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International Journal of Current Research
Vol. 7, Issue, 01, pp.11283-11287, January, 2015

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

ISSN: 0975-833X

RESEARCHARTICLE

MENOPAUSAL TRANSITION AND WOMEN'S HEALTH STATUS IN JAMMU

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ARTICLE INFO

Article History:
Received 21st October, 2014
Received in revised form
14th November, 2014
Accepted 08th December, 2014
Published online 23rd January, 2015

Key words:

Women's health,
Menopausal Transition,
Somatic,
Vasomotor,
Sleep Problem,
Depression.

ABSTRACT

The study was conducted with the objectives to: 1) assess the health status women during menopausal transition, 2) study the relationship of various dimensions of women's health with demographic variables and socio economic status. The sample comprises of 600 women of Jammu, in the age range of 35-65 years, selected through multistage sampling technique. Women's Health Questionnaire and SES Scale were used to collect the data which was subjected to statistical analysis. Results reveal that majority of the respondents were 49 years of age, residing in joint families and belonging to middle class. Majority of the respondents scoremoderateon Health Status. Somatic Behaviour, Vasomotor Symptoms, Sleep Problems, Anxiety and Memory/ Concentration increase as the women age whereas Sexual Dysfunction, Menstrual Symptoms and Attractiveness decrease with the growing age. Women's health is significantly positively correlated with socio-economic status and significantly negatively correlated with age, age at menarche and age at marriage. A need for innovative approach to health care is required to be developed for women during these years as no program for healthcare during menopausal transition is available in India.

INTRODUCTION

Amratya Sen, The Nobel Laureate, says 'health, like education, is among the basic capabilities that gives value to human life.' It contributes to both social and economic prosperity therefore it is important to protect health through health care, besides other means of socio economic development. There is a change in the demographic structure which is occurring worldwide. As health care and awareness about it is increasing there is a higher proportion of older people in the world now. A declining trend in fertility and mortality rates has increased average life expectancy thus presenting a new set of challenges in today's society. Most women can now expect to live at least one third of their lives in the menopause. This age group has aptly been called "the next frontier in women's health care," as health and well-being are important concerns for this large and growing population (Frackiewicz and Cutler, 2000). Women's health during these years is grossly neglected and no developmental programs are available for health care during these years in India. Health is related to status in the society and women are still viewed as an economic burden. The factors that have contributed to her low status in society are preference for sons, daughters' mistreatment, low educational levels and formal labour participation, little autonomy and father's, husband's or son's control, and these factors still govern her fate. India spends a huge amount on health sector, with a number of preventive and curative schemes for women, but still the health indicators do not show a healthy trend. Most of the health programs in India are aimed towards improving the reproductive health, but inadequate attention has been paid to the age group under study. Some onus for this is on the women themselves because they are less likely to seek appropriate and early cure for diseases. Health related research studies show that women do not actively seek health; in fact they are usually the last ones to do so in their family. As they grow older their health problems multiply and they spend an uneasy life thereafter.

The situational analysis of aged in India shows that presently India has around 90 million elderly and by 2050 their number is expected to increase to 315 million, constituting 20% of the population (UNFPA, 2012 shows that 62.5% of India's population is 15-59 years of age and there are 62.2% are males and 62.8% are females). The 2011 Census Report whereas 8% of the population is 60+, 7.7% are males and 8.4% are females. Life expectancy among females is more. In Jammu and Kashmir 65.9% of the population is 15-59 years of age, 65.1% being males and 66.8% being females.8.4% of its population is 60+,8.5% being males and 8.3% females. The Situational analysis shows that 48% of the elderly living in rural areas and women and 55% of them are widows (UNFPA, 2012). The Global Report on Aging in the 21st Century reinforces the observations made in India that there is a multiple

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discrimination experienced by older persons particularly older women, including access to jobs and health care (UNFPA and Helpage India International, 2012). Further the report says that majority of people at 60+ are socially backward and economically poor.

Cause for Concern

Health coverage in the menopausal years or data about it meager. The present findings are a part of UGC MRP on Health seeking behavior of women (35-65 years) of Jammu. The present paper deals with the health status of women during the transitional years. It is beneficial for the people concerned with health care nationally and internationally as it will provide them knowledge about what kinds of problems are women these age groups developing, which need to be addressed by the health providers. A women's access to health depends on care in physical, social and psychological contexts, on health beliefs and her socio economic system along with demographic background (Nayab, 2005). To reach out effectively to people interventions must take into account the gender realities. Hence this paper would study the comparative health status of women from three ecological settings- rural, urban and tribal.

