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**PERCEPTIONS OF MENOPAUSE:
BLACK AND WHITE WORKING-CLASS WOMEN'S EXPERIENCES**

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ABSTRACT

All women who reach the ages of 40 to 60 years will experience menopause. Yet, there is no comprehensive model or perspective that adequately explains the meanings of menopause for women. The biomedical conceptualization of menopause as a disease or syndrome appears to be the dominant model. Feminist and women-centred perspectives have expanded definitions of menopause beyond the biomedical definition, but have tended to leave out the ways in which class, race, and culture shape experiences of menopause.

This thesis aimed to address the ways in which class, race, culture, gender and power shape experiences of menopause by exploring the experiences of South African black and white working-class women. A preliminary pilot study, consisting of three one-to-one interviews and one focus group, was conducted to identify the method most suited to this exploratory study. For the main study, six focus groups were held with 31 participants from predominantly working-class areas within the greater Cape Town metropole. The groups were racially homogeneous (i.e., three groups each of white and black women). Transcribed and translated data were analysed using a grounded theory approach to identify emerging categories of meaning and themes. Silence, embedded in relations of power, emerged as a central theme, as did themes of gender, race, class, culture, ageing, bodies, and change of life. The relationships between these themes were explored to assess their impact on experiences of menopause.

The power of the biomedical model is illustrated by the way women predominantly framed their experiences within a biomedical discourse. For white women this meant menopause was associated with symptomatology (hot flushes, headaches, high blood pressure, depression, anxiety, irritability, etc), and hysterectomies were common. Black women did not talk about menopause in terms of symptoms, but most had first heard about

"the change of life" from a doctor. The experience of ageing, which is mediated through racism, class, gender and power relations, is particularly salient in the conceptualization of the varied meanings of menopause for black women. They spoke about their experiences of being left by men for younger women, about problems with adult children and families, about joblessness and low wages. Instead of talking about symptoms associated with menopause in biomedical discourse, many black women spoke about experiencing pain in their bodies. While the physical pain is real, it may also be interpreted as symbolic of the "pain" women feel as they age in South Africa.

The main implications for theorization on menopause from this study are that (1) there is no single comprehensive model or perspective which alone adequately explains the meanings of menopause for women, and (2) that it is essential to understand the ways in which bodies (the "lived body") shape experiences of menopause when conceptualising theory, taking into account the specific historical and socioeconomic conditions in South Africa.

Health policy recommendations in this thesis are aimed towards promotion of more equitable health care for older women, but also to help promote gender equity more generally. Moreover, the focus group approach for researching experiences of menopause provides a means of education and support for a few women who are experiencing menopause.

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CHAPTER ONE

INTRODUCTION

Menopause is a ubiquitous phenomenon. It is inevitable that all women who reach a certain age (between 40 to 60) will experience the cessation of menstruation. Some women will have already experienced menopause at an earlier age as a result of hysterectomy, chemotherapy, or other hazardous exposures, such as to radiation. Historically, many stereotypes are associated with women's reproductive capabilities giving rise to myths about menopause. For example, in psychiatric discourse menopausal women were said to be at risk for involuntional melancholia, while in lay discourse, menopausal women are said to "go mad". Menopause is often referred to as the change of life, and sometimes as the climacteric (the "mid-life crisis") which is said to be a time of crisis for both women and men. Psychosocial issues such as the death of parents or spouses, divorce, or the event of children leaving home, which may lead to depression or despair in women, are associated with menopause. Issues of ageing such as changes in the body, health problems, and changes in sexuality often are conflated with menopause. Menopause is seen to signify the time of "going downhill" for women with a concomitant loss of identity, sexual attractiveness, and value as women.

Unfortunately, there is no single coherent model or perspective to counteract the many stereotypes and myths about menopause. Conceptualizations of menopause include biomedical, feminist, sociocultural, and psychological perspectives. Biomedical and psychological conceptions are mainly concerned with an individual woman's experience of menopause in terms of symptomatology. Feminist and sociocultural theorists have broadened the conception of menopause beyond biomedical and psychological perspectives, and have addressed the ways in which social context shapes women's experiences of menopause. The present study is an exploration of menopause in all its complexity. The issue of social context - including variables of class, race, culture, gender, and relations of power - and the

Rubinow, 1991); osteoporosis, and increased risk of cardiovascular disease (Oddens, Boulet, Lehert, & Visser, 1994). Essentially, the biomedical model defines menopause as a deficiency disease. Menopause is categorised with other metabolic and endocrine disorders or described as a clinical disorder of the ovaries characterized by estrogen deficiency (Gannon & Ekstrom, 1993).

The rise in the 20th century of a biomedical conceptualization of menopause as a deficiency disease constituted a change from 19th century medical conceptions, and early 20th century psychological conceptions. For example, Victorian physicians viewed menopause as a sign of sin and decay; and menopause was viewed as a neurosis by Freudian psychologists (McCrea, 1983). According to Bell (1987)

The medicalisation of menopause on the level of conceptualization depended upon the 'discovery' of a theory of etiology [which] was made possible by the paradigm of sex endocrinology. (p. 536)

Thus, the ascent of the deficiency model of menopause was provided its first major boost within a framework of work done by sex endocrinologists in the 1930s which showed the possibility of treating hormonal deficiencies in women with hormone replacement therapy. By the 1960s the notion amongst a large number of physicians that menopause was a deficiency disease was entrenched by the increased availability of synthetic estrogens (e.g., estrogen replacement therapy [ERT]; McCrea, 1983). The assumption is that, in younger women, estrogens protect against heart disease and osteoporosis. In menopausal women, however, the loss of these hormones reflects a harmful health state requiring medical treatment.

Research on HRT

The medicalisation of menopause means that many medical professionals favour medical treatment for problems associated

with menopause, typically hormone replacement therapy (HRT). A sample of studies on HRT prevalence reveal some of the medical profession's concerns around this issue.

Braus (1993), in an article on the ways in which menopause has become big business in the USA, commented that many experts see hormone therapy as a viable option for most older women, although "the effects of long-term estrogen therapy are unknown because no major studies have been completed" (p. 47). Nevertheless, the controversy has not hindered the marketing and sale of Premarin (hormone replacement) which in 1991 was the second most-prescribed drug in the country. Two other studies were concerned with how women decided whether or not to take hormones during menopause. In 1991 Schmitt et al. used policy-capturing and clustering techniques with 265 predominantly white women between 45 and 55 years of age to determine how their judgement policies evolved. Current comfort level (i.e., presence or absence of hot flashes) appeared to be a major determinant in the decision for most women in the study.

Similarly, in a study of how 283 self-selected, highly educated women decided whether or not to take HRT, Rothert et al. (1990) noted that women were concerned about "hot flashes and disturbance of their daily life, and that this, for many, is a larger consideration than the morbidity and mortality risk" (p. 363). The study was concerned with the ways in which women used available information to make a decision about use of HRT. Findings revealed that health care professionals may have placed too little value on process factors when discussing options with a patient. This point was indicated by the informants' responses which demonstrated that there was more than one way of looking at the decision to take HRT. The authors stressed, however, that the results should only be generalized to upper middle-class white women.

In a different vein, Oddens et al. (1994) discussed the phenomenon that rates of use of HRT in Western Europe, Denmark and the Netherlands were generally low, even though many women

interviewed consulted a physician for so-called climacteric complaints. The authors concluded that the low usage rates of HRT could be explained by both women's reluctance to use it, and physicians' reluctance to prescribe it. Physicians in the Netherlands were more likely to prescribe tranquillizers than HRT for climacteric complaints. Oddens et al. argued that it would have been just as beneficial if HRT had been prescribed because the complaints which are usually associated with taking tranquillizers (e.g., nervousness, anxiety, sleeplessness, etc) are due to the direct effects exerted on mood by female sex hormones around the time of menopause. An overview of menopause treatment cautioned that the choice of hormone or non-hormonal therapy should be based on each patient's treatment goals and medical history (Greendale & Judd 1993).

The biomedical model, therefore, tends to stick to a rigid disease-oriented definition of menopause, and favours medical treatment for symptoms associated with menopause. This means that the model overlooks other possible meanings that menopause may have for women.

Feminist and Women-Centred Perspectives

Feminist researchers share with critical theorists the need to make a difference through research; that is, the desire to bring about social change of oppressive constraints through criticism and social action. (Seibold, Richards & Simon, 1994, p. 394)

There does not appear to be a feminist model of menopause *per se*. As Seibold et al. (1994) have pointed out (in their discussion on whether or not there is a feminist method), more important than a check list approach to feminist research is "a statement of essentials, that is, what it is to view the world through a feminist lens" (p. 395). In this context, therefore, many feminists have written about menopause or conducted empirical research on menopause.

Definitions of menopause broadened

A feminist perspective on menopause does not dismiss completely the biomedical model of menopause but rather, offers critical analysis of it by exploring other possible meanings of menopause for women. Feminists, women-centred theorists, and health activists (they are not mutually exclusive) have challenged the disease model of menopause. They have disputed the image of women as inevitably debilitated, physically or emotionally, and in need of medical or psychological treatment (Bell, 1987; Cowan, Warren, & Young, 1985; Fisher, 1994; Jones, 1994; Kaufert et al, 1986; Klein & Dumble, 1994; MacPherson 1981; Morokoff, 1988; Seibold et al, 1994; Ussher, 1989, 1992; Voda, 1992). Seibold et al. argued that the medical profession's main contribution to the debate on menopause had been to portray menopause as pathology: women's future was one of thinned and broken bones of osteoporosis and an increased risk of heart disease.

Menopause has been conceptualised by feminists in the United States as a natural process of ageing, and most women who passed through menopause were perceived to do so with minimum difficulty (MacPherson, 1981; McCrea, 1983). Feminist theorists from the USA and Europe have acknowledged menopause as a biological event (i.e, that cessation of menstruation occurs), but have broadened definitions of menopause to include important social and psychological meanings. For instance, Ussher (1989) argued that:

Anxieties about uselessness, asexuality and lack of identity are real for many women during the menopause. We will see that the anxieties are invariably not the result of internal hormonal changes, as many experts may suggest, but of a complex interrelationship between psychological and social factors involving the internalization of a set of negative constructs which reproduce society's view of the menopausal woman. (p. 105)

In much of biomedical literature on menopause, such as in medical textbooks, the negative aspects of ovaries failing to produce female hormones is emphasised (Martin, 1994). Yet,

feminist writers have argued that empirical research on menopause has not conclusively shown that most women experience menopause negatively, and have demonstrated that the positive aspects of menopause often outweigh negative aspects. According to Coney (1994) midlife is the time that women find their own power.

Some writers have pointed to the historical context of attempts to control women through their reproductive capabilities (i.e., their bodies) as an explanation for why the biomedical model dominates the literature on menopause (Klein & Dumble, 1994; MacPherson, 1981; Ussher, 1989; Worcester & Whatley, 1992). This dominance, in turn, has influenced popular media and public opinion on menopause. This interpretation does not mean that there is a conscious conspiracy amongst medical professionals to subjugate women as a whole, but it does serve to alert women to the dangers that an unquestioning adherence to the dominant model alone can lead to.

McCrea (1983) argued that myths around menstruation and menopause were a form of social control. Other writers (Seibold et al, 1994; Whatley, 1986, cited in Dickson, 1990b) have argued that medical research oversimplifies women's experiences of menopause by conceptualizing them in terms of what is considered the norm for men's development and experience. Traditional definitions of females bodies, health, and sexuality have been constructed and defined in male terms.

Menopause cannot be reduced to symptoms

Consistent with other feminist researchers, MacPherson (1981) was emphatic that menopause can not be viewed as a disease. She urged nurses specifically to dismantle the disease model in their daily work with women by educating them on the positive side of menopause. She noted that "concrete knowledge will demystify menopause" (p. 109). Voda (1992) argued that the disease model

[H]as its origins in patriarchal views and beliefs about women as defective and imperfect (as related to men) and/or machines that need to be fixed. This view of menopause has been socially constructed and has overshadowed the concept of menopause as a normal biologic event. (p. 923)

She pointed out that since a causal relationship between hormone changes and clinical symptoms had not been proven (Goodman, 1991, cited in Voda), menopause could not be labelled a disease. Shapiro (1989) criticised the symptom discourse which characterises biomedical explanations of menopause. The term "signs" was considered more appropriate than "symptoms" which imply disease, while menopause is not a disease. The signs clearly associated with menopause include: (a) cessation of periods (the only sign experienced by all women; (b) vaginal changes; and (c) hot flushes. Moreover, rates of psychological symptoms which have been *said* to be associated with menopause, such as depression, irritability, lack of confidence, decreased libido, and poor concentration have been found to be lower in studies of general population samples when compared to the high rates in clinic populations (Ussher, 1992).

According to Berkun (1986) the perception that menopause is a potential threat to mental health tended to be held by those who equated femininity with sexual attractiveness and reproductive viability. MacPherson (1981) contended that physicians frequently focussed automatically on menopause as the cause of their older female patients' reactive depressions or socioeconomic-related problems. Lock (1994) reviewed cross-cultural research on menopause and found that women do not usually considered menopause a difficult period of time. Meanings and subjective experience associated with menopause vary cross-culturally.

Some limitations of feminist perspective

A cautionary note about the power of a feminist perspective to challenge effectively the biomedical model's hegemony has come from Dickson (1990b). Firstly, Dickson argued that the number of feminist studies is small, and are often subsumed in studies on

the menstrual cycle as a whole. Secondly, while "opposing the powerful image of scientific discourses about women and menopause", (p. 19) the dominance of biomedical discourse has not been dislodged - knowledge and power was squarely located on the biomedical model's "turf". McCrea (1983) pointed to a different problem with some North American feminist studies on menopause. She argued that, in their theorization on menopause, some younger feminists have inadvertently contributed to ageism because they do not have an adequate appreciation of the problems of older women. Theories which concentrate on the natural and unproblematic nature of menopause overlook the minority of women who need medical attention during menopause. Moreover, women who suffer during a time which others claim to be normal or unproblematic may feel shame or guilt.

Sociocultural Model

Within a sociocultural model, menopause is viewed neither as a biological given nor as a deficiency disease. Women's social roles are constructed by cultural values and beliefs, and menopause as an experience is mediated through these values and beliefs (Theisen & Kornoff Mansfield, 1993). The emergence of a sociocultural perspective was due to Flint's (1975, cited in Dickson, 1990a) work on how incapacitation during menopause was related to an older woman's social prestige within her culture, and to other studies which attempted to link experiences of menopause with social roles.

Commenting on the differences between biomedical and sociocultural discourse, Dickson (1990a) noted that the latter model's discourse invoked more varied images of menopause, and described the experience of, or response to menopause rather than "the menopause" per se. Bowles (1990, cited in Gannon & Ekstrom, 1993) postulated that experiences of menopause were influenced by attitudes toward menopause, which were embedded in prevailing sociocultural paradigms. In this context, a woman may experience menopause as "trivial or traumatic, negative or positive" (p. 276).

Theisen and Kornoff Mansfield (1993) and Dickson (1990a) differed in their perspective on the power of the sociocultural model. The former writers claimed that the sociocultural model was one of two major explanatory models of menopause (the other one being the biomedical model). Dickson felt that the sociocultural perspective (along with a feminist perspective) was marginal in its influence in the face of the biomedical model's hegemony.

The weaknesses of a sociocultural model for menopause were postulated by Berkun (1986) and Dickson (1990b). Berkun doubted that women whose discomfort during menopause was hormonally based would be helped to understand the meanings of their experiences through a model which set to "obliterate" the biomedical perspective. Dickson challenged the model in terms of its propensity to reduce experiences of menopause to sociocultural variables alone. She claimed that, in this, way its rigid theorising about experiences of menopause was similar to the biomedical model's narrow conception of menopause, and could thus, in the long-term, be similarly disempowering for women.

The oppositional nature of the biomedical and sociocultural models was a major concern for Theisen and Kornoff Mansfield (1993), especially where the models cause "confusion and slow progress toward a complete understanding of this phase of life" (p. 209). Major hormonal shifts that occur at the end of a woman's reproductive life may explain why some women have symptoms, such as hot flashes and vaginal dryness. Yet this hypothesis was not sufficient to explain varied midlife experiences of women from different cultures. A sociocultural perspective which takes into account the biological base of menopause but which also affirms that experience is grounded in cultural values, would help to clear up much of the confusion about menopause for women, health care providers, and health educators.

Psychological Models

Psychological models of menopause tend to individualise women's experiences of menopause. Many psychotherapists (and physicians) specify psychological problems experienced during this time as primarily intrapsychic. In this context, Bell (1987) suggested that the psychological model of menopause contributes to the literature in contradictory ways. Firstly, the model potentially offers a corrective to the narrow biological model by suggesting that gynecologists look beyond ovarian function for an understanding of menopause. Secondly, however, similar to the biological model, it locates the problems and solutions within the individual. An important consequence of this conceptualization of menopause is that the way in which social relations shape experiences of menopause is underplayed. Ussher (1989) was critical of the tendency to blame all psychological problems that occur during this time on menopause, while at the same time neglecting other equally important aspects such as a woman's particular situation and broader social relations.

In contrast to standard gynaecological textbooks on menopause, which list depression, irritability, lack of confidence and poor concentration as specific symptoms of menopause, psychiatric literature does not focus on menopause as a time of high risk for psychiatric disorder in women (Ballinger, 1990). Moreover, comment on menopause in psychiatric textbooks and journals is notably lacking. Psychoanalytic views of menopause have shifted so that it has been variously viewed as a period emphasising the negative impact of the symbolic significance of menopause on mental health, to the view that personality factors are important in determining how a woman will cope during menopause.

Developmental and psychosocial perspectives

Gergen (1990) reviewed what developmental psychologists have written about women at midlife and beyond. She pointed out that in the extant major theoretical accounts on lifespan development (e.g., Erikson; Freud), and in textbooks on the psychology of women, "Women's adult development is staged around the core notion of woman as reproducer" (p. 474). Gergen outlined three

major conclusions regarding developmental psychology's theoretical and empirical research on women's development in midlife.

- * There are no comprehensive developmental theories that address specifically the maturing woman. (In contrast, there are no similar gaps or silences in the literature for the maturing man.)
- * In those areas where women's midlife development does receive attention, the concern is almost exclusively biological.
- * If women's life stories are conceptualized using narratology (the analysis of how life stories are formed through their narrative structures), the woman's story would be exemplified in the developmental paradigm as being "basically downhill, or regressive, from 40 on" (p. 477).

A serious lack of psychosocial research into the developmental issues which arise prior, during, and following menopause was found unacceptable by Wilk and Kirk (1995). While both clinicians and scholars seem to agree that menopause is a developmental stage, studies of the impact of menopause "on developmental issues such as possible changes in identity, in body image, in social roles, in relationships, and in one's view of the future" (p. 233) are in short supply. In the face of the limitations of the deficiency disease model of menopause, the authors called for an intensified exploration of menopause as a developmental stage within the midlife period. Menopause is seen as a normal phase of development and, as with other phases of development, probably will involve changes in biological, psychological, and social elements of a woman's life.

As mentioned earlier, explanatory models or perspectives of menopause and definitions of menopause are interlinked. They offer different conceptualizations of menopause, and they expand the knowledge of menopause in different ways. In the section that follows, theoretical approaches to gender, bodies and society, all of which are pertinent to an understanding of the meanings of menopause for women, are discussed.

THEORETICAL APPROACHES TO: BODIES, GENDER AND SOCIETY

Most social theory,...seems to operate in the world created by Descartes. There is a sharp, defining split between the knowing, reasoning mind and the mechanical, unreasoning body. (Connell, 1994a, p. 7)

The hegemony of modernist theorists' dualistic worldview has had an inestimable impact on how many women (and men) experience their lives. A women's position in this worldview has historically depended on how her physical body is conceptualized or culturally (and symbolically) represented (Gatens, 1988). Many feminist theorists have articulated theories and/or taken up struggles around women's bodies. Their work often focussed on issues of abortion, reproductive rights, and eating disorders. Other writers' work went beyond this focus to include wider conceptualisations of "bodily meaning".

Social Psychology and Bodies

Radley (1991) has argued that social psychology as a discipline should reclaim the *body* - the psychological body, the body as lived. This was not a bid to develop a new or unitary theory, but rather to reveal what the omission of studying the body has meant for social psychology as a whole. He spoke about the "unseen body" in most social psychological theorization: that bodies are irrelevant, outside the terms of theory, invisible. The reasons for the body not being studied in social psychology are complex. However, the traditional opposition between the biological and the social underlie the reasons: "What is of the body belongs to biology; what is social belongs to society and to people in relationships" (p. 12).

Radley (1991) argued that, by including a study of the body, social psychology will have a better understanding of the way in which gender relations contribute to the functioning of groups. For instance, men and women traditionally use their bodies in different ways, which cannot be reduced to a difference in sex. Patriarchy, the relationship that binds and separates women and men, also works through the body to maintain other forms of

social relationships as well. The use of the body is thus "symptomatic of a group's social condition, displaying the contradictions that relationships of inequality can impose" (p. 108).

Women's Bodies: Wicked, Leaky, Hormonal, or a Failed System

Some writers who have theorized about women's bodies in particular have done so in the context of reproductive experiences of women and the meanings given to them by women. Ussher (1989) stated that the female body had been associated with wickedness, badness, or infirmity throughout history. Powerful discourses which define the female body as dangerous and deviant are used in an attempt to confine women to the private sphere while men dominate the public sphere. Women's bodies are conceptualized as out of control due to their inherent tendency to be "leaky" - menstrual blood, vaginal secretions, childbirth (Lupton, 1996). Menopausal women's bodies intensify this "leakiness" through hot flushes, profuse sweating, and heavy bleeding. A state of unregulated body boundaries associated with early childhood and extreme old age thus threaten to overwhelm menopausal women.

The construction of the hormonal body has provided a specific framework and language for explaining "experiences (physical, psychological and social) and defining new diseases in women" (Harding, 1996, p. 101). Using a metaphor analysis, Martin (1994) conceptualised reasons why biomedical discourse views menstruation and menopause as pathological states. It is partly because ageing women are stereotyped in predominantly negative ways, but is also partly the logical consequence of historically viewing the body as a hierarchical information-processing system. In this context, the biological processes of menstruation and menopause take on the meaning of a failed system (Martin, 1994). Women's bodies, through a "master medical narrative", had been reduced to a biomedical reality.

Women's Bodies: Blood and Nerves

Gifford (1994) explored the discourse of menopause, health and illness among 20 Italian-Australian working-class women between the ages of 40 and 60. She found that the women spoke of their lives through their bodies. They expressed the biological and social changes that were brought about by menopause through the discourses of blood (speaks of physical change) and nerves (speaks of emotional change). For Gifford's participants, the "change of life" marked the end of a woman's (re)productive life. It was a transitional phase which entailed both personal, physical and emotional changes and social changes in their roles as women. Specifically, it was a time of looking back on a life that had already been made, thus "Women's talk about the change of life was very much one of reflection on past accomplishments, failures and disappointments" (p. 315).

Gifford (1994) argued that the experiences of the women as they aged can be interpreted in terms of gender and power relations within the larger social context. What underlies women's personal experiences of their bodies are structural issues of power and powerlessness. She concluded that "illnesses representations...are effective political discourses about power relations which become inscribed upon the body" (p. 315).

While Gifford (1994) addressed gaps in the literature on menopause that are relevant to my research, her work also raises an important issue. She commented that "the body as experienced represents the field upon which structural relationships of class, gender and power are played out" (p. 301). This raises the question as to whether bodies are passive? Are they a neutral surface or landscape on which a social symbolism is imprinted or "inscribed?" These issues are discussed in more detail in sections that follow.

The work of theorists reviewed here is informed by the notion that social relations construct or give meaning to the body. (The biomedical model holds the opposite view, that the [biological] body gives meaning to social relations. Menopause,

in this view, means that problems with sexuality, depression, ageing, etc will occur - which are then treated medically.) While this work is essential for an understanding of the ways in which women's bodies shape experiences, the writers have not offered us a theory that adequately explains

[T]he historical discipline and normalization of the female body - perhaps the only gender oppression that exercises itself, although to different degrees and in different forms, across age, race, class, and sexual orientation - [which] has to be acknowledged as an amazingly durable and flexible strategy of social control" (Bordo, 1993, p. 166).

"The Body"

Three theorists have conceptualised the problem in a way that goes further than other writers in answering the questions posed above. Gatens (1988), Bordo (1993), and Connell (1994a; 1994b; 1995), building on the theories of Foucault, Spinoza, and the concept of reflexive praxis, respectively, have centralized "the body" in their writings on gender. (Perhaps Radley's [1991] work comes closest to their theorizations.)

According to Gatens (1988), little critical work has been done on the conceptual dimension of relations between the body of women and the body politic. This conceptual lack is partly due to feminist theorists who, unconsciously, continues to work with culturally dominant conceptions of the body. Gatens cautioned that

How we conceptualize the body forms and limits the meaning of the body in culture in various ways [and] the female body is conceptualized as intrinsically anarchic or disordered. (p. 60)

This way of conceptualizing women's bodies has the tendency to "justify" the exclusion of women from political participation. Gatens argued, however, that the exclusion of women's bodies from political activity and power has more to do with how access to participation is structured and defined, than to biological differences between women and men.

Gatens (1988), suggested that it is possible to bridge the body/mind (private/public) split by building on Spinoza's seventeenth century conception of the body. His theory is capable of suggesting an account for a relation between the body, social life, politics, and ethics that does not depend on the dualisms of a traditional modern philosophy, but also does not neutralise, dichotomise nor polarise difference. Gatens was confident that Spinoza's formulations would help to eradicate "the division between the private/public spheres [which is] particularly resilient to feminist intervention" (p. 68).

