A Sociological Study of Women's Lived Experience of Menopause and Understanding of Menstruation in Mthatha and Makhanda, Eastern Cape Province.

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Abstract

This qualitative study explored different sociocultural factors that influence and inform women's menopause experience and perceptions. The aim of the study was to investigate the cultural beliefs about menstruation and menopause, with a focus on embodied experiences of menopause, as well as the perceptions of the transition from menstruation to menopause. Six in-depth interviews were conducted with women in their 60s and 70s in the Eastern Cape Province: four in-depth interviews were conducted in Umtata/Mthatha and two in Makhanda. Data was analysed thematically. A key study finding is that women's definition and experience of menopause is significantly influenced by their sociocultural context. This also shapes their experience of menopause, and in the case of the women in this study, menopause is experienced as a natural process. Regardless of the participants' acceptance of menopause, some women still need to be equipped with information on severe menopause symptoms, what they mean, and how they can be treated or managed.

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Contents

Chapter 1: Introduction

Menopause is a natural phase woman reach as they age, except when they have a disease such as cervical cancer and it is surgically induced. Moreover, not every woman will experience it the same way, nor is the degree of vulnerability similar among women. It is a complex condition that continues to be scientifically investigated and publicly debated. Biomedicine, social sciences, cultural societies, and women themselves contribute to the discussion of what it is, how it is experienced, and how it should be managed. All these conversations about menopause contribute to how women perceive and later embody it as an experience. As Hvas and Gannik (2008: 177) argue how other people talk about menopause, even in casual conversations, influences how women may perceive it. This then suggests that all these different contributions or discourses around menopause are worth considering when understanding the transition, identifying knowledge gaps, and finding ways to help women have positive perceptions about it, and how they experience it.

Discourses are systemic ways of communicating language, understood as ways that compete to give meaning to the world (McPherson, 2002: 4). Language in this context is more than just an instrument to connect people, but a method employed to structure how people experience the world through interaction (Andrew, 2012: 41). Hence, the investigations of how people construct their reality using "agreed and shared meanings communicated through language" (Galbin, 2014: 85). Kramsch (2014: 32) notes, "language is a guide to social reality … it powerfully conditions all our thinking about social problems and processes… The 'real world' is to a large extent unconsciously built up on the language habits of the group." Thus, social constructionists view Language, speech, and communication as the fundamental elements of the interactive process that is responsible for sponsoring individuals with the understanding of themselves and their reality (Galbin, 2014: 82). However, discourses are not fixed; they can be changed and are subject to redefinition based on either a social or historical context. For instance, the meaning of the menopause transition continues to be contested and redefined in modern society, and this depends on the knowledge held by communities and socio-economic contexts (McPherson, 2002: 5).

In addition, an individual's physical body is shaped by evolutionary, environmental, social, and personal factors to create an embodied experience of related sensations, such as those of happiness, health, and illness (Niewöhner & Lock, 2018: 684). This viewpoint brings us to the idea that embodied experiences of social phenomena are socially constructed. Moreover, social constructionism maintains that individuals collectively "create and sustain all social

phenomena through social practices" (Galbin, 2014: 86). This is where the influence of factors like culture and practices within different cultures come into play, as is the case in the current study. Therefore, the embodiment of an experience becomes a way one represents one's own and other people's bodies according to the local patterns of knowledge and experiences within that setting (Niewöhner & Lock, 2018: 684). These above viewpoints suggest that discourses, together with other socio-economic factors that women find themselves in, shape their perceptions of the menopausal transition and their embodiment of the menopause experience. It is for this reason that a qualitative research approach is used in this study to hear the women's voices on their embodied experiences, and this will contribute to the global debate on menopause. The theoretical framework for the study is social constructionism and post-structuralist feminism theories. Social constructionism lays out the foundation for the social construction of reality. On the other hand, the post-structuralist feminist theory is applied to understand women's consciousness of the menopause transition, the discourses surrounding it, and their subjective experiences. The feminist perspective is also applied to understand the notion of agency by acknowledging the embodiment of a woman within a social context (McPherson, 2002: 2). The study focused on exploring the sociocultural understanding of menopause (and menstruation), and the social shifts that womprofessional workersen are subjected to during this transition.

This study aims to contribute to this limited area of research and debate on menopause, and the sociocultural understandings and perceptions on menstruation. This is done through the participants' perceptions, understandings, and experiences of menopause, including other aspects of their lives (e.g., womanhood, menstruation, motherhood, and aging). This is in line with social constructionism, which does not deny the contribution of biology to our human life experience, but also acknowledges that most of this experience is a result of social and interpersonal influences (Galbin, 2014: 85). Similarly, this study does not deny the biological reality of this phenomenon even though the focus is on the socio-cultural aspect of the menopausal transition. As a result, the study suggests that menopause needs a holistic lens that appreciates sociocultural, biological, and psychological factors to understand it.

1.1 Research objective

This study mainly investigates the cultural beliefs about menstruation and menopause, and the women's lived experience of menopause. This was achieved by:

- Investigating beliefs about menopause in different cultural contexts;

- Investigating women’s perceptions and knowledge of menopause;
- Exploring if (and perhaps how) the existing cultural beliefs on menopause shape the women’s experiences of menopause;
- Enquiring about the biomedical knowledge on menopause that women might have.

1.2 Dissertation outline

This dissertation is divided into five sections starting with the introduction, which includes the study's objective, the methodology, and the dissertation outline. The second section is the literature review that includes a discussion on various discourses on menopause, and the focus is on the sociocultural discourse in the African context. The third section presents the theoretical framework of the study, which are social constructionism and post-structuralist feminist theories. Section four is the study's data analysis, and the final section is a conclusion to the study, which outlines key findings, limitations, and recommendations.

Chapter 2: Literature Review

2.1 Introduction

The term 'menopause' comes from *men* and *pausis*, which describes the psychological and physical events women experience upon the onset of the cessation of their menstruation (Khoza & Akinsola, 2012: 259). It is a complex phenomenon with many diverse discourses around what it is and how it can be understood. Hvas and Gannik (2008: 178) mention seven categories of these discourses: *the biomedical*, *forever-young*, *health-promoting*, *consumer*, *alternative, feminist/critical*, and *existential*. The *biomedical discourse* defines menopause as a developmental stage in a woman's life that marks the end of menstruation and the reproductive phase (Hvas & Gannik, 2008: 179; Mishra, Brown & Dobson, 2003: 405). This commonly used definition enlightens us about how this period is characterized by a physiological shift. Although, at times, this transition can be surgically induced (Bosman, van Wyk de Vries, Bouwer, Jerling, Badham, van Aardt & Ellis, 2008: 27). This type of discourse focuses on the biological shift during menopause, arguing that the distress and hardships faced by middle-aged and older women are due to the horrors that come with the menopause transition (High & Marcellino, 1994: 349).

The *forever young discourse* explores how the aging and the aged seem to be denigrated and rendered invisible while youth and youthfulness are celebrated (Hvas & Gannik, 2008: 179; Voicu, 2018: 12). This discourse results in menopause being viewed as a negative representation of the aging process that must be combated with hormones since hormones are viewed as a *life elixir* to delay aging (Hvas & Gannik, 2008: 179). The '*health-promotion discourse*' suggests that menopausal symptoms and the risk of osteoporosis are modifiable by lifestyle changes like maintaining a healthy weight and adhering to nutritional guidelines, which are increasingly valued and advocated for. Under the *consumer discourse*, menopausal women are viewed as independent, knowledgeable, and empowered consumers who have consumer rights. This view is similar to the *biomedical discourse*, in that women are urged to consult their doctors regarding their menopausal symptoms for a range of treatments that they can choose from. The *alternative discourse* suggests that menopause should be viewed as a standard frequently pleasant phase, but it is also recognized as a temporary imbalance that eventually puts a burden on the body. Natural remedies like vegetables and tofu are consumed to relieve the hormonal imbalance. The *feminist/critical discourse* views menopause as a normal stage of a woman's life that is a natural or beneficial transition whose severe symptoms may appear as a result of stressful situations that women go through. Treatment is thought to

be rarely necessary as women are expected to be knowledgeable about their physical changes during menopause. Lastly, the *existential discourse* suggests that menopause is a journey that elevates a woman to self-discovery, driving her to transformation and personal development (Hvas & Gannik, 2008: 179; Utz, 2011: 147).

The focus of this study is the *sociocultural discourse* of menopause which defines menopause as a bio-social and cultural phenomenon that is characterized by a biological and social shift in which culture may influence (Drew, Khutsoane, Buwu, Gregson, Micklesfield, Ferrand & Gooberman-Hill, 2022: 1). However, the *biomedical discourse* is examined to lay the foundation for a discussion on the *socio-cultural discourse* and to cater for the biological shift noted in the definition above.

2.2 The biomedical discourse on menopause

The *biomedical discourse* is a scientific discourse by the biomedical community outlining their concerns about the symptoms of menopause which include, but are not limited to, hot flashes, muscle pain, night sweats, organ atrophy, urine incontinence, coronary artery disease, bone loss, and mood swings (Berger, 1999: 3). Emotional distress which includes depression, episodes of insanity and irritability are said to be common menopausal symptoms as well (Voicu, 2018: 12).

The main concern in this discourse is the biological shift women undergo during menopause, which is caused by the fluctuation of hormones, and characterised by different phases, namely the pre-menopause, perimenopause, and post-menopause (Drew *et al*., 2022:1). However, not all women progress from one phase to another as the pre-menopause stage occurs when a woman is still menstruating or has not had their menstruation within the last three months in a twelve-month cycle (Ramukuela, Khoza & Akinsola, 2012: 241). It is characterised by vasomotor symptoms such as sweats and hot flushes during a woman's normal menstruation cycle, irregular menses due to ovarian malfunction, or dysfunctional uterine bleeding (Batrinos, 2013: 337). The World Health Organisation (WHO) defines the perimenopause phase as the start of "the clinical, endocrinological and biological feature of approaching menopause", however, it can extend through the first-year post-menopause (Ramakuela *et al*., 2012: 259).

The focus of the current study is the last phase - the post-menopause/menopause stage - which occurs when women start experiencing cessation of menstruation for at least 12 months (Ramakuela *et al*., 2012: 259). The *biomedical discourse* argues that menopause results in a genitourinary syndrome, a group of signs and symptoms mentioned earlier, which is mainly

linked to a decline in oestrogen production, thought to impact the sexuality, quality of life, and affects the daily activities of middle-aged and older women (Moral, Delgado, Carmona, Caballero, Guillán, González, Suárez-Almarza, Velasco-Ortega & Magro, 2018: 1418). In a TED presentation, Mosconi (2019), a neuroscientist, argues that menopause negatively impacts a woman's brain energy levels, in addition to the hormonal transition process, which is frequently argued that it makes women feel insane, adding to their frustration. For the above reasons the *biomedical discourse* came to medicalize menopause and presented Hormone Replacement Therapy (HRT) which will be discussed later, to help women manage and treat menopausal symptoms.