Objectives of the Study

I. To assess the health status of women of Jammu province (Jannu and Kashmir state)during menopausal transition years (35- 65 years).

II. To study the relationship of various dimensions of Women's Health with their present age, age at menarche, age at marriage, age at menopause, number of children and Socio-Economic Status.

MATERIALS AND METHODS

Locale

The study was conducted in rural, urban and tribal areas of Jammuprovince of the Jammu and Kashmir state of India.

Sample

Women in the age group of 35-65 years from Jammu were selected for the purpose of the study. The total sample size was 600 women from Jammu province. The sample was equally selected from amongst the rural (N=200), urban (N=200) and triba l(N=200) areas of Jammu.

Criteria for sample selection

***Age*:** Only women above the age of 35 years and below of 65 years were included.

***Ethnicity*:** Rural, urban and tribal areas of Jammu and Kathua districts, falling in Jammu province were selected.

Health: Women having any apparent signs of physical or psychological disability were not included in sample group.

Marital Status: Only married women were selected.

***Sampling technique*:** Multistage sampling technique was used to systematically select the sample.

Rural: Out of four tehsils of Jammu, three were selected randomly and a list of villages was obtained. From this list, randomly 10 villages from each district were selected. From each village, 10 women were selected through purposive sampling technique. In Kathua District also, there are four tehsils so similar technique was used for District Kathua.

Urban: sample was selected from various wards of Kathua and Jammu City. There are 71 wards in Jammu and 17 in Kathua out of which 10 wards each were selected randomly from both the urban areas and from each ward 10 women were selected purposively.

Tribal: Areas having a concentration of Gujjar tribal population were identified from Jammu and Kathua tehsils. A representative sample was randomly selected from these areas.

Tools Used

Women's Health Questionnaire (WHQ) devised by Myra Hunter in 2003: This scale was used to assesse nine domains of physical and emotional health. This scale includes 36 items rated on four point scale. The questionnaire measures a range of domains of symptom experienced by women, some of which are relevant to the menopause, such as vasomotor symptoms, and others which are associated with psycho-social factors, general health and or ageing, such as sleep and sexual problems and cognitive difficulties. Each score is scaled to give a range from 1 to 4, with higher scores reflecting a greater level of symptomatology or difficulty.

Socio Economic Status Scale

This scale is devised by S.C. Tiwari, Aditya Kumar and Ambrish Kumar (Department of Geriatric Mental Health, King George's Medical University, Lucknow, India, 2004). The scale aims to assess the socio-economic status in rural and urban communities in India. The scale had seven profiles (House, material possession, educational, occupational, economic, possessed land / house cost, social profiles) which were rated on 10-point scale. The validity and reliability of the scale has been established through a defined Visual Analogue Scale (VAS) and test-retest methods. The validity of the scale was high demonstrating its sensitivity to discriminate families between middle and upper classes.

Data Collection

Home visits were conducted to collect the data. For introduction, the help of a local leader was sought.Firstly rapport was established through informal discussions, and then the respondents were told about the objectives of the study. The local language, *Dogri*, was used to ensure that the information received was accurate.

Data Analysis

Data was subjected to quantitative analysis. Mean, SD,ANOVA and Correlation were calculated. Statistical software SPSS version 15.0 was used. The data has been presented in the forms of tables and graph.

RESULTS

Majority of respondents (38.3%) were illiterate, 22.3% have studied upto secondary class, 11.3% have studied upto primary and 10.7% have studied upto higher secondary. Majority of the respondents (67%) were home makers, 16.7% indulge in caste occupation, i.e. rearing of cattle for milk and its products, and 9.7% respondents were service holders. Majority of respondents (52%) were living in nuclear families whereas 48% are residing in joint families. Results further indicates that majority of the respondents i.e. 45.7% belong to middle class, 26.7% belong to lower middle class and 26.1% belong to upper middle class.