The body re-conceptualized

In their research on gender, Bordo (1993) and Connell (1987; 1994a; 1994b; 1995) argued for a re-conceptualization of the body in order to substantiate analyses of how gender is constructed and perpetuated. "The body" referred to here is neither exclusively conceptualized as a biological entity, nor as a "neutral surface or landscape on which a social symbolism is imprinted" (Connell, 1994a, p. 8). Rather, it refers to "the body as experienced...the 'lived body,' as the phenomenologists put it" (Bordo, 1993, p. 142). During menopause, women's bodies neither only experience biological effects (e.g., cessation of menses), nor do women's bodies passively reflect social relations. Their bodies may also embody the dominant social and cultural ideas and myths about menopause, possibly leading to crises around identity.

Construction of the "normal body"

Bordo (1993), focused on the ways in which human bodies are constituted through cultural practices - the practices and bodily habits of everyday life. She made a distinction between the physical body and the "lived body" by focussing on how cultural practices constitute the so-called normal body. Through routine and habitual activity, our bodies learn which gestures are forbidden and which required: how violable or inviolable the boundaries of our bodies are. Mass cultural representations of masculinity, femininity, beauty, and success can lead to homogenized images which, in turn, serve to function as models

against which "the self continually measures, judges, `disciplines,' and `corrects' itself" (p. 25). Bordo pointed out that culture taught women to be insecure bodies, constantly engaged in physical improvement.

Bordo (1993) incorporated into her own theory Foucault's (1979) thesis that modern (as opposed to sovereign) power produces and normalizes bodies to serve prevailing relations of dominance and subordination. However, she took this thesis further to assert that female bodies historically have been significantly more vulnerable than male bodies, possibly because "women, besides *having* bodies, are also *associated* with the body, which has always been considered women's sphere" (p. 143). Women's bodies (through a pursuit of an ideal of femininity) can become "docile bodies" - bodies whose forces and energies are habituated to external regulation, subjection, and transformation. This insight resonates with articles on menopause that focus on women's experiences or expectations of menopause as mainly negative because of fears about loss of identity as sexual or reproductive bodies. Women experiencing menopause are also expected to fulfill the dominant ideal.

The agency of bodies: Body-reflexive practices

Connell's theory of gender (1987; 1994a; 1994b; 1995) is based on gender as a structure of social practice. He expanded on the work of Turner (1984, p. 190) who described body practices in his book *The Body and Society* as: "Bodies are objects over which we labour - eating, sleeping, cleaning, dieting, exercising. These labours can be called body practices." Connell focused on body-reflexive practices - what bodies *do* (as opposed to how they functioned biologically) - to highlight the body's role in the social construction of gender. He stated that:

The concept of body-reflexive practices allows a more exact definition of gender. Gender is a social practice organised in relation to the reproductive arena, a process in which body-reflexive practices are central...The connection with the reproductive arena is cultural, a matter of the organisation of social relations...We are talking about a *historical process* involving the body, not about a fixed set of biological determinants. (1994a, p. 11)

Similar to Bordo (1993), Connell (1994a) criticized sociobiological and social constructionist approaches to an understanding of gender relations. He argued against the notion that a composite model of the two approaches would be sufficient to explain gender relations. Gender is a historically-produced arrangement of social practices through which lives are ordered and people differentiated. In this context, bodies have their own form of agency, just as important as intellectual agency "where bodies are seen as sharing in social agency, in generating and shaping courses of social conduct" (p. 13).

In his research on masculinity, Connell (1994b) looked at the ways in which bodily activity informs gender meanings. He gave an example of how a male throwing a ball "like a girl" was involved in a "bodily doing, a physical practice in which social meanings are called out, not just received" (p. 16). Connell pointed out that

The story has elements familiar in the politics of women's bodies, especially in the attempts to create disgust with one's body as it is, and to offer commercial remedies in the form of diets, exercise regimes, fashion and cosmetic surgery. (p. 17)

"Menopausal bodies" and body-reflexive practices

Connell's comments reflect reports in the literature on how some women experience menopause or expect to experience it. For example, some proponents of HRT claim that it can retard the ageing process. Women who take HRT for this reason may do so because of disgust or rejection of their "body as it is." In terms of menopause specifically, body-reflexive praxis could be explained as follows:

Women's bodies have a biological pattern - they menstruate for many years and then this stops. This is menopause. As a consequence, certain social practices result: women's sexuality, value, status go down. These social practices in turn have an impact on the body: women may take HRT because they believe it will increase sexual desire or retard the ageing process. They may have cosmetic surgery, or use "anti-ageing" cream, etc. A change or transformation in the body could result if women resort to one or more of these bodily activities. For example, if you take a combination of estrogen and progestin, the body may react with breakthrough bleeding. This whole process is embedded in a historically-produced arrangement of social practice through which gender is constituted, and where bodies have their own form of agency.

Bordo's (1993) and Connell's (1987; 1994a; 1994b; 1995) conceptualisations of the ways in which bodies serve to reinforce and perpetuate unequal gender and power relations appear particularly useful in terms of facilitating an understanding of the experiences of the "menopausal body". In the context of this contention, the next chapter explores through a literature review of empirical studies the problems and contradictions that arise for theorising and conducting empirical research on menopause from having different models or definitions and perspectives. Feminist studies are discussed in detail as they are considered to be particularly important for an understanding of what it means for women to experience menopause.

Bias in Biomedical Research

A common critique of biomedical research concerns the use of clinical populations in research on menopause. For instance, Dickson's (1990b) discussion pointed to the methodological problems associated with using data from patient populations. Reporting on the work of McKinlay, McKinlay & Brambilla (1987, cited in Dickson), which is also supported by the findings of Ballinger's (1990) study, she commented that:

Existing evidence indicates that the current state-of-the-art of biomedical research is based on data from a relatively small proportion of self-selecting women who experience and report problems, utilize health facilities and are therefore conveniently available as research subjects. (p. 170)

Helson and Wink (1992) reported that older literature on women portrayed the years of departing children and the menopause as a time of depression and maladjustment, but studies of nonclinical samples have not supported this picture. It has also been suggested that a predominance of clinical samples in biomedical research on menopause, which include a very high proportion of women who have had hysterectomies, leads to possible false assumptions about a generally high incidence of menopausal problems (Lock, 1986).

Perceptions of menopause from 78 medical professionals and 35 menopausal or postmenopausal women (middle-class, married) were analyzed by Cowan et al. (1985) who concluded that medical perceptions stress symptom pathology and psychological causality more than lay perceptions. Differences in perceptions may derive from medical professionals' clinical observations of the minority of women who experience sufficient menopausal discomfort to seek treatment. A noteworthy point raised in this study was that physicians and nurses did not indicate that they were aware of research findings that demonstrated that "women do not live in dread of menopause and do not experience it in a predominantly negative way" (p. 12).

At the same time, there was scant data available on the "normal" menopause, a situation which had not changed much since the 1970s (Delaney, Lupton, & Toth, 1988, cited in Dickson, 1990b). Reports that many younger women view menopause as a more significant life event than older women, and may even dread its arrival (Neugarten, Wood, Kraines, & Loomis, 1963, cited in Morokoff, 1988), may be partly explained by this gap in the literature.

MENOPAUSE: IDENTITY, SEXUALITY, AND AGEING

Relationships between menopause, identity, ageing, and sexuality have also been explored (Jones, 1994; Leiblum, 1990; Morokoff, 1988; Ussher, 1989). Ussher (1989) discussed the connections between loss of identity during menopause and adult children leaving home, or the so-called empty-nest syndrome. Research by Gilligan and Murphy (1979, cited in Ussher, 1989) showed that women generally look to their relationships for their achievement and successes: "As many of these relationships are changing during the middle years of a woman's life, a sense of loss may be experienced" (p. 126). For some women, children leaving home may be particularly influential in contributing to an overall sense of loss at this time. However, Ussher argued, firstly, that the "empty-nest syndrome" is not inevitable or universal; and, secondly, that evidence shows a majority of women experience an improvement in their lives when their children leave home. Women reported that they have less domestic work to do, and they have more time to spend with their partners.

Moreover, the contention that after the age of 40 women are "past it", is debatable. Comments reported in Ussher's (1989) work on menopause illustrate this point. Menopause was said to be a new lease of life, a new identity, and freedom from the ties of mothering. A longitudinal study of 101 women in their early-40s to early-50s substantiates these comments (Helson & Wink, 1992). The study's participants decreased in dependence and self-criticism, and increased in confidence and decisiveness

as they grew older. A significant drawback of the study, however, is that all the women are college graduates, restricting generalization to other populations.

Most of the 17 women (white, middle-class) who participated in Jones' (1994) qualitative study on menopause reported that menopause did not change their sexuality. However, in the context of society's perception of menopausal and post-menopausal women as less sexual, the women feared the possibility that change would still occur. Yet, many of the women had begun to consider the possibility of a "changing - rather than an end to - sexuality in the years ahead" (p. 55). About half of the women discussed ageing in terms of what it meant to be a woman growing older in a culture that values youth. For the majority of the study's participants, it was hard to conceptualize the boundaries between menopause and ageing. Some of the women were more comfortable attributing bodily changes to the menopause rather to ageing, mainly because of the association of ageing with the finality of death.

Morokoff (1988) argued that much of the research conducted on the effects of ageing on sexuality in women allow us to note differences among age groups but not to attribute them to specific endocrine changes that occur with menopause. In terms of menopause specifically, it appears that menopause does not necessarily play a causal role in women's sexuality. Leiblum (1990) offered a similar explanation. She suggested that changes in women's sexual response may be attributed (a) to the psychological effects and to the physical effects of ageing, or both; (b) to the ageing partner's psychological or physical difficulties; and (c) to the hormonal changes associated with the climacteric.

In a Commentary on Leiblum's (1990) paper, it was illustrated that the manner in which language is used, the tendency towards reporting on, and encouraging research on clinical populations rather than on healthy ones, and assumptions about women's sexual orientation weakens an otherwise commendable article

(Cole & Rothblum, 1990). Notable examples of the impact of the discourse Leiblum used are the use of the terms "symptoms" (which signifies disease), and "foreplay" (which assumes the centrality of intercourse and orgasm in sex). It is considered possible, even imperative, to discover alternative terms to "vaginal atrophy" and "senile skin changes," both of which connote images of "weakness and decay...equating age with 'rotting'" (p. 510).

Leiblum (1990) also neglected to point out that most published work on menopause is based on samples drawn from clinical populations, and that research findings should be interpreted accordingly (Cole & Rothblum, 1990). Additionally, sexual orientation is either disregarded, or assumed to be heterosexual (except in one paragraph which discussed lesbians at menopause). In other words, it followed the norm in the literature on menopause. Since Cole and Rothblum considered it probable that heterosexual and lesbian women experience sex at menopause differently, they proposed that sexual orientation be established for future research on menopause. The exclusion of sexual orientation as a key variable in research on menopause is unacceptable, although perhaps understandable. It fits with my contention that a better understanding of how women experience menopause needs to include women that so far have been neglected in this area of enquiry.

Overall, the studies reviewed indicate that sexual desire does not necessarily depend on levels of hormones in individual women (as the biomedical literature characteristically suggests), nor is it directly related to a woman's age. The extent to which the reproductive process contributes to a woman's identity as a woman, and the degree to which women, especially older women, are valued in society may also affect women's sexual desire.

THE MEDIA'S PERCEPTION OF MENOPAUSE

The literature also explored ways in which various forms of media perpetuate the biomedical model of menopause (Ballinger, 1990; Klein & Dumble, 1994; Ussher, 1989; Voda, 1992; Worcester

& Whatley, 1992). Ballinger (1990) questioned why, in the face of significant evidence to the contrary in the medical literature itself, the disease model of menopause continues to be dominant in the popular media. This situation ties in with the question of who controls the information which gets disseminated through the press, women's magazines, radio and TV. In other words, who controls knowledge about menopause and why?

Ussher (1989) argued convincingly that the dominant biomedical discourse on menopause (as reflected in the popular media) reinforces the oppression of women through attempts to control the reproductive process. One example of this control is the way in which HRT is proselytized. However, it appears that the marketing of HRT is especially directed towards white, middle-class women who are in a position to be more health conscious generally and can presumably afford to pay for the medication (Klein & Dumble, 1994; Worcester & Whatley, 1992). The question of whether women from different class, race and cultural backgrounds are equally affected has not been adequately addressed.

The notion that younger women view the arrival of menopause with dread raises similar questions. Although often alluded to in the literature, it has not been fully explored. Questions such as the following have not been adequately addressed: Does this assertion only hold true for white, middle-class younger women? Who has access to information on the experiences of menopause? If most women do not have negative experiences of menopause (as many feminist writers have asserted), why do younger women still fear it? Why does the media predominantly perpetuate a negative stereotype of menopause?

DEBATE ON HRT

In the biomedical literature, menopause is usually portrayed as a hormonal deficiency disease or syndrome (Bell, 1987; Jones, 1994; Klein & Dumble, 1994; Lewis, 1993; Voda, 1992; Worcester & Whatley, 1992). Women experiencing menopause are depicted as "ill" and in need of treatment (Rosenberg, 1993; Worcester &

Whatley, 1992). The medicalization of menopause leads to medical treatment, typically hormone replacement therapy (HRT). Worcester and Whatley (1992) argued that, in the USA, the medicalization of menopause is informed by the need of the medical establishment and the drug industry to find a new market for their products due partly to a decline in the number of women having babies, and partly to the health system's difficulties in accessing sick people generally. Klein and Dumble (1994) concurred, but expressed it more forcefully:

The discovery of the midlife woman as lucrative business is not surprising. After all, the dwindling population of contraceptive pill users meant that a substitute was needed to maintain profits for pharmaceutical companies. (p. 329)

The benefits and risks of HRT were discussed by Rosenberg (1993) who observed that many studies suggest benefits of taking unopposed estrogens (taken without progestin), yet they do not tackle important questions such as: How long do estrogens need to be taken to achieve a beneficial effect? What doses of estrogen are effective? Which groups of women benefit from taking estrogens? In addition, while unopposed estrogens cause endometrial cancer, and possibly increase the risk of breast cancer, little is known about the long-term effects of the various estrogen/progestin regimes.

Rosenberg (1993) suggested a reconsideration of the benefits and risks of HRT use particularly in view of the tendency to count potential benefits of HRT as real benefits, to discount real risks, and to prematurely extend use from high-risk to lower-risk women without adequate knowledge to support this step.

Feminist and women-centred writers are generally more cautious than their biomedical counterparts in recommending HRT. Two notable exceptions are for the times when women experience vaginal dryness or hot flushes as particularly debilitating or unbearable. At the same time, this literature is often critical of the notion that HRT is a wonder drug which can "cure"

osteoporosis and cardiovascular disease, increase sexual desire, and retard the ageing process (Klein & Dumble, 1994; Riley, 1991; Rosenberg, 1993; Ussher, 1989; Worcester & Whatley, 1992).

Commenting specifically on the issue of sexual desire, Riley (1991) indicated that considerable inconsistencies remain in the literature on the connections between hormonal levels and sexual desire. Writing on how the fear factor is manipulated to market and sell HRT to women in the USA, Worcester and Whatley (1992) criticized the way in which the marketing of hormone products "plays on the fears of specific disabling or life-threatening conditions and also, very purposefully, on *women's fear of ageing*" [italics added] (p. 3). In an ageist society which devalues older women, it is particularly deceitful to consciously manipulate these fears.

Similarly, recommendations that HRT be prescribed for psychological problems which medical professionals attribute to menopause have also been questioned. For instance, not only were Klein and Dumble (1994) and Matthews et al. (1990) skeptical about claims that HRT prevents depression during the menopause, they also pointed out that it could cause depression in women who take it. In addition, writers have expressed alarm that some medical professionals have suggested that HRT be prescribed as a preventative measure to all women who will experience menopause, beginning as early as 35 years old and continuing indefinitely thereafter (Gannon & Ekstrom, 1993; Klein & Dumble, 1994; Rosenberg, 1993). This trend is illustrated by Gannon and Ekstrom's comment that

Medical opinion [in the USA] recommends that all women, when suspecting the beginning of menopause, be evaluated by a physician and be treated with estrogen for the rest of their lives. (p. 276)

Matthews et al (1996) recommended that important selection biases for hormone therapy (e.g., users of ERT had a better cardiovascular risk factor profile prior to the use of ERT than nonusers did) be considered when interpreting results of observational studies of who benefited and who did not benefit

from taking hormone therapy. Dickson (1990b) argued that it remained unclear who the major beneficiary is of returning women to their premenopausal physiologic states with the use of hormones. However, Worcester and Whatley (1992) pointed out that the selling of hormones became profitable for the drug industry, health-service providers, and consumers (in the USA) after it was "discovered" that healthy menopausal and postmenopausal women represented a huge market.

Klein & Dumble (1994) were alarmed, firstly, that women could become addicted to HRT, and, secondly, that they would be blamed for their drug dependency if they did. They cited Garnett et al's (1990) study on the relationship between women using HRT implants and tachyphylaxis (diminished responsiveness to increasing amounts of a physiologically active substance), and Bewley and Bewley's (1992) report on drug dependence with estrogen replacement therapy, to substantiate their argument. The latter report suggested that women "taking HRT might be investigated for DMS-III-R criteria of dependence. Clinicians should be aware of the possibility of dependence and the importance of reporting cases" (p. 291, cited in Klein & Dumble).

Other interesting aspects of the debate on hormone replacement include: (1) the formation of pressure groups of women who have insisted that it was a basic right of women to have access to HRT which was being withheld from them by antifeminist doctors (Greer, 1992; Lewis, 1993). Lewis argued that, in the context of feminist struggle to make medical care available for all women through a national health, there are "no simple answers" (p. 52) to the HRT debate. (2) many women who embarked on a regime of hormone replacement stop taking it after a period of time (Coney, 1994; Klein & Dumble, 1994; Worcester & Whatley, 1992). Women abandon the treatment of HRT because of side effects, advice from general practitioners, fears relating to getting cancer, and because it is ineffective.

PSYCHOLOGICAL SYMPTOMS AND MENOPAUSE

Various writers focussed specifically on psychological aspects of menopause. One study aimed to compare the causal attributions of groups of pre-menopausal and post-menopausal women on the positive and negative moods of a target woman in the climacterium (Lyon, 1984-5). The three sources of attribution were stipulated as environment, age and menopausal symptoms. The underlying assumption was that the participants would attribute another woman's mood to the same source as she would her own in similar circumstances. While postmenopausal women placed much more importance on the environment as a source of attribution than premenopausal women, both groups more often attributed negative moods to age and menopausal status than to environment. Lyon concluded that a reattribution of negative mood to environment or age might help women who became anxious when they experience physiological symptoms during menopause.

Lennon (1987) used data from two community surveys to empirically analyze three major perspectives in the literature about menopausal depression. The three perspectives were that (1) physiological changes of menopause result in increased psychological distress; (2) menopause is most depressing for women who occupy traditional female gender roles; and (3) menopause is not especially depressing for most women. Lennon noted several shortcomings in her study; for example, that she neglected to elicit women's attitudes about menopause, and about traditional and nontraditional gender roles. Nevertheless, Lennon reported that "the analyses failed to demonstrate any association between menopausal status and depressive symptomatology" (p. 14).

A study amongst 541 North American women aged between 42 to 50 years old was also interested in the associations between traditional female roles of wife and mother and midlife depression. Women who had a high level of education, and who had been married to the same partner for a long period, were amongst the least depressed women at midlife, whether they were employed or not. Married women with children who had only a high

school level of education were at highest risk for depression, unless they were in paid employment, in which case their risk was not increased. The study concluded that level of education is inversely related to the risk of depression amongst women "married with children".

Stewart, Boydell, Derzko, and Marshall (1992) investigated the possible differences in psychologic distress in perimenopausal and menopausal women attending a menopause clinic, and concluded that the transitional (perimenopausal) stage is more distressing than the completed (menopause) stage. In another study, Stewart and Boydell (1993) analyzed the relationships between previous depression, psychologic distress and reproductive cycle events amongst women attending a menopause clinic. Findings in this study corroborated other recent studies that showed that women who suffer from affective disorders following one reproductive event are more vulnerable to recurrences associated with subsequent reproductive events.

An article written by Schmidt and Rubinow (1991) illustrates the point raised earlier in this section about psychological adversity and its connection to a biomedical perspective. Schmidt and Rubinow's study cautioned against premature conclusions that menopause-related affective syndromes do not exist. They cited selective interpretation of the data, lack of methodologic precision, and failure to consider that affective syndromes other than major depressive disorder might be associated with menopause as crucial areas of weakness in the research on menopause. However, it is noteworthy that the underlying intention of this article was to stimulate interest in further investigations of the relation between reproductive endocrine change and disturbances in mood and behaviour.

An interesting and unusual psychiatric study looked at integration of aspects of gender and ethnic identity in menopause brought to the psychotherapeutic setting (Zucker Goldstein, 1987). In the context of acknowledging the importance of the roles of gender and of cultural specificity in the

psychodynamic process, Zucker Goldstein discussed two case studies of Italian-American middle-aged women "whose emotional problems began following menopause" (1987: 384). In terms of Italian culture, motherhood is considered the centre from which all family well-being emanates. Women who do not cope well with hysterectomy and menopause often are excluded from crucial family support during these times, which may have devastating implications for self-image and mental health.

The therapist's task is not to alienate the client by attempting to supplant her ethnic value systems with traditional tenets of psychotherapy. The task is rather to integrate all these aspects to facilitate making decisions about interventions and goal-setting in therapy. Zucker Goldstein (1987) was concerned, however, that in the every day practice of psychiatry, attention to this task is frequently overlooked.

Feminist Critique of Psychological Studies

In a recent review of prospective studies carried out in Europe and North America which compared pre- and post-menopausal women, Hunter (1990a, cited in Ussher, 1992) reported that no evidence was found for an association between menopause and emotional problems. Matthews et al. (1990) conducted research on the psychological effects of natural menopause and concluded that there are few detectable changes in women's psychological characteristics during the natural menopause. Similarly, Jackson, Taylor, and Pyngolil (1991) found that menopause per se is not the primary factor responsible for psychological health alterations in midlife women.

A review article that focused on a comparison between gynecological and psychiatric approaches to menopause and general population surveys concluded that no relationship has been established between menopausal hormonal changes and psychological symptoms (Ballinger, 1990). It was noted that the gynaecological and psychiatric approaches are very different, which is directly related to clinical practice. On the one hand, psychiatrists see many women with psychiatric problems, but only

a few are menopausal. On the other hand, gynaecologists see many menopausal women of whom a large number present with psychiatric symptoms. It was hoped that "the bias associated with clinic attendance would be avoided" (p. 775) in the general population surveys. The results of the surveys indicated no major effect of the menopause on a variety of common psychiatric symptoms.

A failure to consider particular life stresses at this time in a woman's life, which are separate from the biological processes of menopause, was emphasized by Morokoff (1988) and Ussher (1989). For example, McKinlay (in press, cited in Morokoff, 1988) pointed to how the stress of being a wife, employee, or mother affects health outcome measures such as depression. Ussher claimed that stressful life events are probably more likely to influence a woman's menopausal symptoms than the biological event of cessation of menstruation, and that the experience of being menopausal may in itself be perceived by some (but not all) women as stressful.

While psychological and life stress theories have contributed to an understanding of how individual women may experience menopause, my research will not be limited to this level of understanding alone. The intention is to incorporate these aspects into a broader social psychological perspective which will also take into account the social construction of menopause and how this affects women from different class, race and cultural backgrounds.

CONTRIBUTIONS AND LIMITATIONS OF STUDIES

Feminist or women-centred writers' main contribution to the research on menopause so far has been to alert us to the diverse meanings menopause can have for women. In this way, it provides a challenge to the dominant biomedical discourse. But the literature still tends to speak primarily for white middle-class women (usually from the USA or Europe), which means that the voices of other women are not heard. We still do not know what menopause "means" for them. Nevertheless, a hint of what could transpire was provided by Dickson (1990a) who hypothesized that,

if black women and working-class women were indeed exposed to different competing discourses (meanings) of menopause, their everyday discourses would be different from her reported sample (11 white, middle-class women). Significantly, Dickson stated that the next step in her menopause research was going to be with black women.

In addition, some feminists have been criticized for implying that menopause is only a socially constructed phenomenon. Posner (1979) compared and contrasted the medical model of menopause with the feminist position, which she claimed stresses cultural factors and downplays physiological ones. While no ally of the medical model, Posner stated that "The feminist position is suggesting (along with the medical establishment) that the experience of menopausal symptoms is largely in the mind" (p. 188). This is a problem for women who experience symptoms because they tended to feel guilty. In the long run, the feminist position can unwittingly be detrimental to the cause of women. A similar sentiment was articulated by Cole and Rothblum (1990) who pointed out that the suggestion that women should "sail through" menopause would be devastating to the woman who does not.

Although Posner's (1979) criticisms are useful in terms of cautioning feminists not to be rigid in their theorising, to my mind they are compromised by her perception that issues of ageing women can be better served by using a sex-role perspective. Connell (1994a) argued that sex role theory's conceptualization of gender is based on a composite model of biology and culture. He rejected the model because, firstly, biology is always seen as the more real, the more basic, of the pair. Secondly, sex role theory constantly falls back towards biological dichotomy. Thus, by resorting to sex role theory as a framework to explain women's experiences of menopause one may be in danger of repeating the same mistakes that Posner argued feminists made in their theorising - reducing the experience to one where one phenomenon (biology) largely constructs destiny.

In a similar vein to Posner (1979) above, Estok and O'Toole (1991) criticized proponents of meaning (including feminists) who

[B]elieve that if some women have a particular menopausal symptom, then all women do. According to this view, all women have all problems. Or if some women have no problems with menopause, then all women have no problems or, at least, no problems of real consequence. (p. 37)

Although Estok and O'Toole believed that meanings are socially constructed, researchers were advised not to neglect the different levels of analyses (social, political, economic, biological) if the meaning of menopause to the health of women is to be adequately understood. McCrea (1983) was also concerned that many feminists in the United States ignore structural factors in their studies on menopause. She felt that studies which illustrated the structural affinities between the economics of health care and the status of women are crucial for pointing the way toward more meaningful change in the health care system.

