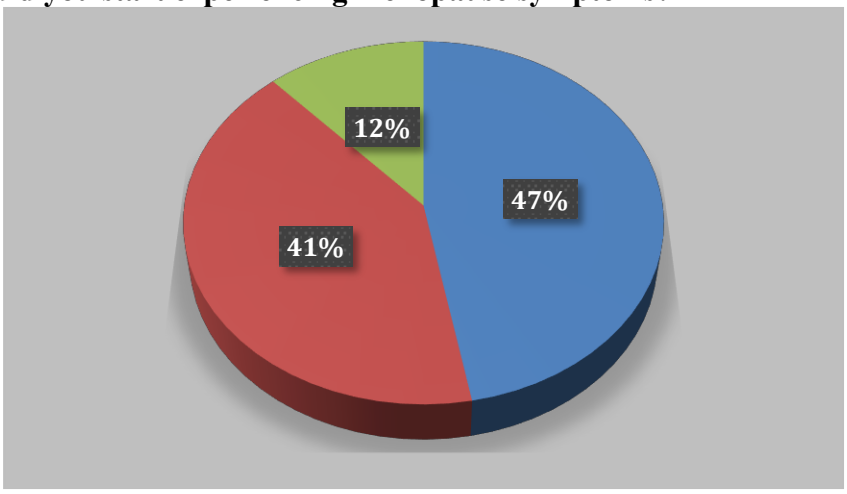

Fig No: 1. menopause symptoms

Here's a simple breakdown you might use for a "What age did you start experiencing menopause symptoms?" pie chart. The exact data can vary depending on the survey or population, but here's a general example based on common trends:

Sample Age Groups and Percentages:

Under 40 (Premature Menopause): 5%, 40–44: 10%, 45–49: 35%, 50–54: 40%55 and older: 10%

2. What symptoms have you been experiencing related to menopause?

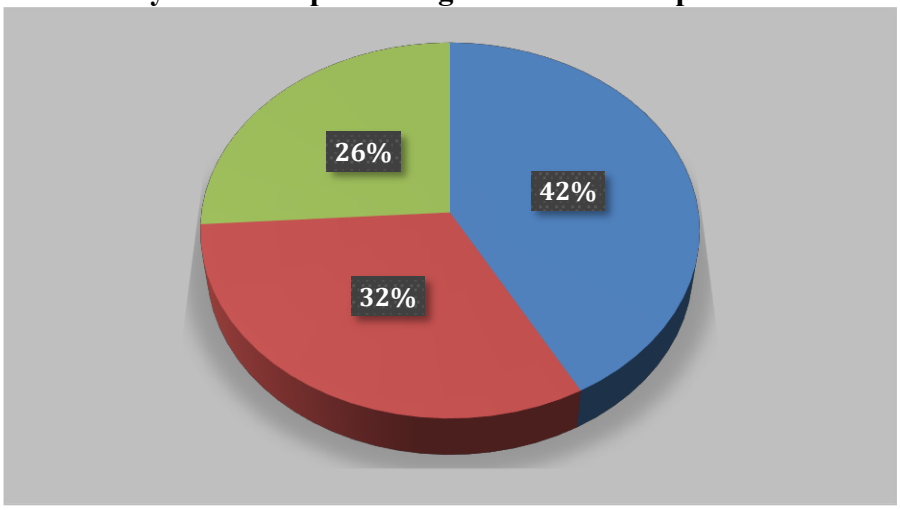

Fig No: 2. Experiencing related to menopause

42% of women clearly reported experiencing symptoms such as hot flashes, sleep issues, mood swings, vaginal dryness, etc.

26% reported no symptoms, possibly due to mild menopause, hormone therapy, or being in earlier stages. 32% were unsure or had intermittent symptoms, which is common in the premenopausal transition phase when changes are still developing.