2.3 Conceptualizing Medicalization

Medicalization is a broad concept, consisting of various processes and degrees. According to Busfield (2017: 760), medicalization is a process of putting the labels *healthy* and *ill* to human conditions and problems and making medicine to treat or manage them. Ballard and Elston (2005: 228) give an interesting argument by many sociologists, that, as our society enters a post-modern period, with growing concerns about people's declining trust in expert authority among other things, the modern-day consumer of healthcare actively participates in resisting or bringing about medicalization. Ballard and Elston (2005: 235) further use the social model of disability which was in recent years publicized by the disability movement attempting to delegitimize the medicalized conceptual framework applied to the *issues* faced by the disabled – as an example of the consumer's resistance to the medicalization of a condition/problem. Moreover, Correia (2017: 1) alludes that empirical studies demonstrate that medicalization is increasingly being achieved through people's efforts, particularly those who seek to legitimize their distress by defining a problem as a *medical* issue or as needing medical attention. As Fainzang (2013: 2) suggests at times individuals outside the medical profession choose to *pathologize* a physical manifestation or phenomenon by themselves by consulting a medical professional about it or *self-medicating.* Conrad (1992: 211) uses alcoholism as an example of cases like the above where medical professionals or their medicines are not always directly or entirely involved in the medicalization process. Finally, Ballard and Elston (2005: 236) note that when the healthcare consumer has faith in the effectiveness of medicine, then medicalization, the expansion of the medicine's authority, influence, supervision, and jurisdiction to other aspects of life and social phenomena is likely. This viewpoint emphasizes that healthcare consumers and the members of the medical profession both play an active role in the process of medicalization (Conrad, 1992: 219).

On the above argument's account, Conrad (1992: 211) alludes that what counts as the involvement of the medical profession in the medicalization process is whether medical language/medical terms have been used to describe a problem or condition, the use of a medical framework to understand the problem or whether medical intervention has been adopted to *treat* it. On the other hand, however, Correia (2017: 3) contends that it is not as clear or straightforward what *medical terms*, *language*, *framework*, and *interventions* mean anymore in the current debate. This contention is based on the vagueness of whether these terms should refer to medicine in a broader sense or specifically biomedicine. Although medicalization as a concept originated in Western countries, it now involves and in one way or another impacts everyone across the globe. This is to suggest a need for the vagueness of the abovementioned terms to be clarified as the debate becomes more complex; because from a global point of view, various medical knowledge branches fall under the medicine knowledge umbrella. Consequently, Ballard and Elston (2005: 228; Correia, 2017:3) allude that when conceptualizing medicalization in our post-modern era we need to consider the specific social contexts in which medicalization takes place, and to quit viewing the process as a uniform, unidimensional process or solely the result of biomedical dominance, because such an approach does not sufficiently cater for medicalization's much more ambiguous, complex, and debated process and nature.

2.3.1 Broadening the scope of conceptualizing medicalization

Much of the literature on medicalization has focused on the roles both the medical professionals and the post-modern day healthcare consumer play in bringing about the medicalization of certain things but with relatively little reference to the broader social context in which the medicalization occurs (Ballard & Elston, 2005: 236). For instance, according to (Busfield, 2017: 760) medicalization is assumed to: (a) depend on the expansion of what the profession of medicine deems as relevant to medicalize; (b) 'the retention of absolute control over certain technical procedures', illustrated by the work of plastic surgeons to improve physical appearance (though this is mostly focused on physical enhancement rather than an illness), and the increasing prescription of biological medicine, including medicines used to treat psychosocial states; (c) medicine's almost absolute access to taboo areas and nearly exclusive license to treat the functioning of the mind and body; and (d) the expansion of what the good practice of biomedicine deems as relevant to the good practice of life (Correia, 2017:3).

Moreover, most empirical analyses of the concept of medicalization take place where medicine from the West has been institutionalized and this strengthens the link between medicalization

and biomedicine (Correia, 2017:3). Biomedicine or biological medicine is a knowledge branch that is built on physiology and biology and is closely supported by technological practices and evidence (Correia, 2017: 3). Furthermore, the expanding laboratory medicine, consumerism, global-scale medical tourism, informed societies, and the role of transcontinental regulatory agencies in health across the globe help explain the increasing acceptance of this overlap even beyond the West (Correia, 2017: 3). Yet, Conrad explicitly suggests that medicalization as a general trend is shaped by wider social processes (Ballard & Elston, 2005: 236). Moreover, Oinas (1998: 54) notes that medicine does not exist outside of culture and society, but is rather an active part of these, in that it does not only form society but is to some extent formed by society. This study regards Conrad's point of view because of the weight and position he holds, not only in the debate but in Sociology and beyond. It could be argued however, that Conrad's conceptualization of medicalization is profession-based, i.e., focusing on the link between medicalization and the medical profession (Correia, 2017:3). However, his conceptualization is empirically grounded; hence, he seems to argue from a profession-based standpoint. Moreover, this is so because of factors like the success of the medical model and the rise of rationalism since the 19th century in the social context in which his conceptualization occurred (Ballard & Elston, 2005: 236).

Therefore, Correia (2017: 3) suggests the removal of the profession-based approach to medicalization, which is most common in the medicalization debate, and introduce a more knowledge-based approach. The 'knowledge-based approach' expression suggests that medicalization as a concept be considered as broad enough to include the various branches that fall under medical knowledge, irrespective of the scientific or political status of such branches in society (Correia, 2017: 4). Furthermore, this will show the conceptualization of medicalization to be broader and analytically neutral since it will be acknowledging and including different players and forms of medical knowledge structures and development, and not just the medical profession (Correia, 2017: 3; Ballard & Elston, 2005). This suggestion may assist in making medicalization remain relevant in medical debate in Sociology.

Thus, Correia (2017: 3) strongly suggests "a clear theoretical standpoint to the definition of medical knowledge…," to be more inclusive and relevant since scholars engaging in the medicalization debate study the concept from quite different empirical contexts. Furthermore, if we are not careful to balance and acknowledge the distinction between the empirical context medicalization is being studied and the theoretical scope of the concept, we risk "reproducing a misleading and culturally biased argument" that suggests medicalization refers only to

Western biomedical knowledge (Correia, 2017: 3). Misleading and culturally biased in a sense that it is grounded on a profession-based perception of medicine, *overlooking* other existing and influences of other social factors and branches of medical knowledge in our highly diversified society. Despite the critique that the acceptance of the *empirically grounded* perception to conceptualizing medicalization will risk the possibility of causing medicalization to lose its adaptive dimension and become essentialist about the boundary of the medical/non-medical (Correia, 2017: 3).

2.3.2 Levels of medicalization

There are several debates on medicalisation as the form and extent to which anything is medicalised differs according to the sociocultural authority and the degree of mobilization for supporters and detractors of this process (Ballard & Elston, 2005: 236). This includes the perceived efficacy of medical interventions in a particular sociocultural context. Medicalization can occur on various levels namely, conceptual, interactional, and institutional levels (Correia, 2017: 3). As Ballard and Elston (2005: 235) note that the conceptual level is where medical language is utilized to define the condition/problem; the interactional level is about the interactions between patients and doctors, where medical treatment is administered after defining a problem as a *medical condition;* and the institutional level occurs when and where the medical profession allies with other authorities to gain legality over managing the problem. These different levels of medicalization can be separated when analysing the social problems that have been defined in medical terms.

Conrad (1992: 220) suggests three possible outcomes of medicalising a problem/condition, that, it may not always be complete due to competing definitions that may exist, or due to remnants of the problem's previous definition clouding the picture. Thus, some conditions are almost fully medicalised, like childbirth, while others like menopause and opiate addiction are partially medicalised, and yet others like spouse abuse and sexual addiction are minimally medicalised (Conrad, 1992: 220). Furthermore, Conrad (1992: 220) argues that there is not yet a good understanding as to which factors exactly influence medicalisation. Even though things like the medical profession’s support, the availability of treatments/interventions, medical insurance coverage are most likely argued to be significant factors. Finally, how ready people are to accept, apply, or reject the medicalised definition may differ, be it in groups, subcultures, or individuals (Conrad, 1992: 211). This means that de-medicalisation of certain conditions may occur (Ballard & Elston, 2005: 235).

2.3.4 Critiques of medicalisation

Initially, the medicalisation concept in social sciences was to address the tendency of medical institutions in dealing with non-conforming behavior, and replacing previous social control institutions like the law and the church in managing deviance (Correia, 2017: 2). Consequently, medicalisation is believed to inappropriately define certain social phenomena as medical issues, through adopting an exclusively drug-based approach to both psychological suffering and natural processes such as pregnancy (Conrad, 1992: 211).

Another critique is based on the authority the medical profession possesses through its expertise and specific knowledge, which it exercises to create its specialized ideas of what should be known as disease and control it (Ballard & Elston, 2005: 231). As Correia (2017: 3) points out that such autonomy is fuelled by the institutionalization of the medical profession which was gained based on laboratory-based knowledge built on physiology and biology. Furthermore, some critiques go as far as to suggest that the objects of biomedicine are not discoveries of diseases more than they are *fabrications* or *inventions* (Bury, 1986: 137). Finally, the pharmaceutical industry, is thought to be profit-driven, in that its eagerness to create new markets and engage in the medical exploitation of everyday life events encourages the "appropriation of human problems to medicines" (Fainzang, 2013: 3). However, the problem with overemphasizing the profession's imperialistic tendencies is that it underplays the benefits offered by the medical profession in many instances (Ballard & Elston, 2005: 228). Moreover, some literature does not view medicalization from a lens of medical imperialism because this idea would make people think of medicalization as misguided human motives or efforts (Busfield, 2017: 760).