Some feminist writers have been criticised for contributing to the construction of the menopausal body (Lupton, 1996), and for seldom questioning, within the domain of feminist discourse on HRT and other women's health issues, the ontology of the natural body and the category sex inscribed in medical discourse (Harding, 1996). Lupton argued that a perception of women's bodies being "invaded" by the vested interests of doctors and drug companies invoke an image of women as passive, duped by medical claims or oppressed by medical power. Yet, women are engaged in the type of rational action and prevention strategies that are considered important in the context of late-modern societies. Ironically, feminists who attempt to persuade women to stop using HRT use similar "rational" discourse which tend to

Valor[ize] the active, informed, educated female subject against the passive, dependent subject swayed by the 'false' values of vanity or sheer 'ignorance' into becoming 'medicalized'. (p. 96)

CULTURAL STUDIES ADDRESS THE "GAP"

Other current research has attempted to redress some of the gaps in the literature by centralising either culture, race, or class in their work on menopause (Beyene, 1989; Davis, 1986; George, 1988; Gifford, 1994; Heurtin-Roberts; Lock, 1993; Okonofua, Lawal & Bamgbose, 1990; Rosenberger, 1992; Sillick Standing & Glazer, 1992). To varying degrees, these studies have highlighted the possible connections between culture, race and class and women's experience of menopause, issues which may also prove to be particularly relevant to my research.

Mayan, Greek, Sikh Indo-Canadian Women Reported No Problems

Beyene's (1989) ethnographic research focused on the reproductive lives of rural Mayan Indian women in Yucatan, Mexico and on the reproductive lives of rural Greek women living on the Greek Island, Evia. She spent over 12 months in each location, and used both participant observation and informal and unstructured interviewing to collect data. The Mayan and Greek women shared similar cultural values, for example, beliefs and practices regarding menstruation and child bearing. They also had similar experiences of menopause.

The Mayan women reported no psychological or physiological problems during menopause, and did not experience it as a life crisis. They had no "hot flushes" or "cold sweats," and they had no terminology for these events in their language. The only recognised symptom of menopause was the irregularity and final cessation of menses. Premenopausal Mayan informants looked forward to the onset of menopause. Informants' reports were corroborated by the midwives and healers whom the women consulted. Many Greek women reported having had hot flushes but had not consider them to be disease symptoms. They felt that it was a natural phenomenon causing temporary discomfort and did not seek or feel a need for medical intervention.

Both Mayan and Greek women reported better sexual relations with their husbands after menopause. Since the risk of pregnancy was no longer present, they felt relaxed about sex. They felt young,

and free of the restrictions and taboos that younger women faced. Beyene (1989) suggested that the women's changed status in their respective communities (e.g., no longer involved in the reproductive process nor considered a "sexual threat;" advisor to their sons and to younger women, especially their daughters-in-law) significantly contributes to their overall experience of menopause.

In a modified ethnographic approach with participant observation and open-ended interviews, George (1988) interviewed 50 immigrant Sikh Indo-Canadian women aged 35 and above. Sikh women who emigrated to Canada lived in an ethnically concentrated and insulated community, and maintained their traditional ideology. For these women, marriage and bearing children, especially sons, was seen as a duty. Women's identity and status within the community depended on childbearing. Menopause was neither perceived as a negative life event nor was it perceived as a period laden with symptoms or deficiencies. George noted that the effects of variables such as culture, ideology, and social position contributes to a wellness orientation toward menopause.

Nigerian Study: One of Few Studies in Africa

In 1990, Okonofua, Lawal and Bamgbose reported that very few studies were available from the African continent on menopause and menopausal age. They asked 563 postmenopausal Nigerian women of Yoruba descent to complete a questionnaire designed to determine age of menopause and incidence of menopausal symptoms. Since periods of prolonged amenorrhea were not uncommon for perimenopausal women, only women who had not menstruated for at least five consecutive years were recruited for the study. The relationship between menopausal age and variables such as social class and parity (number of live births) was analysed. The authors hypothesised, firstly, that menopausal age in Nigerian women would be lower than that for Caucasian women, and, secondly, that the symptoms of menopause would probably be less severe due to more favourable socio-cultural circumstances. However, the mean and median ages of menopause in Nigerian women (48.4 and 48.0 years, respectively) matched reported findings

from previous studies done in industrialised Western countries. Menopausal age was found not to be affected by social class or parity.

Joint pain was the main complaint of women in the Nigerian study, while only 30% of women reported incidences of hot flushes (in one study of Caucasian women, the rate of hot flush was reported as 100%). It was suggested that these findings could be due to a higher level of symptom awareness in Caucasian women, because women conflated hot flushes with Nigeria's hot climate or due to endemic malaria fever in Nigerian women. Since the women's adjustment to menopause was essentially positive (up to 94% of the respondents still felt adequate as woman), the authors suggested that the "adult orientation of African societies could be of benefit to postmenopausal women in this population" (Okonofua et al, 1990, p. 344). Interestingly, only 42% of the women reported still having sexual intercourse, which was also considered to be culturally influenced since it appeared much lower than for women in Western societies. The authors indicated that there is a need for more work on menopause in Nigeria.

The Implications of Contextual Divisions and Differences

Rosenberger (1992) gathered data on usages of a Japanese medical term associated with menopause from interviews with 25 Japanese physicians, and, informally, in conversations with a small number of, mainly middle-class, Japanese middle-aged women. By analysing usages of the term "autonomic nervous disorder," she demonstrated how the process of discourse gave voice to both the powerful (physicians) and the less powerful (clients). The doctors' power was demonstrated by not using the term with women they considered to be afflicted with it. By resorting to silence, doctors were putting into practice widely-accepted norms of social relations in Japan. Yet this same silence gave women space to reinterpret the term in other contexts.

They twisted a term that others used to denigrate middle-aged women, employing it to assert their ability to revive the very psycho-spiritual energies that doctors suspected they had lost. (p. 244)

Rosenberger pointed out that the study illustrated the importance of contextual divisions and differences which are neglected in similar research in Western societies. Differences in class, race, gender, and age constrain voices in almost all contexts, yet it is assumed that "the multiple voices of social discourse emerge without constraint" (p. 246).

African-American Women's Experiences

In an area of research in the USA inundated with studies on middle-class white women, Sillick Standing and Glazer (1992) conducted a rare study which assessed the attitudes towards menopause of 66 low-income, predominantly black women between the ages of 18 and 70. The study's informants were recruited from a women's health care clinic affiliated to a mid-western university. Significantly, women who had attended the clinic expressly for treatment of menopausal problems were excluded from the sample. The authors were aware, firstly, that menopausal attitudes could indirectly affect women's perceptions of their menopausal experiences, and, secondly, that attitudes were learned. Furthermore, it was suggested that cultural factors, such as societal norms and expectations, would affect women's attitudes and belief formation toward menopause.

Contrary to the results of a number of previous studies that found that lower income women had more negative attitudes towards menopause than higher income women, Sillick Standing and Glazer's (1992) findings suggested "a trend toward low-income Black women having more positive attitudes toward menopause than middle income White women" (p. 278). The authors suggested a number of possible interpretations for the apparent trend: (1) the notion that black families get more emotional support from their kinship network than white families; (2) the discomforts of menopause possibly seem less significant than other day-to-day problems of survival; and (3) menopause means the end to stress about unwanted pregnancies.

Sillick Standing and Glazer's (1992) study also highlighted other important results which significantly differed with menopause research mentioned earlier in this literature review. For example, in the study under review an unexpected finding was that women between the ages of 18 and 25 reported significantly higher positive attitudes towards menopause than was reported in other studies for women of comparable age. Participants in the study also strongly indicated that menopause did not mean the end of a women's sex life.

Heurtin-Roberts (1993) was among the first to study how a chronic folk illness was used as a resource to help a group of women between 45 to 70 years of age to cope with the problems of everyday life. She discussed how 60 low-income, African-American women who attended an outpatient clinic in New Orleans used a chronic folk illness - "high-pertension" - to

[T]ry to make sense of and organize their health experiences by fitting them in with what their own "mythic world" of health suggests as well as what is learned from biomedicine, personal experience and social interaction; all part of the behavioral environment. (p. 293)

According to Heurtin-Roberts, blood represented great importance in her informants' mythic world. Older African-American women's overburdened social roles were expressed by their blood, which "rises with the problems of the world, at times it boils up and almost spills over" (p. 290). Hysterectomy and menopause aggravated women's "pressure troubles" because when menstruation stopped, the excess blood went up to the head. However, hysterectomy, menopause and high-pertension were also a marker of a life passage; for example, menopause was commonly referred to as a "change of life." High-pertension was used as a legitimate expression of this change from one phase of life to another, and it released Heurtin-Roberts' informants from social norms which governed younger women in good health. High-pertension was a real illness and women did not want it anymore than they wanted cancer, Heurtin-Roberts' (1993) concluded. Yet, while her informants could not say they were

tired of being mothers, it was acceptable to claim, as they did, that high-pertension disallowed them to fulfill the excessive demands of motherhood. They thus emerged with a freer and more powerful sense of themselves.

Blood and Nerves

In a different milieu from the study previously mentioned, but with some notable similarities in informants' beliefs about the change of life, Gifford (1994) explored the discourse of menopause, health and illness among 20 Italian-Australian working-class women between the ages of 40 and 60. Using methods of interpretative anthropology and the perspectives of critical feminist theory, she found that women spoke of their lives through their bodies. The meanings of change in their lives were expressed through the discourses of blood and nerves. The change of life was seen as a transitional phase which entailed both personal, physical and emotional changes and social changes in their roles as women. Specifically, it was a time of looking back on a life that had already been made, thus "Women's talk about the change of life was very much one of reflection on past accomplishments, failures and disappointments" (p. 315). Gifford analyzed how the women's background of migration from Italy (mainly southern regions) to Australia, in the 1950s and 1960s, helped to shape the way they experienced menopause. She commented on a previous study of Southern Italian women who lived in Melbourne which described how the desire to return to Italy increased as the women aged (Kasnitz, 1981, cited in Gifford, 1994). The dilemma that the women faced, however, was that if they returned to Italy, they lost their children; if they stayed in Australia, they became lost in their old age. This latter point had relevance for Gifford's participants who felt that in Italy they would have gained a new status as older women that was not possible in Australia.

The local language of nerves and blood in a Newfoundland fishing village provided the basic structure of the menopausal discourse of 38 women involved in a study based on qualitative ethnographic description and an emic analysis (Davis, 1986). The

terms menopause or climacteric were unfamiliar to the women; however, the term "the change" was almost equivalent in meaning. The change entailed different processes related to the cessation of menses and any coincident benefits or disturbances, such as: "the change from women to child", "the turn of life", or "the final clearing out" (p. 78). Women seldom referred to the change, however, but rather to what happens "to your nerves on the change" (p. 80). Nerves (which could be bad, good, strong, thin, tight, weak, or come unstrung) were seen as directly or indirectly related to women's experiences of menopause.

As with the Italian-Australian women in Gifford's (1994) study, the women perceived menstrual blood to be an indicator of health, yet there was not the same feeling that the end of the flow inevitably means a decline in health: "the final clearing out (menopause) must last for the rest of life and should be thorough" (Davis, 1986, p. 80). In the context of understanding the nature of behaviour "on the change" and the semantics of blood and nerves, Davis hypothesised that the meaning of menopause can not be reduced to symptomatics, folk or otherwise, because in Harbour culture there is no body/mind dualism or any marked self/society dualism. Finally, Davis critiqued earlier ethnographic studies which found an association between improved or high social status and a positive attitude towards menopause. Women may draw on high status as an extra resource during menopause, but it does not guarantee an easier menopause or positive change in their social lives.

Another study looked at the politics of ageing and menopause in Japan and North America (Lock, 1993). In both settings, the study described female ageing as constructed out of assumptions about the place of women in society. Personal experience of ageing was ignored and women were "reduced to a uniform mass, their variety obliterated" (p. 357). The many ways in which the majority of Japanese and North American women resisted, manipulated, and laughed at these assumptions were also ignored.

It is refreshing to reflect here on a study illustrating yet another example of women's refusal to passively accept being devalued as women.

SOME SOUTH AFRICAN VIEWS ON MENOPAUSE

In order to see the ways in which various models, perspectives, and empirical studies apply locally, the following section will explore activities, media reports, and published articles on menopause in the South African context.

Who Gets to Know What Menopause Is

A conference on menopause, sponsored by several drug companies, was held in Johannesburg last year. The Conference was entitled: *Fear of 49: A national symposium for women in their prime*. The conference's brochure claimed that

Today, advances in medical research have reached unprecedented heights. As a result *never before has so much been known about menopause*. The National Symposium will provide all women with an opportunity that has NEVER BEFORE been available - access to information which will eliminate fear.

All [italics added] women over, and under, the age of 35 years were urged to attend the conference. However, it was most likely that only women who could afford the R195 attendance fee, could speak or read English, or who already had access to literature on menopause, would take part. Around the same time as the conference was being organised, the Women's Health Project at the University of the Witwatersrand launched a competition to encourage research on menopause. The idea for the competition arose when interviews with older black South African women attending rural clinics found that the women were having problems identifying "a hot feeling all over the body". The Project's researchers, themselves not sure if the women were experiencing hot flushes, realised that there is a dearth of information on menopause in South Africa.

Thus, for a middle-class, predominantly white urban audience, menopause in South Africa appears to be a relatively high profile issue with source of important, if not unbiased,

funding. For a group of marginalised rural predominantly black women, however, menopause appears to be uncharted territory, a mysterious "hot feeling" of unknown origins.

Review of South African Literature

A search on various computer referencing databases (BORIS, SA Periodicals Index, and Medline) reflected both the biomedical dominance in literature on menopause elsewhere, and the lack of empirical research on older women generally. I first did a search at the beginning of 1995 and repeated this search towards the end of 1996. Only a few new references came up, and they were biomedically-oriented.

So what does the literature say? The benefits and risks of hormone replacement therapy was the focus of much of the reviewed literature, both biomedical and non-medical (Anonymous, 1990; Cape Times, 6/96; Davey, 1994; Khan, 1996; La Rose, 1992; McAllister, 1989). The benefits of taking HRT were seen to outweigh the risks in the majority of articles. Two examples will be used to reflect the argument of the writers, as there is consistency in the approach in all articles.

Khan (1996), described menopause as a physiologic rather than a pathological state. However, the author then went on to list the signs and symptoms of menopause as including headaches, tiredness, loss of concentration, insomnia, irritability, nervousness, forgetfulness, weepiness or crying spells, depression and diminishing sex drive, and recommended that all symptoms be treated with HRT. (Besides Khan's description of menopause seeming more psychological than physiological, one wonders, if menopause were to be a pathological condition, how much worse could the conception of menopause be!) Most of the articles are similar in assuming a range of physical and psychological symptoms are associated with menopause.

Davey (1994) focussed on the issue of HRT, and suggested that the indications for prescribing HRT should include:

- (1) *Premature menopause* - as soon as diagnosed or ovaries removed.
- (2) *Before "menopause"* - if any typical symptoms.
- (3) *At menopause* - ideally all women with or without symptoms.
- (4) *Postmenopause* - start at any age to relieve symptoms or to help prevent/treat osteoporosis and atherosclerosis.
(p. 1016)

The implication is that most women, especially around menopause, will be, or should be, on HRT. This approach to HRT was a common theme throughout the majority of articles reviewed.

Research on menopause that was not concerned with HRT but still fell within a biomedical framework included: Investigation of factors that made some menopausal women at higher risk than others for breast cancer (Hill et al, 1980; Walker et al, 1984); the implications for further study and preventative measures derived from investigation of bone loss for white and coloured postmenopausal women (Kalla, Fataar, & Bewerunge, 1994); a study designed to assess the demographics, knowledge, attitudes, and experiences of menopause (including symptoms and treatment of them) of women in the community of Mamre, a rural village 60 km from Cape Town (Ambler et al, 1996). Amongst other things, the latter study found that there was a lower level of knowledge about menopause than anticipated amongst participants, and that most participants wanted more information about menopause. Recommendations to help increase the community's knowledge of menopause were included in the report (e.g., holding a workshop, disseminating pamphlets, women forming support groups).

Two postgraduate course papers in the Public Health Programme, University of the Western Cape have addressed menopause. Struthers (1996) wrote on medical and cultural perspectives of menopause, and made recommendations for public health policy

which included: (1) a publication on menopause with unbiased information to be made available from community health centres, general practitioners' rooms, and at public places, such as libraries; (2) to conduct qualitative research on menopause and use the findings in the abovementioned publication; and (3) to monitor the promotion of HRT and the use of it in trials. Rendall-Mkosi (1996) reviewed the literature on menopause and concluded that research has been predominantly biomedically-oriented. Moreover, in South Africa there is little research done or literature on South African women's experiences of menopause. In this context, she recommended that cross-cultural research on menopause be conducted, that informative literature based on a balanced view of HRT be easily accessible, and that health care providers take a holistic approach to women's health.

In what appears to be unique in the South African context, a cross-cultural study focussed on the differences in experiences between premenopausal and postmenopausal South African Indian women (Du Toit, 1990). Women were interviewed in their homes. Participants were 29 premenopausal (approximately 35 to 45 years old) and 27 postmenopausal (approximately 55 to 65 years old) women. Findings of the study included: firstly, younger women discussed menopause openly, while middle-aged women would discuss it with women who had had an early menopause. Women had no standard preparation for menopause, and they had little idea of what to expect of menopause. Secondly, menopause was seen amongst the participants as a procreative marker only in theory: "Women had completed their reproductive careers years before biological change and had overtly recognized this by altering their sleeping arrangements" (p. 290).

Thirdly, older women generally did not grant much importance to menopause, and it was expected that this trend would continue with younger women. This finding was partly related to women's attitudes about sex. Older women mainly saw sex as a means for reproduction, while younger women recognized their own sexuality and actively sought enjoyment in sexual relations. Since older

women had virtually stopped having sexual relations in their late-30s, the onset of menopause appeared to have no effect on their sexuality. Younger women did not expect sexual relations to end with menopause. Lastly, for older women who were mainly full-time homemakers, menopause was associated with old age and a decrease in physical activity. Younger women generally were more involved in activities outside the home and menopause was not expected to alter this situation: "[P]rofessions and jobs are uninterrupted, and new roles open up that are not affected by biological conditions" (Du Toit, 1990 p. 293).

In the light of the above review of the empirical studies, especially the literature in South Africa, I turn now to discuss the aims and objectives of this study.

AIMS AND MOTIVATION

The major aim of this study was to attempt to discover the meanings of menopause for black and white working-class women in South Africa. The study sought to conduct empirical research which was informed by feminist and social psychological perspectives and to compare women's experiences of menopause reported in empirical studies in the literature to the experiences of black and white working-class women in South Africa. In order to meet this aim, the following objectives were pursued: (1) to compare the experiences of menopause between black working-class women and white working-class women in South Africa; (2) to explore if there were differences or similarities in the experiences of menopause that were due to race, class, or culture; (3) to explore the ways in which gender relations and dominant theories on women's bodies informed experiences of menopause.

Most research conducted on menopause has been on white middle-class women, or has used a biomedical model. Without wanting to belittle this work, especially that done by feminist theorists, I think it is equally important to hear the voices of women who have been marginalised in this area of research. To my knowledge very little research has been done on how black and white

working-class women in South Africa experience menopause. It is my intention, therefore, to add their voices to the debate, believing that it will be an important contribution to the body of existing knowledge and understanding of menopause.

Another motivation was to explore the application of alternative models to the biomedical framework, models that may reflect more accurately women's "lived" experiences of menopause. In so doing, it makes it possible to develop a more coherent theoretical approach to understanding menopause. It was also hoped that this study would be able to make recommendations on health policy which may contribute to attempts to improve the health and well-being of older women.

CHAPTER THREE

METHODOLOGY

In this Chapter the reasons for using a qualitative research framework to explore the experiences of menopause are outlined. Briefly stated, focus groups comprised the main form of data collection and the data was analysed within a grounded theory approach. The research process is described in detail, and the procedures used for data analysis are outlined.

QUALITATIVE RESEARCH

For research on women in midlife and menopause, it has been suggested that a qualitative research design producing open-ended data (which is analysed by either a phenomenological or grounded theory approach) may well be the ideal way of answering a question if "the question to be answered is about discovering and understanding women's experiences" (Seibold et al, 1994, p. 398). It is considered essential that the method chosen be the one that is most likely to yield relevant answers. The philosophy underlying much qualitative research is one which stresses the importance of gaining insight into the socially constructed subjective and first-order reality of human beings. Primary data in qualitative research is derived from participants' words and the meanings that they attached to them (Marshall & Rossman, 1989).

An underlying principle of qualitative research identified by Schmid (1981, cited in Krefting, 1991) is that human behaviour goes beyond what a researcher observes to include subjective meanings and perceptions of participants. It is the responsibility of the researcher to assess these latter phenomena. Moreover, people involved in qualitative research are not seen as passive recipients of environmental stimuli, but rather as social actors who are able to create their own worlds (Ferreira, Mouton, Schurink, & van der Burgh, 1988).

Patton (1987) suggested that both qualitative methods and quantitative methods have their own unique advantages. The use

of standardized measures in quantitative methods leads to a broad, sometimes (although not always) generalizable set of data. Qualitative data, on the other hand, retains depth and detail because data is not usually subjected to predetermined categories of analysis. The literature, however, gives different interpretations on the question of generalisability, however. For instance, it has been noted that the aim of the qualitative approach is not to generalize findings *per se*, but to specify the conditions, action/interaction, and associated outcomes of phenomena under study (Strauss & Corbin, 1991). Miles and Huberman (1994) have argued that:

The findings from qualitative research have a quality of 'undeniability'. Words, especially organized into incidents or stories, have a concrete, vivid, meaningful flavor that often proves far more convincing to a reader...than pages of summarized numbers. (p. 1)

It is also important to acknowledge the socio-political dimension of a debate on the credibility of qualitative methods. For instance, Ackroyd and Hughes (1983) commented on the context in which particular types of research emerge. They stressed the influence of powerful social groups and authoritative doctrines on both the development of methods and methodology, and the kind of presuppositions on which they are based. Finally, qualitative methodology fits better than quantitative methodology for particular types of research, especially for exploratory or descriptive research where context, setting, and subjects' frame of reference are prominent features (Marshall & Rossman, 1989).

For feminist scholars the question of rigour in feminist research, particularly regarding data analysis and theory construction, is a fundamental issue for debate. Two criteria - dependability and adequacy - have been identified as a way to inject more rigour into feminist research. The dependability of research increases if different investigators using similar analytic procedures perceive similar meanings. Dependability can also be demonstrated if the findings of a study are found to be consistent if the study is replicated with the same subjects or

in a similar context (Krefting, 1991). Adequacy embodies reliability and validity, which are seen as continuous in nature (Lincoln & Guba, 1985, cited in Seibold et al, 1994). Research processes and outcomes are considered adequate if they are well grounded, cogent, justifiable, relevant and meaningful.

The issues outlined above helped to persuade me that, for the purposes of my study - an attempt to discover the meanings of menopause for black and white working class women in South Africa - qualitative research was the most appropriate method.

GROUNDED THEORY

Grounded theory strives for coherence in the development of theory but at the same time stresses that grounded theory does not develop grand theories. (Seibold et al, 1994, p. 401)

The data collected in conducting qualitative research is often voluminous (Marshall & Rossman, 1989; Miles & Huberman, 1994; Patton, 1990). Although the point has been made that there is no right way to go about organizing, analyzing, and interpreting qualitative data (Patton, 1990), in terms of the aims and objectives of this study, I decided that grounded theory is the most appropriate approach for this study.

The grounded theory approach was first conceptualized by Glaser and Strauss (1967) in their book *The Discovery of Grounded Theory* where they stated that: "We suggest as the best approach (to generating theory) an initial, systematic discovery of the theory from the data of social research. Then one can be relatively sure that the theory will fit and work" (p. 3). The "discovery" process consists of the researcher creating discoveries about the data and constructing the analysis (Charmaz, 1990). In other words, a grounded theory approach does not start with a hypothesis, but rather collects and explores data to generate theories. Under these circumstances, the process of data analysis is not totally separable from the process of data collection - the researcher is from the outset immersed in data analysis processes (Strauss & Corbin, 1991).

In the grounded theory approach intersubjective meaning is rooted in the "multiplicities, variations, and complexities of participants' worlds (Henwood & Pidgeon, 1994, p. 231). The development of new theory is thus firmly grounded in participants' own accounts of their experiences. Feminist researchers made the important recognition, however, that the meaning of women's experience is always mediated - women's experiences are constructed as meaningful within cultural frameworks, and within social and power relations (Henwood & Pidgeon, 1995). Moreover, analysis is not predominantly concerned with participants' accounts as language or text. On a theoretical level, therefore, the tendency towards leaving out "the body" when formulating theory, as happens with other approaches such as discourse analysis (Connell, 1995) need not be perpetuated by a grounded theory approach.

The actual process of analyzing the raw data is outlined in guidelines which revolve around schemes of coding and categorizing the data into manageable units of analysis. In grounded theory, there are three major types of coding: (1) open coding - data is broken down into discrete parts, closely examined, and compared for similarities and differences; (2) axial coding (or pattern coding) - aims to relate more specifically the categories and subcategories discovered during open coding, now focussing on uncovering and validating possible relationships; and (3) selective coding - conscious choices are made about who and what to sample to obtain data. This is followed by an integration of categories along a dimensional level to form a theory, validate the integrative statements or relationship, and fill in any categories that need further development (Strauss & Corbin, 1991).

A notable critique of grounded theory is concerned with its apparent inductivist underpinnings which prompted some important revisions. For instance, a constructivist version of grounded theory was advocated by Henwood and Pidgeon (1995) to:

[C]larify how qualitative researchers must have a perspective from which they actively seek to build their analyses, but without merely 'applying' it to the new data, problems or contexts. (p. 117)

The researcher's perspective, which leads to asking certain kinds of questions, embodies not only a philosophical stance or school of thought, but also one's personal experiences, values, and priorities. A revised grounded theory approach helps to keep researchers on an 'analytic path' (Henwood & Pidgeon, 1995, p. 117) while simultaneously alerting them to the dangers of simply reproducing their pre-existing perceptions, ideas and concepts unchanged.