3. Are you experiencing vaginal dryness?

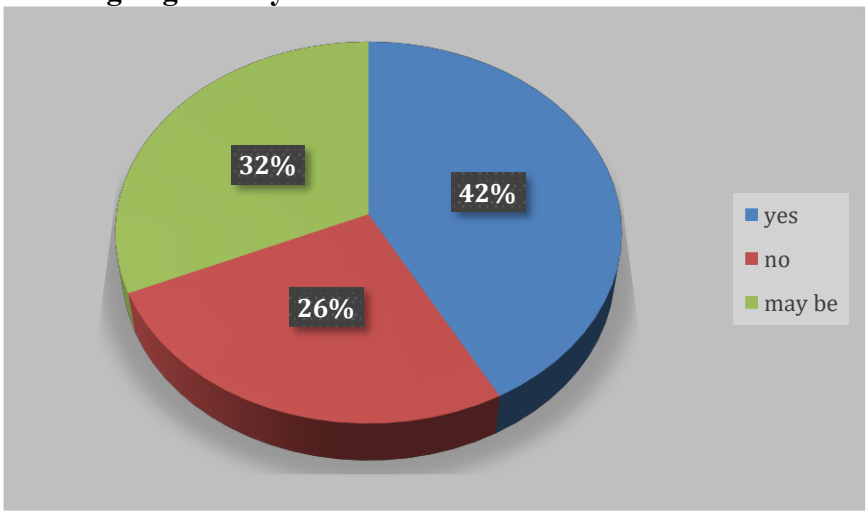

Fig No: 3. experiencing vaginal dryness

A significant portion of women — 42% — reported experiencing vaginal dryness after menopause. This is a common symptom in post-menopausal women and is often caused by reduced estrogen levels, which lead to thinning and drying of the vaginal tissues. This condition, known as vaginal atrophy, can result in: Discomfort or pain during intercourse Around one-quarter of women (26%) reported not experiencing vaginal dryness. This shows that while common, it is not universal. Factors such as genetics, hormone therapy, use of vaginal moisturizers, or even lifestyle choices (like regular sexual activity) may help prevent or reduce symptoms.

A relatively large group — 32% — were unsure if they have experienced vaginal dryness. This could be due to: Mild or gradual onset of symptoms confusion with other causes of discomfort.

4. Do you have frequent urination?

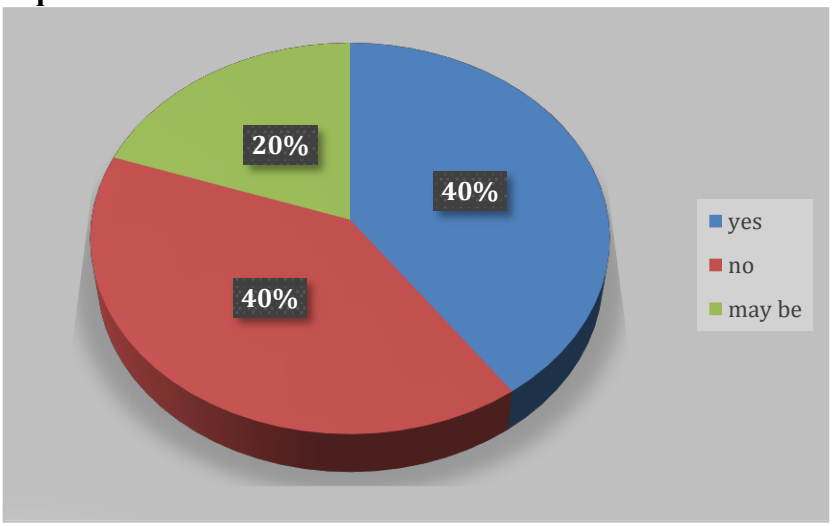

Fig No: 4. frequent urination

50% (Yes): Half of the women surveyed are clearly experiencing frequent urination, likely due to hormonal changes, weakened pelvic floor muscles, or overactive bladder—all common postmenopausal issues.
34% (No): Over one-third of the women do not report this symptom, which may be due to stronger pelvic support, lifestyle factors, or hormone therapy.
16% (Maybe): These women may be experiencing occasional or mild symptoms that are not frequent enough to clearly identify as a problem.