2.4 Feminism and the medicalisation of the female body

In the 1970s feminists from diverse academic backgrounds explored the allegedly *unacceptable* and *not restricted* medical control to deviance, some explicitly addressing medicalization (Bustifield, 2017: 763). At the time of these contentions, the medical profession was male-dominated, so, the feminists' key concern was against men exercising power over women's reproduction processes like menstruation, birth control, pregnancy, abortion, and childbirth (Busfield, 2017: 763). Radical feminists went to the extent of arguing that the seemingly ever-increasing medicalization of female health was due to gender politics in the hands of patriarchal medicine (Oinas, 1998: 53). Yet other scholars challenged this interpretation based on a more complex process of collaborations between different groups of medical professionals and categories of women grouped, for instance, by social class (Oinas, 1998: 53). This latter

contention's point is that women cannot be viewed as a homogenous group that is passively victimized by the medicalization of the female body, but rather, due to different women's conflicting interests, others actively participate in the medicalization process, meaning it becomes a matter of gaining and losing for different groups of women (Oinas, 1998: 53). For instance, other authors recognized great gains of the medicalization process like the strategy for women to be liberated and safe when giving birth, terminating, or needing birth control assistance (Busfield, 2017: 763). Moreover, although many second-wave feminists in the 1970s and 1980s accredited the medicalization of childbirth to the *unacceptable* patriarchal medical power, now women sought biological interventions related to their reproduction during their pregnancy and even before conception as the new norm to improve their own and families' wellbeing (Ballard &Elston, 2005: 232).

2.5 The social construction of menopause

Scholars like Obermeyer (2000: 185) contend that menopausal symptoms should not be standardized as they may not be adequate to reflect every woman's menopause experience. Obermeyer (2000: 186) further notes that menopausal symptoms may arise due to innate bio-physiological differences among people, environmental influences, or distinct cultural experiences of physical states. Utz (2011: 144) also notes that in addition to the factors mentioned earlier, the historical context in which women experience their midlife also contributes to the significant difference in menopause experiences, meaning that several factors influence how women experience their menopause. This results in diverse experiences of menopause.

The theory on social group membership, which attempts to explain the distinctive variations in lived experiences, states that the experiences of healthy women report will mirror the standard definitions held by their social group members (Utz, 2011: 144). Social groups extend from a micro to a macro level, such that there are families grouped by clans for instance, ethnic groups, gender, racial groups, social classes, political interest groups, bureaucracies, nationality groups, and so on. The above viewpoint suggests that the body is socially constructed depending on our worldview and that different cultures and generations perceive and socially construct bodies differently (Crossley, 2012: 76). As Utz (2011: 143) notes, "biology interacts with history and culture to create a unique individual experience of health." Furthermore, social constructionists contend that our perceptual experiences of matter are *the other side* of our body and not secondary or *add-ons* to the body because they contribute just as much to the nature of bodies as do the *objective* (physical) features (Crossley, 2012: 83).

The above viewpoint is supported by Lock and Kaufert (2001 cited in Drew *et al*., 2022: 2), who argue that menopause deserves a more nuanced approach and understanding, suggesting that the different menopausal experiences can be understood as *local biologies.* The notion of *local biologies* was developed to conceptualize the mutual construction of subjective bodily experience – i.e., the use of language and the inclusion of historical, political, social, and medical contexts during the menopause transition (Niewöhner & Lock, 2018). *Local biologies*, in a broader sense, describes how the physical body, which is reliant on evolutionary, environmental, social, and personal factors, contributes to the embodied experience of sensations related to the body, such as those of happiness, health, and illness (Niewöhner & Lock, 2018: 684). Furthermore, the embodiment of an experience is how one represents one's own and other people's bodies according to the local patterns of knowledge and experiences (Niewöhner & Lock, 2018: 684). As Fu, Anderson, and Cortney (2008: 77) conclude "people's experiences, beliefs, attitudes and customs regarding menopause form a menopausal stereotype through which physical and emotional sensations are perceived and interpreted."

To further explain the above viewpoint, Utz (2011: 144, see also Drew *et al*., 2022) highlights that different birth cohorts in American history, for instance, experience and perceive menopause differently despite similar biological symptoms. Birth cohorts are groups of people born and lived around the same time in history, who, by reaching the unique stages of the life course under the same social, cultural, and political limitations, share everyday experiences with their cohort members (Utz, 2011: 114). The sociological viewpoint of birth cohorts further shows that each birth cohort's patterns and experiences around health and mortality may be explicitly shaped by the circumstances, limitations, and resources that it is born into and in which it lives its collective life (Keyes, Utz, Robinson & Li, 2010: 1101). For example, Utz's (2011: 153) study found that different cultures affected how two generations of American women experienced menopause. The younger birth cohort accepted the culture that increasingly medicalized menopause in the last decades of the 20th century; thus, their definition, acceptance, reaction, and or treatment of the bodily changes during menopause were different due to the urge to control the biological changes, unlike the older cohort which just accepted their fate (Utz, 2011: 149-153).

This study aims to add to the limited sociological perspective on menopause – i.e., other social and cultural discourses of menopause. Not only does the sociocultural paradigm, which includes beliefs and expectations, influence women's menopausal experiences but it also shapes attitudes (Baloyi, 2013: 1). As Hvas and Gannik (2008: 178) note that women generate the

meanings of their menopausal experiences from their cultural and social environments. In that, how other people perceive and converse about menopause, even casually, has an influence on the woman's perception (Hvas & Gannik, 2008: 177). Thus, looking beyond the women's experiences to their perceptions of and cultural beliefs about menopause is crucial to know and comprehend the kinds of menopausal social shifts they may be experiencing despite similar biological shifts. Perceptions can be referred to as "the receiving, selecting, organizing and interpreting of sensory information or stimuli by combining them with the results of previous experience to produce a meaningful picture of one's world" (Makuwa *et al*., 2015: 2). Therefore, the following section will look at how some women describe both their perceptions (if they consider the changes during menopause positively or negatively) of and experiences of this transitional phase of their lives.

2.6 Positive perceptions of menopause

A study conducted on the perceptions of menopause among members of the Church of Jesus Christ of Latter-Day Saints in the United States of America found that women had positive perceptions and reported few severe menopausal symptoms (Steffen, 2011:1). The women drew on their spirituality during challenging times, including menopausal symptoms. This finding is contrary to the expected outcome (loss of identity and purpose) since religious women are assumed to base their identity on family and child-rearing while menopause marks the end of their reproduction and household roles (Steffen, 2011:1). Similarly, a study on Pakistani women found that most of the participants viewed menopause as a normal aging process and associated it with greater wisdom and higher status (Syed Alwi, Brohi & Awi, 2021: 8). As Makuwa *et al*. (2015: 4) found in their study that several participants above the age of 60 who had a prolonged duration of the menopausal phase, still maintained a positive perception and experience of the transition. They expressed happiness and relief from the reproduction phase. As one of the participants in the study said:

> I think menopause is the time when you become old and you are no longer going to fall pregnant again. It is a natural change of life and ageing. We are living a good life like children. You no longer have a problem of buying some pads. I really enjoy this stage. You can sleep without clothes and not being disturbed (Participant cited in Makuwa *et al*., 2015: 4).

This is also like the earlier cited study on birth cohorts which found that the older birth cohort not only accepted menopause as their fate, but some perceived it positively (Utz, 2011). As one older woman said:

> Menopause was a time in life when I shifted priorities and interests. It opened up possibilities and allowed me, for the first time, to focus on myself - not on my children, their school, my husband, my family, or my house. It allowed me to honour myself and to dream of what I could still become.… It wasn't the end; it wasn't the beginning; it was a soul-searching transition, which set the stage for a whole new phase of life" (Participant cited in Utz, 2011: 147)

This is a perception that is rooted in the *existential discourse* of menopause (Hvas & Gannik, 2008: 179; Utz, 2011). The women in the older cohort did not think of the menopause transition as a problem that needed treatment, and they simply waited for it to be over (Utz, 2011). This was a common finding in the study I conducted for the Honours research project, the participants viewed their menopausal experience as a normal phase of life and a temporary burden (Makalima, 2022: 22). A study in Ecuador also found that women expressed positive attitudes towards the menopause transition: 93.7% perceived it as a natural event with minimal problems; 65.3% noted the relief that comes with not having to worry about getting pregnant; and 60.7% said that life becomes simpler and peaceful (Syed Alwi *et al*., 2021: 8). Another study conducted in Nigeria found that more than 86% of the respondents expressed a positive perception of menopause, and some of them regarded it as a 'positive physiological event' with enjoyable sex, and most of the participants did not seek medical treatment (Han, Cheng, Ige & Ige, 2022: 61). The women in the Nigerian study reported a comparatively low incidence of menopausal symptoms such as irregular menses, high blood pressure, and urinary tract infections (Han *et al*., 2022: 62).

A study found that some women's positive menopausal experience and perceptions are shaped or influenced by how they view both the presence and absence of menses (Berger, 1999: 49). For example, a study in Mamelodi, Tshwane District found that most participants considered menopause as a natural aging process and life changes (Makuwa *et al*., 2015). One of the participants had this to say about the transition:

> I feel alright with the stage of menopause. I must admit that now is the time I did not start of being in the stage of menopause, but I started there, way back, as a lady. Now is the time to be in this stage because everything has its time and I cannot be ever young (Participant cited in Makuwa *et al*., 2015: 4).

The Zulu culture views menopausal women as now clean, for that reason, they are allowed to enter the field or cows' kraal since they will no longer ruin the crops or cause sickness to the cattle because of their menses (Makuwa *et al*., 2015: 2). Another study in the Philippines found that women had positive attitudes toward menopause not only because of how their culture

embraces older women for their strength and wisdom, but also for the relief from child-bearing and painful menstruation (Berger, 1999: 49). Similar findings from a Nigerian study show that many of the participants expressed gladness for this natural event that needs no medical intervention, since it only signals a new phase of life and getting older (Ibraheem, Oyewole & Olaseha, 2015: 87). Furthermore, contrary to popular belief, more than half of the participants in the Nigerian study do not see menopausal women as having lost their youthfulness (Ibraheem *et al*., 2015: 87). It is interesting to note that women from different parts of the world and generations enjoy and embrace this phase, some to the point of *overlooking* the biological burdens it entails. However, this is not to undermine or take for granted the fact that other women experience serious menopausal symptoms, which do not allow them to rest and passively wait for the transition to pass.

2.7 Negative perceptions of menopause

A study on perimenopausal and postmenopausal Christian women in Limpopo, South Africa, understood the signs of aging as following God's nature, in that they believed that they had to endure the *punishment* from God that came as physical menopausal symptoms (Ramakuela *et al*., 2012: 267). Similarly, some non-Christian participants who were postmenopausal believed that ancestors caused the cessation of menstruation, thereby signaling that it is time to age, and they also view menopause as a *punishment* since old age may come with serious health complications (Ramakuela *et al*., 2012: 267). Furthermore, an A. Vogel UK's (2021) expert presentation on menopause's emotional side effects and its prevalent symptoms draws women's attention to discussing the 'horrors' that come with this phase. One woman from the comments section replied to the video and shared her experience:

> I too had a lot of emotional issues when I went through the big change last year. I had crying spells, weepiness, I felt so alone, I felt so vulnerable, I felt so needy, I felt so lonely, and I was reaching out to anyone, especially strangers, just for communication and comfort. I also experienced irrational fears. And at times, I felt like I was going crazy. Good God I never want to go through that period again. I am much much better now (Commentator on A. Vogel UK, 2021).