FOCUS GROUPS

I decided to use focus groups as a method of data collection in order to facilitate the process of collecting data that was broad and as rich as possible. My decision was informed both by the pilot work (discussed below), and by the literature on focus groups which stresses that for exploratory or phenomenological research, the quality and depth of information from focus groups was often better than that for one-on-one interviews (O'Brien, 1993). Moreover, focus groups are seen as particularly useful for exploratory research where little is known about the phenomenon of interest (Stewart & Shamdasani, 1990). I think the focus of my research aptly fits the profile of this latter assertion.

Jarrett (1993) commented that contributions of participants in focus groups serve to stimulate and encourage other participants to talk about their own experiences more freely. Moreover, there is potential for intensive examination of viewpoints by other participants, or by the facilitator (provided it is done in a sensitive and respectful manner), through direct questions or probes. According to Stewart and Shamdasani (1990), focus group moderators have the opportunity to reopen topics that receive too shallow a discussion when initially presented. Group rapport is established, especially in homogeneous groups, which increases the potential for all participants to contribute to the discussion. Jarrett also noted that the tendency for

idealized versions of experiences is diffused, specifically amongst low-income participants who are under "strong pressures...to present idealized versions of their lives, especially to researchers" (p. 199).

Focus groups are grounded in the "human tendency to discuss issues and ideas in groups" (Sink, 1991, cited in Albrecht, Johnson, & Walther, 1993), giving focus group methodology a degree of external validity. However, Albrecht et al. cautioned researchers that internal validity of focus group data might be threatened by the human communication behaviours of compliance, identification, internalization and fantasy spinning. Strategies to decrease this potential threat include critical consideration of (1) the role of the moderator/facilitator; (2) group size and demographic composition which has implications for language choices, cultural ways of speaking, and disclosure levels; and (3) communication phenomena such as social desirability, low levels of trust, face-politeness needs, researcher bias, and deception which should be anticipated and accounted for in the data collected.

TABLE 1: Strengths and weaknesses of focus groups

| Strengths | Weaknesses |
|--|------------------------------|
| Participants stimulate others to participate | Threats to internal validity |
| Potential to examine viewpoints in detail | - role of facilitator |
| Can reopen topics | - group size & demography |
| Group rapport increases participation | - communication |
| Diffuse tendency to idealize | |

Pilot study

A pilot study which consisted of three one-on-one interviews (one white, working-class woman and two black, working-class women), and one focus group (five coloured, working-class women) was conducted prior to the main study. Two of the women for the individual interviews and all the women for the focus group worked at the University of Cape Town and were recruited through connections I had as a previous employee at UCT. The participant for the third individual interview was recruited from the Zibonele Health Project in Khayelitsha. This interview was conducted primarily by a Xhosa-speaking interpreter, and by myself. All the women fit selection criteria (Stewart & Shamdasani, 1990), which are discussed in more detail in the section on Participants.

The intention of the pilot study was threefold: firstly, it was anticipated that participants coming from diverse backgrounds and speaking different first-languages would use different terms to refer to menopause (Stewart & Shamdasani, 1990). The individual interviews thus served to familiarise me with the terms commonly used in discussing menopause. Secondly, it was a way to help determine the focus of the interview guide subsequently used for the groups. Through a careful reading of the literature on menopause, I constructed the interview schedule for the one-on-one interviews by extracting the issues that were most commonly focussed on, as well as issues I was particularly concerned with. Questions from this interview schedule were then synthesised into a workable interview guide used for the pilot focus group. I felt it was important for the overall study to try to assess in what ways, if any, the preoccupations of the literature might be similar or different to those of the study's participants.

Thirdly, the pilot focus group was held in order to familiarise myself with conducting group sessions; to help determine appropriateness of the interview guide; and to help determine if focus groups were indeed the most appropriate technique to use

in terms of the aims and objectives of the research upon which I was embarking (Crabtree, Yanoshik, Miller, & O'Conner, 1993).

MAIN STUDY

Interview Guide

Stewart and Shamdasani (1990) suggested that a certain amount of direction and structuring is useful in focus groups for moving the discussion along, controlling dominant participants, and drawing out reticent participants. Moreover, a more directive and structured approach may be a prerequisite for discussion of issues relevant to the researcher's needs. Following this view, I developed an interview guide before conducting focus group discussions. The guide consists of five open-ended questions which reflect the conceptualizations and issues with which my research is concerned with (Frey & Fontana, 1993; Knodel, 1993), such as identity, sexuality, expectations of menopause compared to actual experiences, etc. Several points are listed below each question which were ticked off when, or if, participants discussed them.

Sometimes a probe was used to stimulate discussion on what I considered an important or sensitive issue, but was not spontaneously raised by participants. For example, the probe "Sometimes I fear my partner will want to leave me for a younger woman" was used to explore participants' possible fears of growing older and what this might mean for them. In addition, as Stewart and Shamdasani (1990) have suggested, offering personal anecdotes of this nature may facilitate group discussion.

The guide was structured so that initial questions would gradually steer participants towards questions that were fundamental to the study's purposes (Krueger, 1993; Stewart & Shamdasani, 1990) - questions of a more probing or sensitive nature. However, the facilitator should be prepared to be flexible with the order in which questions are introduced and discussed by participants (Jarrett, 1993; Stewart & Shamdasani, 1990). For instance, I started the discussion with a question which explored participants' sources of general knowledge about

menopause. Yet, a number of participants "ignored" this question and discussed their own personal experiences instead. Additionally, although I felt some compulsion to try to cover all the questions and points included in the guide, it was not always appropriate or possible within the time allotted for the group discussions. Because comparisons were made across differently defined subgroups, all groups were asked similar questions (Knodel, 1993).

Problems that can arise with interview guides include asking questions that are too directive and having too many questions to cover in the time allotted for a group session (Knodel, 1993). In the light of these possibilities, the interview guide was assessed after the pilot group discussion. Questions were determined as neither too directive nor too many. Nevertheless, I did make changes to the guide during the interviewing process. For instance, at the suggestion of my supervisor, I added questions on how religion or low-income may impact on experience of menopause. Other changes to the guide were mainly structural to make it easier for me to use during discussions. A copy of the guide is included in Appendix A.

Adverts

To determine if an aid to stimulate discussion was appropriate (Stewart & Shamdasani, 1990), I photocopied several adverts on menopause from medical journals and handed them out to participants at the beginning of the pilot focus group. The adverts, in my view, were obscure and directed towards middle-class readers - typical of biomedical information on menopause. I wanted to see if they had any relevance for working-class women. From what the participants said about the adverts, it seemed that the way in which menopause was being depicted did not have any relevance for them in the context of their own experiences of menopause.

In any event, I decided not to use the adverts for the main study, due to time constraints which developed for several reasons. For instance, it took over 30 minutes for participants

in one focus group to complete consent and biographical data forms. In another group, participants arrived late and had to leave to get back to their work after a shorter time than I had anticipated. In instances such as these, it seemed preferable to focus on the interview guide to stimulate discussion rather than on the adverts. Copies of these adverts are included in Appendix B1 and B2.

Biographical Questionnaire

The biographical questionnaire was designed to elicit data relevant to working-class women's experiences of menopause and included questions on place of residence, age, race, employment status, income, marital status, number of children, level of education, health status and problems, and menstrual and menopausal status. As mentioned above, for a minority of women, it took some time to complete the form. This may have been partly due to it only being available in English which was not the first language for the women who struggled to complete it. Yet, not all first-language Xhosa-speaking women appeared to have the same difficulties. The importance of language and how it influenced the recruitment and research process is discussed in more detail later on in this section. See Appendix C for a copy of the questionnaire.

Pamphlets

During both the process of recruiting participants for this study and the actual study itself, it became clear that many women wanted information on menopause. In response, I wrote a pamphlet to give to participants at the end of group sessions. Extra copies were also available for participants to distribute to other interested people. The pamphlet includes general information on menopause such as the age range when it is most likely to occur, and the fact that menstruation patterns often change before cessation of periods. It also includes information on issues that were raised by women involved in the study. For instance, participants wanted to know what happened to the blood when periods stopped. Some women speculated that it would go to the head and cause headaches or high blood pressure. The

pamphlet discusses, in accessible terminology, what actually does occur. The pamphlets were made available in English, Xhosa, and Afrikaans. A copy of the English version is included in Appendix D.

Journal

The process of recruiting participants and conducting focus groups was challenging and, at times, problematic. I kept a journal in order to be able to document this process, as well as to record some of my thoughts during this time (Strebel, 1993). Some of the problems encountered in the recruiting process are discussed in more detail in the following sections.

TABLE 2 : Summary of methods

| |
|--|
| * Focus Groups - Interview guide - Adverts : discussion prompt |
| * Pilot Study: not a method - one-to-one interviews - focus group |
| * Biographical Questionnaire |
| * Pamphlets |
| * Journal |

Terminology

Throughout this study I use the terms "white" and "black" to differentiate between the groups of participants. The racial categories used were those defined by previous apartheid legislation, which structured the social, economic and political institutions in South Africa under apartheid. Their use in this study does not indicate my support for the legislation, and the problematic nature of their use is understood. However, since race classification shaped the daily experiences and consequent health patterns of South African women in the past, and continues to do so, and because there is a strong association between the classification and socioeconomic status, I believe

the use of racial categories to be a justifiable strategy for the purposes of this research.

PARTICIPANT SELECTION

Participants in the main study were black and white, working-class women. A prime motivation to focus on this particular group of women was that most research reviewed in the literature was conducted on menopause had been on white, middle-class women using a biomedical model. Moreover, to my knowledge, there has been little research done on how black and white working-class women in South Africa experience menopause. I believe that documentation of the experiences of women marginalised in this area of research will make an important contribution to the body of existing knowledge and understanding of menopause.

Selection Criteria

Selection criteria included the following:

(1) Women had to be working-class. Determining social class was problematic, especially because apartheid racial classification has affected the way class is expressed and experienced in South Africa. After consulting several social scientists¹, I decided to determine social class on the basis of individual income for black women (not to exceed R2 000 per month) and by residential suburb (e.g., Brooklyn, Ysterplaat) or occupation (e.g., sales clerk) for white women. Unemployed women, self-employed women or women working in the informal sector who otherwise met participant criteria were not excluded from the study. However, some women who met the income criteria were not included, such as black teachers and nurses because they are often perceived as middle-class in their communities.

It is worth noting here that determining women's social class is difficult partly because the criteria for so doing is often gender insensitive. For example, a traditional Marxist analysis based on productivity would exclude the millions of South African women who are involved in service and sales work. A

1. I consulted with Debbie Budlender (Community Agency for Social Enquiry), my supervisor Cheryl de la Rey, and with members of the Psychology Postgraduate Committee.

husband's occupation also is often used to determine women's social class.

(2) Women were to be menopausal, i.e., were no longer menstruating regularly. Existing literature on menopause most often stipulates, firstly, that a woman is considered to have reached menopause if she has not menstruated for a period of at least 12 months or more, and, secondly, that the age range for women experiencing menopause is between 45 and 60 years old. To allow for a diverse range of experiences of menopause, women who had in the past had treatment for menopause or who were presently being treated (for example with hormone replacement therapy) were included in the study. On the other hand, women who had had hysterectomies were not included in the study. This exclusion was informed by literature on menopause which suggested that there are important differences between women who have had hysterectomies and women who have a "natural menopause" (Ballinger, 1990; Kaufert & Gilbert, 1986).

TABLE 3: Participants in focus groups

| Group | Description |
|-------|---|
| 1 | 3 white women - Members of church group, Observatory |
| 2 | 7 black women - Members of church group, Langa |
| 3 | 4 black women - Attended Women's Wellness Clinic, Khayelitsha |
| 4 | 7 white women - Employed at local hospital |
| 5 | 3 white women - Members of women's group, Ysterplaat |
| 6 | 7 black women - Employed at a Langa school |

Setting up the groups

The selection of participants for the groups was facilitated by contact with key people in different environments. To help me organise groups of white, working-class women, I contacted a general practitioner, a social worker, and an Anglican minister,

who all worked in predominantly white, working-class areas of Cape Town. Contact with black, working-class women was facilitated through contacts with community health workers and women's wellness workers in a women's health project in Khayelitsha, through a local women's college, and through the co-ordinator of a domestic workers' organisation. Other organisations approached included Rotary-Anns, trade unions and hospital staff organisations, women's church organisations, and community training centres. Contact and recruitment of participants was usually done by telephone - I made contact with a single liaison person who contacted other people interested in the research. In two instances, I met potential participants to explain the nature of my research before group sessions were held. The meetings also gave these women a chance to "check me out" as a researcher.

Most people contacted expressed an interest in the research and a concurrent willingness to assist in organising the groups. However, this was not always the case. For instance, one worker in a community training centre said that it was "a tall order" to ask for participants who were working-class and, at the same time, preferably spoke English. Another contact expressed doubt whether women would participate unless they were paid to do so. Nevertheless, there was an overall sense of cooperation from most people I contacted.

Group number, size, and composition

The literature suggests that six to eight groups might be needed for meaningful group comparisons (Crabtree et al, 1993) and that a range of six to 12 people per focus group is compatible with most research criterion (Frey & Fontana, 1993; Jarrett, 1993; O'Brien, 1993; Stewart & Shamdasani, 1990). I held six focus groups, and aimed to recruit between six to 10 women per group. However, only three of the groups had six or more participants per group. Two groups (in both cases, consisting of white women) had three participants per group, and one group had four participants.

Reflection on the recruiting process helps to clarify why this situation arose. It was not possible to recruit all participants personally. In most cases, I relied on women interested in becoming involved in the study to recruit a specified number of other interested women. More participants than required was stipulated to offset the possibility that a group would have to be cancelled because too few people arrived (Stewart & Shamdasani, 1990). It became evident in the course of the research, however, that it was going to be very difficult to recruit an optimal number of white women per group. A major constraint here was the number of women, who otherwise met the criteria, who had previously had hysterectomies and were therefore not suitable for inclusion. This phenomena in itself deserves further investigation! I must have personally contacted approximately 10 women of whom more than half had previously had an hysterectomy. Due to these difficulties, I was reluctant to press women to organise what seemed, in the circumstances, an inordinately large group of women (more than six), or to cancel a group although only three women were present.

Each of the groups was racially homogeneous; that is, each group consisted of only black women or only white women. Knodel (1993) argued that it was easier for participants who share similar key characteristics to identify with each other's experiences, thus producing greater depth of information. Similarly, O'Brien (1993) stressed that focus groups sometimes yield more useful information if participants hold important background characteristics in common such as race or economic status. Jarrett (1993) mentioned that the establishment of group intimacy and rapport "that facilitates the exchange of information derives, to some degree, from group homogeneity" (p. 192). However, policies of past governments and structural racism in South Africa also determined this study's group composition. Black and white South African women, particularly working-class women, are effectively divided along racial lines. The consequences of this enforced segregation had the potential to hinder the process of group intimacy and rapport mentioned above by Jarrett.

In all the groups except possibly one, the participants appeared to be acquainted with one another. For instance, participants attended the same church organisation; lived in the same community; or were workers for the same employer. The literature is inconclusive on the question of whether it is better for participants within a group to be strangers or not. Stewart and Shamdasani (1990) remarked that "A frequent assumption about focus group interviews is that better data are obtained when participants are strangers" (p. 34). In contrast, Kitzinger (1990, cited in Strebel, 1993) commented that there were advantages to using pre-existing groups. In her own research, Strebel concluded that there were no marked differences between strangers' groups and friends' groups. In my own research, I found that women generally spoke openly about what I perceived to be personal and potentially sensitive issues.

Venues and procedures

Venues for the groups were dictated by what was most convenient for participants, particularly in terms of time and transportation constraints. Two groups were held at participants' place of employment; two were held at church halls in the women's communities; one was held in a community health centre; and one in a community hall.

Procedures at the groups were as follows: The participants were thanked for coming and for agreeing to participate in the research. The purpose of the research and how the group session would be structured was briefly explained. Participants were ensured of confidentiality and reminded that the session would be tape recorded. They were asked to sign consent forms, which were in English. The consent forms stipulated that participants could withdraw from the research process at any time if they so wished. I informed participants that I would return to give feedback on the results of the study, and that I would make the results available in an accessible form if groups or organisations wanted to use them for workshops, etc.

Crabtree et al. (1993) stated that "The unit of analysis in focus group interviews is the group and should be sampled and analyzed accordingly" (p. 145). Yet, during group sessions individual participants could conceivably articulate very different or unique responses to issues under discussion. In these instances, it may prove useful to scrutinize a participant's biographical details for clues to her responses. A method was therefore devised to be able to make such a link: At the beginning of the recorded sessions, participants were asked to introduce themselves using first names or, if preferred, false names only. They were asked to put the same name on the tops of their biographical questionnaires. If necessary, I could then identify a participant by matching her voice on the tape to her biographical questionnaire. This strategy did not hinder me from maintaining full confidentiality.

Biographical forms were completed either at the beginning or the end of the session. At the end of the session, we had tea or cool drinks and biscuits, which I provided. I felt that it was important to end sessions in this way not only to answer questions, but also just to chat - to spend a short while together "debriefing" before we all departed.

The practical constraints of recruiting women for the groups played an important and instructive role. For example, a group of black women approached at Marconi Beam informal settlement near Milnerton did not want to become involved in the study "due to the culture prevailing in Marconi Beam" (personal communication, 10/5/96). A group of coloured women were "afraid to become involved" (personal communication, 5/96). The number of white, working-class women who had had hysterectomies (but otherwise met the study's criteria) was a major constraint in organising groups of white women. These were additional reasons for including women who were still menstruating and who were outside the suggested age range in the literature. In essence, therefore, it would have been difficult and possibly counter-productive to turn away women who did not meet all the pre-set criteria completely. Moreover, while these eventualities did

alter the direction of the study, they did not detract from the overall research design or the aims of the study.

LANGUAGE

Klein (1989, cited in Albrecht et al, 1993) suggested that reliability was enhanced when the same moderator was used across focus group sessions. Because of the specific context of my research, however, the important issue of language had to be carefully considered. I wanted to facilitate as many of the groups as possible myself, but I only speak English. Thus, a criteria for group participants was that they preferably spoke English. However, where participants preferred to use their first-language (one group), a facilitator who spoke that language conducted the group, which I attended. I facilitated groups "alone" (see below) where women's first-language was English, or where participants' first-language was another language (e.g., Xhosa or Afrikaans) but who had agreed to attend groups that were to be conducted in English.

The groups I facilitated on my own included the three groups of white, predominantly first-language English-speaking women. Of the three groups of black women, where Xhosa as a first-language predominated, one was facilitated by a woman whose first-language was Xhosa. Before the session, we spent approximately one hour discussing the Interview Guide to familiarize her with my aims and objectives for the group session and the research more generally. During the session, she translated the participant's Xhosa speech into English which meant that I was also included in the discussion. At times, I asked questions in order to further explore views expressed by participants; or I was asked to clarify issues raised by questions from the interview guide.

In the other two groups of black women, difficulties around the issue of language arose. Firstly, in one group my role as facilitator was blurred. In this group, one participant effectively took on the role of co-facilitator. Whereas participants spoke English during the first 30 minutes or so of

the session, albeit some struggling more than others, they tended to speak Xhosa during the remainder of the session. The "co-facilitator" would then interpret their speech into English for my benefit. Although participants had "agreed" to attend a discussion where they had to speak English, it seemed obvious that they were more comfortable speaking Xhosa. It is perhaps significant that the participant who did the translating had also organised women in her community to attend this group session. By taking on the role of translating Xhosa into English, she sustained her initial initiative and responsibility for the successful running of the group.

In another group of black women, participants mainly spoke English during the discussion. However, one participant, who had been quiet for the most part, "rebelled" by speaking in Xhosa during a discussion about sexual relationships with men. Her initial comment was translated by another participant as: "She says she's tired of speaking English all the time." The problems mentioned above have the potential to undermine the rigour of this research. In order to ensure as much as possible that the experiences of participants involved in the study are reflected, all translatable Xhosa speech recorded during group sessions (that was not distorted, inaudible, or unclear) was subsequently translated into English by a Xhosa-speaking researcher and included in the data analysis process (see section on Data Analysis for more detail).

Morgan and Krueger (1993) suggested that another promising combination within qualitative studies is "the pairing of individual and group interviews" (p. 10). In a small but nevertheless important way, I explored this option in relation to the white groups of women. At the completion of the three focus groups of white women I interviewed one white, working-class woman who had not previously been involved in the study. Because the number of white women who participated in the study (13) was not as many as originally intended (see section on Group number, size, and composition above for suggestions why this occurred), this interview was undertaken to help determine

if there were any significant issues or differences in experience of menopause which had not surfaced during the focus groups held with white, working-class women. In order to facilitate this process, I restructured the original one-to-one interview questionnaire in an effort to maximise participant spontaneity during this interview. After the interview I was satisfied from the responses that it would not be necessary to collect additional data on the experiences of menopause for white, working-class women.

PARTICIPANT CHARACTERISTICS

In practice, I had some problems in meeting the criteria for menopausal status. Firstly, there were a number of women who were uncertain about their menopausal status when requested to complete the biographical questionnaire. This may reflect the degree to which accessible information on menopause is available to working-class women. There were also some women who had experienced menopause at a younger age than 45, and I felt I had to be flexible about the age criteria used. Secondly, all of the groups attracted a number of women who fit the revised age criteria (40 to 65 years old) but who were peri, or even premenopausal, but who were clearly interested in the issue. For this reason, I felt it necessary to include these 17 women, as their experiences would be valuable and could enrich the study. As the groups developed, it was clear that they had valuable things to say, and the groups as a whole benefited from their participation. As participants, these women also benefited directly because of the opportunity to hear the perceptions and experiences of women who were postmenopause.

In the end, 31 women participated in all the focus group discussions. Eighteen of the women were black, and 13 were white. The age of participants ranged from 41 to 65, with an average age of 52 years. There were nine women between the ages of 41 to 45 (29%), and eight women over 60 years of age (26%). Over half the participants (55%) therefore did not fall within the initial criteria of 45 to 60 years of age. Seventeen participants (55%) reported they were still menstruating, while

TABLE 4: Demographics of participants : Age, employment status, income levels, marital status, number of children, education level, health status, and menopausal status

| Variable | | Number |
|-----------------------------|--|-------------------------|
| Age | Average: 52 years Range: 41 to 65 *17 women < 45 or > 60 | |
| Employment status | Full-time Part-time Informal sector Retired/housewife Unemployed-looking for work | 13 1 2 5 10 |
| Income levels Own income | Less than R1 000 per month R1 000 - R1 500 per month R1 500 - R2 000 per month | 23 7 1 |
| Household income | Less than R1 500 per month R1 500 - R2 250 per month R2 250 - R3 000 per month More than R3 000 per month | 25 4 1 1 |
| Marital status | Married Living with partner Separated/divorced Widowed Single | 14 1 7 5 4 |
| No. of children | 1 to 3 4 to 6 7 to 9 No reply | 12 12 4 3 |
| Education level | Matric or higher High school Primary school | 3 19 9 |
| Health status | Excellent Good Satisfactory Poor | 5 12 10 3 |
| Menopause status* | Pre- or perimenopause Postmenopause | 17 14 |

* See discussion below on women who were "unsure" of their menopausal status.

13 women (42%) reported that they were postmenopause. In the end, the participants were women between ages 40 and 65. They included women who were nearing menopause, in the middle of menopause, or had completed menopause.

The responses to the Biographical Questionnaire are discussed in more detail below.

Menstrual and Menopausal Status

In the literature on menopause, the terms most often used to categorise different phases of menopause are:

- * *premenopausal* - menstruated within the last 3 months
- * *perimenopausal* - menstruated within the last 12 months
- * *postmenopausal* - have not menstruated in the last 12 months

The categories for menstrual and menopausal status used on the Biographical Questionnaire approximated the ones used in the literature. For instance, women were asked, firstly, about menstrual status, and secondly, if they were at the beginning, middle, or finished with menopause; or were not sure (see Appendix C). Not all women were clear about their menopausal status, however. Seventeen women (55%) reported that they were still menstruating; and, just over half of this group of women said that they were either at the beginning or in the middle of menopause. Yet, three women in this group in answer to a different question also claimed to be finished with menopause (defined as the cessation of menstruation); and four women selected Not sure for menopausal status. Thirteen women (42%) reported that they had not menstruated for 12 months or more. Nevertheless, not all of them said that they were also finished with menopause: three women reported that they were in the middle of menopause, or perimenopausal.

Hence, 10 women (five white women and five black women), or almost a third of the study's participants indicated that they were unclear about their menopausal status. If I add to this the women who needed my assistance to answer this question while

completing the questionnaire, it would appear that more black participants than white participants were unsure of menopausal status. This situation may be partly due to who has access to what kind of information about menopause. Perhaps the categories that I used (based on the biomedical literature on menopause) were foreign to many women. Perhaps, too, these different "stages" of menopause do not necessarily resonate with all women's experiences. The way in which I worded options to choose from could also have been problematic, as seemed the case for the question on menstrual status. The first option read (see Appendix C): "Still have monthly periods?" It may have been more appropriate to ask: "Still have a period every month?" Since all the women who reported that they were still menstruating (17) selected the first option, it meant that the questionnaire did not reflect possible changes in menstrual patterns. This is particularly important for black women, where the use of injectable contraceptives that cause long-lasting disruption of menstrual cycles, is common.

Place of Residence, Race, Language

Other biographical information showed that social class and race were generally linked to participants' place of residence. White participants mainly lived in the working-class areas of Ysterplaat, Goodwood, Observatory, Milnerton, Sanddrift, while black participants lived in Khayelitsha, New Crossroads, Langa, and Guguletu. Amongst the 13 white participants, eight women reported their race to be white (57%), three women said they were European, while two women did not indicate any racial classification. (One of these women was not comfortable with having to indicate her race and asked me if it was necessary, to which I replied no.) English was the first-language for all but one of the white participants.