5. Have you noticed weight gain or changes in metabolism since menopause?

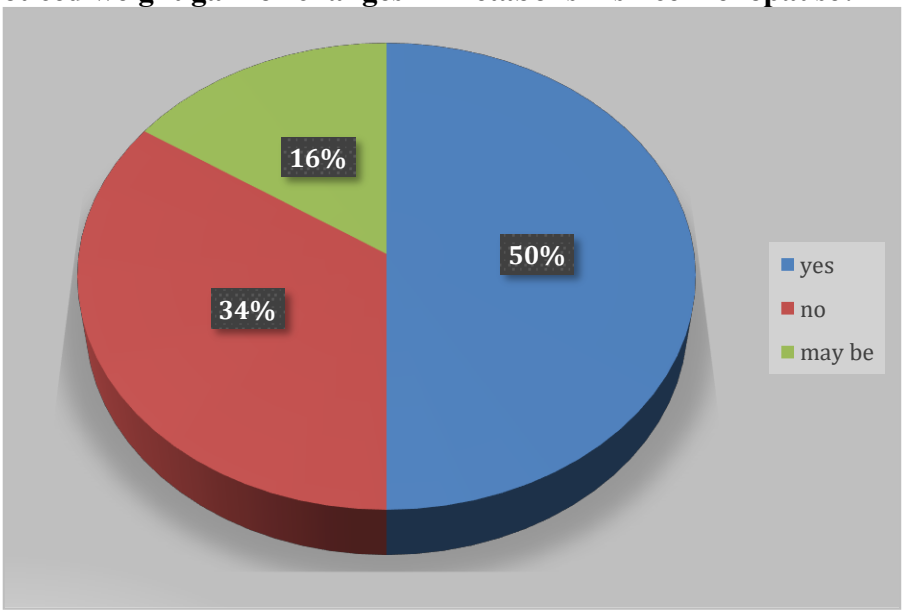

Fig No:5. Weight gain or changes in metabolism since menopause

50% (Yes): Half of the women reported a definite change. This suggests that menopause is commonly associated with noticeable metabolic changes, including slower metabolism and weight gain, particularly around the abdomen. This may be due to hormonal shifts such as decreased estrogen levels, which can affect how the body stores fat and burns calories.
34% (No): Over a third of respondents did not notice any changes. This might indicate individual differences in how menopause affects the body. Lifestyle factors like diet, exercise, and genetics could play a role in maintaining weight and metabolic rate despite hormonal changes.

16% (Maybe): A smaller portion of women were unsure. This group might have experienced subtle or gradual changes that are difficult to attribute directly to menopause, or they may be in early stages where the effects are less noticeable.

6. Are you having trouble sleeping?

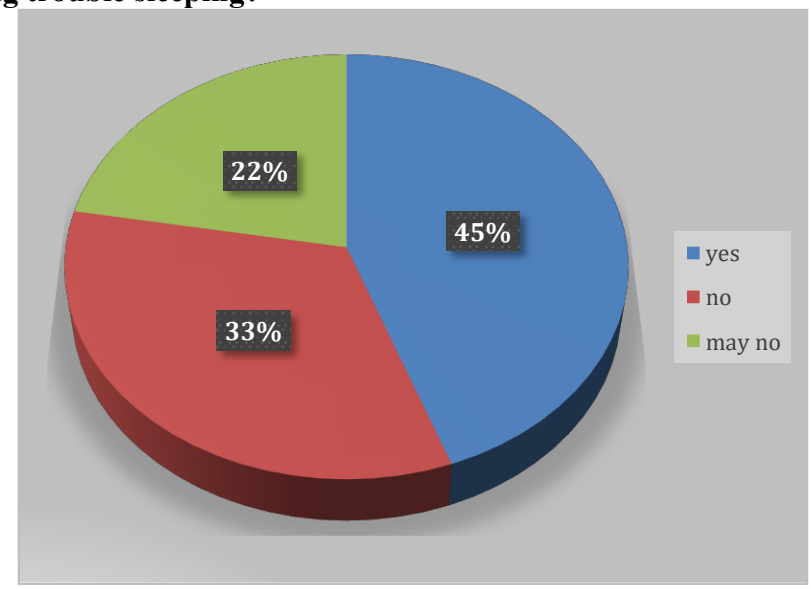

Fig No: 6. experiencing trouble sleeping

Yes – 65% the majority of respondents are experiencing sleep disturbances after menopause. This is very common and likely due to: Hormonal changes: Drops in estrogen and progesterone can disrupt sleep cycles. No – 24% a smaller group reports no issues. These individuals may have milder menopausal symptoms. Use hormone replacement therapy (HRT) or other treatments effectively.
Maybe – 11% this group may experience occasional issues or are unsure if menopause is the cause. Sleep problems can stem from multiple sources, such as: Stress or lifestyle factors. Age-related sleep changes unrelated to menopause.

