University of Venda
Creating Future Leaders

# A MODEL TO FACILITATE WOMEN'S COPING WITH MENOPAUSE.

BY

RAMAKUELA-MASHAMBA NDITSHENI JEANETTE

Submitted in fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in the

Department of Advanced Nursing Science

University of Venda

PROMOTER: PROFESSOR LB KHOZA
CO-PROMOTER: PROFESSOR HA AKINSOLA

August 2012

© University of Venda

University of Venda
Creating Future Leaders

# DECLARATION

I, **NDITSHENI JEANETTE MASHAMBA RAMAKUELA,** declare that this thesis, entitled "**A MODEL TO FACILITATE WOMEN' COPING WITH MENOPAUSE**" is my own work and is being submitted in fulfillment of the requirements for the degree of Doctor Philosophy in the subject of Advanced Nursing Science at the University of Venda. All the sources that I have used or quoted have been indicated and acknowledged by means of complete references and this work has not been submitted before for any other degree at any other institution.

SIGNATURE:..... DATE: 10 MAY 2012

NDITSHENI JEANETTE MASHAMBA RAMAKUELA



© University of Venda

University of Venda
Creating Future Leaders

# DEDICATION

This thesis I dedicate to the following people:

My late father, Elias Naledzani Mashamba, my mother Annah Rolani Mashamba, my late sister Joyce, my youngest sister, Mukondi and brother, Mboneni whose love and support of my every endeavor sustained and encouraged me in everything I did.

To my children Jacqueline, Konanani, Tshimbiluni and Junior, I share with you this dissertation that is a testament to the value of education and a model of lifelong learning and inquiry. I also hope I have set a challenge to you all and hope you will do more than I did.

To my grandchildren Adaobi and Roanda, I wish you grow up to be bright and talented happy and independent women capable of dreaming and making your wishes come true.

To my colleagues, women from Hamakuya villages and everybody who so generously shared their thoughts, feelings and experiences, I hope I have accurately captured voices and that your messages were positively heard through this thesis.



© University of Venda

University of Venda
Creating Future Leaders

# ACKNOWLEDGEMENTS

Thanks and Glory be to the Almighty God, who never failed me, for the strength and courage He granted me to persevere and complete this study, against all odds.

I wish to express my sincere gratitude to the following people for their respective roles and contributions to the thesis:

- Professor LB Khoza, my promoter, I would like to thank you for sharing your love of research and for teaching me a lot about the complexities of it. I appreciate your continuous guidance, support and encouragement during the course of this study.
- Professor HA Akinsola, my co-promoter, for his endless and untiring support, guidance and words of encouragement throughout. I will never forget your generous spirit in helping to build my publication record and how enjoyable it has been to work with you.
- My children Jacqueline, Konanani, Tshimbiluni and Junior, my two grandchildren Adaobi and Roanda for persevering when I could not give them enough attention when I was busy with my thesis.
- My colleagues at the University of Venda, Department of Nursing Dr RT Lebese thank you for contributing your talents to this work, and Dr M Maluleke thank you for your endless support and encouragement throughout the study.
- My colleagues from the Department of Health, Hamakuya clinic for the support they gave during the study.
- The University of Venda for financial support to complete this study.
- Hamakuya Tribal Authority, headmen and women from all the villages of Hamakuya that contributed to this study.
- …….for editing the thesis.



© University of Venda

University of Venda
Creating Future Leaders

# ABSTRACT

Over the past decades, there have been several comprehensive surveys on the subject of menopause, many of which have focused on menopausal symptoms and symptoms reporting. However, a focus on Vha Venda women and their menopausal experiences, reporting and challenges they face, seem to remain silent and often receive little or no attention or may be equated in an unproblematic way, probably because menopause seems to be still a taboo and or an embarrassing situation and/ or they are exposed to mixed feelings about menopause and lack the information and skills to cope effectively with their own menopausal experiences. This study focuses on the experiences of Vha-Venda menopausal women in Hamakuya villages.

The purpose of this study is to develop a model to facilitate women's' coping with menopausal challenges at Hamakuya in Vhembe District in the Limpopo Province, South Africa. The study design will be triangulated to the use of qualitative and the cross sectional descriptive survey. Purposive sample of 500 women of menopausal age between the ages of 40 years and above will be included in the study. Instruments for data collection will be 4 unstructured focus group interviews and a self-administered questionnaire collected by the researchers after permission has been granted.

The study will be guided by Dorethea Orem's theory of self-care deficit. A frame work will be developed as indicated by (Dickoff, James & Wiedenbach 1968:415) which will incorporate themes and subthemes which will emanate from the results of the phases 1 and 2. This frame work will serve as a guideline for developing the model which will be based on literature review, focus group interviews and questionnaires. Before the model can be developed an analysis of concepts will be adopted incorporating the methods advocated by Walker and Avant (2008: 65). Model evaluation will be done by means of critical reflections essentially as described by Chin and Krammer (1999:110). Critical evaluation will involve evaluating the model for simplicity, clarity, accessibility and importance.

**Key words:** Model, coping, experiences, menopause, self-care deficits, concept analysis and model evaluation.



© University of Venda

University of Venda
Creating Future Leaders

# TABLE OF CONTENTS

DECLARATION i

DEDICATION ii

ACKNOWLEDGEMENTS iii

ABSTRACT iv

LIST OF TABLES v

TABLE OF CONTENTS vi

LIST OF FIGURES vii

LIST OF ABBREVIATIONS viii

LIST OF APPENDICES xv



© University of Venda

University of Venda
Creating Future Leaders

TABLE OF CONTENTS PAGE

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION 1

1.2 BACKGROUND OF THE STUDY 3

1.2.1 A historical perspective of menopause 3

1.2.2 The biological construction of menopause in women 4

1.2.3 Global menopausal experiences and menopause 5

1.2.4 The experiences of menopausal women in developing countries 7

1.2.5 The South African context of menopausal experiences 9

1.3 PROBLEM STATEMENT 10

1.4 PURPOSE OF THE STUDY 11

1.5 RESEARCH QUESTION 11

1.6 OBJECTIVES OF THE STUDY 11

1.7 SIGNIFICANCE OF THE STUDY 12

1.8 ASSUMPTIONS OF THE STUDY 14

1.9 THEORETICAL FRAMEWORK 15

1.10 OPERATIONAL CONCEPTS 19

1.11. STUDY DESIGNS 21

1.12 ORGANISATION OF CHAPTERS 22

1.13 SUMMARY 22



UNIVERSITY OF VENDA

© University of Venda

University of Venda
Creating Future Leaders

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION 24

2.2 Phases of menopausal experiences 24

2.2.1 Premenopause, perimenopause and menopause 24

2.3 Models of Menopause 26

2.4 Phase 1: Experiences of menopause by women in other settings 28

2.4.1 Prevalence of menopausal experiences 28

2.4.2 Experiences by educated /uneducated women and menopause 30

2.5 Challenges due to menopausal experiences 32

2.5.1 Physical changes 33

2.5.2 Psychological changes 35

2.5.3 The socio-cultural context and menopause 36

2.5.4 Midlife women menopausal experiences/ challenges 38

2.5.5 Midlife women menopausal experiences 39

2.5.6 Age at menopause 41

2.5.7 Menopausal therapies and lifestyle intervention 44

2.5.8 Menopause, culture and sex 49

2.6 CONCLUSIONS 50



© University of Venda

University of Venda
Creating Future Leaders

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION 51

3.2 STUDY SETTING AND POPULATION 51

3.3 STUDY DESIGNS AND METHODS 52

3.3.1PHASE ONE: QUALITATIVE DESIGN 53

3.3.2 PHASE TWO: QUALITATIVE STUDY 62

3.3.3 PHASE THREE: MODEL DEVELOPMENT 69

3.3.4 PHASE FOUR: MODEL VALIDATION 71

3.4 ETHICAL CONSIDERATION 72

3.5 LIMITATION AND DELIMITATION 74

3.6 SUMMARY 74

CHAPTER 4

RESULTS AND DISCUSSIONS (QUALITATIVE AND QUANTITATIVE)

PHASE 1: QUALITATIVE STUDY 76

4.1. INTRODUCTION 76

4.1.2 THEME 1: PARTICIPANTS' UNDERSTANDING OF MENOPAUSE 78

*4.1.2.1 Participants meaning of menopause* 79

*4.1.2.2 Participants' experiences of menopausal self-care deficits and old age* 87

4.1.3 THEME 2: PARTICIPANTS' EXPRESSION OF FEELINGS /PERCEPTIONS AND BELIEFS OF MENOPAUSE 96

*4.1.3.1 Positive, negative and neutral feelings about menopause* 96

*4.1.3.2 Cultural beliefs, misconceptions and myths regarding menopause* 101



© University of Venda

UNIVERSITY OF VENDA

University of Venda
Creating Future Leaders

*4.1.3.3 Discrimination and stigmatization of participants by family and community members* 105

*4.1.3.4 Taboo not a shared subject among villagers* 107

*4.1.3.5 Lack of participants' support by family and community members* 109

*4.1.3.6 Lack of adequate knowledge and information by participants* 111

**4.1.4 THEME 3: PARTICIPANTS' INADEQUATE COPING WITH SELF-CARE DEFICITS** 113

*4.1.4.1 Inadequate support systems/traditional strategies in place* 113

*4.1.4.2 Lack of formal education and adequate social support systems by the girls initiation schools, churches, families, friends and colleagues* 117

*4.1.4.3 Insufficient information by other health team members* 121

**4.1.5 SUMMARY** 124

**PHASE 2: QUANTITATIVE STUDY**

**4.2 THE RESULTS** 125

**4.2.1 INTRODUCTION** 125

*4.1.2.1 SECTION 1: DEMOGRAPHY* 125

*4.1.2.3 SECTION 2: THE TYPES OF MENOPAUSAL SYMPTOMS BEING EXPERIENCED BY THE PARTICIPANTS* 127



© University of Venda

UNIVERSITY OF VENDA

University of Venda
Creating Future Leaders

*4.1.2.4 SECTION 3: AVAILABLE SUPPORT SYSTEMS FOR PARTICIPANTS TO MITIGATE THE EFFECTS OF MENOPAUSAL CHALLENGES* 137

**4.3 DISCUSSIONS OF QUALITATIVE STUDY** 139

**4.3.1 INTRODUCTION** 139

**4.3.2 THE DISCUSSIONS** 139

**4.4 CONCLUSIONS** 151

**CHAPTER 5**

**CONCEPT ANALYSIS AND CONCEPTUAL FRAMEWORK FOR MODEL DEVELOPMENT**

**5.1 INTRODUCTION** 152

**5.2 OBJECTIVES** 152

**5.3 CONCEPT ANALYSIS** 152

**5.3.1 Identification of the concept of interest** 153

**5.3.2 Definition of the concept of interest** 154

**5.3.3 Identification and selection of appropriate setting and sample for data collection** 164

**5.3.4 Collection of data regarding attributes of the concept antecedents and consequences** 164

**5.3.5 Critical attributes** 165

**5.3.6 Identification of surrogate terms** 167

**5.3.7 Antecedents and consequences** 169

**5.3.8 Identification of related concepts of interest** 170



© University of Venda

University of Venda
Creating Future Leaders

5.3.9 Analysis of data regarding the characteristics of the concept "coping" 171

5.3.10 identification of a model case 173

5.4 CONCEPTUAL FRAMEWORK FOR MODEL DEVELOPMENT 175

5.4.1 Six elements of the practical model 175

5.4.2 Framework/context 175

5.4.3 Self-care agents and recipients 178

5.4.4 The dynamics 180

5.4.5 Procedure of effective coping 183

5.5 MODEL DEVELOPMENT 186

5.6 Purpose of the model 190

5.7 Nature of the model 190

5.8 EVALUATION OF THE MODEL 192

5.9 SUMMARY 192

5.10 GUIDELINES TO IMPLEMENT THE MODEL 194

5.10.1 Guidelines pertaining to the context 195

5.10.2 Guidelines pertaining to the self-care agents and recipients 197

5.10.3 Guidelines regarding the dynamics of coping 197

5.10.4 Guidelines regarding the process of coping 197

5.3 SUMMARY 202



© University of Venda

University of Venda
Creating Future Leaders

CHAPTER 6

EVALUATION, JUSTIFICATION, LIMITATION, CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION 203

6.2 EVALUATION OF THE STUDY 203

6.2.1 The purpose of the study 203

6.2.2 The objectives of the study 203

6.3 JUSTIFICATION OF THE ORIGINAL CONTRIBUTION OF THE RESEARCH STUDY TO THE BODY OF KNOWLEDGE 205

6.4 LIMITATIONS 206

6.5 RECOMMENDATIONS 206

6.5.1 Coping within the family and community context 206

6.5.2 Menopause and coping within the health care context 208

6.5.3 Coping as a process 209

6.5.4 Research 209

6.6 CONCLUSION 209

7. REFERENCES 210



© University of Venda

University of Venda
Creating Future Leaders

## LIST OF TABLES

PAGE

Table 1.1: Participants' distribution according to focus groups, age and menopausal status 59

Table 1.2: Zoning of Hamakuya villages 64

Table 1.3: Themes and sub-themes of menopausal participant's experiences of menopause 77

Table 1.4: Participants' distribution according to age, educational level, marital status, parity and work status (N= 489). 124

Table 1.5: Distribution of the participants' according to their perceived relationship with family members, whether or not they usually feel depressed, smoking and alcohol consumption status respectively, and body mass index. 125

Table 1.6: Distribution of the participants' responses regarding the following: challenges of self-care deficiencies according to: vasomotor, urogenital, musculoskeletal, psychological, gastrointestinal and psychosomatic( N= 489).. 128

Table 1.7: Themes and subthemes 170

Table 1.8 Guidelines to implement the model 196



© University of Venda

University of Venda
Creating Future Leaders

**LIST OF FIGURES** **PAGE**

**Figure 1:** Distribution of participants according to the following variables: contraceptive use, whether or not they suffer from selected menopause-related/associated diseases, use of hormone therapy, and involvement in "exercise"(N= 489). 126

**Figure 2:** Participants' distribution according to vasomotor challenges. 130

**Figure 3:** Participants distribution according to urogenital /libido challenges. 132

**Figure 4:** Distribution of the participants according to musculoskeletal challenges 133

**Figure 5:** Distribution of the participants according to psychological /emotional /psychosomatic symptoms challenges 135

**Figure 6:** Distribution of the participants by menopausal status and the source of support to reduce the effects of menopausal challenges 136

**Figure 7:** The Context of coping 175

**Figure 8:** Structure of self-care agents and recipients 177

**Figure 9:** Dynamics of effective coping 179

**Figure 10:** Procedure for effective coping by women 183

**Figure 11:** Outcome of coping 183

**Figure 12:** The four phases of effective coping 183

**Figure 13:** Awareness of self-care deficits 184

**Figure 14:** Actions for coping towards independence 184

**Figure 15:** Adaptation of coping 185

**Figure 16:** Effective coping with menopause 186

**Figure 17:** The structure of the model to facilitate women's coping with menopause 187

**Figure 18:** Ramakuela model to facilitate women' coping with menopause 192

© University of Venda

University of Venda
Creating Future Leaders

## LIST OF ABBREVIATIONS

The following abbreviations were used in this study:

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ANOVA | Analysis of variance |
| BMI | Body Mass Index |
| CAM | Complementary and Alternative Medicine |
| CHCW | Community Health Care Workers |
| FDG | Focus Group Discussion |
| FSH | Follicle Stimulating Hormone |
| HIV | Human Immuno Deficiency Virus |
| HRT | Hormone Replacement Therapy |
| HT | Hormone Therapy |
| IHCM | Integrative Health Care Model |
| LH | Luteinizing Hormone |
| NHS | National Health System |
| OVC | Orphans and Vulnerable Children |
| PHCN | Primary Health Care Nurse |
| SPSS | Statistical Package of Social Science |
| USA | United States of America |
| UK | United Kingdom |
| WHLSP | Women's Health Life Style Project |
| WHO | World Health Organization |
| ZCC | Zion Christian Church |



© University of Venda

University of Venda
Creating Future Leaders

**LIST OF ANNEXURES** **PAGE**


| | | |
|---|---|---|
| **ANNEXURE A** | Central question and an interview guide for FGD | 233 |
| **ANNEXURE B** | Questionnaire for the interviews | 234 |
| **ANNEXURE C** | Permission to conduct the study | 241 |
| **ANNEXURE D** | Permission from Hamakuya Tribal Authority | 243 |
| **ANNEXURE E** | Informed consent | 244 |
| **ANNEXURE F** | Programme for conducting workshop for research assistance | 245 |
| **ANNEXURE G** | Focus group interview transcripts | 249 |
| **ANNEXURE H** | Participants in a FGD | 263 |




© University of Venda

University of Venda
Creating Future Leaders

# CHAPTER 1

# OVERVIEW OF THE STUDY

## 1.1 INTRODUCTION

The word 'menopause' is derived from the words 'men' and 'pause' and is a direct description of the psychological and physical events in women when menstruation ceases to occur. It is the time in a woman's life when she has experienced the last menstrual bleed (Voda, 1993:447). On the other hand, Henn (2010:405) made similar findings that the word menopause is derived from the Greek word, *men* (month) and *pausis* (cessation). It literally means cessation of the monthly cycle. According to Bulbeck (2003:12) menopause in Chinese is defined as 'it being over' referring to cessation of bleeding that marks menopause. Greenfield (2007:488) also studied the meaning of menopause among the Greeks. The word 'climacteric' is the Greek derivation of the 'ladder' or the steps of the ladder and is another word for menopause. It is the last period of a woman's life and begins some years before the last menstruation (Greenfield, 2007:488).

On the other hand, Chinese and Western medical texts described menstruation as a life time wound and menopause an 'Indian summer', a period of increased vigor and physical beauty (Bulbeck, 2003:12). Conversely, the Japanese use the word 'Konenki' usually translated into English as menopause. But Konenki does not convey the same meaning as menopause, rather it is similar to the concept of the climacteric which is a long, gradual process to which the end of menstruation is just one contributing factor (Melby, Lock, Kaufert, 2005:12).

Kakkar, Kaur, Chopra and Kaur (2007:306) view menopause as a transitional period for women, whereby levels of the main reproductive hormone, oestrogen, decrease leading to a functional deficiency of oestrogenic activity and a variety of symptoms associated with this deficiency. Similarly, Bosworth, Bastian, Rimer and Siegler (2003:32) view menopause as the midlife transition, often prompted by cessation of menses and ovarian failure gradually occurring in women between the ages of 47-55 years.



© University of Venda

Menopause is the time that represents a passage from the reproductive to the post-reproductive life stages. It is an aspect of human aging and a useful predictive risk marker of a variety of aging–related diseases and/or health problems. It signals the end point of the menstrual journey in a woman (Akinrogunde, 2010:1). Furthermore, it signals continuous change in the bodies of older women as many of them are symptomatic. There is a huge difference in the experiences of symptoms of menopause among individuals and across cultures, owing to cultural beliefs and the manner in which symptoms are perceived and accepted (Bosworth et al., 2003:32). The number of menopausal/postmenopausal women (i.e. those women who have experienced cessation of menstruation for at least 12 months) all over the world is increasing, especially in the developing countries, owing to life style changes. This may raise the issue of increased health problems even among women in rural communities who are not excluded from these experiences. The severity and reporting of symptoms also vary enormously worldwide because in some communities menopause is a silent and symptomless experience, while in others it is regarded as normal and people take it as it comes. Other differences in the experience of menopause include the frequency that symptoms are reported and their relative rankings when compared with other symptoms. Some studies indicate that increased frequency and severity of menopausal symptoms are associated more with black than white women (Schneider, 2007:639). Kilaf and Kirchengast (2008:313) point out that although menopause and menopausal transition are not diseases per se, this phase of life reduces the health-related quality of life of stressed women.

At menopause, various menopausal changes occur; the ovaries stop ovulating and become less active in producing sex hormones and menstruation stops over a period of several months with intermittent profuse bleeding. The blood levels of oestrogen and other female hormones decrease causing menopausal problems. At this stage, menopause should be considered a time of adaptation and transition to a new biological situation that involves loss of the reproductive function. It is a necessary stage that all females must go through from middle adulthood (Bosworth et al., 2003:32).



© University of Venda

University of Venda
Creating Future Leaders

## 1.2 BACKGROUND OF THE STUDY

### 1.2.1 A historical perspective of menopause

In many parts of the world like America, menopause is often regarded as a major event in a woman's life. It should be regarded as a perfectly normal, natural state that should not be taken as some sort of disorder or ailment. It is a condition designed by nature whereby a female, past the age when a safe and healthy pregnancy and delivery can be assured, is deprived of further possibility of impregnation. Regardless of culture and country of origin, all women all over the world will experience menopause should they live to that point in their lives (Vanda, 2003:3).

There are very few early references to menopause. Medical interest in menopause increased considerably in the mid-19$^{th}$ century when people started describing menopause as a deficiency disease. In the 1970s, the medicalization of menopause was complete and menopausal symptoms were ascribed to oestrogen deficiency. Oestrogen replacement therapy was exhorted as the ultimate liberation of middle-aged women. Hormone Replacement Therapy (HRT) was enthusiastically promoted by pharmaceutical companies because of oestrogen being seen as a cure-all for anxious, wrinkled, sexually frustrated older women. It was believed that HRT restores youth, beauty and sexual prowess (Coney, 1991: 2). The social construction of lost youth and beauty being considered as a disease means that menopause was a terminal blow and only hormones could, to some extent, prevent 'the death of a woman within a woman' (Wolf, 1990:1). Furthermore, during the twentieth century, Chinese and Western medical texts showed similar sets of physiological and mental symptoms of midlife women. Menstruation was described as a life-time wound and menopause an 'Indian summer', a period of increased vigour and physical beauty. In some Indian medical texts, a menopausal woman was described as an even sorrier creature than a menstruating woman. She was frail, dependent and prone to mental disorders and other illnesses, having exhausted her fixed quantum of life forces. On the other hand, the medical terminology used by the Chinese was modest, concerning the physical cessation of bleeding that marks menopause and defined it as 'it being over'. Both traditional Chinese and Indian medicine comprehend menopause as a natural process accompanied by socially prescribed behaviours (Bulbeck, 2003:12). The twenty first century medical world described menopause as manifesting both physical and



© University of Venda

psychological symptoms owing to oestrogen deficiency and a time when ovaries stopped functioning. Thus HRT was promoted as the drug of choice (Coney, 1991: 3).

### 1.2.2 The biological construction of menopause in women

Women are born with a certain number of immature (oocytes) eggs in their ovaries. In an interaction between the ovaries and the hypothalamus-pituitary gland in the brain, a specific number of these eggs are released each month. A female ovary has the greatest number of oocytes during the fifth month of gestation and has about 1-2 million of oocytes at birth. When a woman reaches the age of about 40-45 the process of atresia reduces the number of the oocytes. At this stage, a woman's ovaries no longer become receptive to the effect of the Follicle Stimulating Hormone (FSH) and Luteinizing Hormone (LH) because of the decreased number of receptors binding on each site of the follicle when an increased number of follicles is disappearing (Ho, Chan, Yip, Chan & Sham, 1999:219; Ho, Chan, Yip, Chan & Sham, 2003:149).

As years pass, at the time of menopause, a woman may have only a few hundred to a thousand oocytes left. The ovaries produce oestrogen, progesterone and androgen. Oestrogen and progesterone are the two major hormones in a woman's body. Estradiol is produced by the dominant ovarian follicle during the monthly menstrual cycle and is the most potent natural oestrogen while estrone is the dominant form of oestrogen during menopause and it is produced in small quantities by the ovaries and the adrenal gland. Progesterone is produced by the corpus leteum and promotes thickening of the endometrium in preparation for the fertilised ovum. At menopause, the body reduces the production of oestrogen to 40 or 60% of what it was. As a result, oestrogen deficiency also increases, putting more and more numbers of women at risk of conditions such as osteoporosis and ischemic heart diseases. Peri-menopausal women (defined by unpredictable or irregular menses and confined to those women with cessation of menses for at least three months within the previous 12 months but not due to hysterectomy, oopherectomy or pregnancy) can become pregnant until menopause has occurred. At the same time, since there is no longer ovulation, the production of progesterone reduces to almost zero, resulting in the cessation of ovulation and the halting of the monthly production of natural progesterone (Hidayet, Sharaf, Aref, Tawfik & Moubarak, 1999:307; Ho et al., 2003:149; Lyytinen, Pukkala & Ylikorkala, 2009:65).



© University of Venda

University of Venda
Creating Future Leaders

Before actual menopause, gradual changes such as decrease in the amount of menses, lengthening of the interval between menses, periodic amenorrhea and finally spotting occur. These changes create a very unpleasant physical and psychological imbalance called hormonal imbalance which leads to menopausal symptoms. Thus, the menopausal period marks the end of a woman's reproductive capacity (Ho et al., 2003:149).

### 1.2.3 Global menopausal experiences and menopause

In developed countries, women's attitudes towards menopause are multi-dimensional. Some women might display positive attitudes, some negative, while others remain neutral and are not influenced wholly by the adoption of biomedical paradigms (Backel, 1999:19). Women in the peri-menopausal group, described earlier, reported a high intensity of symptoms. This has been associated with newer stresses of modernisation, work or inability to cope with the onset of symptoms which are taken as a threat to looking young and beautiful. These women frequently associate the experience of their aging process with a feeling of self-devaluation and fear of no longer being attractive. This often impairs their self-confidence considerably and the mental perception of being a woman. Others fear old age, because they associate it with loss of attractiveness and as such they often display negative feelings towards menopause (Backel, 1999:19).

Krishna (2002:207), like Backel (1999:19), expresses similar views that the attitudes to menopause of women in developed countries are positive, negative or neutral. Women in Eastern and Western countries have similar negative views of menopause because they see menopause as a punishment in life and only a few Eastern women view menopause positively. Krishna (2002:207) further observes that a woman's positive attitude to climacterium, produces minimal symptoms while a negative attitude seems to produce a full menopausal syndrome.

Flint (1995:161), on the other hand, posits that for some communities in developed countries, menopause is viewed as a reward because it indicates women's transition to other challenges of life. For others it is perceived as a punishment because of the conditions of aging that come with it. In his study done on Korean women, Flint (1995:161) reveals that the majority of the women perceived menopause as a natural phenomenon and not a medical disorder. The study revealed that 53% of women thought



© University of Venda

that the psychological symptoms at this time of life were mainly due to life changes and 51.3% thought women could not control the menopausal changes. Thai women in the same study showed positive attitudes towards menopause. In Thailand there is no equivalent word for menopause, instead the term is interpreted to mean 'blood will go and the wind will come', referring to the emotional changes during menopause. Thus the majority of women indicated that they had a positive outlook for menopause because of their positive roles in their societies (Punyahatra, 2002:7). Nusrat, Nishat, Gulfareen, Aftab and Asia (2008:56) conducted a study in the Outpatient Department of Isra University and found that most of the women who participated considered menopause to be a natural process of aging. Even though they were bothered by symptoms they did not consult medical practitioners as a result of lack of awareness and poverty.

A study of the attitudes of Jewish and Cuban women living in the same country showed that Jewish women had a relatively more positive image of menopause. They perceived it as providing freedom from menstruation compared with Cuban women, who felt that menstruation kept them young and free from ailments like joint pains, headaches and others associated with aging. Women in Northern India demonstrated a very positive image of menopause compared with a very negative image held by Varanasi women who suffered from menopausal symptoms like hot flushes but would not seek medical advice. Flint (1995:161) further indicates that in a study of South East Asian women living in the United Kingdom, 79% were afraid of menopause because of the possibility of losing their partners as a result of sexual inactivity and menopausal problems. Only 33% felt positive about menopause and accepted it for what it was. In Illinois in the United States of America, Wilbur's study (1995:19) showed that the majority of women regardless of ethnicity or socio-economic status had neutral feelings towards menopause. In that study, some postmenopausal women had mixed feelings since they were unsure whether to accept it or not, because of the symptoms they had experienced. 'Konenki' meaning 'change of life' or 'climacterium', a term commonly used in Japanese culture, to motivate a positive attitude towards menopause. Japanese women do have symptoms but do not frequently seek medical advice because they believe that they are hardworking and have no time to seek medical advice (Lock, Kaufert and Gilbert, 1998:318).

According to Melby et al. (2005:4), African-American women also have positive attitudes towards menopause, because they take menopause as a transition of life, other than Hispanic and non-Hispanic



© University of Venda

white women. On the other hand, Japanese- and Chinese-American women expressed negative attitudes and were less likely to say that sex was very important. The African-American women were most likely to express the view that sex was important and to report on having sex more than twice a week. Sommer (1999:686) made similar findings when studying the attitudes of various ethnic groups living in the United States of America. Most negative attitudes were expressed among Chinese American women followed by Japanese Americans. Hispanics and American whites had the most positive attitudes, followed by African Americans. The reason for these findings was probably that white Americans talked freely about menopause and were supported by medical interest. Filipino women, unlike women of other cultures, were found to be largely unaware of menopausal developments and exclusively ascribed to the belief that menopause was normal. They accepted menopausal changes positively as they perceived physical problems as minor concerns. This is probably because they were too busy to listen to the minor changes taking place in their bodies (Berger & Wenzel, 2001:11).

Furthermore, Australian and Filipino women also expressed positive as well as negative attitudes regarding physical and psychological menopausal changes. Regarding the former, better sex, improved moods, more energy and time, greater freedom and happiness, relief from pregnancy and menstruation and a feeling of being loved were reported. Negative changes included loss of libido, palpitations, weight gain, headaches, night sweats, vaginal dryness, hot flushes, depression, fear of aging, no longer feeling being loved and respected, and irritability. Among the peri-menopausal group the incidence of negative changes was somewhat higher than in the post–menopause group, the latter bringing relief from discomforts and a more mental outlook (Berger & Wenzel, 2001:9).

### 1.2.4 The experiences of menopausal women in developing countries

Menopause in some African cultures is not regarded as negatively as it is in most Western countries. A study of Zimbabwean domestic women by McMaster, Cormie and Pitts (1997:1) cited positive benefits such as freedom from illness, menstrual-related pains and regaining of physical strength. They believed that menstrual periods were considered to cleanse the body of semen and that if women had intercourse after menopause, semen would remain in the body and produce stomach bloating and then death. This belief indirectly protects women from menopause-related sexual problems, such as painful sex owing to decreased vaginal lubrication (McMaster et al., 1997:1).



© University of Venda

George (1996:271) studied menopause experiences among middle aged women in a fishing village on the southwest coast of India. She concluded that the experience of menopausal women in developing countries did not correspond with that of women in developed countries. This was shown by women in the fishing village of Kerala who had a positive attitude towards menopause. The most frequently reported symptom of menopause was weight gain, while a few reported hot flushes and none thought that they were severe. Vaginal dryness was reported by very few women while other features, like hot flushes, were attributed to other factors in their lives such as hot weather. Thus, these women believed that menopause was a natural phenomenon which did not hamper their daily activities.

In another study in rural and urban states of Mexico, negative scores of depression and anxiety were higher among rural women than urban women. Depressive moods were associated with rural residence, low level of schooling, body mass index (BMI), smoking habits and age at menopause, while loss of memory or forgetfulness, hopelessness, stomach upset, persistent coughs and joint problems were associated with life style changes of women in the urban areas (Malacara, Canto de Cetina, Bassol, Gonzalez, Cacique, Vera-Ramirez & Nava, 2002:11).

According to the World Health Organisation (WHO) (2009: 4) as women in rural developing countries moved towards the years of menopause, they were at the risk of developing health problems associated with hormonal changes. These included heart disease; stroke; osteoporosis; gynaecological malignancies, such as breast cancer, cancer of the cervix and various genitourinary disorders such as frequency of urinating, lack of sexual desire and vaginal dryness. When combined with other factors such as a lifetime of poverty and under nutrition, such disorders might take a much greater toll on their health, or have a much more significant meaning. The implication is that such women may not seek health care because they see physical discomfort associated with menopause and aging as natural. This could probably be associated with the shutdown of the ovarian cycle due to stress-related issues that stop the normal cycle of hormones. (WHO, 2009:1).

In the sub-Saharan countries, menopausal symptoms are found to be well tolerated by some women but regarded as troublesome by others. Severe symptoms, such as heart problems, depression and irritability leading to mental confusion, as well as severe headaches associated with a rise in blood pressure compromise the overall quality of life for those experiencing them. In a study conducted among urban



© University of Venda

African women, scores were such that 40% of women who experienced menopausal symptoms did not associate them with menopause, and only 19% believed that hot flushes were related to menopause (Frederichs & Hall, 2005:56; Huffman, Tingle, & Bond, 2005:48). In some countries, for example Nigeria, the experiences of joint and bone pains were found to be more prevalent symptoms (40%) than hot flushes. Adegoke, Iranloye, Osibogun and Tomiri (2005:72) studied the postmenopausal experiences of Nigerian women and observed that educated women were aware of the changes taking place in their bodies and tolerated vaginal dryness and hot flushes. On the other hand, uneducated women reported dizziness, headache, irritability and insomnia. These symptoms were not associated with age at menopause as the subjects were not aware of them. The study mentioned above conducted by Frederichs and Hall (2005:56) on postmenopausal rural Xhosa women in South Africa found that some women experienced severe hot flushes, while others experienced nocturnal sweating.

### 1.2.5 Menopausal experiences in the South African context

There are models that have been developed and implemented in South Africa in an effort to deal with menstrual issues but there are relatively few that deal with menopause (Orner, 2005:1). Although access to health facilities has improved in many rural communities, access to menopausal services and menopausal information is still a problem. In many rural communities of Limpopo, including the Vha Venda cultural group, menopausal women face different challenges that seem to have an influence on their perception of the world and themselves (Orner, 2005:1). However, many of the target population were poor and did not seem to have medical insurance, and therefore had no access to regular check-ups (Vhembe District Municipality, 2009).

Traditionally rural communities consisted of extended families that formed part of the support systems for family members and the community at large. Families and communities were responsible for providing the youth, both males and females, as well as midlife women with information and guidance about life in general, sex, sexuality, menopause, cultural norms and values through communal initiations and support (Maluleke, 2007:11). However, these community roles seem to be lacking owing to factors like rapid urbanisation, migration, education and religion. The traditional ways of sharing information and knowledge in many rural families and communities have been destabilised (Maluleke, 2007:11). According to Orner (2005:1) women from rural communities lack resources such as libraries, bookshops



© University of Venda

University of Venda
Creating Future Leaders

or supermarkets where they can obtain materials with information on menopause. While they might be able to obtain such information from municipal, or university libraries in big cities, such facilities are usually far from their communities (Orner, 2005:1). Some families in rural communities can afford televisions or radios but these media seldom broadcast programmes on menopause, unlike other health-related issues. The only sources of information on menopausal issues for rural women are perhaps pamphlets or foreign books obtainable from outside the country (Orner, 2005:2).

## 1.3 PROBLEM STATEMENT

In the past there have been several comprehensive surveys on the subject of menopause, many of which have focused on menopausal symptoms and the reporting of symptoms. Other surveys have focused on the general health and attitudes towards aging and menopause in certain cultures (Orner, 2005:1). However, there has been little attention focused on Vha Venda women and their experiences of menopause, their reporting of symptoms and challenges they face. Certain ethnic groups and their menopausal experiences like the Vha Venda women may be equated in an unproblematic way probably because menopause seems to be still a taboo in their culture. These women may experience it as silent and unnoticed episode due to their adaptation to natural coping mechanisms. In their daily lives these women also seem to have mixed feelings about menopause as they lack proper information to cope effectively with menopausal challenges.

The researcher is a health professional and a rural woman who lives and works in rural settings of the Limpopo Province of South Africa. On several occasions, neighbors, friends, colleagues and family members who were not medically orientated have approached the researcher on critical issues related to menopausal experiences. During the discussions they verbalised the problems they experienced owing to a lack of information on how to recognise and deal with the challenges of menopause. The WHO (2009:4) observes that as women in developing countries move towards menopause, they are at the risk of facing various health challenges. They lack information and knowledge of such problems and attribute them to supernatural powers. The concern that is raised by the researcher is whether the situation that these menopausal women find themselves in, has an impact on their quality of life and ability to cope with menopause and menopausal issues. This could imply that they lack models that could effectively address their problems or challenges.



© University of Venda

University of Venda
Creating Future Leaders

## 1.4 PURPOSE OF THE STUDY

The purpose of this study was to develop a model to facilitate women's coping with menopause.

## 1.5 RESEARCH QUESTION

- What are the experiences of menopausal women aged 40 and above in the Mutale Municipality of the Vhembe District Limpopo Province?

## 1.6 OBJECTIVES OF THE STUDY

The objectives of this study are arranged as follows:

**Phase 1:**

- Explore and describe the experiences of menopausal women aged 40 and above in the Mutale Municipality of the Vhembe District, Limpopo Province;

**Phase 2:**

- Identify the challenges experienced by women owing to menopause;
- Analyse the support systems available to women to deal with menopausal challenges;

**Phase 3:**

- Develop a model to facilitate women's coping with menopause;

**Phase 4:**

- Validate the model developed in phase three.



© University of Venda

University of Venda
Creating Future Leaders

## 1.7 SIGNIFICANCE OF THE STUDY

The study identified challenges faced by women when they experience menopausal symptoms. The issues related to menopause are often a neglected area in South African research. Data on most aspects of menopause in South Africa are lacking and therefore pose a great need for research on all aspects of menopause (Orner, 2005:1). This is very important because the findings of the extensive literature review undertaken in this investigation showed that this is a pioneer study. Evidence-based data on menopause in South Africa is also scarce.

Almost every individual woman is exposed to menopausal transition at a certain age. It is a universal event in the lives of all women and it is a natural phase of growth and development. Irrespective of race, socio-economic status, education, occupation, ethical and religious convictions, all women will undergo menopause should they live to that age (Arroyo & Yeh, 2005:7; Voda, 1993:447). Unfortunately most of the women living in poor rural communities of South Africa seem to be less likely to report menopausal problems owing to misconceptions, cultural beliefs, lack of knowledge and information about their rights, fear of stigmatisation and lack of social support from colleagues, partners and family members. It may also be due to the failure of health workers to assess and adequately document menopausal challenges reported to them or to a lack of adequate knowledge among health workers themselves. This study hopes to equip rural women and community health workers (CHW) with adequate knowledge and information on menopause and menopausal issues.

Many women in rural communities may pass this stage unnoticed and as a result they become silent simply because they adapt to natural coping mechanisms. The model on coping with menopausal symptoms developed as a result of this study will be used to assist menopausal women, their families and community health care workers to address adequately issues related to menopause in their community.

Furthermore, the model will contribute to helping existing community support systems by providing them with information that will clarify any confusions and contradictions on menopause that might have been held by traditional community support systems (like older women) and other sources. It is hoped that the model will offer ways of enabling women to discuss their experiences. The researcher



© University of Venda

University of Venda
Creating Future Leaders

agrees with Maluleke (2007:11) who refers to traditional support systems as information, guidance and support provided by the families and communities about life in general including menopause and menopausal issues, and feels that their experience should be used to the benefit of midlife women and menopausal women in general.

Trained peer education facilitators and health care educators could be used to help in the education of the women in families as well as the community about coping with menopausal problems. The developed model provides guidelines for primary health care nurses (PHCN) in the Department of Health for the support of women in dealing with menopausal challenges. The model also provides a conceptual frame work for developing and testing models that will benefit women, researchers and primary health care nursing practitioners to help them to:

- Alleviate the stress associated with menopausal symptoms experienced by rural women during the transition through the climacteric period;
- Appreciate that model development is essential for nursing practice to be accepted as a supportive and scientifically-oriented profession;
- Apply the Health Care Act as knowledgeable and informed community health workers (CHW);
- Support rural women in their efforts to cope with menopausal challenges;
- Develop intervention strategies based on identified needs or self-care deficiencies.

## 1.8 ASSUMPTIONS OF THE STUDY

Mouton (1998) defines assumptions as the basic principles that are believed to be true without proof or verification. These assumptions are statements that are taken for granted or considered true, even though they have not been scientifically tested. The basic assumptions of this study are that an effective coping model will enhance rural menopausal women's self-care and independence in dealing with menopausal challenges. The accomplishment of self-care requires the expenditure of effort from rural menopausal women to meet the demands of perceived challenges. Activities of self-care are learned in relation to the beliefs and practices related to community health care services. Basic assumptions regarding Orem (1991)'s theory relate to menopausal women having self-care deficits and are recipients of intervention within the context of community health care services. The specific assumptions underlying the study are as follows:



© University of Venda

University of Venda
Creating Future Leaders

### 1.8.1 Assumptions regarding theoretical-conceptual commitments

It is assumed that Orem's self-care deficit and self-care theory forms an appropriate basis for this study. Rural menopausal women's self-care deficits will be revealed in their level of incompetence and dependence. Therefore, it is assumed that a model for coping with menopausal challenges might be needed to guide rural menopausal women towards competence, independence and self-care.

### 1.8.2 Assumptions regarding methodological-technical commitments

It is assumed that focus group interviews, individual interviews and a questionnaire can produce data that will provide an understanding of experiences and self-care deficiencies of rural menopausal women. This will enable the researcher to develop a model that will help menopausal women to cope with menopause and to develop guidelines for the use of the model in the community and community health care services.

### 1.8.3 Assumptions regarding ontological commitments

It is assumed that researchers will have an idea of a model to facilitate menopausal women's coping with menopause in the community.

## 1.9 THEORETICAL FRAMEWORK

According to Crookes, Davies and Chiarelli (2004) a theoretical framework describes a formal and well-developed mechanism for organising phenomena to be studied. A theoretical framework asserts relationships among the concepts and enables the researcher to explain observations and make predictions about what is likely to happen in a given set of circumstances. In this study Orem's theory of self-care and self-care deficits will be used as a frame of reference.

Dorethea Orem's model was created in the late 1950s as a way of defining nursing domains and boundaries. The interest in clarifying nursing domains and systematically developing nursing knowledge



© University of Venda

arose when she was asked to design curricula for nurses at various educational levels. A brief description of Orem's model follows.

### 1.9.1 Self-care deficits

A self-care deficit exists when the self-care demand of a person exceeds her/his self-care agency. Self-care deficit refers to the relationship between self-care agency and the therapeutic self-care demand in which self-care agency is not equal to therapeutic self-care demand. A person can have partial or complete self-care deficit which indicates whether a partial or whole compensatory nursing system is needed to accomplish a self-care demand. Nursing is needed in the case of an existing or potential self-care deficit. A future self-care deficit can be foreseen owing to predictable decreases in self-care abilities and increases in self-care demand (Fitzpatrick & Whall, 1996). Menopausal women could have self-care deficits regarding menopausal challenges and could expect to be assisted with intervention programmes to deal with their incompetence.

### 1.9.2 Self-care agency

Self-care agency refers to the capacity of a person to voluntarily and deliberately engage in goal-achieving activities. It also includes the capacity to engage in actions that are directed towards her/his own health and well-being and to perform self-care activities. For these activities to be performed there should be attention, physical energy, mobility, reasoning, motivation, decision making, utilisation of technical knowledge, a repertoire of skills, organisation and coordination, and integration of self-care with other aspects of life. Persons with self-care deficits have attributes to assess themselves with regard to the needs for self-care. Furthermore a person should decide on a course of action as a transitional process and be able to prepare for performing and monitoring of her/his self-care activities in order to be productive (Fitzpatrick & Whall 1996). Primary health care nurses in community clinics have undergone specialised training and hence are equipped with skills to help perform self-care activities.



© University of Venda

University of Venda
Creating Future Leaders

### 1.9.3 Nursing Systems

If there is a potential self-care deficit, then a supportive educative nursing system would be appropriate. Nursing systems have three (3) components, namely, a totally compensatory nursing system, a partially compensatory nursing system and an educative-supportive nursing system. These are described as follows:

- **Totally Compensatory Nursing System**

  In a totally compensatory nursing system, the nurse takes responsibility for carrying out activities that will meet a patient's self-care needs when she/he has no active role in her/his own care (Horan, Doran & Timmins, 2004:33). During this phase, elderly women and primary health care nurses would probably serve as totally compensatory nursing systems for rural menopausal women with severe symptoms. Thus the women will be enabled to cope properly with their symptoms by being supported through education and by being taught how to cope with menopausal challenges.

- **Partially Compensatory Nursing Systems**

In partially compensatory nursing systems, the nurse carries out some activities that contribute towards meeting self-care needs. However, the patient is able to meet some of the needs herself (Horan et al., 2004:33). As rural menopausal women learn skills to cope with menopausal challenges, they consult nurses only when they need to. The menopausal women do not come to nurses as blank slates waiting to be written on, instead they are able to perform certain skills competently, no matter how minimal their skills might be.

- **Educative supportive nursing systems**

In educative supportive nursing systems patients are potentially capable of meeting their self-care needs. The nurses' activities relate to teaching and supporting the patients so that they will eventually be able to meet their self-care needs. Research has identified that support and the provision of information are



© University of Venda

University of Venda
Creating Future Leaders

closely linked and that patients require information to help prevent stress and improve their coping with hospital events (Horan, Doran & Timmins, 2004:33). Support for menopausal women should be available through activities, such as responding to their requests for contact with nurses and providing them with contact sessions. Nurses should assess the relationship between menopausal women's demands and their abilities.

### 1.9.4 Therapeutic self-care demand

Therapeutic self-care demand includes self-care measures required to meet the specific self-care requisites of a person. Self-care requisites are necessary and need three types of purposeful actions namely: universal, developmental and health deviations. Universal requisites are actions that all persons need to take and are described as maintaining sufficient intake of air, water and food, managing elimination processes, maintaining a balance between activity and rest as well as between attitude and social interaction, preventing hazards to life, health and well-being, and promoting health. Developmental requisites are actions that support normal development or are needed at certain developmental stages. Health deviation requisites are actions related to health problems and treatment regimes. The therapeutic self-care demands of a person are determined by evaluating the need for specific actions in the universal, developmental and health deviation requisites. To determine a need for nursing the nurse considers whether the abilities of the person are adequate for accomplishing self-care demands (George, 1996:271).

Nurses should support menopausal women to enable them to meet the therapeutic self-care demands required in the community. This could imply that nurses should take into consideration that menopausal women's basic needs should be maintained during the support. The basic needs include physical needs such as safe water and oxygen supply, safety needs such as secure buildings for safe execution of duties, need to be loved and belong to a community, need for self-esteem in that they feel being valued by those around them, and the need for self-actualisation that menopausal women would be able to fulfill their potential of personal growth.



© University of Venda

University of Venda
Creating Future Leaders

### 1.9.5 Self-Care

Orem's theory describes self-care as the care that is performed by oneself when one has reached a state of maturity that is enabling, consistent, controlled, effective and purposeful. Orem (1991) refers to self-care as the deliberate action of making judgments about how individuals can and should be assisted to perform self-care activities and to know and meet their self-care demands. Self-care is described as an action that is positive, practical and involves a decision and a choice. The essential condition for self-care is awareness of reality, while for self-care action, it is the ability to persevere to achieve self-help and help to others – in other words the activities that the individual initiates and performs on her own behalf in maintaining life, health and well-being. These activities and behaviours are learned, deliberately chosen and intentional. Self-care is a learned behaviour aided by intellectual curiosity, instruction and supervision from others and is experienced in the performance of self-care measures (Pearson, Vaughan & Fitzgerald, 1996).

Self-care behaviours could focus on changing internal aspects of the self, such as thoughts and feelings. In self-care, the person assesses the need for self-care, decides on a course of action, plans, implements and evaluates the course of action. Menopausal women need to be active in the decision making process such as being able to identify their self-care needs, establish their learning needs and evaluate their self-care behaviour. Self-care deficit refers to that period of time when there is the inability of the recipient of care to maintain self-care. According to Burns and Grove (2001), Orem's self-care model explains how nurses facilitate the self-care of clients. However, assisting menopausal women to achieve self-care is not adequately addressed in the literature. Menopausal women will instead make decisions and do things for themselves leading to self-care. Self-care could imply that when menopausal women achieve personal growth they might be competent and independent.

### 1.9.6 Reasons for choosing Orem's theory and application thereof to menopausal women

Orem's theory can be applied to nursing practice when dealing with menopausal women. Hopefully, community health care nurses will strive to assist menopausal women by educating and supporting them with the information necessary to make informed decisions to meet therapeutic self-care demands required in the community.



© University of Venda

University of Venda
Creating Future Leaders

The structure of Orem's model focuses on the client as a learner and the nurse as a teacher. The learner moves along the maturity continuum from dependence to independence in self-care. The teacher offers support and guidance along the way. The aim of teaching is to promote independence as much as possible (Hill and Howlett, 1993 as cited by Muniski, 1999:25).

In this study the primary health nurse and elderly women can be viewed as teachers and the client (the menopausal woman) as the learner. When menopausal women face menopausal challenges and are unable to cope entirely with them, they depend on the nurse and elderly women for guidance and support (from a state of dependence to the one of independence). The menopausal woman with self-care deficits depends on the nurse when she visits the health care facility. The nurse with specialised skill and knowledge assists the woman with guidance and support until she is independent. Therefore, Orem's theory serves to define the support provided to menopausal women by the community health nurses as well as elderly women. An inexperienced menopausal woman can be viewed as having menopausal self-care deficits and might need the nurse and the elderly woman to provide her with the necessary support and guidance until she reaches independence. The nurse should assist the woman towards independence by demonstrating clinical skills, guiding, directing, providing physical and psychological support and creating an environment of personal independence and development.

## 1.10 OPERATIONAL CONCEPTS

### Model

According to Chin and Jacobs (1987) a model is a symbolic representation of perceptual phenomena. Models attempt to objectify the concept they represent, and might provide a sense of understanding on how theoretical relationships develop. In this study, a model refers to a process that describes an intervention support for menopausal women in a rural community to cope with menopausal experiences. Mouton (1998) suggests that a model is an attempt to represent the dynamic aspects of the phenomenon by illustrating the relationship between elements in a simplified form. A model might suggest new areas of research related to the identified relationship of the variables that have been studied.



© University of Venda

University of Venda
Creating Future Leaders

**Woman**

A female person who is elderly (South African Oxford School Dictionary, 2004) and for this study it means a midlife woman of 40 years and older.

**Coping**

In this study, coping means successfully managing menopausal symptoms, and a way of assisting women who are experiencing menopausal problems to deal the with challenges. Historically every culture has had its way of coping with traditional problems as they come. Some women had no way of coping with these problems while others coped in a scientific way using medical intervention, homeopaths or traditional medicines (for example the Chinese women) (Bulbeck 2003: 17). In this study mechanisms to assist women to cope with menopausal symptoms were investigated.

**Menopause**

This is a time of life when a woman finally ceases to menstruate. It is the time that represents a passage from the reproductive to the post-reproductive stage of life. It is an aspect of human aging and a useful predictive risk marker of a variety of aging–related diseases and health problems. It signals continuous change in the body of older women as many of them are symptomatic (Ho et al., 2003:149). During this period levels of the main reproductive hormone, oestrogen, decreases leading to a functional deficiency of oestrogenic activity and a variety of symptoms associated with this deficiency (Kakkar et al., 2007:306). In this study menopause means a time when a woman stops menstruating and experiences menopausal challenges.

**Experiences**

Something that happens to an individual during his/her lifetime. It includes views, ideas or feelings that are neutral, positive or negative. It is the actual observation or practical acquaintance with fact or events (Thompson 1994: 474). Menopausal women experience specific feelings that occur during the transitional stage of life known as menopause. These experiences occur in all women irrespective of



© University of Venda

University of Venda
Creating Future Leaders

colour, culture, religion, creed or status. Menopausal experiences depend on how a woman perceives symptoms and refers to the way women feel about themselves (self-esteem), the way they feel about their bodies (body image), roles they adopt, the expectations other people have on them (social roles), and the way in which they relate to others (relationships) (Maluleke 2007:15). In other words, if women like themselves, accept and feel comfortable about their bodies and believe in themselves they are more likely to be comfortable with the experiences of menopause. For the purpose of this study experiences mean events, views and feelings that menopausal women display during their menopausal transition.

## 1.11 THE STUDY DESIGN

The study design was triangulated with equal weighting of qualitative and quantitative methods to increase objectivity. Triangulation designates a conscious combination of qualitative and quantitative methodology within a single study and enables the expansion of research methods to enhance diversity and enrich understanding of the research problem (Schneider, Elliot, Lobiondo-Wood & Haber 2004).

The study was conducted in four phases, namely, qualitative, quantitative, development of the coping model and validation of the model as outlined in Chapter 3. In the first phase of the study, a qualitative research design was applied to explore and describe the experiences of menopausal women in rural communities. Furthermore, the researcher attempted to get a first-hand, holistic understanding of phenomena and data collection evolved as the study proceeded. In this design the researcher had the opportunity to understand the extent of self-care deficiencies as perceived by menopausal women who required guidance and support. The data was analysed using Tesch's method (Cresswell, 2003:142) by classifying themes and subthemes.

The second phase of the study was quantitative in nature: a cross-sectional descriptive study design was applied to identify and describe the experiences of menopausal women, and analyse the support systems in place. In quantitative research a formal, rigorous, objective, systematic process is implemented to obtain information, describe variables and their relationships, and deal with numerical data and measurements that focus on specific variables that are quantified through rating scales, frequency counts and means (Burns & Grove 2005:257). Quantitative data was analysed by using SPSS (Statistical



© University of Venda

Package for Social Sciences) Version 19. Frequencies were examined and data was analysed descriptively to create relevant tables and charts.

In the third phase of the study a model to facilitate women's coping with menopause was developed to guide and support their self-care deficiencies with regard to menopause. This phase involved the analysis of concepts that emerged from the data analysis and literature control (Rodgers & Knafl, 1993:78). Steps were adapted and used during the conceptual analysis. The framework of Dickoff, James and Wiedenbach (1968:426) was used to classify concepts. These concepts formed the basis of the developed model and gave it meaning. The model was developed using the steps explained by Chinn and Kramer (1999:51). Validation of the model, Phase 4, was performed in accordance with the guidelines as outlined by Chinn and Kramer (1999:110). Five evaluative criteria were used namely: clarity, simplicity, generalisability of the model, accessibility and importance (see Chapter 5).

## 1.12 ORGANISATION OF CHAPTERS

The chapters of this study were organised as follows:

**Chapter 1:** Overview of the study
**Chapter 2:** Literature review
**Chapter 3:** Research methodology
**Chapter 4:** Results and discussions of qualitative and quantitative studies
**Chapter 5:** Concept analysis and conceptual framework for model development
**Chapter 6:** Implementation of the model
**Chapter 7:** Evaluation, justification, limitations, conclusions and recommendations

## 1.13 SUMMARY

Chapter 1 provides an overview of the study and includes the introduction, background, problem statement, purpose, research questions, objective assumptions, theoretical framework, operational definitions and the design of the study.



© University of Venda

University of Venda
Creating Future Leaders

# CHAPTER 2

# LITERATURE REVIEW

## 2.1 INTRODUCTION

The previous chapter presented a detailed description of the overview of the study. This chapter reviews literature. The literature study involves a systematic and in-depth investigation of published scholarly literature available in journals, book chapters, unpublished scholarly articles and computer accessed materials. The literature review contains information on the topic, theoretical framework, models and methodological issues pertaining to the study.

## 2.2 PHASES OF MENOPAUSAL EXPERIENCES

At the time of menopause, the hormonal output of women does not necessarily reduce gradually, but often alternatively stops and restarts. This general re-adjusting of the body's endocrine balance leads to many menopause symptoms. The oestrogen supply eventually regulates itself and reaches a plateau where it remains until around age 70. The body undergoes three different phases, namely pre-menopause, peri-menopause and post-menopause (or menopause) months (Biri, Bakar, Maral, Karabacak & Bumin 2005; Buckler, 2005:11 & Ho et al., 2003:149).

### 2.2.1 Pre-menopause, peri-menopause and menopause

When categorising a woman according to her menstrual pattern, Kaufert, Gilbert and Tate (1987:217) describe the stages/phases of transition as pre-, peri- and post-menopausal. Pre-menopause is a state when a woman is still having menses or has menstruated within the previous three months. Peri-menopause occurs when a woman has menstruated within the last 12 months; the phase is divided into two, namely early peri-menopause (defined by unpredictable or irregular menses) and late peri-menopause (confined to those with cessation of menses for at least three months within the previous 12 months but not due to hysterectomy, oophorectomy or pregnancy) (Anderson, Yoshizawa, Gollschewski, Atogami & Courtney 2004:173; Ho et al., 2003:149; Orner, 2005:2). Mansfield, Carey, Anderson, Barsom and Koch (2004:220) found that peri-menopause begins with the start of irregular



© University of Venda

University of Venda
Creating Future Leaders

menstrual cycles and ends with menopause. The WHO defines peri-menopause as starting with the clinical, endocrinological and biological features of approaching menopause but extending through the first year after menopause (WHO,1996), while, in epidemiological studies, peri-menopause is usually defined as the period when menstrual bleeding becomes irregular and amenorrhea becomes more frequent (Frohlich, Kuh, Hardy & Wadsworth, 2000:35). Post-menopausal status or menopause is defined as the time of life when there has been a cessation of menstruation for at least 12 months (Ho et al., 2003:149; Orner, 2005:2).

Soules, Sherman, Parrot, Rebar, Santoro, Utian and Woods (2001:874) suggest that while most normal women will progress from one stage of menopause to the next not all healthy women follow this pattern. Furthermore, it is commonly acknowledged that there are considerable hormonal fluctuations underlying the period of menopause, but no biochemical measurement has been considered acceptable as a precise marker of this stage. As a result, menstrual variables have become the most useful means of gauging a woman's menopausal status in a staging system.

The study conducted by Chedraui, Aguirre, Hidalgo and Fayad (2007:271) showed that pre-menopausal women have regular menses but may have more than 12 menses during the previous 12 months. Peri-menopausal women are those who experience irregular menses, i.e. fewer than 12 menses during a 12-month period, while post-menopausal women are defined as those who have experienced no menses in a 12-month cycle. These studies had similar findings to those conducted by Ho et al., (2003:149).

Furthermore Chedraui et al. (2007:271) observed that during peri-menopause the body still produces some oestrogen. This negates the common misconception that menopause happens when a woman runs out of oestrogen. The symptoms of menopause are caused by oestrogen dominance in the body that occurs as progesterone production declines in the years leading to this change in a woman's body. Women experience water retention, weight gain, memory loss, irritability and depression. During menopause, decreased oestrogen levels may cause bladder and vaginal atrophy. Vaginal walls become dry and thin leading a woman having less interest in sex or experiencing a slower arousal time. The hormonal changes also disrupt the delicate acid/alkaline balance of the vagina which can lead to increased susceptibility to yeast and bacterial infections. Some women might develop fibrocystic breasts, breast cancer, fibroids or endometrial cancer. However, during this time many women tend to



© University of Venda

experience increased energy, greater focus on their life goals and a renewed interest in sex since pregnancy cannot result.

Basttastini and Youcha (2009:1) also made similar findings to those of Ho et al. (2003:149), as well as Chedraui et al. (2007:271), which shows that natural menopause is a normal part of the aging process. It is divided into three stages namely pre-menopause, peri-menopause and menopause, as described above. Medical or surgical menopause occurs as the result of chemotherapy or ovaries, uterus and cervix removal. 'Cold turkey' menopause, on the other hand, occurs as a result of being taken off menopausal hormone therapy owing to conditions such as, breast cancer.

## 2.3 MODELS OF MENOPAUSE

- **The lifespan of the biological model of menopause**

According to Derry (2006:393) the lifespan biological model begins with the observation that hormones are team players in complex, multi-determined systems that have a purpose. Hormones help to coordinate bodily functions by altering the rate at which cells do their jobs. However, hormones do not function alone. A powerful cause-and-effect relationship involving hormones is embedded in the larger context. This is illustrated by Pfaff's (1999) review of the biology of reproductive hormones in rats. A female rat whose ovaries have been removed, who has no oestrogen in her body, will not engage in lordosis. However powerful this cause-and-effect relationship of this model may be, there is a gap identified in this literature. Firstly, the model is not applicable to the context of the effective coping model to be developed in this study. The effect of hormones on the changes that take place in the three stages of menopause was not addressed.

- **The medical model**

The medical model as described by Berger and Wenzel (2001:16) illustrates the relationship between the patient and the doctor. The social role of a patient visiting a medical office is explained as occurring when someone demonstrates symptoms of disease which have to be examined and defined by the complementary partner in the interaction, namely the physician. The doctor's function is to provide



© University of Venda

health care and to examine those individuals who approach him/her when they suffer from some sort of disease. Physicians are trained to see people as patients from a medical perspective. An individual requires ample energy, self-esteem and social support to meet his/her own bodily rhythms and needs. Furthermore, the model indicates that people are what they are because they live in certain environments, follow mostly local diets, breath local air and are subject to local climatic conditions. Lastly, as the body carries the mind, it functions because the mind tells it to (Berger &Wenzel, 2001). A gap was also identified in the literature here, as this model describes general patients and not menopausal women. The type of disease the patients presented to the physicians in the study were not those specifically experienced by menopausal women. The model does not describe strategies to assist menopausal women to cope with menopause.

- **The socio-cultural model**

The socio-cultural model as developed by Berger & Wenzel (2001:16) indicates that the social model positions the body in the center of human interaction. Human beings act according to normative expectations they have of significant others with whom they wish or have to interact. The process of aging is viewed as being more acutely felt by women than men because their aging process has a clear social and cultural indicator - menopause. The social construction of menopause is viewed as the entry point to old age and represents a challenging and often difficult time, because, while women may feel rather young and full of energy, society tends to perceive them as becoming increasingly less attractive and less fully functioning. The time of menopause is characterised by a series of losses such as loss of youth, beauty, fertility, libido, health, hormones, femininity and calcium. These symptoms possibly impact on the physical and psychological well-being in midlife women (Banchmann, 1994:113; Barron, & Monticelli, 2007:381; Brown, 1976:109; Buck & Gottlieb, 1991:410; Howard & Kelly, 1994:18; Kaiser, 1990:430). A gap identified in this model was that it concentrates on the process of aging and not that of menopause. The model developed in the present study addresses coping with menopause in general and not only the challenges that women face.



© University of Venda

- **The integrative health care model for climacteric women**

The integrative health care model (IHCM) designed by Doubova, Espinosa-Alarcon, Flores-Hernandez, Infante & Perex-Cueves, (2010:1186) includes a multidisciplinary approach based on a non-hierarchical combination of conventional medicine with complementary and alternative medicine. It promotes the harmonious continuity in decision-making and care that should be focused on the patient. The IHCM is based on a set of core values such as addressing health care in a holistic manner and promoting personal health and well-being. The multidisciplinary approach of the IHCM is based on the collaborative participation of health team members, their mutual respect for and shared vision with the patient. This circumstance allows each provider and each patient to contribute their knowledge and particular skills to focus on providing health care to persons within individual health care plans.

The IHCM is viewed as being consistent with the empowerment approach which is the social process of recognising, promoting and enhancing the capacity of people to meet their needs, solve problems and mobilise the resources needed to take control of their lives (Jones & Meleis, 1993:1). The goal of patient empowerment is to build the patient's capacity for self-care, identify problems, set goals related to their needs, identify personal and social obstacles, develop solutions, consider possible consequences of alternative solutions and make appropriate decisions for themselves (Lau, 1994:39; Anderson & Funnell, 2005:153). The empowerment approach is linked to counseling as regards the possibility of long lasting changes (Doubova et al., 2010: 1186). Upon reflection of the IHCM, the researcher decided that it is integrative but very general and not specific to the context of menopause. The model applies empowerment of patients to patients in general and not specifically to menopausal women. Counseling was also viewed as being too general and not applicable to the effective coping model for menopause of this study.