All of the 18 black women responded to the question on race, but only four reported that they were black. Interestingly, eight women put down Xhosa for race. Out of the six remaining women, two reported that they were African, one reported that she was African-Xhosa, and one reported that she was Fingo. The

remaining two women reported female (!) for race. This means that 14 women (78%) indicated something other than black for race.

Employment Status and Income Levels

Seven of the 13 white women worked full-time (all were housekeepers at a local hospital); one woman was self-employed; the rest of the women reported that they were retired or housewives. Income levels were between R1 000 to R1 500 per month for six of the seven full-time workers, and less than R1 000 per month for one full-time worker and the women who were not in paid employment. Household income varied from less than R1 500 per month (seven women) to more than R3 000 per month (one woman).

Six black women worked full-time (mainly as cleaners at a local adult learning centre); one woman worked part-time; and one was self-employed (ran a creche at her home). However, the majority of black women (10) were unemployed but looking for work. The average age of the women was 57. Income levels for black women may partly explain why so many older women were looking for work. Sixteen black women (89%) indicated their own income to be less than R1 000 per month. Yet, this group included five full-time workers. Moreover, 17 women had a household income of less than R1 500 per month.

Marital Status

When recruiting participants for the groups, I stipulated that women should presently have or recently have had a male partner (i.e., that they should be heterosexual). I believed that this would optimize the data on sexuality, one of the issues I was particularly concerned with¹. In practice, however, it was not

1. Most of the research on menopause has focussed on heterosexual women's experiences, or has assumed that all respondents are heterosexual (Cole & Rothblum, 1990). Because of this assumption, sexual orientation and its possible impact on experiences of menopause may be obscured. My approach was to restrict participants to heterosexual women because I wanted to compare sexuality experiences of my focus group participants with the experiences of women discussed in the literature. It was also practically difficult to raise

easy to adhere to this criteria, as the following discussion reflects. Fourteen participants (45%) were married; one woman was living with her partner but not married. Sixteen women (53%) reported being one of the following: single (4); separated or divorced (7); widowed (5). The age range of these participants was 41 to 64 years, with an average age of 52 years. So age level does not necessarily appear to be a salient factor related to marital status. However, the issue of age and how this affects particularly black women's relationships with men is discussed in more detail in Chapters Four and Five.

There was not a separate category to ask specifically if a woman had a partner. The closest category was: Living together (not married). Women who may have had partners but were not living with them may therefore not be adequately represented. From the group discussions, however, it does not appear that this was a strong possibility as women generally talked openly about men and, I believe, would not have hesitated to mention male partners if they had them. Sometimes participants spontaneously volunteered the information that they did or did not have a partner, or group members mentioned that other group members were married or had a partner.

Number of Children

Twenty-eight participants reported having had children: 12 women had one to three children; 12 women had four to six children; and four women had seven to nine children.

Level of Education

Much of the research on menopause has been about the experiences of often highly educated white, middle-class women. In comparison, participants in my study have a much lower level of education. For example, the highest level of education amongst the participants was achieved by one black woman who had gained a post-matric diploma. Two women (1 black, 1 white) reached standard 10; 11 white women and eight black women had attended

sexual orientation amongst working class women, a methodological difficulty overlooked in the literature.

high school; and nine black women had reached a primary level of education. Whether or not the lack of higher levels of education had an impact on focus group members' experiences of menopause is assessed in the section on Results.

Health Status, Health Problems

An overview of the health status and health problems of participants in this study showed that most women (73%) reported their health status as good (12/30) or as satisfactory (10/30); five women reported having excellent health, while three women reported having a poor health status. Health problems reported included high blood pressure, asthma, tension, ovarian cancer, diabetes, epilepsy, vaginal discharge, and high cholesterol. The health problem most often reported by participants was high blood pressure - 19 women reported having this illness. It is interesting to note here that although high blood pressure was prevalent, most of the women still considered themselves to be in good or, at least, satisfactory health.

A number of writers on menopause research note that participants are generally drawn from clinical populations (Ballinger, 1990; Cole & Rothblum, 1990; Cowan et al, 1985). This situation gives rise to bias because it produces an erroneous profile of how the average woman experiences menopause. The hypothesis is that women who do not seek medical treatment are coping well with menopause, yet this perspective does not get the attention it deserves. While this may be an accurate assessment for many women, it is also important to be mindful that not all women have equal access to health resources or information about menopause which may be important factors to consider when assessing treatment-seeking behaviour of older women. Moreover, it may elicit an image that, in relation to the daily struggle to survive, women may consider menopause to be less significant (Sillick Standing & Glaser, 1992). It is necessary to be cautious, however, not to patronize women's experiences which could be one interpretation of the latter comment.

DATA ANALYSIS

Transcription and Translation

All the group discussions were recorded on audiocassette. After each group was held, I transcribed verbatim the English speech from the discussions onto computer. Xhosa speech was translated to English and transcribed onto computer by an experienced Xhosa-speaking transcriber and researcher. (She was paid an hourly rate for her work commensurate with current rates for professional transcribers.) These latter transcriptions were incorporated with my transcriptions and included in the data analysis process.

Problems which arose during the recording process (e.g., several participants talking at once, inaudibly soft speech, or speech distorted by background noise) coupled with my being an inexperienced transcriber made the transcription process at times arduous and time-consuming. In a grounded theory approach, however, the researcher is expected to become "immersed" in analysing the data from the outset of a study (Strauss & Corbin, 1991). I found transcribing the group discussions myself - an intent listening to what participants said - a valuable way to begin to engage in the data analysis process. Nevertheless, due to not having a research partner(s) who could critically question my analyses (Marshall & Rossman, 1989), the possibility of researcher interpretation bias was increased during this process.

Codes and Categories

In a grounded theory approach to analyzing raw data, coding and categorizing helps to begin to take the data apart and to frame analytic questions about it. The researcher is committed to examining the collected data, yet she also could "invoke her theoretical perspective to raise questions about the data" (Charmaz, 1990, p. 1168). The most useful codes, or labels, described the "meaning" of a unit of text. A label that occurred only once, therefore, could still be very important (McCormack Steinmetz, 1991). As analysis of the data proceeds, a set of categories is built up to which one or more instances or quotes

in the data can be referenced (Henwood & Pidgeon, 1993). In terms of analysing the data of focus groups specifically, Carey (1994) advocated using one's own interview guide questions as the initial categories. While reading the transcripts, the researcher could look for:

- * the direction and magnitude of these initial categories;
- * additional categories that emerge;
- * themes that transcend the categories;
- * patterns of relationships between categories, themes, and individual characteristics.

The data analysis process I followed, although perhaps not really "pure" grounded theory, was predominantly informed by the examples of grounded theory outlined in this section.

Initial Coding

Firstly, I read and coded one transcript of a group of white participants. The codes were written on the margin of the transcript next to the relevant text. The codes were also recorded onto index cards, along with the quotes from the text to which they referred (Turner, 1981, cited in Yancey Martin & Turner, 1986). (Later on, I found it less time-consuming to use a computer instead of cards to record codes and quotes.) Some of the quotes were referenced under more than one code. I read through all the quotes on the cards to look for similarities and differences in the discourse across this group of women - to see if any categories, patterns or themes could be discovered in their experiences (Charmaz, 1983). At the same time, I wrote memos to record any ideas raised by the data which I could subsequently use for reference while writing up the results and conclusions (Chamaz, 1990; Glaser, 1978; McCormack Steinmetz, 1991; Riley, 1990).

I repeated the same coding process with the transcripts for the other two groups of white women and for the three groups of black women. At this time, however, I did not have the

translated versions of the Xhosa data for these groups. About one week later, I re-coded all the transcripts of all the groups, which now included the translated Xhosa data, following the same pattern described above.

I read and compared a second time the translated Xhosa data with data interpreted during group sessions for any possible new codes. The translated Xhosa data did not engender an appreciable shift in the analysis process because the meaning, if not the exact words, of what participants said in Xhosa usually corresponded to the interpretations of it during group sessions. However, the translated versions of the original Xhosa speech often provided data which was richer (i.e., expressed more "eloquently") than the interpretations of it, and sometimes added more information on an issue being discussed. It was possible, however, that the transcriber of the Xhosa data may have also been "projecting [her] own understanding of what was being communicated" (Strebel, 1993).

The data analysis process outlined above enabled me to identify categories and themes. The major themes to emerge from the data analysis process - power, silence, race, class, gender, ageing, bodies, and change of life - are discussed in the next two chapters in the context of the intention of this study to explore the meanings of menopause for black and white working-class women.

CHAPTER FOUR
RESULTS

In this Chapter I discuss the categories and themes that emerged from the data analysis process and explore the relationships between the different themes through a discussion on what women said about their experiences of menopause.

EMERGENCE OF CATEGORIES AND THEMES

The results of the two coding sessions discussed in the previous chapter were compared (Krefting, 1991). I looked for possible categories or patterns in the data across the groups of white participants, and repeated this process across the groups of black participants. In this process, many codes were subsumed under the emergent categories; some codes which did not seem to "fit" (McCormack Steinmetz, 1991) were dropped. The common categories that emerged across all the groups reflected the concerns and issues outlined in the interview guide used to facilitate group discussion.

TABLE 5 : Categories that emerged from the data

| | |
|-------------|------------------|
| * Race | * Sexuality |
| * Class | * Bodies |
| * Power | * Relationships |
| * Silence | * Change of life |
| * Gender | * Menstruation |
| * Ageing | * Children |
| * Culture | * Health |
| * Knowledge | * Reproduction |

According to Garner (1991) a theme is "a statement of meaning that (a) runs through all or most of the pertinent data, or (b) one in the minority that carries heavy emotional or factual

impact" (p. 150). After reading the categorized data again several themes emerged which were: power, silence, race, class, gender, ageing, bodies, and change of life. These themes are thoroughly explored in the next two chapters. Figure 1 illustrates the relationships between the major themes and categories identified.

SILENCE

Silence emerged as an important theme of women's experiences of menopause. The silence around menopause appears to be embedded in relations of power and control over women's bodies, and appears inextricably linked to the other categories of meaning that emerged from the data. Comments from participants corroborated the theme of silence. Participants in white groups noted that (see page 108 for Coding Conventions):

We didn't talk about it. (Group 1)

Well, you don't hear people talk about it. (Group 1)

It's something we never talk about. (Group 1)

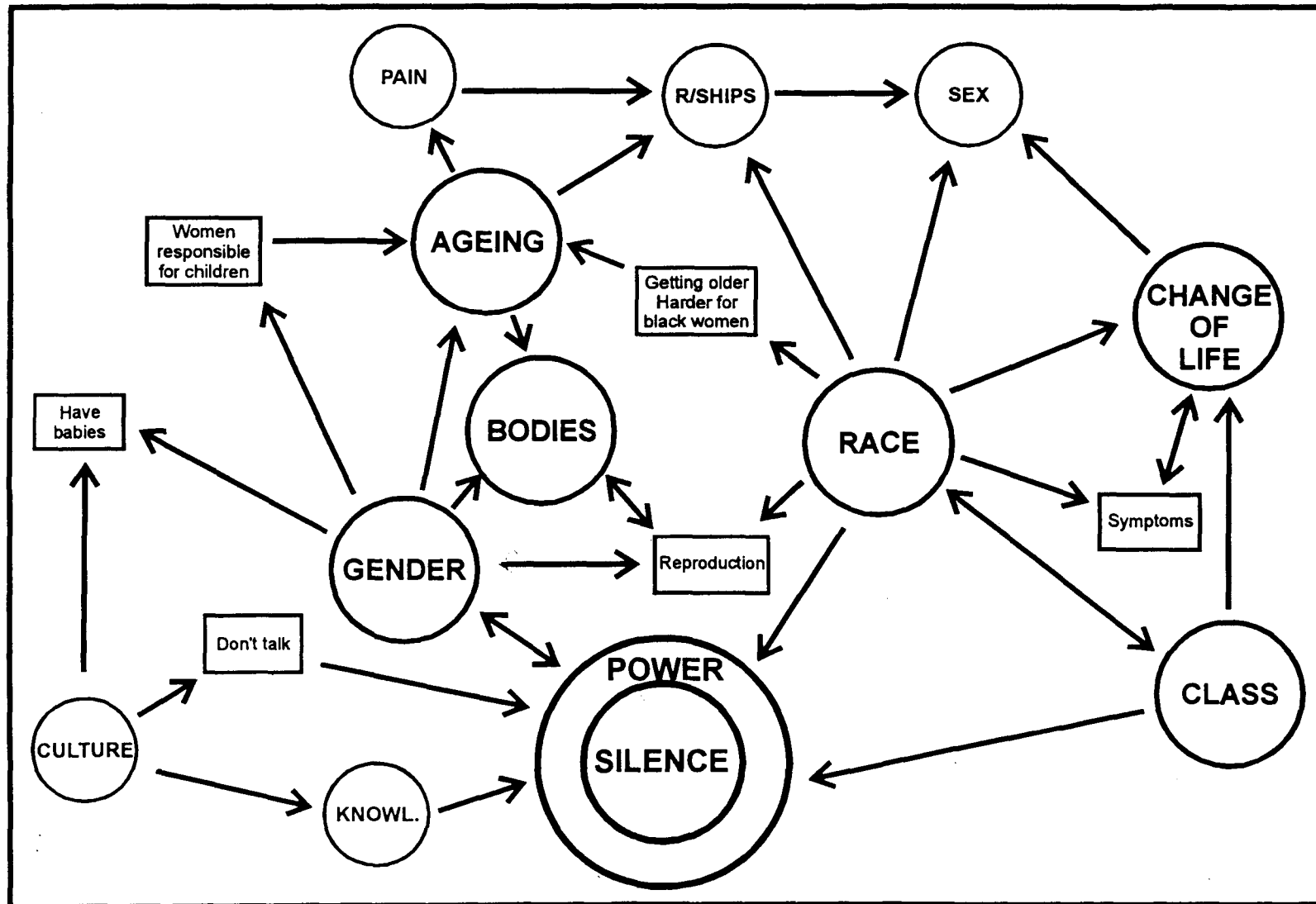
I mean, here we really seldom talk really about change of life or menopause or things like that. Something that nobody really discusses. (Group 4)

That's it. That's what I was gonna say. A lot of people don't want to discuss it. (Group 4)

You don't talk about it because then people then look at you, say: Oh please, don't start moaning/ya. (Group 4)

These quotes and the following discussion reflect not only the intensity and extent of silence around menopause, but also the confusion and dismay that women feel about that silence. The questions raised include: Is there a safe place to talk about menopause? Is it really okay to talk about it? Will I be rejected, laughed at, ridiculed, or dismissed with platitudes if I talk about it? I got the feeling from what participants said that menopause is a topic that must be broached with extreme caution, if at all.

Figure 1: Relationships Between Major Themes and Categories Identified in the Data



Women speculated that the silence may be broken in the right context. At work or in a group (such as the focus group) women may talk more about menopause. Being at home or with family members, however, did not make discussion easier or more likely. *But when you're at home, I mean, who are you gonna go sit and have a chat to.* (Group 1) *And, But at home, or even if I be with my mother, I never going to talk about it with my mother.* (Group 4) For one participant, being silent about menopause was felt to be a less stressful option than discussing the experience with family:

I'll tell you honestly if I must tell my people that I think I'm going through change they think it's like a big joke. They don't expect/ya/that you're getting older, you know. Even if I must tell my daughter tomorrow, she, she's gonna be doing (unclear) I say: Ooh, today I'm feeling sick, my blood pressure, I wonder if it's change of life. She's gonna say: Oh, Ma, don't feel sorry for yourself/ya/unsympathetic, yes/ya. even my sisters and so on. They will never expect me to talk in terms of that. They will think I'm mad. I'm now being sorry for myself/so you rather say nothing/so you rather say nothing/you rather say nothing, yes. (Group 4)

Women must accept menopause and "handle it" with dignity. One participant reported her daughter saying: *Mom, you've gotta go through it. They all gotta do it, Mom. Let's face it, it's an accepted opinion, just handle it, go through it, finish with it.* (Group 5) Participants implied that a lack of knowledge about menopause also affects women's experiences. *Or maybe they're not sure, maybe they're not, er, know what's happening to them. They might feel a fool if it's not/they don't know they're going through the change of life.* (Group 4) This comment raises a question about the relationship between knowledge and silence. It appears that women do not "know what's happening to them" not only because they do not have access to knowledge, but also because menopause is a taboo topic.

Further probing produced replies that related the silence to ageing. *It's funny why you always think of menopause as old, hey/yes, I think so too/I mean if she's gone through the change*

of life, then she's old. (Group 5) It was implied that to get old, and by association to experience menopause, is a shameful process.

Oh, people almost feel like embarrassed. When you say: I'm sure I must be going through change of life, automatically you get: You, oh, you must be getting old. (Group 4)

An important and relevant point is that women often spoke about their experiences as "going through" menopause, which seems to reflect a negative experience or the expectation of a negative experience (cf: "going through a divorce"). Moreover, the "gone through/going through" discourse of menopause was associated with ageing, which for women in particular is a time fraught with uncertainty.

Discussions with black focus group participants similarly illustrated that menopause is not talked about:

No we never talk about it. (Group 2)

People do not talk about it. (Group 2)

You do not even know whether your friend has stopped [menstruating] or not. (Group 3)

I only heard about [menopause] when I went to the doctor, and I asked somebody else afterwards. (Group 6)

It is your secret. (Group 6)

It is your own thing. (Group 6)

An important difference between the two groups is that while white participants had heard about menopause before experiencing it, and frequently had had expectations about what it was going to be like, most black participants had not heard about menopause before experiencing it. *I never heard of it before. I would like to know more about it though.* (Group 3) *I do not know anything about menopause.* (Group 3) Black participants spoke about hearing about "the change of life" for the first time from a doctor they had consulted about changes in their menstrual

patterns. When their periods stopped or when they noticed changes, women became worried. Some women thought they were pregnant, others thought they were ill. *I thought the doctor would say that I had a disease.* (Group 3)

Generations of Silence

Although overall it seemed that cessation of periods was an unexpected event for most women, some women mentioned that they had overheard older women talking amongst themselves about being "too old for such things". On the other hand, it appears to be considered a cultural and traditional norm to be secretive about menopause. At the same time, however, not talking about menopause was connected with silence around menstruation in their families or in their communities.

F: Do people talk about it or do they keep it a secret?

No, we're not used to, it's a secret thing, these are secret things to us. (Group 2)

Because it's in our culture to be secret, ya.
(Group 2)

It is just our way of life. (Group 2)

[I]t's a traditional matter not to discuss with anybody. (Group 2)

Ya, you don't have to show everybody that you've got periods/or you don't have periods/it's one thing that they hide. (Group 6)

The following comments illustrate how silence may be "passed down" from older women to younger women.

You were too scared to talk about it [menstruation], or ask: Mommy, what's this now? You know, it's the same thing now. (Group 4)

We grew up not discussing such things. We did not sit together to talk about such things. Sometimes we would talk to our mothers or relatives, but they also did not know that much. (Group 2)

I: She never knew anything. Her mother never told her anything. She just saw that, ok, her mother is not getting anymore children. So, there was not a direct, maybe lecture, or a person who says: Ok, when you reach a certain age, your periods will stop now. It was not like that. They just picked up. (Group 3)

Younger Women Also Silent

Silence around menopause is seen to be common amongst younger women. When considering the lack of talk about menopause between women generally, this is not a surprising finding. Some of the reasons for this silence resonated across the spectrum of groups. The speculations of participants about younger women often seemed to reflect their own fears or concerns about getting older. For example, younger women were characterised as not wanting to think about getting older.

Yes, the only reason they wouldn't like to go through it because then they realize then, in their mind, they'd think: Well, now they're getting old. (Group 4)

They do not think about it. They are not aware that the time of change is coming. They do not even know that they are going to reach 40. (Group 3)

Not having knowledge about the change of life was also a possible determinant of the silence. *I never heard the youngsters chatting about the change of life. I think you become aware when you start, because I know it from I start. But I never heard before.* (Group 6) One participant offered the suggestion that: *Maybe [Phyllis], it is not a secret amongst their age. They discuss it but not with us.* (Group 6)

Relationship Between Power, Gender, Culture and Silence

While the last two comments highlight the central theme of silence around menopause, they also reflect a silence among younger and older women about menopause. The dialogue that ensues invokes an image of how culture, gender, and relations of power serve to "manufacture" this silence.

Younger women would like to have the change of life, as far as I see....If they know about what is the change of life, they can ask for it. They'd order it. But the only think they don't know because in our custom we're not allowed to tell them. They must have babies, and they must have their period. We only warn them that if you don't get the period, you know that you are pregnant. (Group 6)

F: Why must they have babies?

When they get married, we want our daughters to have babies....So the husband can be happy. If you're married and you don't get a baby, you haven't got a life. You don't have a life, ah, not a good life with your husband. Then your husband must go outside to look for another girl that gives a baby. Leave you in your house with your furniture, with all the money you've got, because you don't have a child. (Group 6)

The black participant above voiced her perception of the relationship between silence around menopause and reproduction - the imperative to have babies. Implicit is a criticism of the situation where women are expected to have babies. A discussion amongst another group of black women which started off with a question about whether or not the end of periods is marked or celebrated in any way, and went on to discuss younger women's views of menopause, also reflects this relationship. The quotes highlight the way in which issues around menstruation and menopause appear interchangeable.

F: [W]hen periods stop, do you do anything, do you celebrate?

No there is nothing/stopping periods. (Group 2)

Everyone says: Ah, change of life, nothing will be done. Unless the periods, she stopped the periods before time. Then, we are to find out means of helping her/have a baby/produce something. Because in our tradition, to marry and then don't get children, there's no ways. We are to go to this doctor, doctor, doctor, this doctor, every, until you must have a child. So as to be respected as a woman/woman.

If you speak of the younger woman, I don't know if I understand the expression of yours, we mean maybe, ah, a person who's married, na. So if she she gets her menstruation but she isn't, she doesn't become pregnant, so that is something that worries her/mm/so she won't keep quiet.

Unlike black participants, the groups of white women did not talk about what it meant for younger women as women to have children. Participants perceived that younger women's views on menopause are that they looked forward to the end of periods, but do not look forward to getting older. *Yes, and, you know, the tension, aggravation being stopped, the headaches will stop, and things like that. But, I mean, it's not a matter of wanting to be old, if you know what I mean.* (Group 5) The participant's own disquiet about being old was unconsciously revealed in this comment, which may help to explain why younger women are perceived to have misgivings about ageing. The participant's comment (and other comments she made about her daughter) also reflect earlier speculative discourse by some participants that the silence around menopause may be related to context. In this instance, however, unlike for other women, mother and daughter seemed able to break the silence and be supportive of each other.

WOMEN HAVE DIFFERENT EXPERIENCES

There was consensus across the focus groups that women had different experiences of menopause. *They [experiences] are not the same because women are also different.* (Group 2) The biomedical model which tends to conceptualize the experience of menopause as universally uniform in physical and psychological terms seems not to be borne out by the experiences of participants in this study. The differences that women experienced during menopause were compared to differences that women experienced when giving birth: no two experiences are the same. Some women experienced problems with their menopause, while other women did not. *I went through it without a hassle, without a problem. [But] I've got a sister that went through TERRIBLE hot flushes. I mean, she couldn't handle it.* (Group 5)

However, it was not always easy to ascertain if participants' perceptions of different experiences of menopause included a broad spectrum of women. For example, I attempted to explore whether or not black women felt that their experiences were

different or similar to white women's experiences of menopause. Due to the silence around menopause and due to language difficulties (which may have resulted in confusion about what I was asking), answers to my question could be interpreted in different ways, as the following illustrates.

I asked one group of black women if they thought women had similar or different experiences of menopause. The question was translated from English to Xhosa as: Do you think that other women experience the same period problems as we do? The answer was: *We are not the same because some people stop when they have reached their 40s, while some stop before that.* (Group 2) A response from a participant in Group 6 was less ambiguous.

F: Are women's experiences of the change of life the same or different?

Yes, it is different. For the others are sick when they are getting their change of life. The others are just ok. They just stop. (Group 6)

F: So, you're talking about other women that you know? Friends?

Ya, friends. The other friends.

"CHANGE OF LIFE"

In all the groups, the term "change of life" was used most frequently when women talked about their experiences of menopause. White participants were familiar with the term menopause, but they said that amongst themselves the more common term used is change of life. For them change of life had connotations that went much further than cessation of menstruation alone. For instance, some women stated that menopause caused various symptoms and illnesses such as hot flashes, palpitations, depression, anxiety, dizzy spells, irritability, sleeplessness, high blood pressure, and arthritis. All of these symptoms are commonly mentioned in a biomedical perspective of women's experience of menopause. A glimpse at one way the biomedical model perpetuates its power in some women's

lives is revealed by a participant's comment: *My doctor tells me it's change of life. But everything nowadays is change of life.*
(Group 5)

Some of the meanings of change of life for participants are revealed in the following discussion. When I asked the question in one group of white women: "What comes into your mind when you hear the expression "change of life?", one participant responded: *Getting old.* (Group 4) Other participants mentioned no more babies, no more periods, and changes in the body which were described in the same symptoms mentioned above. A fear of going "off her head" in the same way her mother did was voiced by one participant.

Excuse me now, if I look at my mother, she went right off....She was going through change of life, and she actually went right off. And through that I sort of watch myself all the time, and my children watch me and say: Don't get like granny, you know. So, I sort of watch myself all the time for that sign that I'm getting like my mother was. And she was very bad. (Group 4)

None of the members of this group disputed the notion that menopause could cause "madness". Nonetheless it was also felt that nowadays women were less vulnerable to this happening because there are ways to prevent it that did not exist in their mothers' day: women can have their hormone levels tested to see if an imbalance exists, and they can take hormone replacement treatment to rectify the imbalance. Yet it seemed that many white participants were aware that not all women would "go mad" or need to resort to HRT. Women spoke about other women they knew (sometimes their own mothers) who had had a very easy time with menopause, and several women did not have any problems with menopause themselves.