7. Have you experienced mood swings, anxiety or depression?

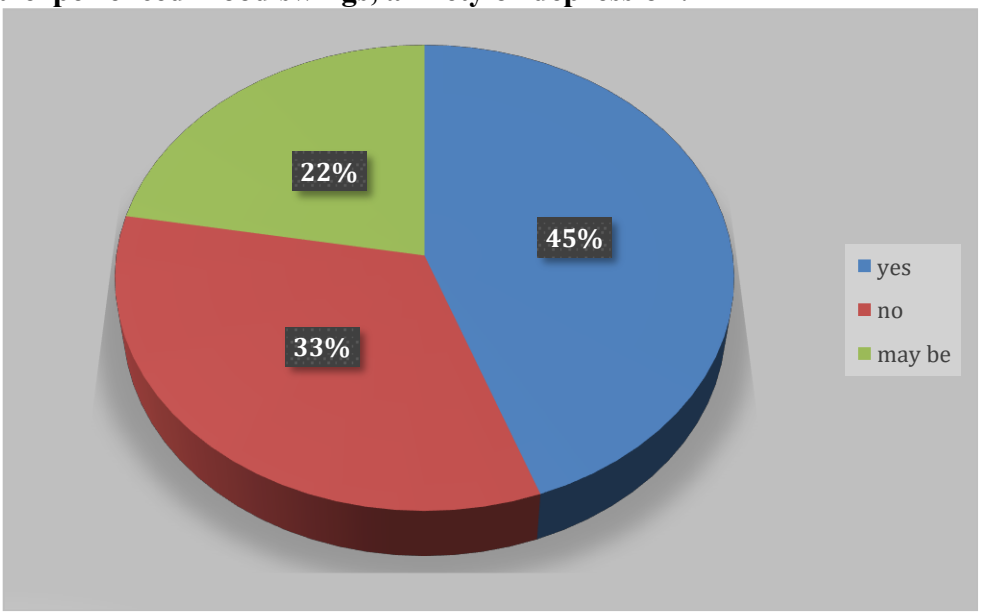

Fig No:7. Experienced mood swings, anxiety or depression

Yes – 45% nearly half of the respondents reported experiencing mood swings, anxiety, or depression after menopause. This is consistent with medical research: hormonal fluctuations, especially drops in estrogen and progesterone, can significantly affect brain chemistry, leading to

mood-related symptom.
No – 33% One-third of respondents did not report these emotional changes. Possible reasons include: Milder hormonal shifts Strong emotional coping mechanisms or support systems Maybe – 22% these respondents may have experienced some emotional changes but were uncertain if menopause was the direct cause. Reasons for uncertainty might include: Overlapping life stressors (e.g., aging, care giving, work stress)

8. Do you feel more fatigued or having low energy as compared to before menopause?

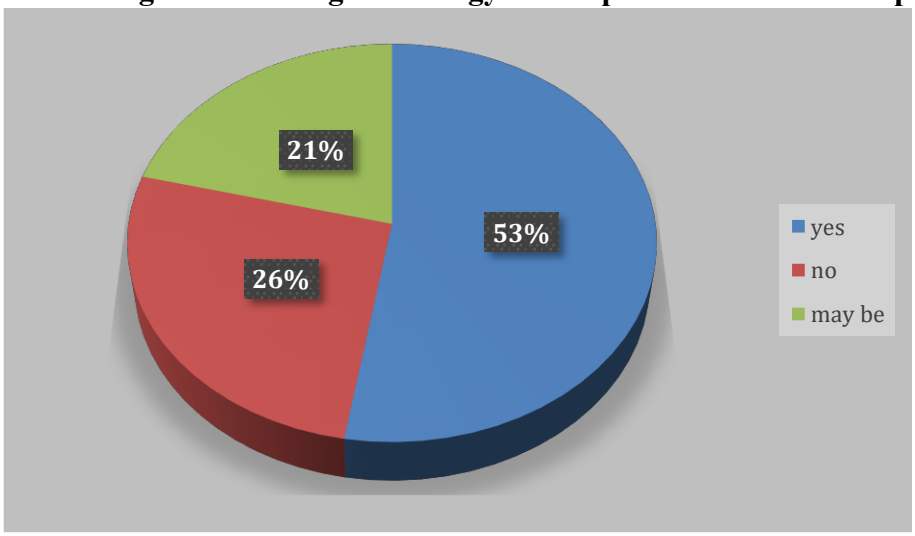

Fig No: 8. Feel more fatigued or having low energy

53% (Yes): Over half of the women experience increased fatigue or lower energy after menopause. This is commonly due to: hormonal changes (drop in estrogen and progesterone) Poor sleep due to night sweats or insomnia mood swings or depression slower metabolism 26% (No): These women may have maintained energy through good sleep, exercise, or hormonal support.
21% (Maybe): These women may be experiencing occasional tiredness but aren't sure if it's menopause-related or from other causes (e.g., aging, stress, work).