© University of Venda

University of Venda
Creating Future Leaders

## 2.4: EXPERIENCES OF MENOPAUSE BY WOMEN IN OTHER SETTINGS

### 2.4.1 Prevalence of menopause

The prevalence rates of menopausal symptoms have previously been based mostly on studies of selected populations, such as nurses or menopause clinic attendants. Recent population-based studies have been conducted mostly among Caucasian populations. A high prevalence of menopausal symptoms ranging between 40% and 60% has been reported among a community in Babol, Iran (Agajani & Mahmoud, 2011:1213). In contrast, studies on Asian women from different ethnic backgrounds have reported lower prevalence rates (between 10% and 40%). A study on the population of Singaporean women on the experience of menopausal symptoms was found to be significantly lower than that of Caucasian women (Chim, Tan, Ang, Chew & Chong, 2002: 275).

Another study conducted by Ho et al. (2003:149) among Caucasian women concurred with the studies on Chinese women. It reported a significant increase in the prevalence in vasomotor symptoms during the late peri-menopausal period with some elevation of such symptoms for some years after menopause. These observations suggest that vasomotor symptoms are related to hormonal changes during this period of life. A comparison of symptoms reported among Chinese women as well as women from other populations in Hong Kong revealed a lower prevalence of vasomotor symptoms. The study concluded by identifying social and health variables associated with reported symptoms. It found that Chinese women experienced menopause differently from Caucasian women in that their hormone-related vasomotor symptoms were not specifically high, while other psychological and physical symptoms were equal or even more prevalent. The results also showed these women experienced the symptoms most acutely during the peri-menopausal period. Factors related to reported symptoms included socio-economic status, stress and health factors. The frequency of the symptoms of menopause was found to differ among women from four countries. The country of residence seemed to influence reported symptoms more than other factors. Hot flushes were reported everywhere, joint pains, fatigue, impatience, nervousness, sleep disturbances, memory loss and some emotional symptoms were the most frequently reported symptoms. Hot flushes and vasomotor symptoms were more frequently reported than emotional and sexual symptoms (Obermeyer, Reher & Saliba, 2007:788; Dennerstein, Burrows & Hayman, 2005:852).



© University of Venda

In the United States 85% of women report having hot flushes and 49% had symptoms severe enough to seek medical assistance. As reported in the previous studies, Japanese women seem to have far fewer hot flushes than American women as they were perceived to be too busy to listen to their bodies (Lark, 2006:202). The frequency and intensity of menopausal symptoms were also found to correlate with factors such as ethnicity, geographical zone, climate, diet, lifestyles, hormonal levels, women's attitudes to and perceptions of menopause and the aging process. The black race was found to be an important determinant. Low backache, muscle and joint pains, obesity and hot flushes among black women were observed to be the symptoms most frequently presented. There were higher incidents of obesity among the black subjects than among the Caucasians, who, in turn, presented with a higher frequency of vasomotor symptoms (Monterrosa, Blumel & Chedraui, 2008:182).

A study conducted among Saudi women found that 68.51% suffered from hot flushes and excessive sweating, 75.32% suffered palpitations and shortness of breath, 70.63% reported sleeping disorders, 74% experienced tension and anger, 51% presented with urinary symptoms, 37.7% had vaginal dryness and 30.7% experienced sexual problems. It was concluded that vasomotor dysfunction and vaginal dryness were consistently associated with peri-menopause and that their prevalence and frequency were the most common and most severe owing to changes in hormonal levels (Al-Olayet, Al-Qahtani, Al-Essa, Al-Saleek, Al-Moutary, Al-Mudimeg, Al-Marri, Al-Shemari, & Ajab nor, 2010: 4077).

In a study of Indian women aged 45-65 and living in Sydney, Australia, the most prevalent menopausal symptoms were hot flushes, impatience, poor memory and change in appearance, skin tone and texture (34%). Night sweats were experienced by 30.8%, changes in sexual desire by 38.8%, vaginal dryness during intercourse, and avoiding intimacy together with feeling nervous by 32.7%, urinary incontinence by 36.7%, difficulty in sleeping by 33.7% and aching muscles and joints by 46% of their respondents (Hafrz, Liu & Eden, 2007:329). Another study of the prevalence of menopausal symptoms among Nigerian teacher, found a high prevalence of skin dryness (44.2%), hot flushes (43.2%), fatigue (41%), irritability (35.8%) and excessive sweating (34.7%). Comparing the above-mentioned studies it was found that the prevalence of hot flushes and excessive sweating was the highest among Saudi females while the prevalence of vaginal dryness was less than one in the Nigerian study. The prevalence of mood



© University of Venda

changes and nervousness was highest among Saudi women but urinary symptoms seemed to be universal (Al-Olayet et al., 2010: 4077).

### 2.4.2 Experiences among educated/uneducated women and menopause

Education plays a vital role in maintaining a good quality of life. It seems as if lower incidents of psychological and somatic symptoms are directly linked to the fact that during the transitional phase of menopause, educated women seem to be aware of the approaching life transition. They tend to emphasise their dietary and life style changes which help them to maintain good health. Urogenital symptoms were more prevalent among the educated group because they consulted physicians frequently when something was wrong in their bodies. On the other hand uneducated groups reported fewer urogenic problems, including frequency of urinating, urinary tract infections, vaginal dryness and others, probably because they did not present their problems to physicians or else they might have presented them with some limitations (Kakkar et al., 2007:306). Conversely the study by Chim et al., (2002:275) observed no significant relationship between education and menopausal symptoms.

In addition, the incidence of early menopause was higher among less educated women than among more educated women. The difference was found to be statistically significant, in that educated women found happiness and satisfaction obtained from their working lives, which positively influenced their lives at menopause. Of interest was that the correlation of early age menopause and education was found to be the early stoppage of reproductive hormones as a result of reproductive- and poverty-related stresses caused by factors such as low income. It was also observed that less educated women concentrated less on family planning probably owing to either a lack of health facilities available in their communities or ignorance (Ozdemir & Col, 2004:211). In a study of post-menopausal experiences among Nigerian women it was observed that uneducated women or those with little or no education were either ignorant of the changes or did not admit to the experiences of menopause (Adegoke et al., 2005:72).

These findings are not necessarily generalizable because in one study conducted by Jassim and Al-Shboul (2008:358) on Bahraini women, the researchers reported a positive attitude in well-educated women, but in another study conducted by Wilbur, Miller and Montgomery (1995:19) no significant relationship was found between menopause and the educational status of women. Donati, Cotichini,



© University of Venda

University of Venda
Creating Future Leaders

Mosconi, Satolli, Colombo, Liberati and Mele (2009:246) found that 63% of women received information during menopause and that a high level of education was associated with a higher probability of receiving information, hence the positive attitudes. However, three quarters of the women who participated in this research said that they would like to receive more information about health risks related to menopause. Well educated women who had never smoked, who had reached menopause, who had undergone gynaecological check-ups during the preceding five years, and who had adhered to oncologic screening programmes as well as those who had received information from the Women's Health Initiative (WHI) and who were taking possible alternatives to Hormone Therapies (HT) tended to have more information and knowledge about menopause and menopause-related issues. Having a high educational level and having reached menopause naturally was associated with a higher probability of receiving information on disadvantages and health risks related to menopause (Donati et al., 2009:246).

Regarding HRT and other therapies, Donati et al., (2009:246) revealed that 64% of educated women reported that they had taken HRT to relieve hot flushes while 46% had taken them to prevent menopause-related risks, in particular osteoporosis and cardiovascular diseases. They discovered that 52% took oral HRT, 56.5% used transdermal HRT and 8% used local therapies like vaginal creams and pessaries. Donati et al. (2009:246) concluded that well-educated women reporting menopausal symptoms had six times the risk of using HRT to prevent menopause related symptoms. That was interpreted as a consequence of a medical consultation. While among women with low educational levels there was no correlation between the use of HRT and menopausal symptoms. Seventy three per cent of HRT users revealed that they had interrupted HRT mainly because of a fear of side effects, while 12% of those who had never used HRT admitted they had thought of taking it, and only a few had used natural methods to control menopausal symptoms.

Jolleys and Olesen (1996:91) in their survey among European women found that most of the educated women in their investigation did not talk about menopause and its symptoms to their doctors, but preferred to discuss it with pharmacists. They found that in Nordic, educated women behaved in the same way as other European women. They concluded that this behaviour had a positive effect on women's attitudes towards menopause and the use of HRT, probably because women who visited doctors were often those who suffered severe symptoms and therefore needed the most HRT (Sorgaard, Tollan, Berntsen, Fonnebo & Magnus, 2000:229).



© University of Venda

University of Venda
Creating Future Leaders

## 2.5: THE CHALLENGES OWING TO MENOPAUSAL EXPERIENCES

In recent decades, there have been several comprehensive reviews on menopause, attitudes towards menopause, status of women, education and menopause across cultures. As previously observed, in some cultures certain symptoms are so uncommon that there is no word for them. The difference in reporting of symptoms is described as a tendency to under report owing to a lack of education or embarrassment (Melby et al., 2005:1)

The question of whether a universal 'menopausal syndrome' exists has been debated for some time. Some clinicians suggest that there is a constellation of symptoms experienced by women owing to declining levels of oestrogen as they pass through menopause. However, there are opposing views that no universal symptoms exist, but that women experience a variety of symptoms that may be physical, psychological or social and those reported are due to individual and cultural influences (Schneider, 2007:640).

### 2.5.1 Physical changes

Menopause can trigger a wide variety of symptoms which are different for each woman. For some, the symptoms are mild and tolerable; for others, they are so severe that they influence their quality of life (Margolese 2007:1). Those commonly associated with the condition such as hot flushes and changing menstrual patterns commonly tell if the woman is approaching menopause. Others are more subtle and may seem like actual behavioural changes, such as anxiety and depression (Louise, 2006:3357). Before women assume that they are undergoing profound personality changes, they should become familiar with all the symptoms of menopause and begin a plan of action (Donavan, Neugarten, McKinley & Holte, 2006: 1281). Physical changes that occur in the body include hot flushes that are defined as recurrent, transient periods of flushing, sweating with sensations of heat, often accompanied by palpations together with feelings of anxiety sometimes followed by chills. There is no evidence that the physiology of nocturnal sweats is different from that of daytime hot flushes (Kronenberg, 2006:112).

Identifying physical symptoms that are most troublesome to women during the menopausal transition and distinguishing between those that are due to hormonal changes as opposed to having ageing or



© University of Venda

University of Venda
Creating Future Leaders

socially-related etiology is crucial for clinical care and the creation of a public health policy. Women often report symptoms, such as anxiety and headaches, at menopause, but such reporting is by no means limited to women. Not only do middle-aged men report similar symptoms at approximately the same rates as women, but younger and older women do as well. In Japan, the most reported symptoms during peri-menopause were shoulder stiffness owing to the type of work to which women were exposed. (Melby et al., 2005:5). Furthermore, several studies carried out in Thailand also recorded physical symptoms such as hot flushes, frequency of urination, low back pain, vaginal dryness, trouble sleeping and headache. Some findings include fractures and lack of sexual desire (Sukwatana, Meekhangvan, Tamrongterakul, Tanapat, Asavarait, & Boonjitrpimon, 1991:84).

An investigation of Japanese women carried out by Vanda (2003:3) concurred with the study of Melby et al., (2005:5) that found that the type and prevalence of physical symptoms women exhibit during peri-menopausal and menopause were often related to their cultural background. In some cultures menopause is regarded as part of aging and is accepted as it comes while in others it is embarrassing and painful. Hot flushes were the most common symptoms among Western city dwellers. Among Japanese women hot flushes were uncommon and hence there is no Japanese word for it. As mentioned above, the most common physical symptom of menopause experienced in Japan was frozen (stiff) shoulders a condition whereby shoulder movement is severely restricted and painful.

Although Monterrosa et al., (2008:182) also cite reports by Vanda (2003:3), they further posit that the frequency and intensity of physical menopausal symptoms correlate with ethnicity, geographical zone, climate, diet, lifestyles, hormonal levels, a woman's attitudes, perceptions towards menopause and the aging process. In this regard the black race was seen as an important determinant. Among black women muscle and joint problems as well as obesity were found to be symptoms that presented most frequently while Caucasian women presented with a higher frequency of vasomotor symptoms. In other cultures many women do not seem to have the physical side effects of menopause that are common to American women. Oriental women reported far fewer hot flashes than women from western societies. However, Mayan women in the Yucatan in Mexico reported no symptoms at menopause other than irregular menstrual cycles. This might be due to the geographical zone, climate and the attitudes towards menopause (Menopause: Blessing or Affliction? (2007: 2).



© University of Venda

Malacara et al., (2002:11) found that reports of menopause in three different states of Mexico identified hot flushes, vaginal dryness and diminished sexual interest. Hot flushes, among Mexicans varied from 72-32% and were associated with menopause, schooling, rural residence, body mass index and state of residence. Furthermore, Chedraui et al., (2007: 271) found that the most frequently reported symptoms among Ecuadorian menopausal women were muscle and joint problems being rated the highest, followed by depressive moods, sexual problems, hot flushes and sleeping disorders.

Wilbur, Shaver, Kogan, Buntin and Wang (2006:600) studied menopausal transition symptoms in midlife women living with fibromyalgia and chronic fatigue and found that peri- and post-menopausal women suffering form these conditions had symptoms with high severity scores for musculo-skeletal, gastro-intestinal and vasomotor symptoms but not for mood factors. Another study by Ozuzu-Nwaiwu (2007:34) conducted in the UK among black women concurred with other studies and revealed that the most common symptoms suffered by these women were hot flushes, night sweats, headaches, high blood pressure, tiredness, irritability and forgetfulness. The women perceived menopause as old age or as a stage when they were no longer able to bear children or the process of the symptoms they were experiencing.

### 2.5.2 Psychological changes

Psychological attitudes towards menopause were shown to have a major influence on menopausal symptoms. Women with a negative attitude towards menopause were much more likely to suffer more symptoms than women with a positive attitude. Moreover, women with a high self-esteem had fewer menopausal symptoms (Malacara et al., 2002:11). This was supported by the study by Bloch (2003:303) that showed that self-esteem had a major influence on women's personal well-being. Individuals, including menopausal women, with low self-esteem were often more vulnerable to depression, anxiety and increased health risks and thus were more vulnerable to menopausal symptoms (Bloch, 2003:303).

Caucasian women reported significantly more symptoms, notably psychosomatic symptoms including tension, depression, irritability, forgetfulness and headaches. African-American women reported a higher frequency of vasomotor symptoms while Chinese and Japanese-Americans reported significantly fewer symptoms than Caucasians, African-Americans or Hispanic women. Caucasian middle-aged



© University of Venda

University of Venda
Creating Future Leaders

women during menopausal transition seemed to present a wide spectrum of physical and psychological symptoms. Vasomotor and urogenital complaints have been considered the most frequent and typical presenting symptoms. Additionally emotional and somatic symptoms, such as headaches, insomnia, anxiety, irritability, sexual problems, fatigue and muscle joint aches are said to be highly prevalent during the climacteric (Chirawatkul & Manderson, 1994:1; Freeman, Sammel, Liu & Martin 2005:258).

Malacara et al., (2002:11) reported psychological symptoms of menopause in three different states of Mexico. Scores for depression and anxiety were lower in women in the semi-urban Yucatan area than those in the rural areas. Depressive moods were associated with rural residence, state of residence, menopause, high BMI, smoking habits, age and schooling. Anxiety was associated with menopause, rural residence, low schooling, high BMI and age. Loss of sexual interest was associated with age, BMI, menopause and a number of pregnancies. They concluded that the frequencies of symptoms at menopause had ranges similar to those of other countries.

Studies in menopause and gynaecology clinics and hospitals made similar findings of the prevalence of psychological symptoms. Reduction of sexual interest and reduced sexual activity with partners and the possibly achieving orgasm were associated with menopause. The study observed that oestrogen seemed to have some beneficial effect on sexual desire. Where oestrogen alone was ineffective, testosterone was usually beneficial (Pearce & Hawton, 1996:385).

A study on Australian and Filipino women indicated that across both cultures physical menopause experiences were reported to be quite similar but psychological profiles differed considerably. Roughly one quarter of Australian women found it difficult to come to terms with the aging process and among the symptoms reported were irritability, depression, fear of aging, loneliness, mood swings, unhappiness, as well as loss of self-esteem, respect and admiration. However, among Filipino women, a more positive outlook prevailed. They remarked that they only felt minor psychological irritations. Therefore, physical problems were found to be usually of minor concern for most women but psychological difficulties were due to the inability of women to come to terms with the aging process (Berger & Wenzel, 2001:9). Symptoms experienced by pre-menopausal women in a study of women in Karachi, Pakistan included lack of sleep, urinary incontinence associated with marital problems which showed not much difference from the finding of other authors above (Baig & Karim, 2006:71)



© University of Venda

University of Venda
Creating Future Leaders

### 2.5.3 The socio-cultural context and menopause

Attitudes and socio-cultural perceptions provide the context in which women experience menopause. Cultural influences greatly affect how women perceive and manage their menopausal symptoms (Hall, Callister, Berry & Matsuma 2007:106). Menopause is a natural process that all women go through, but menopausal symptoms and experiences might be shared differently by women from diverse cultures. Berlin (2009:421) argues that the experience of menopause and menopausal symptoms often reflect cultural differences among women. The age at which women reach menopause may be rooted in part in their culture (Berlin,2009:424). The author goes on to mention that studies on menopause have shown that there is no uniform pattern of symptoms. Learning about cultural differences might help post-menopausal women to become more comfortable with their experiences of menopause and might find a more positive way to approach it. The study revealed differences in Eastern and Western perspectives on the emotional and physical changes women typically experience as they get older. Differences in menopausal symptoms were also noted among racial and ethnic groups. Caucasian women noted more muscle aches, difficulty sleeping, and irritability than African Americans who were more likely to experience hot flushes and night sweat but had a more positive attitude about menopause. Chinese and Japanese women were less likely to have night sweats or hot flushes and tended to be less enthusiastic about undergoing menopause. Japanese and Nigerian women more commonly experienced frozen shoulders than women in other cultures approaching menopause. Studies among Mayan Indian, Chinese and Japanese women illustrate that menopause is not a uniform experience, as they had no hot flushes. This was coupled with a progressive change in status within their community and in turn they have a feeling of freedom. The possible reason for this is that when women from indigenous cultures cross into menopause, they often become known as wise women or spiritual leaders and hold a place of power in their communities (Berlin, 2009:421; Shea, 2006:30).

Another study among Caucasian women revealed that besides the apparent physiological changes during menopause, women in mid–life often went through social transitions. There was an increased level of stress, depression and irritability that might have required additional coping mechanisms. Thus, symptoms reported during mid-life were influenced by multiple factors, such as socio-cultural factors like fear of getting old and a lack of respect by the community. Life styles changes, state of residence, age and schooling were also associated with menopause (Ho et al., 2003:149).



© University of Venda

Berger and Wenzel (2001:10) observed that as with other life transitions, menopause does not occur in a vacuum. The socio-cultural environment is of key importance in modifying a woman's experience of her change of life. Their study of Australian women found that they experienced depression which reflected a common fear of getting older. It seemed as if beauty affected the idea that women had of themselves. The older a woman becomes the harder it becomes for her to live up to the beauty standards other women have set. In Australia visual and printed information focused on young women and hid the old. An alleviation of depression and irritability was no longer supported because of the association with getting older. The perceived 'loss' of youth and beauty represented a major stumbling block for Australian women. They described feelings of uselessness, no longer being needed or wanted, unable to sleep or rest, being insecure, being sexually undesirable, as well as not being appreciated and valued for their capabilities and wisdom. It was important for them to keep looking youthful and attractive as a way of love, happiness and respect by the husband and the rest of the family.

Filipino women, on the other hand, spoke of looking forward to the joys of old age. Physical changes brought about by the aging process were more readily accepted. They stated that there were some losses and some gains because being elderly in Filipino society meant being loved and respected by people in general. For instance, it was seen as a privilege for an elderly woman to be offered a seat on public transport and being politely addressed as 'Madam'. To them, the physical problems were usually of minor concern. It seems as if psychological difficulties were due to an inability to come to terms with the aging process and were inextricably linked to the socio-cultural environment.

### 2.5.4 Midlife women and menopausal experiences/challenges

Midlife transformation represents a changing point for any women to start living life on their own. However, menopause is not always a change women are ready to accept, neither do they wish to choose when it should happen. Menopause at midlife is not an easy transition for many women. Kilaf and Kirchengast (2008:313) suggest that menopause and menopause transition are not diseases per se, but it is a phase of life that reduces health-related quality of life among stressed women. Stressful life events have a clear impact on reduced well-being and are important contributors to a painful menopausal transition. Midlife women were found to have high levels of psychological distress which dramatically reduced their health-related quality of life. The study revealed that in Western industrialised societies the



© University of Venda

psychological distress associated with female midlife was seen as a result of the general problem of aging. Some women tended to be overwhelmed by midlife crises and midlife transformation. Biologically, midlife is a very important time in a person's life. Midlife transformation concerns reprogramming bodies to become more sustainable, improving the quality of life and allowing the body to age more gracefully (Kilaf & Kirchengast, 2008:313).

A cross-cultural study carried out by Bulbeck (2003: 6) in Taiwan and Australia Bulbeck among the Chinese and Indian women on their attitudes to menopause and aging, found that midlife health professional women acknowledged having had a symptom-free midlife transition to full and happy lives without high levels of stress. Women felt that instead of gaining status as they aged, they lost the negative status of being a menstruating woman of reproductive age. According to Bulbeck (2003: 6) midlife transition among Chinese women meant that they were going into another stage of their lives. While it meant the same for the Taiwanese women, it also meant the time when life was undergoing change, namely a transition from midlife to old age. Chinese women appeared to have fewer menopausal symptoms, did not use HRT, had not had hysterectomies and did not have fibroids. Their main health interest was their skin tone but they had facials every month.

### 2.5.5 Knowledge, attitude and practice in relation to menopause

Women in different cultures have different experiences, knowledge, attitudes and practices concerning menopause. Some of the factors that might affect beliefs and attitudes and influence the insight include social background, education, occupation, physical or emotional health and the general health symptoms. In a study conducted on menopausal women in Shiraz by Ghaderi, Ghazanfarpour and Kaviani (2010:698), the general attitudes, knowledge and practices concerning menopause have shown to be positive. These findings concurred with those of some other studies mentioned above (Vanda, 2003:3; Melby et al., 2005:5 &.Berlin, 2009:421)

In an investigation of Ecuadorian women aged 40 and over participants more frequently perceived menopause as a positive event than a negative one. Eighty point five per cent of the participants agreed that menopause was the definitive cease of female fertility, while only 60.2% correctly defined menopause as the definitive cease of menses and fewer than 50% admitted to having sufficient



© University of Venda

University of Venda
Creating Future Leaders

information regarding menopause. A high percentage indicated that they had a need to receive more information about menopause through education. They said that the three main sources of information available to them were friends, television and physicians. Only 50.4% of the participants had received information through education sessions (Leon, Chedraui, Hilgado & Ortiz, 2007:233). Other studies indicate that Saudi women have less information about menopause than Latin American women. Most of Saudi women learn from relatives, in contrast to the educational sessions mentioned by Latin American women. Regarding practices during menopause, there seemed to be little awareness of menopause among Saudi women especially in post-menopause (Al-Olayet et al., 2010: 4077). In a study conducted among Italian women Donati et al. (2009:246) found that 68% had received information about menopause and in that group 72% had received it from media, 69% from health professionals and 59% from friends and relatives.

In a study conducted by Yahya and Rehan (2002:252) in Pakistan, they found that the majority of women seemed to understand what menopause was and considered it as a positive change of life. Women often became self-centered during menopause, a fact that seemed to reflect a positive attitude towards this phase of life. The majority of the participants in the study were not concerned with how their husband would feel about them after menopause. These studies concur with the studies conducted by Ayers, Forshaw and Hunter (2010:28) who found that women who lacked positive attitudes towards menopause tended to report more negative symptoms. The study among Italian women mentioned above, found that more than 90% of the participants had a positive attitude towards menopause and believed it to be a normal phase in a woman's life and not a disease. More than 40% stated that it was a good experience for women and only 30% considered it to be a bad experience. They also found that a lack of knowledge seemed to be associated with women's low education level and willingness to seek health services (Donati et al., 2009:246).

Somboonporn, Seejorn, Kleebkaow, Junthathanrongwat & Ratanasiri (2002:167) conducted a study on Thai post-menopausal women regarding their knowledge, attitudes and practices. They found that 67% of their participants had adequate knowledge. However, some were misinformed about certain aspects: 58.5% thought that having sex lead to myoma uteri and that postcoital bleeding was a normal event in post-menopause. Regarding the source of information, 40% said that they had received it from mass media, 33.1% claimed to have received it from medical personnel and very few said that they were



© University of Venda

University of Venda
Creating Future Leaders

given information from husbands and friends. Eighty three point one per cent said that they required additional knowledge on sex during the post-menopausal period while 16.9% said that they did not require additional information as they were not sexually active, and thus had no sexual problems. Regarding attitudes towards menopause and sex, 92.9% of the participants talked freely about sex as they saw it as natural and an important factor in their lives. Considering the practice, 85.4% said that they had either less or no sexual desire and activity. Regarding the practice of sex during post-menopausal period 86.9% was reported (Chompootweep, Tankeyoon, Yamara, Poomsuwan & Dusitsin, 2009: 63).

Pfeiffer, Verwoerdt and Davis (2008:1262) revealed that sexual desire and activity decreased with the advance of age in post-menopausal women. Regarding concern, 73.9% were not worried about sex and 26.1% were worried about sex issues like dyspareunia, husband dissatisfaction, future family problems, prospects of cervical cancer and urogenic trauma and bleeding. In another study by Sharps, Phillips, Oguntimalide, Saling and Yun (2003:9) comparing the knowledge, attitudes, perceptions and practices related to menopausal health among African-American women from diverse levels, revealed that in general most women were knowledgeable about the process of menopause. They sought information from printed materials and physicians but suggested that more materials should be provided in all women's settings, through the media and places where women gathered, including churches, beauty parlours and community centers.

### 2.5.6 Age at menopause

While the main focus of this study is to develop a model to support menopausal women in dealing with menopause, much research consulted has focused on age at menopause. As age might influence long term disease risk and mortality the researcher considers that it can be included as part of the experiences of menopause. Findings from the Study of Women's Health Across the Nation (SWAN) showed that ethnic background seemed to influence the age at which menopause started. Latin and African-American women often entered menopause earlier than Caucasian women, while Asian women reached menopause several months later. Studies also reveal that women who smoked tended to begin menopause one to two years earlier than non-smokers (Berlin, 2009:421).



© University of Venda

UNIVERSITY OF VENDA

The studies by Ozdemir and Col (2004:211), Gold, Bromberger and Crawford (2001:865), Renolds & Obermeyer (2001:21), Vahid, Aran, Koksal, Isiloglu and Senocak, (2006:1381) regarding age at menopause and associated factors, agree that the average age at natural menopause was 47 ± 4.2 years among Turkish women. Education, smoking, age at menarche, age at menopause of the mothers and the sisters were found to be related with age at natural menopause. Cross-sectional surveys among women of different ages show that hot flushes were most common soon after menopause and could be severe and continue for up to 10 years. About half of 50-year-old and one quarter of 60-year-old Swedish women experienced hot flushes during those years (Luoto, 2009:1186).

Mean menopausal ages were found to be between 47 and 50 years. The difference in women's ages was minimal as can be seen by the following: Koreans living in Korea: 49.3; Lebanese: 49.3; Singaporean: 49.1; Korean emigrants to China: 48.9; Greek: 48.7; Moroccan: 48.4; Mexican: 48; Chinese women living in Taiwan: 48; and Turkish: 48. The lowest reported average menopausal age, was found in Turkey at 45.8. Most studies report mean age, but a few report the median age. The studies by Dasgupta and Ray (2009:20), Singh, Kaur and Walia (2002:121) and Kaur, Walia & Singh (2004:175) found that age at menopause was higher among Indian women (48-50) when compared to the range of 45-47 years for women in other developing countries. The mean ages seem to have risen to the range of 50-51, with the median age of natural menopause in Spain was estimated at 51.7 years (Lock, Kaufert & Gilbert, 1998:30; Raynolds & Obermeyer, 2005:331). Factors such as age at menarche, menstrual bleeding length (>5 days), BMI, marriage and parity, poor oral contraceptive use, mother and sister's age at menopause were found to be positively associated with age at menopause. The relationship between age at menopause and factors such as education and rural-urban residence varied with populations. Smoking was consistently negatively associated with age at menopause while economic status, unemployment and history of heart diseases were positively associated with it (Melby et al., 2005:3; Raynolds & Obermeyer, 2005:852).

According to Krishna (2002:207) an international investigation involving 18 000 women revealed a median age of 14 years for menarche and 50 years for menopause. A study on British Asian women living in the UK over the past 10-20 years revealed almost the same age of 14 years for menarche and 48 years for menopause. Thus menarche and menopause have remained constant but life-span has been slowly increasing all over the world. This study also revealed that in 1990, 467 million women all over



© University of Venda

the world were in the post-menopausal age group; this number is projected to increase to 1200 million by 2030. However, it seems as if the major increase in the number of post-menopausal women will be in developing countries with the inclusion of rural women. Bernis and Reher (2007:777) in their studies of median age at natural menopause in three contexts found that rural women had a later onset of menopause: rural: 52.7; semi–urban: 51.9; urban: 51.2 years respectively. These researchers also reported a decline in oestrogen levels resulting in symptoms such as hot flushes (rural: 56%; semi–urban: 43%; urban: 46%). The study concluded that significant differences existed in median age at menopause in the three contexts. On the other hand, Malacara et al., (2002:11) observed that the mean age at menopause for women between 45 and 60 in three different states of Mexico was 48.0 years.

The study by Kakkar et al., (2007:306) found the mean age at which menopause set in it to be 48.7% of women between the ages of 46 and 51. A significantly higher percentage of peri-menopausal women (35%) were reported while post-menopausal women scored 40%. This study concurs with the studies of Melby et al., (2005:3) that found that mean menopausal ages were between 47 and 50. Another study by Chedraui et al., (2007; 271) found that among Ecuadorian menopausal women aged 40-53 years, the menopausal statistics were: pre-menopausal 40.6%; peri-menopausal 48%; and post-menopausal 11.4%. This revealed that the majority of menopausal women were in the peri-menopausal state and showed a slightly significant difference from the findings of Kakkar et al., (2007:306). It was found that among the most predominant psychological symptoms depressive mood swings were prevalent among the peri-menopausal women in their sample, whereas physical, mental exhaustion and irritability were found to be prevalent among the post-menopausal women.

The findings of Singh et al., (2002:121) concur with those of Melby et al., (2005:3) that the age at menopause was higher among Western women, than among women developing countries like India. These women viewed menopause with a positive outlook. When one compares these findings with those of Baig and Karim (2006:71) the mean age of women in Karachi, Pakistan was below 50, mean 47.1 years. Similar findings were found in a study conducted among post-menopausal rural Xhosa women. The mean age was found to be 53.6 in a range of 45 to 61 years, while the mean age at onset of menopause was 50.2 in a range of 45 to 57 years. The mean age found in several studies were between 50- 53 which reflects a normal range for the onset of natural menopause (Frederichs & Hall, 2005:2). A mean age of 49.2 (48.6) years was slightly lower than that of urban Zulu women residing in Durban. It is



© University of Venda

University of Venda
Creating Future Leaders

suggested that this might have been as a result of malnutrition or climatic factors (Abramson, Gampel, Slome, Scotch & Majola, 2010:356).

Studies in rural developing countries revealed that rural women experienced menopause about eight years earlier than those in developed counties. Statistically, on average American women experienced menopause at about 51 while rural Bangladeshi women were about 43 at menopause. Many researchers see the normal range as being 51 years while most see 43 years as being lower than normal. According to the WHO (1996), 75% of the world's post-menopausal women live in developing countries with increasing life expectancy, however, the prevalence of post-menopausal problems was found to be substantial (WHO, 2009:1).

A lower mean age of 47 (in a range of 45 to 49 years) was also revealed in a study of British women conducted by Torgerson, Avenell, Russell and Reid (1994:83). They concluded that of the factors associated with early menopause age was a leading contributor. Smoking, age at maternal menopause, parity, social class, as well as meat and alcohol consumption were all independently associated with early menopause, thus reducing age at menopausal. These indications of early menopause were found not only among rural communities; because of poverty and poverty-related stresses leading to early stoppage of reproductive hormones, they were also found among women in developed countries.

In developing countries like the Philippines, Papua New Guinea and various countries of Africa such as Ghana and Tanzania the mean age is 48, while in India, Pakistan, Turkey and Thailand it is reported to be lower than 50 years. In South Africa the mean age is 48.9 and is comparable with those of other developing countries. In Ankara the mean age was found to be 45.2 (+- 47) years with 96% of women over the age of 50 years experiencing natural menopause or peri-menopause. Among the group experiencing natural menopause 35.9% had reached menopause before the age of 46 while 64.1% had reached normal menopause (Ozdemir & Col, 2004:211).

### 2.5.7 Menopausal therapies and life style interventions for menopausal women

Studies on menopausal therapies have been conducted in several countries across the world in different cultures. In the 1970s various countries formed national societies on menopause and menopausal



© University of Venda

therapies. For historical reasons herbalism was much more widely used in Africa and China than in other countries. Brockie (2004:1) conducted a study on menopausal therapies, which found that there was wide-spread belief among the public that natural therapies were harmless, they did not realise that herbs might contain potent chemicals and should be used with caution. The active ingredient used in most preparations is unknown and women with contraindications to HRT, such as breast cancer or a history of venous thrombosis, should use therapies with caution. From the great number of herbs available in Germany, only a few have research support for their use and control, but is much more organised in the UK. Brockie (2004:1) explains that homeopathy is one of the most widely accepted therapies, sometimes available on the National Health System (NHS) for self-treatment. A study conducted by Ozuzu-Nwaiwu (2007:34) in the UK revealed that some women used alternative methods while others used HRT. Those who used alternative methods seemed to feel that their symptoms were not severe enough to justify medical treatment or that they could overcome them with will power.

In Western countries, complementary and alternative medicines (CAM) have become popular in the treatment of menopausal symptoms and many women use them despite limited evidence to support their efficacy and safety. Therapies frequently used include aromatherapy, homeopathy and herbalism, massage, reflexology and acupuncture, however, there is no scientific evidence to show that these therapies on menopause symptoms are of any benefit. What is possibly known is that they are helpful in stress reduction and this might have a domino effect on other symptoms. Other international and national recommended therapies for menopause include lifestyle changes, like exercise and diet (Anderson, 1999; Brockie, 2004:1).

In another study of menopausal women aged between 50 and 60 living in Alexandria, it was found that almost 40% had prior knowledge of menopausal symptoms. The great majority 90.7% had never heard about hormone replacement therapies (HRTs). Regarding beneficial practices after menopause 60.7% said that they were taking vitamins and 55.3% reported ensuring exposure to sunlight. Eighty eight point nine per cent had not consulted a physician regarding menopausal problems Loutfy, Abdel, Dabbous & Hassan 2006:760). This is in contradiction to the findings of a study conducted by Somboonporn et al., (2002:167), that revealed that the majority of menopausal women in their study had sufficient knowledge about HRTs and sexual intercourse during menopause. Although most of them (30%) had experienced decreased sexual desire and activity, it did not cause them concern. As far as HRTs are



© University of Venda

University of Venda
Creating Future Leaders

concerned, Lock (2006:1) observed that a Korean study had revealed that 40% of respondents knew about the prevention of osteoporosis with the use of HRT. However, only 15% knew about the prevention of cardio-vascular disease. The African Americans (42.6%) in the sample knew about the prevention of osteoporosis and 23% knew about the prevention of cardio vascular disease, against 70.8% and 35.2% of the Caucasian Americans who knew about the same information. The reason for this might be that the African-American women in the sample had higher educational levels than the Caucasian Americans (Lock, 2006:1).

Donati et al., (2009:246), who included attitudes of Italian women to menopause and HRT in their study, found that 68% of women believed that HRT was a good solution to menopause-related symptoms. Seventeen per cent believed it was useful when menopause-related symptoms were not distressing, 42% believed it prevented age-related diseases, 45% believed HRT had many side effects, while 23% thought that it should be avoided. Forty five per cent claimed to have suggested the use of HRT to a friend suffering from distressing menopause-related symptoms. Thirty nine per cent of women said that information on HRT had been provided more frequently in a proactive way, but 57% reported to having received conflicting information on HRT. Ninety per cent received both suggestions and prescriptions from gynaecologists while 18 % had consulted general practitioners. The findings of Donati et al. (2009:246) concur with those of Lock (2006:1) and Ettinger, Grady, Tosteson, Pressman and Macer (2003:1225) that the majority of clinicians who prescribed HRT reported advantages more frequently than disadvantages and risks.

Appling, Allen, Bellantoni, Brager, Hallerdin, Olsen, Van Zandt, Gaines and Young (1999:319) as well as Eaker, Chesebro, Sacks, Wenger, Whinsnant and Winston (1993:1999) studied factors associated with the use of HRT among low income women and found that HRT has more benefits in age-related disease prevention like cardiovascular diseases and osteoporosis. The studies revealed that there was a higher incidence of oestrogen use among white women than among black women. In addition, previous use of oestrogen by white women was more than double than that by black women. They found that women were more likely to take HRT if they had had hysterectomies, suffered from menopausal symptoms, had increased risk of developing osteoporosis, heart disease or risk factors for heart disease, were younger, thinner, exercised, drank alcohol, smoked, were more knowledgeable about HRT, or believed that menopause was a medical condition for which treatment with HRT was appropriate. The



© University of Venda

University of Venda
Creating Future Leaders

common barriers to HRT were found to include the reluctance of physicians to prescribe or provide counseling regarding HRT, concerns about side effects, a history of breast cancer and a fear of breast or uterine cancer (Thomas, 2010:38). Appling et al., (1999:319) also revealed that numerous studies had found that women were significantly more likely to take HRT as it was recommended by the provider. Less frequent use of HRT among low-income women compared with middle and higher income women was reported. Key variables associated with HRT use among low-income women included age, history of hysterectomy and discussion with physicians about HRT. They indicated that the two studies that had evaluated attitude and knowledge of HRT in low-income African-American women revealed a lack of knowledge but a high interest in learning about menopause and HRT, an increased tolerance of menopausal symptoms, a more positive attitude towards menopause, but a significant underestimation of heart disease risks (Luoto, 2009:1186).

Many women across the world take HRT to relieve menopausal symptoms, reduce bone loss and reduce the risk of colon cancer. However, studies by Margolese (2007:1) and Davey (2005:16) reveal that HRT has risks and should not be taken for the long-term prevention of heart disease. Taking HRT increases rather than reduces the risk of heart disease and stroke. It also increases the risks of breast cancer and blood clots. Studies reveal that women who had had hysterectomies could take oestrogen replacement therapy (ERT) alone while other should take a combination of oestrogen and progesterone known as HRT (Margolese, 2007:1). Ballagh (1999:1049) studied the link between HRT and breast cancer and concluded that women who seek therapy for menopausal symptoms were uniformly concerned about the risk of breast cancer. The study emphasised the link of taking HRT, alcohol consumption and breast cancer and concluded that this relationship should be stressed to women who did not admit to alcohol use. Another study by Luoto (2009:1186) on hot flushes and quality of life during menopause among Estonian post-menopausal women involved in HRT trials concluded that quality of life was not related to hormonal therapy use but rather to other factors like smoking and high body weight. However, other studies such as those conducted by Paterson (2007:16) indicate that the majority of women seem to be turning to alternative products that have been used successfully to reduce and alleviate debilitating hot flushes.

Studies have shown that menopausal women often feel upset, confused, angry and unsure of what to do when biological changes occur in their bodies. In their opinion they do not possess sufficient knowledge



© University of Venda

to make an informed choice regarding their menopausal experiences. A study of Australian women shows that menopause is viewed as an ailing experience and as a disease and that when typical biological changes occurred, it was necessary for them to take HRT. On the other hand, Filipino women subscribe to the belief that menopause is a normal phenomenon and so are against using HRT because of the risks associated with it (Berger & Wenzel, 2001:11).

Krishna (2002:207) indicated that the media were largely responsible for the negative imaging of menopause hence they must take responsibility for giving clear, concise and evidence-based information as they confuse women in their decision-making processes. Unfortunately only women in developed countries with access to medical care and pharmacies make decisions to seek medical advice on the basis of symptoms suffered. These women can also make choices on mechanisms of coping with menopause, such as taking HRT. They were also aware of its negative image on health and the side effects, the need of finding symptomatic relief and were aware that they were at high risk of other progestonic diseases especially cancer (Schmitt, 2007:915).

MacDougall (2002:1) found that physicians' attitudes played a major role in the decision-making process and in initiating the use of HRT. Through their recommendation and counseling physicians could address not only the biomedical aspects of illnesses and their management but also the socio-economic and behavioural characteristics of their patients such as life-style, family traditions, living circumstances and unique cultural needs. He further contends that medical training on menopausal issues needed to be addressed because the failure of HRTs could not be blamed only on patient compliance to HRT, but also on physicians' and pharmacists' lack of knowledge (MacDougall, 2002:1).

Regarding lifestyle changes, many countries all over the world are faced both with an aging population who suffer from chronic health conditions such as diabetes, obesity, cardiovascular diseases, joint problems and many more. In addition, the years surrounding the menopause are associated with weight gain, increased central adiposity, and decreased physical activity. Data from the Women's Healthy Life Style Project (WHLP) provide clear evidence that weight gain and increased waist circumference along with elevations in lipid levels and other cardiac heart diseases are preventable through the use of life style intervention in healthy menopausal women. Thus, life style intervention should be recognised as an



© University of Venda

University of Venda
Creating Future Leaders

important health goal for women before they reach menopause (Khoo & Rerera, 2005: 6; Simkin-Silverman & Wing, 2000:47; Lewis & Kuller, 2011).

Wellons (2011:2) revealed that life style intervention proved better than metformin in women who were 45 years old and reduced the rate of new onset of diabetes. Post-menopausal women who had been randomly subjected to life style interventions were found to have a low incidence of diabetes. Therefore, life style modification such as physical activity was found to prevent diabetes. Simkin-Silverman, Wing, Boraz and Kuller (2003:212) conducted a study of healthy pre-menopausal women aged between 44 and 50 to see if life style intervention could prevent weight gain during menopause. They found that in healthy women, weight gain and increased waist circumference during the peri- to post-menopause could be prevented with long-term life style dietary and physical activity interventions. In another study by Simkin-Silverman and Wing (2000:47) on weight gain during menopause, it was found that weight gain at menopause increased the risk of high blood pressure, high blood lipid and insulin resistance.

Wildman, Schott, Brockwell, Kuller and Sutton-Tyrrell (2004:579) conducted a study to investigate whether dietary and exercise intervention slowed menopause-associated progression of subclinical atherosclerosis as measured by intima-media thickness of the carotid arteries. The studies found that subclinical atherosclerosis could be linked to higher rates of coronary heart disease. Diet and exercise intervention slowed menopause-related cardio vascular diseases.

### 2.5.8 Menopause, culture and sex

A study by Akinrogunde (2010:2) of unfounded taboos associated with menopause, cultural beliefs and sex found that women had difficulties coping with menopause leading to a sexless life. Their experiences had to do with cultural beliefs that a woman in post-menopause should not have sexual intercourse with her partner again, because a woman who had stopped menstruating was considered to be a man. Men practice polygamy as a natural way to quell their sexual appetites once their main wives reached menopause. The diverse cultural experiences of menopause among menopausal women might be influenced by diet, environment, cultural beliefs (myths) and genetics (Berlin, 2009:421).



© University of Venda

University of Venda
Creating Future Leaders

Akinrogunde (2010:2) also found that another uninformed cultural belief was that it was dangerous for post-menopausal women to engage in sex, since the semen could cause damage inside the woman because she now lacked the ability to flush out semen through menstruation. On the other hand, some women said they found freedom from the monthly menstrual periods and the risk of pregnancy quite liberating and enjoyed sexual intercourse more after menopause (Bulbeck, 2003: 6). In another study conducted on the effects of Iranian culture on menopausal women it was found that the women were freer, more independent and had more time after menopause. It seems that women in the Iranian culture were not as concerned about menopause in comparison with women from other cultures, as they accepted menopause as a natural change occurring in all women. It was also found those Iranian men's attitude helped women to accept this change and to be aware of menopause (Jassim &.Al-Shboul, 2008:358).

The study by Winterich (2007:189) on sex, menopause and culture concluded that most women emphasised cultural and social issues such as relationship status, quality of health and sexual history more than menopausal changes when they described sex after menopause. Past research findings were that some women experienced mostly negative changes such as vaginal dryness, decreased libido and decreased orgasm quality while positive changes were given little attention.

## 2.6 CONCLUSION

In this chapter the rationale of the literature that was relevant to the study was discussed. Literature was reviewed from various sources that focused on different aspects of menopause, menopausal experiences, challenges and support systems for menopausal women as seen from a global perspective. Literature related to menopausal issues was then summarized. The next chapter discusses the methodology used in the present study.



© University of Venda

University of Venda
Creating Future Leaders

# CHAPTER 3

# RESEARCH METHODOLOGY

## 3.1 INTRODUCTION

This chapter outlines the methodology of this study according to the four phases. The design of the study was triangulated with equal weighting to complement the methods that were qualitative and quantitative, and to increase objectivity. In the first design of the study (Phase 1), the researcher applied the qualitative research design to explore and describe the experiences of menopausal women in rural communities. In this design the researcher had the opportunity to understand the extent of self-care deficiencies as perceived by the menopausal women. In the second design (Phase 2), the cross sectional descriptive study design was applied to identify and describe experiences of menopausal women and analyse support systems in place. Phase 3 involves model development while Phase 4 describes the validation of the model before implementation according to the guidelines of (Chinn & Kramer 1999:10).

## 3.2 STUDY SETTING

The study was conducted in a community called Hamakuya. Geographically Hamakuya is in the Vhembe district, which is one of the districts that form the Limpopo Province in South Africa. The Vhembe district extends across from the North West and is the most northern district of the province. The most significant geographical demarcation of this district is the Limpopo River which is the country's third most important river. This river forms South Africa's northern border and separates the province from Zimbabwe. The Vhembe district is divided into four municipalities namely Mutale, Thulamela, Makhado and Musina. Hamakuya is located in Mutale municipality which consists of eleven (11) wards namely Balethavha, Lupepe, Tshiombedi, Lumvulini, Matalinga, Mulondodi, Folovhodwe, Big Tree, Masisi, Tshamavhudzi and Niani, Hamakuya specifically falls in the Niani ward. According to the Mutale Municipality census of 2009, the Hamakuya population in the Mutale municipality is approximately 5000.



© University of Venda

University of Venda
Creating Future Leaders

## 3.3 STUDY DESIGN AND METHODS

The study design is the researcher's overall plan for obtaining answers to the research questions or to test the hypothesis (Polit & Beck, 2010:259). In this study, the design was triangulated with equal weighting as a means of complementing the two methods of qualitative and quantitative and to increase objectivity. Triangulation designates a conscious combination of qualitative and quantitative methodology within a single study and enables the expansion of research methods to enhance diversity and enrich understanding of the research problem (Schneider et al., 2004). The study was conducted in four phases, namely, qualitative, quantitative, development of the coping model and validation of the model.

### 3.3.1 Phase 1: The qualitative design

The objectives of the qualitative design were to explore and describe the experiences of menopausal women aged 40 years and above in the Mutale Municipality of the Vhembe District. The study design was qualitative, explorative, descriptive, contextual and phenomenological in nature.

- **Qualitative**

Qualitative research is a way of gaining insight through discovering meanings. It is a means of exploring the depth, richness and complexity inherent in a phenomenon (Burns & Grove, 2009:51). Polit and Beck (2010:17) on the other hand, maintain that the findings from the qualitative research are typically grounded in real life experiences, while, De Vos (2005:282) is of the opinion that without the holistic view, there is little value to qualitative research. All the relevant information possible is obtained to enable the researcher to draw a clear picture aimed at analysing the in-depth picture of the network of relationships within and among the various aspects relevant to the problem. In this study the qualitative research focus was on lived human experiences, which enabled the development of a detailed description of the phenomenon under investigation. The researcher also obtained rich, in-depth information from the participants. The researcher utilised the phenomenological approach to obtain descriptions of the lived human experiences of menopausal women; this formed part of the baseline for the development of a questionnaire and the model. In qualitative research the participants are viewed as



© University of Venda

University of Venda
Creating Future Leaders

having the knowledge that the researcher seeks since they have lived through the experiences that the researcher is studying. The qualitative approach was important in this study as little was known about the experiences of the menopausal women being studied.

- **Exploratory**

The aim of exploratory design is to establish facts, gather new data and determine whether there are interesting patterns in the data. The method is typical when a researcher examines a new interest or when the subject of the study is relatively new (Babbie & Mouton, 2001:79). Exploratory design gains a broad understanding of a situation, phenomenon, community or a person. In this study the researcher selected the exploratory method to gain new insight, discover new ideas and increase knowledge about menopausal women. The experiences and challenges faced by menopausal women were explored and the strategies used to deal with them (Mouton & Marais, 1990:43).

- **Descriptive**

Descriptive research accurately portrays the characteristics of persons, situations or groups within a certain phenomenon (Polit & Hungler, 2006:716). Burns and Grove (2001:200) state that in a descriptive design, the researcher intends to describe phenomena accurately within a specific context, on the basis of collected data. Descriptive research documents describe the behaviour, events, beliefs, characteristics, attitudes, structures and processes that occur in a phenomenon. It gives complete and accurate information about the phenomenon that is being studied (Brink, 2003:10). The purpose of using descriptive designs is to gain more information about the characteristics of situations and to provide a picture of situations as they naturally happen. In this study descriptive design was used to describe the experiences of menopausal women.

- **Contextual**

In contextual study, the phenomenon is studied for its intrinsic and immediate contextual significance (Mouton, 1998:122). Burns and Grove (2001:200) state that contextual studies focus on specific events in naturalistic settings. Naturalistic settings are uncontrolled real-life situations sometimes referred to as



© University of Venda

field settings. Research done in a naturalistic setting refers to an enquiry done in a setting free from manipulation. De Vos (2005:280) state that it is believed that human behaviour is influenced in many ways by the environment or setting in which it occurs. In this case the Focus Group Discussions (FGD) and individual interviews were conducted in a venue convenient for the participants. The study was conducted in the Hamakuya villages of Mutale where the participants resided. It was contextual in the sense that the researcher took into account the participants' ethnic backgrounds, as well as their physical and cultural values.

- **Phenomenological**

Phenomenology offers research methods that value a holistic perspective of the experiences of participants and the ability of the participants to reflect on those experiences and make sense of them. The aim of phenomenology is to develop an understanding of a phenomenon or an event in human experience. Only those individuals who have experienced a phenomenon are capable of communicating their experiences to the outside world. Phenomenology aims to understand and interpret the meaning that participants give to experiences in their everyday lives (De Vos, 2005).

In phenomenology bracketing and intuition are included. During bracketing, the researcher suspends or sets aside what is known about the experiences being studied, thereby excluding preconceived ideas (Krueger, 1994:115). However, through intuition the researcher develops an awareness of the lived experiences.

The research participants in the phenomenological study were chosen because of their experience of the phenomenon being studied and because of their ability to articulate their experiences. The researcher paid careful attention during the focus group interviews, asked probing questions and summarised each response at the end. The researcher then analysed the discussions and interactions that occurred, assigned meaning and created categories and general descriptions of the experiences.



© University of Venda

University of Venda
Creating Future Leaders

- **Community entry**

Access to the community was gained through the help and support of the health workers in the clinic, the tribal authority, volunteer health workers as well as community leaders. After gaining entry, depending on the structure of the community, meetings were held with the heads of the households – males and females. The aim of the meeting was to familiarise the researcher with the community. During the meeting, details of the research activities were presented in the local language. Interested women met the researcher at venues identified by them for data collection and they were asked if they were willing to participate.

### 3.3.2 Study Methods

#### *3.3.2.1 Population*

Population is referred to as the entire group of people that meet a designated set of criteria (De Vos, 2005:232; Burns & Grove, 2001:368). The study population consisted of all women between the ages of 40 years and above residing in Hamakuya villages. From the preliminary investigations done by the researcher the population pyramid showed a young population with few elderly men and women. This assertion was based on the oral history narrated by the community leaders in the Hamakuya tribal authority, who were interviewed by the researcher. In the personal communication, the elders reported that owing to post-independence developments in South Africa, some people had migrated to the new villages nearby. These were either relatively young families or those that were single parent headed families.

The target population is the entire population or set of individuals in which the researcher is interested and wishes to use to generalise the results of the study (De Vos, 2005: 232). In this study the target population consisted of women between the ages of 40 years and above who resided in Musanda village of Hamakuya in the Mutale Municipality. An accessible population is that portion or part of the target population to which the researcher has reasonable access. The population was accessible to the researcher as a pool of participants for the study (Burns & Grove, 2005: 341; Polit & Beck, 2006:511). In this study the accessible population consisted of those participants who came to the arranged venues



© University of Venda

University of Venda
Creating Future Leaders

to form part of the focus group discussions. As indicated above, according to the Mutale Municipality census (2009), the Hamakuya population was approximately 5000.

### *3.3.2.2 Sampling methods and sample*

Sampling refers to the process of selecting a portion or subset of the population to represent the entire population. It includes selecting groups of people, events, behaviours or other elements with which to conduct a study. Researchers usually work with samples rather than the whole population as it is more economical and practical to implement and obtain reasonable information from the sample (Polit & Beck, 2010: 307; Burns & Grove, 2009: 343). In this study a representative portion of the population of women between the ages of 40 years and above was selected. A sample is considered representative if it has similar characteristics of the population from which it is drawn. If all critical attributes in a population are identical to those in the sample, then a sample is representative of the population. If the population is homogeneous, a sample would be sufficient for drawing conclusions about the population because the effect of the attributes of the variables under study in the sample and population would be the same. Sampling is more economical than studying the entire population (Burns & Grove, 2006:351).

- **Sampling of the village**

Demographically the Hamakuya community comprises a cluster of 20 scarcely populated villages. The total villages of Hamakuya are 20 in number. In other words, for the sake of sampling the study concentrated on sixteen (16) of the 20 villages only. The reason for the exclusion of the other four (4) villages was that they consisted of only a few people each and there was hardly any elderly man or woman in the families. The Hamakuya villages that were included in the study were namely: Domboni, Khavhambe, Mutshikilini, Dotha, Gondeni, Muhotoni, Tshambuke, Fandani, Mbuyuni, Maholoni, Guyuni, Musanda, Tshianzwani, Tshifunguduli, Sanari, Mukoma, Hankotswi, Tshampisa, Manyalani and Tshikalini (**Annexure B**). The four villages that were excluded from the study were: Hankotswi, Tshampisa, Manyalani and Tshikalini owing to the reason mentioned above.

The Hamakuya villages in the Niani ward are entirely rural communities and the people of these villages predominately belong to the Vha Venda tribe and their setting is entirely rural. They speak the



© University of Venda

Tshivenda language and their major occupation is farming and cattle rearing. The area is rich in natural resources such as coal. Some of the peasant crop inhabitants were employed by the road construction company which was constructing the new Masisi- Makuya road.

Purposive sampling was used to select a village (Musanda village) for this study from the sixteen villages of Hamakuya. The researcher purposefully chose this village as it had the largest population (2059) and had a majority of midlife and elderly population. Midlife and elderly menopausal women were selected as they were knowledgeable regarding the experiences required for this study.

- **Sampling of participants**

Non-probability purposive sampling was used to select participants rich with information, who were able to make a point clearly. Purposive sampling, known as judgmental sampling, is based on the belief that a researcher's knowledge about the population can be used to handpick the cases to be included in the sample. In this study, purposive sampling involved the conscious selection by the researcher of certain subjects or elements to include in the study. One way of selecting the subjects when using this method is to include subjects who are known to be knowledgeable about the issues under study. Participants from whom a great deal about the focus or purpose of the study could be learned and who were extremely important in understanding the purpose of the study (Polit & Beck, 2010:319; Burns & Grove, 2009:355) should be chosen.

Furthermore, purposive sampling was used to select participants for the focus groups, where the researcher's knowledge of the population and its elements was used to select the participants to be included in the focus groups. Women were requested to gather at venues arranged during community entry. Sample size was determined by data saturation which is a point at which no new themes or essence emerged from the data.

- **Inclusion criteria:**

To ensure inclusion in the sample, the research participants met the following criteria.

- Menopausal women age 40 years and above;



© University of Venda

University of Venda
Creating Future Leaders

- Menopausal women staying in Musanda village;
- Menopausal women who had not had hysterectomies.

### *3.3.2.3 Methods of data collection*

Focus group interviews were chosen as an appropriate method of data collection for this study. Krueger (1994:6) defines a focus group as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment free from interruptions. It is conducted with between seven and ten people led by the interviewer. The author maintains that the key principle in the formation of a focus group is homogeneity, which is determined by the purpose of the study (Krueger, 1994:6-7). Four focus-group discussions were conducted with menopausal women for data collection by an interviewer who skillfully facilitated the discussions in order to elicit information about the desired topic.

The groups were small enough to give all participants the opportunity to share insight related to the phenomenon and large enough to provide diversity of perceptions. Each focus group comprised 8 – 10 women. Purposive discussion took place among women with similar backgrounds and common interests. Focus group interviews promoted self-disclosure and revealed what the women really thought and felt. Throughout the focus group interviews the researcher's essential task was to listen and learn from the participants. Each focus group interview lasted for 60 minutes or more. The purpose of using the focus group interviews was to encourage self-disclosure by the participants and to allow the researcher to access their attitudes and perceptions while observing their interaction. The researcher arranged for interview dates with the contact person of a particular group. The arrangements were made by a formal telephone conversation with the contact person and followed up in writing a letter which was obtainable from the tribal office. Focus group discussions were conducted at the venues chosen and most suitable to the participants; for example if the focus group interviews were to be conducted at the homes of the participants, care was taken to ensure that the place was quiet. The environment was made comfortable and conducive to privacy without any disturbance. The environment was non-evaluative and non-threatening with women sitting in a circle to allow face-to-face interaction (See **Annexure H**). Focus-group interviews were conducted in the mornings before the women prepared lunch for their



© University of Venda

University of Venda
Creating Future Leaders

families and after lunch when the teachers were back from school as this were convenient for them. Permission was requested from the participants before the beginning of the focus-group interviews. An audiotape with a cassette in position was used with the participants' permission (Krueger, 1994:113). The participants and the interviewer established ground rules to facilitate the smooth running of the discussion. The following ground rules were set:

- There was to be no unnecessary standing up by participants.
- Cell phones, if any, were to be turned to the silent mode.
- All participants were to respect the others' view point.
- Participants were not to interrupt anyone speaking.

The four focus groups interviews were conducted with women according to age and menopausal status as shown in table 3.1:

**Table 3.1: Participants' distribution according to focus groups, age and menopausal status**

| Focus group interviews | Age of participants | Menopausal status |
|---|---|---|
| **Focus group interview no.1** | 40 – 50 years | Pre-menopause |
| **Focus group interview no.2** | 51 – 60 years | Peri-menopause |
| **Focus group interview no.3** | 61 – 70 years | Post-menopause |
| **Focus group interview no.4** | 71 years and above | Post-menopause |

A central question was asked during the interviews to stimulate the discussions: '**Please tell me your experiences with regard to menopause'.** Probing questions followed after each response from the participants until saturation, a point where no new data no longer emerged during the data collection process **(Annexure A)**. The researcher encouraged participants to justify and validate their perceptions. Summarising highlighted the main ideas, thoughts and feelings expressed by participants. It was also ensured that participants contributed equally to the discussions. When data saturation was reached, the cassettes were labeled accurately in preparation for transcription. The cassettes were destroyed after the research report was written (Krueger, 1994:115).

The following approaches were used as methods of data collection: interviews, observations and field notes. These methods were used to explore and describe the phenomena of menopause experienced by



© University of Venda

University of Venda
Creating Future Leaders

menopausal women. Data was collected and meanings, themes and general descriptions of the experiences were analysed within a specific context.

During the interviews, the principles of active listening were applied in order to stimulate the interview process. Verbal and non-verbal communication skills, such as clarification, paraphrasing and probing, were employed, to elucidate the most important themes and feelings. Because the researcher was directly involved with data collection, it was possible to observe verbal and non-verbal behaviour, and the environment.

Observations: The researcher observed participants in the venue suitable to them as they interacted with each other during the discussions. During observation the researcher established close relationships with the women and obtained significant information, while on the other hand, the participants gained a good knowledge of the researcher. An overview of the experiences of menopausal women was also obtained. The researcher listened, asked questions and collected artifacts. Observations were done throughout the study. The women were allowed to talk freely in their own language.

Field notes in this study were taken throughout to capture the lived experiences of menopausal women in coping with menopause. The field notes were observational, personal, methodological and theoretical (Krueger, 1994:114). The researcher wrote field notes to capture the main responses and these were preserved as a record of the researcher's observations and experiences during the interviews. Field notes were also used to augment the tape. Data was tape recorded and transcribed verbatim.

### *3.3.2.4 Trustworthiness*

The model of Lincoln and Guba (in De Vos, 2005) for ensuring trustworthiness, namely, credibility, dependability, transferability and confirmability was used

Credibility refers to whether the researcher has established confidence in the truth of the findings from the participants (De Vos, 2005; Lincoln & Guba, 1985). Credibility was ensured by checking the accuracy of descriptions of menopausal women's' experiences. Prolonged engagement was ensured through rapport with participants for about one hour and in participants' own language. At the end of the



© University of Venda

focus group interviews, follow up discussions were conducted to verify the data. Literature control was done to ensure triangulation of data sources. Field notes and the tape recordings were given to an independent coder to check and allocate categories and sub-categories.

Dependability on the other hand, relates to the consistency and replication of the study, whether the findings are consistent and whether the inquiries can be replicated with the same subjects in a similar context (Emmelin, 2004). Variability is possible in a qualitative study owing to the uniqueness of human nature, therefore consistency is defined in terms of dependability. Field notes were written during data collection and triangulation of the data collection methods was used to discern any weaknesses in the focus group interviews; these were compensated by the use of a questionnaire to ensure dependability.

Transferability refers to the degree to which findings can be applied in other contexts and settings within groups. It includes the ability to generalise the findings to larger populations (De Vos, 2005:35). Transferability was ensured through the triangulation of the research designs and multiple sources of data to strengthen the study's usefulness for other settings. A comprehensive description of the background information about the participants and the research context was followed.

Lastly, confirmability refers to the degree to which the findings are a function solely of the participants and conditions of the research and not of other biases, motivations and perspectives. Confirmability also refers to whether the findings of the study can be confirmed by others (Cresswell, 2003). The tape recordings and field notes were preserved to ensure that conclusions, interpretations and recommendations can be traced to their sources and whether they are supported by the study. Conducting such a study involves raw data, recorded tapes, written field notes, documents and survey results. In this study, confirmability was ensured by the involvement of the independent coder.

