A STUDY ON MENOPAUSE HEALTH STATUS OF WOMEN IN TAMIL NADU

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ABSTRACT:

The post-menopausal health issues of women are the major challenge of the Indian public health system. Even though menopause is the part of life, it covered with lots of traditions and prohibitions. If symptoms are recognised at an early stage, it will help in the reduction of stress and fears among women. During the transition to menopause, women may face various issues, including psychological and painful symptoms. These symptoms are not uniform between females. It is influenced by the ethnic, socio-economy, rural and urban characteristics. The lifestyle between rural and urban people are very different. Menopausal symptoms differ in rural and urban areas. The average age of menopause is somewhat lower in the rural population than the urban population. Nevertheless, the beliefs regarding menopausal syndrome are different in the rural and urban population. As a result, the present study is an attempt to rule out the myths and to know the prevalence of menopausal symptoms among the rural and urban population. This study was conducted in Sendamangalam Block, Namakkal District, Tamil Nadu. The Primary and Secondary data were used in this study. It is a cross-sectional community-based study. The paper analyses the menopausal health status of women in the context of the health of women. The study found that the prevalence of menopausal symptoms was higher among the sample respondents in the study area. Most common menopausal complaints reported by the menopausal women among the study population were hot flushes, night sweats, sleep disturbances & easy fatigability. Addressing this problem is the need of the hour because the women population concentrates half of the world population.

KEYWORDS*: : health issues , easy fatigability , Menopausal symptoms.*

INTRODUCTION

The postmenopausal health issues of women are the major challenge of the Indian public health system. The term menopause means termination of the menstrual cycle. The term developed from the Greek word 'Meno' or month, and 'pauses' means a pause or suspension. Menopause is the unspoken and unattended issue reality of life, which is still an and ignored by the male community. Even though it is the part of life, it covered with lots of traditions and prohibitions. If symptoms are recognised at an early stage, it will

help in the reduction of stress and fears among women. During the transition to menopause, women may face various issues, including psychological and symptoms. These symptoms are not uniform between different women.   It is influenced by the ethnic, socio-economy, rural and urban characteristics. In India, only a few authors attempted to study the variance in the symptoms and the age of menopause among the women living rural and urban. Due to the hike in the life expectancy, almost 1/3rd of women's lifespan is in menopause. Menopause, in general, occurs in the middle age, alarming the termination of the reproductive period in the life of a woman. The average menopause age in developing nations is around 44-45years. When a woman nearing her middle age; the estrogen and progesterone production are slowing down and finally stops altogether at menopause. During this, some women face mild issues, and some have severe problems.

DEFINITIONS OF MENOPAUSAL PHASES

The language used for the age and stages of female reproduction concerning the menopause transition is not uniform, and this has been repeatedly discussed by many authors and organisations over the last three decades. Neither the definitions are given by WHO, nor was the terminology provided by the International Menopause Society from 1999-16 satisfactory for use in dealing with the menopause transition. "The Stages of the Reproductive Aging Workshop" (STRAW) suggested seven stages based on various aspects like menstrual cycle characteristics and reproductive hormone levels during 2001-17. Later, Harlow modified this method and proposed a shorter period of amenorrhea as defining the late menopausal transition. The STRAW suggested model – with alterations – is not, however, related to women using HT, who have had a hysterectomy, are smokers, or who have below 18 or above 30 kg/m2 BMI.

The lifestyle between rural and urban people are very different. The economic status between the various categories of Indian population is very different. The people living in different geographical locations are subjected to different climates and have varied food habits and lifestyles. India is the nation with contraindications between traditions and modernism. It is offensive to discuss reproductive health and sexual issues. Improper compliance by patients on the changes in lifestyle and medication is another issue. The average age of menopause is somewhat lower in the rural population than the urban population.

Menopausal symptoms are different in the rural and urban areas. Uro-genital symptoms, body aches and pains are the predominant symptoms in both rural and urban menopausal women. Menopause is recognised by all women in all culture as the termination of menstruation for one year, thus can be said universal reproductive phenomenon. Even there is a remarkable diversity like symptoms and frequencies across the nations and also in the same culture. But the beliefs regarding menopausal syndrome are different in the rural and urban population. Thus the present study is an attempt to rule out the myths and to know the prevalence of menopausal symptoms among the rural and urban population.