9. Have you noticed any changes in your menstrual cycle recently?

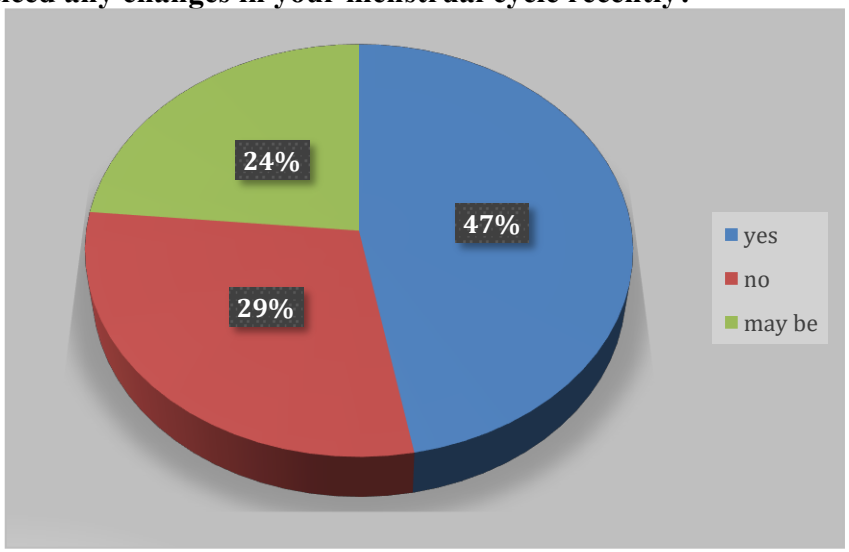

Fig No: 9. Changes in your menstrual cycle recently

47% (Yes): Nearly half of the women surveyed have noticed changes in their menstrual cycle. This is common during the premenopausal phase, where hormonal shifts lead to irregular, lighter, or heavier periods.

29% (No): About a third reported no noticeable changes. This could be due to individual differences in how menopause progresses. Some women may experience a sudden stop in menstruation without many irregular cycles.
24% (Maybe): Almost a quarter of women is unsure or have experienced minor or inconsistent changes that they're not confident are related to menopause. This is also normal, as symptoms can be subtle and vary from month to month.