### *3.3.2.5 Method of data analysis*

Data analysis is conducted to reduce, organise and give meaning to data. Data analysis is the systematic organisation and synthesis of research data and the testing of research hypothesis using the data (Polit & Beck, 2010:463; Burns & Grove, 2009:695). The purpose of data analysis is to reduce, organise and provide structure to, and elicit meaning from research data (Polit & Beck, 2010:463). The analysis of



© University of Venda

University of Venda
Creating Future Leaders

qualitative data is typically an interactive process (Polit & Beck, 2010:464). According to Morse and Field as described by Polit and Beck, qualitative analysis is a process of fitting data together, making the invisible obvious and of linking and attributing consequences and antecedents (Polit & Beck, 2010:464). Tape-recorded interviews were transcribed verbatim. Data was analysed using Tesch's open coding method in Cresswell (2003:142) by classifying themes and sub-themes. Data was also analysed by the researcher and thereafter by an independent coder with experience in qualitative research to identify the themes and sub-themes.

### 3.3.3 Phase 2: Quantitative study

In this phase of the study, the objectives were to identify and describe challenges faced by menopausal women and analyse the available support systems; thus quantitative research was carried out. Quantitative research (also referred to as *The Survey of the Study*) refers to those studies whose findings are quantified and reported as summary statistics and analysis. Data that are mainly numerical were dealt with. In quantitative design, the researcher's role is that of an objective observer focusing on specific questions and objectives that remain constant throughout the study (Schneider, 2007:639). In this study a quantitative, cross-sectional descriptive research design was used. A descriptive design is also called *observational* because the researcher only describes the results without intervening. Descriptive studies are aimed at providing an accurate portrayal or account of the characteristics of the individuals, events or groups with the purpose of problem identification, justifying actions, making judgments or finding out what others are doing in similar situations. The design does not involve manipulation of variables and there is no attempt to establish causality (Polit & Beck, 2006:22).

A cross-sectional descriptive study generates insight about a phenomenon under study. Data collection takes place during one data collection period from a cross-sectional sample, appropriate for the description of the phenomenon under study (Polit & Beck, 2006:239). Descriptive studies on the other hand, aim at determining the frequency with which events occur and classifying information (Burns & Grove, 2005:26). The study explored challenges experienced by menopausal women. A structured questionnaire was used to collect data from these women. Activities included in this phase were: selection of the population and sampling, community entrance, sampling of villages and participants, method of data collection and analysis.



© University of Venda

University of Venda
Creating Future Leaders

### *3.3.3.1 Sampling methods and sample*

As indicated above, the target population for this study included all women between 40 years and above residing in Hamakuya villages in the Niani ward in the Mutale Municipality; this was a population of approximately 5000 according to (Mutale Municipality census, 2009). Owing to resource limitation such as time and finance, it was proposed that a sample of 500 women between the ages of 40 years and above be selected. Sampling was done by combining two probability sampling methods – cluster and systematic sampling procedures. This procedure ensures adequate representation of the study population and villages in the sample. The first method involved cluster sampling, all the villages in the Niani ward in Hamakuya were clustered and randomly selected to obtain the four villages required for the study. The second method consisted of selecting villages within the participating cluster systematically and with equal probability of participating. Systematic sampling was used to select the households where participants lived. This afforded all participants in the selected villages the eligibility to participate in the study. In order to take this sample randomly, the process involved the following stages:

- **Community entrance**

As discussed in qualitative study, access to community followed the same procedure. The aim of community entrance during quantitative study was to familiarise the research team with the community people and to present details of the activities of the research including arrangements and appointments. Community entry was also done to allow the women to make informed decisions about whether to participate or not.

- **Sampling of villages**

As indicated on page 55, the total number of villages of Hamakuya is 20 in number. In other words, for the sake of sampling, the study concentrated on sixteen (16) of the 20 villages only. The reason for the exclusion of the four (4) villages was that they consisted of a few people each and there was hardly any elderly man or woman in the families. One of the clarifications made was the fact that of the 20 villages, only four were selected randomly by the researcher. In order to randomly select the four villages, the 16 villages mentioned on page 52 were zoned into four (4) according to their population of study table 3.2.



© University of Venda

University of Venda
Creating Future Leaders

-From each zone, a village was chosen by balloting (a procedure of taking a simple random sample in order to avoid bias to give everybody a chance to be selected randomly).

Table 3.2: Zoning of Hamakuya villages

| | |
|---|---|
| • **Domboni** | • **Gondeni** |
| • **Khavhambe** | • **Muhotoni** |
| • **Mutshikilini** | • **Tshambuke** |
| • **Dotha** | • **Fandani** |
| • **Mbuyuni** | • Tshianzwani |
| • **Maholoni** | • Tshifunguduli |
| • **Guyuni** | • Sanari |
| • **Musanda** | • Mukoma |

- **Sampling of participants**

In quantitative studies, the sample size can be determined by using statistical computation. This is based on the assumption that data would be available for calculation of the sample size. Some of the factors utilised in the calculation of sample size are: effective size, standard error, confidence interval (Burns & Grove, 2006:354; Sarantakos, 2005:171) and the size of the total population from which the sample will be drawn (Saunders, Thornhilll & Lewis, 2003:173). In this study in order to select 500 (10%) participants randomly from the four villages, proportional allocation was made based on the population size of each of the four villages. The systematic random sampling technique was used to sample the households where participants lived and to select the sample size allocated for that village. From each of the four villages 125 participants were selected for the study. Participants who met the criteria within a household were all interviewed. However, if within that particular household a woman that met the criteria did not live there, the research team proceeded to the next house. The procedure was continued until the sample size was met.



© University of Venda

University of Venda
Creating Future Leaders

### *3.3.3.2 Instrument for the survey (Questionnaire)*

Research instruments are devices used to collect data. These can be in the form of questionnaires, tests and observation schedules (Polit & Beck, 2006:502). The research instrument that was used in this study was a questionnaire. The questionnaire adopted from Donati et al., (2009:246) and Avis, Kaufert, Lock, McKinlay, & Vass (1993:345) were used to design a self-administered questionnaire to collect relevant data regarding the experiences of menopause by menopausal women. Questions were derived from literature review and personal observations. The questionnaire was translated into the local language (Tshivenda) by the language expert. As shown in Annexure B, the questionnaire was designed following the objectives of this study and was divided into 3 sections as follows:

- Section 1: Demography of participants
- Section 2: The type and severity of menopausal challenges experienced by the participants aged between the ages of 40 years and above. A Likert scale was used to measure their knowledge.
- Section 3: Available support systems to mitigate the effect of menopausal challenges.

- **Validity and reliability of the instruments**

Reliability and validity are two important criteria for assessing the quality of the design and the instruments for the quantitative research (Nachmias & Nachmias, 2004:165). Validity is a quality criterion that measures the degree to which inferences made in a study are accurate and well founded. In a research instrument, validity is the degree to which an instrument measures what it is intended to measure. As such, validity ensures that appropriate steps are followed in designing instruments and that results reflect the variables under study, not some other concepts (Nachmias & Nachmias, 2004:238; Polit & Beck, 2006:571). It is important for the instrument to be valid. The types of validity include: face, content, predictive and construct validity (Nachmias & Nachmias, 2004:328). For this study, content validity was used to determine the validity of the quantitative instrument.

- **Content validity**

Content validity refers to the extent to which the instrument covers the complete content of the particular construct that it sets out to measure (Cresswell, 2003:142). Content validity deals with the adequacy of



© University of Venda

University of Venda
Creating Future Leaders

the coverage of the content of the topic of interest being measured. It assesses the degree to which the statements, questions or indicators contained in the instrument adequately represent the characteristics of the construct being measured (Nachmias & Nachmias, 2004:170; Polit & Beck, 2006:328). In this study attention was given to content validity. With the help of literature review and constant review by the researcher's supervisors who are experts in the field of research methodology, the content of the questionnaire was reviewed and revised to meet the expected standard. In addition, the experts assessed the wording of each item for clarity, sensitivity and bias. The sequence of the items was also assessed so that there was a meaningful order (Polit & Beck, 2006:328). The review was followed by removal or re-wording of the inappropriate items. New items were added to enhance the content validity of the quantitative instrument.

- **Reliability**

Reliability of an instrument is the ability of an instrument to yield consistent numerical results each time it is applied (Brink, 2003; Polit & Beck, 2006: 324). The instrument/questionnaire was completed by the researcher and research assistants on the first day of data collection to different women on different occasions and the results of the interviews on the different occasions were compared in order to assess whether the questionnaire would give the same results at its point of the administration. The test-retest method was carried out by administering the instrument twice to the first set of the same participants. The researcher used the experience gained to measure whether the instrument passed the test of reliability or whether there was need to revise or review it. The researcher then supervised the data collection process on an ongoing basis. This confirmed the consistency of the data collected.

- **Pretest**

Pretesting a research instrument is the trial administration of the developed instrument in order to identify anomalies, to assess the time requirement and to make necessary adjustments. Pre-testing also determines whether the instrument is useful for generating the desired information. In addition, the clarity and the sensitivity of the questions are also assessed during the process (Polit & Beck, 2006:296). Pre-testing is a small scale trial of a particular research component (Brink, 2003:191). For the purpose of the pre-test, ten menopausal women aged between 40 years and above who lived within the area of study



© University of Venda

were selected and interviewed using the study questionnaire. Pre-testing took place two weeks before the actual study began in order to eliminate problems that might have been overlooked. The selection of the ten women was done in a manner that the women would not live within the communities where the study participants were randomly selected. The researcher purposefully selected one village namely Muhotoni for the purpose of the pre-test. The pre-test was done by both the research assistants and the researcher. Based on the results of the pre-test and the comments from the supervisor, who is an expert in quantitative research, the questionnaire was revised to accommodate the necessary changes. Information collected from women during pre-testing was not included in the final analysis of data and Muhotoni village was also excluded.

#### *3.3.3.3 Method of data collection*

Data collection refers to gathering information to address a phenomenon under study. Researchers can gather data using existing records in the form of written, narrative records of the past (diaries, letters, newspapers and minutes of meetings); observations of the activities, interviews (face-to-face or telephone interviews), focus group interviews and through the use of questionnaires (Nachmias & Nachmias, 2004:224; Polit & Beck, 2006:253). Data for the survey was collected by the researcher and four research assistants. Before data could be collected, four research assistants were recruited from the four villages that were purposefully selected by the researcher and trained to assist in data collection. Data was collected using a designed instrument as adopted from Donati et al., (2009:246) and Avis et al. (1993:345).

- **Training of research assistants**

Considering the nature of the study, there was a need to recruit and train professional nurses as research assistants who could write and speak the Tshivenda language and who could provide necessary assistance to the researcher during the second phase of the study. The training took two to three days (**Annexure F**). It included the following:

Day 1: Activities related to administration of the questionnaires

Day 2: Assistance in relation to the workshop activities



© University of Venda

University of Venda
Creating Future Leaders

Day 3: Field work consisting of demonstrations and return demonstrations with regard to questionnaire administration.

Four female professional nurse research assistants who fulfilled the following requirements were recruited:

They were professional nurses who can speak and write the Tshivenda language.

They live within the community they serve.

They are between the ages of 40 and 50 years.

The researcher trained the research assistants at the tribal office provided by the tribal authority. Training included how to handle culturally sensitive questions. After training, the research assistants were taken for their first day of field work in order to administer the first questionnaire.. The completed questionnaires from the first participants were compared to ensure the reliability of the instrument (Nachmias & Nachmias, 2004:347). The differences identified were clarified with the research assistants before they embarked on actual individual interviews (Burns & Grove, 2009:378). Questionnaires were self-administered because the majority of the respondents were not literate in English. The questionnaires were translated into Tshivenda and the interviewer made appointments with individual respondents and carry out the interviews on the appointed dates and times. The researcher continued to observe the administration of the questionnaires on an ad hoc basis and regularly checked the completed questionnaires to identify missing information or to query unexpected responses, such as the taking of HRT which was unlikely in the rural villages of Mutale. The interviewers asked each question and recorded each response according to the variable included in the questionnaire.

Considering the sample size of 500, it was expected that data collection would take ten working days which was two weeks. That implied that 50 questionnaires were completed per day at the rate of approximately 13 questionnaires per day per research assistant. Assuming that each interview would take 30 minutes for 13 questionnaires, each research assistant spent six-and-a-half hours for the interviews per day which continued until 15;00. This was followed by daily evaluation meetings between the research assistants and the researcher/supervisor. The aim of these daily meetings was to serve as part of quality control whereby the daily activities could be reviewed, challenges discussed and



© University of Venda

UNIVERSITY OF VENDA

University of Venda
Creating Future Leaders

solutions found. Data collection occurred at the four villages concurrently until the target number of women had been interviewed.

### *3.3.3.4 Data analysis*

Quantitative data analysis is the systematic manipulation of numerical data through statistical procedures in order to describe the phenomenon under study or to assess the magnitude and reliability of relationships among them (Polit & Beck, 2006:508). Before commencing data analysis, data cleaning was done. That was done by paying particular attention to the quality of data collection by the research assistants. Specific attention was given to the issue of missing data by ensuring that all questions were answered by all the respondents. Data analysis was guided by the study objectives and Orem's theory of self-care deficits. The numerical data was done using the Statistical Package for Social Sciences (SPSS Version 19.0) computer programme with a statistician's assistance. The first stage involved obtaining the frequency distribution of each of the variables. The researcher carefully examined the frequencies to detect whether there were any errors. If satisfied that the frequencies were error free, the second stage involved analysing the data descriptively to draw relevant tables and charts. In this study, pie charts and bar charts were used to present the findings.

According to the objectives of the survey, relevant descriptive statistical tests were applied to examine the relationship between demographic variables and other variables. This included the ANOVA test (analysis of variance), the means, range and standard deviation. Contingency tables or cross tabulation were used to summarise findings. Cross tabulations allowed the researcher to visually compare summarised data related to two variables within the sample. To test the significance of the association between variables under study, the Chi-square ($X^2$) was used and the P-value was calculated. The Chi-square is defined as a test used to evaluate whether the relationship between two variables is statistically significant. The Chi-square is usually applied in situations involving two nominal variables (Nachmias & Nachmias, 2004:490; Polit & Beck, 2006:370). The level of significance or alpha (a) entails the probability that the observed differences are due to chance. This is referred to as the P-value. Usually the level of significance is set at .05 or .01, which means that the chances that the findings would have occurred by chance are not more than 5% or 1% of the time respectively (Nachmias & Nachmias, 2004:483; Polit & Beck, 2006:366).



© University of Venda

University of Venda
Creating Future Leaders

### 3.3.4 Phase 3: Model development

A framework was developed as indicated by (Dickoff et al., 1968) which incorporated themes and sub-themes that emerged from the results of Phases 1 and 2. This framework served as a guideline for developing the model that was based on literature review, focus group interviews and questionnaires. Before the model could be developed, an analysis of concepts was adopted incorporating the methods advocated by Walker and Avant (2008: 65).

- **Concept Analysis**

Concept analysis is a process of examining the basic elements of a concept. It is ultimately only a careful examination and description of a word or term and its uses in the language. Concept analysis was conducted on the major categories (concepts) that emerged after data analysis. Based on the procedure for concept analysis by Walker and Avant (2008:65), concept analysis involves the following steps:

- Selecting a concept appropriate to the focus of the study;
- Determining the purpose of the analysis;
- Identifying the uses, characteristics and connotation of the concept that can be discovered from dictionaries, literature and from colleagues;
- Determining and defining attributes by finding instances where a concept is mentioned and by making notes of the characteristics of the concept that appear repeatedly (thereafter, the researcher decides which attributes are the most useful in relation to the aim of the analysis);
- Identifying a model case which is a real life example of the use of the concept that includes all the critical attributes of the concept;
- Identifying borderline, related, contrary, invented and illegitimate cases;
- Identifying the antecedents and consequences;
- Defining the empirical referents.

In this study the results of concept analysis yielded to the researcher a basic understanding of the underlying attributes of the concepts that supported the model for menopausal women in their experiences with menopause.



© University of Venda

University of Venda
Creating Future Leaders

- **Model development**

A model is a graphical representation of a theory and its parts should correspond with the parts of the theory they represent (Walker & Avant, 2008:28). De Vos, Schurink, & Strydom (2001:35) posit that a model classifies the concepts; with the aim of discovering and exposing certain relationships between them. Conceptual frameworks for model development were used according to the six elements of Dickoff et al., (1968:426).

- **Overview of the model**

A brief discussion of the context, dynamics, processes and purpose of the model is presented. The primary purpose of this model is to provide support for elderly women and primary health care nurses in the community so that menopausal women in the Mutale Municipality can cope with the experiences of menopause. Primary health care nurses will facilitate the transition of menopausal women from being self-care deficient to being completely competent with regard to self-care, enabling them to function independently as menopausal women. The model further contains the following six components namely: goals, concepts, definitions, relationships, structure and assumptions as outlined in Chinn and Jacobs (1987:116).The model attempts to provide guidelines for elderly women, primary health care nurses and menopausal women as recipients in the community, with regard to coping with the experience of menopause in the Mutale Municipality.

### 3.3.4 Phase 4: Model validation.

Walsh (1998:21) states that a model becomes part of the wider nursing community, and it should be open to scrutiny, critique, evaluation and amendments. In this study validation was done by means of critical reflections essentially as described by Chin and Krammer (1999:110). Critical validation involved evaluating the model for simplicity, clarity, accessibility and importance.

With regard to simplicity the model was checked to determine the number of elements within each category and particularly whether concepts and their relationships were minimal in order to avoid misinterpretations. In other words the model was checked for the breath of the scope of the concepts,



© University of Venda

University of Venda
Creating Future Leaders

their purpose within the model and their applicability in other situations (Chinn & Krammer, 1999:110).

Concerning clarity, the model was checked for the extent to which it could be understood as well as for consistency of conceptualisation.

With regard to accessibility the model was checked for the extent to which concepts were grouped in empirically identifiable manner. The model was checked to determine if it could be accessed through other resources.

Finally concerning importance, the model was checked for the extent to which it led to valued goals in practice, research and education (Chinn & Krammer, 1999:110).

In this study the purpose of model validation in the community health care services was to determine the worth of the model and the evidence that could support or refute its relevance. Furthermore, validation would contribute to the improvement of the model, refinement of data and the evaluation process. Experts in the development of the nursing models would be requested to evaluate the model according to the above criteria. Changes could then be effected accordingly in order to promote the authenticity of the support model that was developed.

## 3.4 ETHICAL CONSIDERATION

- **Permission to conduct the study**

The proposal for this study was presented to the Higher Degree Committee of the School of Health Sciences of the University of Venda and was recommended for ethical approval by the University Senate, the Ethics Committee and the Department of Health and Social Development of Limpopo Province **(**See **Annexure C)** and the Hamakuya Tribal Authority (See **Annexure D).** Letters were written to the chief to ensure access of the researchers to the six different villages where the women were to be interviewed.



© University of Venda

University of Venda
Creating Future Leaders

- **Informed consent (Annexure E)**

Informed consent was obtained from each participant prior to distribution of the questionnaires. In securing consent the participants had adequate information regarding the study, understood the information and had the power of free choice enabling them to voluntarily participate in the study or decline participation. Participants were allowed to make an informed decision and provide direct consent to participate in the study (Burns & Grove, 2001:196).

- **Confidentiality and anonymity**

The researcher explained the purpose of the study, the procedures involved, the maintenance of confidentiality and the right to withdraw from participation whenever they felt like doing so. In order to ensure anonymity the researcher ensured that there were no link of participants with their data. Names of families were not used. Participants remained anonymous and no names were written on the questionnaires. Stringent methods were in place to prevent linking any questionnaires to any individuals. Access to completed questionnaires was restricted to the research assistants and members assisting in the Statistical Package of Social Science (SPSS) for the analysis of data. Raw data was destroyed after completion of the report.

The confidentiality of the information revealed to the researcher would not be made known to the public and would not be available to the any other persons although this right might be waived when the information collected was made known through the research report (Schneider et al., 2004).

The principle of justice was ensured, and participants had the right to fair and equitable treatment before, during and after their participation in the study. The researcher selected participants in a fair manner, treating those who declined or withdrew after agreeing to participate in a non-prejudicial manner.

Regarding the principle of beneficence, the potential risks and benefits were explained to the participants and they were protected from all forms of harm from humiliation or embarrassment, physical discomfort and emotional stress. To ensure participant comfort, participants selected suitable venues, times and days for the interviews.



© University of Venda

University of Venda
Creating Future Leaders

The researcher ensured that the participants' privacy was maintained throughout the study. Private information was not to be shared without the participant's knowledge or will. A participant's dignity, friendship, or employment was not compromised. Participants were interviewed in a venue which was quiet and suitable to them. They were informed that a tape cassette recorder would be used and that the tape would be destroyed after the results were published (Burns & Grove, 2001:196).

## 3.5 LIMITATION AND DELIMITATION

Owing to the sensitive nature of the study, it was not easy for participants to provide accurate information and honest responses in the investigation about menopause. Women from rural communities, especially elderly women found it difficult to engage freely in an interview on sensitive issues, such as menopause and sexual activities and this might have affected the quality of data. However, in order to meet this potential challenge, the researcher utilised her skills in community health nursing practice to train the research assistants on how to handle culturally sensitive questions.

Owing to time and financial limitations, the study was limited to women of Ha- Makuya aged 40 years and above and thus the results were not generalised to the whole of Limpopo Province. The workshop would include a sub-group of women who participated in the survey and not the entire study population.

The model developed might need to be piloted in different settings in order to prove its adequacy to meet the objective which was to facilitate the coping mechanisms of menopausal women in rural communities.

## 3.6 SUMMARY

In this chapter, the research methodologies used to explore the challenges experienced by menopausal women in the Mutale Municipality of Hamakuya were described. The designs were triangulated using both qualitative and quantitative methodologies for Phases 1 and 2. The combination of qualitative and quantitative methodologies provided a comprehensive investigation into the challenges experienced by menopausal women aged 40 years and above. Different instruments were used to collect data for the two



© University of Venda

University of Venda
Creating Future Leaders

phases. Data collected for Phase 1 were analysed following Tech's open coding method in Cresswell (2003:142), while, data collected for Phase 2 were analysed using the SPSS (Version 19.0).

In Phase 3, a framework for the model was developed as indicated by Dickoff et al. (1968) emanating from the results obtained in Phases 1 and 2. Before the model could be developed, an analysis of concepts was adopted incorporating the methods advocated by Walker and Avant (2008:65). In Phase 4 the model was evaluated by means of the critical reflections described by Chinn and Krammer (1999:110).

The researcher observed all the professional, legal and social requirements. To protect participants the following ethical principles were considered in relation to institutional review: respect for human dignity, beneficence and justice. The following chapter presents the findings of this study.



© University of Venda

University of Venda
Creating Future Leaders

# CHAPTER 4

## RESULTS AND DISCUSSIONS (QUALITATIVE AND QUANTITATIVE STUDIES)

Since the design of this study is triangulated, this chapter is arranged as follows: Phase 1 consists of the results and discussions of the qualitative study while Phase 2 consists of the results and discussions respectively of the quantitative study..

## 4.1 PHASE 1: QUALITALITVE STUDY

### 4.1.1 Introduction

The purpose of this study was to develop a model to facilitate women's coping mechanism with menopause. Furthermore the study attempted to validate the model and develop guidelines for its use. In the previous chapter the methodology that was used to conduct this study was discussed. In this chapter the results emanating from the qualitative and quantitative data collected through focus group and individual interviews with menopausal women are discussed. The analysis and interpretations of the qualitative data is guided by Dorethea Orem's Self-Care Model (1991:70). The researcher provides quotations from the participants giving their views. Conclusions have been drawn according to Orem's Theory of Self-Care; these are self-care deficits, self-care agencies and nursing systems (Orem, 1991:70). The analysis and interpretations of quantitative results are discussed based on the findings of the questionnaires. Literature control has been applied to validate the findings

Four focus group interviews were conducted with pre-menopausal, peri-menopausal and post-menopausal/menopause rural village women. Pre-menopause is considered as the state in which a woman is still having menses or has menstruated within the previous three months. Peri-menopause is where the woman has menstruated within the previous 12 months. This is divided into early peri-menopause (defined by unpredictable or irregular menses) and late peri-menopause (defined by cessation of menses for at least three months within the previous 12 months but not due to hysterectomy, oophorectomy or pregnancy). Post-menopausal status or menopause on the other hand, is defined as those women having cessation of menstruation for at least 12 months (Ho et al., 2003:149; Orner,



© University of Venda

University of Venda
Creating Future Leaders

2005:2). One central question was asked during the focus group interviews and was followed by probing questions. **'Please tell me your experiences with regard to menopause?'** The independent coder and the researcher used open coding according to Tesch in (Cresswell, 2003) for data analysis. The steps considered during qualitative data analysis were as follows:

- Data collected by tape recording were transcribed verbatim.
- Data were interpreted by listening to all the tape recordings and the transcriptions of the field notes during the focus group interviews. The records on the tapes and the written notes were compared to verify the transcribed data. Following data analysis, discussions and verification of findings were conducted with members of the focus groups.
- A list of all the topics identified was written down. Similar topics were clustered together and written in columns.
- Data that belonged to each category were assembled, collated and analysed.
- Similar topics in the columns were arranged in themes and subthemes

Raw data not arranged in categories were forwarded to a qualitative specialist. The qualitative researcher allocated the themes from the original raw data given by the researcher. Thereafter a meeting was held between the qualitative researcher and the researcher of this study. Later a consensus on the themes was reached. The findings are discussed in relation to the themes and relevant responses from participants emanating from the focus group interviews. Three themes emerged from the focus group data analysis as shown in the table 4-1



© University of Venda

University of Venda
Creating Future Leaders

**Table 4.1: Themes and sub-themes of menopausal participant's experiences of menopause**

| Themes | Subthemes |
|---|---|
| **Participants' understanding of the concept menopause.** | • Participants' meaning of menopause<br>• Participants' experiences of menopausal self-care deficits and old age |
| **Participants' expression of self-care deficits regarding feelings/ perceptions and beliefs of menopause** | • Negative, positive, neutral feelings about menopause<br>• Cultural beliefs, misconceptions and myths regarding menopause<br>• Discrimination and stigmatisation of participants by family members and the community<br>• Taboo not a culturally shared subject among villagers<br>• Lack of participants' support by family and community members<br>• Lack of adequate knowledge and information by participants |
| **Participants' menopausal self-care deficits and coping with them** | • Inadequate support systems/Traditional strategies in place<br>• Lack of formal education and adequate social support by initiation schools, church conferences, families, friends and colleagues<br>• Insufficient information by other health team members |



© University of Venda

University of Venda
Creating Future Leaders

### 4.1.2 Theme 1: Participants' understanding of the concept of menopause

Theme 1 was divided into two subthemes namely: participants' understanding of the meaning of menopause and participants' experiences of self-care deficits of menopausal symptoms and old age. In this study Orem's Theory of Self-Care and Self-Care Deficits Theory of Nursing will be used as a frame of reference. Self-care deficits exist when the self-care demands of a person exceed their self-care agency. Self-care deficit refers to a relationship between self-care agency and the therapeutic self-care demand in which self-care agency is not equal to therapeutic self-care demand. A person can have a partial or a complete self-care deficit which indicates whether a partially or a wholly compensatory nursing system is needed to satisfy self-care demands. Nursing is needed in case of an existing or potential self-care deficit. A future self-care deficit can be foreseen owing to predictable decreases in self-care abilities and increases in self-care demands (Fitzpatrick & Whall, 1996).

#### *4.1.2.1 Participants meaning of menopause*

In this study, it was found that the majority of menopausal participants attached various meanings to the concept of menopause, namely: cessation of menstruation, normal transition, Gods nature of doing things and the aging process/old age.

With regard to the cessation of menstruation, menopausal participants in this study perceive and acknowledge menopause as a cessation of menstruation from midlife to old age. In all the focus group discussions, menopause was regarded in traditional terms as 'blood is gone' referring to cessation of menstruation, whereby a woman past 50 years of age became aged. This was commented on by a post-menopausal participant who said: *Eeee....we say Ndi u tuwa ha nowa* which is a Tshivenda phrase meaning *blood is gone when there is stopping of menstruation for good due to aging.* Through probing she explained: *This is the beginning of a woman aging and menstruation also starts to disappear gradually with on and off episodes. Blood become scant and eventually disappear for good. This signals old age.*

Participants emphasised different experiences by different individuals as expressed by one late peri-menopausal participant: *You see it differs with individuals, when menstruation is about to cease, some*



© University of Venda

University of Venda
Creating Future Leaders

for good. Some late peri-menopausal participants explained that it differed with individuals when blood is about to cease; whereas other women experienced bleeding on and off, and others experienced heavy clots before the actual cessation. Participants also understood that menstruation gradually ceases at midlife and later disappears for good in the absence of pregnancy.

It was evident from all the focus group interviews that none of the menopausal participants in this study associated cessation of menstruation with menopause but with old age. Some pre-menopausal participants on the other hand had not heard of or attached meaning to the concept of menopause. What is of interest is that they were aware that after menstruation they would age but could not attach it to menopause. This group of pre-menopausal participants was also aware that they lacked information on this aspect. The peri-menopausal and post-menopausal participants were aware and understood that cessation of menstruation and aging was accompanied by health-related problems that could be regarded as the self-care deficits experienced by menopausal women at menopause. While the majority of the pre-menopausal women did not know that cessation of menstruation is also accompanied by health-related challenges. Furthermore, the majority of the post-menopausal participants acknowledged that being old was the end of youth and the beginning of age-related self-care deficits like hot flushes, frequency and urgency of urinating, joint and back pain, sexual dysfunction, and others. The majority of participants also understood that some symptoms affect the body (physical) and others the mind (psychological). They understood that some symptoms may be severe and/or may or may not be troublesome during that period of life. Some peri-menopausal participants expressed feelings of frustrations caused by menopausal symptoms that were severe and bothersome to them.

Other studies, like that of Voda (1993:447) describe the concept of menopause as derived from 'men' and 'pause' and is a direct description of the psychological and physical events in women where menstruation ceases to occur. It is the time in a woman's life when she has experienced the last menstrual bleed. On the other hand, Henn (2010:405) made similar findings that the word menopause is derived from the Greek *men* (month) and *pausis* (cessation). It literally means cessation of the monthly cycle.

According to Bulbeck (2003: 12), menopause in Chinese is defined as 'it being over' referring to cessation of bleeding that marks menopause. Greenfield (2007:488), also studied the meaning of



© University of Venda

University of Venda
Creating Future Leaders

menopause among the Greeks. They indicate that the word 'climacteric' is a Greek derivation of the word for 'ladder' or the steps of the ladder and is another word for menopause. It is the last period of a woman's life and begins some years before the last menstruation. Menopause is also viewed as the time that represents a passage from the reproductive to the post-reproductive life stage. It is an aspect of human aging and a useful predictive risk marker of a variety of aging–related diseases and/or health problems. It signals the end point of the menstrual journey in a woman (Akinrogunde, 2010:1). On the other hand, Chinese and Western medical texts show similar sets of physiological and mental symptoms for midlife women. Menstruation is described as a lifetime wound and menopause an 'Indian summer', a period of increased vigour and physical beauty. Generally, according to some Indian medical texts, a menopausal woman is described as an even sorrier creature than a menstruating woman. She is seen as frail, dependent and prone to mental disorders and other illnesses, having exhausted her fixed quantum of life forces (Bulbeck, 2003:12).

Conversely, the Japanese use the word 'Konenki' usually translated into English as menopause. However, Konenki does not convey the same meaning as does menopause, rather it is similar to the concept of the climacteric which is a long, gradual process to which the end of menstruation is just one contributing factor (Melby et al., 2005:12). The western Turkish on the other hand refer to the climacteric as 'the end of youth', 'the end of fecundity' and 'the end of unclean days'. Most women indicated that cessation of the menstruation periods was the most positive thing as they do not have to wait for monthly bleedings, use sanitary equipment, or take birth control measures (Ayranci, Orsal, Orsal, Arslan & Emeksiz, 2010:1472).

In the mid-19$^{th}$ century, people started describing menopause as a deficiency disease. In the 1970s, menopause was ascribed to oestrogen deficiency causing anxiety, wrinkles and sexual frustration to older women. Henn (2010:405) on the other hand also indicates that in adult life, oestrogen falls to a critical level during a period commonly known as the climacteric. Significant hormonal changes occur at the time of menopause which has an impact on all oestrogen sensitive tissues.

Regarding Gods' nature of doing things, the peri-menopausal and post-menopausal participants from the Christian denomination comprehend the symptoms of aging as God's nature of doing things. This was



© University of Venda

University of Venda
Creating Future Leaders

confirmed by the following responses: *Eeee! We all agree, this is 'Nwali' God's nature of doing things, HE took menstruation away and we have to live with it.*

Another post-menopausal participant, also from the Christian denomination, added thus:

*When you think that the body is feeling hot, not long you start feeling cold and you will think you are catching a cold. This is like a punishment from God but we accept it as God' nature of doing things.*

Other late peri-menopausal and post-menopausal participants, who believe in the ancestors said: *Ndi zwa vhadzimu hezwi, vho khaula nowa nge tshifhinga tsha u kegula tsha swika.* This literally means that the ancestors stopped menstruation because it was now old age.

*Yes menstruation ceases when it is time to age and it is the works of the ancestor who control our lives.* Through probing she continued and said: *Health problems still come in spite of the protection by the ancestors. You suffer some health problems that may or may not be troublesome and severe. It is like a punishment of old age.*

Such expressions imply that the majority of the peri-menopausal and post-menopausal participants from either the Christian or ancestral denominations understood that nature played a role in their lives. Some situations were beyond their control and they had to adapt to the new biological situation. Menopausal participants accepted that nature does take its course. The peri-menopausal and post-menopausal participants in all the focus group interviews from a Christian denomination were aware and agreed that everything was made by God. They said: 'We are His making and He is our creator who controls our lives'. Even though they had different religious beliefs, some being Christian and others believing in their ancestors, all believed that their God caused menstruation to cease because it was time they rested from the bleeding as they were aging or aged. For them, menstruation and the menopause came from their God and they regarded it as a natural process made by Him. When menstruation stopped at that age it meant the time of aging had arrived or it signalled old age and they had to deal with it and adapt to the changes. Both the peri-menopausal and post-menopausal participants were aware that even if their God was there they still suffered health-related problems that may or may not be troublesome and frustrating. Some pre-menopausal participants in the study also belonged to the different denominations. These participants also agreed and were aware that they were their Gods' creations and that they would age one day but were unable to associate that with menopause. Some pre-menopausal participants were



© University of Venda

aware that some family members suffered from health problems. To them it was associated with old age and not menopause. Thus they regarded old age as a punishment because of the severity of the symptoms that disrupted their quality of life (Researcher's own experiences with the participants, 2011).

A study conducted among rural Mayan village menopausal women and Greek menopausal village women revealed that they believed that everything depended on God's will since He provided the number of children as His gift and He determined when they must stop bearing children (Beyene, 1986: 47).

Another study conducted by Ozuzu-Nwaiwu (2007:34) among black women in the United Kingdom revealed that women believed that God would heal their symptoms. This appeared to be consistent with the studies by Nixon, Hodge, Parr, Willis and Hunter (2001:81), who found that African-American women managed their symptoms through the use of prayer. Holland and Hoggs (2001), who stated that people of African and the Caribbean origin perceived illness to be caused by or treated with supernatural force.

All the participants in the post-menopausal focus group interviews believed that menopause is a natural and normal transition. Participants regarded menopause as a natural process of aging as cited by a post-menopausal participant who said: *This is the time of transition from childhood, adulthood and now old age. We have to live by it and is natural there is nothing we can do lets accept old age it has come no more going back.* Through probing she said, *Ah! Nature should take its course and we have to live with it because we cannot go back to childhood our time has passed.*

Another post-menopausal participant said: *You see it is like when we were young we menstruated and now we have stopped and crossed over to old age. Blood has gone and we are facing another type of life, that of old age. Our normal lives become disrupted with age-related health problems.* Through probing she said, pausing and shaking her head: *Ho! I am referring to severe joint and back pains, urinary frequency, sleeplessness, forgetfulness and depression.*

Furthermore, another late peri-menopausal participant commented about health problems brought about by the transition: *The transition brings problems that disrupt our normal life. When I started aging, I*



© University of Venda

University of Venda
Creating Future Leaders

*developed frequency of urinating. This is really a problem to me especially if I have taken too much water or fluids.* Through probing she said: *I mean you cannot take fluids when you travel or at bed time. You feel you quickly want to relieve yourself all the time and by the time you reach the toilet some urine has wet your under wears. It is quiet embarrassing when you smell of urine and each time you are from the toilet your clothes are wet with urine.*

A participant who is in her late peri-menopausal state supported her: *Yaaa! The transition is natural but it is an embarrassing time of your life. Yes, I accept that I am aging and it is natural but what I feel is not what I had before.* Through probing she said: *I am still a working woman and I do not like smelling urine at all and because I have frequency I am forced to bathe twice a day, in the morning when I go to work and immediately I am from work.*

Menopause to the majority of participants in all the focus group interviews was regarded as a natural process that all women must go through should they live to that age. The majority of late peri-menopausal and post-menopausal participants indicated that the natural process of aging was taking place in their bodies and allowed nature to take its course. They were aware that aging was accompanied by age-related conditions and that some were bothersome because of their severity, but that did not hamper their lives. Though some peri-menopausal participants had problems accepting the symptoms well, they felt that these were severe and hampered their daily living and quality of life. To some late peri-menopausal and post-menopausal participants, life was a transition where they had moved from one stage to the next meaning that they had moved from childhood to adulthood and then to old age.

The troublesome health challenges experienced by peri-menopausal participants were, for example, severe joint and back pain, frequency of urination, lack of sexual desire, and vaginal dryness. Some symptoms were regarded as more troublesome than others; this included hot flushes, night sweats, memory loss, depression and forgetfulness. Although they experienced these troublesome symptoms, some participants did not believe that there was anything wrong with them. They believed that these symptoms were part of the natural process of aging and were associated with hormonal changes that take place in a woman's body and cause health-related problems.

UNIVERSITY OF VENDA
LIBRARY



© University of Venda

University of Venda
Creating Future Leaders

The researcher concluded that participants may or may not seek health care because they see physical discomfort associated with aging. Therefore health education is an important factor in providing adequate knowledge and information regarding the physiology of menopause and health-related challenges.

In many parts of the world, such as America, Japan, India, Australia and others, menopause is often regarded as a major event in a woman's life. It should be regarded as a perfectly normal, natural state that should not be taken as some sort of disorder or ailment. It is a condition designed by nature whereby a female, past the age when a safe and healthy pregnancy and delivery can be assured, is deprived of any further possibility of impregnation. Regardless of culture and country of origin, all women all over the world will experience menopause should they live to that point in their lives (Vanda, 2003:3).

Nusrat, et al. (2008:56) conducted a study at the outpatient department of Isra University and revealed that most of the women considered menopause as a natural process of aging, though bothered by symptoms but did not go for consultation owing to lack of awareness and poverty. Traditional Chinese and Indian medicine comprehend menopause as a natural process accompanied by socially prescribed behaviours (Bulbeck, 2003:12). Flint (1995:161) also cites the statement by Bulbeck that the majority of the women perceived menopause as a natural phenomenon and not a medical disorder.

Kakkar et al., (2007:306) view menopause as a transitional period for women, whereby levels of the main reproductive hormone, oestrogen declines leading to a functional deficiency of oestrogenic activity and a variety of symptoms associated with this deficiency. Bosworth et al., (2003:32) on the other hand, view menopause as the midlife transition often prompted by the cessation of menses and ovarian failure gradually occurring in women between the ages of 47-55 years. Kilaf & Kirchengast (2008:313) pointed out that although menopause and menopausal transition are not diseases per se, this phase of life reduces health-related quality of life among stressed women.

When the levels of hormones diminish or drop, the body also undergoes changes that may or may not bring physical or psychological discomforts (Ho et al., 2003:149; Henn, 2010:405). Schreiber (2008:1) indicate that the ovaries produce lower levels of natural hormones with a ripple effect on the brain where body temperature is altered. This area in the brain is misled into believing that the body is overheating,



© University of Venda

University of Venda
Creating Future Leaders

which leads to hot flushes, night sweats and even palpitations. A woman might feel like a different person as one symptom creates or worsens another. They would not suffer the symptoms continuously during this period as some women progress through it effortlessly.

WHO (2009: 4) indicates that as women in rural developing countries move towards the years of menopause, they are at the risk of developing health problems associated with hormonal changes. These include heart disease, stroke, breast cancer, cervical cancer, frequency of urination, lack of sexual desire and dryness of the vagina. Such disorders when combined with other factors such as a lifetime of poverty, under-nutrition and lack of education might take a much bigger toll on the health of women. Before actual menopause, gradual changes such as a decrease in the amount of menses, lengthening of the interval between menses, periodic amenorrhea and finally spotting occur. These changes create a very unpleasant physical and psychological imbalance called hormonal imbalance which leads to menopausal symptoms.

The menopausal period marks the end of a woman's reproductive capacity (Ho et al., 2003:149). Flint (1995:161) on the other hand, posits that for some communities in the developed countries, menopause is viewed by women as a reward because of their transition to other challenges of life; for others, it is perceived as a punishment because of the aging conditions that come with it. In his study done on Korean women, Flint (1995:161) revealed that the majority of the women perceived menopause as a natural phenomenon and not a medical disorder. The study revealed that 53% of women thought that the psychological symptoms at this time of life are mainly due to life changes and 51.3% thought women could not control menopausal changes. Filipinos subscribe to the belief that menopause is a normal phenomenon and so are against Hormone Replacement Therapy because of the risks associated with it such as cancer (Berger & Wenzel, 2001:11).

#### *4.1.2.2 Participants' experiences of menopausal self-care deficits and old age.*

The study results revealed that physical symptoms of menopause included hot flushes, profuse sweating, night sweats, musculo-skeletal problems, vaginal dryness and sexual problems. A midlife peri-menopausal participant said: *Mmm! This whole body will feel hot from chest upwards to the face. This*



© University of Venda

*disturbs our sleep when one is sleeping peacefully. During the day it's worse as sometimes it is hot and especially in summer.*

Another late peri-menopausal participant who experienced the physical symptoms supported her by saying: *We experience hotness and coldness of the body with severe sweating on the face and chest.* She added: *You see, in hot weathers is worse, be it during the day or at night. This is like a punishment of old age.* She continued to say this: *When you think that the body is feeling hot, not long you start feeling cold and you will think you are catching a cold.*

This statement was cited by one post-menopausal participant who experienced severe symptoms. She said: *I have a terrible backache that I would also not sleep some night because the back is painful I would not even unbend my back. I usually maintain the same position throughout the night without turning. " Imagine using one position the whole night and my children assist me by putting a warm towel on my back in winter and in summer I just support it.*

*I have a problem of back and waist pains,* a late peri-menopausal participant said, pointing at her waist and back. *'Azwi pfiwi zwo rali' meaning the pains are unbearable and throbbing. I am unable to straighten my back properly. As you can see, I'm always bending and the only time when I do not feel pains is when I am sleeping on my back which is very tiring. My grandchild took me to the doctor in town but the treatment he gave me helps a bit. I usually take the treatment at night so that I can sleep.*

An early peri-menopausal participant with bothersome and embarrassing symptoms said: *I have frequency of urine especially if I have taken too much water. By the time I reach the toilet part of the urine has come out and I would wet my under wears. She* looked down then continued to say: *It is quite embarrassing when you smell of urine and each time you are from the toilet your clothes are wet with urine. I do not like smelling urine at all and because I have frequency I usually bathe twice a day, in the morning when I go to work and immediately I am from work.*

A pre-menopausal participant shook her head and said: *I do not feel all this things they are talking about maybe it is too early for me. This is very strange to me I think I need information on this aspect. Maybe*



© University of Venda

*we as youngsters are ignorant about our life and health in future thus we need to be educated adequately.*

The majority of the peri-menopausal and post-menopausal participants were aware of the physical symptoms. The participants were able to describe the hot flushes as recurrent, transient periods of flushing, sweating and a sensation of heat, often accompanied by palpations and a feeling of anxiety and sometimes followed by chills, joint and back pains and frequency of urinating. Most of the participants had experienced this sudden feeling of heat accompanied by profuse sweating. Participants also reported suffering episodes of hot flushes and could give detailed accounts of the experience. In all the focus group interviews, none of the menopausal participants associated these symptoms with menopause but with old age. The majority of the post-menopausal participants were elderly, hence they associated the symptoms with old age and not menopause. None of the participants reported shoulder stiffness; this is a rare condition in the geographical area of study probably because this area does not become very cold in winter. The condition is likely to be experienced by people living in cold climates. At this time of the season, participants do not engage themselves in too much heavy work in the fields as the land would be dry.

Furthermore, the early and late peri-menopausal participants were stressed and worried that some physical menopausal symptoms were so severe that they impacted on their quality of life. Some physical symptoms forced them to seek medical assistance from the health service or deal with the symptoms in their own way like using traditional remedies. Others adapted to the bodily changes by accepting them as they came. A few early peri-menopausal participants who were aware of their bodily changes were stressed, afraid, shocked and depressed by these changes. They also indicated that they ignored the changes but could not cope as they affected their daily activities and quality of life. Some became angry with themselves as the symptoms embarrassed them in front of people who were not familiar with the symptoms. On the other hand, the pre-menopausal group indicated that they were ignorant of these symptoms as they had never heard of them and had never seen anyone with the condition. This could imply that this group of participants was ignorant about the menopause. Even though they saw their elderly mothers or grandmothers suffering with the symptoms, they did not bother to ask what the cause of the condition could be.



© University of Venda

Regarding severe physical symptoms such as of hot flushes and joint pains it would seem they could be associated with heavy weight, diet, lack of exercise and drinking of alcohol. In all the focus group interviews, participants were not aware that these physical symptoms could be associated with heavy weight, lack of exercise and drinking of alcohol. Overweight late peri-menopausal and post-menopausal participants indicated that that they were stressed and discouraged and had to sleep on one side for long periods without getting assistance to be turned to another side. Participants expressed severe body pains that were not relieved by any medication. Some indicated that they associated these symptoms with aging rather than menopause. A few menopausal participants indicated that they lacked exercise while the majority indicated that they exercised on the farms by ploughing and by fetching wood from the bush and doing household chores. Very few menopausal participants indicated that they drank alcohol. The study found that participants who were found to be drinking alcohol were those who suffered severe physical symptoms like joint and back pains, and hot flushes. This could probably be due to the accumulation of uric acid in their joints and tissues.

Some peri-menopausal participants expressed discomfort especially in the presence of other people who were not familiar with the symptoms. Participants felt stressed and embarrassed when they suddenly experienced sweat dripping down their faces or urinated frequently because people asked if they were feeling unwell. Going out was unthinkable because of the discomfort they felt in the presence of other people. Participants were also worried about the frequency of urination which was also embarrassing in front of other people, as urine would start to drip before they could reach the toilet. Some disliked it when they smelt of urine in the presence of other people, owing to incontinence. Participants experienced self-care deficits owing to their inability to cope with severe symptoms that were uncomfortable, troublesome and embarrassing to them. It would seem these participants' required additional coping mechanisms as they lacked self-confidence and experienced low self-esteem, felt discouraged and embarrassed in the presence of others. Participants could not immediately deal with some embarrassing symptoms when these appeared in front of people not familiar with them. Some menopausal women associated urinary frequency with diabetes mellitus which also causes urinary frequency.

Furthermore, some late peri-menopausal and post-menopausal participants indicated that the severe physical symptoms they suffered were traumatising and frustrating both to themselves and their family



© University of Venda

University of Venda
Creating Future Leaders

members. Their families felt stressed and traumatised to watch their mothers or grandmothers in agonising pain. They were unable to sleep at night because of the pain suffered by their family member groaning or screaming with pain because they suffered severe joint pains throughout the night with little or no relief of the symptoms from the medication that they took. Sleep was thus disrupted and they had to go to work or school in the morning without resting at night. These participants, according to Orem, required partial or total compensatory nursing systems to meet their therapeutic self-care demand. This was mostly referred to those participants who were either helpless or could partially help themselves and needed additional coping mechanisms. Family members felt stressed that their mother or grandmother was suffering from the symptoms owing to old age and not menopause. A gap was identified regarding menopause and aging and their impact on the quality of life.

The researcher found that some participants had little knowledge of these symptoms and could cope with the symptoms on their own or could seek medical help if the need arose. Furthermore, the study found that the low level of knowledge of the participants contributed to the lack of understanding of these physical problems that they associated with menopause not old age. The results of this study further indicated that although some women have acquired some knowledge of the physical symptoms of menopause, they still suffered from severe symptoms, thus implying that there were major gaps in the knowledge about menopausal experiences. On the other hand, the pre-menopausal group had no information about menopause. Some indicated that they had only heard about it for the first time and others showed no interest as the changes had not started showing in them. This implied ignorance and a lack of information in younger midlife women. Before a woman reached midlife she should be educated about menopause either at school or at health facilities such as clinics as happened when they reached puberty.

According to Orem (1991), participants in this study experienced self-care deficits that were wholly or partially compensatory as they were unable to meet their therapeutic self-care demand. In self-care the person assesses the need for self-care, decides on a course of action, plans, implements and evaluates the course of action. Nurses and family members thus deliberately and intentionally decided on the course of action, planned and implemented activities that addressed self-care deficiencies in executing activities themselves. To meet the wholly compensatory nursing systems, the nurses or family members took the responsibility to carry out activities to meet the person's self-care needs when they took no



© University of Venda

University of Venda
Creating Future Leaders

active role in their own care (Horan et al., 2004:33). Sick menopausal women who needed partially compensatory nursing were able to carry out some activities themselves. These participants consulted the local health facilities, physicians or traditional healers for help only when there was a need.

Menopause can trigger a wide variety of physical symptoms which are different for each woman. For some, the symptoms are mild and tolerable. For others, the symptoms are so severe that they impact on their quality of life (Margolese, 2007:1). These are commonly associated with conditions such as hot flushes and indicate that a woman is approaching menopause because menstruation starts changing. Other symptoms are more subtle and may seem like behavioural changes, such as anxiety and depression (Louise, 2006:3357).

Malacara et al., (2002:11) also found menopausal symptoms reported in three different states of Mexico to be hot flushes, vaginal dryness and diminished sexual interest. Hot flushes, among the Mexicans varied from 72-32% and were associated with menopause and other factors such as schooling, rural residence, body mass index and state of residence. Furthermore Chedraui et al., (2007: 271) also revealed that the most frequently reported symptoms amongst Ecuadorian menopausal women were muscle and joint problems (which were rated the highest), followed by depression, sexual problems, hot flushes and sleeping disorders.

Before women assume they have a profound personality change, they should become familiar with all the symptoms of menopause and begin a plan of action (Donavan, et al., 2006: 1281). Physical changes that occur in the body among others include hot flushes which are defined as recurrent, transient periods of flushing, sweating and heat sensations often accompanied by palpations and feelings of anxiety, sometimes followed by chills. There is no evidence that the physiology of nocturnal sweats is different from that of daytime hot flushes (Kronenberg, 2006:112). In Japan, the most reported symptoms during peri-menopause were shoulder stiffness owing to the type of work women did (Melby et al., 2005:5), while among the Mayan and Greek cultures hot flushes and night sweats were commonly reported.

Monterrosa et al. (2008:182) also cite reports by Vanda (2003:3) and they further posit that the frequency and intensity of physical menopausal symptoms correlate with ethnicity, geographical zone, climate, diet, lifestyles, hormonal levels, women's attitudes and perceptions towards menopause and the



© University of Venda

University of Venda
Creating Future Leaders

aging process, the black race being an important determinant. Among black women, muscle and joint problems and obesity were determined to be more frequently presented symptoms than among Caucasian who presented with a higher frequency of vasomotor symptoms. In other cultures many women do not have the physical side effects of menopause that are common with American women. Oriental women reported far fewer hot flashes than did women from western societies.

In this study sexual problems were frequently reported among the psychological symptoms of menopause in all the focus group interviews. This was followed by irritability, forgetfulness, sleeplessness and depression. Lack of sexual desire was associated with age and cultural belief, while, irritability, forgetfulness, sleeplessness and depression on the other hand were associated with old age and family events such as the loss of family members. Only a few participants reported irritability as self-care deficiency.

This was confirmed by one post-menopausal participant who said, *Irritability is another problem I experience I am not certain about others.* All then responded: *Yes we do.* Through probing she continued looked aside and said: *This is one of the bad experiences I ever had. It happens from nowhere and some people would be angry with you from your behaviour.* Through probing she said: *I am always at my old husband, he would just ignore me or stand up and go away from me sometimes to his friends or to the fields. He is now used to my behaviour and I feel I push him away he is such a quiet old man.*

Another late peri-menopausal participant supported her and said: *Another experience is that of forgetfulness especially if trying to hide my pension grant money. I am staying with my three grandchildren and we always fight for the money lost. I will accuse them of stealing when it is my fault forgetting where I put it. Shame poor kids they are now used to me and my accusations.*

Regarding the sexual problems, many expressed self-care deficiencies and had this to say: *The vagina is dry, secretions gradually diminish and eventually disappear, thus sex becomes painful, no longer pleasant and enjoyable like before.. If you still have a husband who is a migrant labourer sometimes when he comes back home, he brings sexually transmitted infections and you will end up at the clinic for treatment when he goes back.*



© University of Venda

UNIVERSITY OF VENDA
LIBRARY

Another peri-menopausal participant reported: *Yes you become no longer interested in sex once blood is gone. Sex becomes unpleasant, it is painful as the vagina becomes dry and atrophies. You only do it to satisfy your partner if he demands it.*

One post-menopausal participant expressed her opinion by saying: *Yes it depends with some people who still have relationships, if you still have sexually active men, of course they will demand sex and if the desire is gone that is where you will experience pain during sex.*

Furthermore, some late peri-menopausal participants with different opinions regarding their experiences said: *My menstruation have stopped for a year now, I do not experience what they said about vaginal dryness and loss desire for sex. My husband works in Polokwane and he comes back more often and there is no problem of sex with us.*

Some of the participants in this study were still young adults in their early peri-menopausal state as reflected in the following excerpt: *I do not experience any lack of sexual desire or forgetfulness. It may be that I am still young and active.* Through probing she said: *Yes my grandmother forgets too much and always blaming people for stealing her pension grant.*

A pre-menopausal participant on the other hand said: *Oh no! I do not experience anything of that sort; everything is still perfect with me. Maybe I will experience that when the time comes.* Through probing she said, *Of course I am aware some old women like my mother she is 56 years old, experience some form of forgetfulness and sometimes irritability. We always think it is because she is aging.*

It was observed in this study that participants in their pre-menopausal and early peri-menopausal state had no problem with the lack of sexual desire. They continued with normal sexual relationships as they had not yet experienced sexual problems like vaginal dryness and loss of libido. Some late peri-menopausal and post-menopausal participants experienced a lack of sexual desire probably owing to age, culture and menopause. These participants indicated that sex at that age was painful, no longer pleasant as the vagina was dry and it had atrophied which made penetration difficult and painful. Participants were aware that sexual interest had changed as compared with when they were still younger and used to enjoy sex. They felt stressed as they were now forced to have sex in order to satisfy their



© University of Venda

University of Venda
Creating Future Leaders

partners or spouses. As they were no longer sexually active their partners had sex with other women and gave them sexually transmitted infections when they come home. In all the focus group interviews elderly women were inclined to stay away from sex as a means of protecting and respecting their age and culture. Some early peri-menopausal participants regarded lack of sexual desire as family disruption. Some families were disorganised as their spouses were frustrated and had to leave them to stay with younger women who met their needs.

Other psychological symptoms like irritability, sleeplessness, depressive moods and forgetfulness were reported less as compared to lack of sexual desire. Participants were aware of symptoms like irritability and that they pushed away the people they lived with, but there was nothing they could do about it. Participants appeared stressed and regarded these symptoms as bothersome as they caused family disruptions. Other participants in their post-menopausal state reported forgetfulness also caused poor relationships with their family members. A few reported that other family members like their children and grandchildren stole their pension grants because they had forgotten where they hidden them. When the money was later found, it embarrassed them and they appeared like old fools or liars. On probing about what could be the cause, only two out of ten indicated that they were aware that their forgetfulness was related to old age but not menopause. The study identified a gap in literature pertaining to health education on the aspect of menopause. It would seem that these participants had had no prior information about menopause from elderly women, health facilities or printed material. Such events were mainly dealt with when they were experienced.

Several studies carried out in Thailand recorded physical symptoms such as vasomotor dysfunction, frequency in urinating, low back pain and vaginal dryness. Some findings include fractures and lack of sexual desire. Among these women, lack of sexual desire was rated among the highest symptoms (Sukwatana et al., 1991:84). Al-Olayet et al., (2010:4077) in a study on the severity of menopause among Saudi women revealed that many symptoms have been attributed to menopause, but only vasomotor dysfunction and vaginal dryness are consistently associated with this time of life in epidemiological studies, while other symptoms may be secondary or related to other causes.

Caucasian women reported significantly more symptoms, notably psychosomatic symptoms including tension, depression, irritability, forgetfulness and headaches. African-American women reported a



© University of Venda

UNIVERSITY OF VENDA

University of Venda
Creating Future Leaders

higher frequency of vasomotor symptoms while Chinese and Japanese-Americans reported significantly fewer symptoms than Caucasian, African-American or Hispanic women. Caucasian middle-aged women presented a wide spectrum of physical and psychological symptoms during menopausal transition. Vasomotor and urogenital complaints have been considered the most frequent and typical presenting symptoms. Additionally emotional and somatic symptoms, such as headaches, insomnia, anxiety, irritability, sexual problems, fatigue and muscle joint aches are said to be highly prevalent during the climacteric (Chirawatkul & Manderson, 1994:1).

A study on Australian and Filipino women indicated that across both cultures, physical menopause experiences were reported to be quite similar, but psychological profiles differed considerably. Roughly one quarter of Australian women found it difficult to come to terms with the aging process and the symptoms reported included irritability, depression, fear of aging, loneliness, mood swings, unhappiness, and loss of self-esteem, respect and admiration. However, among Filipino women, a more positive outlook prevailed. They remarked that they only felt minor psychological irritations. Therefore physical problems were found to be usually of minor concern for most women but psychological difficulties were due to the inability of women to come to terms with the aging process (Berger & Wenzel, 2001:9). Symptoms experienced by pre-menopausal women in a study of women in Karachi, Pakistan included lack of sleep, urinary incontinence associated with marital problems and poor education which showed not much difference from the findings of other authors above (Baig & Karim, 2006:71)

Malacara et al., (2002:11) reported psychological symptoms of menopause in three different states of Mexico. Scores for depression and anxiety were lower in semi-urban Yucatan and higher among the rural women. Depressive moods were associated with rural residence, state of residence, menopause, high BMI, smoking habits, age and schooling. Anxiety was associated with menopause, rural residence, low schooling, high BMI and age. Loss of sexual interest was associated with age, BMI, menopause and the number of pregnancies. They concluded that the frequency of symptoms at menopause had similar ranges to those of other countries.

Another study among Caucasian women revealed that besides apparent physiological changes during menopausal years, women in midlife often go through social transition. There is an increased level of



© University of Venda

University of Venda
Creating Future Leaders

stress, depression and irritability that may require additional coping mechanisms. Thus symptoms reported during midlife were mainly influenced by multiple factors, such as socio cultural factors, like fear of getting old and lack of respect by the community. Life style changes, state of residence, age and schooling were also associated with menopause (Ho et al., 2003:149).

### 4.1.3 Theme 2: Participants' expression of feelings/ perceptions and beliefs about menopause

#### *4.1.3.1 Positive, negative and neutral feelings about menopause*

In all the focus group interviews of this study, participant's attitudes towards menopause were found to be multi-dimensional. Some participants displayed positive feelings and some negative feelings while others remained neutral. During a focus group discussion with a group of peri-menopausal and post-menopausal participants, many held positive feelings towards menopause, others held negative feelings while a few had neutral feelings. Amongst the late peri-menopausal participants with positive feeling one said: *This is God's nature of doing things, as we are aging we have to accept them as they come as we will not retain our youth for good.*

Another peri-menopausal participant who had not heard of menopause before said: *I do not have a problem with aging as we were told at a church conference about menopause.* Through probing she continued and said: *A nurse at our church conference gave us a health talk on menopause. She talked about the symptoms of menopause and how to cope with them. Since then I accept it and keep myself busy at the farms as part of exercise. By the time I reach home, I am tired, have no time to listen to my body and after supper I sleep.*

A post-menopausal participant with negative feelings expressed the following frustrations: *Hah! You can see for yourself I am of days (old), this head is grey but I enjoy baldness because of the heat and these things are personally experienced by those who feel them.* Through probing she said: *I sometimes feel severe back and joint pains. I am unable to sleep at night because they would be hot and painful. I sometimes spend half the night awake and seated as the joints would be aching a lot. I do not like it at all; it is really frustrating me. Nothing helps me for long as everywhere I go they tell it is part of aging.*



© University of Venda

University of Venda
Creating Future Leaders

Another frustrated post-menopausal participant supported her. She said: *Old age is bad look at my skin is becoming wrinkled and no longer shiny and firm. You know I used to be very big and fresh and now I have lost weight I look wasted. My breast was so big and nice, my children would get enough milk from one breast, but now they are so thin with no flesh. My big curves and bums are gone with old age.*

Another post-menopausal participant who claimed to be her childhood friend supported her and said: *Yes she used to look great with her beautiful body we grew and attended initiation school together. She used to be very light in complexion, I was light but she was lighter than me.* Through probing she said: *Maybe it is because we no longer eat good food as our teeth are falling off. What is it that is nice other than meat when you have to chew it in order to enjoy it. When I plough maize I hardly eat it, I only eat maize porridge, no nuts nor sugar cane. This body needs nourishing food and all food is sugar or salt and you cannot enjoy it without them.*

Later towards the end of the discussion one of the peri-menopausal participants also expressed her frustration. She said: *I dislike these symptoms, they disturb our sleep when one is sleeping peacefully. During the day its worse as sometimes it is very hot here at our place in summer.* Through probing she continued and said: *The heat is unbearable in summer coupled with the hot flushes and this zinc roof, you will burn and sweat profusely.*

Some participants in this study indicated that menopausal symptoms had impacted on their lives in a positive way, but others said it had affected them negatively. Participants with positive attitudes accepted and adapted well to the symptoms as they already had a bit of information about them and realised they had confidence in themselves and could cope with the symptoms in their own traditional ways. Participants kept themselves busy at home and on the farms or used traditional herbs which were introduced to them by their elderly women to minimise the symptoms. It would imply that these participants had no prior knowledge of Hormone Replacement Therapies (HRT) as indicated in the quantitative study where the majority of participants (71.4%) were found to be non-users and only 28.6% used HRT (Akong, Hoon, Dial, Andrewin, Diaz, Charles, Sandiford, Ward, McDougall, & Teelucksingh, 2001:155). Some were advised to seek medical assistance at the local health facility. They tended to trust and follow the health workers' instructions which in turn increased their coping and self-confidence or self-efficacy. As a result they were healthier, fit and free from bothersome and severe



© University of Venda

symptoms. Participants indicated that once they had confidence in themselves, family support also improved. They also felt they had achieved self-actualisation as they had achieved victory in coping with the menopausal challenges that frustrated and bothered them for long. It would seem that the health education given to women at some institutions managed to enlighten them and empower them with knowledge about menopause.