Ya, of course me with my menopause as I say when, I mean, I can't, I can't actually say anything happened to me 'cause I went plain sailing through this. (Group 1)

As I said, I didn't even know I was going through it.
(Group 1)

I went through it without a hassle, without a problem/ya/I never had hot flushes or anything. No, I mean, I don't think menopause is, you're not really ill. You live a normal, natural life. It's, you know, just one of those things you've got to go through. I mean, it didn't affect me in anyway. (Group 5)

There was a tendency for some white participants, who themselves said they had not experienced problems during menopause to nevertheless imbue it with an almost mysterious power to create difficulties in women's lives. *I know a lot of people have lots of complaints. They have a patch put under this thing/ya/and have that done.* (Group 1) One participant who said she had "sailed through menopause" invoked a dismal picture for other women.

Some people can actually be very sick through their menopause/ya/they say so/ya, they go through very trying times. (Group 1)

F: And you think menopause causes those illnesses?

Ya, it is through, as I said, as I said the change of life, you know. And I think some women can get very very sick.

F: What do you mean by sick?

They always (pause)/headaches/headaches, and their blood pressure goes up and, I don't know, lots of things seems to happen.

There appeared to be a perception in Group 1 that I was looking for very "bad cases" of menopause, and the women sounded almost apologetic for not being able to provide them. *I think you've had three very easy people (laughter). (unclear) you next one will be lucky.* (Group 1) Perhaps this tendency for women to "pathologise" menopause even when their own experiences were described as easy can be partly explained by popular notions that menopause, and not ageing, and gender, class or social inequities, is the cause of women's problems as they get older, and that menopause is a physiological problem to be seen in biomedical terms.

Black Women: Change of Life or Change in Life?

Black participants were not familiar with the term menopause, but they were familiar with the term change of life, which most seemed to have heard for the first time from a doctor. One participant said that "ukuyeka ukuya exesheni", which means "to stop menstruating", was the Xhosa translation of the term "menopause". However, it was not clear if she was referring to the cessation of menstruation as defined in the literature on menopause, or when periods stopped for other, possibly unknown reasons, or both. Many of the comments that women made about the change of life indicated that they equated it with issues around menstruation. I think this was particularly evident when I asked one group a question which was subsequently translated into Xhosa (also discussed later).

F: Do you think all women have the same experience [of menopause] or do they have different experiences?

[Xhosa translation] Do you think that other women experience the same period problems as we do? (Group 2)

Women mentioned that change of life meant they would no longer be burdened with constant washing of their bodies and cloths that they used instead of pads. They would also not have to spend money on expensive pads. Unlike the white participants, black women did not produce a litany of physical and/or psychological symptoms that they associated with the change of life. Rather, they often grounded their experiences in material consequences of menstrual changes. However, some participants felt that pain they were experiencing in their bodies was directly connected to menopause. *There are things that I fear. When I have pains, I think it is because of this.* (Group 3) Yet, menopause did appear to signal a change in life for some women. *It is a warning that there are things that we cannot do well anymore.* (Group 3) Another participant felt that: *My children have noticed that I have changed. They are concerned about me.* (Group 3)

GROWING OLDER: POWER AND GENDER

A discussion on how women felt about growing older supports my previous perception that, for some women, change of life involves a change in life. The discussion also highlighted the complex nature of women's experiences of menopause - the way in which it transcends the boundaries of a rigid biomedical definition and includes experiences of getting older, gender relations, sexuality, and issues of power, is evident in the following dialogue from Group 6:

F: Are there other feelings about getting older?

Yes, the old men, if the women gets, ah, periods, doesn't get the periods, and then the change of life come, the man that you live with is going out to young girls. He's looking up the young girls/ya/and he leave the old woman in the house/ya/that's always the change IN life. They say your old men would always go outside and scratch to the young girls. (Group 6)

F: Why do they do that?

Because they are, they don't have change of life. And then, they won't get change of life, only women.

Men, men is stronger than a woman/ya/because, eh, the woman sometimes she doesn't feel strong/ya/as a man, I mean for sex/ya/like men, even an old man, they're still hunting outside/hey, hey/for women. We are, we are not like them. They are too strong. (unclear) when you get older, they run for the young girls/yes/yes, they are going to call them sugar daddies/ya/yes.

F: So are you saying that when a woman gets older she doesn't want to have sex, and that's why men go to young women?

Men, are are not, they, they are always greedy. They are, they don't get satisfied/mm/you see, more especially when you get old.

I think you don't have feelings for men/mm.

You're old man leaves you/more especial African men/African men, they leave you, and they say: Leave the old woman stay in the house, really, that makes change of life, something that changes really into your blood.

F: How does that make you feel?

Very sore.

And they feel sore, but what can they do. A man goes and gone, and you stay with your children.

Men are always heartbreakers. They are heartbreakers. When you get old they forget about, eh, those things you said in front of the (unclear) (laughter) they forget about that/their vows/yes/ and they said: Stay with your children. Why do you run after me? You an old woman, you got children, then you got your grandchildren also watching you. Now you think that I must stay home.

F: So, it sounds like you're saying that, as a woman gets older, life is more difficult for her than for a man.

Yes/yes/definitely/yes.

Ya, your life changes. That's change of life....I mean changes of the, when we are getting old, in your family, in your house. There are certain changes for your husband, for your wife. There is no more love in the house. No.

The issues raised in this group were similarly echoed in the experiences of another group of black women. *They [men] go up and down looking for younger women.* (Group 3) Older women who were no longer able to reproduce were portrayed as not being valued, and this was resented. *It is not fair. There is nothing nice about it. Once your kids are married and you have grandchildren, then that is the end. This is the thing I always think about.* (Group 3) Women did not want to reveal their age. *Even when she has a birthday party, no one will know how old she is.* (Group 3) What it would mean for women to reveal their age was grounded in their own experiences of gender relations. Participants worried that men would no longer look at them because they were old. They lamented the fact that men leave older women for younger women. It is interesting to note that, in contrast to the silence around menopause, many women spoke openly about their conflicts with men.

Getting "Old" is Harder for Black Women

Women in this study revealed a complex set of relations toward the experience of growing older. Connections between differences in experiences of getting older and issues of race, class, and power (i.e., political power) are often relatively easy to make.

Black women have more difficulties not only because they are women and working-class, but also because they are black. While negative expectations or negative experiences of growing older were expressed by participants across the spectrum of groups, positive aspects were more obvious in the talk of white women than black women. For instance, the meanings of getting older for white women seemed to embrace the possibility of more freedom or more energy to do things; or at least that their situation would not inevitably get worse. For black women, getting older seemed to represent a time of increasing sorrow, hardship, and loss:

Ah, that as we are growing older, there are certain problems that we come across. Ah, such as, ah, having children and got a lot of problems of your own children. So, we don't feel the same as the time we were still young. Ah, there is a change, ya, in our body, or life, because also at times we get, ah, worried of certain things amongst the family. (Group 2)

Moreover, the above response was to a question I had asked to probe issues of identity. The English interpretation by one participant of the group's experiences reflected that what it means to be an older black women goes beyond an analysis of the ways in which social role shapes identity to include issues of class, race, and gender.

Connections between differences in experiences between black and white group members and issues of gender relations and power are more difficult to make. For example, while many black women voiced the desire to stay young to hold on to male partners, except for one instance, there was no mention in any of the sessions that white women felt the same. Yet, conflict with male partners was apparent in some of their discourse and although it was not voiced in the context of being left for a younger women, it does not necessarily mean they do not fear this happening.

A frequent kind of response from white participants about the issue of ageing is reflected in the following dialogue:

F: How do people here feel about getting old?

It's not too bad. (Group 4)

I mean most people don't seem to/take notice/mind getting old, you know. They don't sort of, um, you wouldn't get the impression, you know, that they don't want to get old.

F: And yourself, how do you feel?

I'm quite happy to grow old....When you're young you're just looking for excitement all the time, you're never satisfied. when you're older you/ya/more relaxed/ya.

No babies anymore is also an advantage of getting older.

Participants drew comparisons between an old age which was characterized by illness and dependence on children for care, and one where they could continue to be healthy and active.

I suppose it depends what your outlook on life is/ya/keep yourself busy/if you gonna sit there and think: Ok, I'm old, I can't do anything anymore then you are gonna/get old, ya/but if you always busy, either baking cake, or you sewing, or whatever, then it keeps you a bit younger. (Group 5)

During discussions with white participants in two of the focus groups, I spoke about my own fear of being left by my partner for a younger woman. Responses to this probe were either met with silence or were low-keyed. *I mean my husband's never been one (unclear)/ya/He wasn't a person for going out on his own or anything like that.* (Group 1) Another participant said: *I've never actually even thought mine will, you know. I mean, even look at somebody else. It never bothered me.* (Group 5) A contradictory reply by a participant, however, seemed to reveal her foreboding of the unpredictable nature of relationships:

Do you know that I have 150% surety that he will never leave me....I know he won't leave me....As much as what I love him, if he's got to leave me for a younger woman, I won't stop him. Sorry, life's got no guarantees. (Group 5)

MENOPAUSE AND SEXUALITY

When compared to similar discussions in groups of black women, white older women appeared relatively secure in their relationships with male partners. Moreover, there was not a comparable outpouring of discourse about the behaviour of older men as a group in any one of the focus groups of white women. Yet, men were not completely let "off the hook". For instance, during discussions about sexuality and menopause, conflictual issues of gender relations were sometimes highlighted.

Most probably if you have a old randy husband, or whatever/you say because of my/and that's because of my hormones/ya/(laughter) that's why I'm like this now, you know. I suppose you want to get out of it at stages. But, I suppose each one of goes through, ah, a different experience. And I don't think we enjoy it at all/not at all/you know. (Group 4)

Participants in one group discussed the difference between a man's response to a woman who has had an hysterectomy and a woman who had had natural menopause. They concluded that it was possible that male impotence could play a role in problematic sexual relations.

You must understand too, men, they can say that but now some men become impotent. And early in their 50s, and they don't like it, they don't like their wives to know about it....I think that's their worry, that's their change. (Group 1)

Then they want to blame the women because they/ya.
(Group 1)

F: Are you saying problems people might be having with sex sometimes has more to do with the man than the woman?

Could be, could be. (Group 1)

Could well be, yes. (Group 1)

Sexuality Changes With Age

A range of feelings about sexual experiences emerged during group discussions. Experiences of participants include complete indifference, sometimes getting the urge, still being a bit interested, putting up with sex, heightened expectations, renewed and continued enjoyment. A perspective that frequently arose in different groups was that sex was better before menopause. *When I was 40, I got the seven-year-itch. I wanted to enjoy it. Yet today, I'm not interested.* (Group 4) Other participants voiced similar experiences.

F: Is that a change? Did you feel differently about sex before?

Definitely so. (Group 4)

It was different before/different/ya/yes/yes. (Group 4)

Definitely. I couldn't wait for my husband to come home before. (Group 4)

It was fine and exciting before but not anymore. (Group 3)

I must be very honest with you....Nothing. (laughter)
Really, really, I definitely did change in that ya.
Mm, kaputz. No, it really did. (Group 4)

Participants voiced different reasons for experiencing a loss of interest in sex with a male partner. Some women felt that they may have lost interest in sex because of putting on weight, feeling stiff or having pain in their bodies, being too old, not having a partner, not wanting a partner, as a single person not having sex for religious reasons, or because the blood had stopped coming out. *There is no energy to have intercourse once I have stopped menstruating.* (Group 2) After discussion, one participant in a group of black women summed up what most group members felt.

Once you, eh, you stopped menstruating, there isn't much of, ah, this feeling come into contact with a man. It's something not so much interested in. (Group 2)

Some women seemed to feel unable to come to terms with the changes in their sexual feelings, and the changes seemed to represent a loss of what they had previously valued and "felt good" about. I was asked for my opinion about this phenomenon: *Can't you help us, you [Phyllis] with the reason why?* (Group 2) And, in another group: *Alright please, let's hear, let's listen to the lady now.* (Group 4) Again, issues of silence and power were raised by these comments. In this case, working-class participants asking the "expert" researcher who has access to knowledge (and, therefore, power) to enlighten them about their apparent dilemma about sex. Beyond demonstrating many similarities in participants' feelings towards their sexuality, the discussions reveal the fluidity of women's experiences of sexuality.

F: Do you think menopause means the end of a woman's sex life?

It didn't make a difference to me, it didn't make me hotter or anything like that (laughs) Still up to today if my husband wants something and I'm not in the mood, I just tell him: No....He doesn't hassle me. `Cause, I mean, when we went out he knew me as a person like that...that was me. [People at work would say]: So wonder your husband puts up with you. I say: Well, maybe he loves me. (Group 1)

Yes, even if, ah, there is this change of life (unclear), at times there is a feeling of, having, ah, sexual domdom [sexual intercourse]. (Group 2)

I enjoy it. So I can't really complain really. You know, that hasn't changed. It hasn't changed at all....It didn't make me cold or anything. (Group 4)

As I say, it's more my husband's side that we we we don't, but it hasn't stopped us from loving one another...from cuddling up in bed and that sort of thing. (Group 5)

I look at it as a ticket to freedom. There's no hangups of falling pregnant....I look at it, ah, Enjoy yourself now, that's the way I see it. (Group 5)

No, I feel it's the start. Other people say it's starting off, it's starting your life. You have sex more than you had sex before. (Group 6)

It depends, eh, [Phyllis]. Depends. `Cause, ah, I didn't have sex since 1992. Up to now. And I thought, ah, my feelings are dead to sex. Until I had a new boyfriend. You see. (laughter) So now I have feelings, but didn't have feelings. (Group 6)

These quotes highlight several aspects of women's sexuality: that sexuality for women does not necessarily mean only sexual intercourse; that menopause can signal a time of heightened sexuality; and that sexual feelings and enjoyment of sex can be renewed for women in relationships with interested partners.

BODIES SHAPE EXPERIENCES

Women's feelings about their bodies have an effect on sexual practice. *I do not know, but ever since I gained weight, I am not interested in sex at all.* (Group 3) Other participants spoke about how pain and stiffness in their bodies affect their sexual relations:

Everything gets stiff [during sexual relations]. (laughter) Ya, a lot of people say: I don't feel like, ooh, moving my legs around like this/I see/I think it's arthritis. (Group 4)

Bodies and Appearance

Most participants, however, did not speak about their experiences of sexuality in terms of appearance of the body. Thus, it appears that older bodies are not explicitly experienced as a hindrance to sexuality. Yet, this contradicted the experiences that many black participants reported about how men went after younger women. Feelings about the body were more salient during discussions about appearance and how growing older mediated the meanings of this for women. When asked specific questions about whether or not participants did anything to look or feel younger, the most frequent kind of responses were:

F: Do you do anything to look or feel younger?

I mean, even if you are fat or something, if you dress properly/ya/then you will look nice. (Group 1)

I do not want to change for any other person. I want to change for myself because I want to feel good.
(Group 3)

Amongst the groups of white women, an obsession with keeping the body young in order to be more attractive to men did not surface during discussions. Older people were not *sommer* unattractive, and more important than dieting and going to the gym was to look and feel nice. *I mean I like to always/look nice/ya/But, I mean, further than that, I wouldn't go on a diet or anything like that.* (Group 1) One participant noted that older women naturally put on weight. Some participants' responses appeared to contradict their acceptance of their altered appearance. *But, ok, I do have my hair dyed. It's a hard thing to stop.* (Group 1) Another participant's responses revealed her experiences of what is expected of her as a woman:

I mean I do, I colour my hair, I mean, and I never go out without make-up and that type of thing. It's just one of those things, you know. (Group 5)

F: Is it to make yourself feel younger or look younger?

I'm sure yes, you know/probably/it's just one of those things, you know. (Group 5)

It was not explicitly stated in the following exchange, but one black woman revealed the way in which gender, ageing, and class can interweave and mediate the experiences of women.

F: Do you do anything when your hair gets grey, or when you get wrinkles?

Just because I have no money I can't do anything, but if I have money I should go to the chemist and say: Look, ah, doctor, I'm getting old and don't like wrinkles. But just because I have no money, I can't do anything. I'll sit with the wrinkles. (Group 6)

F: Why don't you like wrinkles?

I don't want to get old. Yes. I don't want anybody to notice (unclear) I got an old woman. If I have no wrinkles, nobody will notice if I'm old. (Group 6)

Older Bodies versus Younger Bodies

Participants did not explicitly focus on their bodies during the discussion on sexuality. There was a "silence" around the possibility of older bodies *per se* being less sexually attractive than younger bodies to men. In contrast, during discussions on ageing the *limitations* of an older body compared to a younger body was a persistent theme amongst black participants. Older bodies racked with pain were less able to do things that were once relatively easy.

Ah, ah, getting old. I think there's some things you can't do, like, you can't climb on the train now because you body getting stiff. (Group 2)

When you are old the body is always sore, even when you do everything to keep it fit. Like me, I walk most of the time. I do it to lessen the pains that I have. Getting old has its own problems. (Group 2)

Now, when I'm getting old, my body has lot of problems. Yes, eh, everything is sore. That, ah, that is what I notice about getting older. There are changes. (Group 6)

I feel pains easily now...My body aches and I do not know where they pain comes from. (Group 3)

Although I do not doubt that participants felt a lot of physical pain, the "pain discourse" of the women could also be symbolic of the more extensive pain that they seemed to feel about getting older: the pain of being black working-class women in South Africa. In the context of day-to-day life, black women also have to struggle more with fewer resources than white women. For example, black participants have to rely on taxis or trains for transport, while white women are more likely to have access to automobiles, if not their own, through their husbands or children.

POWER OF BIOMEDICAL MODEL

Generally, white participants spoke of their experiences of menopause in terms of biomedical symptomatology. For instance, white participants seldom spoke about changes to their bodies as

being specifically associated with ageing. Rather the body changes they experienced were directly related to "going through menopause":

F: So, when you hear the expression change of life, what comes into your mind?

Change in the body/mm. (Group 5)

F: What kind of change?

You know like, ah, shame, maybe some people go through like their attitudes/grump/grumpiness/ya, depression/depression/anxiety/most probably high blood pressure, you know. All kinds of things that everybody goes through/dizzy spells/you know/dizzy spells. I mean, there's quite a lot of things, you know. And you think: Oh, my gosh, am I going to go through that as well, you know.

They suggested biomedically-oriented treatment, such as hormone replacement treatment (HRT) for symptoms, and suggested that biomedical discourse was an ideal way to distribute information about menopause to women. One participant's suggestion about how to break the silence around menopause also raised issues of power and control of women's bodies.

I think what, what women really like to know is say, if you're, say you're 45. And go to a doctor and say: Look, you can expect your body's going to change, and so on, you know. Like a lot of people don't realize what is the age. I think if they knew MORE about it, then they wouldn't be so scared/ya/to go about about it, you know. They'd go into it then with an open mind/that's right/you know. This is what we should, could expect, and so on.

(Group 4)

F: Where do you think that information should come from?

From the doctor. He should say to you: Well, at this stage now, you must remember/yes, you must expect this/this is now time for to go through menopause. And maybe I don't know what menopause means even, and he explains to me: this is what's gonna happen to your body, this is gonna change. You might be moody, you might aggravated/ya/you know, things like that/even (unclear), they haven't got clinics like that, that for the sole purpose, hey? You know. For ordinary people, you know. And you take a tablet if you're

getting say, hot flushes. There's a tablet you can take three times a day or/ya/you know. Just to put you at ease a little bit/yes.

Biomedical terminology was not used extensively by black participants to describe their experiences of menopause. Nevertheless, women sought and received knowledge/meanings for menstrual changes from medical doctors. A few women indicated that they had experienced hot flushes. Yet, it was unclear if black women who experienced hot flushes were treated with HRT, although the cost of the tablets would probably be prohibitive for the working-class black women.

To me I had, um hot flushes. I went to the doctor. So he told me that: change of life. Then I stop with my menstruation. But it never got worse. After that, I was alright, I was ok. That is why I went to the doctor. I was worried about this [having hot flushes].
(Group 6)

Me I am stopped in '89. When I stop, tonight my body feel hot. I am going to the doctor. Doctor say me change in life (unclear) hot. But now I'm alright.
(Group 2)

F: Did the tablets help?

Yes. (Group 2)

F: What were those tablets?

I don't know. (Group 2)

NO PERIODS, NO BABIES: NO PROBLEM

While there were marked differences in how participants articulated their experiences of menopause, most women agreed that no more periods and no more babies are positive aspects of menopause. *I would be lying if I said that there is something that I dislike* [about the end of my period]. (Group 2) Another participant stated: *I would be happy when it's* [periods] *finished. It's a schlep.* (Group 5) No participants expressed a feeling of loss that they had stopped menstruating or that their periods would stop one day. Ironically, a few women who were anxious about the approach of menopause were nevertheless looking forward to the end of their periods. *Well, I'm looking forward to it* [menopause]. *The only reason that I'm looking*

forward to it is because then I won't get a period (laughs).

(Group 1) The end of periods meant no more anxiety about smelly and messy menstrual blood.

It's not nice because there's this smelling of/bad smells/of bleeding. So it's something you must always think of/all the time/as it is something penetrating my clothing. So, yes, it is something natural, but at the same time when you are doing it, because of this smell.

(Group 2)

Periods Are Not Just Biological

As the following comment illustrates, menopause may be experienced in a way that reflects the confluence of class, race, and gender. Water is often a scarce commodity in black townships and, especially, in informal settlements. Where this is the case, women are usually responsible for collecting it for their households. Therefore, for a number of participants in this study the end of menstruation may signify much more than a biological milestone. In this context, it is not surprising that the extra burden of constant washing during menstruation would be abandoned with joy.

No problem. There's no reason to wash/it's no washing/no washing, anymore washing. Get up early in the morning, got to wash yourself (laughter). When you go to bed (unclear) wash yourself, ooh. Pleasure (laughter). (Group 1)

Where Does the Blood Go?

Many women involved in this study appeared perplexed or concerned about what happened to menstrual blood when periods stopped. As mentioned earlier in the section on sexuality, some women seemed to associate the end of the flow of blood with the end of sexual feeling. While this may reflect unfamiliarity with reproductive processes of the body, it could also reflect that menstrual blood had meaning for women beyond its biological function. For example, negative feelings about blood - it was smelly, messy, potentially embarrassing if it showed, etc - were frequently mentioned. Women may thus have worried about

"leftover", or possibly "bad" blood, in their bodies when periods ended. Probing questions in one group revealed this possibility in the talk of one participant's experiences:

When I was 40 till 44, it stopped altogether because my periods was on and off....I didn't know if I'm pregnant or I stop altogether, because I didn't care. I care less because I wasn't sick. And I wasn't, eh, there wasn't no problem about it to me....And then I didn't worry going to doctors or asking what's going on. But I just stopped. Then after all, the only thing in 1978 I joined the blood transfusion....While I don't have my periods, there must be, the blood must be overflowing. And then I start thinking that, taking the blood. (Group 6)

F: So you had blood taken out of your body?

Ya, out of my body. (Group 6)

F: Did you think there was blood in your body that needed to come out?

Mm, I know that....And I thought maybe they would tell me if there's any disease in me. (Group 6)

No More Babies is OK

In a number of groups, participants expressed satisfaction that menopause meant the end of their reproductive lives.

F: Are there any reasons that you're glad about the change of life?

YES/don't have any more babies. (Group 6)

I am happy that I have stopped having babies. (Group 3)

I've done my duty as a woman and now I can get on with my life. Just be me. That's what I'm looking forward to. (Group 5)

However, one participant grounded the experience of satisfaction in the number of children black women had:

F: What about, um, not having babies anymore. How does that make you feel?

It's ok. (Group 2)

But I don't think it is ok to a person maybe who hasn't got a child, or maybe she's got only one child. Let's say it's a girl and she was expecting to have a boy. Now, she's stopped her menstruation. Now, she's going to have this ONE child. It's not nice to have. She doesn't feel comfortable because, I think, our tradition is to have babies, not one. Ya. Yes to, ah, a mother whose got four or five child, well, is she stopped. I think she's satisfied. But a mother whose got only one child, she's not satisfied. She's always, ah, trying something to have one. To have one small menstruations, so as to/(unclear) overcome/pregnant.

In contrast to the cultural ideal reflected in the above dialogue, an alternative depiction of the complexity of the reproductive lives of participants was revealed during group sessions. In most sessions, one or more participants revealed that they had been sterilized. One participant spoke about taking Depo Provera, while two participants had had hysterectomies, and at least two others spoke about their intentions to do so. Talk about women's experiences with their adult children appeared to reinforce the complex nature of women's lives.

"EMPTY-NEST SYNDROME" NOT LIKELY

During discussions about grown-up children leaving home, there was very little evidence of the so-called empty-nest syndrome amongst the participants in this study. Women's talk of their experiences reflected acceptance, pleasure and/or relief with the prospect or the event of children leaving home.

And my one son, he was 25, he moved out. My one daughter moved out. And I felt sorry, ah, but they were quite happy so I'm happy. `Cause there's less for me to do....With six children to cook for. Oh, it's too much. And I feel, you know, take a load off me....So it's quite fine. (Group 1)

Another comment appeared to express the sentiments, if not the reality, of many participants. *I am happy that I am now all alone. The children are no longer there.* (Group 3) While comments made during group sessions indicated a relative

consensus in the way participants felt, actual experiences of black and white women differ as the following dialogue from a group of black women illustrates:

Our children, they want to stay with us. (Group 6)

F: Your grown-up children?

Yes.

They are big. They don't want to go out. They said their father's house.

They want to live (unclear)/they want to stay here. We've got a lot of problem like that.

F: Do you feel that you want them to go?

Yes/ya.

F: If they go, how would you feel.

Very, very nice. I would buy a tin of pork, a small one. Not big. (laughter) The cost of things is too high, you know.

And we don't get money, we don't, our wages is too little/is too little/we don't get any money.

The issue of grown-up children was another example of the different experiences between white and black groups and shows how race, class, and gender modulates participants' experiences. At the same time, women were aware of a different set of possibilities.

F: If you had more money, do you think you would experience the change of life in a different way?