Some of the participants in the study on Limpopo women's conceptualization of the transition perceived it as a phase of many various health problems both physical and psychological (Ramakuela *et al*., 2012: 264). The key trend in this chapter is the influence that women's attitudes toward menopause have on their embodied experiences.

2.8 Hormone replacement therapy

Although discussions about menopause are still taboo in certain cultural contexts, conversations on negative perceptions and experiences of menopause are becoming common, and they draw the attention of many women, particularly those who seek relief from serious menopausal symptoms. For example, a recent discussion on menopause on the Oprah Daily Show was centered on negative sentiments about menopause like those mentioned above. For this reason, Dr Heather Hirsch (2023), the author of '*Unlock your menopause type*,' and the guest speaker on the Oprah Daily, advocates for Hormone Replacement Therapy (HRT), especially for women who are already considering it. HRT is used to treat most symptoms that are associated with menopause (Stuenkel, Davis, Gompel, Lumsden, Murad, Pinkerton & Santen, 2015: 4). According to Dr Williamson (2016: 32), a psychiatrist, the HRT can be in the form of antidepressants for depression and anxiety, and it also relieves vasomotor symptoms and the improvement of women's well-being (Guidozzi, Alperstein, Bagratee, Dalmeyer, Davey, De Villiers, Hirschowitz, Kopenhager, Moodley, Roos & Shaw, 2014: 538). HRT primarily targets symptoms related to the decreasing levels of sex hormones, such as vaginal atrophy, vaginal dryness, sexual dysfunction, hot flashes, rapid skin aging, and bone loss (osteoporosis). To counter the decreasing levels of sex hormones, the primary drugs used in HRT are oestrogens and progestogens (Stuenkel *et al*., 2015: 5). Moreover, HRT and recently the non-oestrogenic preparations that the biomedical community urges menopausal women to consider for some of their menopausal symptoms help to (a) measure women's bone density and identify *abnormalities* therein; (b) increase women's access to the therapy; (c) manage the risks of osteoporosis that both women and biomedical professionals are concerned about (Ballard & Elston, 2005: 237).

Furthermore, like any other medication/treatment, HRT has risk factors such as progressing benign breast cancer (Guidozzi *et al*., 2014: 539). Thus, healthcare professionals tend to individualize HRT, and offer other options for women who prefer not to use HRT, or those who have a higher risk of breast cancer, cardiovascular diseases, or dementia (Stuenkel *et al*., 2015: 5). Moreover, the HRT health-related benefits heavily depend on how severe the menopause symptoms are before the use of HRT, in that the severe the symptoms the higher the benefits (Guidozzi *et al*., 2014: 538). The majority of women who are likely to benefit from HRT are those who are under sixty years of age, or those who have less than ten years since the onset of their menopause transition (Stuenkel *et al*., 2015: 4). Women who consider HRT

need to undergo screening for breast cancer or cardiovascular issues before treatment to tailor the HRT treatment (Stuenkel *et al.*, 2015: 5).

2.9 Sociocultural beliefs contributing to negative perceptions of menopause.

Other negative perceptions about menopause, however, are not a result of physical symptoms but stem from socio-cultural beliefs about menopause, menstruation, and the female body in general. Socio-cultural refers to a vast "array of societal and cultural influences that impact thoughts, feelings, behaviours, and ultimately health outcomes" (Gonzalez & Birnbaum-Weitzman, 2020). Moreover, the beliefs referred to above are those shared and learned across groups of people. Some African culture views menopause as a negative life event that causes illness or poisons the woman's body following the cessation of menstruation (Makuwa *et al*., 2015: 2; Baloyi 2013). For example, a study outside Malamulele Township in Limpopo found that the experiences and perceptions of menopause that women have are influenced by the beliefs and expectations that are intrinsic in their socio-cultural paradigm (Baloyi, 2013: 3). Therefore, women in cultures where they are primarily defined by their ability to procreate, versus those in cultures that afford women prestigious status beyond the procreation stage, tend to experience more distress during menopause (Baloyi, 2013: 3). To some women, it is the beliefs/ideas of self-concept and identity that tend to contribute to their distress and negative perceptions about menopause. Utz (2011: 148), in her study on birth cohorts, found that the negative attitudes that the younger birth cohort held stemmed from their frustration at their inability to control or manage the changes that come with the menopause transition. As one participant said: "Things keep happening that I do not want to happen — that's what is hard for me to accept" (Utz, 2011:148). The author believes that the fact that the younger birth cohort fears the loss of youth, more than just the inability to control the changes that come with the transition adds to their emotional distress. This is a fear that the *feminist discourse* persuades women to let go of since the transition, in this discourse, is viewed as a passage to claiming a better, stronger, and different older self (Coupland & Williams, 2002: 439).

Other researchers argue that the vulnerability women experience is because of the idea that aging takes away their *beauty and youthfulness*, which has been worshipped by society, and the loss leads to low self-esteem (Saucier, 2004: 420). A study of Nigerian women from different ethnic groups found that low self-esteem linked to menopause was due to the women's concern about their husbands' feelings about them on their menopausal stage (Osarenren, Ubangha & Nwadinigwe, 2009: 160). Moreover, the loss or decrease in self-esteem seemed to be largely influenced by the women's recognition of the extent to which their self-esteem relies

on the male gaze (Saucier, 2004: 420). According to Bonafini and Pozzilli (2011:62), there has been a shift in how female beauty has been conceptualized over time and across societies – i.e., from a *symbol of fertility* to a body, especially body size, that responds to what men sexually desire. This, it could be argued that the above viewpoint causes the majority of women to fall into the trap of loss of self-esteem and confidence during menopause. However, the idealized female body that feeds the male gaze is based on the biases that mostly male artists/photographers portray in advertising of products using sexualized female models (Bonafini & Pozzilli, 2011: 64). Some psychologists note that women are socialized from a very young age to focus on being attractive, as a result they seem to base their identity on physical/sexual attractiveness (Saucier, 2004: 422). This is also confirmed by the Nigerian study finding that the majority (98%) of the participants were more concerned about their husbands' feelings regarding their menopausal stage and the changes it brings (Osarenren *et al*., 2009: 159).

The above discussion on the negative body image that some women experience means that most negative perceptions about menopause, are not in and of themselves due to menopause. For example, in some African cultural contexts, marriages end the minute childbearing ceases (Baloyi, 2013: 2). This is not only due to how *less physically attractive* a woman *becomes*, but it can be based on cultural myths and beliefs. Ibraheem *et al*. (2015: 87) in their study found that most of the participants believed that engaging in sexual intercourse after menopause would cause illness, and that menopausal women should refrain from sexual intercourse. Some participants believed engaging in sex after menopause would result in physical punishment of having a big stomach (*xikuru-nyimba*) or that seminal fluid would cause a foul bodily odour (Ibraheem *et al*., 2015: 87). The participants provided no evidence for the above beliefs and myths, however, menopausal women in such communities are subjected to unnecessary fear and a negative perception of the female body and menopause. This also means that negative perceptions of menopause lead to some women's unsatisfactory understanding of what menopause is. Such information is a danger to their health, and it can also endanger future generations' understanding and experiences of menopause. This is due to the assumption that the attitudes that women have towards menopause will always influence their menopausal experience (Osarenren *et al*., 2009: 157).

2.10 Lack of scientific knowledge about menopause among women

The lack of knowledge and access to proper and accurate information is not only displayed by the myths that cultures uphold. Most participants in the sub-Saharan African studies do not

have basic medical knowledge about what menopause is (Baloyi, 2013; Ibraheem *et al*., 2015; Osarenren *et al*., 2009). Most of the participants referred to menopause as something that depends on a divine being or ancestors. They also associate it with old age, which means that they endure serious menopausal symptoms. This is similar to the findings from a study among menopausal women in a rural Mayan village on the island of Yucatan, who expressed that they believe that menopause transition depends on God's will since He is the one who gifts people with children (Ramakuela *et al*., 2012: 268). Both Mayan and sub-Saharan African women lose their sense of agency regarding their menopausal selves. As a Mayan participant said, "When you think that the body is feeling hot, not long you start feeling cold and you will think you are catching a cold. This is like a punishment from God, but we accept it as God's nature of doing things and should adapt to it" (Ramakuela *et al*., 2012: 266). Two participants in a study conducted in Mamelodi, Tshwane district demonstrated this seemingly common lack of knowledge, as one participant said:

> At least, when you were menstruating every month, it prevented you from being ill. But now, my menstruation is no longer coming out and causes a lot of diseases. I am a person who is having a lot of blood. Since I stopped to have my monthly period, my blood pressure is high. It can be a problem; you can maybe have … womb cancer. There are lots of diseases which can occur in your body (Participant in Makuwa *et al*., 2015: 5).

Another participant acknowledged her lack of knowledge:

> I do not have enough information about menopause. It is a difficult stage because you do not have the experience and knowledge of what to expect. I do not understand why there are changes in my body or life as whole (Participant cited in Makuwa *et al*., 2015: 5).

This shows a need for awareness campaigns on menopause within low-income communities. As per the recommendation of the researcher, suggesting that all healthcare providers in healthcare institutions provide every woman with health-related information regarding their developmental stages (Makuwa *et al*., 2015: 6).

Lack of knowledge was common among participants in the study conducted in 2022, they described how their first menopausal experience left them astonished and scared because they did not understand what they were experiencing (Makalima, 2022). Participants, like those in other studies, were not sure about what constitutes menopause symptoms, because a few years before the onset of menopause, women's bodies begin to change, and sometimes their health begins to deteriorate (Blümel, Lavín, Vallejo, & Sarrá, 2014: 235; Makalima, 2022). The early

signs arguably prepare women for the soon-coming transition, and they need to understand these changes from a medical knowledge perspective. Nevertheless, some women will not know what the onset of menopause feels like, and this includes those who experience menopause without serious symptoms.