Table 1. Background information about the respondents

Background Variables Education	Frequency N = 600	Percentage (%age)
Illiterate	230	38.3
Primary	68	11.3
Secondary	134	22.3
Hr. Secondary	64	10.7
Graduation	57	9.5
Post-Graduation	45	7.5
Technical	2	0.3
Occupation		
Service Holder	58	9.7
Business	11	1.8
Pension Holder	14	2.3
Daily Labourer	3	0.5
House Hold Work	12	2
Home Maker	402	67
Caste Occupation	100	16.7
Family Type		
Joint	288	48
Nuclear	312	52
Socio-Economic Status		
Upper	8	1.3
Upper Middle	157	26.2
Middle	274	45.7
Lower Middle	160	26.7
Lower	1	0.17

Table 2. Mean age of the respondents during transitional phases of life

VARIABLES	MeanN = 600	Std. Deviation
Age	49.59	9.312
Age at menarche	14.08	1.396
Age at marriage	19.42	4.221
Age at menopause*	48.6	4.47
No. of children	3.15	1.539

* N = 270 respondents

Results indicate that majority of the respondents were 49 years of age. Their mean age at menarche was 14.08 ±1.39 years, age at marriage was 19.4 ± 4.22 years and mean number of children was 3.15 ± 1.53. Mean age at menopause was 48.6 ±4.47 years for the 270 respondents who had attained it.

Health Status of Women

Women's Health questionnaire (WHQ) was used to assess a wide range of physical and emotional symptoms or sensations experienced by women in the menopausal transition years. It has been designed specifically to study possible changes in health and well - being during menopausal transition. Higher scores are interpreted as low health status.

Table 3. Levels of Women's Health

LEVELS OF WHQ	Total N = 600	%age
Low	151	25.16
Moderate	283	47.17
High	166	27.67

Percentage in parentheses, *significant at p≤0.05, **significant at p≤0.01

Results reveal that most of respondents (47.17%) have moderate health status followed by 27.67% having high health status and 25.17% low health status.

Table 4. Scores on various dimensions of WHQ (Mean and standard deviation)

VARIABLES(Total score)		Mean	Std. Deviation
Somatic Symptoms	(28)#	21.28	4.473
Vasomotor Symptoms	(08)#	4.81	1.526
Sleep Problem	(12)#	19.23	2.721
Depression	(28)#	7.75	1.798
Sexual Dysfunction	(12)#	5.84	3.300
Anxiety	(16)#	12.96	3.071
Menstrual Symptoms	(16)#	8.56	2.724
Memory/Concentration	(12)#	4.57	1.700
Attraction	(08)#	5.36	1.599
WHQ	(144)#	90.31	13.746

Table 3 shows the mean scores of respondents on the various dimensions of WHQ. The mean score on Somatic behaviour was 21.28 ± 4.47,on Vasomotor Symptoms it was 4.81 ± 1.52, on Depression 19.23 ± 2.72, on Sleep Problems 7.75 ± 1.79, on Sexual Behaviour 5.84 ± 3.30, on Anxiety 12.96 ± 3.07, on Menstrual Symptoms 8.56 ± 2.72, on Memory 4.57 ± 1.70, and on Attraction it was 5.36 ± 1.59. Overall mean scores on WHQ was 90.31 ± 13.74 which is 68.97% of the total score.

Results (Table 3,4,5) reveal significant ethnicity wise differences on all the dimensions except attraction. On somatic symptoms mean scores are higher among the respondents of tribal areas i.e. 24.3±3.111, followed by the respondents of urban areas 20.87 ±4.046 and lower among the respondents of rural areas i.e 18.68±4.24. On Vasomotor symptoms scores are higher for the respondents of tribal area 5.61±1.37, followed by the respondents of urban areas 4.63 ±1.38 and lower for the respondents of rural areas i.e. 4.2±1.48. Sleep Problems scores are again higher among the respondents of tribal areas i.e. 8.54 ±1.47 than the respondents of urban and rural areas (7.58 ±1.795 and 7.15 ±1.81). On the dimension of Depression, higher mean scores are obtained by the respondents of tribal areas i.e 17.32 ± 2.92 followed by the respondents of urban areas i.e. 15.71 ± 3.65than the respondents from the rural areas i.e. 15.52 ± 3.54. Mean Scores on sexual dysfunction are higher among the respondents of tribal areas i.e. 5.99 ± 2.62 followed by the respondents of rural areas 5.5 ± 1.79 and lower among the respondents of urban areas i.e. 5.2 ± 2.02. On Anxiety tribal respondents obtained higher mean scores than the respondents of urban i.e.12.41±2.96 and rural i.e. 12±3.05 areas.

