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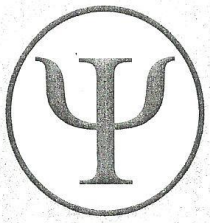

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Introduction

Women in midlife face a variety of challenges. These challenges include the physiological and psychological concerns associated with menopause. Many women go through these years without any difficulty but for some, it is a time of real stress, which is often made difficult because of ignorance and lack of knowledge according to Fox, Sheeha and Del (1999). Most societies have localised sets of social beliefs about different aspects of life, including menopause. In some cultural settings, it is believed that menopausal women become wiser and thereafter can rise in social status and even assume leadership positions; findings by Kaufert (1996); Zurayk, Sholkamy and Khattab (1997). However, menopause is associated with losses, poor health and low self-esteem. According to Yangi, Kukulu and Sozer (2010), the most important aspect of polyclinic services related to menopause is to increase and maintain women's quality of life.

Paterson and Lynch (1988) found that menopause is one area of human physiological development that has been shrouded in myths and taboos. Women are led to expect an inevitable and swift decline in their physical, psychological and intellectual well-being which means becoming unhealthy, emotionally bereft and mentally dull. A survey reports by Quinn (1991) found that separating myth from reality may be difficult for women who do not usually seek medical advice about the menopause on a routine basis. Hsien-An, Meng-Hsing, Chao-Chin, Bor-Lin and Ko-En (2002) investigated the perception of menopause among women in Taiwan and also evaluated the prevalence of various acute menopausal symptoms and women's attitudes towards receiving hormone replacement therapy. The researchers designed a cross-sectional study, using structured questionnaires, targeting women who attended the health information seminar on the menopause and HRT, held in an urban area in Taiwan. More than 2000 questionnaires were collected but only 386 women completed all items of the questionnaire and were included in the study. Among them, 161 women were postmenopausal and their responses to questions regarding acute menopausal symptoms were collected for statistical analysis. The other 225 women were non-menopausal and their perception of menopausal symptoms was also collected for analysis. Qualitative data, in the form of transcripts, were interpreted using text-based content analysis. The study found that among the sampled women, 375/386 (97%) had previously heard of the menopause but only 207/386 (53%) knew the definition of the term. The most commonly indicated source of knowledge on the menopause was reading material, such as newspapers and magazines 283/386 (43%); less common sources of information were friends 141/386 (22%), medical personnel 114/386 (18%) and family members 49/386 (8%). Among the participants, 276 (71%) thought they should receive therapy. The most common acute menopausal symptoms in postmenopausal women and perception of menopausal symptoms in non-menopausal women, respectively, were insomnia 68/161 (42%), 111/225 (49%); hot flushes 61/161 (38%), 115/225 (51%); heart palpitation 55/161 (34%),

103/225 (46%); an irritable temper 54/161 (34%), 138/225 (61%); dyspareunia 52/161 (32%), 100/225 (44%); headaches or dizziness 45/161 (28%), 74/225 (33%); a lack of energy 42/161 (26%), 73/225 (32%); depression 32/161 (20%), 114/225 (51%); night sweating 29/161 (18%), 61/225 (27%); and loss of bladder control 26/161 (16%), 37/225 (16%).The researchers concluded that Taiwanese women have a much higher percentage of awareness of the menopause than other Asian women and a greater willingness to receive treatment. They also found that most of their knowledge of the menopause was obtained from reading material (43%) or friends (22%). Furthermore, the percentage of recognition of menopausal symptoms, especially of vasomotor symptoms, is lower than that of Western women and higher than that of women in Hong Kong and Southern China.

Jahanfar, Ramezani and Hashemi (2002) observed that life expectancy has increased dramatically in developing countries. According to the researchers, menopause as a relatively recent phenomenon brought about new challenges since early complications of menopause can greatly influence the quality of life. Jahanfar *et al* (2002) investigated early complications of 441 menopausal women who lived in Tehran using cluster sampling method. The mean age of menopause was 48.51±4.45. The variables of age, age of menorah, education status, marital status, breast-feeding, history of oral contraceptive usage and hormone replacement therapy, exercise, calcium intake (diet/drug) and smoking were considered in the study. Using Jones standard questionnaire, questions were raised on the early complications of menopause. The mean value for total score of the complications was 12.1±6.8, 60.3% of which had severe complication. Exercise was found to reduce the rate of complications significantly (p.= 0.001). The study suggested the use of exercise to reduce early complication of menopause.