Others had positive attitudes mainly because of their age and educational status. Looking at their age they realised that they had aged and were faced with age-related symptoms and had no way other than to adapt and accept it. They accepted for instance vasomotor symptoms as they came and associated them with the aging process. There were some who used traditional herbs prepared by elderly women in the families and found relief from them as they trusted and respected their elders' instruction. However, there were some menopausal participants who had negative attitudes towards menopause and aging. These participants seemed stressed and viewed menopause as a punishment from God as they had lost their youth and attractiveness. They also seemed to have lost confidence and trust in themselves as they had devaluated themselves as no longer being attractive especially to the people of the opposite sex. The participants also felt being undermined by young children as they felt useless to assist with household chores. Their lack of confidence made them develop a fear of old age, thus they could not mix with other people of younger ages. Because of some bothersome symptoms like frequency and urgency of urination, the participants felt they would rather stay at home as they might make other people uncomfortable from their smell of urine. Some indicated that they liked winter because they rested from these symptoms and in summer they were forced to drink a lot of water that also created urinary problems.. Participants indicated that they are sometimes afraid to go outside at night because it was dark and that people might attack them. These participants were faced with the dilemma of dealing with the symptoms in their own traditional way like drinking water. At the same time they were faced with darkness at night where they might be attacked. It was clear that these participants held negative attitudes towards menopause that were aggravated by other factors like geographical area, climate and lack of information and knowledge.

Some participants were very frustrated, stressed, sad and angry as there seemed to be no treatment that was effective to relieve their symptoms or self-care deficits. Participants felt they had no social support and were burdens to their families who should be looking after them all the time. It was also evident that



© University of Venda

because of their negative psychological attitudes they feared relieving themselves; they could not cope with the traditional strategies they had developed themselves. Therefore they required additional coping mechanisms.

Very few menopausal participants in the focus group discussions displayed neutral feelings towards menopause. Although they were aware of the menopause they were unsure of their attitudes towards it. Participants did not display positive or negative attitudes towards menopause simply because they were still in the pre-menopausal stage and were still menstruating well. Some of these participants were domestic workers, others worked in the Department of Water Affairs helping to dig trenches for water pipes. They felt no changes in their bodies were still strong and active but had no information regarding menopause. Others, such as home-based carers or those involved in school feeding projects had obtained a higher primary school education enabling them to read and write showed that they had no information about menopause; they thought the symptoms they observed in elderly people were age-related. This implies that young women below the ages of forty also lacked relevant information on menopause even though they had not experienced menopause. On the other hand some menopausal participants were also embarrassed to openly talk about menopause or to tell others that they had menopause. They felt menopause was a sensitive matter that is difficult to discuss in public or with elderly women at home.

In the developed countries, it was found that some women also displayed positive attitudes; some were negative while others remained neutral. Women in the peri-menopausal group reported high symptom intensity. This has been associated with the newer stresses of modernisation, work or inability to cope with the onset of symptoms which is taken as a threat to looking young and beautiful (Backel, 1999:19). Krishna (2002:207) further observed that a woman's positive attitude to menopause produces minimal symptoms while a negative attitude seemed to produce a full menopausal syndrome. Conversely Ayranci et al., (2010:1472) in a study done on midlife Turkish women regarding their attitudes towards menopause, found that the majority of women had mixed feelings, ideas and opinions concerning the menopause and were also suffering from complaints about it. The study posited that educating women on attitudes towards menopause could assist health care providers with the provision of culturally competent health care to midlife women.



© University of Venda

University of Venda
Creating Future Leaders

Backel (1999:19) indicates that women frequently associated the experience of their aging process with a feeling of self-devaluation and fear of no longer being attractive. This often considerably impaired their self-confidence and the mental perception of being a woman. Others feared old age, because they associated it with loss of attractiveness and as such they often displayed negative feelings towards menopause. While Krishna (2002:207) like Backel (1999:19) also mentions that the attitudes of women in the developed countries towards menopause are also considered as positive, negative or neutral. Women in the Eastern and Western countries have similar negative views about menopause because for them menopause is viewed as a punishment in life while only a few Eastern women view menopause positively.

Flint (1995:162) on the other hand, posited that for some communities in the developed countries, menopause was viewed as a reward because of their transition to other challenges of life, while for others it was perceived as a punishment because of the aging conditions that comes with it. The study conducted by Beyene (1986:47) in Yucatan among the Mayan menopausal women revealed that women reported better sexual relationships with their husbands. They felt more relaxed about sexual activities and were relieved from the anxieties and risks of unwanted pregnancies. In the same study in the Greek culture, growing old was not desired as an older woman wore grey, dark blue, brown or black. If she wore the wrong colours for her age it was criticised by others. Menopausal women reported that menopause signifies that they were no longer in the mainstream of society and life. While in the same study most of the pre-menopausal women expressed negative attitudes and anxieties associated with menopause.

#### *4.1.3.2 Cultural beliefs, misconceptions and myths regarding menopause*

Normal lives of menopausal participants in their families often become disrupted because some still hold strong cultural beliefs. Some post-menopausal participants are not expected by culture to be sexually active one participant reported: *At this stage, in the villages, you are not expected to have sexual relationships because culturally menopause is associated with old age and no desire for sex.*

Participants indicated their cultural beliefs and myths as evidenced by another post-menopausal participant who said: *With me the sexual desire is gone because I am afraid my tummy will bulge and*

UNIVERSITY OF VENDA
LIBRARY



© University of Venda

*later it might burst and offensive stuff will come out of the vagina.* Through probing she further explained: *Women die from the burst tummy and people might be reluctant to help you because of the smell. Only elderly people might sort of help but they become reluctant and annoyed because they expect you to have stopped sex matters at this age.*

Another post-menopausal participant supported this by saying: *Oh yes! A lot of old women die because the men's dirt (sperms) gets into their tummy and fail to come out that's what causes the tummy to bulge.* Through probing she said: *The big tummy later burst, dirty and offensive staff comes out from the vagina and they die. In our villages some elders were responsible to clean up the dirt after a woman died so that children should not see anything and she was later buried*

Other participants also held strong cultural beliefs regarding the myths associated with the use of condoms at menopause: *Condoms for what, those plastics into my body? Never in my life, let them use it not me.* Through probing she continued: *Heee! Where have you seen a plastic being used in a human body? People will die and they will fail to account for it. Still, those old women stink, they have a foul smell because of the dirt that comes from the vagina.*

One of the early peri-menopausal participants expressed it differently: *I am still sexually active as I am still young, suppressing my sexual desire could be a problem both to myself and my husband.* Through probing she said: *Yes I love and respect my culture but it should not dictate what I should do in my house especially private matters like sex. My husband would not approve of it; he works in town and when he returns sex is sex.*

In this study, it was observed that participants often placed strong focus on their cultural roots and this affected their understanding of menopause, menopausal issues and the benefits of coping with the symptoms. There were misconceptions and myths surrounding the issue of aging, menopause and sex. The late peri-menopausal and post-menopausal participants found it difficult to engage themselves in sexual relationships owing to strong cultural beliefs and myths prevailing in the villages. Some participants in this study, despite their level of education held firm cultural and traditional beliefs about the myths attached to sex, menopause and aging. These myths made them develop fears and negative attitudes towards menopause. They developed fears of not honouring their cultural beliefs. The results of



© University of Venda

University of Venda
Creating Future Leaders

this study indicated that beliefs, culture and attitudes have a great impact on the participants' viewpoints and behaviour.

Some post-menopausal participants indicated that their sexual desire was gone because they were afraid of having a bulging tummy. They said that the bulging tummy developed in women who engaged themselves in sexual activities at old age or rather if they had reached menopause. It implied that these women were forced to suppress their sexual desire that destroyed their self-concept and self-esteem. The late peri-menopausal and some post-menopausal participants indicated that sexual desire was controllable, but there were times or situations that made control difficult, for example sitting next to their partner or husband, talking to him in the house, bedroom or over the phone. Those who can afford a television or happen to read a magazine with people kissing aroused their feelings for sex. Although most of the post-menopausal participants acknowledged the existence of sexual desire or rather sexual arousal at old age and menopause, some felt it should be suppressed at this time of life and age. The majority of the peri-menopausal participants expressed difficulty in suppressing sexual desire at this age. Participants felt that culture could at times interfere and cause family disruption. Participants' respected their culture but felt some beliefs were myths since some of them were more informed. Thus culture encompassed all spheres of these women's lives, including their cultural and religious beliefs. Participants were unable to receive social support from traditional family members to openly and honestly discuss issues of sex at menopause. The researcher thus realised that every ethnic group, tribe or nation has a belief system which determines and shapes the lives and everyday activities of its members.

UNIVERSITY OF VENDA
LIBRARY

It was also revealed in this study that culture and myths impacted on the participant's understanding in the use of condoms at old age and menopause. During interviews some participants indicated that some men and women still held strong cultural beliefs against the use of condoms thus making it difficult for them to take precautions to protect themselves and others. Participants regarded condom use as being immoral thus held negative attitudes towards it. Other pre-menopausal participants indicated, with great concern, that some men did not use condoms when they engaged in sexual relations. This caused their partners to contract sexually transmitted diseases. The study concluded that some participants still held misconceptions regarding condom usage thus requiring necessary information on condom use at menopause. In the quantitative study, it was shown that 52.1% of participants used contraceptives while



© University of Venda

University of Venda
Creating Future Leaders

47.9% were non-users. This implied that condom use was only meant for the younger age group as a means of contraception while older participants had nothing to do with it owing to cultural and traditional beliefs prevailing within the community.

Menopausal symptoms and experiences are shared differently by women from diverse cultures. Berlin (2009:421; Kowalcek, Rotte, Banz & Diedrich, 2005:227) indicated that the experience of menopause and menopause symptoms often reflect cultural differences among women. The age at which women reach menopause may be rooted in their culture. Berlin (2009:421) further indicates that studies have shown that with menopause, there is no specific age of its onset and learning about cultural differences might help post-menopausal women become more comfortable with their experiences of menopause and they might find a more positive way to approach it.

A study by Vanda (2003:3) on Japanese women concurred with the study by Melby et al., (2005:5) which states that the type and prevalence of physical symptoms women exhibit during peri-menopause and menopause are often related to cultural background. Specifically, some cultures regard menopause as part of aging and accept it as it comes while to others it is embarrassing and painful.

Flint (1995:161) added that other cultures treat their menopausal women differently. The Qement, a pagan-Hebraic peasant population in Ethiopia, allow a woman who has reached menopause to tread upon the ground of a sacred site and come into contact with ritual food and beverages, something unheard of before this time as she was considered unclean while she was capable of menstruating. While among the Hutterites of South Dakota, women aged 45-50 years are relieved of their heavy duties in agriculture such as milking and hoeing but maintain an important function in their extended families, along with a great deal of respect. In other words the menopausal woman is allowed to assume this once forbidden role and her status in her culture is much more elevated than before her menopause. In contrast, when American women reach menopause, they received no reward for it in fact it is a time for punishment. Their children will have gone from home and many suffer the 'empty nest' syndrome. For many, their husbands suffer a male climacteric and will be out pursuing young women to prove their virility. Thus there is no elevation of status in American culture for the menopausal women. If she attains a higher status at this time, it is through socio-economic means by either inheriting her husband's wealth at his death or through her own professional endeavours.



© University of Venda

Walusimbi and Okonsky (2004:92) revealed that there is a significant positive relationship between knowledge and attitudes and a significant relationship between knowledge and levels of fear of contracting a disease. Women with strong cultural beliefs prefer to consult traditional healers on issues that affect their lives. Traditional healers play an important role in South African cultural folklore (Peu, 2001:1).

Maluleke (2007:78) revealed that continuous suppression of women's feelings interferes with their growth and development. Sexuality is a powerful force that is capable of breaking all barriers, opening the self to connect with human beings and experiences. According to Maluleke (2007:79) sexuality is about personality, communication and how individuals express themselves in relationships with others and it was important to give people information about sexuality as well as space to make decisions about their own sexuality. Dialogue between older women should be encouraged to ensure that young menopausal women make informed choices so that they may enjoy their sexuality and fully participate in community activities. A safe environment with trusted older women will make menopausal women grow into responsible women who can communicate and express themselves all the time.

Deeply rooted cultural beliefs can override and shape people's behaviour despite their level of education (Berlin 2009:421). Berger and Wenzel (2001:10) observed that as with other life transitions, menopause does not occur in a vacuum. The socio-cultural environment is of key importance in modifying a woman's experience of her change of life. Lewis (1996:2) posited that cultural diversity is a phenomenon in which people of different cultures share basic concepts, but from different perspectives and opinions which often result in behaviours that may be considered irrational, conflicting or contradictory.

Another study conducted among Mayan menopausal women revealed that women perceive menopause as a life stage free of taboos and restrictions, offering freedom of movement. In their culture, menopausal women can now participate in church activities, are free to go anywhere, make cheese…., because when a woman has her period, she salts cheese, the cheese spoils. A menopausal woman is also free from being a sexual threat to the community and a potential cause of shame for her family, since she is no longer considered sensual and desirable by other men (Beyene, 1986:47). Contrary, Orner (2005:20) posited that a women's desire for sex does not only depend on her hormone levels or her age,



© University of Venda

but to the extent to which the reproductive process contributes to a woman's identity. The degree to which women, especially older women, are valued in society may also affect their sexual desire.

#### *4.1.3.3 Discrimination and stigmatisation of participants by family and community members*

One woman reported: *There are some young children and other people who do not care about you when you are old. I stay alone in my house and never had children of my own. I am sick all the time for over two years now. Only neighbours sometimes assist me with cleaning the house, cooking food and giving me treatment.* Through probing she said: *It all started when I aged. I felt joint and back problems later, headache, forgetfulness and memory loss at times. Now people think I have mental illness and are reluctant to come near me because I sometimes become irritable to them thus they reject me. I do not do it on purposes it just happens you know.*

One of the post-menopausal participants also said: *It is difficult when you are old and cannot help yourself. This illness is frustrating us as even if you get support from family members, they get tired of helping you all the time. They would say that 'gegulu li a dina' meaning that old lady is troublesome. When they start doing that I feel isolated. I even lost sight and my hearing has diminished. My ears become very dry and I would not hear for a long time especially on waking up in the morning. I am unable to see people I thus identify them by their voices.*

The findings of these studies revealed that although old women receive respect and trust from young ones and other people, they still seem to be discriminated against and are stigmatised by others. In the rural villages, elderly people in spite of their sex or age, still seem to be trusted, respected and receive special attention from community members. Elderly people are still regarded as important veterans who deserve respect and special attention. However, there were still people who addressed them as *gegulu* literally meaning that old woman. They were addressed or referred to old women who were old, sick and useless because of their condition. They regarded them as being physically and mentally unstable. Old women who were seen to misbehave in the community by either drinking alcohol or were promiscuous, lacked respect and trust in the community. Later in their lives when they became sick they were discredited, discriminated against, labelled and stigmatised.



© University of Venda

Some participants indicated that discrimination and stigmatisation impacted on the quality of life, especially for the old women who suffered from severe menopausal symptoms like the bulging tummy which they associated with promiscuity. These women were viewed by the villagers as bad people who engaged in immoral behaviour. This always influenced the attitudes of other villagers towards these women. Villagers who considered these old women to be bad seemed to believe that they have been immoral since their youth and adulthood. This implied that old women with bulging tummies were viewed by villagers as bad women, were stigmatised, discriminated against, stressed and lacked family and community social support (Researcher's own experiences with the participants 2011).

Herek (1999:1102) described stigma as a state of prejudice, discounting, discrediting, discriminating that often resulted in stereotyping and labelling.

The issue regarding menopausal women is as old as mankind. As far back as 1991, Graves (1996) indicated that few women have observed specific incidents of direct discrimination against menopausal women, although many acknowledge a work environment that diminishes them with daily demeaning behaviours and joking at their expense. People in power, from managers to government appear disinterested in the concerns of older women, so most women struggle alone regarding stresses and fears surrounding negative myths about menopause. There is a certain vulnerability some women feel about menopause. Partly owing to being associated with the lesser valued and ridiculed 'female stuff,' this fear of exposure regarding menopause burdens women who may already feel less useful, more mortal, fatter yet more invisible than ever before. In a sadly typical pattern, women blame womanhood for any problems at work or home which becomes a source of deep shame for some women who then hide the fact that they are menopausal. Women who decide to make a new life from their menopause begin by educating themselves. They read books, seek good medical advice before making decisions, talk to other women and perhaps to a therapist. In general, these women feel surer of themselves and are more assertive than ever before. Many say they are more content and freer than at any other time in their lives (Graves, 1996).

#### *4.1.3.4 Taboo not a shared subject among villagers*

Menopause like menstruation was found to be a taboo in all the focus group interviews conducted with menopausal women; it is never shared with other people. This was revealed when participants were



© University of Venda

University of Venda
Creating Future Leaders

asked if they shared a subject on menopausal issues. Then a peri-menopausal participant said: *Ahhh! No one should know except that it is your own thing because if you tell other people they might know your secrets. Tomorrow they will point and label me what they like.* Through probing she continued and said: *Why should I discuss my secrets with strangers or other people. At the girls initiation when we were still young, old women told us blood will cease and since then no one ever talked to me about it that is why I say it is my secret.*

An early peri-menopausal participant said: *I stay with my mother-in-law. She is now very old and in my entire stay with her I never heard her make mention or discuss about it. She used to tell me about all other things but menopause is a taboo.*

One peri-menopausal participant with some information said: *My grand-mother mentioned something to do about it some years back and some friends also discussed about it in my presence. Both did not say much probably because this subject is taboo in our culture and in the villages.* Through probing she said: *People in our villages are reluctant to talk about things that are taboo. But there are also some misconceptions about it like we should not have sex with men as the stomach will bulge, certain food is not to be eaten like beans as they increase the flow of blood.*

A post-menopausal participant who still looked attractive said: *My husband knew that if we continue having sex at this age, he might invite trouble for me and my tummy will bulge and I might die and my family might be angry with him. The villagers might stigmatise and label the family as old people who like sex at old age.*

One of the post-menopausal participants had this to say: *Ah! What is the use, children these days do not have secrets; they go about telling strangers their secret. 'Ndi madabadaba' meaning people who do not hold secrets and morals. If you tell them something, tomorrow you will hear it being discussed somewhere.*

It was evident in this study that some topics were taboo and not to be shared with anyone. In the focus group discussions it was found that a secret remains with the owner and it is never to be shared as people might see your things and talk about you with others. People might even label your family as being



© University of Venda

people who like sex in old age if they see a bulging tummy. Participants indicated to have been told at the initiation schools about issues related to aging and a little bit about menopause. They were only told that one day they will age and blood will cease, meaning they would no longer menstruate. At the initiation schools when they were still teenagers it was emphasised that they were not to discuss their secrets with other people. When these women grew older, they had no one to turn to and openly discussed bodily changes brought about by menopause. They had no one with whom to be open and transparent and to share their challenges. They needed honest and truthful information from someone they truly trusted. On the other hand, other participants said that these days young girls no longer kept secrets; they told their secrets to anyone and were thus seen to disrespect their culture. These are villagers who respect and honour their culture; they stick to cultural beliefs without being disobedient. Others indicated that they had been married for long and their in-laws or parents never discussed such topics with them. This confirmed that to villagers, taboo was respected and a person who divulged information on secret matters was taken as '*dabadaba*' meaning that a person who talks about secrets even if not asked to do so. It also implied a deficiency in parent-child, grandparent-child relationships and support.

Furthermore, it shows a lack of openness and trust among parents and daughters and grandparents and daughters which cannot lead to a good relationship and boost self-confidence. Some participants who were married indicated that they also lacked family support as they did not discuss such topics with their husbands. It would seem that these men were told by their elders to stop having sex with their wives at a certain stage to prevent them from developing a bulging tummy. Thus the participants would just see their husbands staying away from them without prior discussions. It would seem that these men do not want to be blamed should their wives develop bulging tummies or die as a result of sex at old age. The participants will not even ask elderly women in their families about it as it is a rumour that is known in the villages. This implied that women at menopause in the villages lacked social support both from the families and communities. These participants were also not assertive enough to talk about their feelings or have the right to receive adequate information.

Maluleke (2007:67) in a study of sexuality indicated that young people were of the view that parents did not talk to them about sexuality because they were uncomfortable and shy to talk about sexual matters with their children. They would rather not talk about sexuality before they make irreversible mistakes.



© University of Venda

University of Venda
Creating Future Leaders

As Newitz (1994:1) rightfully puts it, that although sexuality is about expressions of perfect human connections and relationships, it is often viewed in many cultures as a taboo subject and portrayed as a shameful and abjectly terrifying experience.

According to Leichhardt Women's Community Health Centre (SA: 3), many women do not know their sexual capabilities because of social conditions about women's sexuality. The societal expectation that a woman should play a passive role during sex has robbed women of their responsibility to make choices about their sexuality and sexual life..

#### *4.1.3.5 Lack of participants' support by family and community members*

A participant said*: My husband is supportive regarding sex and menopause because he knows about our culture and age. He does not want me to die so he stays away from me maybe because he is also elderly. I know of husbands who become bored once they discover that their wives have menopause and leave them for other younger women. The problem is when things do not go well and they have to come back home and they expect to be accepted back. That is unfair because you remain suffering and being sick alone.*

The following response by a late post-menopausal participant typifies this notion: *I simply take my time to unbend and if severe I go to the clinic for medication. My problem is, I sometimes have to walk a long distance to the clinic and I think that aggravates my problem.* Through probing she said: *Our clinic is far and there is no transport, sometimes you can be lucky someone with a car might pick you up if they know you other than that you have to foot it right to the end. Our place does not have taxis the people here are used to walking. Others get tired of walking a long distance thus do not use the clinic all the time.*

Another post-menopausal participant said: *It is difficult in the life when you are sick, some people tend to back off as if you are infectious. Only your immediate family will sort of assist if they are available other than that you have to see it for yourself.*

UNIVERSITY OF VENDA
LIBRARY



© University of Venda

University of Venda
Creating Future Leaders

Some participants indicated that not all partners were supportive regarding sex at menopause. They left them for other young women who were still sexually active. There were family members who showed support when they knew that their family members were suffering from menopausal symptoms especially if severe by providing them with medication, food, hygiene and taking them to the clinic. These family members were of the impression that their mothers' or grandmothers' illness was related to old age. Some participants were to face the challenges themselves and deal with them in their own way or seek medical assistance that was very far away behind the mountains. Some concerned family members who had money managed to assist their sick mothers or grandmothers by taking them to physicians elsewhere in town. There were those who lacked transport and had to walk to the clinic that was far while experiencing severe symptoms. Participants also mentioned a lack of support from the community as they feared the old women and they associated the symptoms with infections. Families and community support was what was mostly needed by participants during times of turmoil. Instead they were neglected and left to suffer the symptoms alone without family and community assistance. This implied a lack of information regarding menopause at that age by families and communities.

Shirley (2007:39) indicated that inaccessible health services, including the distance travelled to the health care facilities, contributed to patients' not utilising the service.

Primary health care's mission in South Africa was to ensure the provision of essential health care accessible at a cost the country and community could afford, with methods that are practical, scientifically sound and socially acceptable. Furthermore, everyone in the community should have access to it, and everyone should be involved in it. At the very least it should include education of the community on the health problems prevalent and on methods of preventing or controlling them. It also includes appropriate treatment of common conditions and the provision of essential drugs (Vlok, 2006:29).

According to Maluleke (2007: 11), traditional rural communities are mainly extended families and form part of the systems for the support of their family members and the community at large. Families and communities are responsible for providing the youth (both males and females) and midlife women with information and guidance about life in general, sex, sexuality, menopause, cultural norms and values through communal initiations, guidance and support. The traditional ways of sharing information and



© University of Venda

knowledge in many rural families and communities have been destabilised owing to rapid urbanisation, migration, education and religion (Maluleke, 2007:11)

Maluleke (2007:67) also posited that many parents were not ready to teach their children about sexuality. Most parents gave very little information owing to shyness or lack of sufficient knowledge about the subject. It is important to provide opportunities for parents to learn about the subject. Many parents feel uncomfortable and embarrassed to talk to their children about sexuality because they are not confident that they have the knowledge and information to teach their children

#### *4.1.3.6 Lack of adequate knowledge and information by participants*

Participants expressed a lack of information and knowledge about menopause. They indicated that most of the people in their villages were not literate and issues of menopause were not familiar to them. One early peri-menopausal participant responded: *Well my sister, majority of us here are uneducated, we thus lack knowledge of these things, we just bump into them as we are living. No one can actually tell what is happening in our bodies.*

Another peri-menopausal participant said: *We think we know these things when we are just blind. We just assume and mix things which are risky to our lives. I can hardly identify which are the menopausal symptoms and which are age related. Now I am confused and confusing myself. Why can't you educate us to be enlightened on this subject?*

A post-menopausal participant added: *We lack proper information and knowledge regarding menopause and how to effectively cope with the symptoms especially if they are severe. Even our clinic nurses seem to lack information on what to prescribe for menopausal challenges. We thus require more support to deal or cope with the symptoms.*

Some young pre-menopausal participants with high school education expressed a feeling of confusion as evidenced in this citation: *Everybody seems to be confused because according to me there must be a difference between menopause and old age right? It means we need information on menopause not old age of which we do not have especially me.*



© University of Venda

A pre-menopausal participant also said: *I also lack information this is a difficult subject because during my time at school in life orientation subject nothing was mentioned about menopause. Life orientation emphasises puberty issues and other things not menopause.*

The majority of menopausal participants in this study expressed the lack of honest and accurate knowledge and information concerning menopause and menopausal issues. Among those emphasised were issues related to identifying menopausal symptoms and how to cope with them effectively. These menopausal participants expressed self-care deficits in coping with menopausal challenges. The peri-menopausal participants were confused as they were unable to identify and differentiate between menopause and old age. To them menopausal symptoms were old age related rather than menopausal and hormonal issues. Participants seemed to have been engaged in trial and error in coping with menopausal challenges. Some seemed to accept and adapt to the changes as they come and treated them in a silent manner. They also seemed to be afraid to ask questions as they were unsure as to what to ask. Participants were also afraid to discuss openly such topics in the villages with elderly women, parents or grandparents. Such participants seemed to be stressed as they had to keep these changes to themselves in respect of culture. Participants who were in their pre-menopausal state seem to lack information on menopause as some indicated not to have been taught in life orientation at school. The researcher realised with great concern that subjects at schools dealing with health issues did not touch on matters or issues pertaining to menopause. School children need an introduction to menopause to enable them to realise the symptoms once they confront them be it themselves or any other person they might encounter.

This statement was in contrast with that of Donavan, et al., (2006: 1281) that before women assume they have a profound personality change, they should become familiar with all the symptoms of menopause and begin a plan of action.

Richter, Greeney, MCKrown, Cornell, Littleton and Pulley (2001: 174) assert that if women are not given adequate information, they might not be able to collaborate with their health facilities or be willing or able to ask questions. Lack of shared information was thus an obvious concern. Information sharing in advance could thus build the necessary trust with these women. Limited information, ideas and options are often cited as reasons why women accept pain a lot in their life (Mahmoud, 2006: 412).



© University of Venda

Other studies indicate that the communities need to know how disease is transmitted as well as the signs and symptoms associated with the diseases so that they can independently apply knowledge to develop and actively participate in lifestyle strategies that reduce disease incidence and prevalence (Foundation for Professional Development, 2007:44). Orem's theory of self-care deficits (George, 1996:271) implies that treatment guidelines is a health care obligation that will give direction to patients on how to continue with treatment in their home environment.

Ozuzu-Nwaiwu (2007:34) conducted a study among blacks in the UK and revealed that although some women understood the meaning of menopause, some did not understand the health implications of some of the symptoms. Some chose to ignore them owing to other social factors happening at the same time as their menopause such family commitments and changes, and financial issues which were competing with menopause in their lives.

### 4.1.4 Theme 3: Participants' inadequate coping with self-care deficits

#### *4.1.4.1 Inadequate support systems / Traditional strategies in place*

The following responses from the participants during the focus group interviews exemplify these in the context of menopausal strategies developed by menopausal women as a way of coping with the symptoms: This was evidenced by the following citations: *I am unable to sleep at night because the hot flushes would come when I am fast asleep and I would have sleeplessness. I hardly use a blanket at night but I use a cloth to cover my waste and bum only. My feet and upper body remain uncovered for the rest of the night and I will feel a bit cool.*

A peri-menopausal participant said: *I sometimes depend on traditional herbs, they help a lot because my grandmother is a traditional healer and she get the herbs from the bush, prepares them for us and we drink if we have some challenges.* Through probing she continued and said: *Yes! We do get some relief from other sources like the clinic for assistance but not all. So we mix the herbs with clinic treatment for speedy recovery of severe symptoms. Others use church tea but they usually say it does not help at all.*



© University of Venda

Another post-menopausal participant who supported her said: *Err you see, I am familiar with traditional herbs my grandmother taught me when she was still alive. I know what to look for in the bush, herbs for the relief of some menopausal symptoms like joints and back problems.* Through probing she continued to say: R*eturning from the bush, I wash the herbs, dry, grind and boil them. You need to drink a tablespoon twice daily and after a few days you begin to feel some relief.*

Another peri-menopausal participant exemplified this. She said: *I was using church tea and then stopped as I was not getting any relief from it. I tried it several times and our church elders encourage us to use it as they believe we will be relieved of the symptoms one day.*

Another post-menopausal participant supported her and said: *Church tea? Forget about it, hot flushes and severe sweating are not relieved by it. It is good for other things, even those with joints and back pains they seek other alternatives like clinic treatment or traditional herbs if they cannot reach the clinic as it is far.*

An early peri-menopausal participant in her late thirties and a primary school teacher said: *I think it is wise for people to consider what they eat at old age. Our elderlies do not use their pension grant for buying themselves food rather they give it to their grandchildren, some look malnourished and some conditions become worse due to lack of healthy food.* Through probing she continued to say: *Aaa*! *They can buy or farm mealies, green veggies like spinach and moroho, sweet potatoes and fruit trees with avocadoes, papaws, mangoes and others. The vegetation is not bad for farming though mountainous in some areas which are much cheaper for them. Some own cattle, goats, pigs and/or chickens and they could sell them to buy other food.*

Some participants in all the focus group discussions indicated that they depended on traditional herbs for the relief of some menopausal symptoms as they were readily available in the bush. Participants could traditionally deal with some bothersome symptoms on their own by cooling their environment through opening doors and windows or using fans for those who could afford them, drinking cold water or taking off the blankets like in cases of hot flushes. Participants hold strong beliefs that they get relief from these herbs for treating problems such as headache, insomnia, constipation, palpitations and some joint pains. Some accepted that they mixed traditional herbs with clinic treatment for speedy recovery from



© University of Venda

University of Venda
Creating Future Leaders

bothersome symptoms. Participants agreed that if they experienced self-care deficits or symptoms that were severe they would seek medical treatment if they had money for transport, but would still continue with their traditional herbs. Most of them were familiar with herbs and know their use to relieve some bothersome symptoms like joint and back pains. In some focus group interviews some participants indicated that they resorted to traditional herbs as they were not receiving relief from clinic treatment. Others said they preferred herbs as they had used them since childhood and they believed in them as they obtained relief from them. Meanwhile, others cited the issue of transport that was not available to reach the clinic. They stayed far behind the mountains and this made walking to the clinic difficult. The participants confirmed that they lacked information on how the signs and symptoms of menopause came about as well as coping strategies. These women lacked additional actions related to health problems and treatment regimens to cope with their health deviation deficits.

The participants in this study had various religious affiliations. Some belonged to the Zion Christian Church (ZCC), while others were Protestants, Jehovah's Witnesses, and so forth. Thus, religion has been implicated in the participants' understanding of how they were affected by diseases including menopause. Very few participants agreed to be using church tea from the ZCC for menopausal deficits. Furthermore, the ZCC participants believed in spiritual healing espoused by their church elders. Some confirmed that they were using church tea for other health problems but not for the relief of menopausal symptoms. Some participants were aware that church tea had nothing to do with menopause and its symptoms thus they did not bother to use it, while others still continued to use it even if they did not get relief from the symptoms at all. These participants were convinced by their church elders to continue using church tea as they belonged to the church. Participants were afraid the symptoms would get worse if they stopped using it. Some had used it several times with no relief thus they abandoned it.

The health care facility was also considered and acknowledged in all the focus group discussions by menopausal participants of this study as another available support system. The majority of participants indicated that they consulted the health care facility for various health problems including menopausal challenges. For menopausal challenges little or no assistance was offered by the health care facility as they were only told to accept the symptoms with or without any treatment. Sometimes they were given the same treatment that was previously prescribed when they visited the health service, and had not had any relief from their symptoms. This made them reluctant to come to the health care facility.

UNIVERSITY OF VENDA
LIBRARY



© University of Venda

Participants also indicated that some nurses at the clinic would refer them for further management if they did not get better or could not effectively deal with severe symptoms. Those with some information indicated that they had not received any proper treatment for menopause.

The prerequisite for good menopausal prognosis is in line with Orem's theory of self-care deficits in nursing practice and the provision of psychological support directed at patients. This underscores the significance of the therapeutic self-care demand that includes self-care measures required to meet the specific self-care requisites of a person. Self-care requisites are necessary and purposeful actions required by menopausal women to meet their own self-care demands. Universal requisites were viewed as actions that all persons needed to take and are described as maintaining sufficient intake of air, water and food, managing the elimination process, maintaining the balance between activity and rest, between attitude and social interaction, preventing hazards of life, health and well-being and promoting health. Health deviation requisites are actions related to health problems and treatment regimes. The therapeutic self-care demands for a person are calculated by evaluating the need for specific actions in the universal, developmental and health deviation requisites (George, 1996:271).

The study conducted by Beyene (1986:47) amongst rural Mayan and Greek women, revealed that women do nothing to alleviate menopausal symptoms like hot flushes and night sweats except going out in the fresh air and cooling themselves.

Flint (1995:161) indicated that psychotherapy was mostly used by American menopausal women to alleviate many problems associated with self-image and identity crises. Hormone therapy was also used to replace the lessening oestrogen and alleviate physiological symptoms of aging process. Many menopausal women joined feminist movements as a means of exchanging ideas about their menopausal problems.



© University of Venda

#### 4.1.4.2 *Lack of formal education and adequate social support for girls at initiation schools, churches, families, friends and colleagues*

A participant reported: *At the girls' initiation when we were still young, old women told us blood will cease and since then no one ever talked to me about it that is why I say it is my secret.* Through probing she said: *No I don't remember much but they do not tell us many things only what I said just now.*

Another peri-menopausal participant in her midlife had this to say: *You see it is cultural in our villages that all girls should go to the initiation school at a certain age for preparing us for adulthood. It is customary but if you do not go there other girls will label you as 'shuvhuru' meaning an idiot who does not know what others know from the initiation school. Topics such as menstruation, sex and cessation of menstruation are talked about. Unfortunately there is no time for asking questions and the only information provided is the one we rely on.*

One of the late peri-menopausal participants added thus: *You know at the girls' initiation schools not much is said especially regarding old age and cessation of blood.* Through probing she continued to say: *Menstruation and sex are mostly emphasized than cessation of menstruation. This may probably be due to the fact that old women at the initiation school lack knowledge regarding menopause or that such topics are taboo in our culture thus they find it difficult to talk to us about it .At our girls initiation schools nothing was made mention of cessation of menstruation only sexuality and menstruation. Oh yes you are right maybe those old grannies lack enough information.*

Another peri-menopausal participant said: *You know, not much is mentioned at the girls' initiation school. Regarding menopause, it was said when you age you are not supposed to have sex as you will have a bulging tummy. How and why was not explained to us because if you ask they say you ask or talk too much. We are also warned not to discuss anything with other people who did not attend the initiation school. It thus ends there with no further questions or information.*

Participants indicated that some churches offer their congregants health talks as a means of empowering them on health issues. One peri-menopausal participant said: *I do not have a problem with aging as we were told at a church conference about menopause.* Through probing she continued and said: *A nurse at*



© University of Venda

*our church conference gave us a health talk on menopause. She talked about the symptoms of menopause and how to cope with them. Since then I accept it and keep myself busy at the farms as part of exercise. By the time I reach home, I am tired, have no time to listen to my body and after supper I sleep.*

Another peri-menopausal participant added thus: *Our church usually invites speakers from inside and outside to give us talks on various topics. The topic on menopause was also discussed. There were nurses who shared with us the symptoms of menopause and how to cope with them.* Through probing she continued to say: *Of course, I can deal with some of them but not all because not everything was mentioned due to time on that day. You see sometimes you may think you can cope with them but they may be severe and frustrate you.*

A post-menopausal participant supported her and said: *Some of us attend church, as indicated before our church provides us with different health talks and amongst them was menopause. They schedule them once a month to us if they are off duty and we enjoy it. What is interesting is that the little that they know, they share with us and we gain if you listen.*

Some participants obtained some information from family members like grandmothers and colleagues as exemplified by an early peri-menopausal participant: *My grand-mother told me some years back about it and some friends also discussed about it in my presence at work.* Through probing she said: *They all talk about some misconceptions of it like we should not have sex with men as the tummy will bulge, certain food is not to be eaten like beans as they increase the flow of blood.*

Another peri-menopausal participant expressed herself thus: *We also share information as colleagues at church, home and work but we do not share much but the little we share brings change into our lives.* Through probing she continued: *Yes those who managed to get some information they do share with us who did not attend the conference. Oh ho! Old women do not share anything with us the only thing is the bulging tummy they will show you if someone have it. It is a pity that we will age being a generation with poor knowledge.*



© University of Venda

Another late peri-menopausal participant in her late forties shared this formation: *Some of us blame family planning pills and injection for the bulging tummy as those pills stay long in the tummy without coming out.* Through probing she said: *Ok when we share information among ourselves, we convince each other that the bulging tummy and hot flushes are due to family planning pills and injections they give us at the clinic.*

A post-menopausal participant said: *Well as you know, friends and colleagues share a lot when together. We like convincing each other especially when it comes to our life experiences. We believe our tummies are bulging because of contraceptives. Others disagree and we usually seek for the other opinion from nurses and teachers.* Through probing she continued: *Ag they do not say much seemingly they also lack information. We end up disliking family planning as we believe it causes the bulging tummy.*

From the information provided by the menopausal participants, it would seem that the majority attended the girls' initiation schools as a requirement by the culture in the villages. This served as a means of preparing girls for adulthood regarding sexual activities at that age. At the initiation school topics such as menstruation, sex and menopause formed part of the teaching. Menstruation and sex were emphasised but menopause was not given a priority. Girls at the initiation school were not allowed to ask questions. This is said to be caused by the fact that elders at the initiation schools had no information regarding menopause. They mainly talked about old age. The researcher noted with concern that it was not easy for elderly women to deviate from their culture once it is rooted in them. They stuck to their culture and the promises they made and would not be persuaded to divulge information. Parents and grandparents should gradually introduce menopausal topics to young girls in preparation for menopause. If possible menopausal topics should be emphasised at the initiation schools for girls. The topic should receive priority and emphasised so that when they reach menopause they should accept and be able to effectively cope with menopause from midlife.

During the focus group interviews it was also identified that women were given health talks by nurses at the church conferences and this led them to have some information and they could understand how to cope with some menopausal challenges. It is interesting that most of the participants interviewed in this study regarded menopause as old age. This can be misleading to menopausal women as these are not the same issues. Furthermore, some menopausal women were still confused about what was taking place in



© University of Venda

University of Venda
Creating Future Leaders

their bodies probably because of insufficient knowledge. They perceived cessation of menstruation and menopausal symptoms as old age related. They lacked the physiological and hormonal aspects of menopause. The study also realised that health talks to many people especially those who are illiterate should not to be given as a once-off thing. Some women need regular reinforcement to gradually understand and comprehend the matters effectively. (Researcher's own experience with the participants, 2011)

Since religion is regarded as an integral part of culture, some illnesses are frequently seen as a curse from God for sins committed by sufferers while witchcraft is sometimes blamed for the scourge (Berlin, 2009:421). Maluleke (2007:77) suggests that religion has an impact on the lives of individuals and explains how societal reaction to young people who transgress the norms and values of society can affect their lives. According to Surgery (1996:2), women who attempt to assert their sexual autonomy usually come up against opposition from family and society that seek to control it.

Kyriacou and Pratt's (2007:33) study with teachers showed that having a strong religious faith helped people to cope with stress at work and that attending religious services were effective coping actions for them. The effectiveness of this coping strategy is empirically supported by studies that reveal a positive relationship between religious behaviours and well-being (Raab, 2007:441). The effectiveness of religious coping largely depends on whether the menopausal women have rational religious beliefs or irrational beliefs about themselves. Loewenthal, Cinnirella, Evdoka & Murphy (2001:293) suggest that religious activities were seen as less helpful by the ever-depressed than by never-depressed. Buchko (2004:89) confirmed empirically by studying college students that women to a greater extent than men experience a strong spiritual relational component to their religious faith. Through faith in God and prayers by pastors and priests, women were able to cope with stress and find meaning and purpose to life more than men do.

It was indicated in the focus groups that parents and grandparents contributed a great deal to the sexuality of the youth. Not much was mentioned regarding menopause; their contributions were both positive and negative. However, the majority of the participants provided mainly negative contributions. The participants who mentioned positive contributions from their parents or grandparents were those who had earlier on indicated they were told that menstruation will cease one day and it was natural and



© University of Venda

God's nature of doing things. It would seem family members had difficulties in stimulating discussions around the issues of menopause. When elders talked about menopause it would be when they talked about avoiding sex at the menopausal stage. Further than that, no information was provided. The above comments indicate a deficiency in the parent- or grandparent-child relationship regarding menopausal issues. The deficient relationships later impacted negatively on the lives of menopausal participants as they had negative attitudes towards menopausal symptoms. It also indicates that some menopausal participants were bound to have negative attitudes towards menopause owing to the influence of their parents or grandparents. It also means that there was no openness and transparency among parents, grandparents and menopausal participants to enhance their self-confidence and self-esteem. (Researcher's own experiences with the participants, 2011).

A study conducted among Italian women showed that more than half of the women reported that they had not had any information on menopause and available therapies. Those who received information rated it often as poor and contrasting. Lack of knowledge was statistically associated with women's low educational level and no access to health services. Furthermore, the study recommended that more and better information should be given to middle aged women, particularly to those having a lower level of education to allow them an opportunity to make informed choices on their health status with regard to menopause, menopause-related symptoms, the length and management of menopause, the availability of therapies, related risks and appropriate lifestyle changes (Donati, et al., 2009:246; Lewin, Sinclare & Bond, 2003:112).

#### *4.1.4.3 Insufficient information by other health team members*

Participants blame the health care personnel at the health facilities for the lack of information and skills regarding menopause. This was evidenced by a late peri-menopausal participant who said: *The clinic provides some information on the cessation of menstruation and that it is part of aging and menopause and one should accept it.* Through probing she continued and said: *They do not say much as if they lack more information about it. Even doctors in town do not explain maybe because of time and many patients they have to consult. They would tell you to reduce weight and since then I reduced my food and do some household shores when I am in less pain from my joints.*



© University of Venda

University of Venda
Creating Future Leaders

Another post-menopausal participant said: *The clinic supplies us with treatment for these health problems, some do not say anything at all they just tell you to use it. If you do not get better they refer you to the visiting doctor when he comes to the clinic for better and stronger medication. But I feel the nurses require some sort of training specifically on menopause if there is such. The clinic supplies us with treatment for these health problems and if you do not get better they refer you to the visiting doctors when they come to the clinic or hospital for better and stronger medication. It is better for them to be more and better trained and be equipped with adequate knowledge on menopause instead of referring us to the hospitals that are far from us.*

Participants indicated that one of the reasons for professional nurses rendering improper care regarding menopause is the lack of relevant information and skills. Lack of training on menopause was seen by participants as also contributing to a lack of knowledge among staff members to render high quality care. The discussions above show that some clinic nurses seem to lack relevant knowledge and skills on menopause as no formal training has been offered to them before. This was attributed to the fact that clinic nurses dealt with general problems and even if some had studied some courses, they still lacked relevant skills and knowledge on menopause. Apart from the knowledge on the strategies to cope with menopause they should still be able to encourage menopausal women to make informed choices and decisions about their sexuality at menopause.

This was evident in all the focus group interviews conducted in this study that the majority of health care personnel at the clinic lacked information regarding menopause and menopausal issues. In addition they indicated that some health care personnel consulting them seemed not to have been well trained regarding menopause. They thus find it useless to consult at the health care facility. It was clear that health care personnel lacked accurate knowledge and skills regarding menopausal issues. To them menopause was regarded as an aging process rather than menopause and hormonal changes. In order to understand and effectively manage menopausal challenges presented by the participants at the health care facility, nurses required adequate knowledge and information. It is thus the responsibility of the government to ensure that health team members are trained on issues pertaining to menopause as indicated by the participants.



© University of Venda

The study found that some villages were situated far behind the mountains from where people had to travel on foot to reach the local health facility or clinic. There was no means of transport, only local villagers with cars would pick them up to reach their destination. Participants in this study stayed far from the health care facility and presumably had no access to accurate information about menopause and menopausal issues. This observation implied that these participants become discouraged, did not bother to travel to the health care facility that is free of charge. Participants also became discouraged to utilise their local health care facility owing to inaccessibility. They utilised their own traditional strategies to deal with the symptoms and stresses brought about by menopause. They thus needed extrinsic motivation to encourage them and their villagers to utilise the health service facility for consultation.

A study conducted among the rural Mayan Indians in Yucatan, Mexico and rural Greek women living on the island of Evia, Greece revealed that village midwives and healers only attended to women of reproductive age. Menopausal women do not go to them for consultation because according to the midwives, there are no special problems associated with this stage in a woman's life. The study also revealed that the village midwives, who were post-menopausal themselves, expressed no knowledge of any other problems associated with menopause except irregular menses before the final cessation (Beyene, 1986:47).

A survey conducted on factors associated with high levels of encouragement and the prescription of HRT among managed care providers revealed that male practitioners were more supportive of menopausal women but they were 38% less likely to prescribe HRT frequently than female practitioners (Exline, Siegler & Bastian, 1998:879). In other studies, it is indicated that the main source of information on menopause was from the clinic the women attended (Akong et al., 2001:155) while according to Al-Olayet et al., (2010:4077), a high number of Saudi women wanted more information regarding menopause through education sessions as their three main sources of information were only through friends, television and physicians.

According to the research that was conducted by Shirley (2007:39), inaccessible health services, including the distance travelled to the health care facilities, contributed to patients not utilising the service and defaulting on treatment. Orem's theory encourages the provision and maintenance of an environment free from hazards that supports personal development (George, 1996:271). A study



© University of Venda

conducted by Reis, Heisler, Amowitz, Moreland, Mafeni, Anyamele and Iacopino (2005), reported that inadequate training of health workers was found to be significantly more likely to refuse to treat patients well than those who reported to have received adequate training. Health care workers were shown to be uncomfortable giving information to women about their status or providing advice to them.

Rahlenbeck (2004:56) found that there was an urgent need for educational programs for health care workers in the rural areas. Lack of understanding of the disease and limited access to timely information meant that rural nurses might not provide the appropriate care required by the patients (Vance & Denham, 2008:59). Another study done by Campbell, Maki, Willenbring and Harry (1991:15) found that there is a need for the training of nurses in hospitals as they lacked the necessary knowledge. Fernandez, Vazquez and Diaz (2004:62), found that adequate care with the best possible attitude is important for nurses, auxiliary staff and other health personnel to offer assistance and preventive care in the best conditions.

Conversely, Italian women seemed to view menopause as a natural transition in life and not as a disease. Interviewed women were found to attend regular general practitioners' praxis, most of them joined female cancer prevention programmes and many had undergone gynaecological checks in the last five years. Thus, health professionals seemed to have had the opportunity to provide women with information on menopause and HRT pro-actively. This implied that health professionals in Italy had sufficient knowledge and information to provide women with menopausal challenges which was not the case in rural communities of this study.

### 4.1.5 Summary

The findings of this study revealed a varied understanding of the concept menopause. The discussion of menopause, however, was mainly related to menopause as synonymous with old age and the menopausal symptoms associated to menopause. Menopause was viewed differently by different cultures and nations across the world by attaching different connotations to the cessation of menstruation. A gap was identified in this study that firstly, the majority of the women were unable to associate the cessation of menstruation with menopause. Secondly, participants lacked information that the cessation of menstruation was due to the decline in the levels of hormones that regulate



© University of Venda

menstruations.. In this study none of the menopausal women perceived menopause as a reward, instead to some it was viewed as a punishment from God because they lacked proper knowledge and information.



© University of Venda

University of Venda
Creating Future Leaders

## PHASE 2: QUANTITATIVE STUDY

## 4.2 THE RESULTS

### 4.2.1 Introduction

This chapter presents the results of the quantitative study under the following headings:
Section 1: Demography; Section 2: The types of menopausal challenges being experienced by the participants and the level of severity; Section 3: The approaches commonly used by the community for managing menopausal symptoms and the participants' involvement in them.

### 4.2.2 Section 1: Demography.

Table 4.2 shows the demographic distribution of the participants. Of the 489 participants, 169 (34.6%) were aged 50 years and below while 174 (35.6%) were 61 years and above. The distribution according to educational level shows that 352 (72%) of the participants either had primary education or no formal education. One hundred and thirty seven (28%) of the participants either had secondary or tertiary education. Three hundred and six participants (62.6%) were married and 469 (94.9%) were parous women. The distribution according to work status shows that 323 (66.1%) were either unemployed or full time housewives.

The socio-demographic profiles of the participants are shown in Table 4.3. Of the 489 participants, 469 (96%) perceived that their relationship with their family members were either good or very good. Four hundred and twenty nine (87.7%) felt that their menopausal status did not usually make them experience feelings of depression. Three hundred and forty-six participants were non-smokers and of those who smoked (n= 143), 67 (47%) categorised themselves as 'mild smokers'. With regard to alcohol consumption, three hundred and fifty one (71.8%) of the participants categorised themselves as non-drinkers. Furthermore, 94 (68%) of those who were drinkers (n=138) said that they were 'mild drinkers'. In order to determine the weight of the participants, the interviewers referred to the participants' hospital cards (kept by them in the house) which have a section for recording weight. Of the 370 whose weight records were available, 321 participants (86.8%) weighed between 80 and 100 kg. Of the 321 participants whose weights were above 80 kg., 290 (90.3%) weighed above 100kg.



© University of Venda

University of Venda
Creating Future Leaders

**Table 4.2: Participants' distribution according to age, educational level, marital status, parity and work status (N= 489)**

| Variables | No. | % |
|---|---|---|
| **Age distribution.** | | |
| 40 - 50 years | 169 | 34.6 |
| 51 - 60 years | 146 | 29.9 |
| 61 - 70 years | 115 | 23.5 |
| 70 years and above | 59 | 12.1 |
| **Menopausal status.** | | |
| Pre-menopausal | 122 | 24.9 |
| Peri-menopausal | 178 | 36.4 |
| Post-menopausal | 189 | 38.7 |
| **Educational level.** | | |
| Primary | 192 | 39.3 |
| Secondary | 116 | 23.7 |
| Tertiary | 21 | 4.3 |
| No formal education | 160 | 32.7 |
| **Marital Status.** | | |
| Married | 306 | 62.6 |
| Single | 105 | 21.5 |
| Widow | 69 | 14.1 |
| Divorced | 9 | 1.8 |
| **Parity** | | |
| Nulliparous | 25 | 5.1 |
| Parous | 469 | 94.9 |
| **Employment status** | | |
| Employed | 52 | 10.6 |
| Unemployed | 188 | 38.4 |
| Housewife | 135 | 27.6 |
| Self employed | 81 | 16.6 |
| Domestic Worker | 33 | 6.7 |



© University of Venda

University of Venda
Creating Future Leaders

**Table 4.3: Distribution of the participants according to their perceived relationship with family members, whether or not they usually felt depressed, smoking and alcohol consumption status respectively, and body mass index**

| Variables | No. | % |
|---|---|---|
| Perceived relationship with family members ( N= 489) | | |
| Poor | 20 | 3.9 |
| Good | 131 | 26.8 |
| Very good | 338 | 69.1 |
| Whether or not they usually feel depressed( N= 489) | | |
| Yes. | 60 | 12.3 |
| No | 429 | 87.7 |
| Smoking status ( N= 489) | | |
| Heavy | 40 | 8,2 |
| Moderate | 36 | 7.4 |
| Mild | 67 | 13.7 |
| Non-smoker | 346 | 70.1 |
| Alcohol consumption status **( N= 489)** | | |
| Heavy | 16 | 3.3 |
| Moderate | 28 | 5.7 |
| Mild | 94 | 19.1 |
| Non-drinker | 351 | 71.8 |
| Body mass index (weight/kg) ( n= 370) | | |
| 40 – 59kg | 28 | 7.6 |
| 60 – 79kg | 21 | 5.7 |
| 80 – 99kg | 31 | 8.4 |
| 100 and above | 290 | 78.4 |

As shown in Figure 1 (a-d), 47.9 % of the participants used contraceptives. Of the four associated diseases that were examined in this study, about half of the participants (49.0 %) mentioned that they



© University of Venda

suffered from hypertension, followed by diabetes (39.7%). Over 70% of the participants reported that they were not on hormone replacement therapy. Exercise in this study refers to the involvement of the participants in activities of daily living commonly undertaken in rural communities which involve vigorous actions, such as participating in and carrying out household chores (cooking, laundry activities, sweeping, collecting water and firewood for domestic use, etc.), walking long distances regularly/routinely and farming. Almost 96% of the participants reported that they were involved in such activities.

### 4.2.3 Section 2: The types and severity of menopausal challenges being experienced by the participants.

- ***Introduction.***

In this study, questions were asked to determine the experience of the participants regarding the common symptoms often associated with menopause. The questions were arranged into six categories of symptoms and the participants were asked to state whether they were experiencing any of the symptoms. The overall distribution for each of the selected symptoms is shown in Table 4.4. As shown in Figures 2-5, further analysis was done focusing on selected symptoms/challenges in order to elucidate the differences between sub-groups in the study based on demographic characteristics. An effort was made to determine whether or not the differences were statistically significant or owing to chance variation.

- ***Overall distribution of the participants for the selected symptoms.***

With regard to the variables categorised as vasomotor symptoms, the range of those experiencing all of them was between 39.1% for those having night sweats and 43.4% for hot flushes and difficulty falling asleep respectively. Among the six symptoms listed under the urogenital category, about 50% reported that they experienced frequency of urination while 41.3% and 35.2% reported having menstrual problems and issues related to avoiding intimacy respectively. Under the category referred to as musculo-skeletal symptoms, between 38% and 41.3% reported having joint aches/stiffness of the joints and low backache/muscle pain respectively. Of the six variables examined under the psychological



© University of Venda

University of Venda
Creating Future Leaders

**Figure 1: Distribution of participants according to the following variables: contraceptive use, whether or not they suffer from selected menopause-related/associated diseases, use of hormone therapy, and involvement in 'exercise' (N= 489)**

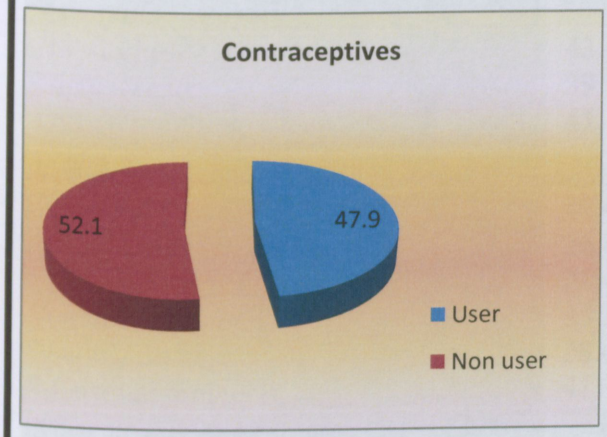



*Figure 1a: Contraceptive use*

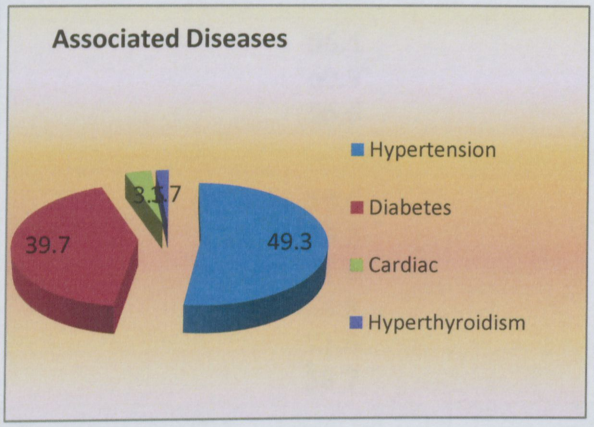



*Figure 1b: Associated diseases*

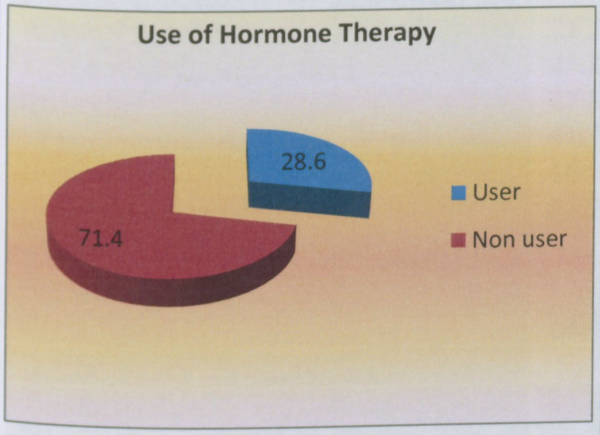



*Figure 1c: Use of Hormone therapy*

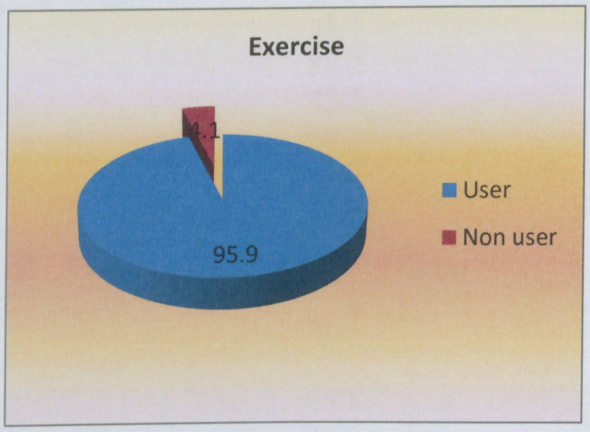



*Figure 1d: Participation in exercise*

category, 63.2% reported having experienced life events related to family death/children growing and leaving home (which can possibly have serious effects on the health of menopausal participants). Furthermore, 45.8% and 41.7% reported having challenges related to poor memory/forgetfulness and depressive mood respectively. With regard to the question on whether or not the participants were having challenges related to constipation (which was categorised under gastrointestinal symptoms), only 18.2% answered in the affirmative. Regarding the eight variables examined under the category referred



© University of Venda

University of Venda
Creating Future Leaders

**Table 4.4: Distribution of the participants' responses regarding the following: challenges of self-care deficiencies according to: vasomotor, urogenital, musculo-skeletal, psychological, gastrointestinal and psychosomatic symptoms ( N= 489).**

| Variables | Yes | No |
|---|---|---|
| Vasomotor category | | |
| Hot flushes | 43.4 | 56.4 |
| Night sweats | 39.1 | 60.9 |
| Difficulty falling asleep | 43.4 | 56.6 |
| Urogenital category | | |
| Frequent urination | 49.4 | 50.6 |
| Urinary tract infection | 26.8 | 73.2 |
| Change in sexual desire | 28.4 | 71.6 |
| Avoidance of intimacy | 35.2 | 64.8 |
| Vaginal dryness | 28.4 | 71.6 |
| Menstrual problems | 41.3 | 58.7 |
| Musculo-skeletal category | | |
| Aches/joint stiffness | 38.0 | 62.0 |
| Low backache/muscle pains | 41.3 | 58.7 |
| Psychological category | | |
| Anxiety/ nervousness | 21.3 | 78.7 |
| Poor memory/forgetfullness | 45.8 | 54.2 |
| Irritability | 27.8 | 72.2 |
| Depressive mood | 41.7 | 58.3 |
| Feelings of hopelessness/worthlessness | 16.0 | 84.0 |
| Life events related to family death/children growing/ leaving home | 63.2 | 36.8 |
| Gastrointestinal category | | |
| Constipation | 18.2 | 81.8 |
| Psychosomatic category | | |
| Tiredness | 23.3 | 76.7 |
| Mood changes | 29.2 | 70.8 |
| Dry/wrinkled skin | 32.2 | 67.9 |
| Darker skin/patches | 23.9 | 76.1 |
| Breast tenderness | 24.3 | 75.7 |
| Lack of appetite | 22.1 | 77.9 |
| Craving for sweet food | 27.2 | 72.8 |
| Alcohol consumption | 21.7 | 72.8 |



© University of Venda

University of Venda
Creating Future Leaders

- **Section 2.1 Distribution of the participants according to specific menopausal challenges/ symptoms and demographic variables (N= 489)**

Figure 2 (a-c) shows the distribution of the participants regarding three variables which specifically focus on vasomotor challenges in the form of cross tabulations. With regard to hot flushes and age distribution, between 40-50 years of age about 8.9% and those between 51-60 years about 10.30% experienced hot flushes (Figure 2a). For sweating more than usual and age distribution (Figure 2b), between 45.2% for those 51-60 years of age and 58.8% for those in the age group 40-50 years had no complaint. None of the respondents mentioned that they had a severe problem regarding excessive sweating. The differences between the groups was not significant (P=0.438, Cramer's V= 0.077). As shown in Figure 2c, between 40.9% and 45.8% of the respondents reported that they were experiencing difficulty in falling asleep either in a mild, moderate or severe form. However, the differences between the age groups was not statistically significant and was therefore possibly due to chance variation (P=0.988, Cramer's V= 0.039). With regard to the question on whether or not the participants were experiencing hot flushes, 63.9% of those in the pre-menopausal stage and 55% of those in post-menopausal stage reported that they had no complaint. Of those who reported that they were experiencing hot flushes, between 42.7% of those in the menopausal stage and 45% of those in the post-menopausal stage had either a mild or moderate type of the problem. The differences between the groups was not statistically significant (Figure 2c) (P=0.063, Cramer's V= 0.424).