OBJECTIVES
The following are the primary objectives of the study:
1. To study the socio-economic conditions of the sample respondents
2. To observe the prevalence of menopausal symptoms among the sample respondents
3. To find out the relationship of their menopausal symptoms with their working situation among the sample respondent.
Based on the above objectives the following hypotheses have been tested;

HYPOTHESIS
1.   There is no relationship between the socio-economic conditions and the menopausal health status of the sample respondents.
2.   There is no relationship between age and the menopausal health status of the sample respondents.

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3.   There is no relationship between income and the menopausal health status of the sample respondents.
4.   There is no relationship between the working situation and the menopausal health status of the sample respondents.
5.   There is no relationship between Education and menopausal health awareness among the sample respondents

METHODOLOGY

This study was conducted in Sendamangalam Block, Namakkal District, Tamil Nadu. The Primary and Secondary data were used in this study. It is a cross-sectional community-based study. The present cross-sectional study was conducted in the year 2018, in Namakkal District. Simple random sampling method has been adopted. Total of 50 samples was collected from the study area (Sendamangalam Block) based on the pilot survey at Government Hospital, Namakkal. Sampling criteria 1. Inclusion criteria- menopausal women more than 45 years to 60 years of age. 2. Exclusion criteria - women who were not interested in participating in the study. A predesigned questionnaire was used to interview the participants. 50 sample women in the menopausal age were selected by random sampling method and data was collected by personal interview in the vernacular language. The collected data was entered into the Microsoft Excel and analysed further using SPSS software. Descriptive statistics, simple average and percentage method were used to elucidate the data.

SCOPE OF THE STUDY

The scope of the present study is to analyse the menopausal health status of women in the context of the health of women. This kind of research will reveal the need of state of women health and develop their efficiency as well as helps to reduce the out of pocket cost by introducing schemes in the health policy to the particular targeted group because nearly half of the Indian population is being women.

LIMITATIONS

The following are the limitations of this study.
1.   The primary data have been collected from the sample respondents. Hence the findings of the study apply only to the women at Namakkal district because of its socio-economic, cultural and demographic background.
2.   The researcher has used tabular analysis and statistical tools to arrive at meaningful conclusions. The limitations of these tools apply to this study also.
3.   It was a cross-sectional study of short period and size of the population is small; therefore, follow up research should be taken up in future as it would be more useful in assessing the menopausal symptoms.

REVIEW OF LITERATURE

To introduce the undertaken research, a review of the literature is present below: In this chapter, efforts have been made to review the select studies pertinent to the research topic and research setting thoroughly.

Beser, E *et al.,* (1994)[1] states that the median age at menopause was 46.24 ± 0.13 (mean ± SEM) years. Obese women reach menopause on an average of 1.7 years earlier than women with chronic energy deficiency (p < 0.01). Other potential correlative measures, education, marital status, number of children, and urban/rural residence were found to have an effect on the age at menopause.

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[1]   **Beser, E,** *et.al,* **(1994):** "Body Mass Index and Natural Age at Menopause", *Gynecologic and Obstetric Investigation*, Vol.37, pp: 40-42.

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Brambilla *et al.,* **(1989)**[2] analysed the factors influencing the age of menopause by using multivariate analysis with the randomly selected samples. The study found that age at menopause differs with the habit of smoking, educational qualification and the level of income and not with the status of their marriage, parity, area of living, the weight and height of the women, oral use of contraceptives or menopausal estrogens. The results of the analysis prove that the differences in age at menopause, identified previously are confusing with the habit of smoking.

Bromberger I T, *et al.,* **(1997)**[3] **attempted to study the** entry on the age of natural menopause among health US women with various factors viz., demographic, reproductive, stress level, and health. The Median age at menopause was earlier for females United Nations Agency who stated irregular menstrual cycles at study record (50.2 years), were African-American (49.3 years), were smokers (50.6 years), or were presently on a weight reduction diet (50.5 years). Results suggest that premenopausal women in their forties who are experiencing irregular menstrual cycle are smokers, are dieting, or are African-American are likely to reach menopause earlier than their contemporaries. African-American females could have a unique "biological clock" than white females, specifically while under stress, or they will experience additional stress of longer period.