Lack of medical knowledge on menopause means that women who experience pain during menopause have no idea that they can seek medical treatment for ailments related to menopause (Makalima, 2022). One participant noted that she only learned of medical treatment for menopause symptoms from a radio program, while another participant noted that she only consulted a doctor because of her fear of cancer rather than menopausal symptoms (Makalima, 2022: 21). However, a participant who consulted a gynecologist for menopausal symptoms was told that she did not need medication as menopause is a natural phenomenon (Makalima, 2022: 21). It is common for women to be told by medical professionals that menopause is a natural event that does not need medication, and this confuses women. For example, a peri-menopausal participant who had witnessed family members' interaction with the medical professionals had this to say:

> Ah! Doctors told them that their pains are not curable because they are old and have to live with it. They always look frail and sick, and they are hardly happy most of the days. Is this the type of life I am going to face when I age? This is some sort of punishment (Participant cited in Ramakuela *et al*., 2012: 267).

It is concerning that there is a gap in knowledge on menopause symptoms among medical professionals, and there is also a need for awareness campaigns on menopause to educate women on medical treatment for serious menopause symptoms (Ramakuela *et al*., 2012: 271). Moreover, women need to be encouraged to talk about their menopausal experiences to gain more medically accurate knowledge. Studies found that most women in Africa report the symptoms only when they are threatening and inexplicable (Makuwa *et al*., 2015: 2; Makalima, 2022). The existing common cultural belief of menopause being a taboo and or sensitive subject to talk about in rural villages like in Limpopo needs to be challenged. Since it makes women feel ashamed to discuss their menopausal issues and experiences. Furthermore, it is not helping them gain more knowledge on the phenomenon and may be the result of the health-related difficulties they end up enduring. Meanwhile, the women who report their symptoms receive support and the necessary and suitable assistance needed (Makuwa *et al*., 2015: 2).

2.11 Menopause and sexuality

Another taboo subject is sex, especially sexuality among older people, especially women. Sexuality refers to sexual identity, sexual function, and sexual relationships (Graziottin, 2012: 254). As with menopausal symptoms, women have different sexual experiences due to various factors such as life events, sociocultural variables, relationships, health, and events related to the reproductive aspect of the woman's life.

As noted above, factors that may impact a woman's sexual function include physical, mental, emotional, and social factors (Nazarpour, Simbar & Ramezani Tehrani, 2015: 480). Physical factors include a woman's age, hormonal changes, the type of menopause (whether it is surgically induced or not), the duration of menopause, and the severity of the woman's menopausal symptoms. Mental and emotional issues include body image, feelings of sexual attraction, and feelings about one's sexual partner, depression and anxiety, the intensity of menopausal symptoms related to the woman's emotional well-being (Nazarpour, *et al*., 2015: 480). Lastly, social factors include racial and ethnic variations, cultural background, religious beliefs, social expectations, access to healthcare, lifestyle, both the woman's and partner's level of education, duration of the relationship or marriage, and how frequently the partners engage in sexual intimacy (Nazarpour *et al*., 2015: 480). It is acknowledged that the complex nature of sexuality makes it difficult to define, assess, and evaluate its disorders (Graziottin, 2012: 254). The current study is exploring the women's perceptions of how menopause affects women's sex life.

The process of aging and menopause are key overlapping factors that affect a woman's sexuality (Graziottin, 2012: 254). Sexual-related problems, especially those caused by hormone deficiency, are most likely to be a source of concern for women, (Graziottin, 2012: 254). A study found that it is common for women to complain about experiencing sexual problems during their entire reproductive phase (Nappi & Lachowsky, 2009: 139). However, menopausal women are the most vulnerable to female sexual dysfunction due to "a complex interplay of individual factors variably affecting well-being" (Nappi & Lachowsky, 2009: 139). A review of studies on sexuality by Scavello, Maseroli, Stasi, and Vignozzi (2019: 2) noted that the above finding is a prevalent global phenomenon. Therefore, women's declining sexual drive during menopause, independent of age, is widely accepted (Scavello *et al*., 2019). Furthermore, low sexual desire, vaginal dryness/poor lubrication, and dyspareunia, one of the genitourinary syndrome's complications, are the most frequently reported symptoms (Scavello *et al*., 2019). Although the presence of low desire is the most prevalent sexual problem in

women during their midlife phase, it does not necessarily represent an FSD (Scavello *et al*., 2019: 3).

2.12 The social and cultural discourse on menopause

As noted earlier, the menopause transition signals the end of a reproductive period to a non-reproductive period (Han *et al*., 2022: 57). The current study is investigating how such a shift impacts women's experiences of menopause and their membership in society after the reproductive period has ceased. As Berger (1999: 49) notes from a young age, women are socialized into feminine roles, which includes the reproductive roles that they are expected to perform when they come of age. The cultural beliefs and practices that enforce these reproductive roles might have an influence on how the women experience their bodies during and after the reproductive period, and the process of aging (Berger, 1999: 52). Houck (2006: 69) echoes this view by highlighting the role that cultural beliefs and practices play in shaping women's membership in the society and how they internalize these beliefs, which in turn inform the perceptions of their bodies. Although women can change or adjust their beliefs about menopause with time, culture remains an important tool for understanding how each society influences women's menopause transition experience and life beyond the transition (Berger, 1999: 50).

2.12.1 An African cultural discourse on menopause

Africa has many cultures such that a single cultural specification cannot entirely describe this diversity. To understand the *cultural discourse* on menopause in such a context, one would need to conceptualize culture and the values that underpin it. Culture is a multifaceted concept with various definitions, and this section discusses some of these definitions. It can be defined as consisting of "derivatives of experience, more or less organized, learned or created by individuals of a population, including those images or encodement and their interpretations (meanings) transmitted from past generations, from contemporaries, or formed by individuals" (Spencer-Oatey, 2012: 2). This definition primarily suggests a social construction of the embodied experiences as earlier discussed, and it further highlights that culture is passed down from generation to generation. This suggests that culture is subjected to change along the way. Furthermore, it draws our attention to the possibility of individuals' minds being programmed by what is experienced around them. Another definition of culture draws our attention to the elements that make out culture: "culture is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (Spencer-Oatey, 2012: 2). These elements are responsible for the

programming of the mind. Both definitions enlighten us that culture is not an individualistic thing but a collective entity. The last definition views culture as "a fuzzy set of basic assumptions and values, orientations to life, beliefs, policies, procedures, behavioural connections that are shared by a group of people, and that influences (but does not determine) each member's behaviour and his/her interpretations of the meaning of other people's behaviour" (Spencer-Oatey, 2012: 2), Likewise, this definition draws our attention to similar aspects discussed in the above definitions. However, it introduces us to another idea: inasmuch as culture shapes how one's mind is programmed, there is a window for an individual to exercise his/her agency, nonetheless.

It is essential to highlight that in a population, people belong to different social groups simultaneously and are subjected to learning the culture of each social group. This suggests that two individuals in the same social group are not likely to share the same sets of attitudes and beliefs, however, their attitudes and beliefs can have similarities (Spencer-Oatey, 2012: 8). This means that people will internalize several patterns and ideas individually. This study adopts the definition of culture as "a set of basic attitudes, values, beliefs, and behaviours shared by a group of people" (Spencer-Oatey, 2012: 2).

This section explores the beliefs on menopause held in some African societies. For example, one of the cultural customs practiced by Xhosa women is *intonjane*, which is a traditional rite of passage to womanhood for young girls who reach puberty (Cloete, 1996: 14). *Intonjane* means that a girl is socially recognized for her ability to conceive because she is sexually and socially mature, and eligible to be taught the appropriate and expected behaviour (Cloete, 1996: 15). The *intonjane* teaching, provided by elders, prepares her for marriage, especially how to behave as a bride (*makoti*). In the past, there was a belief that a girl who was not initiated before marriage would fall sick, give birth to ill children, or fail to conceive (Cloete, 1996: 15). The journey to womanhood in communities that practice *intonjane* is only complete when a woman marries and bears children (Cloete, 1996: 15; Sotewu, 2016: 24). Thus, the earlier discussed notion that some women's struggle to embrace menopause is a result of their fear of how their husbands will feel about them is not far-fetched given the *intonjane* teachings. This illustrates Emile Durkheim's (cited in Sotewu, 2016: 12) idea that a relationship exists between the rituals that people perform and the 'devotion to social order' that produces or strengthens social unity. This study seeks to understand the social norms and values that women are subjected to before, during, and after their menopausal phases.

Like culture, there are multiple definitions of values, for example, the Oxford Dictionary defines values as “principles or standards of behavior: one's judgment of what is important in life”. Principles are essential truths or propositions on whose foundation a chain of reasoning or systems of beliefs or behaviours are founded (Consortium, 2018). There are personal values that individuals hold. However, this study is interested in shared values, which are impersonal social systems imposed on individuals and thus provoke how they react to situations (Adler, 1956: 274). These social systems are many and interconnected and include economic, political, legal, religious, cultural, social, educational, bodily values, emotional values, character values, the value of recreation, moral values, values of life, etc. (Min, 1998: 67- 68). This study focuses on the social and cultural values that are imposed on and upheld by individuals, and how individuals apply them in their daily lives. As interpretive sociologists argue that the meaning of values becomes explicit when we draw on them during social action (Adler, 1956: 275). The main argument from this perspective is that values are present within individual action and correlate with behaviour (Adler, 1956: 274).

Makuwa *et al*. (2015: 2) argue that most African cultures embrace menopause as a natural aging process that is brought about by supernatural entities. For example, a study in Kenya found that women in menopause held a unique position during an ancestral worship practice that was used to fight HIV/AIDS and other tragedies (Baloyi, 2013: 1). A few menopausal women, together with male community leaders, were tasked sacred rituals during the slaughtering of a sacrificial animal. For example, the role of touching the animal's head is only done by a menopausal woman, or a child (Baloyi, 2013: 1). Another study on menopause, in West African countries that practice voodoo, found that menopause in those countries is revered, and perceived as a sacred phase that puts women in a respected position of being a mediator between the dead and the living (Alidou & Verpoorten, 2019: 1). It is for this reason that Baloyi (2013: 1) argues that menopause is a phase in which women either choose to embrace their ‘new self’ or resist the change and hold on to their ‘pre-transition self’. This also includes how they are viewed by society post the transition phase. The significance of these roles in communities that value menopausal women is that conceptions of personhood in other contexts fit into a network of connections that join the living with the dead (De Craemer, 1983: 22).