Yangi, Kukulu and Sozer (2010) conducted a study on the perception of menopause in Turkish. The study was conducted in order to determine the symptoms and perception of menopause as well as factors affecting and influencing this perception. The sample comprised 300 women in menopause, who applied to Akdeniz University Research and Application Hospital in January, 2007. In order to obtain relevant data, the researchers employed socio-demographic data from a descriptive survey form. The data were collected by researchers in face-to-face interviews. The mean menopause age of participating women was $x = 45.75 \pm 4.7$. A total of 41.3% of the women had primary education and 62% of the women also had one or two children. The findings of the study indicated that there was a significant relationship between attitudes towards menopause and a woman's age, educational status, number of children, duration of living with spouse, satisfaction with marriage, menopausal age, menopause duration and sexual intercourse after the menopausal period. Presently, little is known about issues relating to the menopause in Nigeria as there seems to be paucity of literature on the on the developmental changes of menopausal women. The aims of this study, therefore, are to assess how menopausal women perceive the physical changes during menopause and their adjustment practices.

Methodology

The study followed a qualitative approach towards evaluating the perception of menopausal women on the subject of menopause. Multistage sampling technique was used in selecting the participants for the study. The multistage sampling technique was carried out first by the selection of six wards in Ilorin metropolis, Nigeria, representing 50% of the 12 wards in the metropolis and three streets out of six streets in each ward are selected using a simple random sampling technique. Two houses in each street were then selected using simple random sampling technique of the ballot type. In all, a total of 238 subjects were randomly selected for the study. The participants consisted of menopausal women aged 40 years and above, living in Ilorin metropolis, who had stopped menstruating for 12 consecutive months. The researchers explained the importance of the research to the selected sample and sought their consent to participate in the study. All the women in each of the sampled houses that met the inclusion criteria for selection were interviewed. Cases where it happened that the subjects needed in the houses for the study were not available when the survey team made its visit or that the house was empty when visited, repeated visits up to three times were made until the subjects were interviewed. Ten volunteers' subjects of homogenous socio-economic background participated in the Focus Group Discussion (FGD) in the six sessions conducted for different focal groups. In all sixty subjects participated in the Focus Group Discussion (FGD). A tape recorder and a notepad were used to ensure that every aspect of the sessions was clearly recorded for ease of reference. A camera was also available to take a group photograph at the end of each session. At the beginning of each session, the researcher was introduced and the purpose of the study was explained. The benefit of such programme to the individual involved and the community at large was highlighted. Convenient sitting environment and relaxed atmosphere were provided and the sitting arrangement was in circle to permit eye-to-eye contact.

The researcher moderated the discussion while the research assistant took notes of the proceedings and a cassette recorder was placed to record the discussions. Each session lasted for 1–2 hours. The moderator (researcher) presented a summary of the discussion at the end of each session.

Processing and Analysis of Data from Qualitative Methods

After each FGD session, a debrief (meeting) was held between the moderator and recorder to examine the focus group activities and results. A longer debriefing was held at the end of the final session. The tape recordings were transcribed and reconciled with the notes taken. The full recording was then edited to remove responses/ sessions that were poorly transcribed. Finally, similar responses in the FGDs were group-coded, analysed and presented.

Results

All the women who met inclusion criteria participated in FGD. The mean age of the respondents was 57.2±1.2. Majority of the respondents 129(72.5%) were Muslims, 144(80.9%) were of Yoruba ethnic group and 117(65.7%) were married. Over half of the respondents 94(52.8%) had some form of formal education. Table 1 shows the socio-demographic characteristics of the respondents.