10. Do you have night sweats?

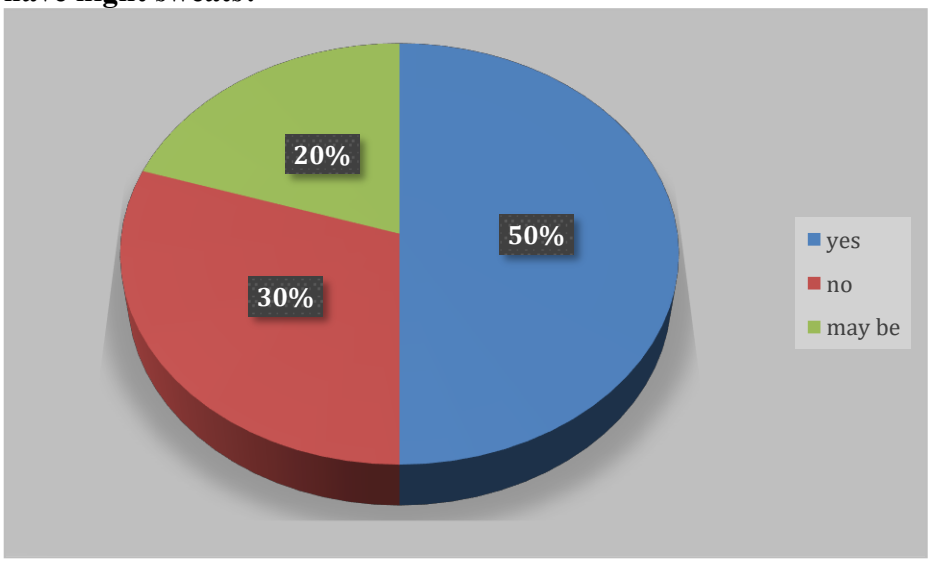

Fig No: 10. Have night sweats

Yes – 50% half of the respondents reported experiencing night sweats during post-menopause. Night sweats are a common symptom caused by: Decreasing estrogen levels, which disrupt the body's temperature regulation No – 30% a third of respondents did not experience night sweats. Possible reasons include: Individual differences in how hormone levels affect the body. Use of hormone therapy, which can reduce vasomotor symptoms Maybe – 20% these respondents were unsure if they experienced night sweats. This could be due to: Confusing night sweats with other causes like anxiety, illness, or medication side effects

11. Do you have any concern about your blood pressure?

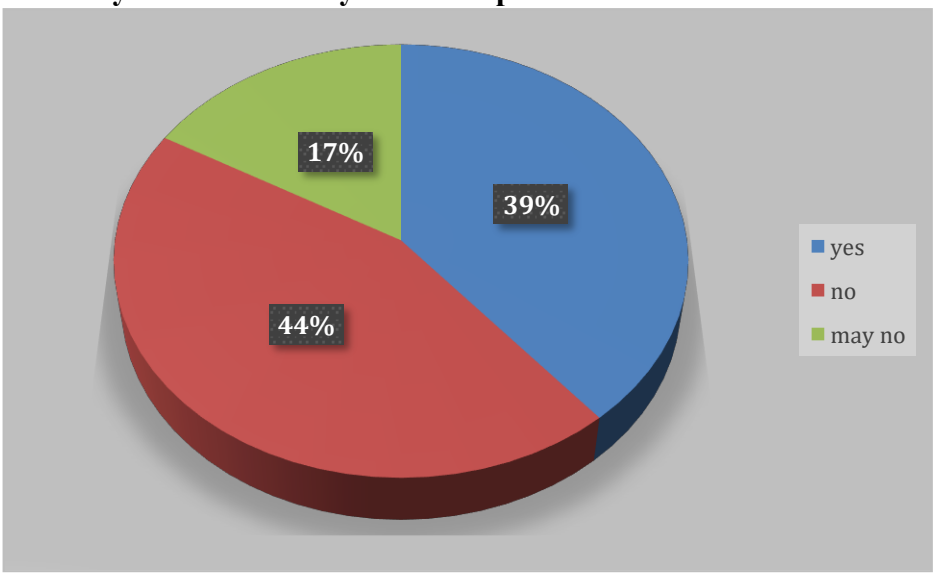

Fig No: 11. Concern about your blood pressure

No (44%) – Largest Group The largest portion of women (44%) reported no concerns about blood pressure during menopause. This might indicate: A lack of awareness that menopause can affect cardiovascular health, including increased risk of high blood pressure. Some women may have normal blood pressure levels and therefore don't feel concerned. Yes (39%) a significant 39% of women expressed concerns about blood pressure during menopause. This group likely recognizes that hormonal changes—particularly the drop in estrogen—can lead to: Stiffer blood vessels, raising blood pressure. Maybe (17%) about 17% of women were unsure whether to be concerned.
This could mean: They're not fully aware of the connection between menopause and blood pressure. They may have other symptoms that take priority, making this a lower concern. They could be in early menopause, where changes in blood pressure haven't become noticeable yet.