UNIVERSITY OF VENDA LIBRARY

The results of the variables examined under the category titled urogenital/libido challenges are as shown in Figure 3 (a-c). As shown in Figure 3a, 62.3% of the women in their pre-menopausal stage compared to 50% and 51.3% of those in the menopausal and post-menopausal stages respectively had no complaint with regard to frequent urination. Furthermore, about 14% of the participants in the post-menopausal stage and 9% of those in the pre-menopausal stage reported that they were having problems with frequent urination which was severe in nature. The differences between the groups were however, not statistically significant (P=0.366, Cramer's V= 0.082). The distribution of the respondents according to menopausal status and changes in sexual desire is shown in Figure 3b. Sixty four point eight per cent, 61.2% and 55% of the women in the pre-menopausal, menopausal and post-menopausal status respectively had either a mild, moderate or severe problem regarding changes in their sexual

UNIVERSITY OF VENDA LIBRARY



© University of Venda

University of Venda
Creating Future Leaders

**Fig. 2: Participants' distribution according to vasomotor challenges.**

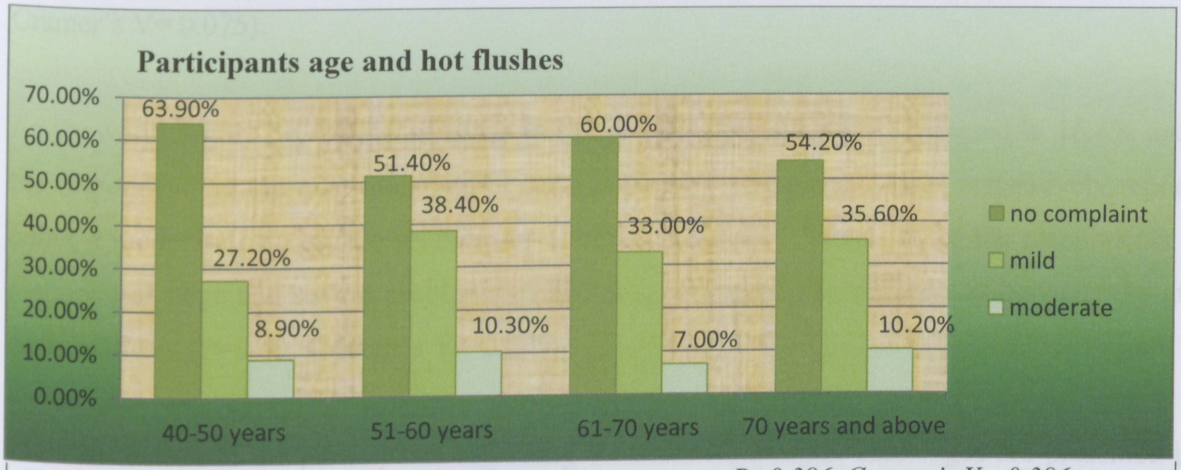



*Fig 2a* *P=0.386, Cramer's V= 0.386*

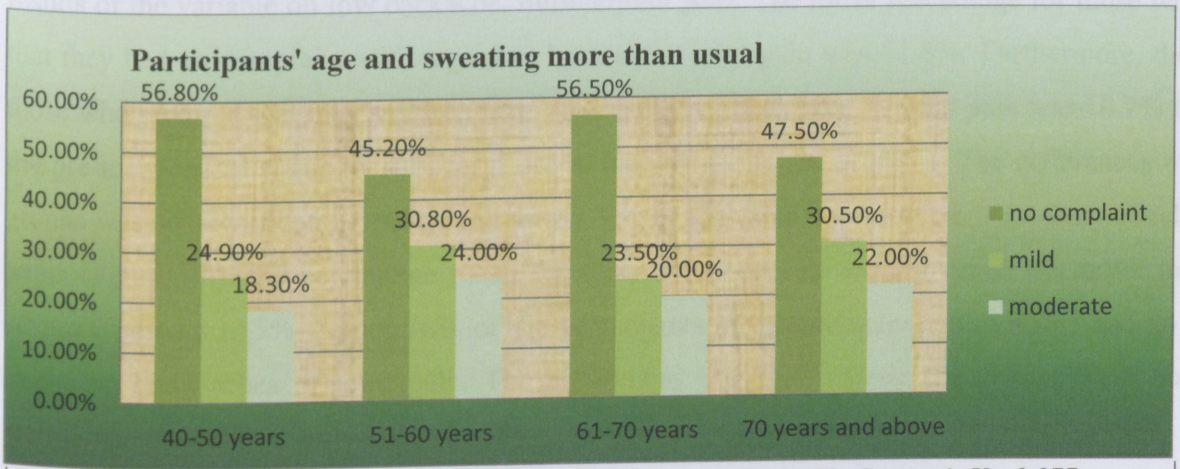



*Fig 2b* *P=0.438, Cramer's V= 0.077*

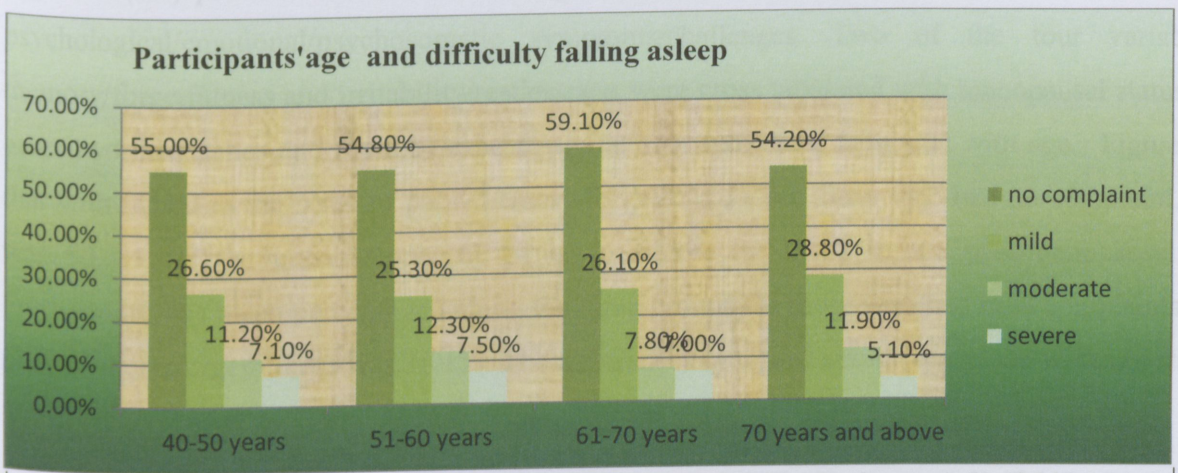



*Fig 2c* *P=0.998, Cramer's V= 0.039*



© University of Venda

University of Venda
Creating Future Leaders

desire/libido. The differences observed between the groups are not statistically significant (P=0.49, Cramer's V= 0.075).

As shown in Figure 3c, 26.2% of those in the pre-menopausal stage compared to 16.4% and 18.6% of the respondents in the post-menopausal status and peri-menopausal status respectively reported having either a moderate or a severe problem of avoiding intimacy. About 6% of the respondents in the pre-menopausal stage had severe problems of avoiding intimacy. The differences between the groups were not significant (P=0.49, Cramer's V= 0.075).

The distribution of the participants regarding the musculo-skeletal challenges are presented in Figure 4 (a and b). The responses were also cross-tabulated using the menopausal status. Figure 4a presents the results of the variable on low backache, muscle/joint pain. The mean percentage for those who reported that they had no complaint with regard to back ache/ joint pain was 51.8%. Furthermore, the range for those who reported that they suffered from severe type of back pain / a joint pain was 10.7% for those in the pre-menopausal status to 14% for those in the peri-menopausal status. The differences between the groups was not significant (P=0.095, Cramer's V= 0.182). With regard to the symptoms of aches or joint pains (Figure 4b), the percentage mean for those who reported having either the mild, moderate or severe type was 30.5%. About 76% of the participants in the pre-menopausal status had no complaint regarding body aches or joint pain. The differences observed among the groups were however not significant (P=0.095, Cramer's V= 0.182).

Figure 5 (a-d) presents the results with regard to those variables examined under the category titled psychological/emotional/psychosomatic symptoms/challenges. Two of the four variables, poor memory/forgetfulness and irritability/restlessness were cross tabulated with menopausal status while the other two, headaches and rapid heartbeat/palpitations were cross tabulated with age. Figure 5a shows that with regard to the issue of poor memory/forgetfulness, for those who had no complaint, the range was 50.6% for the peri-menopausal group to 57.1% for those in the post-menopausal category. Furthermore, the mean percentage among the three groups for those who had mild complaints regarding poor memory/forgetfulness was 36.1%. The differences observed among the group were not statistically



© University of Venda

University of Venda
Creating Future Leaders

**Fig. 3: Participants distribution according to urogenital /libido challenges.**

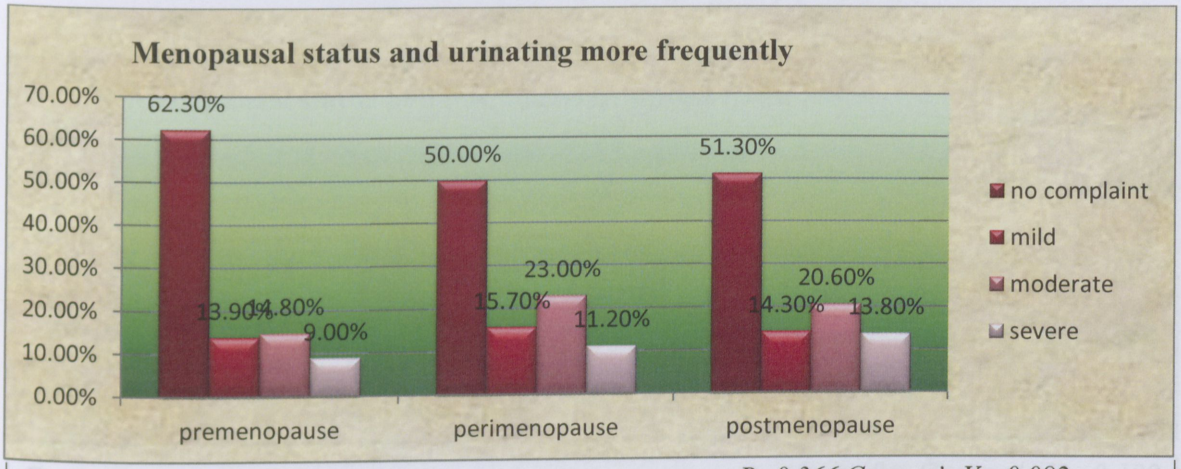



*Fig 3a* *P=0.366 Cramer's V= 0.082*

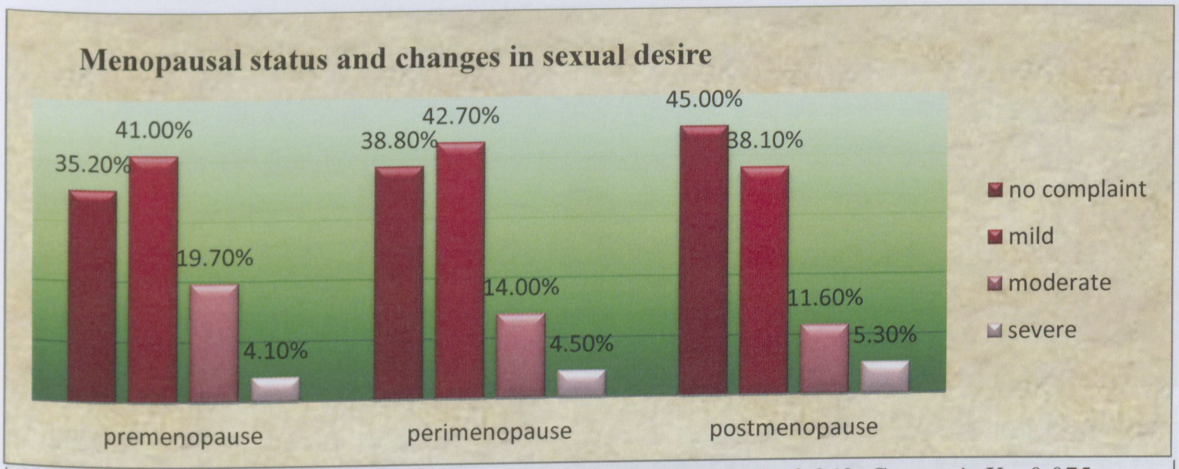



*Fig 3b* *P=0.049, Cramer's V= 0.075*

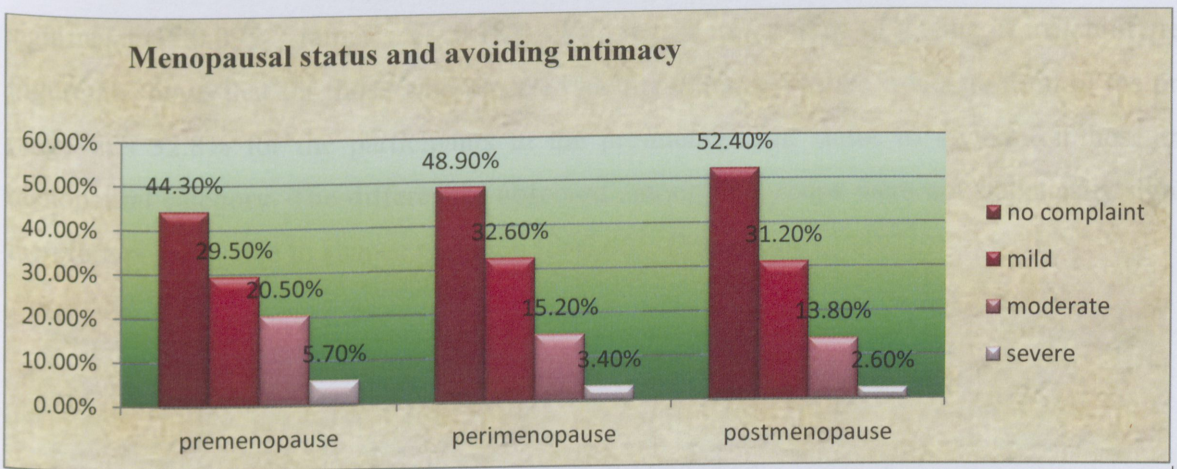



*Fig 3c* *P=0.049, Cramer's V= 0.075*



© University of Venda

University of Venda
Creating Future Leaders

**Figure 4: Distribution of the participants according to musculo-skeletal challenges**

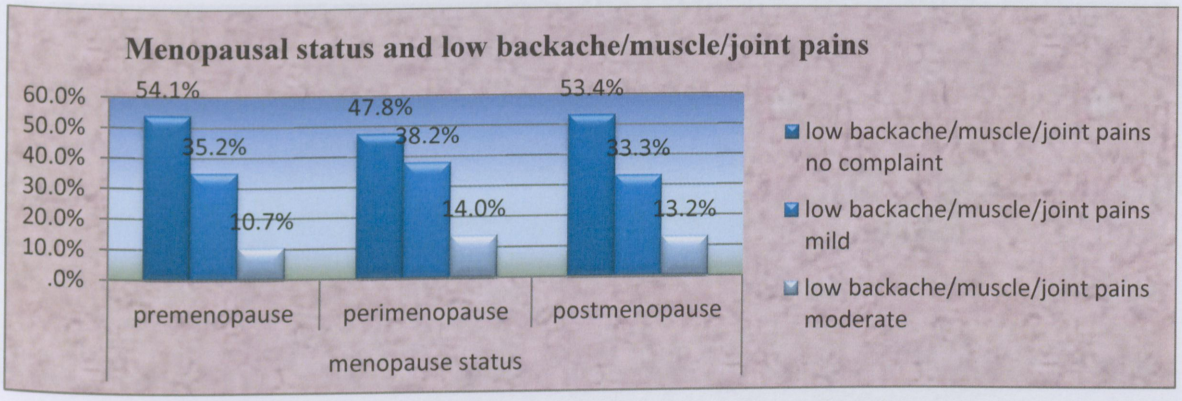



*Figure 4a* *P=0.095, Cramer's V= 0.182*

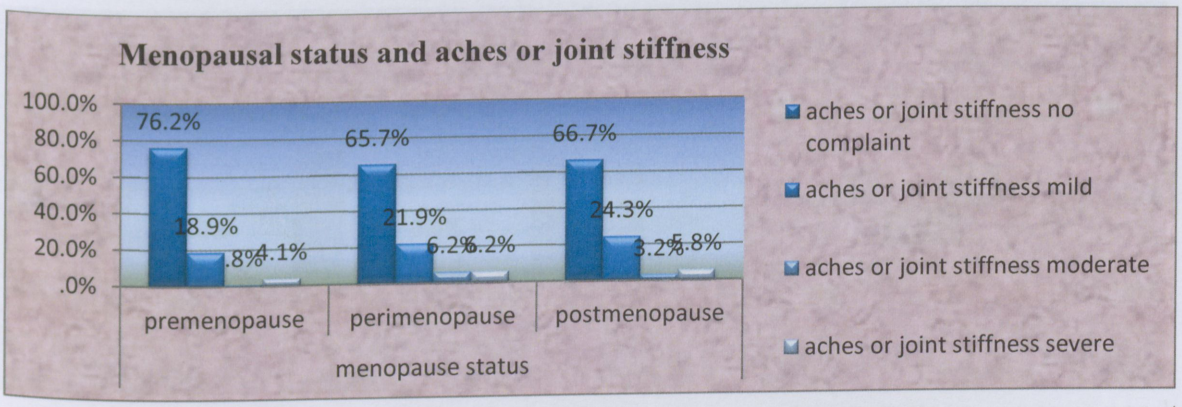



*Figure 4b* *P=0.095, Cramer's V= 0.182*

significant (P=0.095, Cramer's V= 0.182). With regard to the issue of feeling of irritability/restlessness, Figure 5b shows that for those who reported having either a mild or moderate form of the problem, the range was 32.8% for the participants in the pre-menopausal status to 42.9% for those in the post-menopausal category. The differences observed among the groups were not statistically significant and therefore possibly due to chance variation (P=0.065, Cramer's V= 0.393).



© University of Venda

University of Venda
Creating Future Leaders

**Figure 5: Distribution of the participants according to psychological /emotional /psychosomatic symptoms challenges**

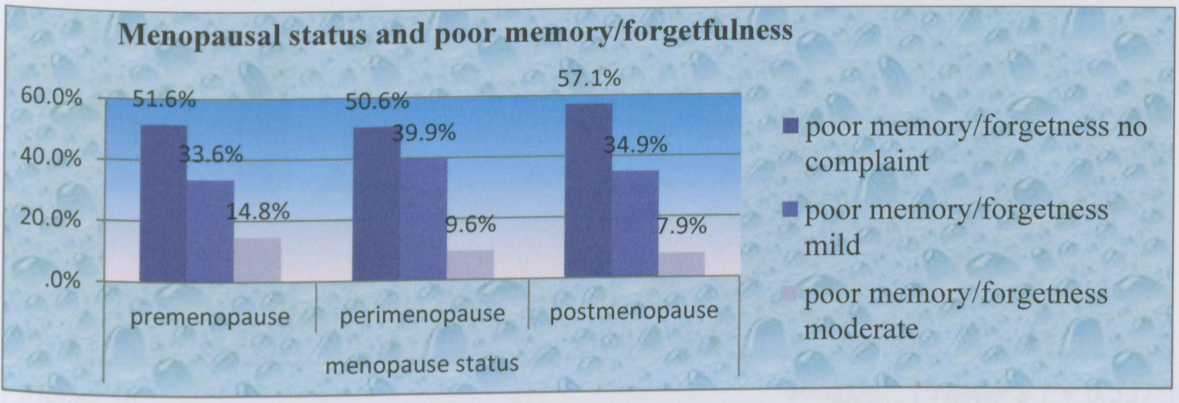



*Figure 5a* *P=0.095, Cramer's V= 0.182*

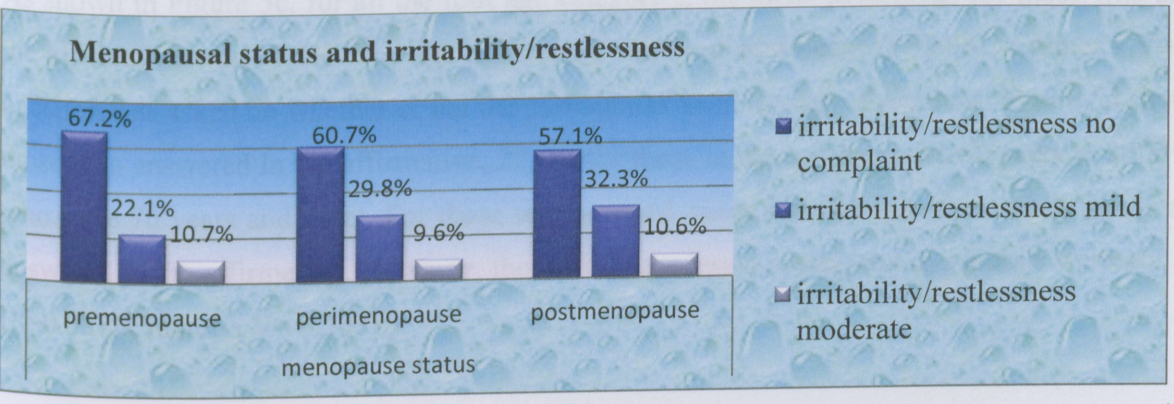



*Figure 5b* *P=0.065, Cramer's V= 0.393*

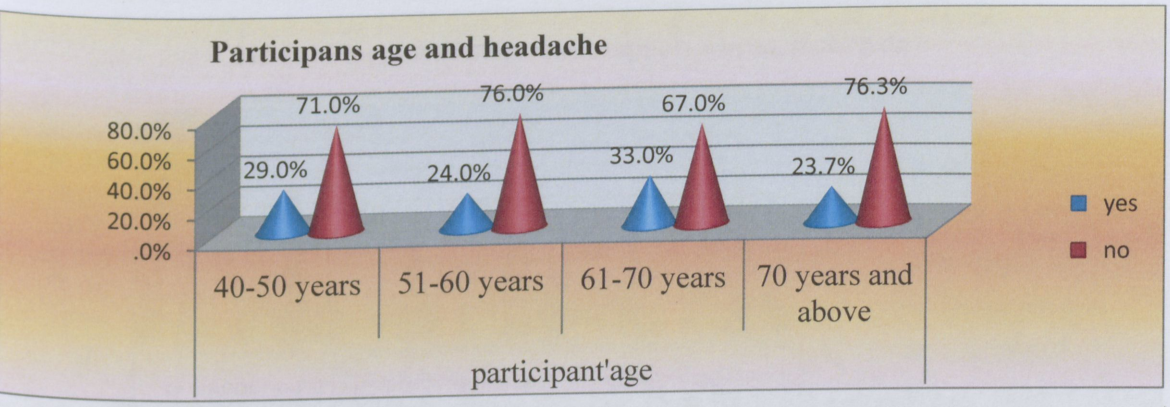



*Figure 5c* *P=0.081, Cramer's V= 0.355*



© University of Venda

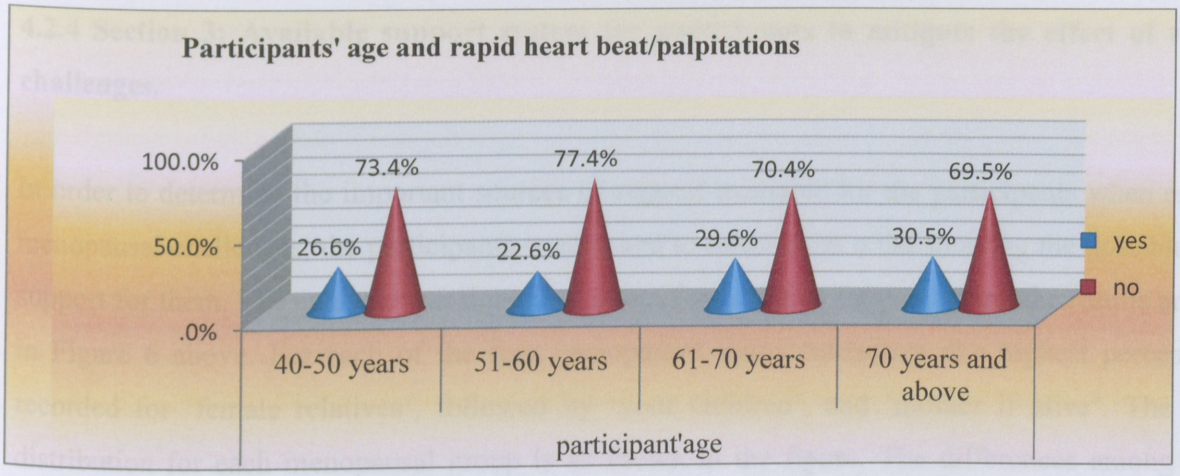



*Figure 5d* *P=0.067, Cramer's V= 0.537*

As shown in Figure 5c, for all the four age categories, the mean percentage for those who answered in the affirmative was 24.4%. The age differences were not significant (P=0.081, Cramer's V= 0.355). A question was asked on whether or not the participants were having palpitations. Figure 5d shows that for those who answered in the affirmative, 22.6% for those in the age group 51-60 years to 30.5% for those who were 70 years and older. For those who were 61 years and above in the overall group, about 30% answered in the affirmative. However, the differences found among the age groups were not significant (P=0.067, Cramer's V= 0.537).

**Figure 6: Distribution of the participants by menopausal status and the source of support to reduce the effects of menopausal challenges**

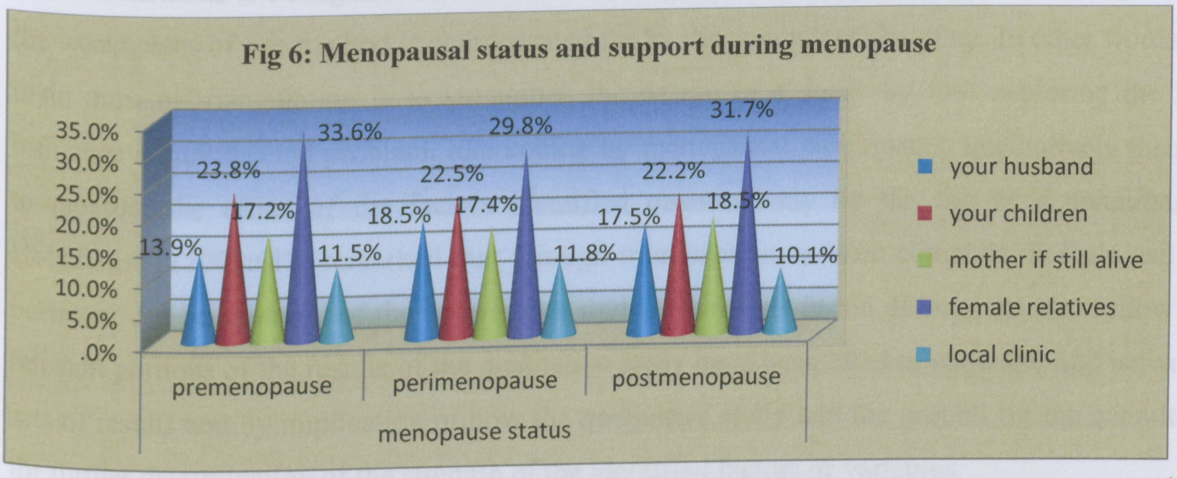



*Figure 6* *P=0.042, Cramer's V= 0.988*



© University of Venda

### 4.2.4 Section 3: Available support system for participants to mitigate the effect of menopausal challenges.

In order to determine the important sources of support available for the participants when experiencing menopausal challenges, the participants were asked to select from a list showing the possible sources of support for them. The analysis was done in a form of cumulative frequency and the results are presented in Figure 6 above. For each of the four menopausal status categories, the highest percentages were recorded for 'female relatives', followed by 'your children', and 'mother if alive'. The percentage distribution for each menopausal group is as shown in the figure. The differences among the groups were statistically significant (*P=0.042, Cramer's V= 0.988).*

## 4.3 DISCUSSIONS OF THE QUANTITATIVE STUDY.

### 4.3.1 Introduction

It is worthwhile noting that since the design of this study was triangulated, it is incumbent on the researcher to show the link between the results of the two studies: qualitative and quantitative studies. One of the assumptions for using a triangulated design in this study is that the challenges faced by menopausal participants can be categorised as a public health problem. As such, both the problems and interventions are multi-faceted and therefore when being examined or researched, require multiple research methods to strengthen the value and relevance of the research outcomes. Through triangulation, the weaknesses of one method is compensated for by the strength of the other. In other words, one of the main aims of triangulation is to strengthen the design of a study by first exploring the factors that influence a multifaceted problem, like coping by menopausal participants, qualitatively then go further to measure the effect of the factors identified quantitatively by the use of a quantitative design. Holtzhausen (2001:618) remarked that through triangulation, a more complete, holistic and contextual portrayal can be captured of the units under study. Therefore, in the discussions that follow below, the relevant portions of the results of the qualitative study have been cited to show the link between the two sets of results and by implication of how the qualitative study laid the ground for the quantitative study for further determination of the strength of the identified factors or variables.



© University of Venda

University of Venda
Creating Future Leaders

### 4.3.2 The discussions.

The findings of this study (Table 4.2) show that the majority of the participants were between the ages of 40 to 50 (34.6%) while less than 12.1% were aged 70 and older. When calculated, the mean age was found to be about 55 years, with a range of 40-70 years. The high number of participants between the age ranges of 40 – 50 years is probably due to the fact that the majority of the participants were in their pre-menopausal and early peri-menopausal states. Secondly, the fact that only a small number among the participants were 70 years and above was probably due to the fact that, as mentioned under methodology ( **3.2: Area of study**), in all the villages under study, there were few elderly men and women. As mentioned above in this study, the mean age at menopause was 55 years; however, in other studies, such as the one done among Turkish women (Ozdemir & Col, 2004:211; Singh, Kaur & Walia, 2002121), the mean age at menopause was reported to be 45.9, 46.3 and 45.8 years. According to Henn (2010:405), the average age at menopause is 50 years in South Africa, and there are over four million (16%) women aged 50 and above who may not reach post-menopause owing to the effect of Human Immuno Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS). This implies that the AIDS epidemic in South Africa might have a declining effect on the population of women in the post-menopausal age except if the efforts currently are being made to curb the epidemic start to yield better outcomes.

When women reach menopause at the expected time, such as at the age of 50 years, it is assumed that the number of their follicles at birth is high and conversely, low when menopause is reached at an early period, such as the finding in the Turkish study (Kilaf & Kirchengast, 2008:313). Considering the calculated mean age of 55 years in this study, one can probably say that the number of their follicles at birth was high. Secondly, although the management of menopause is routine in developing countries (such as South Africa), determining the average age at menopause for a specific community, (such as the Hamakuya community which is the location of this study), is of great importance for planning health services for post-menopausal participants as a target group or cohort. In developing countries, like the Philippines, Papua New Guinea, and various parts of Africa, such as Ghana and Tanzania, the mean age at menopause was 48 years while in India, Pakistan, Turkey and Thailand it was also reported to be lower than 50 years. The mean age in a study done in Ankara was ± 47 years while 96% of the women were over the age of 50 years (Ozdemir & Col, 2004:211). Statistically on the average, American



© University of Venda

University of Venda
Creating Future Leaders

women experienced menopause at about 51 years while in rural Bangladesh, women reached menopause at about 43 years. Seventy-five percent of the world's post-menopausal women lived in developing countries with increasing life expectancy (WHO, 1996). However, Berlin (2009:421) indicated that the experience of menopause and menopause symptoms often reflected cultural differences among women and that the age at which women reached menopause may be rooted in part in their culture. South Africa in particular has a mean age of 48.9 which is comparable to that of other developing countries (WHO, 1996). In support of this assertion by WHO one can observe that in the qualitative study, some of the participants (South African menopausal participants) in the focus groups also defined the age at meneopause as 50 years. On page 78, paragraph 3, line 4, it states: '…hereby a woman that has passed 50 years of age becomes aged'. This implies that from their experience in their community, most women reach menopause at the age of 50 years.

Most of the participants in this study (72%) were either iliterate or had primary education (Table 4.2). This result is supported by the study conducted by Nusrat et al., (2008:56) at an out-patient department of Isra University which revealed that 85 (59.4%) of the menopausal women aged 45-58 years were uneducated and frequently reported symptoms of hot flushes and night sweats (59.4%), backache (75.66%) and insomnia (63.44%). Wilbur et al., (1995:19) reported that well educated women had a more positive attitude towards menopause,although no significant relationship was found. As presented above (section 2.5), education plays a vital role in maintaining a better life status. During the transitional phase of menopause, lower psychological and somatic symptoms scores are directly linked to the fact that educated women are aware of the approaching life transition. Educated women lay emphasis on their dietary as well as life style changes which help them in maintaining a good health.

Urogenital symptoms were more prevalent among the educated group because they frequently consulted physicians when something was wrong in their bodies. The uneducated group on the other hand, reported fewer urogenic problems, such as frequency of urinating, urinary tract infections, vaginal dryness and others, probably due to the fact that these women do not present their problems to physicians or may present them with some limitation (Kakkar et al., 2007:306). This observation agrees with the findings reported in the qualitative study which showed that the low level of education of the participants contributed to the lack of understanding of the physical problems being experienced by them. Conversely the study by Chim et al., (2002:275) observed no significant relationship between



UNIVERSITY OF VENDA
LIBRARY

© University of Venda

University of Venda
Creating Future Leaders

education and menopausal symptoms. The study by Adegoke et al., (2005:72) on post-menopausal experiences among Nigerian women showed that uneducated women or those with little or no education were ignorant of the changes owing to menopause or they could not admit the experience. On the other hand, a study on perceptions and attitudes of educated Nigerian women about menopause revealed that the majority of women had a positive attitude to menopause and it could not affect their relationship with their spouses and children (Adekunle, Fawole & Okunlola, 2000:525). Ozdemir and Col, (2004:211) also observed that the rate of early menopause was higher in less educated women when compared with more educated women. The difference was found to be statistically significant, in that educated women found happiness and satisfaction obtained from work life, which alters life at menopause positively.

In this study, about 63% were married while 95% were parous. Sixty-six percent of the participants were either unemployed or housewives. According to Kilaf and Kirchengast, (2008:313) unemployment, low socio-economic status, low intergration levels, low family income and bad housing conditions all create an enormous social stress which affects well-being and individual health. However, daily working stress is thought to induce an early age at menopause while, paradoxically, happiness and satisfaction obtained from work life may alter age at menopause positively (McKinlay, Brambilla & Posner, 1992:103; Ozdemir & Col, 2004: 211).

As shown in Table 4.3, 96% of the participants felt that their relationship with their family members was either good or very good. This was a good indication of family support for the participants when faced with menopausal challenges. From the results of the qualitative study, it was observed that family members stayed with the participants at night even if they had to go to work or school the following morning without resting and sleeping. They assisted their mothers or grandmothers during their agonising periods of severe and troublesome symptoms by rubbing painful joints, turning them or providing medication to relieve the symptoms.

In spite of the high percentage who reported that their relationship with their families was good, 12.3% still reported feelings of depression. This finding does not concur with the findings in the qualitative analysis of this chapter. Participants showed positive feelings about their menopausal experiences, such



© University of Venda

University of Venda
Creating Future Leaders

as accepting the symptoms, others showed negative feelings like depression. The following citations from the qualitative study, support this point:

*Ho! I am referring to severe joint and back pains, urinary frequency, sleeplessness, forgetfulness and depression.* In the qualitative findings, participants indicated that they experienced feelings of depressive moods possibly in cases of bothersome and troublesome severe menopausal symptoms. Those mostly affected with depressive moods were likely to be those who could not accept the symptoms in good faith considering the fact that some symptoms could be embarrassing and bothersome. This type of negative statement might make the participants regard and treat menopause as a disease which might be associated with unbearable difficulties. Such experience and feeling might invariably lead to depression. Bloch (2003:61) indicated that negative aspects of menopause leads to enormous anxiety among participants. Negative attitudes towards menopause had increasing effects on the severity of specific menopausal symptoms and therefore lead to more complaints, such as depression. A study on Australian women found that some of the participants also experienced depression which according to the authors reflected a common fear about getting older and that beauty affected women's ideas about themselves. The older a woman becomes the harder it becomes to live up to the beauty standards other women have set. In Australia visual and printed information focuses on young women and hides the old. An alleviation of depression and irritability is no longer supported because of the association with getting older. The perceived loss of youth and beauty represents a major stumbling block for Australian women. They describe feelings of uselessness, no longer being needed or wanted, unable to sleep or rest, insecure, sexually undesirable, not appreciated and valued for their capabilities and wisdom (Berger & Wenzel, 2001: 10). Ho et al., (2003:149) explained that besides apparent physiological changes during menopausal years, women in mid–life often go through social transition.

With regard to alcohol consumption and drinking patterns, over 70% of the participants were non-smokers and non-drinkers respectively. This implies that about one-third of the participants take both alcohol and cigarette/tobacco/snuff in one form or the other. Alcohol consumption increases the severity of menopausal challenges owing to uric acid (Bloch, 2003:61). Regarding body mass index, 78.4% of the participants were 100kg and above (Table 4.3). During the focus group interviews in the qualitative study, some of the participants reported having severe menopausal challenges, like joints and back pains, owing to overweight. The findings concur with the qualitative analysis previously described.



© University of Venda

University of Venda
Creating Future Leaders

As shown in Figure 1, about 48% of the participants were on contraceptives and about 29% were on hormonal therapy. The participants who were still using contraceptives in this study were possibly still of child bearing age and were possibly also sexually active. This finding was also reported in the qualitative analysis that some of the women in the pre-menopausal age were still sexually active Another participant said: *I do not experience any lack of sexual desire ..... It may be that I am still young and active.....* ( page 93).

One of the reasons why menopausal women use HRT might be that it restores their sexual activity and that their beauty is affected by reduced hormones in their bodies. Several studies have been conducted on the use of hormonal replacement therapy and other alternative therapies worldwide (Berger & Wenzel, 2001:11; Krishna, 2002:207; Schmitt, 2007:915; MacDougall, 2002:1; Brockie, 2004:1; Loutfy et al., 2006:760). A study on Australian women shows that menopause is viewed as an ailing experience and as a disease and that when typical biological changes occur, it necessitated them to take Hormone Replacement Therapy (HRT). On the other hand, the Filipinos subscribe to the belief that menopause is a normal phenomenon and so are against HRT because of the risks associated with it such as cancer (Berger & Wenzel, 2001:11).

Schmitt, (2007:915) remarked that unfortunately only women in developed countries with access to medical care and pharmacies made decisions to seek medical advice on the basis of symptoms suffered. These women could also make choices on mechanisms of coping with menopause, such as taking HRT. They were also aware of its negative image on health and the side effects, the need of finding symptomatic relief and were aware that they were at high risk of developing cancer. Brockie (2004:1) conducted a study on menopausal therapies, which shows that there is a widespread belief among the public that natural means are harmless but herbs may contain potent chemicals and should be used with caution. Schmitt, (2007:915) revealed that the physicians' attitudes play a major role in the decision making process in initiating HRT for menopausal women. Their recommendations, satisfactory counselling and skilful addressing not only of the biomedical aspects of illness and its management, but also of the socio-economic and behavioural characteristics of patients, such as life-style, family traditions, living circumstances and unique cultural needs, all play a role.



© University of Venda

University of Venda
Creating Future Leaders

Findings of this study indicate that 71.4% (Figure 1c) of the participants were non-users of HRT, probably because they did not know about them and resorted to traditional herbs or because there were no general practitioners to prescibe them, thus they could not access them effectively. Those who admitted to having used them were able to buy them from pharmacists or from doctors in town. Figure 1b shows the result for one of the questions included in the study about the list of the diseases which the participants were experiencing. Hypertension had the highest percentages (50%), followed by diabetes (40%). This was probably due to the fact that the majority of women in developing countries showed a higher pravelence of the two conditions than men because of life style changes (Melby et al., 2005:12). Nusrat et al., (2008:56) said that in their study, hypertension and diabetes mellitus were also reported by 180 (20.9%) and 215 (24.9%) women respectively. Melby et al., (2005: 12), in their comparative study of Japanese and Caucasian women in North America showed that 28% of Japanese women suffer from chronic health problems (diabetes, high blood pressure, allergies, arthritis) as opposed to 45% of Manitoba women and 53% of Massachusetts women.

When asked whether or not the participants were involved in regular physical activities that can be regarded as exercise, about 96% answered in the affirmative (Figure 1d.). This finding is supported by the results of the focus group discussions which showed that the majority of the FGDs participants indicated that they kept themselves busy on farms and doing household chores as they were unemployed. They also mentioned that working on the farms helps them to regain their health as they felt they were relieved from bothersome and severe physical health-related challenges.

As shown in Table 4.3, between 39% and 43.4 % of the participants answered in the affirmative when asked whether they suffered from either hot flushes and night sweats or difficulty in falling asleep. With regard to the symptoms categorised as urogenital, about half of the participants reported that they were experiencing difficulty in urinating while over 40% said that they had problems associated with menstrual period. Furthermore, about one-third of the group felt that they usually avoided intimate relationship. Between 38% and and 41% of the women in this study were experiencing musculo-skeletal disorders, such as joint stiffiness and low back pain. Although the percentages were slightly lower for the proportion that were experiencing the symptoms listed under the other three categories (psychological, gastro-intestinal and psychosomatic categories respectively), but except for constipation and feelings of hopelessness, none of the other variables recorded less than 20%, i.e. one fifth, of the



© University of Venda

University of Venda
Creating Future Leaders

sample for those who answered in the affirmative. Considering the fact that these are troublesome conditions, these percentages are high and the situation calls for action by the primary health care nurses and elderly women in Hamakuya so as to devise programmes or interventions to provide support for the menopausal women in the community. According to Chedraui et al., (2007:271), the symptoms of menopause are caused by oestrogen dominance in the body as progesterone production declines in the years leading to this change in a woman's body.

Several studies have been conducted on the experience of menopausal women in other continents regarding various symptoms and among them are: Chim et al., 2002:275; Ho et al., 2003:149; Obermeyer et al., 2007:788; Lark, 2006:202; Monterrosa et al., 2008:182; Margolese, 2007:1; Bloch, 2003:303. A study by Chim et al., (2002:275) showed a high prevalence of menopausal symptoms ranging between 40% and 60% among Caucasian populations, which was in contrast to the studies done on Asian women from different ethnic backgrounds that reported lower prevalence rates between 10% and 40%. A study conducted by Ho et al., (2003:149) among Caucasian women concurred with the studies on Chinese women where a significant increase in the prevalence in vasomotor symptoms were reported during the late peri-menopausal period and some elevation of such symptoms for some years after menopause. Obermeyer et al., (2007:788) observed that the frequency of menopause symptoms among women in four countries was found to differ across sites with country of residence influencing reported symptoms over and above other factors. However, hot flushes were reported everywhere. Joint pains, fatigue, impatience, nervousness, sleep disturbances, memory loss and some emotional symptoms were the most frequently reported symptoms with high incidence. They were also significantly associated with hot flushes and vasomotor symptoms and to a lesser extent with emotional and sexual symptoms (Obermeyer, et al., 2007:788). Obermeyer, et al., (2007:788) Raynolds and Obermeyer, (2005:331) concluded that factors related to symptoms reporting included socio-economic status, stress and health factors.

There is a paucity of data on the experiences of women living in the African countries regarding menopausal symptoms. However, although the magnitude might differ, most of the studies on menopausal symptoms in other continents and countries established the prevalence of the symptoms across the countries, whether in developed or developing countries. Among them were Monterrosa et al., (2008:182) among American and Japanese women; Melby et al., (2005:5) among Japanese women; Al-



© University of Venda

University of Venda
Creating Future Leaders

Olayet et al., (2010: 4077) among Saudi women; Baig and Karim, (2006:71) among Australian and Pakistan women; and Menopause: Blessing or Affliction? 2007:2) among Mexican women. According to Melby et al., (2005:5), hot flushes were the most common symptoms among the Western city dwellers.

Among Japanese women hot flushes are uncommon while the most common physical symptom of menopause experienced in Japan was frozen (stiff) shoulders, a condition whereby shoulder movement is severely restricted and painful. Lark (2006: 202) posited that in the United States of America, 85% of the women have hot flushes and 49% have symptoms severe enough to seek medical assistance. The author further remarked that Japanese women, as in the previous studies, have far fewer hot flushes than American women as they were perceived to be far too busy to listen to their bodies. Berger and Wenzel (2001:9) estimated that roughly one quarter of Australian women found it difficult to come to terms with the aging process and among the symptoms reported are irritability, depression, fear of aging, loneliness, mood swings, and unhappiness, loss of self-esteem, respect and admiration. On the other hand, Baig and Karim (2006:71); Liu & Eden (2007) identified the following symptoms among Pakistan women: lack of sleep, urinary incontinence associated with marital problems and poor education. According to Menopause: Blessing or Affliction? 2007:2), Maya women in Yucatan Mexico reported no symptoms of menopause other than menstrual cycle irregularity which might be due to geographical zone, climate and the attitudes towards menopause.

One of the most common types of symptoms associated with menopause is hot flushes and in this study, 43.4 % reported having it. Louise (2006:3357) observed that the symptoms commonly associated with menopause, such as hot flushes (which are a sudden feeling of heat often accompanied with reddening of the face and profuse sweating) commonly tell that a woman is approaching menopause because menstruation starts changing. The author further explained that other symptoms are more subtle and may seem like actual behavioural changes, such as anxiety and depression. Thus Donavan et al., (2006: 1281) suggested that before women assume that they have a profound personality change, they should become familiar with all the symptoms of menopause and begin a plan of action. This suggestion is an indication for an effective health education programme focusing on menopausal women in the community of study.



© University of Venda

University of Venda
Creating Future Leaders

The responses to the variables examined under vasomotor category presented in Figures 2 (a-c) show that for each of the variables, more than one-third of the age groups in Figures 2a and b and menopausal status groups in Figure 2c experienced those symptoms either in mild or moderate forms. In other words, although the differences were not statistically significant, the challenges of sweating more than usual, difficulty falling asleep and hot flushes are common among the participants irrespective of age or menopausal status. When the figures were further examined and analysed, one could observe that there was no consistency in the distribution of the sub-groups according to the severity among the sub-groups either according to age or menopausal status. For example, as shown in Figure 2a, as the age of the participants increased, except for the age group 40-50 years which recorded the lowest proportion among the four sub-groups for mild and moderate, there was no increase as their age increased. This possibly implies that in this study, there is no lineal relationship between age and sweating more than usual. This observed inconsistency in the increase according to the demographic factors cuts across the three variables under vasomotor category (Figure 2a-c). However, in this study significance was in the following findings: difficulty in sleeping ($p < 0.01$), difficulty in concentrating ($p < 0.01$), loss of interest in sex ($p < 0.01$), feeling dizzy or faint ($p < 0.01$), feeling depressed ($p < 0.01$), sweating at night ($p < 0.01$), and headache (p, 0.01).

According to a study on Dutch women, a third of menopausal women had severe vasomotor symptoms and 7% had symptoms even 10 years after the menopause (Luoto, 2009:1186). The author further reported that typical menopausal symptoms include vasomotor symptoms, such as hot flushes, vaginal dryness and sleep disturbances and that the probability of other symptoms is higher if the woman has vasomotor symptoms. In another study, Wylie-Rosette (2005:1223) posited that vasomotor symptoms, such as hot flushes, excessive sweating and difficulty in falling asleep, commonly develop one to two years before the cessation of menstrual flow. In a longitudinal study of menopausal women, 46% of the participants reported hot flushes and bouts of sweating in the year immediately preceding menopause. The proportion that reported vasomotor symptoms increased to 67% during the first year after menopause, and fell to 49% in the second post-menopausal year (Wylie-Rosette, 2005:1223). This has implications for age because what these results show is that as the age of menopausal participants' increases and women reach the second and third menopausal stages (peri and post-menopausal status respectively), the severity and frequency of the vasomotor symptoms increase. As mentioned above, this significant statistical relationship between menopausal status and vasomotor symptoms found in the



© University of Venda

above studies is not consistent with the results of the present study. The variation in this study might be related to the high level of illiteracy found among the participants (Table 4.2). Education plays an important role with regard to one's ability to give accurate information.

Specifically referring to hot flushes, Luoto (2009:1186) remarked that hot flushes are most common soon after menopause even though they can occur even 10 years after. In a study on Swedish women, about half of 50-year old and one quarter of 60-year olds experienced hot flushes. However, the associations between hot flushes and BMI were found only among pre- or peri-menopausal women, but not among post-menopausal women. A study by Øverlie, Moen, Holte and Finset (2002:69) found an association between hot flushes and risk factors, such as early onset of menopause, smoking and high body mass index.

As shown in Figure 3 (a-c), apart from frequecy of urination where between 50 and 60% of the participants in their different menopausal stages who had no complaint, more than 50% of the participants reported symptoms of changes in sexual desire and avoiding intimacy respectively. Although there were no significant differences between the menopausal groups, however, it can be observed that quite a good proportion of the participants (over 40%) suffered from urogenital challenges, including frequency in urination, changes in sexual desire and avoiding intimacy, either in mild, moderate or severe form. This result is supported by the study on Saudi women which showed that 51% had urinary symptoms, 37.7% had vaginal dryness and 30.7 % had sexual problems (Al-Olayet et al., 2010: 4077). In another study on Indian women in Sydney, Hafrz et al., (2007; 329) reported that 38.8% had changes in sexual desire, 32.7% had vaginal dryness during intercourse, avoided intimacy and felt nervous while 32.7% had urinary incontinence.

In a study on symptoms, menopausal status and country differences, Obermeyer et al., (2007:788) observed that menopausal status was significantly associated with hot flushes and other vasomotor symptoms and to a lesser extent with emotional and sexual symptoms. In this study, there was no significant relationship between sexual symptoms and menopausal stmptoms and the other two urogenital symptoms. This observed variation between this study and others, such as Obermeyer et al., (2007:788), might be due to the fact that in this study, 72% had either primary education or no formal education. This observation is supported by the findings of Kakkar et al., (2007:306), which showed that



© University of Venda

University of Venda
Creating Future Leaders

urogenital symptoms were more prevalent among the educated group because they consulted their doctors frequently when they noticed something in their bodies. The uneducated group on the other hand reported fewer urogenic symptoms, such as frequency of urination, urinary tract infection and vaginal dryness either because they did not report their problems to the physician or they might present them with some limitations (Kakkar et al., 2007:306). The author further remarked that Chim et al., (2002:275) did not observe any significant relationship between education and menopausal symptoms.

As indicated in the qualitative study, musculo-skeletal symptoms such as joint pains and backache were regarded by the late peri- and post-menopausal participants as severe experiences. In all the focus group interviews, participants were not aware that these physical symptoms could be associated with weight gain owing to lack of exercise, drinking alcohol and old age. Late peri-menopausal and post-menopausal participants who had aged with weight gain indicated that they were discouraged, and that they slept on one side for long periods without being assisted to turn. Participants expressed severe body pains that were not relieved by any medication. A few menopausal participants indicated that they lacked exercise while the majority indicated that they exercised on the farms by ploughing and through fetching wood from the bush and doing household shores. Very few menopausal participants indicated that they drink alcohol and those suffered joints and back pains. This could probably be due to the accumulation of uric acid in the joints and tissues.

The findings in the quantitative study concur with those in the qualitative study, that musculo-skeletal challenges had a higher range across the groups according to menopausal status. The high range of musculo-skeletal challenges in the qualitative and quantitave studies imply that participants lacked information to adequetly cope with the symptoms. Back or joint pain were reported as (46% – 52%) compared with those that reported joint stiffness (24% – 34%) (Figure 4a and b). Furthermore, the problems of musculo-skeletal challenges cut across the groups and there is no significant relationship between the groups. Simkin-Silverman and Wing (2000:47) posited that the years surrouding menopause are associated with weight gain, incresased central adiposity and decreased physical activity. In this study, 78.4% weighed 100 kgs. and above while 38.4% were unemployed (Tables 4.2 and 4.3). Obermeyer et al., (2007:788) observed that the most frequent symptoms reported by most menopausal women are joint pain, fatigue, impatience/nervousness, sleep disturbance, memory loss and emotional symptoms. In a study conducted in Thailand, Sukwatana et al., (1991:84) it was reported that low



© University of Venda

University of Venda
Creating Future Leaders

backache and even fractures were common symptoms among menopausal women. Among black women, the most frequently presenting symptoms were muscle and joint problems and obesity Menopause: Blessing or Affliction? 2007:2). From the experience of the researcher as a nurse, the commonest symptoms that usually bring elderly women, 50 years and above, to the health facilities were joint pains, especially knee joint pain and backache. Furthermore, during the post-menopausal period, some women were brought to the surgical outpatients with pathological fractures which could be so serious and complicated to warrant the use of a Steinman's pin for the fracture to berepaired.

As shown in Figure 6, regarding available support systems for participants to mitigate the effect of menopausal challenges across the menopausal stages, the most popular source of support for the participants was the female relatives, followed by the children and the mother, if alive. It is worthy of note that the local clinic scored the lowest percentage across the groups according to menopausal status. This finding shows that issues regarding menopausal women do not feature prominently in the workload of the primary health care nurses working in the community. This is at variance with one of the important principles of primary health care, i.e. equity. It is expected that the nurses working in the community should pay equal attention to the needs of the menopausal women in their community (Sukwatana et al., 1991:84). There are so many reasons why their needs should form a priority, including the fact that elderly people constitute a vulnerable group, they are the bread winners of many families in rural communities and they are mainly illiterates who lack the basic knowledge to meet their basic need for relevant information (Obermeyer et al., 2007:788). If their needs for a good quality of life are not met, how will they be able to take care of their grandchildren who depend on them for almost everything? Today, in almost all the rural communities in South Africa, in spite of the social grants being provided by the government, the orphans and vulnerable children (OVC) depend on their grandparents or elderly female relatives for survival. Therefore, the fact that most of the participants did not mention the local clinic as their best source of support is food for thought for nurses and health policy makers in South Africa. One of the best ways to measure the success of a society is the level of attention paid to the needs of the vulnerable groups in that society, such as the handicapped the elderly and illiterate menopausal women (Sukwatana et al., 1991:84).



© University of Venda

University of Venda
Creating Future Leaders

## 4.4 CONCLUSIONS

Chapter 4 focused on results and discussions from both qualitative and quantitative studies. Both study designs developed themes or sections to discuss the findings. A gap was identified in this study that the majority of participants lacked adequate social support and education about menopause and menopausal issues. The next chapter focuses on concept analysis, the framework for the development of the model, the validation of the model and the development of guidelines to implement the model.



© University of Venda

University of Venda
Creating Future Leaders

# CHAPTER 5

# CONCEPT ANALYSIS AND CONCEPTUAL FRAMEWORK FOR MODEL DEVELOPMENT

## 5.1 INTRODUCTION

In Chapter 4 the results obtained from the interviews and questionnaire are discussed with reference to the literature consulted. The aim of this chapter is to analyse the different concepts that emerged from the data analysis in Chapter 4, describe the conceptual framework for model development, validate the model and develop guidelines to implement the model. Analysis clarifies, refines or sharpens concepts, statements or theories (Chinn & Kramer, 1999:75). The process of concept analysis involves dissecting the whole into parts for better understanding (Rodgers & Knafl, 1993:78). 'Coping' is the concept that emerged from data analysis.

The framework of Dickoff et al., (1968:434) was used to integrate the results of the concept analysis and to form the building blocks of the model. Among the six survey lists of Dickoff et al., (1968:434-435), 'coping' is viewed as a path and pattern, or steps according to which an activity is performed. Effective coping with menopausal challenges by menopausal participants will assist them to make informed decisions about their menopausal self-care deficits (menopausal challenges).

## 5.2 OBJECTIVES OF THIS CHAPTER

The objectives of this chapter are to:

- Analyse the concept 'coping' using Rodgers and Knafl's (1993:78) steps;
- Develop a graphic representation of coping;
- Classify activities according to Dickoff *et al.*'s six survey lists,
- Develop a model to facilitate women's coping with menopause;
- Develop guidelines to implement the model.



© University of Venda

University of Venda
Creating Future Leaders

## 5.3 CONCEPT ANALYSIS

Chinn and Kramer (1999:74) define a concept as a 'complex mental formulation of experiences' and state that concepts are extracted from life experiences, clinical practice or research. Concept analysis is a process of examining the basic elements of a concept. It also refers to a process that allows the examination of the attributes or characteristics of a concept through a rigorous process of analysis. Furthermore, concept analysis involves the identification and clarification of the variables and concepts around which the model will be developed, including the clarification of statements and their organisation.

In the process of concept analysis the researcher attempts to become conversant with the basic tools of thinking and understanding namely: language, terms, ideas and concepts. By beginning to identify concepts and to derive interrelationships, decisions can be made about which concepts are central to the theory (Chinn & Kramer, 1995: 74; Ridley, 2007:308). The study of the concept 'coping' is central to this study as it is a vehicle that can assist elderly women and primary health care nurses in the Mutale district of Limpopo Province in South Africa to facilitate menopausal women's ability to cope with symptoms of menopause. The description of concepts is crucial because their quality and character facilitate the understanding of the purpose of the theory, as well as the structure and nature of theoretic relationships, and definitions and assumptions (Chinn & Kramer, 1995:74). Concept analysis was conducted using the adapted steps of Rodgers and Knafl (1993:90) and Walker and Avant (2008:39) which are the following:

- Identification of the concept of interest;
- Definition of the concept of interest;
- Identification and selection of an appropriate setting and sample of data collection;
- Collection of data regarding the attributes of the concepts along with surrogate terms, references, antecedents and consequences;
- Analysis of data regarding the above characteristics of the concept;
- Identification of a model case (Rodgers & Knafl, 1993:90; Walker & Avant 2008:39).



© University of Venda

University of Venda
Creating Future Leaders

### 5.3.1 Identification of the concept of interest

Walker and Avant (2008: 40) describe the identification of a concept as a way of choosing the concept that accurately describes the participants' experiences as gleaned from the findings of research. The concept 'coping' was identified as central to this study because participants used it as a way of managing their menopausal self-care deficits otherwise referred to as challenges. The analysis in Chapter 4 reflects that there is some form of coping among menopausal participants regarding their self-care deficits.

Coping was seen when participants in the study experienced mild to severe biological, psychological and social symptoms that might or might not be troublesome, bothersome and frustrating during menopause. It was also identified that menopausal participants also managed to cope with menopausal self-care deficits by using different coping mechanisms. Some participants managed to cope with the symptoms by using internal and external factors. Others used only internal factors of coping like accepting symptoms in a positive way, while participants with a negative attitude could not cope well with the symptoms and used external factors like traditional resources and the local clinic. Those were participants that felt that the symptoms were severe and hampered the quality of their daily lives. The problem that was identified was that both participants with a positive and negative attitude were seen to be lacking accurate and proper information regarding menopause. It was then identified that all menopausal participants should be educated on health-related problems that might occur during menopause.

It was also observed that the late peri-menopausal and post-menopausal participants were aware of the changes that had taken place in their bodies and could cope with the symptoms on their own or could seek medical or traditional help if the need arose. Pre-menopausal and early peri-menopausal participants were aware of the changes in their bodies but lacked the knowledge of how to cope with the symptoms as they experienced them. The low level of knowledge of participants was found to have contributed to their inability to cope with the symptoms. It was further observed that although some participants had acquired some knowledge of the symptoms of menopause, they still suffered from severe symptoms. This implied that there were major gaps in their knowledge of coping with menopausal experiences. Before women assume they have undergone a profound personality change,



© University of Venda

UNIVERSITY OF VENDA
LIBRARY

University of Venda
Creating Future Leaders

they should become familiar with all the symptoms of menopause and begin a plan of action (Donavan, et al., 2006:1281). In this study the meaning of the concept was important as it facilitated the formation of a theoretical definition that directed the description of the model to facilitate effective coping mechanisms for menopausal challenges.

### 5.3.2 Definition of the concept of interest

'Coping' has been broadly defined in psychological terms by Bartram & Gardner (2008:228) and Lazarus and Folkman (1984:417) as 'constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing' or exceeding the resources of a person. Coping is thus seen as expending conscious efforts to solve personal or psychosocial problems, and seeking to master, minimise or tolerate stress. The concept 'coping' was first developed in animal studies and ego psychology (Lazarus & Folkman 1984:417). The Webster's New World Dictionary (1984) defines coping as, '(1) to manage or master (with) successfully and (2) to deal with something difficult, problems or challenges etc.'

Lazarus and Folkman (1984:417) offer an inclusive definition of 'coping' as part of the cognitive-transactional stress theory. They conceive of coping with stress as part of behavioural efforts to master, reduce, or tolerate internal or external demands. Coping is an effort to disengage from goals that are considered unattainable, in which the individual creates conditions that allow her/him to move forward towards desired goals (Carver, Schiever & Weitrub, 1989:267). In this definition of coping, it has been identified that menopausal participants need to make efforts to disengage themselves from unattainable goals of coping with their self-care deficits. Behavioural efforts that are required need to start from the self in order to reduce their internal demands of menopausal challenges.

Furthermore, Lazarus and Cohen (1997:272) describe coping as the action–oriented and intra-psychic efforts to manage environments, internal demands and conflicts among them that tax or exceed a person's resources. Thus coping can be perceived in terms of strategies, tactics, responses, cognitions or behaviour. Menopausal participants require action-oriented coping as without action their troublesome, bothersome and stressful menopausal self-care deficits will continue to stress them.



© University of Venda

Kelly (2010:345) indicates that coping refers to the thoughts and actions we use to deal with stress. In large part, feeling stressed or not depends on whether we believe we have the coping resources to deal with the changes facing us. Compass, Malcarne and Fonacaro (1998:405) define coping as the capacity to generate alternative solutions to cope with stressful events. It might be useful for women to believe in the available resources within their families and communities when they feel stressed with menopausal self-care deficits.

Based on Lazarus and Cohen's (1997:419) explanation of coping, the researcher suggests that coping starts as soon as a person encounters stressful events or situations. There are prominent features of coping that emerge from this definition. These are as follows:

- Coping is a process that changes continually as one appraises his/her stressful event. An event previously appraised as severely stressful may alter and be interpreted as not being stressful. For example, before menopausal participants appraise their menopausal self-care deficits as being stressful and frustrating, and once they are provided with knowledge and skills, their appraisal may indicate that their challenges are quiet manageable.
- Coping is a learned pattern of responding to stressful situations. Once menopausal participants are knowledgeable and informed they can better respond to the stressful events of menopause.
- Coping needs effort to manage a situation. Menopausal participants who were aware of their self-care deficits started to make efforts to manage them in their own way.

It is clear that researchers view coping in terms of its strategies, tactics, responses, cognitions or behaviour. In this study coping was viewed as the way menopausal participants manage their stressful circumstances as they grapple with menopausal self-care deficits to attain the demands of therapeutic self-care.

Coping implies a permanent and on-going effort to respond to the demands of a stressful situation (Lazarus, 1993:234). It can be viewed as a dynamic process where different strategies are triggered, depending on changes in the environment and in the perception of the situation.

However, it is not clear which coping strategies are most effective and how well a coping strategy serves the purpose of solving problems and relieving emotional distress. Previous research has shown that in



© University of Venda

University of Venda
Creating Future Leaders

the long run, emotion-oriented coping strategies may be less adaptive than problem-oriented strategies. Some studies have shown that the use of these strategies depends on the nature of the problem. In uncomfortable situations people tend to use more emotion-focused strategies while in controllable situations they tend to use more problem-focused strategies (Brougham, Zail, Mendoza & Miller, 2009:85; Skinner, Edge, Altman & Sherwood, 2003: 216).

### *5.3.2.1 The Coping Approaches*

Coping strategies can be classified under three categories: problem-solving/cognitive coping strategies, emotion-focused coping strategies, and avoidant coping strategies (Skinner & Zimmer-Gembeck, 2007:233). Each of these are further explained below.

- **Problem-solving coping**

Problem-solving coping refers to efforts directed at dealing with the stressor itself, whereas emotion-focused coping refers to efforts directed at managing the emotional distress caused by the threat (Odirile, Mpofu & Montsi, 2009:321).