Yes, for sure. For sure. Definitely. If I can have more money than I have, I should enjoy life. I don't enjoy life because sometimes there is no bread in the house. (laughter) No supper. Sometimes we have, ah, only tea, and, eh, a slice of bread. And you go to bed/straight to bed/black tea, not tan tea. Yes.
(Group 6)

THE DOUBLE-SHIFT SHAPES EXPERIENCES

The meanings of menopause for women appears to be linked to low wages, and to whether or not women are employed. This perspective also includes the belief that women who do manual

work, and who also are responsible for daily domestic work in their own households are particularly disadvantaged.

I think it depends a lot on your lifestyle too. The type of life you lead/oh yes/also tells on you/yes/I mean look, the woman that's a hard worker or the woman that's just a housewife and stays at home. I think she may, you know the woman at home, will feel a bit better than you that's having to go to work every day may, maybe, you know. (Group 4)

It all depends on the TYPE of job you've got (laughs) You know if you don't sit behind a desk all day. (Group 4)

F: Are you referring to the kind of work that you're doing?

Ya. Well, yes/(unclear) a lot of walking/yes, up and down and so on. It's basically on your feet/and you spend hours, you know. It's shift work, and. It's not very nice. Weekend working.

F: And then, when you get home do you have to do a lot of work as well?

Yes, exactly, ya. I think that is the thing. You can't just go home and sit and there your meal's served for you. You gotta get up and make that meal, and oh. You know the others, they tend to wait on you, you know. (unclear) surprise you, once in a, ONCE in a blue moon, surprise you and make something. I think it's all that.

SUMMARY

It is clear that the main themes of silence, race, class, gender, power, ageing, bodies, and change of life intersect and shape experiences of menopause for all women in this study. The tangible differences in experiences between black women and white women can be explained in terms of the racist policies of past governments. As a result, material resources are particularly scarce in areas where black working-women live and this mediates their experiences of menopause and ageing.

Differences in gender and power relations between groups of white women and black women are harder to "pin down". Black women's experiences of growing older seem to be more problematic than white women's partly because of conflictual experiences

with male partners. White women did not voice the same level of conflict, nor did they frame relationship problems in the discourse of being left by men for younger women as black women often did. Earlier in this section, I discussed possible explanations for this silence. In Chapter Five these findings and their implications are explored in much more detail as are the implications of the findings in general for women's experiences of menopause and ageing.

Coding Conventions:

- new paragraph for each quote
- slash\for overlapping talk
- F: for facilitator
- I: for interpreter
- round brackets to describe occurrences (laughter) or conceal identity (name)
- square brackets to explain talk [Xhosa]

CHAPTER FIVE

DISCUSSION

Researchers must avoid a single level of analysis to the neglect of all other levels if the meaning of menopause to the health of women is to be adequately understood. (Estok & O'Toole, 1991, p. 37)

The data collected in this study seems to corroborate the importance cited in the above quote of exploring multiple levels of analysis to understand what menopause means for women. Participants' discourses about menopause suggests that their experiences traverse the "boundaries" of different models and perspectives to subsume multiple meanings of menopause. The discussion that follows highlights these contentions.

BLACK AND WHITE WORKING-CLASS WOMEN: POWER AND GENDER

Working-class women in South Africa are oppressed and exploited, and both white and black working-class women reported instances where class mediated their experiences of menopause. Women said that they did not have enough money to enjoy life. The type of manual work women did, and the double-shift is a heavy burden for women. But, black working-class women are also oppressed and exploited because they are black. The way in which black women in this study experienced menopause and ageing is shaped by racism. Racist policy means knowledge about menopause is not equally accessible to black and white women, and this helps to shape different experiences. Racist policy also means that ageing black women have less access to resources, such as wages, pensions, running water, housing, which obviously affects women's quality of life.

Class, racism, or culture cannot wholly account for women's different experiences, however. The way in which some participants spoke about their experiences as ageing black women reflects a more complex analysis. The lives of older black women and older black men seem to become polarised. The picture that emerges is one where older men chase after young women, while the older women struggle with little money to care for

themselves, grown-up children and grandchildren. Moreover, women did not speak about these experiences in terms of them being part of their culture, as they did with menstruation and change of life. Strebelt (1993) commented on the links between male power and culture. She cited writers (Campbell, 1991; Seidel, 1990; Stamp, 1989) who discussed the ways in which men invoke culture to legitimate subordination of women. Yet, women in this study said that men who had behaved in this way had broken their marriage vows, or that men's insatiable sexual drive made them act in this way.

COMPLEXITY OF DIFFERENT EXPERIENCES

It is important to try to understand why women's experiences of menopause and ageing are differentiated by race even in the face of apparent similarities in terms of class (e.g., between white and black women in this study) and culture (e.g., between black women in this study and Mayan and Greek women. See later section on Culture and Differences in Experiences). Before I discuss these differences, however, I would first like to explore what appeared to be different experiences of change of life and ageing among the three groups of black women. In two groups of black women, conflict was a prominent theme of gender relations. Indirectly it seemed that the silence around menopause was broken by the conflict discourse women used to describe their experiences of ageing. In one group of black women the conflict discourse did not emerge. The meanings that this group of women attached to their lives as older women, however, did indicate that they experience disadvantages to getting older. Women said that they did not feel the same as when they were young - there was a change in their bodies, and in their lives. They had a lot of problems and worries about their children and families. Moreover, although three women were married and other group members may have had partners, no one spoke about experiencing a "good" relationship. (In the groups of white women where conflict between women and men appeared also not to be a dominant issue, several women did speak about positive aspects of their relationships with men.)

Black and Poor: Different Meanings

Jarrett (1993) suggested that low-income African-Americans are under strong pressures to present idealized versions of their lives, especially to researchers. Her perception was that there is a stigma attached to being black and poor. While this may be the case for many low-income African-Americans, it does not seem that the same can be said for all low-income earners. For instance, participants in my groups spoke openly about their low wages not being enough to survive on, and they lamented having to go to bed without having had enough to eat. Grown-up children living at home were seen as an enormous drain on their wages. And, as mentioned, participants spoke openly about the problems women experienced with men. The women did not appear to feel that they had to hide their material conditions or family problems from a white middle-class researcher.

The way in which political struggle has been, and still is being, expressed in South Africa means that women can be proud of being black and working-class. Their talk reflected the struggle in South Africa for a living wage, and, at times, it seemed to reflect a "struggle" in gender relations. If anything, Jarrett's hypothesis about stigma better fits the situation of white participants: they are part of a minority group who have lost political power; they are relatively poor; they might feel uncomfortable or inadequate with a middle-class academic.

Why, then, did some black women speak openly about conflict with men, while others did not? I do not believe that all older black women have conflictual relationships with their partners, nor do I believe that all older black men fit a stereotype of "sugar daddy". The meanings of the silence around this issue in one group of women can be interpreted in different ways - as it can be for the similar silence in the groups of white women. For example, the silence could mean that a woman's relationship with her partner, while perhaps not "good", may meet her needs. Berkun (1986) suggested that women who felt secure in their marriage (which did not necessarily mean happy) were not unduly worried about ageing. A problem with Berkun's account, however,

is that it does not take into account the way in which class and race differences shape experiences of ageing. The silence could also be interpreted in the way that Jarrett (1993) suggested: the women may not have wanted to reveal certain experiences to me as a powerful researcher (see a later discussion on the power dynamics between white researchers and black participants).

Some women could also "accept" for cultural reasons the status quo in gender relations, as seemed to be a possibility in one participant's account of why married black women have children. On the other hand, for similar cultural or social reasons some women may have felt that it was inappropriate to say, for instance, that they found motherhood excessively demanding (Heurtin-Roberts, 1993). (For some black and white women domestic violence could also partly explain the silence. However, while I am aware of this possibility, the scope of this research does not allow for a detailed analysis of the possible connections.)

Influence of Group Process

Group process may also help to explain the silence; or, alternatively, to help explain why conflict was sometimes talked about. In terms of this latter proposition, Jarrett (1993) argued that group dynamics could serve to discourage an exclusive focus on highly idealized accounts of experiences. The presence of participants who are prepared to disclose highly personal aspects of their lives and who are willing to challenge idealized views may "set the tone for deeper and more reality-based views" (p. 197).

As a researcher I had preconceived ideas about menopause which were reflected in the questions set out in the interview guide. I had the power therefore to set in motion a process which was partly shaped by my own bias. Although the interview guide was a powerful tool in setting the direction of discussion, in all the groups of black women one or two women seemed to "set the tone" of the talk. This also meant that the same women often did most of the talking. While this situation may be partly due to

language differences between participants and myself (some participants spoke more English than others, and I do not speak Xhosa), it does mean that it may have been difficult for women who had "opposing" views to voice them.

In two groups, the talk was often dominated by problems women said they experienced with men. The interview guide did have questions that pertained to this issue. However, in one group the issue of conflict between older women and older men came up spontaneously in the talk of one participant, and was subsequently taken up by some of the other group members, and by the group's interpreter. The setting of the second group was partly responsible for the issue coming up: we sat in a circle in a small room. The participant sitting next to me had no problem reading the guide and "appropriating" the question. In this way the issue was first raised and subsequently taken up by other group members. I think that it is significant that the issue was raised by a participant who later indicated to me that she was involved in a progressive political women's organisation.

The tone of discussion in the third group of black women seemed frequently set by the participant who had not only helped organize the focus group, but had subsequently taken on the role as "co-facilitator" in the group (she appeared to be more fluent in English than most other group members). In terms of attempting to understand why women with similar backgrounds spoke about or experience menopause differently, two seemingly interrelated discourses which emerged during group discussion may provide some clarity. The first discourse framed the experience of change of life within a cultural context: at times the co-facilitator seemed at pains to make sure I understood the cultural context of women's experiences. The second discourse, related to the first, was that group members did not overtly talk about their experiences of gender relations in terms of conflict.

In order to be able to interpret the possible connections between the two discourses above, and to be able to understand differences in women's experiences of menopause in a much wider sense, I think an understanding of relations of power, and gender relations which are embedded in this power help. This understanding not only makes it easier to interpret differences in experience, but simultaneously facilitates a better understanding of the complex and symbiotic relationships between many different variables, such as culture, tradition, power and gender. The rest of this chapter is discussed within the context of these contentions.

SILENCE

The ability to displace one's knowledge with another hinges on women's silence in discussing with each other their experiences at the time of menopause. Free, open discussions with other women could lead to questioning of the assumptions behind the scientific and medical discourses and the resulting expectations of menopause. *Other knowledges of menopause might then be free to emerge from the women's experiences* [italics added]. (Dickson, 1990b, p. 28)

Menopause, especially for black working-class women, is shrouded in layers of silence. The group discussions provide an understanding of the underlying gender and power relations which give rise to, nurture, and sustain this silence. It is important to note that, although white participants seemed to "know" more about menopause (at least in conventional biomedical terms) than black participants, the theme of silence around menopause still emerged to dominate group discussions with white women.

Can Women Talk About Menopause

Drawing from their own experiences, participants advanced reasons for the silence. For example, women said they had nobody to talk to, or if they did talk about menopause they would not get a sympathetic hearing. Women in Wilk and Kirk's (1995) study also said that they had nobody to talk to about menopause. Fisher (1994) commented that women at her workplace felt that they could not talk about menopause with their supervisors or

co-workers, especially if the supervisors were men or younger women. She said that women also felt inhibited to speak to women of their own age or older if they thought their experiences were more severe than their colleagues.

Focus group participants who worked as housekeepers at a local hospital also did not talk about their experiences with co-workers, especially those higher up in the hospital's hierarchy, such as nurses. The fear of rejection or being judged by other people negatively because of what you were experiencing appears to be an issue for women in my study. Women said that they would be accused of "feeling sorry for themselves" if they spoke about their experiences.

Women also implied that they are "forbidden" to talk about menopause, especially to younger women. According to one participant, younger women must have babies; but, if younger women knew about menopause "they would order it". This succinct comment raises two issues: Firstly, women's talk in the groups about their experiences generally reflects the silence between older women and younger women around menopause. Secondly, while it may look as though older women hold power in this way, it is probably a false assumption. Most black participants were unaware that their own periods would stop one day, so it does not appear that they are deliberately "holding back" knowledge. To be able to understand who really holds power, it is also necessary to understand what it means to be a woman within the context of prevailing relations of gender and power (Gifford, 1994).

KNOWLEDGE AND WOMEN'S EXPERIENCES OF MENOPAUSE

Focus group participants described their experiences of menopause predominantly in biomedical terms. It was not only women who experienced "problems" who used this way of describing menopause, but also women who said they had experienced no difficulties during menopause. For example, some of the women who reported "no hassles" for themselves, spoke about other women's menopause in terms of medical symptoms such as

headaches, hot flushes, and high blood pressure. The fact that participants framed their experiences in biomedical terms, illustrates the power of the biomedical model and its far-reaching influence (Bell, 1987; Klein & Dumble, 1994; Ussher, 1989; Worcester & Whatley, 1992).

There were important differences between the black and white groups in their talk about their experiences of menopause, however. On the one hand, menopause appears to be experienced by black participants primarily as a biological event associated with the cessation of menstruation, and "named" by medical doctors as "change of life". On the other hand, white participants, while acknowledging the significance of the end of periods for "going through" menopause, appear to experience or spoke about their experiences of menopause in terms of physical and psychological symptomatology. One of the psychological symptoms that participants reported experiencing was depression. Hunter (1990) suggested that working-class women may be more depressed on reaching menopause which may be partly due to low income, poor health and housing, and having more children. Moreover, already depressed women might "anticipate the menopause more negatively and feel more helpless about it than others who are less depressed" (p. 365).

Political Struggle Shapes Experiences

What could explain these verbalised differences in experiences mentioned above? Through apartheid policy, such as the Group Areas Act, South Africans were forced to live in racially-divided areas. Women in this study still live in these areas. Material conditions and resources in white areas, even white working-class areas, was (and still is) better than in black areas. White participants are therefore in a relatively better position to get information about menopause through easier access to medical professionals (who are often white), the popular media, and so on. This situation could partially explain what appears as a gap in knowledge between black and white participants, at least in the context of biomedical knowledge (see later discussion on Culture and Power).

more accurate reflection of what it means to be an ageing black or white working-class woman in South Africa today.

CULTURE AND DIFFERENCES IN EXPERIENCES

Questions raised about differences in experience can be explored by looking at the findings of studies where participants shared some important variables. (It is noteworthy that literature on the experiences of women from countries other than North America or Europe is relatively scanty, or not easily available in South Africa, both which may partly reflect that "menopause" is not a universal concept [Lock, 1994].)

The women in Beyene's (1989) study are peasants with scarce access to material resources. Gender relations are characterized by the subordination and dominance of women by men. Giving birth to many children is experienced as a cultural norm by Mayan women; and married women, particularly with grown-up sons, enjoy heightened status after menopause. Mayan women also reported that sexual relations with their husbands improved after menopause. Both Mayan and Greek postmenopausal women reported being less restricted generally which they associated with their changed status in their communities. This change of status seems to have more to do with the end of their reproductive lives than with being older per se, although the two usually coincided. It seems that postmenopausal Mayan and Greek women were able to enjoy the "fruits of their labour" in diverse ways.

While there seem to be many similarities between black women in my study and Mayan and Greek women in terms of culture, material resources, and gender relations, women in my study neither reported a similar outcome in their relationships with men, nor did they report heightened respect in their communities after change of life. The only comment during group discussions that reflected a possible raise in older black women's status appears ambiguous: "When you are old most people look at you to do some things for them." (Group 2, translated from Xhosa to English.)

of identity, and competition with younger women. This latter comment echoes the experiences of black participants who, while not explicitly naming their feelings as competitive, expressed anxiety about being left by men for younger women.

Experiences of Sexuality Change

Many women in my study indicated that sexual relations for them changed for the worse during or after menopause. Women who wanted to avoid sex with their husbands said they liked it when their husbands were at work, or if a husband got randy they could always say no to sex because they were "going through change of life". Most women said that this was a change in experience for them: before they had enjoyed sex. (It seems appropriate to make a point here about the ways in which women's perceptions and experiences, including about menopause, are shaped not only by gender relations, but also by race, class, and power. One black participant who was "no longer interested in sex" thought that older white women and men had similar feelings about sexuality as their black counterparts. She had worked as a domestic worker in white homes in Johannesburg and had observed that older white men and women slept in separate rooms.)

Only black women, however, openly proclaimed that men were to blame for this change in their feelings about sex. Older men were said to be "greedy" and "never satisfied". Some black women implied (seemingly without presenting it as a cultural norm) that this type of behaviour was typical amongst black men. One participant thought that it could be more widespread amongst men generally. Women, on the other hand, were characterized as being more in control of their sexuality, and, by comparison, more dignified.

Determinants of Women's Sexuality

Ussher (1989) argued that the way in which heterosexual women express their sexuality is often determined by the presence or absence of an involved and interesting partner. For some women in my study, the deterioration or enhancement of sexual

relations appeared to fit Ussher's conception. For instance, one participant spoke about her sexuality in terms of her current boyfriend: "I do not love him anymore. He does not love me in a way that makes me sexually aroused when he is near me." (Group 6, translated from Xhosa to English). Another participant thought her feelings were "dead to sex" but her sexual feelings were aroused in a new relationship that had recently begun. Still another participant who did not have a partner lamented that she only met "dirty old men" and wanted to know why men were only interested in sex.

Many women without partners, and some with partners, appeared to be confused about feelings towards their sexuality, which was reflected in the words they used to talk about their feelings: "I don't know why..." "Maybe it's...?" "Could it be...?" "Can't you tell us, Phyllis." "Let's listen to the lady now [talk about sexuality]." Yet it seems clear that many women are not prepared to passively accept the notion that their sexuality is defined in terms of a "male sex drive" (Hollway, 1984b, cited in Strebel, 1993). In their talk about whether or not to have sex with a man, women appeared at times to be making their decisions in terms of their own needs. Women who refused to have sex with partners or were not interested in sex may have been partly motivated consciously or unconsciously by a view that male dominance over their sexuality was problematic for them (Strebel, 1993). Notions of men as always chasing after younger women, being sexually "greedy" or never satisfied, of always wanting only sex, of not being romantic enough reflect women's dissatisfaction and resistance to the status quo. However, for older women, particularly older black women, alternatives to the status quo seemed very limited. In this context, it seems doubtful that they are empowered through these forms of resistance.

Power, Gender, and Bodies

Bordo (1993) wrote about the ways in which cultural practices shape women's experiences of their bodies. In their pursuit of an ideal of femininity, women can lose control of their bodies.

In Connell's (1994a) discussion about body-reflexive practices, he argued that bodies (which embody social agency in their own right) help to shape gender relations through social practices which order lives and differentiate positions of power. Similarly, according to Gatens (1988) Spinoza theorized that the body is not part of passive nature ruled over by an active mind; rather the body is a process and its meaning and capacities vary according to context.

Experiences of menopause for women in this study are mediated through the demands and expectations which shaped their lives as younger women. Both white and black women were explicit in their talk about not having any more babies or not having to nurture children as a positive aspect of menopause. A difference between the groups of women is that some black women also explicitly said or implied that satisfaction with menopause depended partly on having had enough children as younger women, while white women did not voice this link during group discussions. In this context, through the exigencies of sexual practices, younger women "lost" control of their own bodies. Moreover, during the change of life older women's body-reflexive practices, or bodily activities, become devalued.

There appeared to be similarities between what black women said about their experiences of menopause and ageing and the experiences of Italian-Australian working-class women reported in Gifford's (1994) study. Gifford spoke about how women's personal experiences of their bodies were shaped through relations of gender and power. Women in her study experienced the change of life through their bodies which was framed in discourses of blood and nerves. A healthy body was one in which the blood flowed; when it did not, such as during menopause, women felt more vulnerable to the exigencies of life, particularly family life. Unfaithful or uncaring husbands, and problems with children were especially serious. Many black participants also spoke about how older women's lives are characterised by problems with husbands or grown-up children.

Although black participants did not speak about their experiences in terms of blood to the same degree as Gifford's interviewees, menstrual blood seems to be a salient factor in their experiences. There were many references to blood in their discourse and the role it played in their daily experiences. For example, participants described the way in which the end of menstruation had bearing on their sexual relations, and the way in which its cessation caused pain in the body. Older women advised younger women that they must expel "the dirty blood" every month (if they wanted to become pregnant). Both black and white women wanted to know what happened to the blood at change of life, or where menstrual blood came from in the first place. One black participant had donated blood because she no longer menstruated and her blood "was overflowing". As Connell (1994a) has suggested the *materiality* of body-reflexive practices - to give birth, to menstruate, to have sex, to stop menstruating - is not erased, but continues to matter in women's lives.

Whether or not the blood "still flowed" also shapes the ways in which women feel about their bodies and their lives (cf. Heurtin-Roberts, [1993]). The way in which experiences of the body are mediated through relations of gender and power are reflected in participants' experiences of being left by men for younger women. In other words, older bodies were being "replaced" by younger bodies, the latter presumably being more sexually attractive and more likely to reproduce. Metaphorically, a negative image of failed production has been attached to menstruation (Martin, 1994). When women menstruate they do not reproduce, thus there is considerable negative power associated with the image of failure to produce when applied to women's bodies. It seems to me that an image of failure to produce and the "negative power" which is connected to it intensifies when associated with menopausal bodies.

AGEING AND POWER

The relationship between menopause and ageing is complex. Focus group participants' experiences do not fit neatly into one category or the other. Getting old was often characterized in

women's talk as a time when bodies are consumed with physical pain, but some women also implied that their pain is caused by the change of life. Ageing seemed also to be associated with loss of sexuality for many women. For black participants, especially, ageing seemed also to be associated with other negative changes in their lives.

Bordo (1993) argued that the *physical* body can be an instrument and medium of power; and Connell (1987) wrote that one of the ways in which the power of men had become "naturalized" was mediated through the meanings imbued to the physical sense of maleness and femaleness. In this sense, older black men's power was reflected in the talk of black women's experiences of relationships between women and men. What this "masculine" power (and the relative power of younger women) seemed to mean for women in my study was a concomitant loss of power for themselves, which appeared to symbolize in important ways the lives of older women generally. (This is not to say that younger women have equal power to men.)

Menopause Means Getting Old

For white participants especially it seemed that if you are menopausal, then you are old. As a group, however, white participants tended to associate negative experiences with menopause rather than with ageing. In the literature, women have equated "getting old" with becoming like their mothers or grandmothers (Wilk & Kirk, 1995). Some white participants equated change of life with becoming like mother which at times meant "going mad", or getting osteoporosis. When compared to their talk about experiences of the change of life, ageing as a process, albeit inevitable, was more often than not framed in positive terms. While this situation may be partially explained by the hegemonic nature of the biomedical model, comments from some white participants reflect a more ambiguous relationship with ageing (Jones, 1994).

Women said that being old was "in the mind"; that "if you want to be old you can sit back and be old"; and, if older women are

active, "it helps them to stay young." Independence, continued good health, and especially not becoming a burden to your children were invoked as a "formula" for a satisfactory old age. Like for other older women, however, this discourse around ageing may also indicate anxiety about changes in bodies and in lifestyles that are difficult to control (Berkun, 1986). Bauman (1992, cited in Lupton, 1996) commented that it is generally believed that ill-health and death can be controlled by rational action.

Change In the Lives of Ageing Women

Black participants often talked about their experiences of change of life within the framework of a biological event - the end of menstruation. The event nevertheless seemed to herald a change in their lives. For instance, bodies that were no longer able to reproduce appeared to be "more vulnerable" bodies (Bordo, 1993). Women in Gifford's (1994) study revealed that change of life for them was about social death and loss of self. When women reached 50, they knew that death would soon come and they felt sadness for a past life that did not fulfil their dreams. Black women in my study said they were no longer young, and some participants implied in their discourse that they had little to look forward to as they got older: once children were married, and there were grandchildren then "that is the end" (Group 3).

Black women did not explicitly name their feelings about getting old as "sadness", nor did they explicitly say that they regretted their past lives. Yet their discourse about being left by men for younger women implied that they feel devalued as older women. It reflects a loss of identity as they get older, as did their talk about loss of sexuality and no longer being young. It seems unlikely that being old made women "happy". Moreover, it often appeared that anger underlies women's discourse about their experiences of what it means to be an older woman. Women said that it was not fair that they were no longer valued as women. When older men were conceptualized as "going up and down looking for younger women" antipathy towards

the men seemed implicit in the women's talk, which appeared to be supported by their tone of voice. Yet women's relative lack of power in gender relations was also implicit: women were said to "feel sore" about the way in which they were treated by men but "what can they do" (Group 6).

Foucault (1979, cited in Bordo, 1993) argued that power is not held by one group and used against another group. Power is a network of practices, institutions, and technologies that sustain positions of dominance and subordination in a particular domain. People and groups are positioned differentially within the network of power. When participants in one group talked about women being stronger than men because they outlived them, to me it was almost as if they were saying that women's positioning within the network of power could shift - that the conflict around power could have a different outcome:

And now, the men are always complaining. They say that, eh, at the funeral we always sing nicely when they die, sing (unclear) (laughter) When, when the woman dies, we sing like this: *Senzenina, senzenina* [What have we done]. (laughter) They are complaining about that/and they say when men die, women are very happy. That's what they say/because they are going to get a lot of money, from the funeral burial society.
(Group 6)

I do not think that "outliving men" is what women aim for in their lives; rather they seem to be expressing what conditions are like for them at present, and underlying relations of power become salient through their discourse. For me, their talk is indicative of Gifford's (1994) suggestion that the "sorrow of a life" (p. 316) is reflected in women's experiences of the futility of their lives as old women.

Ageing and Appearance: Issues of Race and Class

Women in my study expressed complex relations towards the issue of appearance. The way in which many women spoke about how they feel invokes a picture of almost total acceptance of their bodies as they currently appeared. Although overweight bodies are not necessarily seen as healthy bodies, they are also not

denigrated as "bad" or useless bodies. Older women are seen as attractive as long as they look nice - dress properly, are clean, do not let themselves go. Although this is a refreshing view, and probably does reflect women's experiences, it may require a more critical analysis, especially one that considers issues of class, race, and culture.