Table 5. Association of various dimensions of WHQ with Ethnicity

DIMENSIONS OF WHQ	ETHNICITY			
	Urban N = 200	Rural N = 200	Tribal N = 200	F value
Somatic Symptoms	20.87 ±4.05	18.68±4.24	24.3±3.11	109.487**
Vasomotor Symptoms	4.63 ±1.38	4.2±1.48	5.61±1.37	52.573**
Sleep Problem	7.58 ±1.79	7.15 ±1.82	8.54 ±1.47	35.196**
Depression	15.71 ± 3.65	15.52 ± 3.54	17.32 ± 2.92	17.115**
Sexual Dysfunction	5.2 ± 2.02	5.5 ± 1.79	5.99 ± 2.62	6.98**
Anxiety	12.41±2.96	12±3.05	14.47±2.60	42.187**
Menstrual Symptoms	8.61 ± 3.07	7.53 ± 2.17	9.54 ±2.49	29.889**
Memory / Concentration	4.25±1.52	4.31 ±1.64	5.15 ±1.78	18.673**
Attraction	4.46 ± 1.46	4.73 ± 1.52	4.66 ± 1.75	1.505
WHQ	82.52 ± 12.73	78.62 ±13.50	94.49 ±10.58	89.93**

** significant at the 0.01 level.

Table 6. Correlation of dimensions of WHQ with demographic and socio economic variables

VARIABLES	AGE	SES	Age at menarche	Age at marriage	Age at menopause	Number of children
Somatic Symptoms	.115**	.050	-.117**	-.161**	-.041	.195**
Vasomotor Symptoms	.115**	.135**	-.067	.213**	-.021	.214**
Depressed Mood	-.016	.207**	-.021	-.107**	-.080	-.006
Sleep Problem	.069	.233**	-.061	-.181**	-.035	.164**
Sexual Dysfunction	-.563**	.191**	-.001	.126**	-.164(**)	-.205**
Anxiety	.030	.253**	-.061	-.204**	-.066	.108**
Menstrual Symptoms	-.312**	.100*	-.101*	.070	-.082	-.104*
Memory / Concentration	.107**	.323**	.077	-.204**	-.049	.201**
Attractiveness	-.278**	.005	.22	.126**	-.052	.201**
WHQ	-.151**	.269**	-.083*	-.138**	-.121(*)	.066

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

On Menstrual Symptoms scores are higher among the respondents of tribal areas i.e.9.54 ±2.49 than the respondents of urban (8.61 ± 3.07) and rural areas (7.53 ± 2.17). On the dimension of Memory / Concentration, higher mean scores are obtained by the respondents of tribal areas i.e. 5.15 ±1.78 followed by the respondents of rural areas i.e. 4.31 ±1.64 than the respondents from the urban areas i.e. 4.25±1.52. Scores on the dimension of Attraction are higher among the respondents of rural areas i.e. 4.73 ± 1.52 followed by tribal respondent 4.66 ± 1.75 and least among the urban respondents. Overall results reveal that tribal respondents have attained higher scores followed by urban respondent and then the rural respondents showing that tribal respondent's health status is lower than that of the urban and rural respondents and need more attention.

Table 6 reveals that Somatic behaviour of the respondents is positively significantly correlated ($p \leq 0.01$) with age and number of children. It has negative significant correlation ($p \leq 0.01$) with age at menarche and age at marriage. Vasomotor symptoms are positively significantly correlated ($p \leq 0.01$) with age, socio-economic status, age at marriage and number of children Depression has positive significant correlation ($p \leq 0.01$) with socio-economic status whereas it has a negative significant correlation ($p \leq 0.01$) with age at marriage. Sleep problems are positively significantly correlated ($p \leq 0.01$) with socio-economic status and number of children and negatively significantly correlated ($p \leq 0.01$) with age at menarche. Sexual Dysfunction is positively significantly correlated ($p \leq 0.01$) with socio-economic status and age at marriage whereas it is negatively significantly correlated ($p \leq 0.01$) with age, age at menopause and number of children.