Respondents' Perception of Menstruation

When participants were asked why women menstruate every month, some participants provided the following responses:

(a) *Menses allow women to be able to conceive. It is natural because during the month there is a nest that forms in the womb and if there are sexual relations, the eggs fall out of this nest (Apo) and forms the menses, which flow to get out.*

(b) *When the sperm has not met with the eggs during the fertile period and when the eggs are spoiled they are gotten rid of in the form of blood. This phenomenon happens every month.*

(c) *Menstruation represents "dirtiness" within women that has to be expelled from the body. If this "dirtiness" remains inside, it may hamper future conception.*

(d) *The importance of the periods is that they get rid of internal dirtiness of the women in order to facilitate fertilisation. The bleeding that happens to women each month is for no other reason but because it is the dirtiness that comes out in the form of blood. There is no other method of cleaning out the inside and the periods play this role.*

Perceived Meaning, Causes and Consequences of Menopause

When the respondents were asked what menopause meant, its causes and consequences, there was a consensus that menopause was part of an ageing process. The participants in the FGDs used various phrases to describe menopause in local term. Some of such phrases were "Kolelo agbala moo" (i.e. she can no longer procreate); "Alejo re ti lo" (i.e. her menstruation has ceased]; "Asiko re ti to" (i.e. her time is up); and "o ti di okunrin" (i.e. she is now a man).

Some of the participants attributed diseases to be a cause of menopause while others believed that it could be caused by witchcraft or sorcery. The most dreaded social consequence of menopause is the risk that a husband may take another wife

or obtain a divorce either because he (the husband) fears that he may become ill from having sex with his menopausal wife. For instance, a respondent stated that:

> *My husband stopped having an affair with me since my menses stopped. He believes that having sexual intercourse with me may make him contact some diseases.*

Some participants, however, believed that menopause has an advantage in enhancement of religious participation. Several women in all the FGDs noted that with the cessation of menstrual flow, they were now free to fulfill their religious obligations more adequately.

> *Another participant asserted that: "During menstruation, I cannot observe the obligatory prayers and fasting. With the cessation of menses, I am free to participate in all religious activities.*

Only a few participants thought that the physical consequences of menopause were more significant than their social implications. They noted that physical change could be discussed with their husbands or friends who could encourage the menopausal women to seek treatment. Many of the identified physical problems of menopausal women are similar and such changes include generalised body pains, knee pains, insomnia, body weakness and malaise including internal heat (hot flushes).

Sexual Intercourse after Menopause

Different reactions were expressed to the question on whether women should still have sexual intercourse after menopause; the consensus being that it was an abomination to engage in sexual intercourse after menopause. The participants stated that:

(a) *Haaba Olorun Maje (i.e., May God forbid), I can never have sexual intercourse now. If we engage in sex, I will have stomach pains and my partners will become impotent.*

(b) *Sexual activity after menopause could lead to the death of the woman. It may result in pregnancy called "Ibu" or "Iju", (meaning fibroid) or "Oyun Isale" (meaning lower abdominal pregnancy).*

(c) *There would be an accumulation of sperm in the menopausal woman who engaged in sexual intercourse since there was no menses to flush it out and such an accumulation resulted in loss of weight and watery vaginal discharge.*

(d) *Menopause provides opportunities for sexual intercourse with my partner without fear of getting pregnant.*

Social Support Networks for Menopausal Women. The adjustment to major changes in anyone's life is easier if there is a strong social support network of friends and family as well as a self-fulfilling position to occupy in the society. Interaction during the FGD indicated that well-educated women showed a high level of understanding of menopause and accepted their conditions and asserted contentment.

Types of Care and Treatment for Women in Menopause

The way menopause is viewed determines, to a significant extent, whether or not women seek treatment for menopause-related physical changes. When participants were asked the types of care treatments that menopausal women usually sought, the responses obtained are presented below:

(a) *Some younger women whose menstrual flow stopped prematurely occasionally seek assistance from traditional or spiritual healers.*

(b) *Menopause can be a liberating experience and I know of many menopausal women who are happy and are enjoying it. What you need is an understanding of yourself and strong faith in God.*

(c) *I drank water regularly in order to take off my menopausal problem. Early in the morning, on rising from bed, I drink three to four cups of water; it is a habit that helps me to reduce all those problems or complaints of menopause, most especially internal heat (hot flushes).*

(d) *Anywhere I go, I never fail to use bitter leaf as a remedy for menopausal problem. I squeeze the fresh leaves in water and drink. Drinking bitter leaf twice daily relieves me of symptoms like hot flushes, internal heat and rheumatism.*

(e) *Menopausal women should take plenty of pure honey. Those who take pure honey regularly will remain fresh, healthy and strong till old age. They will also go through menopause without falling victim of its symptoms. Mix four desert spoons of honey with ½ glass of water and* drink twice daily.