A question that emerges in this context is: If women had more money would they use it to change their appearance to fit cultural ideals of a "feminine" body? For South African older working-class women that ideal may not be a slim body. Yet, it appears from the talk of some participants that the ideal, in complex ways, may be a younger body. For instance, one black participant said that she wanted to eradicate her wrinkles to look younger, but did not have enough money to do so. This appears to be an example where not only gender but socioeconomic status shapes body-reflexive practice: if the participant had money she might have purchased a cream to eradicate her wrinkles.

Berkun (1986) reported that the changes related to ageing that most concerned participants in her study involved their hair, faces, or their bodies. In order to "delay" these changes, the women "played tennis, golfed, danced, walked, hiked, biked, and gardened" (p. 380). As in the comment above, which illustrates a connection between body image (wrinkles) and lack of material resources, the way in which class and race mediates women's experiences as they get older is clearly highlighted by a another black participant's experiences: She spoke about getting a lot of exercise during a taxi boycott in Khayelitsha when she had to walk miles every day between home and work.

"Empty-nest" Syndrome

A number of writers have argued that, contrary to earlier perceptions, older white middle-class women are not generally negatively affected by children leaving home (Berkun, 1986; Helson and Wink, 1992; Ussher, 1992). The findings of my study seem to bear out the findings in the literature in this respect.

As in other areas, however, there are important differences in experiences due to differences in class, race, and, probably, gender relations as well.

White women's experiences seem to mirror more closely those reported in the literature. Grown up children left home to get married, or sometimes to live with friends. Women, whether with their partner or as single parents, seem to stay in their homes, alone or possibly with other children. Major differences in terms of class appear to be that few children of white (or black) women in my study left home to go to university. Some women expressed relief when children left because it decreased the amount of domestic work they had to do. It was not explicitly stated, but it may also have been a financial relief as well for some families; although this may not have been the case in families where grown-up children's wages supplemented family income.

Many black women expressed the desire for grown-up children to leave home. The reality for most of the women, however, appears to be that grown-up children and sometimes grandchildren live with their parents, or more likely, with their mothers. While many white women spoke about their fear of becoming a burden to their children, the reverse appears to be norm for many black participants - their grown-up children are a major financial and emotional burden for them. Moreover, many women who spoke about their problems with grown-up children linked them to the behaviour of older men. Women talked about their experiences of not only being left by older men for younger women, but of being left with the children (and often grandchildren) to care for.

Gross inequities in material resources for black South Africans, such as the unavailability of adequate housing and high levels of unemployment, clearly play a key role in perpetuating and exacerbating the women's family problems. Yet these inequities and their consequences do not adequately explain why the burden still seems to fall most heavily on the shoulders of women. As I have argued throughout this discussion, an understanding of the

ways in which unequal relations of power between women and men shapes experiences provides for a more comprehensive analysis of the experiences of older South African black and white working-class women.

In the next section of this Chapter, I will discuss the limitations and benefits of conducting this type of research, recommend health policy, and present my conclusions.

LIMITATIONS OF STUDY

Drawbacks of this study include limitations associated with using focus groups as a form of qualitative methodology, problems that arose because of class, race, language, culture, and, possibly, ideological differences between the participants and myself, and issues around the dynamics between participants and the researcher.

Qualitative Methodology: Focus Groups

Six groups were conducted, and 31 women were involved in this study; however, in several groups there were less than six participants. The small number of groups and participants per group may limit the generalisability of the findings of the study to a larger population (Stewart & Shamdasani, 1990). Women who were more than 60 years old may have weakened the generalisability of the findings, although not necessarily in terms of issues of ageing which were salient variables in this study. Groups dominated by one opinionated member may have produced biased results; summarisation and interpretation of responses may have been more difficult because of the open-ended nature of participants' responses. As a facilitator, I may have, knowingly or unknowingly, biased results by providing cues about what types of responses were most desirable.

Class, Race, Language Differences Between Participants and Researcher

Especially for recruiting black participants, being white and not being able to speak Xhosa reinforced the barriers on both sides that had been created by the racist ideology of the apartheid government. Moreover, there were strong implications

from some women that they were tired of "being researched". Women wanted to know what was in it for them to become involved; women wanted to be remunerated; women implied that the research was intrusive in their lives which were already problematic; women questioned a research project that expected black working-class women to speak English.

The issue of language differences between myself and the majority of participants was very important for the entire research process, including the findings of the study. One difficulty was that in groups that did not request an interpreter not only were women expected to talk about experiences of an often sensitive nature, but they were also expected to relate these experiences in a language that was not their first-language. Another difficulty was that women who were more fluent in English than other women often dominated the group discussions. A third difficulty involved the translations of Xhosa speech in the transcripts to English for data analysis purposes. While the sense of what women were saying about their experiences seemed to be recorded relatively accurately, the language differences may have meant that important "nuances" of their experiences were lost (Strebel, 1993).

Power of the Researcher

Where is the balance of power [in the research process]? And though in that situation, power can be with the interviewee during the making of the data, it is the interviewer/researcher who has power of analysis afterwards. (Seibold et al, 1994, p. 396)

At times I appeared to be positioned as "the other" (Strebel, 1993) during discussions with women in the groups. Women told me about cultural practices around menstruation, and I was informed about the "unacceptable behaviour towards women" of black or African men. In the sense of Seibold et al's comments above, this may be an example of the power of the group participant: important information about women's experiences was being imparted and, presumably, this was seen as valuable for both themselves and myself in some way by participants.

However my power as a researcher does not only lie in the process of analysis (while admittedly a very powerful position to be in). Positions of power in the research process reflected the women's experiences of change of life. As a white middle-class first-language English-speaking academic associated with a prestigious university I had the power to interview black and white working-class women about their experiences of menopause. In other words, issues of race and class, which are embedded in relations of power and are powerful determinants of the ways in which women experience menopause, also characterized the research process.

My positioning as a white academic, and as a feminist in the research process, appeared to be the source of further possible contributions to the imbalance of power already inherent in the research process: (1) being seen as the expert on menopause, or as an intellectual who is seen as "the bearer of universal values and as truth teller" (Seibold et al, 1994, p. 401); and (2) as a feminist using feminist ideology to define, construct, and shape women's experiences. This latter comment seems to resonate with a dilemma I had when interpreting the data. I felt anxious that my analysis might undermine the importance of issues such as race, class, and culture by leaning too much toward gender and power explanations: that by making participants in my study seem "powerless" I reinforced my own power. I also wondered at times if I was looking for something "juicy" or dramatic in the data in order to make the research seem important, or to feel that there were "valid" reasons for doing it, or so I would seem clever.

On reflection, however (and through discussions with my supervisor and friends, and through a careful reading of the chapters on Results and Discussion) I felt relatively satisfied that my interpretation of the data was supported by what the participants' voiced about their experiences. In this regard, Krefting (1991) identified the researcher's job to be one of

representing the "multiple realities of participants as adequately as possible" (p. 215).

CONTRIBUTIONS OF THIS STUDY

In spite of the limitations, the study is important in several respects. Firstly, although only a small number of groups were conducted and a small number of women participated in the study this still may have been sufficient to generalize findings to a larger population, especially because the groups were relatively homogeneous with respect to the issue under discussion (Stewart & Shamdasani, 1990). The groups were differentiated along racial lines for reasons of comparison, but the three groups of black women were relatively homogeneous as were the three groups of white women. Moreover, because focus groups are like "social events", they may generate data more like those of a wider population than would a large number of isolated respondents (Albrecht et al, 1993).

Secondly, the focus groups provided a relatively safe place where women could share their feelings and experiences of the change of life and ageing; and they provided me as a researcher a means to come "face-to-face" with these experiences (Morgan & Krueger, 1993). These authors were concerned about the possibility of disempowering participants if, after soliciting their views, the views are ignored. In the context of an important aim of this study, that is, to provide a vehicle where older women's voices can be heard, the likelihood of "ignoring" what women have said about their experiences is lessened. Moreover, it is important to listen to participants' own assessment of the process. Women said that they: (1) had learned something about menopause; (2) felt they were different because they were still menstruating or because they had stopped menstruating, but now knew it was not so; (3) had learned that all women experienced the change of life; (4) thought they were ill, but now knew that they were not; and (5) that they wanted more information.

Finally, in the context of the topic not having been researched before in South Africa, this study may constitute "a beginning" for conducting research which seeks to ensure a broader view of women's experiences of menopause. Moreover, organisations which were involved in the process of the research, such as the Zibonele Health Project in Khayelitsha, Women's Support Group in Ysterplaat, women's church groups in Langa and Observatory, might have benefitted by the process and by the feedback sessions planned. The dissemination of results through these organisations and other organisations that may be interested, may mean that a wider selection of women gain information about menopause. The competition for menopause research organised by the Women's Health Project at the University of the Witwatersrand which I entered may mean that the results will get a wider exposure than the Cape Town area.

IMPLICATIONS FOR THEORIZATION ON MENOPAUSE

As previously mentioned in this study, there is no single coherent model of menopause which, on its own, captures the meanings of menopause for women. The biomedical model focuses on menopause as a time of deterioration for women. Menopause is conceptualized as a disease, and individual women are encouraged to seek medical treatment for the symptoms associated with it. Psychological models also tend to individualise women's experiences of menopause, and there is a tendency to blame psychological problems that occur during this time solely on menopause. The developmental contribution on menopause has been primarily to conceptualize midlife for women as signifying a downhill course, while psychosocial perspectives on menopause are lacking.

Feminist perspectives see social context as crucial in shaping women's experiences of menopause, but often do not include the ways in which important variables such as race, class, culture, sexual orientation, or biological aspects impact on experiences. Socio-cultural and cultural perspectives look at the impact of culture in particular in their conceptualizations, but can produce a too narrow perspective by ignoring other variables

such as mentioned above, as well as issues of gender relations, and relations of power.

Data in this study corroborate the contention that none of these models alone are adequate to explain women's experiences of menopause. For example, women's experiences in this study were neither identical, nor did they consist of a collection of symptoms, as typified in the biomedical model.

What did appear to be important in exploring menopause is an understanding of the role of "the body" in shaping gender relations and relations of power for women experiencing menopause. By drawing on theorizations of the body as agent, it becomes apparent that the ageing body, or the "menopausal body", changes in value and function, from reproductive to nonproductive. Differences in experiences of menopause, due to race, class, and culture may also be better understood in the ways in which ageing is experienced through bodies: for black working-class women, it is an ageing body rather than a "menopausal body" that is "exchanged" (by their partners) for younger (reproductive) bodies, while for white working-class women their bodies speak through symptoms they associate directly with menopause, and through hysterectomies. Even though all participants in this study are working-class, the specific historical and socioeconomic conditions in South Africa means that the way in which they experience poverty appeared very different: it is a racialised, bifurcated poverty, and gives rise to different experiences of menopause. For example, black participants (for whom running water is often not easily available) spoke of their relief at not having to spend so much time washing during menstruation, and voiced the belief that their lives as older women would be easier if they had more money. For white women, their poverty was spoken of in terms of overwork: the burdens of domestic and paid labour.

The impact of historical and socioeconomic factors on the way in which the agency of the body shapes the experience of menopause and ageing is therefore complex and specific to the conditions

experienced by women. For this reason a comprehensive and universal model of menopause is not plausible, as the data in this study show. An approach which combines social-psychological and feminist perspectives with theorisations on the body, and that can take into account historical and socioeconomic specificities, should offer the best theoretical formulation for an understanding of menopause.

This study has also shown the value of using a grounded theory approach to the analysis of women's experiences of menopause. By optimising the process of letting the data speak for itself, it was possible to gain new insights and to integrate existing perspectives of menopause in novel ways. This type of approach to data analysis lends itself better to theoretical innovation, and would be useful for future research where the primary aim is to capture the meanings of women's experiences of ageing and menopause.

RECOMMENDATIONS FOR HEALTH POLICY

Health policy as it stands now reflects the ways in which women are valued in wider society. The focus of health care is on younger women and children, as evidenced by the 1994 decision to introduce free health care for pregnant women and children. In this context, the health of older women (amongst others) is not given the attention it needs. The health services need to be restructured so that the promotion of women's health becomes the focus of one programme, instead of having fragmented programmes and unequal allocation of resources. In addition, restructuring should include the availability of alternative information to counterbalance the predominance of biomedical information, and more resources for education of older women so as to avoid reinforcing the biomedical model of menopause at every point in the health care chain. For example, if there are better alternatives to hysterectomies or HRT then this needs to be taken into consideration when assessing women's health needs.

The responsibility for women's health, moreover, need not be solely located in the Health Department. The Health Department

could lobby and work with other government departments, non-governmental organisations, women's organisations, etc., to improve not only the status of women's health, but to help facilitate a process of empowerment of women more generally. Women's organisations could put the issue of menopause and ageing on their agendas; men could be engaged in a debate which focuses on inequalities in relations of power and gender and their ramifications for older women in particular. Older women who are revered in South Africa could become role models through lobbying for older women's rights, identifying with education initiatives on menopause and ageing, etc.

The curriculums of health care workers, especially community health workers (CHWs), could be changed to include information about menopause and ageing, and retraining and continued education also could be provided for all health care workers. Community health workers (CHWs), who do home visits in various urban and rural areas or who are involved in existing women's wellness programmes, such as the one at Zibonele Health Project in Khayelitsha, could attempt to organise small groups of older women in their homes to discuss issues of health and ageing. These groups may be particularly useful for women who are not literate.

Issues of relevance to menopause and ageing which arise from the groups could be compiled with other relevant information into pamphlets which could be more widely distributed amongst communities. For example, older women's sexuality was an issue that many women in my study wanted more information on, as was the issue of what happened to menstrual blood at the cessation of menstruation. An important aspect of the distribution of information is that it should also be made available to younger women. With scant resources generally, it may prove very difficult to embark on such a process, but I think it is vital that it does go ahead. Disseminating information through community radio stations could be an important option in this respect.

CONCLUSION

Women's experiences of menopause reported in much of the literature and the experiences of women in my study often seem different. Some of the differences in experiences appear due to differences in socioeconomic status: working-class women have less resources than middle-class women and this shapes their experiences. There also seems to be differences in experiences between white and black women in my study.

An analysis of the ways in which issues of race mediate all aspects of women's (and men's) lives in South Africa is fundamental for an understanding of these differences. Racism means that black working-class women have minimal access to material resources, and as older women the inequities seem even greater. While the differences in experiences of menopause and ageing were evident in the talk about experiences of menopause itself, sometimes particularly so when issues of culture were discussed, they were even more strongly suggestive in discourse around issues of ageing.

While I would not dispute that class, race, culture and tradition shape experience, there were indications in the talk of black women in particular, that relations of power and gender may underlie differentiation of experiences. Women spoke about their experiences of conflict as older women with older men, about problems they had with their adult children, and about problems in the family. They did not indicate that they thought these experiences were due to their race or class, or to culture and tradition. Similar to experiences of older women reported in the international literature, it seems clear that gender and power relations are major determinants in the way women in my study experience change of life and ageing.

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APPENDIX A

INTERVIEW GUIDE

1. **Had you HEARD anything about menopause before you experienced it?**
 - * Words used, eg: the "change of life"
 - * Sources of information - family, friends, doctors, traditional healers, radio, TV, reading, other
 - * Any rituals, traditional, or religious ideas about menopause (maybe as a way of marking the end of a woman's periods)
 - * Younger women's views
 - * Are **ALL** women's experiences the same or different

PROBE: Did you know that one day your periods were going to stop?

2. **Do people - family, friends, at work, in the community - talk about menopause, or is it kept a secret?**
 - * Who talks: What do they say?
 - * Who doesn't talk: Why not?

3. **How do you, AS AN INDIVIDUAL, feel about menopause? Are there things you like (eg: no more pregnancies), dislike (eg: getting older, hot flushes), enjoy, or fear about menopause?**
 - * **Sexuality:** Does it mean the end of a woman's sex life?
Does sex get better, or worse, or stay the same?

PROBE: - Sometimes I feel my partner won't find me sexually attractive anymore, or maybe I won't want to have sex anymore.

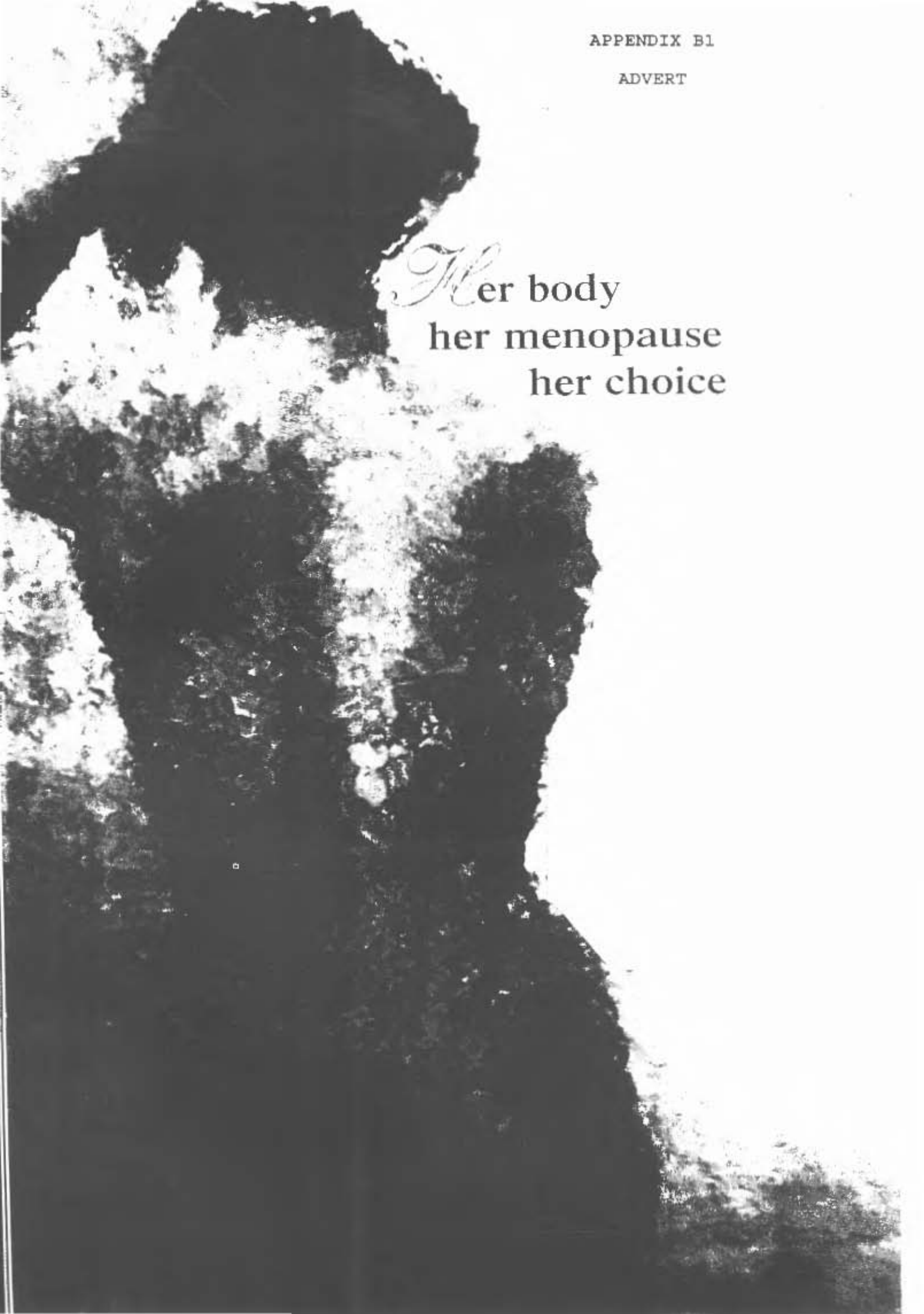
 - * **Getting older:**
What does this mean, especially for women?

PROBE: Sometimes I fear that my partner will want to leave me for a younger woman.

 - * **HEALTH PROBLEMS, or SYMPTOMS or SIGNS** of menopause?
 - * No more babies, and children leaving home?
 - * **AS A WOMAN** - Still feel the same or different?
 - * **BODY CHANGES** - Have you noticed any? How do you feel about them? Do you do anything about them?
 - * **APPEARANCE** - Do you do anything to look or feel younger?
 - * Other people's **RESPONSES** to YOUR menopause?
 - * **EXPERIENCES and EXPECTATIONS** of menopause - Did you have expectations of what it would be like? Did the expectations "come true/happen", or match the experience?
 - * Is anything that makes South African women's experience of menopause unlike other women's experiences?

4. **Has anybody experienced or done anything different from what we've talked about so far?**

5. **Have you learned anything here about menopause? What?**



Her body
her menopause
her choice

The most feminine gift for the mature woman



APPENDIX C
BIOGRAPHICAL QUESTIONNAIRE

1. Where do you live:
2. Race:
3. Language spoken at home:
4. Age:
5. Are you (put an X in ONE box):

Employed full-time

Employed part-time

Unemployed: looking for work

Unemployed: not looking for work

Self-employed/informal sector

Retired

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6. Is your OWN income (put an X in ONE box):

| | |
|----------------------------|--|
| Less than R1 000 per month | |
| R1 000 to R1 500 per month | |
| R1 500 to R2 000 per month | |
| More than R2 000 per month | |

7. Is your HOUSEHOLD income (put an X in ONE box):

| | |
|----------------------------|--|
| Less than R1 500 per month | |
| R1 500 to R2 250 per month | |
| R2 250 to R3 000 per month | |
| More than R3 000 per month | |

8. Are you (put an X in ONE box):

Married

Living together (not married)

Single

Separated/divorced

Widowed

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9. How many children have you had?

10. How many children are staying at home?

11. What is YOUR highest level of education (put an X in ONE box):

Primary school

High school

Completed Std 10

Diploma or equivalent

University education

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12. How do you see your current state of health (put an X in ONE box):

Excellent

Good

Satisfactory

Poor

Very poor

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13. Do you have any health problems, such as high blood, diabetes, TB, vaginal discharge, and so on.

YES

NO

If the answer is YES, what are your health problems?

14. Do you take tablets or medicines? YES NO

If the answer is YES, what tablets or medicines do you take?

What are the tablets or medicines for?

How long have you taken the tablets or medicines?

Do you take herbal or traditional medicines?

If the answer is YES, what herbal or traditional medicine do you take?

What are the herbal or traditional medicines for?

15. Do you use birth control, such as the Pill or injections (Depo Provera)?

YES NO

If the answer is YES, what birth control do you use?

16. Have you had an operation to take out your womb (hysterectomy)?

17. Do you (put an X in ONE box):

Still have monthly periods

Had a period less than 3 months ago

Had a period 3 to 12 months ago

Last period 12 months or more ago

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18. Are you (put an X in ONE box):

Finished with menopause

In the middle of menopause

At the beginning of menopause

No sign of menopause

Not sure

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APPENDIX D
PAMPHLET IN ENGLISH

- * Menopause is a normal event in a woman's life.
- * For most women, menopause will occur sometime between 40 and 60 years of age.
- * Menses (periods/bleeding) may change during menopause, for instance:
 - > Some women have no periods for 2 - 6 months (sometimes this can be even longer), followed by regular periods for awhile.
 - > Bleeding may be much heavier or much lighter than before menopause.
 - > Sometimes periods may become so long and so close together that it seems there is no end to the bleeding!

If this happens, it may be necessary to go to a doctor. But, this does **not** mean that you have to have an hysterectomy (an operation to take out the womb). If the doctor has ruled out any serious problems, the heavy bleeding may still cause an iron deficiency (anaemia). A simple blood test by your doctor can determine if you are anaemic.

However, you can avoid an iron-deficiency by eating as many iron-rich foods as possible, such as: whole-grain cereals, eggs, liver, lean meats (not overcooked), green leafy vegetables, potatoes. Foods rich in vitamin C eaten at the same meal as iron-rich foods help increase the absorption of iron. Vitamin C is found in: tomatoes, broccoli, cauliflower, green/red peppers, green/red cabbage, spanspek, grapefruit, guava, kiwifruit, lemon, lychees, nectarines, orange, pawpaw, and so on. If you **are** anaemic, you can also take iron tablets.

- * If you haven't had a period for one year or more, especially if you are between 40 and 60 years old, you are probably **postmenopausal** (finished with your periods).
- * It can take many years from the beginning of menopause - when your periods may start to change - to the end of menopause - when you stop bleeding altogether. The whole time period is different for individual women.
- * Many women wonder what happens to the blood when periods stop. They may think that the blood that used to come out goes to other places in the body, such as the head which then causes headaches or high blood. But this does not happen.

Normally, every month a woman's body produces an egg. This causes the lining of the womb to swell with blood. When the egg is not fertilised (no pregnancy), the lining of the womb gets expelled (this is a period). The reason why women

stop bleeding is because they are not producing any more eggs. There is no more blood to shed, so no blood is stored in a woman's body.

* Signs that are linked to menopause are:

> **End of periods for at least 1 year.**

> **Hot flushes:** a sudden feeling of heat in the upper body, sometimes accompanied by facial flushing. Some women get hot flushes throughout their menopause. Some women get them for a short period only, while for other women hot flushes come and go.

> **Vaginal changes:** for example, dry vagina which may cause discomfort when having sex.

* Not all women get hot flushes. Some women who do take pills if their hot flushes get very uncomfortable. Some women use herbal remedies instead of pills. Some women don't take anything, but rather change their diets and do exercises such as walking, swimming, yoga. The important thing to remember is that once menopause is finished, you will no longer get hot flushes.

* Wrinkles and greying hair, which happen to both women and men when they get older, are **not** caused by menopause. Nor is irritability ("nerves") which may occur at any time in our lives.

* It is a myth (not true) that menopause causes a woman to go "mad". Sometimes, however, women may get depressed when their periods are changing. If this happens, the depression usually ends when a woman's periods stop (if not before).

* Sexual relations may change during or after menopause. For some women sex may get better, while for some women it may get worse (this may also change again). For some women sexual relations stay the same.