Among the Asante/Ashanti people of West Africa, a queen mother (usually the mother of the king) has her stool in the palace, which is symbolic of the power and the authority she has independently of the king (Stoeltje, 2006: 43). This position was associated with an older queen

who no longer reproduced, “who had paid her debt in fertility to the nation, and who had now earned its respect as its ‘corporate’ mother” (Andreasen, 1983: 183). The queen mother assumes the role of nominating the chief, which grants her influence over him, allowing her the platform to counsel him and be his source of insight when needed (Andreasen, 1983: 185). In addition to her responsibilities, she watches over the royal wives in court and can partake in judiciary processes and political councils (Andreasen, 1983: 185). However, Stoeltje (2006: 43) states that, unlike the queen mothers of other societies, the office that the Asante queen mother operates in, and her power are not the result of her relation to the king. The Ashanti people had an assumption that women were once monarchs but could ‘not properly function’ during their menstrual cycles; hence, they were replaced by men - it is the arrival of the menopause transition that caused such a restriction to be lifted, allowing them to operate in offices of significance (Andreasen, 1983: 184). In the Nupe tribe, the queen mother would be between 40 and 50 (Andreasen, 1983: 184). This is around the estimated period of a woman's onset of menopause as premature menopause happens before the age of 40, early menopause before 45, and 51 years is said to be the average menopause age (Shuster, Rhodes, Gostout, Grossardt, & Rocca, 2010: 162). Forty-seven years is also believed to be the average age for the onset of the menstrual transition (or perimenopause) period, and the symptoms emerge four years before this period (Williamson, 2016: 30).

The notion of a queen mother is a common phenomenon. It was associated with an older queen who was no longer reproductive – i.e., “who had paid her debt in fertility to the nation, and who had now earned its respect as its ‘corporate’ mother” (Andreasen, 1983: 183). Though not every woman in their menopausal age will be privileged to be a queen mother, it is still relevant to demonstrate the prestige a non-reproducing (menopausal) woman could achieve in other contexts. This is the case among the Swati people in the Eswatini Kingdom. *Indlovukati* (the queen mother) who is seen as the mother of the nation, holds the second highest court after the king, which means a ‘dual monarch’ (Andreasen, 1983: 184; Nyane, 2019: 69). Historically, *Indlovukati* commanded the national army, and she partnered with the king on duties concerning land allocation, summoning national gatherings, disbursing the national purse, and overseeing social events (Andreasen, 1983: 184). Similarly, the Nupe in West Africa also regards their queen mother as a ‘strong woman’ who holds immense social, economic, political, and military power (Andreasen, 1983: 184).

2.13 Conclusion

There is a need for more studies about South African women's perceptions and experiences of menopause, especially women from black African cultural backgrounds where menopause is viewed as a taboo subject. Research on the *sociocultural discourse* on menopause should be given the same attention as that given to the *biomedical discourse* on menopause, particularly in South Africa. For example, the South African Menopause Society focuses on the medicalisation of menopause and does not include diverse cultural beliefs and understandings of menopause, and how it is experienced across diverse cultures in South Africa (Guidozzi *et al*., 2014: 541). Furthermore, Literature on the sociological perspective of menopause will help enlighten us on the diversity of the menopausal social shifts experienced by South African women. This new focus can encourage awareness campaigns and basic scientific education about menopause. There is also a need to promote positive roles for and perceptions on menopausal women similar to the esteem given to queen mothers.

2.14 Theoretical framework

The overarching theme of this study, evident in the reviewed literature, is a social constructionist stance on the women's embodied experiences of menopause. Therefore, social constructionism is an obvious theory that provides a broader understanding of the construction of reality from learned knowledge to internalized ideologies to embodied experiences. There are various stances that this theory takes, which emphasize different aspects of the process of the social construction of reality. This study focuses on the stance that emphasizes the interrelatedness of people's many aspects of life, which result in complex realities. For example, as earlier noted, in cultures where there are many restrictions related to menstruation, women tend to have positive perceptions and less severe experiences of menopause (Berger, 1999; Ibraheem *et al*., 2015; Makuwa *et al*., 2015). Even though in such cases social constructionism further stresses the need to be extra careful to draw causality conclusions given the complex nature of human reality. Social constructionism is used to examine the nitty-gritty of how social construction of reality occurs, laying the foundation for the feminist discourse on menopause. A feminist post-structuralist theory will narrow the scope of social reality from a broader context to menopause.

2.14.1 Social constructionism

The theory of social constructionism views our reality and understanding of the world as an intrinsically subjective experience of everyday life. In that Berger and Luckman's (1967 cited

in Andrew, 2012: 40) work on the construction of reality argues that society exists as both objective and subjective reality, with the former brought about through people interacting with their social world and the social world influencing them in turn, such that habits and routines/patterns are formed. This means that individuals perpetually affirm such objectivity through their interactions with one another. These patterns then become an objective reality of knowledge even to the following generations. As such, "social constructionism regards individuals as integral with cultural, political and historical evolution, in specific times and places, and so resituates psychological processes cross-culturally, in social and temporal contexts" (Galbin, 2014: 85).

The above viewpoint suggests that reality is socially defined, however, social constructionists do not deny the contribution that biology makes to social reality. In addition, they primarily focus on understanding how individuals create realities in a social context by looking at their relations and the roles they play in this social construction process, and how these are further maintained (Galbin, 2014: 82). These realities are formed from our experiences, perceptions, ideas, and attitudes, and how these form an agreed upon or lived reality within a social context. Therefore, social constructionists view knowledge and truth about the world as fundamental elements of the construction process which are also constructed by individuals within a society through interactions (Andrew, 2012: 41).

A significant sociological contribution to this theory by Berger and Luckmann's *The Social Construction of Reality* book emphasizes that individuals collectively "create and sustain all social phenomena through social practices" (Galbin, 2014: 86). Therefore, this theory takes culture and society as the primary research focus to understand "the shared social aspects of all that is psychological" (Galbin, 2014: 82). Language, speech, and communication are fundamental elements of the interactive process that enables individuals to understand themselves and others (Galbin, 2014: 82). In certain instances, the youth are given cultural information through storytelling and music that transmits cultural norms and values, thus creating an objective reality of that cultural context. For example, during *intonjane* feminine ethos like womanhood being associated with marriage and child-rearing are taught and the practice itself enforces them (Cloete 1996; Sotewu, 2016). Similarly, the objective reality of menopause can be continuously enforced in a cultural context through the social roles assigned to women who have passed the reproductive stage. It is for this reason that post-structuralist feminists challenge women who pass down traditional views on menstruation and menopause to their daughters (McPherson, 2002: 39). Furthermore, feminists acknowledge that culture

strongly influences menopausal perceptions, which may benefit or harm women (McPherson, 2002: 29; Baloyi, 2013; Ibraheem *et al*., 2015).

2.14.2 Post-structuralist Feminism

In the current study, the post-structuralist feminist theory is used to explore the social construction of menopause. Post-structuralist feminism focuses on studying concepts, statements, and many other representations to explore how truth is constructed in a social context (McPherson, 2002: 36). It acknowledges that concepts like menopause are not intrinsic, rather depend on both the historical and social context in which they are used (McPherson, 2002: 34). It argues that the meanings produced by institutions and practices serve hegemonic interests or at times challenge the power relations that exist within that context. Thus, among other institutions, it accuses the medical field of spreading the idea of menopause as an instrument that sickens and handicaps women (McPherson, 2002: 34; White, 2002).

During the menopausal transition, women face not only the physical shift but also the meanings of the transition, the aging process, and womanhood within their social context (McPherson, 2002: 32; Baloyi, 2013). This is based on the specific ideas of femininity they were socialized into before the transition, or how menopausal women are viewed in their social contexts may challenge the above meanings of most of what their identity/self-concept may have been based on. As such, women are expected to continuously deal with the tension between conforming to the social definition of womanhood and an identity that may now not be determined by gender (McPherson, 2002: 34).

Post-structuralist feminism emphasizes the need to pay attention to the meanings of menopause internalized by women and the social forces that challenge both their agency and consciousness (McPherson, 2002: 32). For this reason, the theory argues that research on menopause should be placed within the social context for a broader and greater awareness of the phenomenon. A woman's psychological and sociological meaning of menopause has significant implications beyond the scope of the biological shift (McPherson, 2002: 18). Moreover, this theory suggests that the increasing understanding and new perceptions of women's aging process can change negative perceptions like the maligned and marginalized narrative around menopausal women (McPherson, 2002: 57). Women can gain a new consciousness of the aging process since the "experience too may be reconstructed, remembered, and rearticulated" (Fenercioğlu, 2017: 91).

2.15 The feminist discourse on menopause

The *feminist discourse* on menopause explores various influences and aspects of the phenomenon, some of their arguments are directed against the medicalization of this transition. Marxist feminists for instance, contend that menopause is natural and should be viewed and treated as such, thus, the medicalization of its symptoms is not supported (Conrad, 1992: 130). The current study, however, is not against the medicalization of menopausal symptoms. But uses the Marxist feminist thought to further outline the complexity and broadness of the transition. They argue against pinning to menopause and all the problems that women face during this transition. Some women pass through the menopause transition without incident except for the cessation of menses, while most experience mild yet manageable symptoms (Farrell, Palmer & Vollenhoven, 1997: 1997: 58). Their contention is based on the primary determining factor of women's (and men's) health and illness, which are ways in which these genders are socialized into social roles, as they relate to femininity and masculinity concepts (White, 2002: 9). Furthermore, they argue that the physical challenges that appear during menopause could be a result of the social roles that women play in society, especially those related to running their households (Campbell & Ettorre, 2011: 59). For instance, Conrad (1992: 130) argues that symptoms of osteoporosis (brittle bones) can be caused by the unpaid household labor they perform. Likewise, cardiovascular conditions can be caused by emotional labor when performing daily household chores such as caring for the children and other family members (Campbell & Ettorre, 2011: 61). Conclusively, Matthews (1992: 1) argues that during and after menopause, there are independent and interactive consequences of social, psychological, and biological changes on women's health and dysfunction. As Farrell *et al*., (1997: 57) note that the demanding career and social roles (e.g., caregivers to their family), other social relationships, and the impending changes (due to menopause) tend to influence the transition.

Marxist feminists' concern with medicalization, in general, is that it turns individuals' social experiences into biological explanations (White, 2002: 10). Moreover, they believe that medicine is used as a tool to enforce conformity to the gender roles assigned to individuals, especially women (White, 2002: 10). This is particularly in societies that pin women's identity and femininity on childbearing and mothering roles, in which case, deviating from these would require medical intervention, as per the abovementioned notion that a non-functional body-machine is a disaster. Thus, one of the feminists' stands on the menopause debate is that before focusing on the actual physical changes that menopause manifest during menopause, medical

professionals should pay close attention to the gendered roles that women play in society (Campbell & Ettorre, 2011: 59). Because among the many symptoms believed to be menopausal, only hot flushes and night sweats are directly linked to oestrogen levels (Collins, 2002: 339).