Problem-focused coping involves efforts to provide a solution to a problem, or a way of alleviating the stressful situation (Odirile et al., 2009:321). Problem-focused coping includes active coping, planning, suppression of competing activities, restraint-focused coping, and seeking instrumental social support (Cattan, 2009:1).

Problem-focused coping alters the source of the stressor. Problem-solving or direct coping strategies are more likely to be used when the demands of a situation are appraised as controllable (Thois, 1986:416). Problem-focused coping leads to more positive long=-term adjustment for the stressed individuals. The strategy has been found to reduce job-related anxiety, lower propensity to leave a place of work and promote greater job satisfaction among professionals. Additionally, people who use problem-focused coping are more likely to show positive adaptation (Ramya & Parthasarathy, 2009:61) and should enjoy better mental health.



© University of Venda

In line with this, it would appear that menopausal participants with an inclination towards using problem-focused coping would have lowered stress levels because it is believed that problem-focused strategies are used more by well-adjusted individuals. In the current study, the majority of the late peri-menopausal participants using problem-focused strategies were regarded as using productive or effective coping strategies. This was because they were able to deal with symptoms directly when they needed to or because they were later found to adapt positively to their stressful demands.

- **Emotion-Focused Coping**

Emotion-focused coping lessens emotional distress and includes strategies such as avoidance, minimisation, distancing, selective attention and positive comparison, among others. Emotion-focused coping includes the seeking of emotional support, positive reinterpretation, acceptance, denial and turning to religion (Lazarus & Folkman, 1984:417).

Emotion-focused coping tends to be used when people feel that there is little that they can do to change a situation and they need to deal with it (Cattan, 2009:1). However, opinions differ with regard to the effectiveness of emotion-focused strategies in moderating perceived stress. On one hand, emotion-focused coping is viewed by some as being unproductive and does little to actually reduce stress. Instead, it merely increases the individual's comfort level. On the other hand, it is perceived as being productive and realistic (Lazarus & Folkman, 1984:417). It must be noted that menopausal women in this study frequently used emotion-focused coping strategies.

It seemed as if the emotion-focused coping mechanisms used by some of the late post-menopausal participants were less productive or ineffective. This was observed especially in those participants who seemed to have lost hope because of their severe, bothersome and frustrating self-care deficits and who could do nothing to reduce or manage their stress.

- **Avoidant coping**

Avoidant coping involves wishful thinking and behavioural efforts to escape or avoid a problem (Shah & Thingujam, 2008:83). Avoidant coping leads people to abuse alcohol and other substances, or to withdrawal coping strategies that keep them from directly addressing stressful events. According to



© University of Venda

University of Venda
Creating Future Leaders

Matud (2007:1401) escape and avoidance-based strategies fail to resolve the underlying problems that generate stress. They seem to lead to greater long-term distress than more active approaches. Avoidant types of coping strategies typically work against people than to their advantage. These coping strategies appear to be psychological risk factors or markers of adverse response to stressful events (Shah & Thingujam, 2008:83). Thus it is conceivable to assume that avoidant coping strategies are dysfunctional as they do not lead to healthy psychological adjustment. One can conclude, therefore that the use of avoidant coping strategies may not lead to positive emotional regulation. In this study, menopausal women who were prone to using avoidant coping strategies were regarded as using maladaptive ways of coping (Brougham et al., 2009:85; Matud, 2007:1401). The study found that some participants in their 40s used alcohol, probably because they were trying to avoid the problem.

- **Social support coping**

Social support has been variously defined as resources provided by others, as coping assistance, or as the exchange of resources perceived by the provider or the recipient to be intended to enhance well-being (Greenglass, 2000:222). In McNeely's (2006:401) study on stress coping strategies it was found that social support was considered by the majority of participants (82%) to be a major coping strategy, while 72% considered it to be effective. Thus, social support was viewed to assist coping and exert beneficial effects on various health outcomes. Social support provided measures that were prophylactic or proactive.

UNIVERSITY OF VENDA
LIBRARY

There is a large body of empirical evidence that indicates that maintaining close personal relationships with others is a social resource that can protect one against illness to a certain degree. Social support includes intimate relationships and it extends networks. For instance, pre-menopausal participants received support from peri- and post-menopausal women, who may or may not have been their friends, from work colleagues, and in particular from their families and primary health care nurses. The study found that 33.6% was the highest score of social support and emanated from female relatives. A study conducted by Matheny, Ashby & Brack (2009:481) found that social support was a central coping strategy in 54% of the studies they reviewed. It was an essential coping resource as it provided a buffering effect, protecting the person from adverse effects of stress. Research has shown that social support as a coping strategy reduces the level of perceived stress (Greenglass, 2000:222). Social support was seen as an exchange of information and the provision of emotional help. It has been found to be



© University of Venda

University of Venda
Creating Future Leaders

positively related to physical and psychological health. Social support has been found to assist people with high stress to cope better (Greenglass, 2000:222).

According to McNeely (2006:401), it is the quality of support that is important, not the quantity. For example pre-menopausal participants who perceived their menopausal symptoms to be distressful were likely to have their stress severely reduced if primary health care nurses assisted them in screening, diagnosing and curing, or by providing health education (high quality support). This was seen to be more effective than having many friends reassuring them that they would overcome the symptoms (low quality support).

Lastly, the researcher found that the support of spouses (18.5%), children (22.2%) and female relatives (33.6%) helped participants to cope with the stress brought about by menopause. The local clinic provided 11.8% of support and, together with family members, provided social support to menopausal participants by increasing their access to information, strengthening a sense of personal control, fostering self-esteem and boosting their feelings of optimism. Menopausal participants in this study used social coping strategies to moderate stress and were viewed as employing effective coping strategies that should lead to successful psychological adjustment (Helgenson, Cohen & Fritz, 2008:563).

Turning to family and friends for support was viewed as an effective strategy to reduce stress. Social coping strategies included:

- Discussions with family members and friends. In this study, menopausal participants were seen to be turning to family members such as elderly women (mother if still alive 22.5%), female relatives (33.6%) and older children (22.2%) to discuss their self-care deficits.
- Involvement in social events e.g. traditional dancing, drinking traditional beer, attending church and church conferences. Menopausal participants were able to socialise at family and community events where they drank alcohol and danced while others attended church services and church conferences (Researcher's own experience with participants, 2011).

However, it should be understood that social support from friends, family and primary health care nurses may not buffer practicum-related stress. Instead it might intensify stress with negative statements such as 'we are here to suffer' or 'there is nothing you can do about it' or 'you have not suffered yet, the



© University of Venda

worse is still to come'. These statements make the situation appear irredeemable and hopeless (Helgenson, et al., 2008:563).

- **Religious-focused coping**

Kyriacou and Pratt (2007:33) studied teachers and found that having a strong religious faith helped people to cope with stress at work, and that attending religious services were effective coping actions for them. The effectiveness of this coping strategy is empirically supported by studies that reveal a positive relationship between religious behaviours and well-being (Raab, 2007:441). The effectiveness of religious coping largely depends on whether menopausal women have rational religious beliefs or irrational beliefs about themselves. Loewenthal, et al., (2001:293) suggest that the 'ever-depressed' regarded religious activities as being less helpful than the 'never-depressed' did and that women saw it as less helpful than men did.. Gender differences in spirituality and related traits are an assumed reality despite the lack of empirical information that directly compares women and men (Bryant, 2007:9240). By studying college students, Buchko (2004:89) confirmed empirically that women experience a strong spiritual relational component of their religious faith to a greater extent than men do. Through their faith in God and prayers by pastors and priests, women were able to cope with stress and find meaning and purpose to life more than men do. In this study participants in all the menopausal groups were found to have rational beliefs about themselves, as the majority had different religious affiliations. Their faith in God, prayers by pastors who laid hands on the affected parts, and health education provided by health workers like nurses, they were assisted to cope with menopausal self-care deficits.

### *5.3.2.2 Factors affecting the use of coping strategies*

Literature has shown that the use of coping strategies might be affected to a large extent by variables such as personality and age, among other factors. However, this is not conclusive, as findings differ.

- **Relationship between coping preferences and personality traits**

Studies have shown that the ability to cope with stress depends largely on one's personality and psychological state of mind. Carver et al., (1989:267) examined the relationship between coping preferences and different personality traits.



© University of Venda

University of Venda
Creating Future Leaders

Thois (1986:416) found that the locus of control was positively associated with problem-focused coping but negatively related to emotional-focused coping, while external locus of control was positively associated with emotion-focused coping. Internal locus of control positively correlates with positive self-concept while external locus of control is individual, and induces a negative self-concept. Carver et al., (1989:267) found that individuals who tend to prefer denial and disengagement were less likely to have internal control and optimism.

It remains to be seen whether menopausal participants in the present study were also influenced in their use of coping strategies by their personalities. In this study the majority of menopausal participants were found to prefer emotion-focused coping strategies. There were participants who held positive attitudes towards menopause and those with negative attitudes. Those participants with positive attitudes were found to cope with the symptoms better than those with negative attitudes.

- **Relationship between coping preferences and age.**

Previous research has shown that there is some association between age and coping. Age was presumed to be negatively correlated with problem-focused coping responses. Older participants tended to rely on the cognitive approach (positive appraisal) and avoidant coping (distancing and escape/avoidance) and were less likely to use behavioural approach processes such as seeking social support, problem-solving and confrontation (Lau, 1994:39).

It seems as if older persons tended to use more adaptive coping responses and were less likely to vent their frustration on others than younger persons. More mature respondents constantly used more passive, interpersonal and problem-focused strategies (Lazarus & Folkman, 1984:417). Conversely, other studies have found that there was a negative association between age and coping; for example, no significant differences were found for rational action, help-seeking, perseverance, expression of feelings, denial, avoidance and withdrawal (Lazarus & De Longis, 1983:282).

In this study the peri-menopausal (39.9%) and post-menopausal (34.9%) groups of participants were found to suffer forgetfulness owing to age, and projected their frustration on family and community members. Some peri-menopausal (50.6%) and post-menopausal (57.1%) participants seemed to be more



© University of Venda

adaptive to coping with forgetfulness as self-care deficits because they had suffered from the symptoms for a long time.

### *5.3.2.3 Common strategies for managing menopausal self-care deficits*

- **Physical and psychological strategies**

It was observed that participants in this study frequently used the following strategies to cope with menopausal self-care deficits: problem-focused coping where they could deal directly with the stressors by drinking cold water, seeking cooler environments, engaging themselves in household chores or working in the fields. Others used emotion-focused coping by resorting to sleep, while others projected their emotions at family members, friends and neighbours. Regarding sexual relationships with spouses, participants avoided intimacy and suppressed their desire for sex. There were those who took medication from the clinic or used traditional herbs. These findings are not unusual as seeking physical and psychological help has been found to be positively related to adaptive coping and has been found to assist those with high stress levels to cope (Greenglass, 2000:222).

- **Social support**

Social support includes intimate relationships and it extends to networks. For instance, pre-menopausal participants in this study were supported by elderly peri- and post-menopausal participants, who had experienced menopausal self-care deficits themselves. The peri-menopausal and post-menopausal participants were supported by their friends, work colleagues, family members and primary health care nurses. A study conducted by Matheny et al., (2009:481) found that social support was a central coping strategy in 54% of the studies they reviewed. It was an essential coping resource as it provided a buffering effect, protecting the person from the adverse effects of stress. Research has shown that social support as a coping strategy reduces the level of perceived stress (Greenglass, 2000:222). Social support is seen as the exchange of information and the provision of emotional help. It has been found to be positively related to physical and psychological health, and indispensable for individual growth and the fostering of personal development Thompson, Murphy, Stradling (1994: 81); Durkin, Bascomb, Turnbull & Marley, 2003:89). In addition, social support is known to assist people with high stress



© University of Venda

University of Venda
Creating Future Leaders

levels to cope and adapt themselves to a new situation (Greenglass, 2000:222). Social support was also found to increase the ability to handle stress (Brougham et al., 2009:85; Skowron, Wester & Azen 2004: 69).

- **Self-efficacy**

Self-efficacy is the confidence or beliefs/values that individuals have that they can control events or cope with stressful demands. Perceived self-efficacy is also regarded as optimistic self-belief or perceived competence (Greenglass, 2000:222). It is the appraised perceptual match that people make between the demands and the ability to cope with stress. Pre-menopausal participants were found to experiment with the strategies learned from elderly women and primary health care nurses. This means that the strategies might not have been as efficacious owing to the lack of experience and lack of competence (Greenglass, 2000:222). On the other hand, in this study the peri-menopausal and post-menopausal participants, entered into the menopausal state bringing with them their own amalgam of beliefs, thoughts and knowledge gained from their families and community. Furthermore, menopausal women might not exhibit their acquired skills if they lack beliefs in their capabilities. However, it must be remembered that the majority of the participants in this study were not empty handed and hence the information and experience they already had made them have confidence in themselves. The late peri-menopausal and post-menopausal participants adapted well and controlled the stress brought about by menopausal self-care deficits.

### 5.3.3 Identification and selection of an appropriate setting and sample for data collection

An appropriate setting in a research project refers to the time period examined and types of literature included in an analysis (Rodgers & Knafl, 1993:90). The appropriate setting and context for this study was the cultural context of a community, the families and health care facility where sharing of coping strategies between menopausal participants, elderly women and primary health care nurses was supposed to take place. The sample for analysis was drawn after relevant literature that discussed coping was studied in dictionaries, books and journals (both national and international) and analysed to arrive at a theoretical definition. The theoretical definition directed the description of the model.



© University of Venda

University of Venda
Creating Future Leaders

### 5.3.4 Collection of data regarding attributes of the concept antecedents and consequences

Rodgers and Knafl (1993:90) describe this step as a phase which reflects all possible sources that were reviewed in the clarification of the concept. Different literature was consulted in trying to clarify the concept of 'coping'. The literature consulted included books, journal articles, subject dictionaries and internet searches. The researcher used primary and secondary sources in trying to gain more insight into the meaning of 'coping'. The search strategy for these different sources was based on the term 'coping' itself within different contexts, as information of how coping is defined in menopause was limited. Most of the literature defined 'coping' in a related or similar manner. An inclusive definition of coping is viewed as part of the cognitive-transactional theory of stress. Coping was conceived as part of behavioural efforts to manage, adjust, control, or tolerate demands whether internal or external.

Coping is an effort to disengage from goals that are considered unattainable, in which the individual creates conditions that allow her/him to move forward towards desired goals. In this definition of coping it has been identified that menopausal participants needed to make efforts to disengage themselves from unattainable goals of coping with their menopausal self-care deficits. Behavioural efforts that were required needed to start from the self in order to reduce their internal demands concerning health-related challenges. Coping was also conceived as the action–oriented and intra-psychic efforts to manage environments, internal demands and conflicts among them, which taxed or exceeded a person's resources. Therefore, coping can be perceived in terms of strategies, tactics, responses, cognitions or behaviour. Menopausal participants in this study required action-oriented coping as without action their troublesome, bothersome and stressful menopausal self-care deficits would continue to be stressful.

### 5.3.5 Critical attributes of coping

Critical attributes are the characteristics that are common to all instances of the concept being analysed, differentiating it from similar or related concepts. The researcher should be aware of the social context in which the concept is generally applied to illuminate more features of its usage. Furthermore, the researcher should determine whether the stated concept has more of certain features in the current study, such as in a model of coping with menopause (Walker and Avant, 2008: 40). In this study the critical attributes of coping are adaptation, mutual understanding, and active participation between the



© University of Venda

University of Venda
Creating Future Leaders

participants, elderly women and primary health care nurses. They were found to be common characteristics of the concept 'coping' in the findings of the study.

- **Adaptation**

Adaptation is a state of adjustment to a new situation or environment because of an alteration of behaviour (Webster's New World Dictionary 1984; Bosworth et al., 2003:32). In this study participants with partial or complete self-care deficits started gradually to adapt to either partially or wholly compensatory nursing systems to accomplish their self-care demands. The new information they received from the elderly women and primary health care nurses enabled them to adapt to the new environment of information and behaviour. The late peri-menopausal and post-menopausal participants tended to rely on a cognitive approach (positive appraisal) and avoidance (distancing and escape-avoidance) coping. This was in contrast to the early peri-menopausal participants who used behavioural approaches such as seeking social support, problem-solving and confrontation. This was probably because they were still young and focused as they had goals to achieve. In this study, menopausal participants seeking physical and psychological help were found to be positively related to adaptive coping and that assisted them to cope better with the severe stress of menopause.

- **Mutual understanding**

Understanding is defined as the power or capacity to comprehend general relations in a particular situation or environment. Mutual understanding means sympathy for each other, relations between people or affinity or harmony (South African Oxford School Dictionary 2004). In this study, the majority of late peri- and post-menopausal participants seemed to understand the concept 'menopause'. Their understanding of the concept was mostly related to aging and not to menopause per se. The reason for this seems to have been that they regarded the cessation of menses was associated with aging. There is therefore, a need for elderly women and primary health care nurses to develop mutual understanding of the concept 'menopause'. Both parties should have a common understanding of the concept and challenges brought about by their experiences of menopause. Information and whatever discussions that take place about menopause should enhance their mutual understanding of menopause and menopausal issues. They should be able to freely share information on this sensitive subject regarding menopause.



© University of Venda

Once a common understanding is reached, action will take place to achieve a goal of effective coping with menopause.

- **Active participation**

Menopausal participants, elderly women and primary health care nurses actively participated in supporting each other regarding issues of menopause. All parties should openly share the little information they have in order to support those pre-menopausal women who have no information at all. Active participation would also imply that each one of the parties should be actively involved by providing new information related to menopause. Because menopausal issues are sensitive it implies that participants should put aside their shyness and reserve.

- **Independence**

Independence refers to a state of liberation from dependence. The aim of teaching people is to promote their independence as much as possible (Hill & Howlett, 1993 as cited by Muniski, 1999:25). In this study, inexperienced menopausal participants can be viewed as having menopausal self-care deficits and might need nurses to provide them with the necessary support and guidance to their independence. In other words, when the women face menopausal challenges and are unable to entirely cope with them, they depend on nurses for guidance and support (to enable them to go from a state of dependence to the one of independence). The menopausal women depend on nurses when they visit health care facilities with self-care deficits. Nurses with specialised skills and knowledge will assist them by providing guidance and support until they are independent. The nurses should assist the women towards independence by demonstrating clinical skills, guiding, directing, providing physical and psychological support and creating an environment of personal independence and development. Menopausal women need to show independence in self-care, long-lasting changes in health-related behaviour, empowerment with knowledge and skills for self-care, self-efficacy, self-esteem, self-actualisation, ability to identify self-care deficits related to menopause and the ability to make informed decisions regarding their health as far as menopause is concerned.



© University of Venda

University of Venda
Creating Future Leaders

### 5.3.6 Identification of surrogate terms

Rodgers and Knafl (1993:83) define 'surrogate' as a philosophical position in that a concept may be expressed in different ways. During data collection it was revealed that surrogate terms for the word 'coping' were: strategies, tactics, responses, cognitions and behaviours.

- **Strategies**

Strategies are ways, measures or methods of dealing with stressors or stressful events (Shah & Thingujam, 2008:322). In this study, many strategies were identified for coping with menopausal self-care deficits. These strategies were developed by participants themselves in dealing with their own menopausal self-care deficits where they managed to cope with the symptoms of menopause in their own way, including the use of physical and emotion-focused coping. Participants were able to deal with the stresses of menopause directly or would avoid them by resorting to dancing, drinking traditional beer or projecting their stress on others. Teaching or seeking information from elderly women and primary health care workers were also seen as coping strategies used by the participants. Others resorted to attending church functions, using tea or herbal medication and prayers from pastors, while others, like the late peri-menopausal and post-menopausal groups used avoidance strategies (avoidance of intimacy). These strategies were found to be ineffective in dealing with menopause because participants were pretending to avoid intimacy while they still wanted to be with their spouses. However, because of culture taboos, they resorted to avoiding their partners whom they still loved dearly.

- **Tactics**

Tactics, according to the Webster's New World Dictionary (1984) means ways of dealing with stressful events. In this study the concept 'tactics' was used as a way of attacking the menopausal symptoms that were bothersome and/or severe. Participants would immediately think of a quickest way of dealing with a bothersome symptom in order to be relieved of the symptom.



© University of Venda

University of Venda
Creating Future Leaders

- **Responses**

Response means that one is responding to or answering what is being asked by the next person. In this study participants were seen to respond to new symptoms by finding ways to cope with them. Participants were also seen responding to questions asked by primary health care nurses by giving honest and truthful information regarding bodily changes they had experienced.

- **Cognitions**

Cognitions imply conscious thinking about dealing with stress (Webster's New World Dictionary, 1984). Participants were consciously able to recognise and become aware of new changes in their bodies. This assisted them to deal with the stress of severe symptoms when they experienced them.

- **Behaviour**

When participants became aware of bodily changes, they started to adapt to the new changes and behaviours. This was due to new information provided by elderly women and primary health care nurses that helped them to achieve their goal of effectively coping with the symptoms. Change in behaviour implies positively accepting bodily changes and showing readiness to deal with stress directly. Behavioural change should start from the self in order to deal with the internal and external demands of menopause. This could be achieved through the support of the family, community and health care facilities and the information they provide.

UNIVERSITY OF VENDA
LIBRARY

### 5.3.7 Antecedents and consequences

Antecedents are those events that must take place prior to the occurrence of the concept (Walker & Avant, 2008:73). Effective coping can only take place if the following antecedents are fulfilled: openness, honesty, mutual trust, active involvement and willingness to learn.

For effective coping to take place participants must be open to new information, and honest in the type of information that they share with each other; they should develop a mutually trusting relationship and be able to share their visions of the future. More importantly, participants should be actively involved



© University of Venda

University of Venda
Creating Future Leaders

and be willing to grow through risks. One participant said: *This is very strange to me; I think I need information on this aspect. Maybe we as youngsters are ignorant about our life and health in future thus we need to be educated adequately and we are willing to learn.* Willingness of the participants to learn could assist them to utilise the coping model more effectively with the help of elderly women and primary health care nurses.

Consequences refer to those events or incidents that follow as a result of the occurrence of the concept, and which is the outcome of the concept (Walker & Avant, 2008:73). The consequences in this study included independence in self-care, long-lasting changes in health-related behaviours, empowerment with knowledge and skills for self-care, self-efficacy, self-esteem, self-actualisation, ability to identify self-care deficits related to menopause, and the ability to make informed decisions regarding their health as far as menopause is concerned.

### 5.3.8 Identification of related concepts of interest.

Related concepts refer to ideas that are similar to the concept being analysed, but have subtle differences when examined closely (Ridley, 2007:203). The following were identified as concepts that were used interchangeably with the term 'coping': manage, adjust, reduce and control.

- **Manage**

To manage, according the Webster's New World Dictionary (1984), is to achieve something or direct an activity to succeed in accomplishing a goal, especially with difficulties, or to continue to deal with a problem. Managing menopausal self-care deficits was used as a type of coping by menopausal participants. They used different strategies to manage the symptoms, despite their severity and frequency.

- **Adjust**

According to the Webster's New World Dictionary (1984), master refers to control, and occurs when one has overcome something or has been expected to be in control of something or gain control of something or someone. In this instance, menopausal participants managed to control the intensity of pains when they were severe. They also managed to control their emotions caused by menopause in



© University of Venda

University of Venda
Creating Future Leaders

times of turmoil. The peri- and post-menopausal participants were able to adjust to the symptoms as some felt it was God's way of doing things and thus they felt they were matters beyond they strength.

- **Minimise /Reduce**

The action of lessening of severity or intensity/strength, or the act of reducing something unpleasant e.g. pain (Webster's New World Dictionary, 1984). When menopausal women experienced bothersome and severe symptoms, they took some action; for example, they used traditional coping strategies to reduce pain. The majority of the participants used traditional herbs while others opted for prayers and church tea as a means of reducing the severity of the symptoms. There were those who could travel to the local clinic to consult when in pain and were given medication to reduce or minimise the pain. Those who could afford to do so visited specialists or general practitioners in town for better and more effective treatment.

- **Efforts**

This means the use of physical or mental energy, the act or results of trying to do something (Webster's New World Dictionary, 1984). For example, participants used their efforts to physically and psychologically deal with menopausal self-care deficits. They did not merely look at the severe and troublesome symptoms affecting their quality of life; instead, they devised efforts to deal with them.

- **Tolerate**

According to the Webster's New World Dictionary (1984) 'to tolerate' is to endure or resist an action without serious side effects or discomfort. For example, the participants tolerated the severe and unbearable menopausal self-care deficits as a way of coping with the symptoms. The late peri- and post-menopausal participants had their own traditional ways of dealing with the symptoms of menopause and could tolerate them as a way of coping. These symptoms did not bother them anymore as they had already devised means of tolerating them. The pre-menopausal and early peri-menopausal group had difficulties tolerating the symptoms, as they felt embarrassed when they were affected by them in front of strangers.



© University of Venda

University of Venda
Creating Future Leaders

### 5.3.9 Analysis of data regarding the characteristics of the concept 'coping'

Data drawn from the definition of the term 'coping' was analysed for similarities and differences. The researcher read through the meaning of coping in literature. Common words were underlined and clustered. Clusters were developed and themes were defined as reflected in Table 5.1.

Theme one describes the *awareness of self-care deficits*. The antecedents included were the following: being aware, worried, shocked, afraid, stressed, avoidant, angry, depressed, accepting (Kubler-Ross, 1969). Premenopausal participants who experienced changes in their bodies for the first time owing to menopause became shocked. They became afraid or had fears of no longer being attractive or of old age, had feelings of denial and anger with depression that impaired their self-confidence, but later they accepted the changes.

**Table 5.1: Themes and subthemes**

| CHARACTERISTICS OF PHASES OF COPING | THEME | SUBTHEMES |
|---|---|---|
| **PHASE 1: AWARENESS** | Awareness of self-care deficits | Being aware, shocked, afraid, worried, stressed, avoidant, in denial, angry, depressed and accepting (Kubler-Ross, 1969). |
| **PHASE 2: ACTION** | Action for coping towards independence | Openness, honesty and communication (Lazarus & Cohen, 1997). |
| **PHASE 3: ADAPTATION** | Adaptation of coping | Adaptation, responsible and willingness to grow (Carver, et al., 1989). |
| **PHASE 4: SELF-EFFICACY AND SELF-ACTUALISATION** | Effective coping with menopause | Self-efficacy, self-esteem and self-actualisation (Greenglass, 2000:222). |

Theme 2 describes the *action for coping towards independence* with menopausal self-care deficits. The following antecedents included openness, honesty, communication and active participation (Lazarus & Cohen, 1997:417). Participants experiencing menopausal self-care deficits had their own ways of



© University of Venda

University of Venda
Creating Future Leaders

dealing with the challenges, but they still needed to be open, honest and to participate actively when they communicated and shared information on menopause.

The third theme describes *adaptation of coping* with menopausal self-care deficits. Included in these antecedents were adaptation, being responsible and willingness to grow (Lazarus & Cohen, 1997:417). When adaptation is related to coping, it implies that the participants in the study constantly and continuously adapted to new changes in their bodies. They had to be responsible for their own health in order to cope effectively. They should also have shown that they were willing to grow.

Lastly, Theme 4 describes *effective coping with menopause* as an effort to disengage from unattainable goals. Based on the characteristics described, Carver, et al., (1989:267) suggest that effective coping means that the participants should strive to attain their desired goals of overcoming the challenges they faced. Thus, the antecedents included in this phase were: self-efficacy, self-esteem and self-actualisation. Effective coping could be achieved if participants showed self-efficacy by being able to control their menopausal self-care deficits, had improved self-esteem because they had managed to overcome their problems and had achieved their goals of effective coping, and self-actualisation because they had managed the stress of their menopausal self-care deficits.

### 5.3.10 Identification of a model case

Walker and Avant (2008:73) describe a model case as something that enables one to distinguish essential from non-essential features. Model cases can be drawn from literature, art or film or any other context in which the concept is accurately symbolised. A model case for this study was developed to reflect the real-life situation in which coping took place. This scenario created greater understanding of the concept as it reflected how the concept was identified. Examples of model cases are as follows:

*I am still a working woman and I do not like smelling urine at all and because I have frequency I am forced to bath twice a day, in the morning when I go to work and immediately I am from work.*
*I am staying with my three grandchildren and we always fight for the money lost. I will accuse and blame them of stealing when it is my fault forgetting where I put it. Shame poor kids they are now used to me and my accusations.*
*A nurse at our church conference gave us a health talk on menopause. She talked about the symptoms of menopause and how to cope with them. Since then I accept it and keep myself busy at the farms as*



© University of Venda

*part4of exercise. By the time I reach home, I am tired, have no time to listen to my body and after supper I sleep.*

*At this stage, in the villages, you are not expected to have sexual relationships because culturally menopause is associated with old age and no desire for sex.*

One of the early peri-menopausal participants expressed it differently: *I am still sexually active as I am still young, suppressing my sexual desire could be a problem both to myself and my husband.* Through probing she said, *Yes I love and respect my culture but it should not dictate what I should do in my house especially private matters like sex. My husband would not approve of it, he works in town and when he returns sex is sex.*

One peri-menopausal participant who had some information said: *My grandmother mentioned something to do about it some years back and some friends also discussed about it in my presence. Both did not say much probably because this subject is taboo in our culture and in the villages.* Through probing she said: *People in our villages are reluctant to talk about things that are taboo. But there are also some misconceptions about it like we should not have sex with men as the stomach will bulge, certain food is not to be eaten like beans as they increase the flow of blood.*

The following response by a late post-menopausal participant typifies this notion: *I simply take my time to unbend and if severe I go to the clinic for medication.*

A post-menopausal participant added, *We lack proper information and knowledge regarding menopause and how to effectively cope with the symptoms especially if they are severe. Even our clinic nurses seem to lack information on what to prescribe for menopausal self-care deficits. We thus require more support to deal or cope with the symptoms.*

The following responses from participants during the focus group interviews exemplify these notions in the context of menopausal strategies developed by menopausal women as a way of coping with their symptoms. This was evidenced by the following citations: *I am unable to sleep at night because the hot flushes would come when I am fast asleep and I would have sleeplessness. I hardly use a blanket at night*



© University of Venda

University of Venda
Creating Future Leaders

*but I use a cloth to cover my waste and bum only. My feet and upper body remain uncovered for the rest of the night and I will feel a bit cool.*

Another post-menopausal participant who supported her said: *Err you see, I am familiar with traditional herbs my grandmother taught me when she was still alive. I know what to look for in the bush, herbs for the relief of some menopausal symptoms like joints and back problems.* Through probing she continued to say: *Returning from the bush, I wash the herbs, dry, grind and boil them. You need to drink a table spoon twice daily and after a few days you begin to feel some relief.*

## 5.4 CONCEPTUAL FRAMEWORK FOR MODEL DEVELOPMENT

### 5.4.1 Six elements of the practice model

The following list provides the identification of the practical activities in relation to the six survey lists of questions suggested by Dickoff et al., (1968:426):

1. In what context is the activity performed? Community cultural context, family context and the health care facility
2. Who or what performs the activity? Menopausal women and elderly women or primary health care nurses (PHCN)
3. Who or what is the recipient of the activity? Menopausal participants
4. What is the energy source of the activity (underlying dynamics)? Awareness, worry, openness and acceptance
5. What is the guiding procedure/process? The procedure/process for coping involves mutual trust, mutual interaction, role awareness and empowerment between menopausal participants and elderly women and primary health care nurses
6. What is the end point of the activity? Menopausal women should achieve effective coping using identified coping strategies and they should be able to adapt to their new situation, have self-efficacy, self-esteem, self-actualisation, be responsible and willing to grow so that they can make informed decisions about their own health.



© University of Venda

University of Venda
Creating Future Leaders

### 5.4.2 Framework/context

The context is viewed from the perspective of the matrix of activity. It is seen in relation to other factors, including persons and activities, and in the interrelation of these other factors as constituting an organism, unity, or total context of activity (Dickoff, et al., 1968:426). The context consists of the cultural context of the community, the family and the health care facility within which coping with menopausal experiences is expected to take place (Figure 7). Common factors have been identified in the entire context where coping is supposed to take place. These include the following:

- The norms, beliefs, values and attitudes that are based on the strong cultural beliefs of all people involved;
- The clear description and acceptance of roles for each person involved;
- Poor dissemination of information within communities that is reflected by a lack of knowledge and skills of the participants;
- Poor strategies for enabling coping with menopausal challenges.

Coping with menopause is influenced by all these activities that are to be carried out by menopausal women, family members and primary health care nurses. They should therefore be taken into consideration during the development of the model to facilitate women's coping with menopause.

***Community cultural context***

This context is important because socio-cultural beliefs that are shared by the community have an influence on beliefs of how coping with menopause should be conducted. The socio-cultural beliefs of the community in which this study was undertaken impose certain rules on members. The role of members of the family with regard to discussions around issues of menopause is also culturally determined. This context therefore interferes with the way in which coping can be facilitated at both the health care facility and home. The community believes that it is taboo to talk about menopause with elders, and there is therefore an absence of communication. The community also believes that menopausal issues are mainly talked about during initiation when the child has reached puberty. It is also believed that no one can talk to menopausal women about menopause except their colleagues, friends and leaders at church conferences. This is disturbing because in most instances women are found



© University of Venda

University of Venda
Creating Future Leaders

to be acting by trial and error about their lives. In addition it means that such discussions could occur only once without any follow-up and thus there would be no important reinforcement about a number of unclear issues about menopause.

***Family context***

According to the systems approach, the family is defined as a unit composed of interrelated parts (Anderson, 1999). The interrelated parts are formed by members of the family such as the husband, wife, children and other extended family members, if any. Each of the family members has a role to play for the survival of the whole family. The family is one of the contexts within which coping with menopausal challenges should take place. The context is characterised by the different roles that each person plays with regard to the social support and care for menopausal women. These roles include teaching women about different aspects of life, including menopause. The type of support and caring for menopausal women occurs when they experience severe and agonising body pains owing to menopause. It is very important to understand this context so that the model will attempt to address the very important dynamics involved in engaging menopausal women in menopausal issues. The family context is also characterised by inequality between elderly women and mid-life menopausal women. Talking about menopause requires both parties to function at the same level which can be difficult for elders because of cultural issues involved. The family also consists of siblings, aunts and uncles who could be the source of both negative and positive influences on menopausal women. These members of the family can be involved in support mechanisms to make the model more effective.

***Health care context***

The health care context involves diagnosis, prescription of treatment, health education, quality patient care, home visits and professional development. This is the context in which menopausal women receive formal health education. Among the topics that primary health care nurses are expected to cover is health issues of menopause. The health care context was found to be not conducive to educating about menopause. From the data analysed it was found that primary health care nurses themselves lacked adequate knowledge, skills and information about menopause and the materials needed to teach the subject were not available. All these factors did not promote an environment for effective coping with



© University of Venda

University of Venda
Creating Future Leaders

menopause. The health care context focused on prevention, promoting and curative aspects of improving the health of the community. It also functioned within the community's cultural context and the cultural beliefs also impacted on how coping with menopause was managed at the health care facility. So, during provision of health care, health care professionals worked collaboratively with providers of alternative medicine, namely, traditional and faith healers. Hanson and Hilde (1989:127) propose that clinicians are needed to model this dynamic transaction between personal knowledge and the clinical situation. The health care staff at the rural clinic should have more information about the community in terms of resources, cultural and ethical norms, and community needs. It should also be noted that elderly women and some primary health care nurses were also menopausal women and therefore they were also influenced by the family values and norms which dictated how they communicated issues of menopause at the health care facility.

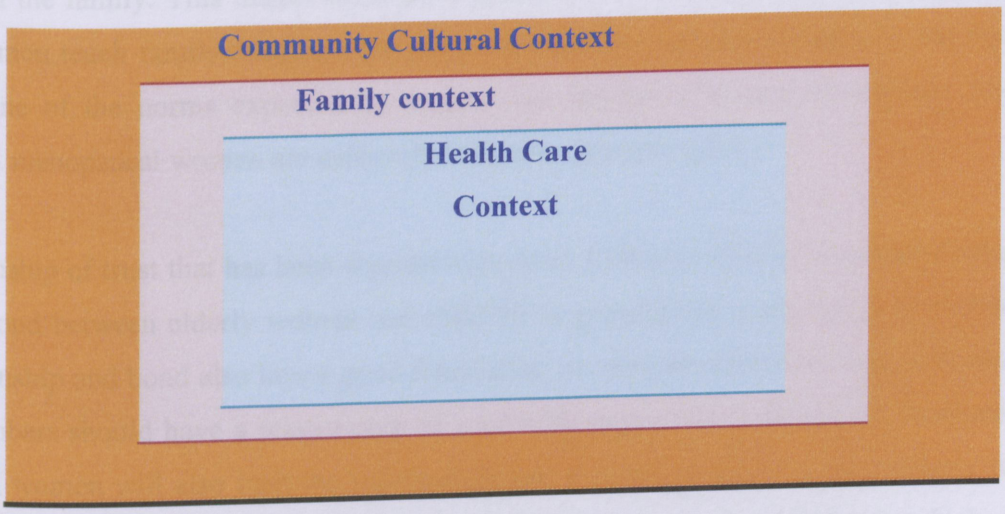



**Figure 7. The context of coping**

### 5.4.3 Self-care agents and recipients

- **Self-care agents**

In this study self-care agents were elderly women and primary health care nurses whose activities contributed towards the realisation of the researcher's goal to develop a model to facilitate women's



© University of Venda

University of Venda
Creating Future Leaders

coping with menopause. Elderly women and primary health care nurses functioned as self-care agents because they both had experience, skills and were educated regarding issues of menopause. Elderly women had also gone through the menopause. These self-care agents could also be classified into two categories, namely primary self-care agents who were elderly women and secondary self-care agents who were primary health care nurses.

***Elderly women as primary self-care agents***

Elderly women form part of the extended family, thus together with the family and the community context define who they are and what their roles are. This means that the community and family cultural practices influence how, what and when they should discuss issues related to menopause with midlife women. Elderly women within the family have an abundance of information and skills needed by members of the family. This makes them good agents for the care and support of menopausal women. Elderly women teach family members the norms and values expected of them by the community. For example, one of the norms expected by society was behaviour during menopause. Such behaviour ensures that menopausal women are culturally valued by the community.

The relationship of trust that has been formed over years within the family is usually strong and there is a healthy bond between elderly women and children or grandchildren who grow to be midlife women. This relationship and bond also lays a good foundation for support offered to cope with menopause. The family members should have a relationship of trust with each other to be able to facilitate coping. The menopausal women will also trust the information that is given to them by their elderly relatives. This was confirmed in the data analysis where menopausal participants indicated that they lacked information on menopause. They said that they would like people with information and experience whom they trusted to share information about menopause with them. It is therefore correct to say that elderly women are primary agents in the facilitation of support for coping with menopause.

***Primary health care nurses as secondary self-care agents***

Primary health care nurses are usually the first people to be consulted when women experience difficulties regarding their menopausal experiences. During consultation they are able to diagnose,



© University of Venda

prescribe treatment, give health education and make follow up visits in the communities. Nurses are often regarded as mothers because of their role in health care facilities. They also impart knowledge and skills to female patients who might be menopausal. Therefore it is important to provide information that will ensure that they also become knowledgeable menopausal women. Health education on coping with menopausal challenges is also central to the teaching nurses provide to prevent women from suffering severe menopausal symptoms like severe back and joint pain, incontinence and frequency of urinating, and others. The model that is to be developed will assist the agents to facilitate menopausal women to cope with menopausal self-care deficits.

- **Recipients**

Menopausal participants in this study are the recipients. They receive action from the self-care agents (elderly women and primary health care nurses) to achieve a certain goal. The goal is for them to effectively cope with their menopausal self-care deficits. Menopausal participants as recipients were aware of their health care deficits, hence they needed guidance and support in this regard. They needed to be open and to be able to communicate with the primary health care workers in order to achieve their goals. It was imperative that there should also be participative interaction between the agents and recipients. Figure 8 below, illustrates the structure of the self-care agents and recipients.

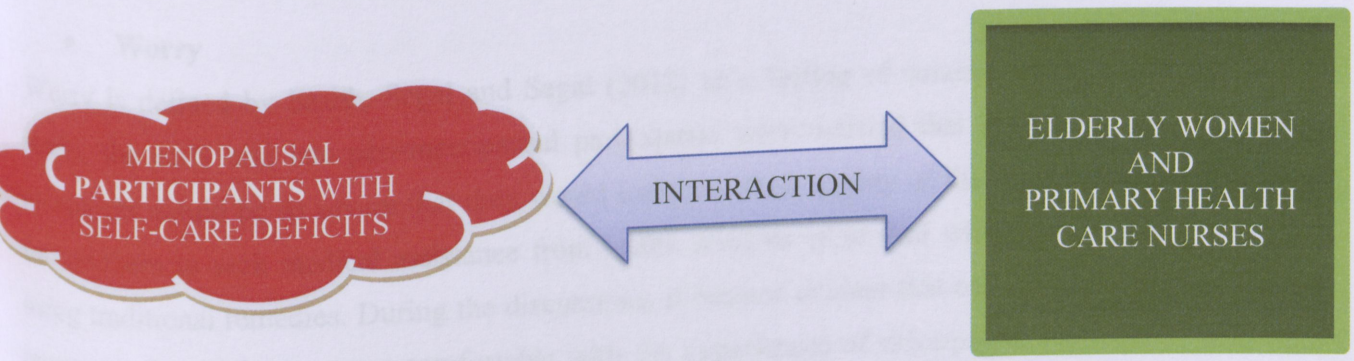



**Figure 8. Structure of self-care agents and recipients**



© University of Venda

University of Venda
Creating Future Leaders

### 5.4.4 The dynamics

According to Dickoff et al., (1968:426), dynamics are the power sources for the activity. They can be chemical, physical, biological or psychological for any person or thing functioning as an agent, patient or part of the framework in realising the goal. The dynamics that emanated from this study were awareness, openness, worry and acceptance, as shown in Figure 9, below.

- **Awareness**

Awareness, according to the Webster's New World Dictionary (1984), implies being cognisant, sensible, awake, watchful or vigilant. It also implies knowledge gained through one's own perception or by means of information. Participants needed to be aware of their menopausal self-care deficits in order to effectively cope with them. Self-awareness of bodily changes should assist in identifying the symptoms that may appear suddenly or gradually. Participants needed to communicate these openly to an agent in order to receive effective advice on coping with the challenges. On the other hand, elderly women and primary health care nurses should have assisted the recipients by making them aware of changes in their bodies by being open and honest during the conversation. This would have avoided a negative impact of the symptoms on the recipients.

UNIVERSITY OF VENDA
LIBRARY

- **Worry**

Worry is defined by Smith, Segal and Segal (2012) as a feeling of concern about something. In this study, the early and late peri-menopausal participants were worried that some physical menopausal symptoms would be so severe that they would influence their quality of life. Some physical symptoms forced them to seek medical assistance from health services or to deal with them in other ways, like using traditional remedies. During the discussions, it became evident that one could not assume that all menopausal participants were comfortable with the experiences of menopause. Participants who were worried about the symptoms of menopause should be encouraged to truthfully and honestly open up to elderly women and the PHCN in order to alleviate their fears and worry.



© University of Venda

University of Venda
Creating Future Leaders

- **Openness**

Openness involves being transparent, being willing or ready to receive (Webster's New World Dictionary, 1984). Honesty is a positive attribute that involves being open to share exactly how one feels and not telling lies or deceiving the other person (Cheung, 2008:81). For effective coping to take place pre- and early peri-menopausal participants who were still not sure of the bodily changes they should be open to the elderly women and primary health care professionals in order to receive new information. They should not be shy or afraid to talk to them. Participants should be able to openly tell the truth about their feelings, thoughts, beliefs and values. They should make their points clear until they are satisfied about the information they require. On the other hand, the primary health care professionals and elderly women should also be willing to be open to menopausal women by honestly sharing even sensitive information and skills. Primary health care professionals and elderly women should be able to encourage menopausal women to be open during the discussions so that the discussions can be fruitful and achieve effective coping with menopause.

- **Acceptance**

Some pre- and post-menopausal participants in this study showed acceptance of the symptoms of menopause they experienced. A few of them and the pre-menopausal group did not accept the symptoms well, as some symptoms were severe that influenced their quality of life. No matter how severe, troublesome and embarrassing the symptoms may be, all women need empowerment regarding menopause in order to adjust to the symptoms and behaviour change. Midlife menopausal women should allow elderly women and primary health care nurses to empower them with adequate information regarding menopausal issues and to learn from women in case they have some information of the matter. All menopausal women should establish a trusting and respectful relationship with each other in order to achieve a goal of effective coping with menopause. Once empowered, acceptance of symptoms, no matter how severe, will be tolerated.



© University of Venda

University of Venda
Creating Future Leaders




**Figure 9. Dynamics for effective coping**

### 5.4.5 Procedure of effective coping

The procedure is viewed as the activity from the vantage point of the principle, rule, routine or protocol governing the activity, to emphasise the path, steps and pattern according to which the activity is performed (Dickoff, et al., 1968:426). The activities that are viewed as being important for coping involves mutual trust, mutual interaction, role awareness and empowerment between menopausal participants and elderly women/health care professional.

- **Mutual trust**

Mutual trust involves both parties engaged in a trusting relationship with each other. Menopausal participants should feel secure and not have doubts, be able to trust the primary health care professionals and elderly women when sharing information with each other. The primary health care professionals and elderly women should also trust and accept menopausal participants' feelings, beliefs and values when sharing sensitive matters regarding menopause. The environment where the discussions on menopause will take place should be conducive to build trust by being peaceful, quiet and restful to enhance trust.



© University of Venda

University of Venda
Creating Future Leaders

- **Mutual interaction**

Effective coping should be a mutually interactive process whereby both the agent and recipient should interact together. Effective coping cannot be achieved if other participants do not participate. Both parties should honestly open up their views and opinions not conceal them as this could hamper communication. Elderly women and PHCN could encourage interaction through probing questions from the menopausal participants who could show shyness and quietness. Probing could also assist menopausal participants to disclose those frustrating, stressing and troublesome events due to menopause. It is also important for the parties to continuously interact with each other on an ad hoc basis to clarify misconceptions, myths and ambiguous information that confuses their understanding of menopause.

- **Role awareness**

In this study, different people played different roles to facilitate coping of menopause by menopausal participants. Their involvement in the study was important as each party was able to assist menopausal women to better cope with the challenges of menopause. The elderly women were able to even assist with clarifying myths, misconceptions and misunderstandings that prevailed within the communities and families regarding menopause. Whilst on the other hand, the PHCN provided scientific knowledge of issues surrounding menopause. The menopausal participants' role was to be aware of changes that take place in their bodies and inform the agents of those changes that were severe and could not deal with them, or changes that impacted negatively on their quality of life.

- **Empowerment**

Rogel's 21st Century Thesaurus (2012); Jones and Meleis (1993:1) defines empowerment as enabling, equipping, emancipating and enfranchising. Empowerment occurs between two or more people, the person who empowers and the one who is being empowered and both benefit from the process (Muller, 2001:221; Smeltzer & Bare, 2003:215). In this context empowerment should be to enable, equip and emancipate menopausal participants on effective coping with menopause by elderly women and PHCN. Their interaction should be on equal footing, respecting each other's knowledge without competing. This spirit encourages them to consult one another for advice when the need arises. Menopausal



© University of Venda

participants should also show readiness and willingness to be empowered by elderly women who have information and experience and professional knowledge by PHCN. Elderly women and PHCN should acknowledge that certain menopausal women are experiencing serious problems of menopause that maybe bothersome, troublesome and uncomfortable.

Recipients should also acknowledge that coping with menopause is no longer a private matter but a community problem that should be addressed by all menopausal participants in the community. All parties should acknowledge that if there are midlife women or younger women experiencing menopause in the community, they tend to become dysfunctional in their families, community and at workplaces thus they need to be empowered with menopausal information and skill to cope with the symptoms. Lastly it is very important for the premenopausal participants in particular to be empowered regarding menopause in order to succeed in dealing with the challenges before they could even start to experience them. Figure 10 shows the procedure for effective coping in a pyramid form whereby the menopausal participant, elderly women and the PHCN start by showing mutual trust in each other followed by mutual interaction, their roles and lastly all become empowered to cope effectively with the challenges

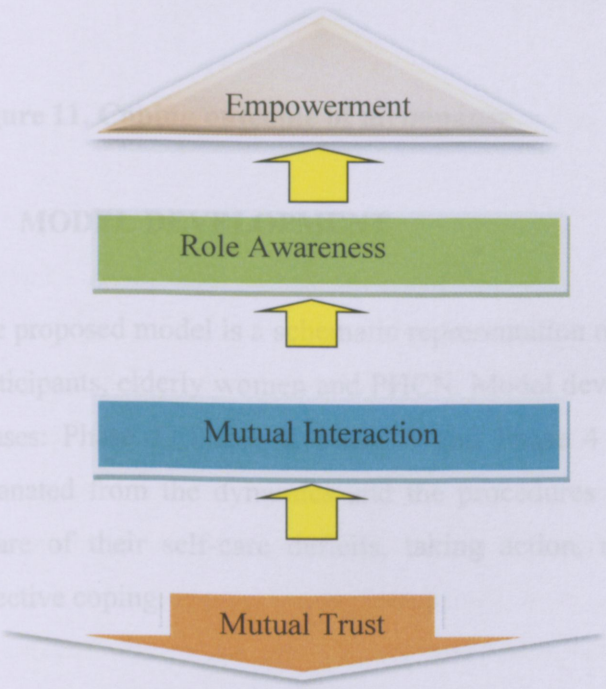



**Figure 10. Procedure for effective coping by menopausal women**



© University of Venda

University of Venda
Creating Future Leaders

**Coping outcome of menopause**

The outcome of coping emanated from the findings of the contexts of this study, the agents who were primary health care nurses and elderly women and recipients who were menopausal participants, the energy source which are the dynamics involved, the procedure for coping and the end point of the activity which is effective coping using identified coping strategies according to the model developed to have self-efficacy, self-esteem, self-actualisation, responsibility and willingness to learn and grow so as to make informed decisions about their own health.

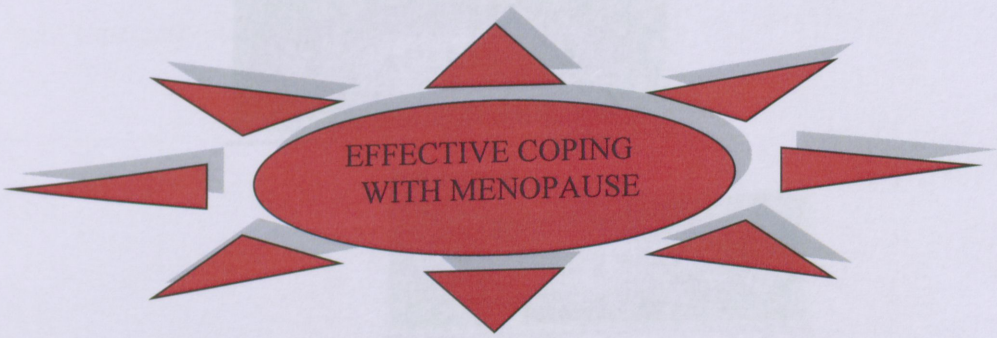



**Figure 11. Coping outcome of menopause**

## 5.5 MODEL DEVELOPMENT

The proposed model is a schematic representation of how coping will be facilitated between menopausal participants, elderly women and PHCN. Model development for effective coping involves the following phases: Phase 1, Phase 2, Phase 3 and Phase 4 respectively as shown in figure 12. These phases emanated from the dynamics and the procedures for coping starting from when participants become aware of their self-care deficits, taking action, adapting to the situation and eventually achieving effective coping.



© University of Venda

University of Venda
Creating Future Leaders

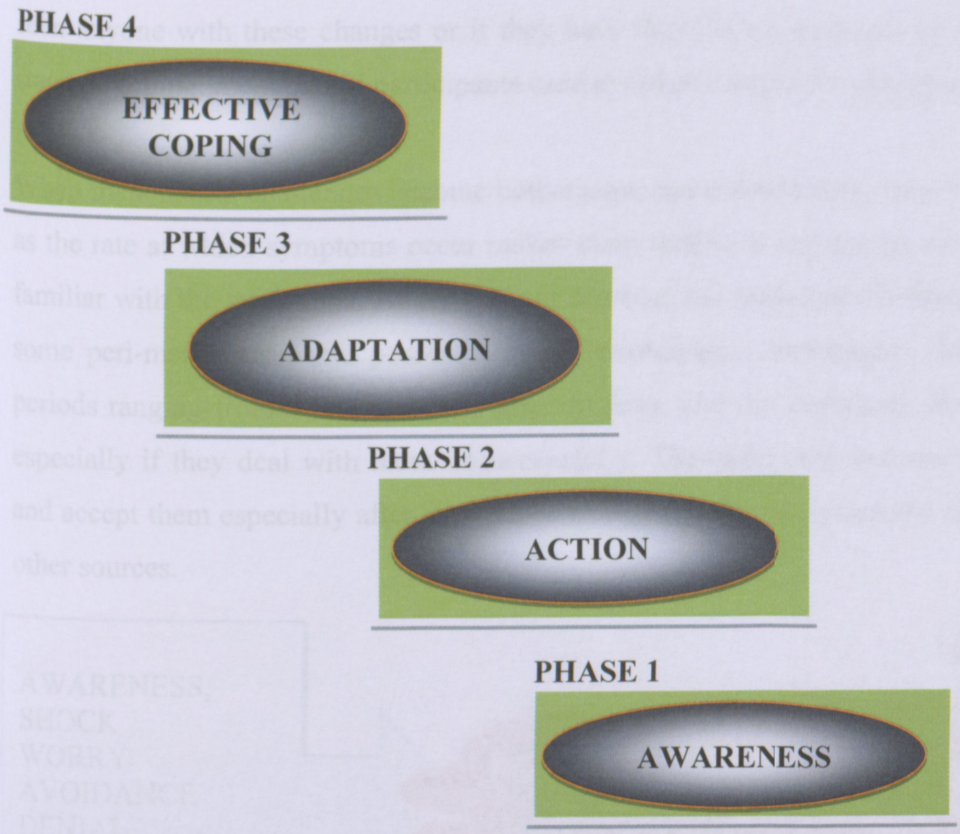



**Figure 12. The four phases for effective coping**

**Phase 1 – Awareness of self-care deficits**

This is the first phase of the model as depicted in Figure 13. Both the agent and recipient are aware of the participants' self-care deficits which are the menopausal challenges (arrows shown in dark red). The menopausal participants (amoeba red diagram showing participants with no shape owing to self-care deficits) begin to experience changes in their bodies that affect their quality of life. The dynamics involved are awareness, shock, fear, afraid, worry, avoidance, denial, anger, depression and acceptance (as shown in blue-ish box) (Kubler-Ross, 1969:482). The pre-menopausal participants become shocked when they experience changes in their bodies especially if they are sudden, troublesome and embarrassing. They start to develop fears and become afraid and worried that these changes will end them to experience denial. They disbelieve the bodily changes as some have never experienced, heard or



© University of Venda

seen anyone with these changes or if they have they do not associate them with menopause. At some stage of coping, menopausal participants used avoidance coping by ignoring the problem.

When menopausal challenges become bothersome and embarrassing, they create anger in the participant as the rate at which symptoms occur makes them unable to explain the challenges to other persons not familiar with the symptoms. Anger leads to mistrust and suspicion of others and ultimately despair. For some peri-menopausal and post-menopausal participants, menopausal challenges could last for long periods ranging from a few minutes, hours to days, and this depresses, discourages or frustrates them, especially if they deal with them unsuccessfully. Thereafter they become familiar with the symptoms and accept them especially after experience in coping with the symptoms and gaining information from other sources.

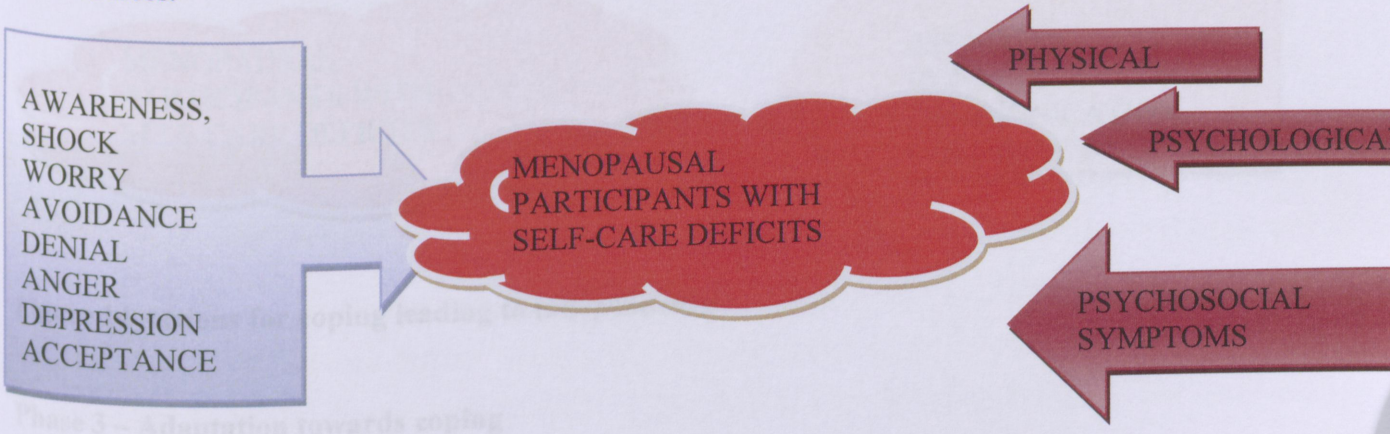



**Figure 13 Awareness of self-care deficits**

**Phase 2 - Actions for coping leading to independence**

Action for coping in this study Figure 14 includes the following dynamics: openness, honesty, communication in order to share their vision of effective coping with menopause. The menopausal participants, shown in amoebic red colours, are expected to show the dynamics as shown in the light pink colour. The community socio-cultural beliefs, values and morality impose certain rules on the people who live in such communities thus these participants feel lost as they have no-one with which to share their agony. The rural community cultural context within which coping is supposed to take place



© University of Venda

influences the way in which discussions about coping with menopause between elderly women and menopausal participants should take place. The cultural beliefs, values and morality in the communities tend to restrict the amount and depth of the information that can be shared between elderly women and menopausal participants. It is therefore very important for the agent and recipient to be open and honest in their discussions about menopause. At this time both the agent and recipient should be given time to open up, be honest with each other's cultural beliefs, values and morality regarding menopause. They should also ensure effective communication with each other by being transparent in information sharing. Lastly the recipient should show commitment in accepting new information given by elderly women and primary health care nurses to share their vision.

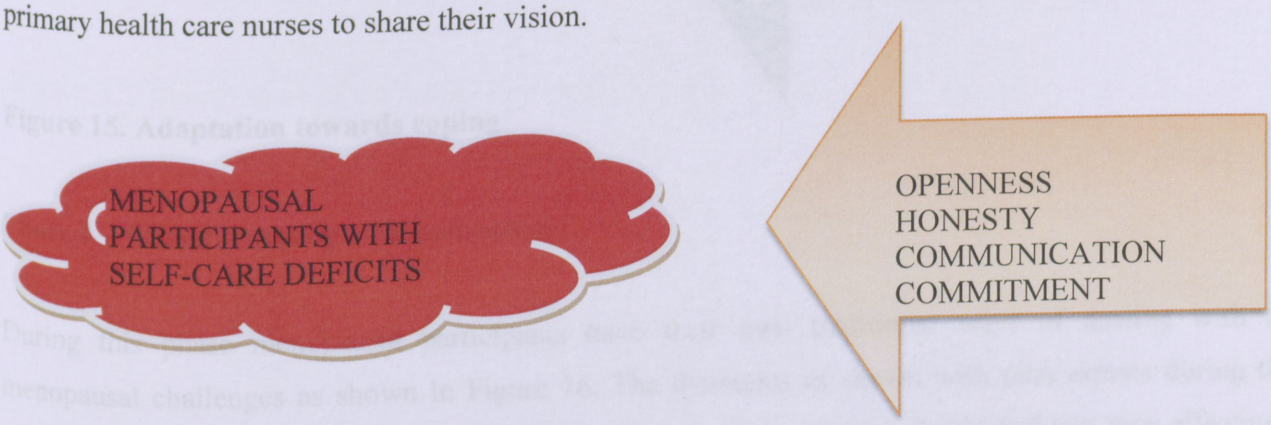



**Figure 14 Actions for coping leading to independence**

**Phase 3 – Adaptation towards coping**

Adaptation of coping (Figure 15) involves the following dynamics as shown in the green arrow box namely: adaptation, confidence, responsible and willingness to grow. Effective coping should lead menopausal participants to successfully deal with menopause during all phases of menopause. Menopausal participants should adapt to the challenges and show confidence after being empowered with relevant information which could be beneficial to the participants and the community as a whole. PHCN should encourage menopausal participants to take responsibility for their own health and assist them to make informed decision about their health. Once menopausal participants develop confidence in effectively dealing with the symptoms, they become responsible for their own actions. Willingness to grow is facilitated when menopausal participants abandon risky practices such as the use of raw herbs from the bush, church tea, etc. without using the correct measurements. Menopausal participants should



© University of Venda

show willingness to grow when PHCN and elderly women provide them with new information, knowledge and skill to cope effectively with menopause.

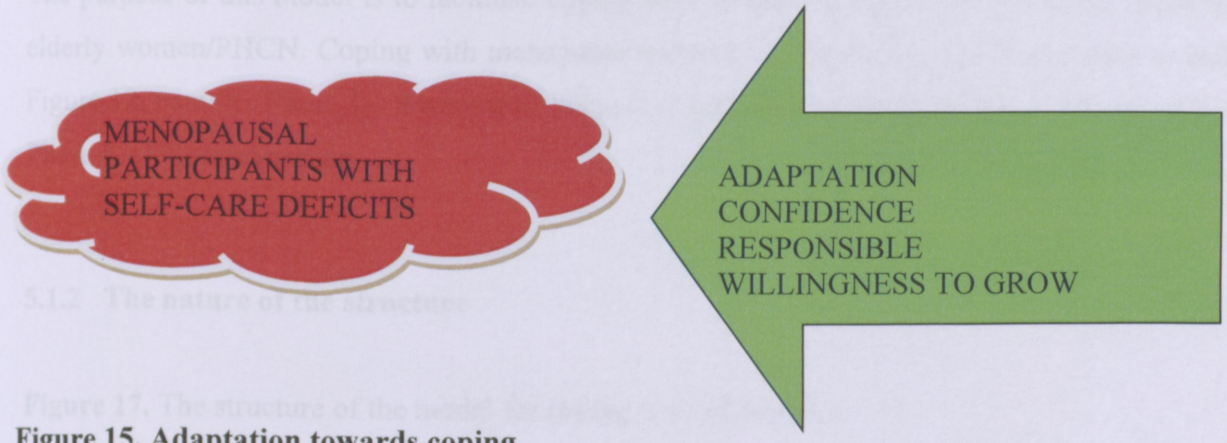



**Figure 15. Adaptation towards coping**

**Phase 4 – Effective coping with menopause**

During this phase menopausal participants have their own traditional ways of dealing with the menopausal challenges as shown in Figure 16. The dynamics as shown with pink arrows during this phase are self-efficacy, self-esteem and self-actualisation as the women should feel that they effectively manage menopausal self-care deficits. During adaptation menopausal participants should start to adjust themselves to the bodily changes brought about by the stresses of menopausal challenges. The agent and the recipient should encourage each other in assisting the recipient to adjust to bodily changes. Recipients should show the boldness of self-efficacy (confidence) in managing the stress brought about by the menopausal challenges. When participants have acquired adequate and reliable information, knowledge and skills to manage the challenges of menopause, they develop self-esteem and self-actualisation. They should then be able to support emerging pre-menopausal women in their midlife stages.