Another useful herbal preparation to ease the symptoms of menopause was described by some of the discussants as.

(f) *The recipe for the tincture included bulbs of garlic and pieces of ginger soaked in dry gin for about two weeks and a spoonful of the concentrate is taken every day.*

Some of the participants, however, believed that the secret to living an enjoyable and meaningful life after menopause is to take care of the body early in life.

Discussion

A few of the respondents had a fairly good idea about why women menstruate. However, most of them perceived menstruation as only means of cleansing the dirtiness in a woman's womb and so it was important that a woman observes her menstruation every month. This shows how important seeing the monthly menses is in this cultural setting. According to Family Health International (2002), in cultural settings where menstrual bleeding is highly valued and seen as a sign of healthy living, menopausal women may welcome abnormal bleeding as a sign of continued fertility and thus fail to seek necessary medical care. However, there are cultural settings where it is believed that women become wiser when menstruation ended and thereafter they could rise in social status and even assume leadership positions (Kaufert, 1996).

Though, there was generally a positive view of menopause among the participants irrespective of age, fewer women expressed negative view about menopause. This finding seems to contradict other studies (Giwa-Osagie, 2003 & Youngs, 1990) which found that women, especially the middle-aged and the older ones, were positive in their attitudes towards menopause. The current finding is not also in support of the notion that negative attitude towards menopause is least among women who were favourably disposed towards getting older (Janice, Samarada & Titilayo, 1998). Their positive attitudes might be a case of beggars having no choice, an attitude that made them view menopausal stage as a fact of life which had to come at its right time and as opportunity for them to meet their religious obligations more regularly and fully as reported in FGD. However, it seems to support the findings of Patterson and Lynch (1998) and Hunter (1993). Yangi, Kukulu and Sozer (2010) also noted that women are generally negative in their attitudes towards menopause.

Sexual intercourse after menopause was viewed as an abominable act by majority of the participants. Any change in sexual activity of women in the climacteric or postmenopausal stage is thought to be more related to their social and psychological states than their physical condition. This is supported by reports from a study which revealed that most of menopausal women experienced no change in sexual desire (Koster & Grade, 1993) and any decrease in sexual desire was more likely to be related to the women's subjective assessment of being climacteric.

Belonging to social groups is one of the adjustment practices made by menopausal women while many engage themselves in business or revive some interesting activity in which they showed talent or had some training in their youth before the business of making a home took up all their time (Giwa-Osagie, 2003). This is reflected in this study as most of the women belong to one or more social groups. Socially, women belong to one association/group or the other where fun and experiences may likely be created and shared. These offer supports to individual members.

In most cases, it was agreed that when women perceive that the cause of these changes is due to the normal cessation of menstruation, they do not seek treatment,

particularly from modern medical services, until the physical complaints get more serious. This is in line with (Giwa-Osagie, 2003) submissions that health-seeking practices of most Nigerian women are poor when it comes to health matters irrespective of educational status. Several participants noted that in the past, herbal treatments were solely relied upon, compared with present day, when some women take advantage of modern alternatives.

Conclusion

From the above discussions, the pattern of behaviour displayed is learnt within a cultural, social-economic and individual context and therefore can be relearned or unlearned, for new positive behaviours that will enhance the quality of human life.

Recommendations

Following the findings of this study, it is recommended that there should be continuous health education on menopause by health personnel and the mass media. The programme should not be limited to the aged only but should include the young, the middle-aged women and other members of the society. This is to promote understanding and emphatic attitude towards menopausal women.

Health providers should establish well-women-clinics and social support networks for women over 40 years in order to provide opportunity for regular discussion of their health problems. Counselling services should also be provided to menopausal women prior to the attainment of the status in order to enhance effective adjustment. Jahanfar, Ramezani and Hashemi (2002) also suggested the use of physical exercises as a mean of reducing menopausal stress. Health personnel should recognise their roles as providers of information on important issues of reproductive health including menopause and in the provision of appropriate management of patients with signs and symptoms of menopause. Also, education modules should be developed to assist women perceive menopause in a more positive way. This will help to dispel the myths surrounding menopause.