Other branches of the *feminist discourse* on menopause can be summed up in four categories: (i) the group that resists the existing *biomedical discourse*; (ii) the other offering a revision of the meaning of menopause; (iii) another advocating for the use of Hormone Replacement Therapy (HRT) through informed choice: (iv) and the one that emphasizes the *multiplicity* of embodied menopausal experiences (Fenercioğlu, 2017: 80). Hormone Replacement Therapy will be discussed later in the study. The first feminist category resists the *biomedical discourse* on menopause and views the transition as a positive life transition that advocates for the avoidance of treatment use, and it embraces the transition as it comes (Fenercioğlu, 2017: 81). This category *overlooks* how complicated menopause can get for some women. Furthermore, is criticized for depriving women of their agency and liberty to choose if they want to use HRT, and somehow undermines those who use it for various reasons (Fenercioğlu, 2017: 81).

The second category emphasizes revisionist feminism that seeks an alternative meaning of the transition by arguing that menopause is a spiritual awakening that re-establishes the divide between nature and women. The criticism for this category is that it "re-interprets resistance of *biomedical discourse* on menopause in a celebratory form" (Fenercioğlu, 2017: 82). It also puts a somewhat negative label on the use of HRT as a symbol of patriarchy and the consumerist culture (Fenercioğlu, 2017: 83). The third category advocates for women to be given the right to choose whether they want to use HRT through informed consent (Fenercioğlu, 2017: 86). This view is criticized for emphasizing women's agency by ignoring the power relations in society, gender inequality, and other social diversities (Fenercioğlu, 2017: 87). The last group argues against viewing the medicalization of menopause or use of HRT as victimizing women (Fenercioğlu, 2017: 88). This group argues that the wall between the reductions of menopause to an event most feminist's reduction of the transition to nature be demolished to allow for diverse experiences and constructions of menopause to be explored (Fenercioğlu, 2017: 89). Furthermore, this approach emphasizes the embodiment of the menopausal experience by asserting that different historical contexts, cultures, societies produce diverse manifestations and constructions of menopause. Thus, it advocates for menopause to be viewed within the woman's broader social context, considering factors like social roles, class, cohort, ethnicity, historical context, etc., (Drew *et al*., 2022; Fenercioğlu, 2017: 89; Hvas & Gannik, 2008).

2.16 Conclusion

Theories are lenses in which the menopausal experiences of the participant are understood and made sense of. Social constructionism examines the construction of the embodiment of social phenomena. The post-structuralist feminist theory narrows down the idea of socially constructed reality to the social construction of menopause. It further narrows the idea of the role interactions play in the social construction of menopause to argue that the discourses on menopause women internalize play a huge role in how they perceive, experience, and choose to deal with the transition. Both these theories complement each other, in that their viewpoint of how experiences come to be embodied is the same, however, one argues it from a broader lens while the other specifically focuses on menopause. Moreover, both these theories allow this study to appreciate the variation in the participants' experiences of menopause, as well as their interpretations of the experience. Furthermore, post-structuralist feminist theory suggests how negative perceptions of women's perceptions can be altered with new perceptions, offering a proper understanding of the transition.

Chapter 3: Methodology

3.1 Introduction

This study employed a qualitative research approach using interviews because it provides excellent prospects for in-depth understanding (Gerrin, 2017: 22). The Qualitative research method also appreciates the subjectivity and diverse social realities as its main aim is to obtain an understanding of people and their cultures intimately through in-depth engagement (Johnson, 2017: 254). It also examines and produces information from in-depth interviews, written documents, and direct fieldwork observations (Patton, 2005). This study used semi-structured interviews as the most suitable for more flexible questioning while allowing the researcher to stay within their clear and primary purpose (Robert, Sitas & Greenstein, 2003: 57). Written documents and fieldwork observations were not suitable for this study as there was a need to understand the participants' cultural beliefs and perceptions about menstruation and menopause, and their menopausal experiences. Cultural beliefs demonstrated through cultural practices like the rite of passage to womanhood would have been interesting and insightful to observe, but it was not possible due to the timeframe set for the study. This fieldwork would have countered some limitations and weaknesses in interviews, such as participants going beyond the discussion to address other issues. For example, during interviews, I had to wait for participants to finish talking about issues that were not related to the question before I could steer them back to the main topic.

Despite the above limitations, semi-structured interviews afford the researcher a platform to probe the participants by asking for more detailed responses, which allowed the participants to disclose their experiences and convey their perceptions and opinions in a manner and context relevant to them. rich subjective information on a specific subject in a particular context (Robert *et al*., 2003: 57). However, during the interviews, there were instances where I struggled with probing due to the sensitive nature of the topic and the age of the participants. In addition, the participant's body language showed that they were not comfortable answering certain questions. Nevertheless, semi-structured interviews produce rich information about a specific subject in a particular context. For this study, semi-structured interviews made it easier to compare responses as the questions were asked in a specific order while allowing the interviews to be more conversational, even though they were time-consuming.

3.2 Sampling

The strategy for participant selection should be incorporated into any study's overall logic, and the justification for sample selection should, from an ontological, epistemological, and

axiological perspective, be in line with the study's overarching goals (Campbell, Greenwood, Prior, Shrear, Walkem, Young, Bywaters & Walker, 2020: 654). According to Campbell *et al*. (2020: 654), "a relatively small and carefully chosen sample may be used to increase the level of knowledge in a qualitative study." This study employed purposive and snowball sampling methods. Purposive sampling is a beneficial technique for choosing participants who will most likely provide appropriate and pertinent information about the study, and it allows for the efficient use of limited research resources (Campbell *et al*., 2020: 654). However, a significant limitation of this sampling strategy is that the sample is so well-managed that there will be no representation of how people who are outside the menopause transition phase perceive the transition. Snowball sampling was also beneficial for this study as it allowed the researcher to choose a participant(s) who knew other participants with similar experiences who could contribute rich information to the study (Punch, 2005: 51). Both these strategies were beneficial since menopause is a sensitive topic and it would have been challenging to approach older women to ask them about menopause. An elderly aunt who participated in the study helped in recruiting participants on my behalf. A significant limitation of snowball sampling is that it is biased, the sample mostly depends on the people with whom the recruiter is on good terms (Punch, 2005).

3.3 Data collection

Interviews were conducted with six women from different cultural backgrounds: one Zulu woman, from Umtata, four Xhosa women, three from Umtata one from Makhanda, and a white woman from Makhanda. The choice of participants from different sociocultural backgrounds allowed for a comparative analysis and understanding of their perceptions of menopause, cultural beliefs, and experiences. All interviews were conducted in person, four were in their homes, and the two were in their workplaces. Before each interview, the participant consented to take part in the study by signing a consent form. Furthermore, the participants agreed to be identified with their real names. As already stated, open-ended questions were used that permitted in-depth investigation (Adams, 2015: 492). With permission from the participants, all interviews were audio-recorded, except in a few instances when participants requested that certain information shouldn't be recorded. They were uncomfortable with me recording some things. This was a challenge as not everything that was said in the interview sessions was captured, especially for four interview sessions that went over 30 minutes. Furthermore, there were no follow-up interview sessions. Two participants had requested to be interviewed together as they are from the same village and are friends.

Before each interview, I explained the purpose of the study in their home languages in isiXhosa (four participants) in English and isiZulu. This exercise negatively affected some participants' responses as they wanted me to simply focus on the summarised purpose of the study, not the interview schedule. Although this was a challenge, it taught me how to ask questions that focused participants on the research topic. I emphasized the questions that redirected the participants from the off-topic responses. All interviews were conducted with the approval of the Rhodes University Human Ethics Committee (Review Ref. 2023-7392-7885).

3.4 Data analysis

The audio-recorded interviews were translated into English, transcribed, and subjected to a thematic review. A thematic review strongly emphasizes identifying, analyzing, and interpreting patterns of significance in qualitative data (Ültay & Çalık, 2012: 688). A thematic analysis was used to compare, and highlight areas of similarity and diversity (Nowell, Norris, White & Moules, 2017: 2). Since data analysis is mainly about reducing the large body of information that has already been collected to make sense of it (Bryman, 2016: 11). A thematic analysis enabled me to manage the data in a well-organized manner for this study to be comprehensible (Nowell *et al*., 2017: 2). Thematic analysis is most suitable for this study because it is said to be a way that provides a platform that allows those who are traditionally unrepresented or underrepresented in research to voice out their views on a matter (Riger & Sigurvinsdottir, 2016: 35). Thematic analysis is flexible but careful not to lose the objective at the same time, and it is useful across a variety of theoretical frameworks and worldviews (Riger & Sigurvinsdottir, 2016: 36). Furthermore, I chose it because of its ability to allow a researcher to work with interview data and inductively identify and develop themes that come up from the data (Riger & Sigurvinsdottir, 2016: 34). Moreover, thematic analysis allowed me to use the interpretive research design to allow my participants to interpret their menopausal experiences and understandings of the transition in their own words. This research design was important and suitable for this study because it acknowledges that reality is not fixed or singular but socially constructed based on people's interpretations of it (Riger & Sigurvinsdottir, 2016: 33). Meaning that individuals attribute meaning to social phenomena through their interactions with those in their social context. Finally, both the thematic analysis and interpretive design allow a researcher to extend a microphone for everyone to share their interpretations of social phenomena because people's interpretations of and responses to social phenomena may differ depending on each person's social setting.

Since it was highly likely that I would interpret and analyze the participants' responses to my questions with biases, I was conscious about not letting my involvement in the interviews nor my opinion of the content generated have much impact on the findings. I attempted to achieve this by allowing interviewees to share all that they wanted to include on the subject, and I tried to allow myself to identify and develop themes as they came up from the data. Moreover, this maintained the subjective quality of the qualitative research approach by extracting common themes from the transcribed data as the primary focus instead of creating new themes myself (Bryman, 2016).

Chapter 4: Data analysis

4.1 Introduction

The data confirmed most of the reviewed literature findings even though most studies were conducted in other countries. An interesting finding of this study is that despite the influence of the socio-cultural context on women's perceptions and embodied experiences, there is still a platform for them to exercise their agency to formulate their perceptions. Like other studies found, a surprising finding in this study is that participants view the aging process positively, as an absence of physiological burden that came with menstruation, childbearing, and motherhood. Another interesting finding in this study is the reason behind some of the traditional restrictions imposed on women during menstruation – the protection of women from unpleasant consequences.