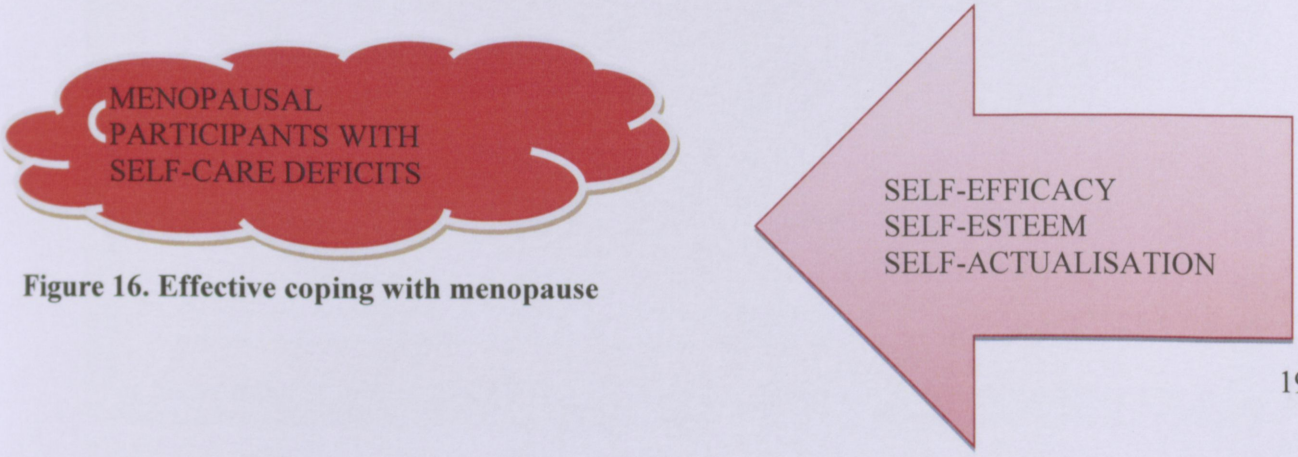



**Figure 16. Effective coping with menopause**



© University of Venda

University of Venda
Creating Future Leaders

### 5.5.1 Purpose of the model

The purpose of this model is to facilitate coping with menopause, between menopausal participants and elderly women/PHCN. Coping with menopause would be achieved through four phases as indicated in Figure 12. namely: Phase 1 – Awareness, Phase 2 – Actions for coping, Phase 3 – Process of coping and Phase 4 – Effective coping.

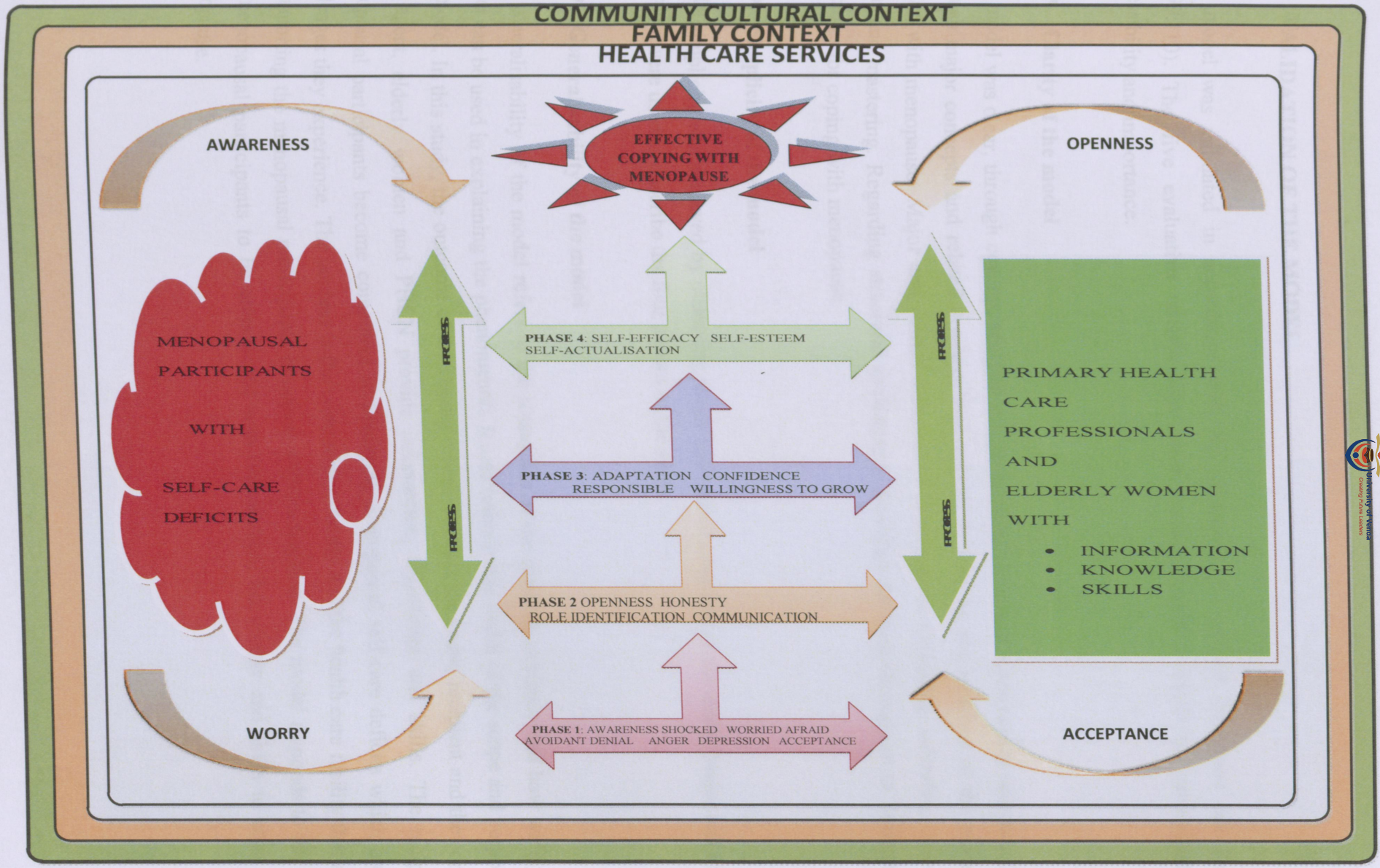
### 5.1.2 The nature of the structure

**Figure 17.** The structure of the model for coping with menopause

UNIVERSITY OF VENDA



© University of Venda




© University of Venda

University of Venda
Creating Future Leaders

## 5.6 VALIDATION OF THE MODEL

The model was validated in accordance with the guidelines as outlined by Chinn and Kramer (1999:110). The five evaluative criteria were used namely: clarity, simplicity, generalisability, accessibility and importance.

- **Clarity of the model**

The model was clear, through concept analysis and participants' evidence. Consistency was maintained through major concepts and related concepts that assisted in forming the structure of the model for coping with menopause. Major and related concepts of coping were: managing, tolerating, reducing, effort and mastering. Regarding structural consistency, drawings are used throughout to illustrate the structures for coping with menopause.

- **Simplicity of the model**

Model simplicity was achieved by observing major and related concepts of the study. Major and related concepts were used to describe the four phases of the study.

- **Generalisability of the model**

The generalisability of the model refers to the soundness of the research evidence and how widely the model can be used in explaining the phenomenon. It also refers to the width of the scope and purpose of the model. In this study, the outcome of the coping model involves the agent, recipient and the context. The agent, elderly women and PHCN provide information, knowledge and skills. The recipient, menopausal participants become competent in managing menopausal self-care deficits which are the challenges they experience. The context is the community, family and the health care facility that assist in supporting the menopausal participants in coping with menopause. The model responds to the need for menopausal participants to be empowered with information, knowledge and skills to cope with menopause.



© University of Venda

- **Accessibility of the model**

The model would be made accessible to the villages where data was collected through workshops that would be conducted by the researcher where the model would be implemented and evaluated. Workshops would be conducted with menopausal participants where the study was conducted. The Reproductive Health Directorate would be involved so that it would be easier to access other districts in the province. The model could be accessible through library search, publications in accredited journals, attendance of seminars, and national and international conference presentations.

- **Importance of the model**

Menopausal participants in the villages where the study was conducted lacked information about menopause. They were unable to make informed decisions regarding their own health as menopause was culturally determined. The model will assist elderly women and PHCN to support menopausal participants by empowering them with information necessary to cope with menopause.



© University of Venda

## 5.7 GUIDELINES ON HOW TO IMPLEMENT THE MODEL

The final step in model development is the application of the model which involves a description of guidelines on how to implement the model (Chinn & Kramer, 1999:110). The guidelines for the model to facilitate coping with menopause by menopausal participants will be presented in Table 5.2 according to the elements in the practice model as presented in Chapter 5 of this study. These elements are:

- Guidelines pertaining to context;
- The agents and recipients;
- The procedure and dynamics;
- Outcomes or purpose.

***Guidelines pertaining to the context***

The following guidelines were derived from the data analysis and conceptualisation of the context where coping with menopause was to be facilitated in the rural areas of the Mutale district in Limpopo Province. The community, family and health care facility were the context where coping with menopause was to be facilitated.

© University of Venda

**Table 5.2**

| Guidelines for the community context | Guidelines for the family context | Guidelines for the health care culture |
|---|---|---|
| • Consideration of norms and values related to menopause by the agents and recipients as community members<br>• Consideration of the rights of other women when communicating menopausal issues so as not to infringe on their rights<br>• Encouragement of interactive participation by all women in the community regarding menopausal issues<br>• Community women to support menopausal participants during the menopause transition and menopausal self-care deficits<br>• Community women to support menopausal participant with adequate knowledge, information and skills to cope with menopausal self-care deficits<br>• Workshops be conducted to clarify values and assist community members to identify issues within | • Families to have well-defined roles in support of menopausal participants by involving every member of the family to share information and support each other<br>• Family members' roles to include teaching menopausal participants about issues of reproductive health including menopause<br>• Families to support initiation schools by providing education regarding menopause as some family members also form part of the initiation schools<br>• Attendance of workshops or awareness campaigns by family members to participate in community activities related to menopause organised at community level<br>• Families to trust each other as lack of trust will hamper information sharing among menopausal women at all levels | • The health care culture to follow the mission, vision and philosophy of the community health care service in providing guidance and support for the communities and families including menopausal participants with regard to their health care needs<br>• The health care culture to involve the prevention, promotion, diagnosis, prescription of treatment, care, referrals and rehabilitation of patients<br>• Health care culture to provide support for the communities and families of menopausal participants with self-care deficits regarding issues of menopause<br>• The health care culture to mutually interact effectively with the community health committees in the planning and provision of health care services including those of menopause |

© University of Venda

| | | |
|---|---|---|
| *cultural values*<br>• *Workshops to involve people with expertise to empower community women with more current knowledge about issues on menopause*<br><br>• Development of health education programmes by community women and strategies for strengthening these to ensure sustainability<br><br>• Involvement of cultural initiation schools in workshops with older women in charge receiving training on topics that emphasise menopause<br><br>• Collaboration to include PHCN at the local clinic as resource centres for the community, reproductive health units and providers of alternative medicine like traditional healers, faith healers and church organisations to gain cooperation in the provision of health of menopausal participants | • *Family members to ensure confidentiality of issues that have been shared with them as other members may share sensitive information that they feel cannot be shared with the whole family*<br><br>• Families to address issues of power inequality between husbands, elderly women and mid-life menopausal participants to function at the same level, which can be difficult for elders because of cultural issues involved<br><br>• Involvement of the husband, siblings, aunts and uncles as sources of both negative and positive influence on menopausal participants and need for their effective support<br><br>• Need for openness and transparency regarding issues of menopause with their husbands and elderly women in the family to ensure free, interesting and fruitful information sharing<br><br>• Need for honesty with each other and in their relationships as honest people always speak the truth | • *The health care culture to work collaboratively with providers of alternative medicine like traditional healers, faith healers and church organisations to empower them on issues of menopause and adjust in sharing these clients*<br><br>• Attendance of workshops, seminars and conferences on reproductive health by PHCN regarding issues on menopause to acquire adequate and current information in order to share it with their menopausal participants in the communities<br><br>• Acceptance that the PHCN at the rural health services have the best information about their communities in term of resources, cultural and ethical norms and community needs and thus know how best to deal with them including issues pertaining to menopause<br><br>• The health care culture to consult adequately and promptly refer menopausal participants with severe self-care deficits that need referral to other services for better management |

© University of Venda

| | | |
|---|---|---|
| | • *Family members to seek information regarding menopause from various sources to keep themselves up to date with current issues of menopause and attending of workshops on menopause* | • The health care culture to demonstrate good communication and good interpersonal relationship with the communities and families |
| **Guidelines pertaining to the self-care agents** | **Guidelines pertaining to the self-care recipients** | **Guidelines regarding the process of coping.** |
| • Elderly women as primary self-care agents to form part of the extended family, thus together with the family and the community context defining who they are and what their roles are.<br><br>• The self-care agents to consider community and family cultural practices that influence how, what and when to discuss with their midlife women issues related to menopause<br><br>• The self-care agent who is an elderly woman/PHCN to have a well-defined role in the family/ community and health care facility to avoid misperceptions<br><br>• The self-care agent to teach menopausal participants norms and values expected from them, e.g. | • Menopausal participants to be aware of their health care deficits, hence needing guidance and support<br><br>• Openness and communication with the self-care agents in order to achieve their goals<br><br>• Participative interaction between the agents and recipients about issues that involve their health, such as those of menopause.<br><br>• Readiness to receive action from the self-care agents (elderly women and primary health care nurses) to achieve their goal of effective coping with the menopausal challenges<br><br>• Recipients to respect and trust self-care agents and the information | ❖ ***Mutual interaction***<br><br>• Effective coping to be a mutually interactive process by both the self-care agent and recipient<br><br>• The interaction between self-care agent and recipient should be on an equal footing, respecting each other's knowledge without competing<br><br>• Exhibiting a spirit that encourages consultation with one another for advice when the need arises<br><br>• The agents and recipients to agree in their interaction about strategies that could best assist them in effective coping with menopause<br><br>• Information sharing to be emphasised during the discussions |

© University of Venda

behaviour during menopause that makes menopausal women culturally valued by the community

- The self-care agents to be aware of their own values, beliefs and ability to engage in planning activities regarding menopause issues based on their values and beliefs
- The self-care agent to create an environment free from threats conducive to discussing issues of menopause with menopausal participants
- The self-care agents to treat participants as equal partners without assuming a position of power
- The self-care agent to support the menopausal participant in coping with menopausal self-care deficits by honestly and truly sharing information
- The self-care agent to ensure good relationship of trust and bond that lays a good foundation for the support on coping with menopause and to trust the information that is given to them by their elderly

they provide them with

- Recipients to take informed decisions about matters that concern their lives and those of menopause to avoid imposing of decisions to them
- Recipients to clarify their own values and norms and roles they are expected to play related to menopause so that it becomes easier to engage self-care agents in the discussions thereof
- Menopausal participants need to belong to support groups within the communities and health care facilities to get support when in need

**Guidelines regarding the dynamics of coping**

❖ ***Awareness***

- Menopausal participants to be aware of their menopausal self-care deficits, hence the need for guidance and support in this regard

with all parties actively participating

- Agents always to offer new knowledge and information to the recipients in order to empower them regularly

❖ ***Commitment***

- Menopausal participants to be committed and willing to be guided and supported during their menopausal transition
- Recipients to commit and devote their time and energy for effective coping to take place.
- Recipients to be willing to learn and consult agents when the need arises.

❖ ***Empowerment***

- Menopausal participants to show readiness and willingness to be empowered by the self-care agents who have information and experience and professional knowledge by PHCN

© University of Venda

| | | |
|---|---|---|
| women<br>• The self-care agent to be a coordinator of menopause services in the communities and other health care services<br>• PHCN as secondary self-care agents to be the first contacts to be consulted when menopausal participants experience difficulties regarding their menopausal self-care deficits.<br>• The self-care agents to continuously interact with the menopausal participants on issues regarding menopause that will benefit both the agent and the recipient.<br>• The self-care agents to be willing to learn from menopausal participants who have much information that could be of benefit to all<br>• Searching for more information about menopausal issues from sources like internet, books etc.<br>• Attendance of workshops, seminars and conferences on reproductive health on menopause to acquire | • *Taking informed decisions towards the choices they make in order to effectively cope and meet self-care demands*<br>• To be cognisant of bodily changes and to communicate with the agents about them<br>• To be open and transparent and not hide feelings or be shy to share information with the agents<br>❖ ***Openness***<br>• Effective coping involving openness and transparency with regard to agents in order to receive new information<br>• Avoiding shyness or being afraid to talk to the self-care agents<br>• Making points clear until they are satisfied about the information they require<br>• Self-care agents to be willing to share all the information and skill they have<br>• To encourage menopausal participants to be open during the | • *Elderly women and PHCN to acknowledge that certain menopausal women experience serious menopausal self-care deficits hence they need to be empowered with information*<br>• Skills transfer regarding effective coping with menopause to be properly done to put the plan of action in place. |

© University of Venda

| | | |
|---|---|---|
| adequate and current information in order to share with their menopausal participants in the communities | discussions so that the discussions are be fruitful<br><br>❖ ***Honesty***<br><br>• Both parties to be honest in the type of information that they share with each other to achieve coping. | |

© University of Venda

University of Venda
Creating Future Leaders

## 5.8 SUMMARY

In Chapter 5 concept analysis according to the steps in Rodgers and Knafl (1993:90) and Walker and Avant (2008:39) was discussed. The concept 'coping' was defined according to the Webster's New World Dictionary (1984); Lazarus (1993:234); Skinner et al., (2003:216), and other sources. Data on coping was analysed and themes were developed. These gave clarity to how effective coping could be successfully utilised in the management of menopause. Model development to support coping with menopause between menopausal participants and elderly women/PHCN was also discussed. Description, overview, purpose and structure of the model were presented. The model was evaluated in accordance with the criteria as outlined in Chinn & Kramer (1999: 110). Guidelines to implement the model for coping with menopause were described. Focus was placed on the following guidelines: community cultural context, family context, health care culture, agent and recipient, dynamics of effectiveness and process of coping.

Chapter 6 will focus on the evaluation, justification, limitations, conclusions and recommendations.



© University of Venda

University of Venda
Creating Future Leaders

# CHAPTER 6

# EVALUATION, JUSTIFICATION, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS

## 6.1 INTRODUCTION

In Chapter 5 concept analysis and the conceptual framework for model development were described, the model was validated and guidelines to operationalise the model were formulated. This chapter focuses on the evaluation of the study in terms of its ability to meet the objectives set out in Chapter 1. A justification for the study regarding its original contribution to the body of knowledge is provided, as well as its limitations, conclusions and recommendations.

## 6.2 VALIDATION OF THE STUDY

The study is evaluated against its purpose and objectives as set out in Chapter 1.

### 6.2.1 The purpose of the study

The purpose of this study was to develop a model to facilitate women coping with menopause in the Mutale district of Limpopo Province and to describe the guidelines to operationalise the model. The menopausal participants' experiences with menopause were explored and compared with relevant literature and this formed the basis for identification and conceptualisation of the concept which was done using Rodgers and Knafl's (1993:77-90) eight steps. The framework of Dickoff, et al. (1968: 426) was used to describe the model as the practice survey list formed the basis for model development. The model was described in accordance with Chinn and Kramer, (1999:84).

### 6.2.2 The objectives of the study

The objectives of the study that were set in Chapter 1 are evaluated as follows:

- Phases 1: Objectives 1 and 2 - Exploration and description of experiences and challenges experienced by menopausal participants age 40 years and above



© University of Venda

University of Venda
Creating Future Leaders

Objectives 1 and 2 were met during the first phase of this study were experiences and challenges were explored during FGD and individual interviews. The discussions that emanated from a central question of the focus group discussions and a questionnaire for the individual interviews were explored. Data were analysed according to Tesch's eight steps (in Cresswell, 2003:145) and themes, categories and sub-categories emerged. Dense descriptions of the findings of the experiences by menopausal participants were also completed against relevant literature. Central to the results elicited from the participants, it was identified that coping with menopause was regarded by all participants as the act of managing menopausal self-care deficits. The concept of coping was identified as a way of managing the challenges experienced by menopausal participants. Culture was also found to have influenced the decisions taken by menopausal participants in managing menopausal challenges. Limited resources regarding adequate and relevant information on menopause also posed a challenge of accessibility. The majority of menopausal participants lacked adequate and relevant information on menopausal issues. The data drawn from these participants formed the basis for concept analysis and model development, hence the importance of this phase on model development.

- Phase 2: Objective 3 – Available support systems

The available support systems were analysed and found to be influenced by cultural beliefs, values and norms that prevail within the community and families. Minimal support was mainly from family members, the community and the local clinic. The type of support that was provided to menopausal participants was a form of coping with menopause. When participants experienced severe self-care deficits, family members would provide emotional and physical support to cope with the symptoms. The community would contact elderly women, religious and traditional healers to provide herbs and spiritual healing. Other participants accepted and adapted to the symptoms while others resorted to the local clinic for treatment, counselling and rehabilitation. Limited resources regarding adequate and relevant information on menopause also posed a challenge in the community. Data that was drawn from the participants regarding resources also formed the basis for concept and model development.



© University of Venda

University of Venda
Creating Future Leaders

- Phase 3: Objective 4 – Model development and description

The results derived from Objectives 1 to 4 formed the basis for describing the model to facilitate women coping with menopause. The survey practice list of Dickoff, et al. (1968:426) was used as a framework for model development. The research of Chinn and Kramer (1999:84) was used to describe and validate the model. Guidelines derived from all three phases were also described.

## 6.3 CONTRIBUTION OF THE RESEARCH

The study developed guidelines for coping with menopausal self-care deficits that will assist menopausal participants, community women and community health care workers in adequately addressing menopause issues in the community. The study will also equip rural women and community health workers with scientific knowledge and information on menopause and menopausal issues. The model could also be utilised by trained peer education facilitators and health care educators in educating women in families and the community in coping with menopausal challenges.

The developed model expounds guidelines for PHCN in the Department of Health, in supporting women in the rural villages when dealing with menopausal challenges. A menopausal service can be established to co-ordinate all menopause activities using these guidelines. The model can benefit nursing education if included in the curriculum for training nursing students, the comprehensive four year course (R425) content and the Diploma in Nursing (Bridging course R683). The model can also benefit the Department of Education if included in the curriculum for life skills in high schools. The model could also provide inputs for these curricula. Model development is essential for nursing practice as a supportive and scientific-oriented profession. Primary health care nurses who are involved in supporting rural women will benefit from this model in terms of acting as knowledgeable and informative community health workers. Community engagement and outreach campaigns can be established within rural community women's structures to assist them in identifying, recognising and coping with menopause. The model developed can benefit researchers in terms of conceptualising coping strategies that are based on identified needs or self-care deficiencies. The findings of this study will be published in journals and books and will be presented at international and national conferences and seminars.



© University of Venda

UNIVERSITY OF VENDA LIBRARY

University of Venda
Creating Future Leaders

## 6.4 LIMITATIONS

Owing to the sensitive nature of the study, it was not easy for the community women to open up and provide accurate information and honest responses in investigations on menopause. Women from rural communities, especially older women found it difficult to engage freely in an interview on sensitive issues, such as menopause and sexual activities, and this might affect the quality of the data. However, in order to meet these potential challenges the researcher utilised her skills in community health nursing practice to handle culturally sensitive questions.

Furthermore, owing to time and financial limitations, the study was limited to Vha-Venda women of Ha-Makuya and thus the results may not be generalised to the whole of Limpopo Province. The study was not be piloted and tested; this will be done as part of a post-doctoral study.

## 6.5 RECOMMENDATIONS.

Recommendations of this study are discussed in terms of the guidelines that have been described for operationalising the model. Several recommendations emanated from the study.

### 6.5.1 Coping within the family and community context

- All female stakeholders in the community namely, traditional healers and traditional leaders, church organisations, girls' initiation school leaders, primary health care services and other community members, should be invited to workshops and actively participate in discussions about issues of menopause. A menopause health committee should be formed in the community including young adult females. The purpose of the committee would be to co-ordinate all menopausal issues within the community. For the committee to be effective, a programme should be drawn up indicating who would be involved, as well as when and how it should be run.
- Dugan (2003:3) asserts that an organisation gives people the power to express their needs effectively without being ignored, Such groups can start as small groups until community-wide organisations are formed. Thus there is a need for small community



© University of Venda

groups to affiliate and collaborate with larger women's organisations for growth, funding and support for their programme until they are financially and economically sustainable.

- Within the families and communities, there is a problem of openness and trust among menopausal women, young adult females and elderly women regarding menopausal issues which impact on their relationships. There is a need to educate all women on how to relate to each other on issues of menopause.
- In the rural villages, menopause is culturally determined and is a taboo, and should be a private and sensitive topic when discussed among villagers. There is a need to introduce and orientate young girls from puberty at schools and in health education programmes about menopause for older women in the community.
- The guidelines in the model developed for all level of menopausal women in the community should provide adequate information and education about menopause, recognition of symptoms and coping strategies. These guidelines could be used to empower young girls in the initiation schools, clubs for young girls, sports clubs and youth churches. There is also a need for continuous support of young girls in the families and community by providing reliable information when the need arises and the researchers' contact details could be given to the community leaders or to the committee.
- Women should form social support groups to support each other in coping with menopause and in times of crisis.
- There is also a need to provide families and communities with written material in their local language concerning menopause.
- Guidelines about menopause for the community could be used in lifestyle change programmes such as the prevention of female obesity, incorrect diets and lack of exercise. Adequate or normal weight, healthy eating and healthy food choices and exercise should be the central pillar in education on menopause to control the symptoms. There is need to make the community aware of the risk factors in the early development of menopausal symptoms.



© University of Venda

University of Venda
Creating Future Leaders

### 6.5.2 Menopause and coping within the health care facilities

- The community nursing fraternity should develop a long-term, multi-faceted approach towards improving the health and quality of midlife to old-age menopausal women. The aim should be to develop menopausal services. To address the issues of menopause, there is a need for collaborative efforts by the families, community, health care workers, church leaders, traditional leaders and healers. To maintain sustainability, the primary health care nurses need to work in collaboration with the Department of Health and Social Development.
- Menopausal health education should form part of the health education programmes in the Primary Health Care Service. There should be the provision of health education and case management services to help elderly women remaining in their homes to empower them to assume an active role in promoting their own health.
- A community health campaign on menopause would raise awareness of the symptoms. Such a campaign should be initiated at the Primary Health Care level as the reality and complications are experienced daily in the clinics.
- The developed guidelines for PHCN in the Department of Health and Social Development in the Limpopo Province should ensure co-operation with women and the health care service to support women in the rural villages in dealing with menopausal challenges. An established menopausal service could co-ordinate all menopause activities. Such a service should be affordable, accessible, available, safe and sustainable for menopausal participants in the community to utilise it.
- Optimisation of contacts with relatives and friends should be stressed as well as in health education to prevent loneliness, depression and irritability as bothersome, frustrating and troublesome challenges experienced by menopausal women.
- The importance of measures to encourage menopausal participants to attend the menopausal service and follow up visits should be stressed as they also meet old friends and have the possibility of making new friends.



© University of Venda

### 6.5.3 Coping as a process

The process of implementing and sustaining a model to facilitate coping with menopause by women should be through planned workshops about how to use the model. Role-playing could also be used to assist participants to understand how coping could be facilitated and supported. Communities, families and the health care service could be encouraged to continue supporting each other in facilitating coping with menopause and to note problems identified as this could also help to refine the model to suit specific communities. Social support groups should also be formed to support groups or individuals who are trying to cope with menopause. Funding could also be sought to support such initiatives.

The process of how the implementation of the coping model is unfolding should also be monitored through review workshops and the exploration of the experiences of the people involved. This would assist with the refinement of the model by addressing common problems encountered. Evaluation could also be done through monitoring how menopause health services were being utilised by menopausal women in the communities.

### 6.5.4 Research

- Further research should be done about coping with menopause in different communities to find out whether there are health risk practices that might threaten the lives of menopausal women.
- More research studies should be conducted to determine the impact of the coping model on menopausal women in families, in the community and in health care services. Piloting, evaluation and implementation of the model could also be conducted. Menopausal challenges experienced in urban areas and among educated women could also be researched.

## 6.6 CONCLUSION

In Chapter 6 the study was evaluated by determining whether its purpose and objectives of the were met in terms of the original body of knowledge.. The limitations of the study were



© University of Venda

University of Venda
Creating Future Leaders

discussed. The recommendations of the study that could be of benefit to the menopausal participants, elderly women, primary health care nurses, family, community and health care facilities were presented. It is hoped that these recommendation will advance the position of menopausal women in their families and communities and at health care facilities and that this will result in improved coping with menopausal challenges as well as a significant decrease in the prevalence of the symptoms.



© University of Venda

University of Venda
Creating Future Leaders

## 7. REFERENCES

Abramson, JH., Gampel, B., Slome, C., Scotch, N. & Majola, CC. 2010. Age at menopause of Zulu women. Department of Social, Prevention and Family Medicine, University of Natal, Durban. South Africa. 132(14): 356-358.

Adegoke, OA., Iranloye, B., Osibogun, A. & Tomiri, T. 2005. Postmenopausal experiences in Nigerian women. *Nigerian Journal of Health and Biomedical Sciences.* 14 (1): 72-75.

Adekunle, AO., Fawole, AO. & Okunlola, MA. 2000. Perceptions and attitudes of Nigerian women about menopause. *Public Medicine*. 20(3): 525-529.

Agajani, DM. & Mahmoud, H. 2011. Age at menopause and measuring symptoms at midlife in a community in Babol, Iran. *The North American Menopause Society*. 18(11): 1213-1218.

Akinrogunde, GT. 2010. Menopause, culture and sex. *African view on Global news*. March 5.

Akong, J., Hoon, KN., Dial, C., Andrewin, A., Diaz, M., Charles, J., Sandiford, N., Ward, C., McDougall, L. & Teelucksingh, S. 2001. Hormone replacement therapy: Knowledge, attitudes and practices of women attending a gynaecology outpatient clinic in Trinidad. *West Indian Medical Journal.* 50(2): 155-8.

Al-Olayet, AY., Al-Qahtani, IF., Al-Essa, DI., Al-Saleek, FH., Al-Moutary RN., Al-Mudimeg, LM., Al-Marri, SA., Al-Shemari, SS. & Ajab nor, MO. 2010. Severity of menopausal symptoms, and knowledge, attitude and practices towards menopause among Saudi women. *Scientific Research and Essays*. 5(24): 4077-4079.

Anderson, D. 1999. Response to the Menopause: Hormone Replacement Therapy and Alternatives. Brisbane: Department of Social and Preventive Medicine, University of Queensland.



© University of Venda

University of Venda
Creating Future Leaders

Anderson, RM. & Funnell, MM. 2005. Patient empowerment reflections on the challenge of fostering the adoption of a new paradigm. Patient Education Counsel, 57:153-157.

Anderson, D., Yoshizawa, T., Gollschewski, S., Atogami, F. & Courtney, M. 2004. Relationship between menopausal symptoms and menopausal status in Australian and Japanese women: Preliminary analysis. *Nursing & health sciences*. 6(3): 173-180.

Appling, SE., Allen, JK., Bellantoni, M., Brager, R., Hallerdin, J., Olsen, S., Van Zandt, S., Gaines, J. & Young, KL. 1999. Factors associated with Hormone Replacement Therapy Use in Low-Income Urban Women. *Women's Health Issues.* 9(6): 319-329.

Arroyo, A. & Yeh, J. 2005. Understanding the menopausal transition and managing its clinical challenges. *Sexuality Reproduction and Menopause*. 3:7-12.

Avis, NE., Kaufert, PA., Lock, M., McKinlay, SM. & Vass, K. 1993. The evolution of menopausal symptoms. *Bailliere's Clinician Endocrinological Metabolism.* 7(1): 17-32.

Ayers, B., Forshaw, M. & Hunter, MS. 2010. The impact of attitudes towards the menopause the women's symptoms experience: A systematic review. *Maturitas*. 65(1): 28-36.

Ayranci, U., Orsal, O., Orsal, O., Arslan, G. & Emeksiz, DF. 2010. Menopause status and attitudes in a Turkish midlife female population: an epidemiology study. *BMC Women's Health.* 11(10): 1.

Babbie, E. & Mouton, J. 2001. The practice of social research. Oxford University Press. Cape Town.

Backel, N. 1999. Sex life, mood swings and hot flushes. Learn to cope with menopause. *Public health*. 19-31.



© University of Venda

University of Venda
Creating Future Leaders

Baig, LA. & Karim, SA. 2006. Age at Menopause, knowledge and attitudes to menopause, of women in Karachi, Pakistan. *Menopause International*. 12 (2): 71-74.

Ballagh, SA. 1999. Alcohol: the link Between Hormone Replacement and Breast Cancer Risk. *Women's health Issues. Elsevier Science Inclusion.* 9(6): 1049-3867.

Banchmann, GA. 1994. The changes before 'The change': Strategies for the Transition to the menopause. *Post Graduate Medicine*. 96(4): 1049-3867.

Barron, D. & Monticelli, M. 2007. The Menopause Industry: *A Guide to Medicine's Discovery of the Midlife Woman.* Auckland: Penguin Books.

Bartram, D. & Gardner, D. 2008. Coping with Stress. *In Practice*. 30: 228-231.

Basttastini, M. & Youcha, S. 2009. Managing Menopausal Symptoms. *Breasts Cancer Organization.* 1-8.

Berger, G. & Wenzel, E. 2001. Women, body and society. Cross-cultural differences in menopause experiences. *Public Health*. 1-16.

Berlin, E. 2009. Your menopause experience may depend on your cultural background. Menopause Centre. *Everyday Health*. Available: http:/www.everydayhealth.com.date accessed2011/06/28

Bernis, C. & Reher, DS. 2007. Environmental contexts of menopause in Spain: comparative results from recent research. *Menopause*. 14(4): 777-787.

Beyene, Y. 1986. Cultural significance and physiological manifestations of menopause: a biological analysis. *Culture, medicine and psychiatry*. 10: 47-71.



© University of Venda

University of Venda
Creating Future Leaders

Biri, A., Baker, C., Maral, I., Karabacak, O. & Bumin, MA. 2005. Women with or without menopause over the age of 40 in Turkey: Consequences and treatment options. *Maturitas*. 50: 167-176.

Bloch, AC. 2003. A Psychological Approach to Menopausal complains: in reply to DeSonto's comments. *Maturitus*. 45 (4): 303-304.

Bosworth, HB., Bastian, LA., Rimer, BK. & Siegler, IC. 2003. Coping styles and personality domains related to menopausal stress. *Women's Health Issues*. 13 (1): 32-38.

Brink, HI. 2003. Fundamentals of Research methodology for Health Care Professionals. 5th edition. Juta & Company.

Brockie, J. 2004. Alternative approaches to menopause. *Reviews in Gynaecological Practice*. 5(1): 1-7.

Brown, MC. 1976. Emotional Response to the menopause in Campbell, S. (Ed). The Management of the menopause and Post-menopausal years. Lancaster: *MTP Press*. 109-115

Brougham, RR., Zail, CM., Mendoza, CM. & Miller JR. 2009. Stress, Sex Differences, and Coping Strategies among College Students. *Current Psychology*. 28: 85-97.

Bryant, AN. 2007. Gender differences in Spiritual Development during the College Years. Sex Roles. *Springer Science Business Media*. 9240-9242.

Bulbeck, C. 2003. Speaking Menopause: Intersections between Asia and Western Medical Discourse. *Gender, History and Culture. The Asian context*. (5).

Buck, MM. & Gottlieb, LN. 1991. The Meaning of Time: Mohawk Women at Midlife. *Health Care Women International*. 12(1): 410-50.



© University of Venda

University of Venda
Creating Future Leaders

Buckler, H. 2005. The menopausal Transition: Endocrine changes & clinical symptoms. *JBR. Menopause Society.* 11: 1-6.

Buchko, KJ. 2004. Religious beliefs and practices of college women as compared to college men. *Journal of College Student Development.* 45: 89-98.

Burns, N. & Grove, SK. 2001. The Practice of Nursing Research: Conduct, Critique and Utilization. 3th edition. New York: Elsevier Sanders.

Burns, N. & Grove, SK. 2005. The Practice of Nursing Research: Conduct, Critique and Utilization. 4th edition. New York: Elsevier Sanders.

Burns, N. & Grove, SK. 2006. The Practice of Nursing Research: Conduct, Critique and Utilization. 5th edition. Philadelphia: Saunders.

Burns, N. & Grove, SK. 2009. The Practice of Nursing Research: Appraisal, Synthesis and Generation of Evidence. 6th edition. Philadelphia: Lippincott.

Cattan, M. 2009. Introduction. In M. Cattan (Ed). Mental Health and well-being in late life. Glasgow. *Open University Press.* 1-8.

Campbell, S., Maki, M., Willenbring, K. & Harry, K. 1991. AIDS related knowledge, attitudes and behaviours among 629 Registered Nurses at a Minnesota hospital: A descriptive study. *Journal of the association of nurses in AIDS care.* 2(1): 15-23.

Carver, CS., Schiever, MF. & Weitrub, JK. 1989. Assessing coping strategies: A Theoretical based approach. *Journal of Personality and Social Psychology.* 56: 267-283.

Chedraui, P., Aguirre, W., Hidalgo, L. & Fayad, L. 2007. Assessing menopausal symptoms among healthy middle aged women with the Menopause Rating Scale. *Maturitas.* 57 (3): 271-278.



© University of Venda

University of Venda
Creating Future Leaders

Cheung, FM. 2008. Relevance of openness as a personality Dimension in Chinese Culture. Aspects of its Cultural Relevance. *Journal of Cross-Cultural Psychology.* 39(1):81-108

Chim, H., Tan, BHIT., Ang, CC., Chew, EMD., Chong, YS. & Saw SM. 2002. The Prevalence of menopausal symptoms in a community in Singapore. *Maturitas.* 41(4): 275-282.

Chinn, PL. & Jacobs, MK. 1987. Theory and Nursing. St Louis: CV Mosby

Chinn, PL. & Krammer, MK. 1995. Theory and Nursing: a systematic approach. St Louis: CV Mosby.

Chinn, PL. & Krammer, MK. 1999. Theory and Nursing: a systematic approach. St Louis: CV Mosby.

Chirawatkul, S. & Manderson, L. 1994. Perception of menopause in north-east Thailand, Contested meaning and practice. *Social Science Medicine* 39 (42): 1-7.

Chompootweep, S., Tankeyoon, M., Yamara, K., Poomsuwan, P. & Dusitsin, N. 2009. The menopausal age and climacteric complaints in Thai women in Bangkok. *Maturitas* 17: 63-71.

Compass, BE., Malcarne, VL. & Fonacaro, KM. 1998. Coping with stressful events in older children and younger adolescents. *Journal of Consulting Clinical Psychology.* 56:405-411.

Concise Oxford Dictionary 1999. *New York University press.*

Coney, S. 1991. The menopause Industry: A Guide to Medicine's Discovery of the Midlife Woman. Auckland: Penguin Books.

Crawford, A. 1981. A Cultural Account of Health: Control, Release and the social Body in McKinlay, JB ed. Issue in the political economy of health care. *Journal of Health Psychology.* New York: Tavistock. 60-103.



© University of Venda

University of Venda
Creating Future Leaders

Cresswell, JW. 2003. Research Design: Qualitative and Quantitative and mixed method approaches. 2nd Edition London: *Sage Publications.*

Crookes, PA., Davis, S. & Chiarelli, M. 2004. Research into practice: Essential skills for reading and applying research in nursing and health care. 2nd edition, Edinburgh: Bailliere Tindal.

Dasgupta, D. & Ray, S. 2009. Menopausal problems Among Rural and Urban Women from Eastern India. *Journal of Social, Behavioural and Health Sciences.* 3(1): 20-33.

Davey, DA. 2005. Menopause and Hormone Replacement Therapy. *South African Pharmaceutical Journal*. 16-28.

Dennerstein, L., Burrows, GD. & Hyman, G. 2005. Menopausal hot flushes, a double blind comparison of placebo, ethinyl estradiol and norgestrel, *British of Journal Obstetrics and Gynecological*. 85: 852-856.

Derry, PS. 2006. A lifespan biological model of menopause: Sex Roles: *A Journal of Research.* 54(5): 393-399.

De Vos, AS. 2005. Research at Grassroots. A primer for the caring profession. Pretoria. Van Schaick Publishers.

De Vos, AS., Schurink, EM. & Strydom, H. 2001. The nature of research in the caring professions. In De Vos. A.S. Research at grass roots. A premier for a caring profession. Van Schaick Publishers. Pretoria.

Dickoff, J., James, P. & Wiedenbach, E. 1968. Theory in a practice discipline. *Practice Oriented Theory,* 17 (5): 415-435.

Donati, S., Cotichini, R., Mosconi, P., Satolli, R., Colombo, C., Liberati, A. & Mele, A. 2009. Menopause: Knowledge, attitudes and practice among Italian women. *Maturitas*. (63): 246-252.



© University of Venda

University of Venda
Creating Future Leaders

Donavan, JC., Neugarten, SL., McKinley, J. & Holte, K. 2006. The Menopausal syndrome: A study of case Histories. *American Journal of Obstetrics and Gynaecology*. 2:1281-1290.

Doubova, SV., Flores-Hernández, S., Pérez-Cuevas, R., & Rodriguez, AL. 2010. Quality of care and health related quality of life of climacteric stage women cared for in a family medicine clinic. *Health Quality Life Outcomes*. 8(20): 1186/1477-7525-8-20.

Durkin, SR., Bascomb, A., Turnbull, D. & Marley, J. 2003. Rural origin of medical students: How do they cope with the medical school environment? *Australian Journal of Rural Health*. 11: 89-95.

Dugan, MA. 2003. Power. Beyond Intractability. Eds. Guy Burgess and Heidi Burgess. Conflict Information Consortium, University of Colorado. Boulder.

Eaker, ED., Chesebro, JH., Sacks, FM., Wenger, NK., Whinsnant, JP. & Winston, M. 1993. Cardiovascular disease in women. *Circulation*. 88: 1999-2009.

Emmelin, M. 2004. Self-rated health in the public health evaluation. Sweden: Umea.

Ettinger, B., Grady, D., Tosteson, AN., Pressman, A. & Macer, JL. 2003. Effect of the Women's health Initiative on women's decision to discontinue postmenopausal hormone therapy. *Journal of Obstetrics and Gynaecological*. 10(2): 1225-1232.

Exline, JL., Siegler, IC. & Bastian, LA. 1998. Differences in providers' beliefs about risks of hormones replacement therapy in managed care. *Journal of Women's Health*. 7: 879-884.

Fernandez, S., Rodriquez, B. & Diaz, S. 2004. Attitudes of nursing and auxillary hospital staff towards HIV infection in Spain. *Journal of the Association of Nurses in AIDS care*. 15(3): 62-69.

Flint, MP. 1995. The Menopause: reward or punishment? *Psychosomatics*. 161-163.



© University of Venda

University of Venda
Creating Future Leaders

Fitzpatrick, JJ. & Whall, AL. 1996. Conceptual model of Nursing: Analysis and applications. 3rd edition. Connecticutt: *Appelton & Lange*.

Frederichs, TJ. & Hall, DR. 2005. Postmenopausal symptoms in a group of rural Xhosa women. *South African Family Practice*. 47(5): 56-58.

Freeman, EW., Sammel, MD., Liu, L. & Martin, P. 2005. The role of anxiety and hormonal changes in menopausal hot flushes. *Menopause Journal North American Menopause Society.* 12(3): 258-266.

Frohlich, KL., Kuh, DJL., Hardy, R. & Wadsworth, MEJ. 2000. Menstrual patterns during inception of peri-menopause: what are the predictors and what do they predict? *Journal of women's Health and Gender-Based Medicine* 9(1): 35-42.

Foundation for Professional Development, 2007. The Integrated Management of Tuberculosis, HIV/AIDS and STI in the Primary Health Care Setting for Nurses. Lynnwood Ridge: LFP.

George, T. 1996. Women in South Indian fishing village: Role identity, continuity, and the experiences of menopause. *Health Care Women International.* (4): 271-9.

Ghaderi, E., Ghazanfarpour, M. & Kaviani, M. 2010. Evaluation of menopausal women's attitudes towards menopause in Shiraz. *Pakistan Journal of Medical Science.* 26(3): 698-703.

Gold, EB., Bromberger, J. & Crawford, S. 2001. Factors associated with age at menopause in a multi-ethnic sample of midlife women. *American Journal of Epidemiology.*153: 865-874.

Graves, B. 1996. Menopause in the Trenches. *Midlife Article*.
http:/www.coaching4midlife.com/article2.html date accessed3/14/2012



© University of Venda

University of Venda
Creating Future Leaders

Greenfield, D. 2007. Menopause as a Physical and Social Women's Problem. 488. Available at http/www. Articlesphere.com/Artivle/Menopase-As-A-Physiological-And-Social-Women. Date Accessed 2010.04/26

Greenglass, E. 2000. Work stress, coping and social support. In D. Nelson and R. Burk (eds). Gender, Work, Stress and Health. Washington DC: American Psychological Association.

Guba, E. & Lincoln, Y. 1985. Naturalistic inquiry. London: Sage Publications.

Hafrz, I., Liu, J. & Eden, J. 2007. A Quantitative analysis of the menopause experience of Indian women living in Sydney, Australian and New Zealand. *Journal of Obstetrics and Gynaecological*. 47(4): 329-334.

Hall, L., Callister, LC., Berry, LC. & Matsuma, G. 2007. *Journal of Holistic Nursing.* 25(2): 106-118.

Hanson, CM. & Hilde, E. 1989. Partnership in Practice: Shaping an Australian urban-rural graduate nursing programme. *Distance education*. 4(1):127-137.

Henn, EW .2010. Menopause and its effect on female lower urinary tract. *South Africa Family Practitioners* 52(5): 405-408.

Helgenson, VS. Cohen, S. & Fritz, HL. 2008. Social Ties and cancer. *In Journal of College Holland.* (Ed). Psychology. New York Oxford Press.

Herek, G. 1999. AIDS and Stigma. *American Behavioural Scientist*. 42(7): 1102-1112.

Hidayet, NM., Sharaf, SA., Aref, SR., Tawfik, TA, .& Moubarak, II. 1999. Correlates of age at natural menopause: a community-based study in Alexandria. *Eastern Mediterranean Health Journal.* 5(2): 307-319.



© University of Venda

University of Venda
Creating Future Leaders

Hill, SS. & Howlett, HA. 1993. Success in Practical Nursing: Personal and Vocational issues. Saunders Philadelphia. 2ed.

Ho, SC., Chan, SG., Yip, YB., Chen, A., Yi, Q. & Chan, C. 1999. Menopausal symptoms and symptom clustering in Chinese women. *Maturitas*. 33 (3): 219-227.

Ho, SC., Chan, SG., Yip, YB., Chan, SY. & Sham, A. 2003. Factors associated with menopausal symptom reporting in Chinese midlife women. *Maturitas*. 44(2): 149-156.

Holland, K. & Hoggs, C. 2001. Cultural Awareness in Nursing and Health care. An Introductory text. London: Edward Arnold.

Holtzhausen, S. 2001. Triangulation as a power tool to strengthen the qualitative research design: The Resource-based learning Career Preparation Programme (RBLCPP) as a case study.

Horan, P., Doran, A. & Timmins, F. 2004. Exploring Orem's self-care model in learning disability nursing. Practical application paper: part 2. *Learning Disability Practice*. 7(4): 33-36

Howard, G. & Kelly, P. 1994. Osteoporosis: Strategies for Prevention and treatment. *Modern Medicine*. 37(7): 18-27.

Huffman, MJ., Tingle, LR. & Bond, LA. 2005. Menopause symptoms and attitudes of African women: closing the knowledge gap and expanding opportunities for counselling. *Journal of Counseling*. 83: 48-56.

Jassim, GA. & Al-.Shboul, Q. 2008. Attitudes of Bahraini women towards the menopause: Implications for Health care policy. *Maturitas*. 59: 258-372.

Jolleys, JV. & Olesen, F. 1996. A comparative study of prescribing hormone replacement therapy in USA and Europe. *Maturitas*. 47: 91-98.



© University of Venda

University of Venda
Creating Future Leaders

Jones, PS. & Meleis, AI. 1993. Health is empowerment. ANS *Advanced Nursing Science*. 15:1-14.

Kakkar, V., Kaur, K., Chopra, A. & Kaur, IP. 2007. Assessment of the variation in the menopausal symptoms with age, education and working/ non-working status in north-Indian sub population using menopause rating scale (MRS). *Maturitas.* 57(3): 306-314.

Kaiser, K. 1990. Cross- Cultural Perspectives on menopause in Flint, M Kronegerg, F & Utian, W eds. Multidisciplinary Perspectives on Menopause. New York: *The new Academy of Sciences*. 430-432.

Kaur, S., Walia, R. & Singh, A. 2004. How menopause affect the lives of women in suburban Chanigarh, India. *Climacteric* 7(2): 175-180.

Kaufert, P. 1996. The social context of menopause. *Maturitas*. 23: (l): 10.

Kaufert, P., Gilbert, P. & Tate, R. 1987. Defining menopausal status: the impact of longitudinal data. *Maturitas*. 9: 217-226

Kelly, O. 2010. Coping. Obsessive-Compulsive Disorder. About Community Guide. http:/ocd.about.com/od/glossary/g/Coping-Glossary.htma. Date ccessed1/26/2012

Kilaf, E. & Kirchengast, S. 2008. Menopause between nature and culture: menopausal age and climacteric symptoms among Turkish immigrant women in Vienna, Austria. *Acta Medica Lituanica.* 15(1): 313-319.

Khoo, CL. & Rerera, M. 2005. Diabetes and the menopause. *Journal of British Menopause Science.* 11(1): 6-11.



© University of Venda

University of Venda
Creating Future Leaders

Kowalcek, I., Rotte, D., Banz, C. & Diedrich, K. 2005. Women's attitude and perception towards menopause in different cultures. Cross-cultural and Intra-cultural comparison of premenopausal and postmenopausal women in Germany and Papua New Guinea. *Maturitas.*51: 227-235.

Kubler-Ross, E. 1969. On death and dying. The stages of grief. Wikipedia, the free encyclopediahttp:/www.tandfonline.com/doi/abs10.1080/15265160490908031accessed4/3/2012.

Krishna, S. 2002. Attitudes towards menopause and hormone replacement therapy in different cultures. *International Congress Series*. 1229: 202-214.

Kronenberg, F. 2006. Hot flashes: Epidemiology and physiology. *Annual New York Academy of Science.* 112.

Krueger, AR. 1994. Focus groups: A guide for applied research. New Dehli: Sage Publications.

Kyriacou, C. & Pratt J. 2007. Burnout, Self-efficacy and Successful Intelligence among Chinese Prospective and In-Service Scholl Teachers in Hong Kong. Educational Psychology: *An International Journal of Experimental Educational Psychology.* 27(1): 33-49.

Lau, BWK. 1994. Stress, Coping and Aging: *Journal of Hong Kong College.* 4(2): 39-44.

Lazarus, RS. 1993. Coping Theory and Research: Past, Present and Future. *Psychosomatic Medicine.* 55: 234-247.

Lazarus, RS. & Cohen JB. 1997. Active Coping Process, Coping Dispositions and recovery from Surgery. *Psychosomatic Medicine*. 35(5): 375-289.

Lazarus, RS. & De Longis, A. 1983. Psychological Stress coping in aging. *American Psychologist*. 38: 245-254.



© University of Venda

University of Venda
Creating Future Leaders

Lazarus, RS. & Folkman, S. 1984. An analysis of coping in a middle-aged community sample. *Journal of Health Social and Behaviour*. 21: 219-239.

Lark, M. 2006. Menopausal Therapies. *Maturitas*. 12(3): 202-232.

Leichhardt Women's Community Health Centre South Africa 3: sexuality. Leichhardt Women's Community Health Centre.

Leon, P., Chedraui, P., Hilgado, I. & Oritz, F. 2007. Perceptions and attitudes towards the menopause among middle aged women from Guayaquil Ecuador. *Maturitas*. 233-238.

Lewis, RL. 1996. When Cultures collide: Managing successfully across cultures. London: Nicholas Bradley Publishing.

Lewis, H. & Kuller, MD. 2011. Heart Disease during Menopause can be avoided with early healthy lifestyle. http://www.madscape.com.accessed 2011/07/01

Lewin, KJ., Sinclare, HK. & Bond, CM. 2003. Women's knowledge of and attitudes towards hormone replacement therapy: *Family Practice*. 20: 112-119.

Lincoln, Y. & Guba, G. 1985. Naturalistic inquiry. Sage Publication. London

Liu, J. & Eden, J. 2007. Experience and attitude towards menopause in Chinese women living in Sydney: a cross-sectional survey. *Maturitas*. 58: 359-365.

Lock, M. 2006. Contested meaning of menopause. *The Lancet* 1-2.

Lock, M., Kaufert, P. & Gilbert, P. 1998. Cultural construction of Menopausal Syndrome. The Japanese Case. *Maturitas*. 317-332.



© University of Venda

UNIVERSITY OF VENDA

University of Venda
Creating Future Leaders

Loewenthal, KM., Cinnirella, M., Evdoka, G. & Murphy, P. 2001. Faith conquers all? Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK. *The British Journal of Medical Psychology*. 74(3): 293-303.

Loutfy, I., Abdel, AF., Dabbous, NI. & Hassan, MHA. 2006. Women's perception and experience of menopause: a community based study in Alexandria, Egypt. *Eastern Mediterranean Health Journal* 12(2): 760-770.

Louise, R. 2006. Menopause the Natural Way. *Women's Health; Health Articles*. (2): 3357

Luoto, R. 2009. Hot flushes and quality of life during menopause. *Women's Health*. 18 May (9): 1186-6874.

Lyytinen, H., Pukkala, E. & Ylikorkala, O. 2009. Breast cancer risk in postmenopausal women using estradiol progesterone therapy. *Obstetrics and Gynecology*. 113(1): 65-73.

Mahmoud, FF. 2006. Human Rights aspects of safe motherhood. *Clinical Obstetrics and Gynaecology*. 20 (3): 409-419.

MacDougall, M. 2002. The role of personal health concerns and knowledge of health effects of HRT on the ever use by menopausal woman. *Woman's Health Gender-based Medicine*. 8: 1-9.

Malacara, JM., Canto de Cetina, T., Bassol, S., Gonzalez, N., Cacique, L., Vera-Ramirez ML. & Nava, LE. 2002. Symptoms at pre- and postmenopausal in rural and urban women from three states of Mexico. *Maturitas*. 43(1): 11-9.

Maluleke, TX. 2007. The Utilization of Puberty rites for Girls for Sexuality Education and Prevention of HIV/AIDS. Among Young People in Vhembe District of Limpopo Province, South Africa. Department of Public Health.



© University of Venda

University of Venda
Creating Future Leaders

Mansfield, PK., Carey, BS., Anderson, A., Barsom SH. & Koch, PB. 2004. Staging the menopausal transition: Data from the Tremin Research Program on Women's Health. *Women's Health Issues*. 14: 220-226.

Margolese, R. 2007. Menopause. Women's Centre. The Well project. Online at http:/www.thewellproject.org/enaccessed2010/12/17.

Matheny, KB., Ashby, JS. & Brack, G. 2009. Increasing Coping Resources: An Experimental Intervention Approach. http://digitalarchive.gsu.edu/cgi/viewcontent.cgi?article=1005&context=cps

Matud, MP. 2007. Gender Differences in Stress and Coping Styles. *Personality and Individual Differences*. 37(7):1401-1415.

McMaster, J; Cormie, K & Pitts, M 1997: The menopausal experiences of women in a developing country/; there is a time for everything: to be a teenager, a mother and a granny. *Women's Health*. 26(4): 1-13.

McKinlay, SM., Brambilla, DJ. & Posner, JG. 1992. The Normal menopause Transition. *Maturitas*. 14: 103-115.

McNeely, C. 2006. Religious Coping by children and Adolescents. 22(3).

Melby, MK., Lock, M. & Kaufert, P. 2005. Culture and symptoms reporting at menopause. *Human Reproductive Update*. 26: 1-18.

Menopause: Blessing or Affliction? 2007. Menopause; the Holistic Approach http://www.liferesearchuniversal.com/menopause.htmlaccessed7/16/2009.

Monterrosa, A., Blumel, JE. & Chedraui, P. 2008. Increased menopausal symptoms among Afro-Colombian woman as assessed with the Menopause Rating Scale. *Maturitas*. 59(2): 182-190.



© University of Venda

University of Venda
Creating Future Leaders

Mouton, J. 1998. Understanding social research. Pretoria. Van Schaick.

Mouton, J. & Marais, JC. 1990. Methodology of the social sciences: Basic concepts. Human Research Council. Pretoria. Johannesburg: RAU.

Muller, LM. 2001. Community participation in health/; perpetual allure, persistent challenge. Health Policy and Planning. Oxford University Press. 16(3):221-130.

Muniski, B. 1999. The educator as a facilitator: A New kind of leadership. *Nursing forum*, 34: 23-29.

Mutale Municipality census 2009. Limpopo Province. South Africa.

Nachmias, CF. & Nachmias, D. 2004. Research Methods in social science. 5th edition. London: Amold/St Martin's Press.

Newitz, A. 1994. Why do you want to get laid: Mapping Sexual Geographies: Available http:/www.eserver.org/bs/17/Newzit htmt. Accessed 13 may 2010.

Nixon, J., Hodge, N., Parr, S., Willis, B. & Hunter, C. 2001. Staying strong: How low income African American manages their menopausal changes. *Women and Health*. 34(2): 81-95.

Nusrat, N., Nishat, Z., Gulfareen, H., Aftab, M. & Asia, N. 2008. Knowledge, attitudes and experience of menopause. *Journal of Ayub Medicine College Abbottabad*. 20 (1): 56-59.

Obermeyer, CM., Reher, D. & Saliba, M. 2007. Symptoms, menopause status, and country differences: a comparative analysis from DAMES. Department of Population Health, Harvard University, Boston, MA, USA. 14 (4): 788-797.



© University of Venda

University of Venda
Creating Future Leaders

Odirile, BE., Mpofu, E. & Montsi, M. 2009. Carer Coping and Subjective well-being among university employees. *Perspectives in Education.* 27(3).

Orner, P. 2005. Sexuality of older women. *Health Systems Trust and Women's Health Review* unit of University of Cape Town. South Africa.

Orem, DE. 1991. Nursing concepts of practice. St Louis: Mosby.

Ozdemir, O. & Col, M. 2004. The age at menopause and associated factors at the health centre areas in Ankara, Turkey. *Maturitas*. 49(3): 211-219.

Ozuzu-Nwaiwu, J. 2007. Black women's perception of menopause and the use of HRT. *Nursing Practice. Clinical research.* 103(2): 34.

Paterson, NJ. 2007. Alternative Medicine. Comprehensive guide to alternative medicine school: Good Health Message Therapy. Rutherford.

Pearce, MJ. & Hawton, K. 1996. Psychological and sexual aspects of menopause. Baillieres. *Clinical Obstetrics and Gynaecological*. 10(3): 385-99.

Pearson, A., Vaughan, B. & Fitzgerald, M. 1996. Nursing Models for Practice. 2nd edition. Butterworth-Heinemann. Oxford.

Peu, M. 2001. Strengthening Health Care *Workers' Update* 30(9): 1.22

Pfaffs, S. 1999. The biology of reproductive hormones. Sex Role. *A Journal of Research.* 10(5):224-312.

Pfeiffer, E., Verwoerdt, A. & Davis, GC. 2008. Sexual behaviour in middle life. *American Journal of Psychiatry.* 128: 1262-7.



© University of Venda

UNIVERSITY OF VENDA

University of Venda
Creating Future Leaders

Polit, DF. & Hungler, BPP. 2006. Nursing research: Principles and methods. JB Lippincott. Philadelphia. Lippincott: Williams & Wilkins.

Polit, DF. & Beck, CT. 2006. Essentials of Nursing Research. Appraising Evidence for Nursing Practice. 6th Edition. Wolters Kluwer Health Philadelphia/

Polit, DF. & Beck, CT. 2010. Essentials of Nursing Research. Appraising Evidence for Nursing Practice. 7th Edition. Wolters Kluwer Health Philadelphia/

Punyahatra, H. 2002. Menopausal Experiences of Thai woman: Part 1. *Maturitas.* 22: 1-7.

Øverlie, I., Moen, MH. Holte, A. & Finset, A. 2002. Androgens and estrogens in relation to hot flushes during the menopause transition. *Maturitas.* 41(1): 69-77.

Raab, K. 2007. Manic depression and religious experience: the use of religion in therapy. *Mental health, Religion and Culture.* 7.473-487.

Rahlenbeck, SI. 2004. Knowledge, attitudes and practice about AIDS and condom utilisation among health workers in Rwanda. *Journal of the Association of Nurses in AIDS Care.* 15.56-61.

Ramya, N. & Parthasarathy, R. 2009. A study on coping patterns of junior college students. Indian Journal of medical research. 134(1): 61-68.

Reis, C., Heisler, M., Amowitz, LL., Moreland, RS., Mafeni, JO., Anyamele, C. & Iacopino, B. 2005. Discriminatory attitudes and practices by health workers towards patients with HIV/AIDS in Nigeria. *PLos Medicine*. 2 (8).

Renolds, RF. & Obermeyer CM. 2001. Age at natural menopause in Beirut, Lebanon: The role of reproductive and lifestyle factors. *American.Humam.Biology*. 28: 21-29.



© University of Venda

University of Venda
Creating Future Leaders

Raynolds, RF. & Obermeyer CM. 2005. Age at natural menopause in Spain and the United States: Results from the DAMES project. *American Journal of Human Biology*. 17: 331-340.

Richter, DL., Greeney, ML., MCKrown RE., Cornell, CE., Littleton, MA. & Pulley, L. 2001. Developing a video Intervention to Model Effective Patient-Physician Communication and Health-Related Decision-Making Skills for Multi-Ethnic Audience. *Journal of American Midwifery and Women Association*. 56(4): 174-176.

Ridley, RT. 2007. Interactive Teaching: a concept analysis. *Journal of Nursing Education*. 46(5): 203-209.

Rogel's 21st Century. Thesaurus. 3rd edition. The Phillip Lief Group

Rodgers, BL. & Knafl, KA. 1993. Concept development in Nursing: Foundations, techniques and Applications. W.B, S Anders Company.

Shah, MD. & Thingujam, NKS. 2008. Perceived emotional intelligence and ways of coping among students. A case of Pakistan Medical School. *Psychology*. 34: 83-91.

Sarantakos, S. 2005. Social Research. 3rd Edition. New York: Palgrave MacMillan.

Saunders, M. Thornhill, A. & Lewis, P. 2003. Research Methods for business students. 3rd Edition. Doring Kindersley: Pearson Education.