Borker S A *et al.,* **(2013**)[4] states that the study was conducted among 106 postmenopausal women staying more than 6 months at Anjarakandy with the help of pretested questionnaire administered by a trained community staff from January to October, 2009. Before that, a pilot study was conducted, and the required sample size of 100 was calculated. A random sampling of houses was done. The mean age of attaining menopause was 48.26 years. Commonness of indications among females were sensitive issues (namely, crying spells, irritability, depression and stress) 90.7%, headache 72.9%, tiredness 65.4%, dysuria 58.9%, absentmindedness 57%, musculoskeletal problems (joint pain, muscle pain) 53.3%, sensual problems (decreased libido, dyspareunia) 31.8%, genital problems (itching, vaginal dryness) 9.3%, and changes in voice 8.4%. Only 22.4% of females knew the accurate reason for the menopausal issues.

Singh Pankaj *et al.,* **(2015)**[5] states that According to Indian Menopause Society research, there are about 65 million Indian women over the age of 45. The present empirical, cross-sectional study was carried out in rural women (n = 220) in the district of Farrukhabad, Uttar Pradesh, to assess the common types of menopausal signs. The majority of the patients were in the age group of 50–55 years, which may be treated as high risk of menopausal age group. The mean age of menopausal issues was evaluated as fifty one years.

The above review of the literature indicates a lack of systematic and comprehensive selected to women and her health care in women. Some general observations and some sporadic studies which have touched certain aspects related to this problem in researches, which have focused on the theme so that then this modern piece of research explores the unexplored element, that is, Women and her menopausal health.

[2] **Brambilla,** *et.al,* **(1989):** "A Prospective Study of Factors Affecting Age at Menopause", *Journal of Clinical Epidemiology*, Vol.42, pp: 1031-39.

[3] **Bromberger I T, et al., (1997): "**Prospective Study of the Determinants of Age at Menopause", *American Journal of Epidemiology*, Vol.145, pp: 124-33.

[4] **Borker S A,** *et al.* **(2013):** "Study of menopausal symptoms, and perceptions about menopause among women at a rural community in Kerala", *Journal of Mid-Life Health.* Vol.4 (3), pp: 182-187.

[5] **Singh Pankaj** *et al.* **(2015):** "A community-based cross-sectional study on common menopausal symptoms in northern Indian population", *Research and Reviews: Journal of Medical Science and Technology.* Vol. 4(1) pp: 1–4p.

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RESULTS AND DISCUSSION

In this study, 50 menopausal women were interviewed, from the study area. Women above 45 years were included. Data interpretation, in general, was made with the help of Percentage and Average analysis. Diagrammatic and Graphical representation of data was also done to strengthen the field data.

SOCIO-ECONOMIC AND DEMOGRAPHIC FEATURES

The socio-economic and demographic profile of the sample respondent is presented in the following tabular column. The most essential part of the life span of women in the reproductive period, which begins with menarche and end with menopause. The age distribution of the sample respondents shown that majority of the people are within the age group of 45 - 50. About 56 per cent of the total respondents are belonging in this category. 32 per cent of the respondents are belonging to the age group of 51 - 55 years. Only12 per cent of the sample respondent comes under the category of 56 – 60.

Table-1
Distribution of the participants according to their Age, N=50.

Sl.no	Age	Frequency	Percentage
1.	45 – 50	28	56
2.	51 – 55	16	32
3.	56 – 60	6	12
	Total	**50**	**100**

Sources: Primary Data

Table-2
Distribution of the participants according to their Education in years, N=50.

Sl.no	Education (in Years)	Frequency	Percentage
1.	Illiterate	5	10
2.	Primary	19	38
3.	Secondary	11	22
4.	Higher secondary	5	10
5.	Degree / Diploma	10	20
	Total	**50**	**100**

Source: Primary Data

Education bears the quality of human life directly. It is believed that there is a close link between the level of knowledge and the adoption of Health care. Hence the nature of the place is rural background 38 per cent of the people are having the educational qualification of primary level, and 10 per cent are illiterate because of their age group we can easily say that those days importance of education is comparatively low. And 22 per cent have a secondary level of educational qualification. It is 10 per cent and 20 per cent for the higher secondary and collegiate level of education respectively.

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5

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Table-3
Distribution of the participants according to their Income, N=50.