12. Do you experience pain during intercourse?

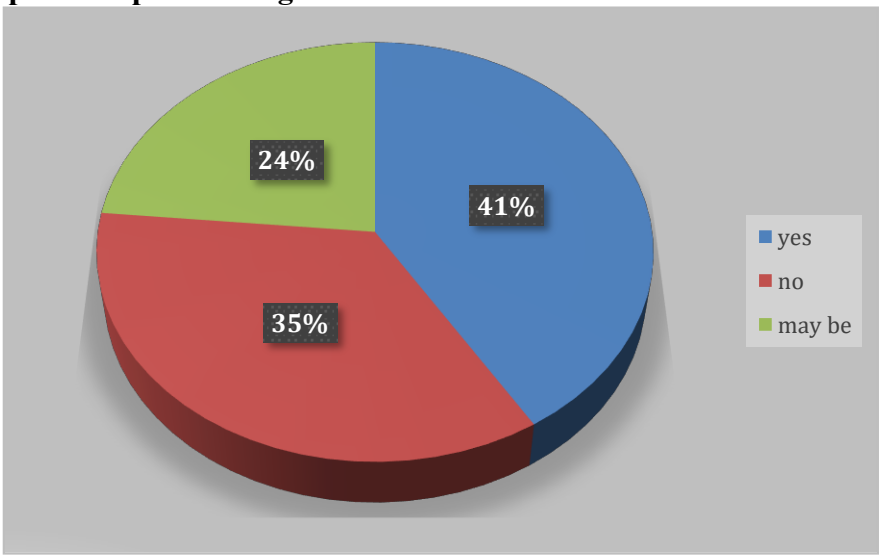

Fig No: 12. Experience pain during intercourse

Yes – 41%: Over 4 in 10 respondents reported pain during intercourse (also known as dyspareunia) post-menopause. This is a common issue, usually caused by: Vaginal dryness due to reduced estrogen levels .Thinning of vaginal tissues (vaginal atrophy), making the area more sensitive No – 35%: About a third of respondents said they do not experience pain. Possible reasons: Milder hormonal changes Use of vaginal estrogen, moisturizers, or lubricants Maybe – 24%: Nearly a quarter were unsure. Reasons for uncertainty may include: Pain that is occasional or varies depending on circumstances

13. Do you have any issue with urinary incontinence?

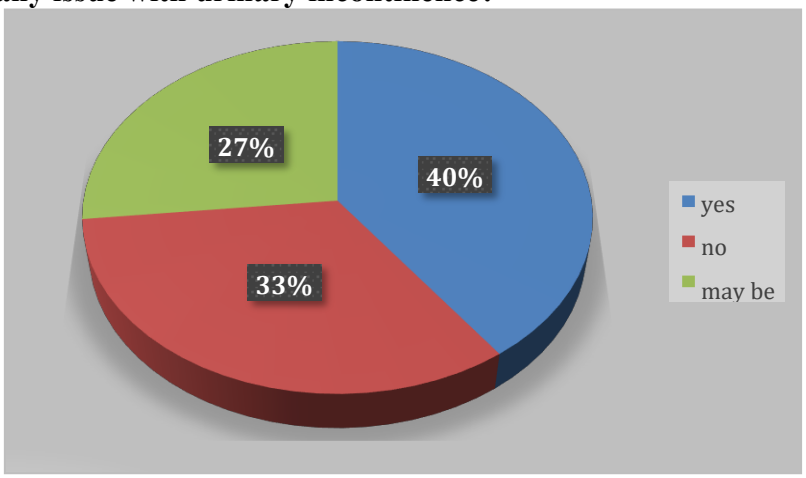

Fig No: 13. Any issue with urinary incontinence

40% (Yes): A significant portion of women surveyed report experiencing urinary incontinence—the involuntary leakage of urine. This is common, especially during and after menopause, due to hormonal and physical changes.
33% (No): About a third of respondents do not experience any urinary incontinence issues. This shows that while it's common, it's not universal, and some women maintain bladder control through menopause.
27% (Maybe): Over a quarter are uncertain, possibly due to mild or occasional symptoms that they haven't identified as incontinence, such as leaking during coughing, sneezing, or exercise.

5. Conclusion:

This study is important as it provides insight into the lived experiences of postmenopausal women, which is a scarce area of research. The data shows that women have a lack of education about this key life stage. Together with a reported lack of education from their healthcare professionals, women may be left undiagnosed and unsupported. We need to ensure that all health professionals have menopause training so they can give women information on managing their symptoms and well-being and this has been addressed in recent years, such as the courses led by the British Menopause Society. Women with severe symptoms may need to be referred to menopause experts. But we must not over medicalize the menopause and present a totally negative narrative. We should give women hope that life post menopause can be a fruitful and exciting time of their life.

6. Summary:

Post menopause is the stage after a woman's menstrual periods have permanently stopped, usually due to natural aging. The drop in oestrogen during this time can lead to several health issues, including osteoporosis, increased risk of heart disease, urinary and vaginal problems, and metabolic changes like weight gain. Managing these complications involves lifestyle changes, medical treatments, and regular health check-ups to maintain overall well-being.

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