Sharps, PW., Phillips, J., Oguntimalide, L., Saling, J. & Yun, S. 2003. Knowledge, attitudes, perceptions and practices of African-American women towards menopausal health. *Journal of National Black Nurses Association.* 14(2): 9-15.

Schneider, HPG. 2007. Issues related to quality of life in postmenopausal woman and their measurements. *Science direct*. 639-654.



© University of Venda

University of Venda
Creating Future Leaders

Schneider, Z., Elliot, D., Lobiondo-Wood, G. & Haber, J. 2004. Nursing research methods, critical appraisal and utilization. 2nd edition. Toronto: Mosby.

Schreiber, E. 2008. Make menopause your friend. Living Naturally and Health Adviser. Sunday Times. Lifestyle. News Paper. 6 June 2010.

Schmitt, M. 2007. Women and menopause. Women decision Making Process. 24(1): 915-931.

Shirley, KC. 2007. Strategies for Preventing TB. 39(3). Pretoria: *Denosa.*

Singh, A., Kaur, S. & Walia, I. 2002. A historical perspective on menopause and menopausal age. Bull Indian Institute. *History Medicine Hyderabad.* 32(2): 121-35

Simkin-Silverman, LR. & Wing, RR. 2000. Weight gain during menopause. Is it inevitable or can it be prevented? *United State National Library of Medicine*. 108(3): 47-56.

Simkin-Silverman LR., Wing RR., Boraz MA. & Kuller LH. 2003. Lifestyle Intervention can prevent weight gain during menopause: results from a 5-year randomized clinical trial. *Annual Behaviour Medicine.* 26(3): 212-220.

Shea, JL. 2006. Chinese women's symptoms: Relation to menopause, age and related attitudes. *Climacteric*. 9: 30-39.

Skinner, EA., Edge, K., Altman, J. & Sherwood, H. 2003. Searching for structure of coping: a review and critique of category systems for classifying ways of coping. *Psychological Bulletin.* 129: 216-269.

Skinner, EA. & Zimmer-Gembeck, MJ. 2007. Development of Coping. *Australian Journal of Psychology.* 58(3): 131-141.



© University of Venda

University of Venda
Creating Future Leaders

Skowron, EA., Wester, SR. & Azen, R. 2004. Differentiation of self-mediates college stress and adjustment. *Journal of Counseling & Development.* 82(1): 69-78.

Smeltzer, SC. & Bare, BG. 2003. Textbook of Medical-Surgical Nursing. 7thEdition. Sage Publishers

Smith, M.., Segal, R. & Segal, R. 2012. Preventing burnout signs, symptoms, causes and coping strategies. Accessed December 4 2011 from http//wwwhelpguide.org/mental/burnout signs, symptoms htm.

Sorgaard, AJ., Tollan, A., Berntsen, GK., Fonnebo, V. & Magnus, JH. 2000. Hormone replacement therapy: knowledge, attitudes, self-reported use and sales figures in Nordic women. *Maturitas.* 35: 229-38.

Somboonporn, W., Seejorn, K., Kleebkaow, P., Junthathamrongwat, N. & Ratanasiri, N. 2002. Knowledge-Attitude-Practice of Sexual Intercourse of Post-menopausal Women using Hormone Replacement Therapy. *Journal of Medicine Association Thai* 85: 167-171.

Sommer, B. 1999. Attitudes towards menopause and aging across ethnic/racial groups. *Psychology of Medicine*. (61): 868-875.

South African Oxford School Dictionary 2004. 2nd edition. Oxford University Press.

Soules, MR., Sherman, S., Parrot, E., Rebar, R., Santoro, N., Utian, W. & Woods, N. 2001. Executive summary: Stages of Reproductive Aging Workshop (STRAW). Fertility and Sterility. 76(5): 874-878.

Sukwatana, P., Meekhangvan, J., Tamrongterakul, T., Tanapat, Y., Asavarait, S. & Boonjitrpimon, P. 1991. Menopausal symptoms among Thai woman in Bangkok. *Maturitas*. 13: 1-20.



© University of Venda

University of Venda
Creating Future Leaders

Surgery, D. 1996. Sexuality: Gender and sexual practices. Arrows for change. 2(2):1-2.

Tesch, R. 2003. Research design: qualitative and quantitative approaches. London: Sage.

Thois, PA. 1986. Social Coping as coping assistance. *Journal of Consulting and Clinical Psychology.* 54: 416-423.

Torgerson, DJ., Avenell, A., Russell IT. & Reid, DM. 1994. Factors associated with onset of Menopause in women aged 45-49. *Maturitus.* 19: 83-92.

Thomas, C. 2010. Menopause and hormone therapy-how confused are you? *Women's health.* CME. 28(1): 38-38.

Thompson, N., Murphy, N. & Stradling, S. 1994. Dealing with stress. London. MacMillan.

Vance, R. & Denham, S. 2008. HIV and AIDS related stigma: Delivering appropriate nursing care. *Teaching and learning in nursing*. 3: 59-66.

Vanda, H. 2003. Japanese Woman: Symptoms Free? Woman's Health Centre. *Discovering Communications*, LLC.17: 1-5.

Vhembe District Municipality, 2009. Limpopo Province. South Africa.

Voda, AM. 1993. The meaning of Menopause: Historical, medical and clinical perspective. *The University of Chicago Press*. 18(2): 447-451.

Vahid, S., Aran, SN., Koksal, S., Isiloglu, H. & Senocak, M. 2006. The prevalence and the age at the onset of menopause in the Turkish women in rural areas. *Saudi-Arab Medical Journal.* 27.1381-1386.

Vlok, ME. 2006. Manual of Community and Communicable Diseases. 5th Edition. Cape Town: *Juta.*



© University of Venda

University of Venda
Creating Future Leaders

Walsh, M. 1998. Models and Critical Pathways in Clinical Nursing, Conceptual Frameworks for Care Planning. 2nd Edition. Bailliere Tindall. London.

Walker, L. & Avant, K. 2008. Concepts analysis. Strategies for theory construction in nursing. Appleton & Lange: Northwalk.

Walusimbi, M. & Okonsky, JG. 2004. Knowledge and attitudes of nurses caring for patients with HIV/AIDS in Uganda. *Applied Nursing Research.* 17(2): 92-99.

Webster's New World Dictionary of the English Language.1984. Poland House. New York. (http://en.wikipedia.org/wiki/Talk:Websters: 275 Dictionary.

Wellons, MM. 2011. Lifestyle intervention in postmenopausal women: winning the case against diabetes. 18(8) 837-838

Wilbur, A. 1995. The influence of demographic characteristics, menopause status and symptoms. Women's attitudes towards menopause. *Women's Health.* 23(3): 19-10.

Wilbur, J., Miller, A. & Montgomery, A. 1995. The influence of demographic characteristics, menopausal status, and symptoms on women's attitude towards menopause. *Women health.* 23: 19-39.

Wilbur, J., Shaver, J., Kogan, J., Buntin, M. & Wang, E. 2006. Menopausal transition symptoms in midlife women living with fibromyalgia and chronic fatigue. *Health Care Women.* 27(7): 600-14.

Wildman, RP., Schott, LL., Brockwell, S., Kuller, LH. & Sutton-Tyrrell, K. 2004. A dietary and exercise intervention slows down progression of subclinical atherosclerosis as measured by intima-media thickness of the carotid arteries. *Journal of American College of Cardiology* 44: 579-585.



© University of Venda

University of Venda
Creating Future Leaders

Winterich, JA. 2007. Sex, menopause and culture. Sexual orientation and the meaning of menopause for women's sex lives. *Quality Health Research*. 17: 189-200.

Wolf, N. 1990. The Beauty Myth at menopause. 1990. London: Chatto & Windus

World Health Organization (WHO) Scientific Group, 1996. Research on the menopause in the 1990's. A report on the WHO Scientific Group. Geneva, Switzerland: World Health Organization.

World Health Organization (WHO) 2009. Women, aging and menopause in developing world. Global Public Health through a feminist lens. May 8:1-3.

Wylie-Rosette, J. 2005. Menopause, micronutrients, and hormone therapy. *The American Journal of Clinical Nutrition.* May 81(5): 1223S-1231S.

Yahya, S. & Rehan, N. 2002. Age, patterns and symptoms of menopause among rural women of Lahore. *Journal of Medical College.* 14(3):9-12.



© University of Venda

University of Venda
Creating Future Leaders

# ANNEXURES

## ANNEXURE A.

A CENTRAL QUESTION AND AN INTERVIEW GUIDE FOR CONDUCTING FGD

One central question '**Please tell me your experiences with regard to menopause?'**

- Please tell me what you refer to in your local language when you age and blood flow decreases or ceases?
- How did you feel when you started seeing the decrease in menses?
- What do you mean by feeling hot in the body and face?
- What do you mean by feeling the urge to urinate?
- How do you experience the urge to urinate?
- What do you mean by avoiding intimacy?
- How does your husband feel when you avoid intimacy?
- Can you explain what you mean by the feeling of vaginal dryness?
- How is your relationship with your spouse at this stage?
- Can you explain how sex affects your relationship with your spouse?
- What are your feelings towards menopause?
- How do you view menopause at your age?
- What are your myths and beliefs regarding menopause?
- How do you cope with menopause?
- Is there any person in the family, community or clinic to support you when you experience menopausal challenges?



© University of Venda

University of Venda
Creating Future Leaders

## ANNEXURE B

## QUESTIONNAIRE

MENOPAUSE RATING SCALE (MRS) QUESTIONNAIRE

MARK THE APPROPRIATE BOX WITH AN **X**

### SECTION 1: DEMOGRAPHIC AND SOCIODEMOGRAPHIC PROFILE

1. Age at menopause

| | | | |
|---|---|---|---|
| 40-50 years | 51-60 years | 61-70 years | 70 years and above |

2. Educational attainment

| |
|---|
| Primary |
| Secondary |
| Tertiary |

3. Marital status

| |
|---|
| Married |
| Single |

4. Parity

| | |
|---|---|
| Nulliparous | Parous |

5. Work status/ occupation

| |
|---|
| Employed |
| Not employed |
| Housewife |

UNIVERSITY OF VENDA



© University of Venda

University of Venda
Creating Future Leaders

6. Relationship with family member

| |
|---|
| So-so poor |
| Good |
| Very good |
| Relative/ friends: Sick; die; worry; care |
| No. of diseases |

7. Self-reported health compared with women of similar age

| |
|---|
| Same |
| Worse |
| Better |
| Affect daily activities |

8. Smoking status

| | | | |
|---|---|---|---|
| Heavy | Moderate | Mild | Non-smoker |

9. Alcohol/ coffee consumption

| | | | |
|---|---|---|---|
| Heavy | Moderate | Mild | Non-drinker |

10. Depression

| | |
|---|---|
| Depressed | Not depressed |

11. Body mass index (weight/kg)

| | | | | | | |
|---|---|---|---|---|---|---|
| 40-49 kg | 50-59kg | 60-69 kg | 70-79 kg | 80-89 kg | 90-99 kg | 100-109 kg |
| 110-119 kg | 120-129 kg | 130-139 kg | 140-149 kg | 150-159 kg | 160-169 kg | 170 and above |

12. Associated diseases

| |
|---|
| Hypertension |



© University of Venda

University of Venda
Creating Future Leaders

| |
|---|
| Diabetes |
| Hypothyroidism |
| Cardiac |

13. Oral contraceptives

| |
|---|
| User |
| Non-user |

14. Exercises

| |
|---|
| Yes |
| No |

15. Use of Hormone Replacement Therapy

| | |
|---|---|
| Yes | No |

16. Sexually active

| | |
|---|---|
| Yes | No |

17. Menopausal status

| |
|---|
| Pre-menopausal |
| Peri-menopausal |
| Post-menopausal |

**SECTION 2A:** THE TYPE, PREVALENCE AND SEVERITY OF MENOPAUSAL SYMPTOMS EXPERIENCED BY PARTICIPANTS AGED 40 YEARS AND ABOVE



© University of Venda

University of Venda
Creating Future Leaders

MARK THE APPROPRIATE BOX WITH AN X

| SYMPTOMS: TYPE | PREVALENCE & SEVERITY | | | |
|---|---|---|---|---|
| VASOMOTOR | No complaint | Mild | Moderate | Severe |
| Hot flushes | | | | |
| Night sweats | | | | |
| Cold sweat | | | | |
| Sweating more than usual | | | | |
| Difficulty falling asleep | | | | |
| | | | | |
| UROGENITAL | | | | |
| Urinating more frequently | | | | |
| Fluid and water retention | | | | |
| Urinary tract/ bladder infection | | | | |
| Avoiding intimacy | | | | |
| Change in sexual desire | | | | |
| Vaginal dryness | | | | |
| Menstrual problems | | | | |
| | | | | |
| MUSCULO-SKELETAL | | | | |
| Aches or joint stiffness | | | | |
| Low backache/ muscle/ joint pains | | | | |
| | | | | |
| GASTROINTESTINAL | | | | |
| Diarrhoea | | | | |
| Constipation | | | | |
| Stomach upset | | | | |
| Lack of appetite | | | | |
| | | | | |



© University of Venda

University of Venda
Creating Future Leaders

| RESPIRATORY | | | | |
|---|---|---|---|---|
| Shortness of breath | | | | |
| Persistent cough | | | | |
| | | | | |
| PSYCHOLOGICAL | | | | |
| Anxious or nervous | | | | |
| Poor memory/forgetfulness | | | | |
| More impatient | | | | |
| Wanting to be alone | | | | |
| Irritability/restlessness | | | | |
| Depressive mood/feeling sad | | | | |
| Feeling hopeless/worthless | | | | |
| Feeling blue | | | | |
| Dizzy spells | | | | |
| Life events related to death in the family, children growing up or leaving home | | | | |
| | | | | |
| SOMATIC | | | | |
| Pins and needles sensation | | | | |
| Headache | | | | |
| Tiredness | | | | |
| Mood changes | | | | |
| Rapid heartbeat/ palpitations | | | | |
| Dry skin | | | | |
| Patches of lighter /darker skin | | | | |
| Breast tenderness | | | | |



© University of Venda

University of Venda
Creating Future Leaders

**SECTION 2B: Challenges faced by menopausal participants (Mark with an X)**

**Are you experiencing the following challenges?**

| | |
|---|---|
| Hot flushes | |
| Night sweats | |
| Sweating more than usual | |
| Difficulty falling asleep | |
| UROGENITAL | |
| Urinating more frequently | |
| Urinary tract/bladder infection | |
| Avoiding intimacy | |
| Change in sexual desire: less/absent | |
| Vaginal dryness | |
| Menstrual problems | |
| MUSCULO-SKELETAL | |
| Aches or joint stiffness | |
| Low backache/muscle/joint pains | |
| PSYCHOLOGICAL | |
| Anxious or nervous | |
| Poor memory/forgetfulness | |
| More impatient | |
| Wanting to be alone | |
| Irritability/restlessness | |
| Depressive mood/feeling sad | |
| Hopeless/worthless | |
| Life events related to death in the family, children growing up or leaving home | |
| Constipation | |
| SOMATIC | |
| Pins and needles sensation | |
| Headache | |



© University of Venda

University of Venda
Creating Future Leaders

| | |
|---|---|
| Tiredness | |
| Mood changes | |
| Rapid heart beat/palpitations | |
| Dry skin | |
| Patches of lighter/darker skin | |
| Breast tenderness | |
| Lack of appetite | |
| Lack of exercise | |
| Craving for sweet food | |
| Liking for alcohol | |
| Other | |

**SECTION 3: AVAILABLE SUPPORT SYSTEMS (tick appropriate response)**

- **Who supports you when you are experiencing menopausal challenges?**

- **your husband**
- **your children**
- **mother if still alive**
- **female relatives**
- **other female elders**
- **neighbours**
- **local clinic**
- **private practitioner**
- **magazines and other books**



© University of Venda

University of Venda
Creating Future Leaders

**ANNEXURE C.**

P.O.BOX 563
SIBASA
0970
07/01/2010

ENQ: Ramakuela NJ.
TEL: 015 963 3999

Head of Department
Department of Health and Social Development
Limpopo Province
Private Bag X9302
Polokwane
0700

Dear Sir/ Madam

**REQUEST FOR PERMISSION TO CONDUCT RESEARCH**

This letter serves as an application to conduct research entitled '**A MODEL TO FACILITATE WOMEN'S COPING MECHANISMS WITH MENOPAUSE'.**

The study will be conducted in Vhembe district of Limpopo Province.

I am presently registered for Doctor Philosophy (Health Sciences) at the University of Venda

I hope my application will receive your favourable consideration.

Yours faithfully
Ramakuela NJ



© University of Venda

University of Venda
Creating Future Leaders

**ANNEXURE D.**

P.O.BOX 563
SIBASA
0970

07/01/2010

*ENQ: Ramakuela NJ.*
*TEL: 015 963 3999*

Chief of Ha-Makuya
Ha-Makuya
P.O. Box 2
Ha-Makuya
0973

Dear Sir/ Madam

**REQUEST FOR PERMISSION TO CONDUCT RESEARCH**

This letter serves as an application to conduct research entitled '**A MODEL TO FACILITATE WOMEN'S COPING MECHANISMS WITH MENOPAUSE'.**

The study will be conducted at Ha-Makuya in Mutale Municipality of Vhembe district in Limpopo Province to Vha-Venda women aged between the ages of 40 years and above.

I am presently registered for Doctor Philosophy (Health Sciences) at the University of Venda

I hope my application will benefit all women in coping with menopausal symptoms.

Thank you
Ramakuela NJ



© University of Venda

University of Venda
Creating Future Leaders

**ANNEXURE E.**

**INFORMED CONSENT**

**Statement by researcher**

Women are exposed to different menopausal experiences in their aging life-time.

The purpose of this study is to:

**Phase 1:**

- Explore and describe the experiences of menopause by women aged 40 and above in Mutale Municipality of Vhembe District.

**Phase 2:**

- Identify and describe the challenges experienced by women due to menopause.
- Analyse the support systems available to women to deal with menopausal experiences.

**Phase 3:**

- Develop a model to facilitate women's coping mechanisms with menopause.

**Phase 4:**

- Validate the model developed in phase three.

I am a PhD student at the University of Venda and I am presently engaged in a study entitled '**A MODEL TO FACILITATE WOMEN'S COPING MECHANISMS WITH MENOPAUSE'.**

Participation in this study therefore voluntary and the participants can withdraw from it without providing any reasons.



© University of Venda

UNIVERSITY OF VENDA

University of Venda
Creating Future Leaders

**Consent by the participants**

I understand the proposed study I was given adequate information and the time to think about the participating. I understand that participation in this study is completely voluntary and that I may withdraw from participating at any time. I agree to this provided my privacy and anonymity is guaranteed.

I therefore give consent to participate in this study.

Signature of participant……..

Date……..



© University of Venda

University of Venda
Creating Future Leaders

**ANNEXURE F.**

**PROJECT: A MODEL TO FACILITATE WOMEN'S COPING MECHANISMS WITH MENOPAUSE.**

**PROGRAMME FOR CONDUCTING WORKSHOPS FOR RESEARCH ASSISTANCE**

**VENUE: HA-MAKUYA**

**DATES: 5-7 July 2011**

**Purpose of the research assistants training workshop:**

- To introduce the topic of menopause
- To introduce research assistants to administration of questionnaires
- To enable the research assistants to apply appropriate data collection skills
- To identify activities in relation to workshop activities
- To demonstrate administration of the questionnaire and return demonstrations in the field work

**DAY 1**

**5TH July 2011**

**Chairperson:**

**Time keeper:**

**Scriber:**

**At the end of the session research assistants should be able to:**



© University of Venda

University of Venda
Creating Future Leaders

- Introduce each other
- Identify good communication skills
- Identify good writing & recording skills

| TIME | TOPIC | FACILITATOR |
|---|---|---|
| 09:00 – 09:15 | Official opening & welcome | Ha-Makuya rep |
| 09:15 – 09:30 | Purpose, objectives of the workshop | Ramakuela NJ |
| 09:30 – 10:00 | Introductions, ground rules, expectations & fears | Group |
| 10:00 – 10:30 | **TEA** | **TEA** |
| 10:30 – 11:00 | What is communication<br>Types of communication<br>Communication skills<br>Community approach and entry | Ramakuela NJ |
| 11:00 – 11:05 | **ENERGIZER** | |
| 11:05 – 12:00 | Background of menopause.<br>Menopausal issues | Ramakuela NJ |
| 12:00 – 13:00 | Contents of the questionnaire | Ramakuela NJ |
| 13:00 – 14:00 | **LUNCH** | **LUNCH** |
| 14:00 – 15:30 | Writing and recording on a questionnaire | Ramakuela NJ |
| | **ENERGIZER** | |
| 15:30 – 16:00 | Summary & closure | Group |



© University of Venda

University of Venda
Creating Future Leaders

**DAY 2**

**6TH July 2011**

**Chairperson:**

**Time keeper:**

**Scriber:**

**At the end of the session research assistants should be able to:**

- Activities related to administration of questionnaire
- Demonstrate interviews and questionnaires
- Demonstrations and re-demonstrations

| TIME | TOPIC | FACILITATOR |
|---|---|---|
| 09:00 – 09:30 | Review day 1 activities | Group |
| 09:30 – 10:30 | Questionnaires/Interviews demonstrations | Ramakuela NJ |
| 10:30 - 11:00 | **TEA** | **TEA** |
| 11:00 – 11:05 | **ERNEGIZER** | |
| 11:00 – 11:30 | Administration of Questionnaire | Ramakuela NJ |
| 11:30 – 12:30 | Administration of questionnaire | Ramakuela NJ |
| 12;00 – 13:00 | Questions and answers | Group |
| 13:00 – 14:00 | **LUNCH** | **LUNCH** |
| 14:00 – 15:00 | Return demonstrations & discussions | Ramakuela NJ |
| 15:00 – 16:00 | Return demonstrations & discussions: questions & answers | Group |



© University of Venda

University of Venda
Creating Future Leaders

**DAY 3**

**7TH July 2011**

**Chairperson:**

**Scriber:**

**At the end of the session research assistants should be able to:**

- Field work consisting of demonstrations and
- Return demonstration of questionnaire administrations

| TIME | TOPIC | FACILITATORS |
|---|---|---|
| 09:00 – 09:30 | Review of day 2 activities | Group |
| 09:30 - 10:30 | Field work and re-demonstrations | Ramakuela NJ |
| 10:30 – 11:00 | **TEA** | **TEA** |
| 11:00 – 11:05 | **ERNEGIZER** | |
| 11:05 - 12:00 | Field work re-demonstrations and return demonstrations | Ramakuela NJ |
| 12:00 - 12:30 | Plenary sessions | Group |
| 12:30 - 13:00 | Return demonstrations | Group |
| 13:00 – 13:30 | **LUNCH** | **LUNCH** |
| 13:30 – 14:30 | Return demonstrations | Group |
| 14:30 – 15:00 | Discussions; questions and answers | Group |
| 15:00 – 15:30 | Way forward; vote of thanks & closure | Group |
| **DEPARTURE** | **DEPARTURE** | **DEPARTURE** |



© University of Venda

University of Venda
Creating Future Leaders

## ANNEXURE G

### FOCUS GROUP INTERVIEW TRANSCRIPT NO 1.

KEY: Researcher = R

Participant = P

R. Good morning?

P. Good morning to you too

R. How are you all this morning?

P. We are very fine

**R. Please tell me your experiences with regard to menopause?**

*Silence*

P. Eeee….we say 'Ndi u tuwa ha nowa' a Tshivenda phrase meaning 'blood is gone when there is stopping of menstruation for good due to aging'. Through probing she explained that, 'This is the beginning of a woman aging and menstruation also starts to disappear gradually with on and off episodes. Blood become scant and eventually disappear for good. This signals old age'.

P. Ah….. It's a difficult conversation but because you want information let me tell you. You see it differs with individuals, when menstruation is about to cease, some women experience a heavy flow of blood with heavy clots for several months. Once it disappears for long at this age we say 'Nowa yo tuwa' blood is gone. It then means you are aging and it is the beginning of health-related problems. **Through probing she continued to say,** You begin to experience many health problems you did not have before and they will appear differently every time. Today you feel this and tomorrow that. They affect both the body and mind. When you seek assistance they tell you it is old age. As I said it all depends on people, you see when we age there are a number of things that happen to our bodies.

**R. Hmmmm things happen to your bodies?**



© University of Venda

University of Venda
Creating Future Leaders

*Pause*

P. Eeee! Once blood start to disappear gradually you start experiencing some changes in your body. **Through probing she said, w**ith others, the blood takes time to disappear whilst with others it happens abruptly where menstruation ceases to occur after coming on and off. This whole body will feel hot from chest upwards to the face. This disturbs our sleep when one is sleeping peacefully. During the day its worse as sometimes it is hot and especially in summer.

P. This is the time of transition from childhood, adulthood and now old age. We have to live by it and is natural there is nothing we can do lets accept old age it has come no more going back. **Through probing she said,** Ah! Nature should take its course and we have to live with it because we cannot go back to childhood our time has passed.

P. Yaaa! The transition is natural but it is an embarrassing time of your life. Yes I accept that I am aging and it is natural but what I feel is not what I had before. **Through probing she said,** I am still a working woman and I do not like smelling urine at all and because I have frequency I am forced to bathe twice a day, in the morning when I go to work and immediately I am from work.

P. The transition is bad, I like winter because we rest from these symptoms and in summer you are forced to drink a lot of water that also create a problem of running to the toilet. You are sometimes afraid to go out at night because its dark and people might attack you. Other concerned members of the family might even ask what the problem is when you frequently run outside the house to relieve yourself. My children even said why can't I use a bucket at night unlike going out in the danger when others are fast asleep.

P. I have a problem of frequently running to the toilet and by the time I reach the toilet I have already wet myself and it embarrasses me especially when my grand-children are around. To come back from the toilet with wet clothes is just an embarrassment and I now dislike drinking a lot of tea in the evening that I like a lot. One cup is enough for me and at night I avoid it.

**R. You said your body becomes hot can you tell me more about it?**



© University of Venda

University of Venda
Creating Future Leaders

P. Eee! The chest and face feels like is burning and you sweat for some time and later cool or feel cold. **Mmm!** During the day I either drink water or stand outside where there is fresh air but at night I simply throw off the blankets and my body will be cool. Sometimes I wash my whole body with cold water if it is too hot but it is dangerous because you might end up catching flu.

P. Hei you! I also agree with her, winter is better, in summer things go wrong at night. You find that the house itself is hot due to steel roof and thinking of going out becomes difficult because of thugs and witches. You end up burning and you will eventually cool off. The mud hut with grass roof is much cooler than this one of steel roof but I cannot use it as the roof is sort of falling and no one is prepared to repair it for me.

**R. Hmmm**

P. I think hot flushes are due to blood unable to move to other parts of the body. The blood become stagnant and accumulates causing health problems. Some people like me have blood pressure and at times it goes high and at the clinic when I consult, the nurses say it is due to old age.

P. With me the sexual desire is gone because I am afraid my tummy will bulge and later it might burst and offensive staff will come out of the vagina and people might be reluctant to help you because of the smell. Only elderly people might sort of help but they become annoyed because they expect you to have stopped sex matters. It also brings a stigma to the family as everyone will talk about it in the community, that you were still having sex at your age because at this age you are supposed to be looking after your grand-children teaching them cultural things, braai nuts and corn, plough and use your pension grant to buy food and things that are not available in the family. Why should you make yourself a laughing stock because other children will tease your grand-children to say your granny has a big tummy which is not nice.

**R. Lets hear from you, you look a bit younger.** I am not sure about that as I have not experienced it and had never asked anyone about it. Maybe one day when I have reached that



© University of Venda

University of Venda
Creating Future Leaders

stage I will be able to tell what it is. **Through probing she continued and said**, Well for now I cannot say anything as I lack information, yes later when I have asked.

P. I have never heard of this before, it is my first time to hear of this thus I cannot budge on the subject. Through probing she said: I just know that one day I will get old but whether blood will cease or not no-one ever talked to me about it. **Through probing she said,** Perhaps I need a serious health education on this aspect.

**R. You said sexual desire disappear can you tell me what happens to those who are still married and stay with their husband?**

P. *Laugh.* Ah! He should be told because if you don't, he will keep on dragging you and want sex and you will refuse knowing what you are afraid of the bulging tummy. Some men become angry for sex because they feel if you have been doing it why all of a sudden you turn your back on them. Another thing you do not know, is that the vagina becomes dry and what's the use of having sex when someone will be enjoying it whilst you don't. Haaaa! It is very painful and it is better to forget about it. I do not want to use anything for my dryness let me accept that I had my time and it is other people's turn to enjoy what we had.

P. Mine once gave me a hot clap on the face and forced me into having sex. One day I forced myself to tell him and also asked him to look for someone he can have sex with.

**R. Hmm**

P. My husband knew that if we continue having sex at this age, he might invite trouble for me and my tummy will bulge and I might die and my family might be angry with him.

**R. Can I take you back, you talked of the bulging tummy, and that one might die, can you tell me more about it?**



© University of Venda

University of Venda
Creating Future Leaders

P. Oh yes! A lot of old women die because the men's dirt (discharges and sperms) get into their tummy and fail to come out that's what causes the tummy to bulge and later it burst dirty and offensive staff comes out from the vagina and they die. In our community area some elders were responsible to clean up so that children should not see anything and she was later buried.

**R. What do you think? What is your opinion?**

P. If you are a jealous old woman, you do not tell it to your husband because he will leave you and go look for a young woman and they will stay together there and leave you on your own. Some unmarried old women who are still sexually active it is said they use condoms.

P. Ah! Ah! Ah!! Followed by laughter and shaking and shaking her head. Condoms for what, those plastics into my body? Never in my life, let them use it not me. Where have you seen a plastic being used in a human body? People will die and they will fail to account for it. Still those old women stink, they have a foul smell because of the dirt that comes from the vagina. They are lazy to bath daily that is the reason they smell so much.

*Silence*

**R. Mmmm**

P. Haaa! Mine is worse, I experience forgetfulness a lot, it's like something has gone into my head. Sometimes I put pension grant money away trying to hide it and I will forget where I put it. I go to the extent of accusing my children and grand-children that they stole it because they are unemployed. When they find it I become ashamed but do not ask for forgiveness. How can you ask forgiveness to your children and grandchildren? They are used to me accusing them every time. I also have these mood swings where I just feel I want to be alone. When someone greets me I simple keep quiet and later regret it that it was unfair to that person I shouldn't have done it. Funny enough I will repeat it on someone else.

P. I have joint and back pain. These are very painful symptoms because if you were busy ploughing or sweeping it becomes difficult to stand up straight. Your back will hurt and you



© University of Venda

University of Venda
Creating Future Leaders

might sometimes feel like crying. These leg joints become so stiff and cold, once you have bended them it becomes difficult to straighten them up.

**R. What do you do when you encounter such a problem?**

P. I simply take my time to unbend and if severe I go to the clinic for medication. My problem is, I sometimes have to walk a long distance to the clinic and I think that aggravates my problem. **Through probing she said,** our clinic is far and there is no transport, sometimes you can be lucky someone with a car might lift you if they know you other than that you have to foot it right to the end. Our place does not have taxis the people here are used to walking.

P. Ah, nurses at the clinic say it is part of old age (*laugh)* and I should accept it as it comes. They would give me rub-rub and some pills for pain to drink after feeds. **Mmm!** At times I become better and at times it is not and I will take warm water to do warm compresses which does help especially in winter so that I can sleep. During the day you keep yourself busy with house hold shores or work in the fields.

**R. Mmm**

P. (*Laugh)* We lack peaceful sleep on other nights, who can fall asleep with such throbbing pain? Some nights it will be so severe that you can nearly see morning comes and at around dawn you start feeling sleepy a bit.

P. Old age is bad, look at my skin is so wrinkled with no flesh. You know I used to be very big and fresh and now I have lost all weight I look wasted. My breast was so big and nice, my children would get enough milk from one breast, but now they are so so thin with no flesh. My big curves and bums are gone with old age.

P. Yes she used to look great with her beautiful body, we grew and attended school together. She used to be very light in complexion, I was light but she was more lighter than me. Maybe it is because we no longer eat good food as our teeth are falling off. What is it that is nice other than



© University of Venda

University of Venda
Creating Future Leaders

meat when you have to chew it in order to enjoy it? When I plough maize I hardly eat it, I only eat maize porridge, no nuts nor sugar cane. This body needs nourishing food and all food is sugar or salt and you cannot enjoy it without them.

**R. Can I ask you granny to please tell me other things other than what we already mentioned?**

P. Eeee! We forgot to mention that ears and eyes deteriorate. These ears have ringing sounds things I never experienced when I was still young, it comes with old age. They become so dry that they always itch and I have to use Vaseline or oil with a chicken feather to instill inside them. Regarding these eyes I would see a person who is nearby, someone far I cannot see nor hear only when nearer I will recognize the voice that it is so and so. I can hardly put a cotton into a needle it is difficult.

P. Constipation is another challenge, if I eat porridge with milk or with spinach I become so constipated that last for days. It hurts and people would say I should drink lots of water but it does not help instead it becomes worse.

**R. Can you please tell me who support you when you experience menopause?**

P. Ahhh! No one except that it is your own thing because if you tell other people they might know your secrets. **Through probing she continued to say,** Why should I discuss my secretes with strangers or other people. At the girls initiation when we were still young old people told us blood will cease and since then no one ever talked to me about it that is why I say it is my secrete.

P. My grand-mother told me some years back about it and some friends also discussed about it in my presence. **Mmm!** There are also some misconceptions about it like we should not have sex with men the stomach will bulge, certain food are not to be eaten like beans as they increase the flow of blood.



© University of Venda

University of Venda
Creating Future Leaders

P. I stay with my mother in law she is now very old and in my entire stay with her I never heard her make mention or discuss about it. **Ok!** She used to tell me about other things but menopause is a taboo.

**R. Mmm**

P. I feel sometimes is better to be open to your friends and colleagues because some people have knowledge and information you can learn a lot from them. **Through probing she said,** I assist with cooking at the school feeding some women are more elderly and they talked about the on and off of menstruation and it is exactly what is taking place in me. I would ask them what could be the cause and they indicated that it is part of aging.

*Silence*

P. As for me, my mother in law with her sister once told me about it when I reported missing of periods for months and coming back again on and off. They indicated that if blood is doing that in the absence of pregnancy it is a sign of menopause. **Mmm!** I stayed with my husband for long in Gauteng and I was so afraid to tell him thinking he would leave me, but my mother in law explained to him when she visited us and since then he is very supportive.

P. *Laugher.* Ah! Others when you tell them they leave you to stay with someone who is still sexually active and when you ask him to come back home he simply say that you are old look after your grandchildren forgetting that he will also become old one day.

**R. Mmm**

P. My children took me to the private doctor because I was not getting any better from my knee joint and back pains. He gave me something but indicated that the medication is just temporary, I should accept that it is part of old age and there is no cure for that. Since then I am trying to cope and I usually tell myself that I have to accept this situation.



© University of Venda

UNIVERSITY OF VENDA

University of Venda
Creating Future Leaders

**R. Thank you very much for your time and sharing your experiences with me. Should I need more information I might contact you. I hope its fine with you.**



© University of Venda

University of Venda
Creating Future Leaders

## FOCUS GROUP INTERVIEW TRANSCRIPT NO 2

KEY: Researcher = R

Participants = P

R. Good morning?

P: Good morning

R. How are you?

P. We are fine and how are you?

R. I am also fine

**R. Please tell me your experiences with regard to menopause**

P. *Laughter* then *Pause* shaking her head, We say blood is gone in our language and it is when menstruation stops, but first on and off, with too much waterish blood, no more clots and eventually disappear slowly. **Mmm!** This is the time of aging as you are no longer young it brings a lot of health problems and you are no longer sexually active.

P. When we grow, one has to move from one stage to another I mean form childhood to old age and it is a process of aging created by nature. **She continued through probing to say,** We just have to live by it and accept nature to take its course. It also means that our lives should continue as usual not hampered by the symptoms we experience.

P. *Hah!* You can see for yourself I am of days (old), this head is grey but I enjoy baldness because of the heat and these things are personally experienced by those who feel them. Some health problems are mild whilst others are severe. The biggest problem is when you sometimes feel severe back pains and joints problems. One is unable to sleep at night because the joints are hot and painful. I sometimes spend half the night awake and seated as the joints would be aching a lot.



© University of Venda

University of Venda
Creating Future Leaders

P. '*Ndi zwa vhadzimu hezwi, vho khaula nowa nge tshifhinga tsha u kegula tsha swika'.* Literally meaning the ancestors stopped menstruation because it was now old age. **Through probing she said,** I have a terrible backache that I would also not sleep some night because the back is painful I would not even unbend my back. I usually maintain the same position throughout the night without turning. Imagine using one position the whole night and my children assist me by putting a warm towel on my back in winter and in summer I just support it. Eating is also difficult when you are sleeping because someone has to feed you especially during the acute times. Sometimes it disappears for a long period especially in summer.

P. Yes menstruation ceases when it is time to age and it is the works of the ancestor who control our lives. **Through probing she continued and said**, Health problems still come in spite of the protection by the ancestors. You suffer some health problems that may or may not be troublesome and severe. It is like a punishment of old age.

P. You see it is like when we were young we menstruated and now we have stopped and crossed over to old age. Blood has gone and we are facing another type of life that of old age. Our normal lives become disrupted with age-related health problems. **Through probing she said: pause and shaking her head**, Ho! I am referring to severe joint and back pains, urinary frequency, sleeplessness, forgetfulness and depression.

P. Yes nodding her head and looking down, the transition brings problems that disrupt our normal life. When I started aging, I developed frequency of urinating. This is really a problem to me especially if I have taken too much water or fluids. **Through probing she said**, I mean you cannot take fluids when you travel or at bed time. You feel you quickly want to relieve yourself all the time and by the time you reach the toilet some urine has wet your under wears. It is quiet embarrassing when you smell of urine and each time you are from the toilet your clothes are wet with urine.

P. What about the issue of hot flushes, I'm telling you this is the other worst health problem. The bleeding on and off and stopping of menses is a big problem. **Mmm!** I feel this heat starting on the chest radiating to the face like a heat wave (hot flushes). In hot weathers I have a problem of



© University of Venda

University of Venda
Creating Future Leaders

surviving with the heat and hot flushes because I sweat severely from the face and neck. I sometimes drink cold water but it is only temporary.

P. Haa! I am unable to sleep at night because of this transition, the hot flushes would come when I am fast asleep and I would have sleeplessness. **Through probing she continued to say,** I hardly use a blanket at night but I use a cloth to cover my waste and bum only not my feet and upper body. Funny enough sometimes my body would feel very cold even if it is hot , I would even think I am catching a flu/cold but to my surprise in the morning on waking up I am fine and that I do not understand.

R. **Mmmm!**

P. As for me I blame the on and off of menses because I now have these headaches. Once it start it is not relieved by clinic tablets but I have to sleep until I feel a bit better. Sometimes if it is not so severe I ignore it. **Through probing she said,** Yes I started experiencing it when my menses started to be on and off. Since then it does not stop as I said it is on and off.

P. I also experience headache and was once referred to the visiting doctor at the clinic and the doctor checked my blood pressure and sugar. **Mmm!** They were both found to be high and the doctor advised me to reduce salt and sugar because they aggravate the condition, he also checked my age and said it could also be part of menopause. When I asked him what he meant he just said it is part of aging and I have to take it easy.

**R. Mmmm!**

P. Doctors do not have enough time to explain to us because he would refer you to the clinic nurses for explanation. **Through probing she continued to say,** Even the clinic nurses would say the same things like the doctor that you have to live with it and take it as it comes. **Mmm!** But they do prescribe something to relieve the symptoms.



© University of Venda

University of Venda
Creating Future Leaders

P. It also happened to me quite often, I also have frequency of urine especially if I have taken too much water. By the time I reach the toilet urine comes out dripping and my under wears are wet. It is true, it embarrasses when you smell of urine and each time you are from the toilet your clothes are wet with urine.

**R. You previously indicated to be no longer sexually active can you elaborate on that please?**

P. Yes you become no longer interested in sex once blood is gone. Sex becomes unpleasant, it is painful as the vagina becomes dry and atrophies. **Ok!** You only do it to satisfy your partner if he demands it. If you are really old and no longer experiencing menses, you need to stay away from sex as you may experience bulging of the stomach which is full of smelling dirt from the man's sperms and discharges. If you persist to have sex the tummy enlarges, later burst as too much stinking fluid comes out and one may die.

P. As for me the sex desire is still there and I still experience my menses though sometimes is on and off. **Through probing she continued to say,** It is difficult if you are married and live with your husband as he wants us to have sex every time. No one tells me anything my mother in law passed on and other elders are not saying anything and we are continuing as usual. I hear it from friends and colleagues but we just laugh about it and it ends there. We lack knowledge and information on this topic maybe you can help us since you are here.

**R.** ***Nod head***

P. I am also sexually active and I do not have a husband but I have a boyfriend whom we have been together for long. He is also elderly but we enjoy sex together. I do not see anything wrong in engaging in sex at our age as long as you are faithful to each other. I have not yet experienced the bulging tummy maybe it will still come as many people talk about it. I am not afraid of it I will consult the doctors if I see any bulging of my tummy.

**R. Hm! Ok tell me your other experiences regarding menopause please?**



© University of Venda

University of Venda
Creating Future Leaders

*Silence then pause*

P. Tiredness of the body especially in hot weathers. We are unable to do anything because this whole body becomes weak and tired and the skin feels hot. **Mmm!** You can see for yourself the skin is wrinkled it is no longer shiny it is baggy and hanging. Fat and muscles have disappeared only the skin is left. I have since lost weight and it happens as I am aging. Look at the colour of my skin, it has gone very dark than before. Anyway I have to accept these changes as they come.

P. When I was still a girl at the initiation school the old ladies used to say our skin will no longer be shiny when we grow old, it is going to wrinkle like theirs which is part of aging and have to accept it. I am now able to see and remember it well now.

P. I am currently experiencing ringing and irritation in the ears. It is so disturbing at night causing sleeplessness. **How were assisted by the doctor?** When I consult the doctors it stops for a while and start again there is no help. I sometimes put cotton wool in the ears to avoid the irritation.

P. My eyesight is disappearing gradually. I used to see well from far and was a dress maker sewing traditional dresses but now I cannot do that anymore.

**R. Hm!**

P. Another experience is that of forgetfulness especially if trying to hide my pension grant money especially if trying to hide my pension money. Researcher, **Mmm!** I am staying with my three grandchildren and we always fighting with for the money lost. I will accuse them of stealing when it is my fault forgetting where I put it. Shame poor kids they are now used to me and my accusations.

P. *Oh!* We nearly forgot bleeding gums and falling of teeth. Teeth fall out one by one without any cause and the gums would bleed especially on waking up. **Mmm!** This is very stressing to see blood when you spit out saliva. This not only it, they are also sensitive to some cold or hot



© University of Venda

University of Venda
Creating Future Leaders

food. If you happen to eat very hot porridge or drink hot tea, you will feel the sensitivity throughout the day.

P. Irritability is another problem I experience I am not certain about others. *All*. Yes we do. This is one of the bad experiences I ever had. It happens from nowhere and some people would be angry with you from your behaviour. **Ok!** I am always at my old husband, he would just ignore me or stand up and go away from me sometimes to his friends or to the fields. He is now used to my behaviour and I feel I push him away he is such a quiet old man.

**R. Now that you have said a lot about your experiences, can you tell me where you get the support from when you experience menopause?**

P. *Silence*..... No one ever discussed with me, these are things you get form the initiation school when we are still young girls and we hardly talked about them till now. In our culture it is taboo to talk about issues from the initiation school and if the elders could hear you talking about it they would pinch your mouth very hard.

P. This is my own experience and I cannot discuss it with anyone especially friends as they will know my secrete and go about telling other people that I have menopaused. **Through probing she continued to say,** my mother in law warned me about avoidance of sex when my first daughter had a baby. She just said I will develop enlargement of the tummy if I persist engaging in sex which can later burst and I might die.

**R. What happened there after?**

P. I just saw my husband avoiding me and later realized he was seeing someone from our village. When I asked him about it , he said his mother told him if we continue having sex I will die and he is to be blamed.

**R. How did you feel about it?**



© University of Venda

University of Venda
Creating Future Leaders

P. It was sad on my side because I still felt sexually active at the time and if I were to be found having sex with my husband the old ladies were going to talk about it loudly. **R. Nodding,** there was a time when he would be back and drunk at night he would force me to have sex with him and I would not say anything to anyone the following day.

P. My husband knows, he does not say anything about it maybe when we are too old. He works in town and comes back home daily and we still enjoy sex like before whenever we feel like it.

P. We also consult at the clinic for some health problems, we elders are given some tablets and told it is part of aging and have to live with it.

**R. What is your opinion regarding treatment you receive at the clinic?**

P. Well, the treatment is the same every time as some nurses do not bother to refer us or change treatment. They would say there is no other better treatment for our ailments. **Mmm!** It is better to make other alternative treatment at home if you have otherwise you will suffer with pain.

P. When I feel body pains I take my *dzembe* (tool) and go the fields and start ploughing and when I come back I have a bath eat and sleep and the same goes for the other days. You see you do not have to listen to your body when in pain that exercise do me good.

P. The same goes for me too I also do what she does and since I started with it my body pains are gone and I do not entertain it I ignore it and continue with my work.

P. Walking to the bush and coming back with fire wood, fetching water from the tap from the street corner is part of my daily exercise and it relieves my body aches.

**R. Thank you very much for your time and sharing your experiences with me. Should I need more information I might contact you again. I hope it is fine with you.**



© University of Venda

University of Venda
Creating Future Leaders

## FOCUS GROUP INTERVIEW TRANSCRIPT NO 3

KEY: Researcher = R

Participants = P

R. Good morning?

P: Good morning

R. How are you?

P. We are fine and how are you?

R. I am also fine

**R. Please tell me your experiences with regard to menopause**

*Silent for some time followed by looking at one another.*

P. Mmmm, Ok! This is the beginning of a woman aging and menstruation also starts to disappear gradually with on and off episodes. Blood become scant and eventually disappear for good. This signals old age and it is God's nature of doing things and is natural to us though not nice.

P. Eeee! We all agree with her but in our Tshivenda culture, we refer to cessation of menstruation as "u tuwa ha nowa" meaning that you are old when you are not pregnant. **Through probing she continued to say,** this is God's nature, HE took menstruation away and we have to live with it.

P. We experience hotness and coldness of the body with severe sweating on the face and chest. In hot weathers is worse, be it during the day or at night. This is like a punishment of old age. When you think that the body is feeling hot, not long you start feeling cold and you will think you are catching a cold.

P. Old age is like a punishment of getting old, we are suffering and it is painful as no one can help us. **Through probing she said,** once you start to age, there are bodily changes that are



© University of Venda

University of Venda
Creating Future Leaders

sometime severe and bothersome. Some days you do not sleep well and it disrupt our quality of life.

P. I have a problem of back and waist pains. **Pointing to her waist and back.** "Azwi pfiwi zwo rali" meaning the pains are hot and throbbing. I am unable to straighten my back properly. As you can see, I'm always bending and the only time when I do not feel pains is when I am sleeping on my back which is very tiring. My grandchild took me to the doctor in town but the treatment he gave me helps a bit. I usually take the treatment at night so that I can sleep.

P. I do not feel all this things they are talking about maybe it is too early for me. This is very strange to me I think I need information on this aspect. Maybe we as youngsters are ignorant about our life and health in future thus we need to be educated adequately.

P. I have not yet experienced changes, nothing has changed so far. We are still young and have not reached old age. **Mmm!** Maybe the worst is still yet to come we will cross the bridge when we reach it. **Through probing she said,** well I do feel it is important to have information if available to prepare myself in time before I start experiencing these changes.

P. Oh no! I do not experience anything of that sort everything is still perfect with me. Maybe I will experience that when the time comes. **Through probing she said**, Of course I am aware some old women like my mother she is 56 years old, experience some form of forgetfulness and sometimes irritability. We always think it is because she is aging

P. We were told at our church conference that menopause is accompanied with health problems and one of them is back and joints pains. **Ok!** We were told that exercise is the best remedy and if you do not exercise your joints will be stiff and deform and will be very painful. I do not experience much of the joints and waist pains as I am always busy at the farm. I work from morning till sunset and by the time I am home after bathing I eat then go to sleep. Even the hot flushes you are referring to I no longer experience them like before. I used to think that I was sick and would consult with the clinic with little help. Now after the church talk I can deal with my health problems.



© University of Venda

University of Venda
Creating Future Leaders

P. Yes one of the nurses gave us a talk at the church conference and she indicated that there are no myths attached to menopause and we are to accept these challenges as they come. **Through probing she continued to say,** we are to take menopause positively in order to deal with its challenges. They indicated many health challenges that accompany menopause and as for me I have forgetfulness which is a serious problem at home. If I have to put away important documents or money, I write down in my booklet to remind me. I stay with my last born daughter who is a lady teacher at a nearby school and her little son they are always away during the day that school. So I need something to remind me where I put things.

**R. Mmm!**

P. I have high blood pressure and it started when I was 46 years old. **Mmm! Ok!** I avoid a lot of salty food and the doctor also indicated that I must not touch salty food. I usually suffer from severe headache which the sister at the clinic said it maybe aggravated by menopause.

P. If one has diabetes like me you experience frequency of urine every time. I like taking a lot of water as I was advised by the clinic sister but I pay the price when I have to run to the toilet to relieve myself. **Yesss!** Only on a few occasions I do not wet my under wear like the days that I did not take too much water.

P. I do not like smelling urine at all and because I have frequency I usually bathe twice a day, in the morning when I go to work and immediately I am from work. But my biggest health problem these days is irritability, mood swings and depression. **Ok!** This became worse when I lost my husband two years ago. I am always irritable by small things and still feel depressed and as a teacher I sometimes realize that it is not good for the children in class. I feel I want to be alone after all this is my last year as a teacher I am going to rest.

**R. Hmm!**



© University of Venda

University of Venda
Creating Future Leaders

P. Another thing that we experience is loss of weight and wrinkling of the skin that is no longer firm and shiny. As for me I took it as part of aging, I cannot go back and I accept it because I take it that I had my time during my youth and womanhood days.

**R. You said your skin look wrinkled, do you still feel attractive in spite of that, please tell me more about it?**

P. Ah! How can you feel attractive if you are wrinkled with no breast and old? Who would look at you as you are no longer sexually attractive? At this stage you are not expected to be having sexual relationships because menopause is associated with no desire for sex. **Through probing she continued to say,** the vagina becomes dry, secretions gradually diminish and eventually disappear thus sex becomes painful, no longer pleasant and enjoyable like before. If you still have a husband who is a migrant labourer sometimes when he comes back home, he bring sexually transmitted infections and you will end up at the clinic for treatment when he goes back.

P. Some of us do not experience sexual problems because we do not have relationships, but it is said sex is associated with enlargement of the tummy which is full of dirty stinking fluid from the men's discharges and sperms. **Ok!** When the fluid is too much the tummy would burst and one would die from it. The smelly staff from the vagina ooze out and only old women are allowed to help clean the staff because they are afraid the young women will gossip about it and it will be embarrassing on the part of the family.

P. It is better to stay away from sex if you are single or a widow to avoid this bulging tummy as other old women do not approve of it. **Through probing she said,** everyone in the village knows you do not have a husband and where does the bulging tummy come from. If your husband is still alive some old women would tell him about it as the wife might die. Some do not listen to it and continue as if they were not told while other are afraid and respect it well.

P. Eee! Those who do not listen do it secretly in the house while others look for someone younger as it is allowed by culture to satisfy their need for sex. **Yesss!** Other marry for the second, third time or take as many women as he pleases if he has money especially the highly



© University of Venda

University of Venda
Creating Future Leaders

sexual males. While other leave their homes to stay with someone younger elsewhere. It is said some men use condoms these days from the clinic to avoid the bulging tummy. We disapprove of it because where have you see a plastic being used on a human being because they say it also burst inside the woman's vagina. Some of us blame family planning pills and injection for the bulging tummy as those pills stay long in the tummy without coming out.

**R. Please tell me who support you when you experience menopause?**

P. As I indicated before our church provide us with different health talks and among them was menopause. There are many nurses who on different days relieve each other and we enjoy it. **Ok!** What is interesting is that the little that they know, they share with us and we gain if you listen. Also the clinic supply us with treatment for these health problems and if you do not get better they refer you to the visiting doctor when he comes to the clinic for better and stronger medication.

P. I sometimes depend on traditional herbs, they help a lot because my grandmother is a traditional healer and she get the herbs from the bush, prepares them for us and we drink if we have some challenges. We do get some relief from other challenges but not all and we go to the clinic for assistance. Others use church tea but the usually say it does not help at all.

P. My husband is supportive because he knows everything and he does not want me to die so he stays away maybe because he is also elderly. **Through probing she continue to say,** I know of husbands who become bored once the discover that their wives have menopause and leave them for other younger women. The problem is when things do not go well and they have to come back home and they expect to be accepted back. That is unfair because you remain suffering and being sick alone. Like myself I used to work in a house as a maid but had to leave working because of my painful back and joints while he was away with other women.

P. As I indicated I stay with my daughter and her child, I do not need to explain anything to her because she will not understand as she is still young. When I am sick yes they help me by taking



© University of Venda

University of Venda
Creating Future Leaders

me to the clinic or doctor for medication and the assist me with household shores and giving me food and water for my medication.

**R. Thank you very much for your time and sharing your experiences with me. Should I need more information I might contact you again. I hope it is fine with you.**



© University of Venda

University of Venda
Creating Future Leaders

## FOCUS GROUP INTERVIEW TRANSCRIPT NO 4

KEY: Researcher = R

Participants = P

R. Good morning?

P: Good morning

R. How are you?

P. We are fine and how are you?

R. I am also fine

**R. Please tell me your experiences with regard to menopause**

P. Hooo! Cessation of menses or rather menstruation gradually disappears on and off and eventually stops for good. It is a normal transition for all women to go through towards aging. It start by heavy bleeding with a lot of clots and later blood thins out like water then disappear. Vaginal lubrication also thins out no more thick and heavy and later also disappear. The vagina dries and atrophies and sex becomes painful.

P. Oh! Cessation of menstruation in our culture is referred to as "*U tuwa ha nowa*" meaning blood is gone for good. **Mmm**! Sometimes blood is gone when you are pregnant but in our case when we are aging it is different, it signals old age. **Through probing she said,** Eee! I agree with her as she has said, blood start to disappear on and off with heavy clots. It is true also true that the vagina dries up, the desire for sex also disappear and no longer pleasant. You see when menstruation disappear it means you are aging and it is the beginning of health-related problems. You start to experience many problems you did not have at first and they appear differently every time. Today you feel that and tomorrow that. When you seek assistance they tell you it is old age.

P. I also agree with them, you see it all depend on individuals, others have menorrhagia for months while other would skip menses for months on and off. You do not experience it like



© University of Venda

University of Venda
Creating Future Leaders

before when you were still young because with some women menstrual pains are no longer there. While with other you still experience them for long like myself I am still experiencing them to date. **Through probing she continue by saying,** when I talked my mother about it she said at my age it signals aging as I have passed 50 years. **Mmm!** She also said when I should stay away from my husband "*ndi songo dzhena nduni ni dovha na tshikulimimba*" meaning I should not engage in sex with him I will develop a bulging tummy.

**R. Hmm!**

P. I am also agreeable with them, life is no longer enjoyable because the whole body is now tired and cannot do heavy duties like before, if you are obese like myself health problems crop up every day. **Yesss!** I experience joint and lower back pains more often than any other problem. I am always sleeping , turning is painful because of my painful back. I also lost appetite because the doctors told me I have diabetes and high blood pressure. They also indicated that my body is too heavy for my joints. I am very frustrated as it is as no one is able to lift me because of my weight.

P. My menstruation have stopped for a year now, I do not experience what they said about vaginal dryness and loss desire for sex. **Ok!** My husband works in Polokwane and he comes back more often and there is no problem of sex with us.

P. Yes it depends with some people who still have relationships, if you still have sexually active men, of course they will demand sex and if the desire is gone that is where you will experience pain during sex.

**R. Please tell me if it your lack of sexual desire is acceptable to these men?**

*Pause*

P. Er! It all depends on the type of men you stay with because some men are knowledgeable about it while other do not care. Some men, who stay with us at home, take it very seriously, if



© University of Venda

University of Venda
Creating Future Leaders

informed they would not like to harm you as they know the consequences of the bulging tummy. **Through probing she said,** they know that if they continue engaging in sex at that age, the tummy will enlarge and may burst and you may die and he will be blamed for your death by the family.

P. You know to tell you the truth, women here in the community are afraid of the bulging tummy and death so they would not unnecessarily engage themselves into sex at this stage. Even men are afraid to be blamed by family members should the woman present with a bulging tummy and die.

P. Yes as indicated it depends on some families as to how serious they might take it. Some people say even if you engage in sex at this age nothing happens while others say it is not true if you die it is because of your own/ other problems.

**R. Please tell me more about the health problems you mentioned before?**

P. Hmm! Some of us experience health problems that easily come with aging and are said to be due to cessation of menstruation. I experience frequency of urinating before I could reach the toilet my panties are wet a bit because holding urine is difficult now. The more you drink water the more frequency you experience. I used not to say it to anyone until a friend of mine remarked about it that my dress was wet at the back. It then became a topic and we share that she also experienced the same.

P. I experience hot flushes and they are bothersome at night as the whole face and neck become wet while sleeping and this causes sleeplessness for me always. **Ok!** I also blame the hot weather because our area is very hot in summer thus one would feel better only in winter or during rainy weathers when it is chilly.

**R. Hmm!**

© University of Venda

P. I blame aging for my skin darkness and being wrinkled as blood become stagnant and no longer moving. Joints, spine and lower back pains are really a problem. This waist is always hot with pains one cannot bend or stand for long. **Through probing she said,** I experience difficulty in working in the fields as it requires me to bend and unbend. What I manage to help with which is also part of exercising is when I sweep at home and it should not be for long of a larger portion. The doctor also asked me to lose weight like her. I used to be healthy before I aged and now look at me….

P. I do not like being alone, I feel like I am going crazy as I even tend to speak alone and sometimes I will realize it when I am speaking loudly. At the same time I experience mood swings as when I have people around me they tend to irritate me and when I am lone and quiet I would cry. I am not sure of what I want as I become too harsh to others. My husband has another wife somewhere and when he is around he is always drunk and it aggravates my irritability.

P. I experience forgetfulness because my brain is no longer functioning well, I even forget my grandchildren's names when they come visit me or it might be because they are many and tend to confuse me. **Through probing she continued to say,** you know when you age it is easy to forget easily though I accept it as part of aging and it is normal in elders like me.

P. My eyesight is disappearing gradually though old I can manage to see a needle hole. Sometimes in the evening I cannot see my way to the toilet and as people staying in the villages I help myself behind the hut. My ears too are also loosing hearing, I want the radio to play louder which is bad for others. When I consult doctors they give me something which helps for a short time.

P. I also experience bleeding gums and teeth, bleeding is worse when I try brushing my teeth. Teeth fall out more often and eventually I will be left with no teeth at all. **Ok!** When visiting the dentist, he indicate no medicine for that instead I use traditional herbs from the bush to stop the bleeding and falling out of teeth that is why I still have a few left to bite meat.

© University of Venda

P. Oh! Another problem is constipation, some food constipate me for example peanuts, traditional porridge and samp. They say water helps if you drink a lot of it but here at our place water is scarce we fetch it from far and we cannot have vegetable gardens due to dry land and lack of water.

**R. Please tell me who support you when you experience menopausal symptoms?**

P. The clinic provides some information on cessation of menstruation and that it is part of aging and menopause and one should accept it. The doctor in town said I should reduce weight and since then I reduced my feeds and do some household shores when I am in less pain from my joints.

P. We also share information as colleagues at church, home and work but we do not share much but the little we share brings change into our lives. Old women do not share anything with us and it is a pity that we will age being a generation with poor knowledge.

**R. Thank you very much for your time and sharing your experiences with me. Should I need more information I might contact you again. I hope it is fine with you.**

© University of Venda

University of Venda
Creating Future Leaders

NEXURE H



© University of Venda

ANNEXURE I

University of Venda
Creating Future Leaders

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

## NAME OF RESEARCHER/INVESTIGATOR:
## RAMAKUELA N.J.

**PROJECT TITLE:** *A model to facilitate women's coping mechanisms with menopause.*

**PROJECT NO:** SHS/11/PDC/004

**SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS**

| NAME | INSTITUTION & DEPARTMENT | ROLE |
|---|---|---|
| Prof. L.B. Khoza | University of Venda, Dean: Nursing Science | Supervisor |
| Prof. H.A. Akinsola | University of Venda, Public Health | Co-supervisor |
| Mrs. N.J. Ramakuela | University of Venda, Advanced Nursing Science | Student |

**ISSUED BY:**
**UNIVERSITY OF VENDA, HEALTH, SAFETY AND RESEARCH ETHICS COMMITTEE**

Date Considered: 21 April 2011
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Prof. C.V. Nikodem

UNIVERSITY OF VENDA
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8484 /8313 FAX (015) 962 8439

*"A quality driven financially sustainable, rural-based Comprehensive University"*

© University of Venda

ANNEXURE J

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

University of Venda
Creating Future Leaders

DEPARTMENT OF HEALTH

Enquiries: Selamolela Donald

Ref: 4/2/2

23 September 2011

Ramakuela NJ

University of Venda

Thohoyandou

0950

Greetings,

**Re: Permission to conduct the study titled: A model to facilitate women's coping mechanisms with menopause**

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
   - Further arrangement should be made with the targeted institutions.
   - In the course of your study there should be no action that disrupts the services
   - After completion of the study, a copy should be submitted to the Department to serve as a resource
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible

Your cooperation will be highly appreciated

DM Mafubelu

Head of Department

Department of Health

Limpopo Province

18 College Street, Polokwane, 0700, Private Bag X9302, POLOKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

© University of Venda

ANNEXURE K

University of Venda
Creating Future Leaders

8 August 2012

To whom it may concern

I completed the editing of the PhD thesis of Nditsheni Jeanette Mashamba Ramakuela entitled *A model to facilitate women's coping with menopause.*

Language usage is not an exact science and different people have different ideas about correctness. To my knowledge the manuscript is free of language errors. In some instances the student was required to decide on certain corrections herself after the editing had been completed.

Yours faithfully

Jean Mitchell (PhD)
(signed)

Tel 012654 2345
Cel 0822022389
Fax 0866116172

Abridged Curriculum Vitae of Jean Elizabeth Mitchell

ACADEMIC QUALIFICATIONS:

BA (Drama)
MEd *An analysis of the content of the Std 7 English first language item bank tests with special reference to problematic items. An evaluative and analytical study*
PhD *Strategies for the development of academic literacy of first-year Education students at Vista University*
Transvaal Higher Teachers' Diploma

EDITING EXPERIENCE
Co-editor of *Progressio, South African journal of distance education practice*
Language and technical editor of *Review of Further and Higher Education and Training*
On editorial board of *The African Education Review*
Freelance editor for *Educor* (the education arm of Naspers publishers)
Freelance editing for PALAMA
Freelance editing for NRF
Freelance language and academic editing of post graduate dissertations and theses of graduates from the University of South Africa; Limpopo University; University of the North; Pretoria University; Milpark Business School
Member of Professional Editors Group.

© University of Venda