Sl.no	Income	Frequency	Percentage
1.	2000- 5840	22	44
2.	5841- 7840	7	14
3.	7841- 9840	4	8
4.	9841- 11840	5	10
5.	above 11840	12	24
	Total	50	100

Source: Primary Data

It is believed that the monthly salary of a person influences the level and nature of consumption. A higher income group people can easily intake useful calorie food items and could afford for health intakes. It is interesting to observe from the data in Table no.1 that the majority of respondents are coming under the income bracket of below Rs. 5840 per month, which is registered 44 per cent to the total. Another 14 per cent also comes under the category between Rs. 5841 -7840. According to the World Bank (2011) annual income less than one lakh or a monthly income of $1,025 (or) less is considered to be **Economically Weaker Section or Below poverty line**. Therefore one can easily say that the majority of the respondents belong to **Low Income Group** (income up to two lakhs). But the irony is the majority of the respondent's income are only secondary income that is, the head of the family income contributes the significant share. Only eight per cent are there in the third income group. And income group between Rs. 9841- 11840 concentrates 10 per cent, whereas, it is interesting to note that 24 per cent of the people living in the Middle Income Group (Income up to six lakh). It is also due to the educational background they have good earnings.

Table-4
Distribution of the participants according to their BMI, N=50.

BMI	Frequency	Percentage
>18	3	6
18.5 – 20	30	60
21 -24	11	22
25 – 27	5	10
>27	1	2
Total	50	100

Source: Primary Data

60 per cent of the sample respondents comes under the BMI scale of 18.5 - 20. These respondents are moderately malnourished due to inadequate calories of food. Only 22 per cent of the respondents are normal. The remaining 10 and 2 per cent are overweight and obese, respectively.

Haemoglobin (Hb) level was measured to detect the anaemic stage among the sample respondents, and **Body Mass Index (BMI)** has been computed using the formula, weight (Kg)/ height (m) [2] as defined by **James *et al.,* (1988).** BMI is a useful tool in both clinical and public health practice for assessing the nutritional status. BMI was calculated as weight (kg) divided by height (m) squared (kg/m2).

$$BMI = \frac{Weight \ in \ kg}{(Height \ in \ meters \ )^2}$$

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According to the United Nations (UN) classification of BMI,

< 18   -   severely malnourished,
18-20   -   moderately malnourished,
21-24   -   normal,
25-27   -   overweight and
> 27   -   obese.

The Body Mass Index is widely used (WHO) as a practical measure of Chronic Energy Deficiency (CED), i.e., 'steady' underweight in which an individual is in energy balance irrespective of a loss in body weight. CED is caused by inadequate intake of energy accompanied by a low level of physical activities and infections **(Shetty and James, 1994; Shetty *et al.,* 1994**). CED has been associated with reduced work capacity, performance and productivity. Some evidence in developing countries indicates that malnourished individuals, that is, women with a Body Mass Index (BMI) below 18.5 kg / (m)², show a progressive increase in mortality rates as well as increased risk of illness **(Rotimi *et al.,* 1999).**

Table-5
Distribution of the participants according to their Man Days Loss, N=50.

Sl.no	Man Days Loss	Frequency	Percentage
1.	0 day	7	14
2.	1 day	6	12
3.	2 day	28	56
4.	3 day	9	18
	Total	**50**	**100**

Source: Primary Data

Man day's loss is the highest indicator of the health of women. In the above table, only 14 per cent were registered that there is no man day's loss. But the majority that is 56 per cent of the respondents are suffering due to ill health every month at least two days. 18 per cent of the people registered that three days man day lost due to their discomforts. This shows that how the man-days loss are highly correlated with the health of the women that too in their menopausal stage.

Table – 6
Distribution of the respondents based on knowledge regarding the reason for menopause, N=50

Sl.no	Knowledge menopause	Frequency	Percentage
1.	**Yes**	21	42
2.	**No**	29	58
	Total	50	100

Source: Primary Data

Knowledge of menopausal problems known to most of the respondents says, 42 per cent. Whereas the majority of the respondents say, 58 per cent are not aware of the reason for menopause. This itself shows that their ignorance on health complications. This requires many health campaigns to address the problems and difficulties related to them. Otherwise, it is not easy to improve the health of women who are all suffering from menopausal complications. We all know that the women contribution is half of the world. In this sense, it will lead to reducing the efficiency and productivity of women on the whole.