Anxiety has positive significant correlation ($p \leq 0.01$) with socio-economic status and number of children whereas it is negatively significantly correlated ($p \leq 0.01$) with age at marriage. Menstrual Symptoms are positively significantly correlated ($p \leq 0.05$) with socio-economic status and negatively significantly correlated ($p \leq 0.01$) with age, age at menarche ($p \leq 0.05$) and number of children ($p \leq 0.05$). Memory/ Concentration has positive significant correlation ($p \leq 0.01$) with age, socio-economic status and number of children but is negatively significantly correlated ($p \leq 0.01$) with age at marriage. Attraction has positive significant correlation ($p \leq 0.01$) with age at marriage, and number of children where as it is negatively significantly correlated ($p \leq 0.01$) with age. Overall results indicate that WHQ has positive significant correlation ($p \leq 0.01$) with Socio-Economic Status whereas it is negatively significantly correlated ($p \leq 0.01$) with age, age at menarche ($p \leq 0.05$), age at menopause and age at marriage.

DISCUSSION

In the light of above results, we can interpret that majority of the respondents were 49 years old, illiterate; belong to middle socio-economic status and living in joint families have moderate health status. Results reveal that Somatic behaviour of the respondents is positively significantly correlated with age and number of children. Vasomotor symptoms are positively significantly correlated with age, socio-economic status, age at marriage and number of children. Depression has positive significant correlation ($p \leq 0.01$) with socio-economic status. Sleep problems are positively significantly correlated ($p \leq 0.01$) with socio-economic status and number of children. Sexual Dysfunction is positively significantly correlated with

socio-economic status and age at marriage. Anxiety has positive significant correlation with socio-economic status and number of children. Menstrual Symptoms are positively significantly correlated with socio-economic status. Memory/ Concentration has positive significant correlation with age, socio-economic status and number of children. Attraction has positive significant correlation with age at marriage, and number of children. Overall results indicate that WHQ has positive significant correlation with Socio-Economic Status. Okonofua *et al*. (1990) in a study conducted in South-west Nigeria found joint pain and hot flushes to be the most commonly reported menopause symptom. Agwu *et al*. (2008) in South East Nigeria also found the commonest menopausal symptom to be hot flushes. Williom s*et al*. (2006) reported that in US vasomotor symptoms are associated with energy and sleep. Weight gain, mental health and vaginal dryness were some of the common symptoms discussed with health care provider. A study by Kuh *et al*. (1997) reveals that women who had experienced an early natural menopause had a strongly raised risk of vasomotor symptoms (hot flushes or night sweats), sexual difficulties (vaginal dryness or difficulties with intercourse) and trouble sleeping.

However, there was little or no excess risk of other somatic or psychological symptoms. A study by Ollofsson and Collins (2000) reveals that vasomotor symptoms and joint pain were associated with postmenopausal status. Other symptoms were significantly related to psychosocial factors, life-style and attitude towards menopause. Overall the present results reveal that health of women declines with the increasing age. Significant association of ethnicity was observed with nearly all the dimensions of women's Health (WHQ) i.e. Somatic, vasomotor, Sleep Problem, Depression, Sexual Behaviour, Anxiety, Menstrual Symptoms, Memory, except Attraction. Somatic behaviour, vasomotor, sleep problems, depressed mood anxiety, increase with the increase age. Sexual Dysfunction, menstrual symptoms, memory/concentration and attractiveness decreases with the age.Women's health in the later years is grossly neglected as can be seen from the present results hence following approaches need to be developed and strengthened for improving their quality of life during later years.

Suggestions based on findings:

1. Women's health during menopausal years to be given as much importance as reproductive health to improve her quality of life in later years of life.
2. Promoting regular health check-ups through the available health care systems especially during menopausal transitions
3. Bone density assessment and cancer screening should become a part of public health programs. More focus on this age group as Osteoporosis and osteopenia is increasing according to the WHO which is leading to injuries and physical limitation among the women.
4. Schemes for empowerment of women to include health initiatives for menopausal transition like supplementation, community health care, forums of discussion,
5. Folk media can be used effectively- bhajanmadalis, religious congregations etc, as women need to be encouraged to talk and identify their problems.
6. Volunteers who can talk, discuss, console and refer as women are generally not aware of the physiological and psychological changes accompanying the menopause.

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