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Table – 7
**Distribution of the respondents based on knowledge regarding Hormone Replacement Therapy,
N=50**

Sl.no	Reason for menopause	Frequency	Percentage
1.	Yes	4	8
2.	No	46	92
	Total	50	100

Source: Primary Data

Of the **Table no 7,** Ninety two per cent of the respondents are disclosed that they are not aware of the **Hormone Replacement Therapy.** It shows that though many of the respondents are having at least secondary school level education, they are not aware of it. Merely eight per cent of the respondents are known to it that too because they are working in the medical field.

Of the **Table 8** connotes the relationship between Income and OOP Cost. It shows a low-level correlation between Income and Out Of Pocket (OOP) Cost. 46 per cent of the respondents say that there is no OOP cost incurred by them. That is a zero cost. The reason for the low-level correlation between household income and Out Of Pocket expenditure on menopause is, women consider this physiological change as normal since every woman of that age group get it. In this study area, this attitude is found common among women, irrespective of their status of income.

Table – 8
Income and Out of Pocket cost (for menopause) wise Classification of the Respondents.

Classification of Income	Classification of OOP Cost					
		0	< 500	501-1000	1001-1500	>1500	Total
	2000- 5840	7	10	0	3	2	22
	5841- 7840	4	3	0	0	0	7
	7841- 9840	3	1	0	0	0	4
	9841- 11840	2	1	2	0	0	5
	above 11840	7	1	1	2	1	12
	Total	23	16	3	5	3	50

Sources: Primary Data

No doubt, this will surely affects the health of women adversely in the immediate short run and in the long term. If one can see the man day's loss, they could easily understand the problem. The remaining 30 per cent of the respondents (Lower income group or Below poverty line) are spending less than 500, 500 to 1000, 1001 to 1500 and above 1500 wise, 20, zero, six d four per cent respectively. Only 10 per cent of the Income Group (above 11, 840) people are spending the OOP cost. This again clearly depict that higher the income lower will be the health cost spending and vice versa. Therefore, awareness campaigns among women may positively change this attitude.

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Table –1.9
Occupation and Mental Stress – Cross tabulation

S. No.	Occupation	Mental Stress		Total
		No	Yes	
1	Agriculture	4	15	19
2	White Collar Job	2	4	6
3	Business	2	6	8
4	Self Employed	1	10	11
5	Home Maker	1	5	6
Total		10	40	50

Sources: Primary Data

Majority of the respondents that is 72 per cent registered that they are suffering from mental stress. Among them, 30 per cent are from agricultural coolies. It shows that they are often losing jobs and searching for jobs in the offseason may give them more stress. Likewise, 20 per cent of the self-employed women recorded that they are in distress due to their job nature. Next comes the business group that is 12 per cent and the white collar job group is very meagre as well as less affected, it may be due to awareness about their health and taking adequate calories.

4.2   Karl Pearson's Correlation has been applied to study the causal relationship between the Income and Expenditure, it was given as,

$$R = \frac{\sum XY}{\sqrt{\sum X^2 \cdot \sum Y^2}}$$

X = 482,000 (X = Income)
Y = 281,000 (Y = Expenditure)
r = 0.785

The Correlation coefficient value **(0.785)** between the Income and Expenditure shows that they are highly related. It is shown that the respondent's Income and Expenditure are highly correlated with each other. Most of the respondents are recorded that their income is capable of meeting their monthly expenditure but not helpful to meet their health issues.

FINDINGS, SUGGESTIONS AND CONCLUSION
1. The most essential part of the life span of women in the reproductive period, which begins with menarche and end with menopause. The age distribution of the sample respondents shown that majority of the people are within the age group of 45 - 50. About 56 per cent of the total respondents are belonging in this category.
2. Hence the nature of the place is rural background 38 per cent of the people are having the educational qualification of primary level.
3. It is interesting to observe from the data that the majority of respondents are coming under the income bracket of below Rs. 5840 per month (Below Poverty Line/ Low Income Group) which is registered 44 per cent to the total. It is believed that the monthly salary of a person influences the level and nature of consumption. A higher income group people can easily intake useful calorie food items and could afford for health intakes.
4. 60 per cent of the sample respondents comes under the BMI scale of 18.5 - 20. These respondents are moderately malnourished due to the low calories of food. Only 22 per cent of the respondents have a healthy BMI. The remaining 10 and 2 per cent are overweight and obese, respectively.

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5. Man day's loss is the highest indicator of the health of women. The majority that is 56 per cent of the respondents are suffering due to ill health every month at least two days. 18 per cent of the people registered that three days man day loss due to their discomforts. This shows that how the man-days loss are highly correlated with the health of the women that too in their menopausal stage.

6. Knowledge of menopausal problems are known to most of the respondents say, 42 per cent. Whereas the majority of the respondents say, 58 per cent are not aware of the reason for menopause. This itself shows that their ignorance on health complications.   This requires many health campaigns to address the problems and difficulties related to them. Otherwise, it is not easy to improve the health of women who are all suffering from menopausal complications. We all know that the women population is contributed to half of the world population. In this sense, it will lead to reducing the efficiency and productivity of women on the whole.

7. 92 per cent of the respondents are disclosed that they are not aware of the Hormone Replacement Therapy. It shows that though many of the respondents are having at least secondary school level education, they are not aware of it. Merely eight per cent of the respondents are known to it that too because they are working in the medical field.

8. The relationship between the Income and OOP Cost shows a low-level correlation between Income and Out Of Pocket (OOP) Cost. 46 per cent of the respondents says that there is no OOP cost incurred by them. That is a zero cost. The reason for the low-level correlation between household income and Out Of Pocket expenditure on menopause is, women consider this physiological change as usual since every woman of that age group get it. In this study area, this attitude is found common among women, irrespective of their status of income. No doubt, this impacts the health of women adversely in the immediate short run and in the long term.   If one can see the man day's loss, they could easily understand the problem.

9. 30 per cent of the respondents (Lower income group or Below poverty line) are spending less than 500, 500 to 1000, 1001 to 1500 and above 1500 wise, 20, zero, six d four per cent respectively. Only 10 per cent of the Income Group (above 11, 840) people are spending the OOP cost. This again clearly depict that higher the income lower will be the health cost spending and vice versa. Therefore, awareness campaigns among women may positively change this attitude.

10. Majority of the respondents that is 72 per cent registered that they are suffering from mental stress. Among them, 30 per cent are from agricultural coolies. It shows that they are often losing jobs and searching for jobs in the offseason may give them more stress. Likewise, 20 per cent of the self-employed women recorded that they are in distress due to their job's nature. The business group is 12 per cent, and the white collar job group is very meagre as well as less affected, it may be due to awareness about their health and taking adequate calories.

11. The Correlation coefficient value (0.785) between the Income and Expenditure shows that they are moderately related. It shows that the respondent's Income and Expenditure are highly correlated with each other. Most of the respondents are recorded that their income is capable of meeting their monthly expenditure but not helpful to meet their health complications expenditure.

12. Sleeping disturbance was reported by 48 per cent of women in the study area in the current study.

13. In this study, 82 per cent, menopausal women complained of muscle or joint pain.

14. Irritability was reported by 48 per cent of post-menopausal women in the Study Area.

15. It was observed that 78 per cent of menopausal women in the study area.

16. Similar to the prevalence of palpitation (32 %) found in the current study.

17. The incidence of headache in the present study was observed to be 88 per cent in the study area.

18. Prevalence of night sweats in the current study was found to be 48 per cent in the study area.

19. In this present study, 68 per cent of menopausal women complained of hot flushes in the study area.

20. Almost more than 90 per cent of menopausal women in the study area suffered from one or more menopausal symptoms, which is a matter of concern and cannot be ignored.

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CONCLUSIONS

The prevalence of menopausal symptoms was higher among the sample respondents in the study area. Most common menopausal complaints reported by the menopausal women among the study population were hot flushes, night sweats, sleep disturbances & easy fatigability. Addressing this problem is the need of the hour because the women population concentrates half of the world population.   Furthermore, these menopausal complications lessen the efficiency and effective productivity among the specific age group, and they may be burdensome to the society as a whole if their problems are not unaddressed. Henceforth, it is vital to sensitize the women suffering the complications of menopausal symptoms. Through health campaign, their difficulties should be remedied. The policymakers should come forward to take into account this sort of unaddressed problems and introduce schemes to improve the health of women in the menopausal group especially, 45 to 54 to improve the health of the women and in turn increase the productivity and efficiency of women in this age group as well as can avoid to many dependent in the age group and transforming them as a productive human resources.

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11