This section presents and examines different aspects of participants' experiences and perceptions of menstruation and menopause. The first broad theme of menstruation is covered under the following sub-themes: understanding menstruation; menstruation and childbearing; menstruation and adulthood/womanhood; the secret event; and whether menstruation should be kept a secret. Menopause is discussed in the following sub-themes: what is menopause? And aging; menopause and sexuality; learning about menopause; experiencing menopause; and overall perceptions about menopause. The analysis starts with a brief biography of each of the six participants.

4.2 Participants

Ms. Knowles (PhD), a white lecturer at Rhodes University in her 60s, is a widow, a mother of two children and one grandchild. She is a feminist activist, and as such, her perception of the menopause transition is deeply rooted in the feminist view of menopause – i.e., as a developmental stage of self-discovery in a woman's life. She started her menopausal transition in the mid-40s. The 'manifestations' of menopause that she experienced were irregular menses and hot flushes. Although she had irritating hot flushes, she did not consider HRT because she did not want to 'medicalize' a normal and natural aging process for women.

Mamu Ndamase, a 63-year-old Xhosa widow, is a mother of 7 children and several grandchildren. She lives in rural Umtata and was diagnosed with diabetes before the onset of premature menopause when she was 35 years old. The key indicator of her menopause phase was both irregular menses and hot flushes. She struggled a lot with hot flushes, which would sometimes be confusing to tell if it was them because they were similar to her diabetic

symptoms. At the time of the interview, she noted that her hot flushes had become mild and irregular.

Mamu Shwashwa, a 73-year-old Xhosa widow, is a mother of 3 children, who lives alone in rural Umtata. She was diagnosed with cervical cancer after she gave birth to her last-born child, and her menopausal transition was surgically induced after a hysterectomy.

Mamu B is a 60-year-old Xhosa mother and grandmother. She works and lives in Makhanda with her grandchildren. She started menopause at age 40. Irregular menses, vaginal dryness, and hot flushes were the key indicator of her menopausal transition. She consulted a doctor for her vaginal dryness and received ointments to treat it, which proved to be very effective.

Mamu Sihlobo, a 74-year-old Zulu widow, is a mother, grandmother, and great-grandmother. She lives in rural Umtata with her 35-year-old granddaughter and great-grandchildren. She started menopause at 40 and had only experienced hot flushes as a menopausal symptom. She did not treat her hot flushes.

Mamu Ntelwa, a married Xhosa woman in her 60s, is a mother and grandmother. She lives in rural Umtata with her husband. She had no idea when her menopause began, and never experienced any menopausal symptoms. She was diagnosed with menopause after the breastfeeding period of her last child.

4.3 Menstruation

4.3.1 Understanding menstruation

This section focuses on the participants' understanding of the cultural beliefs on menstruation and explores the idea of menstruation as a biological event. Biomedically, menstruation is defined as a natural process of cyclical bleeding that occurs in a woman during the reproductive phase of her life (Gómez-Sánchez, Pardo-Mora, Hernández-Aguirre, Jiménez-Robayo & Pardo-Lugo, 2012: 372). Moreover, menstruation is a result of endometrial shedding that occurs if ovum fertilization does not occur, implying a mature neuroendocrine axis (Gómez-Sánchez *et al*., 2012: 372). The cycle takes between 21 and 35 days, with an average of 28 days, and the duration of menses varies between two and seven days (Gómez-Sánchez *et al*., 2012: 372).

There are several factors, such as biological factors, psychological, environmental, and social conditions that affect or influence how women experience and manage their menstrual cycles (Gómez-Sánchez *et al*., 2012: 372) like in the case of menopause. A participant from Coutinho and Segal (1999)'s study noted that her mother taught her that menstruation is the way 'nature

keeps the woman's insides clean'. Mamu Sihlobo (74 years, Xhosa woman) shares similar sentiments with the above participant on what menstruation mean. She believes that "menstruation is an activity in the woman's body that cleans the body of all filthiness." Although she did not spell out what the filthiness is or where it comes from.

Contrary to the above understanding of what menstruation is, some cultural contexts place menstruation on a high pedestal, as such, the appearance of menarche (the onset of menstruation) is celebrated and honoured with rites and festivities (Gómez-Sánchez *et al*., 2012: 373). This is the case with the earlier discussed, Xhosa *intonjane* ceremony, where puberty-aged girls are initiated into womanhood. *Intonjane*, however, is not the only rite of passage that some of the Xhosa people observe at this stage. Other Xhosa families perform other traditional ceremonies that are specific to their clans with the same intention of initiation a girl to womanhood. For instance, Mamu Ndamase (63 years, Xhosa) noted that depending on the customs upheld by a specific family, the family will perform a traditional ceremony for a girl who had just experienced her menarche. Moreover, the celebration involves the sacrifice of an animal, some of its skin will be used to make a band for the girl to wear. Another participant also spoke about a traditional practice that is like the one mentioned by Mamu Ndamase (63 year, Xhosa):

> After the girl has reported the appearance of menarche, the mother tells older male family members of the household that '*intombi le indala'* (which means the girl is now old). Then, the family that observes such traditional customs and practices will perform a traditional ceremony by wrapping a band made from a sacrificial animal's skin around the girl's waist. The ceremony is symbolic of *paying a debt,* accepting the phase that the girl is in so that she may not have any challenges conceiving when she gets married, but rather conceive sooner (Mamu Ntelwa, over 60 years, Xhosa).

The participant further stated that observing the above ceremony brings relief to the mother as well. She said:

> Then as the mother of the girl, you will not be worried about the girl's ability to bear children when she is married (Mamu Ntelwa over 60 years, Xhosa).

In her cultural context, menstruation is a value attached to fertility and menstruation signals the readiness to bear children, a necessary and expected woman's role in most African cultures. For instance, as shared before the Ashanti culture sees a woman as indebted to the nation, giving birth then frees her to become a queen mother, particularly one who is legitimate to be one.

As previously stated, the sociocultural viewpoint on the embodiment of social phenomena argues that different sociocultural beliefs may inform women's perceptions and management of their menstrual cycles. As Gómez-Sánchez *et al*. (2012: 373) note:

> It is expected for the menstrual experience to vary according to the context, the popular and cultural beliefs, and the information received. Popular beliefs are based on precepts that have been historically transmitted generation after generation.

This idea is similar to what the post-structuralist feminist theory argues about the impact women's internalized discourses on menopause have on their experience of the transition. Furthermore, this supports the argument made by both post-structuralist feminist theory and social constructionism. Moreover, Mamu Ntelwa (over 60 years, Xhosa), as an adult, still maintains the idea of menstruating and is ready to get married and bear children for your husband. As such, she expressed disappointment and concern about the teachings about menstruation, that young girls receive but end up cohabiting. She does not seem to understand that people's realities are not the same and they continue to change.

Ms. Knowles (over 60 years, English) spoke about how she felt at the start of her first menarche:

> I can't really remember at the time, but I think it just gave me a sense of credibility, you know, that I'm becoming something that is important. I can be a mother, you know. I can. So, it made me feel like I've arrived somewhere. Not just this invisible child in the house kind of thing. So perhaps it was that. But I can't really be sure.

Her recollection is linked to her experience as a child whose achievements were never celebrated compared to her brother, whose achievements were always celebrated by her parents, making her feel. To her, menstruating had earned her a platform to be celebrated. The idea she had in mind made her not only perceive menstruation as a wonderful idea but also made her enjoy the experience. This is similar to the argument made by the post-structuralist feminist theory that positive internalized ideas about a phenomenon lead to perceiving that phenomenon in a positive light. Hence, the theory advocates for new positive discourses about menopause to be shared with women to help build new positive perceptions about menopause. Similarly, a study conducted on post-graduate students in the Eastern and Western Cape found that some of the female students who participated in the study experienced *joy* and *feelings of being alive* when they started menstruation (Padmanabhanunni, Jaffer & Steenkamp, 2018: 710). Some of them expressed how much the period affirmed their womanhood and ability to bear children.

What is intriguing about Ms. Knowles's (over 60 years, English) case is that contrary to what the theories and reviewed literature suggest, her positive welcoming of the menstrual phase was not necessarily a result of her context, as she explained:

> It was a December holiday, we were on holiday, staying in a little shack in Gonubie when I started my period. And I was so excited because now I was a woman. I went rushing to tell my mother. And she was, like, not quite excited. And she, you know, showed me what I must do. She said when it's used, you wrap it up in newspaper and you put it in the outside bin, not in the inside bin blah blah. And then at breakfast, I talked about my period, and Mom said, 'Never talk about it again,' you know, and everyone was very embarrassed. But why? I'm a Woman, now you know. So, I just remember a sort of disconnect between how I was welcoming it and how, you know, the cultural beliefs about it made us not speak about it, and then I never really spoke about it to my mom again (Ms Knowles, over 60 years, English).

This suggests that there is a platform to attempt to exercise one's agency regardless of what the beliefs held around you suggest.

4.3.2 Menstruation and childbearing

Females are thought to have recently adopted the regular experience of menstrual cycles due to societal and cultural shifts that have been happening (Coutinho & Segal, 1999: 2). The authors argue that before this regular cycle of menstruation, women rarely menstruated regularly. It is believed that the reason for this shift is that women then were constantly in contact with men from the time of the onset of their menstruation. As such, they were almost either continuously pregnant or breastfeeding which interrupted the regular menstrual cycle (Coutinho & Segal, 1999: 2). Their reproductive cycle was continuous, in that it was not uncommon for the women to be impregnated while they were still breastfeeding, although this has not changed for other women in this era.

The interesting part about this suggestion is that both the distant ancestor and modern women carry the same genes for the reproductive system, but the patterns of their reproductive lives are different (Coutinho & Segal, 1999: 2). Evolution played a significant role in this shift, in that it programmed females to different kinds of reproductive behaviours (Coutinho & Segal, 1999: 3). For instance, it could be argued that since most women work, the demands and responsibilities on them among other factors rarely afford them the constant contact with men. This idea is supported by social constructionism which emphasizes the ongoing fluidity of embodied experiences in various contexts.

Coutinho and Segal (1999: 2) note that an interruption that would occur to the distant ancestors' reproductive cycles would be due to a rare secondary infertility caused by tubal infection. It would be such unpleasant circumstances that women would then be introduced to regular menstruation or menopause. Now, the idea of secondary infertility shows that contrary to the common assumption, menstruation does not always signal signals the readiness of childbearing. As Montgomery (1994: 143) suggests many communities understand and believe menstruation to be a signal of fertility and readiness to bear children. Moreover, Small, Manatunga, Klein, Feigelson, Dominguez, McChesney, and Marcus (2006: 52) allude menstruation has characteristics that can be associated with fertility. These characteristics include menstrual history, which includes the length of the cycle, bleeding length, the bleeding amount, and how regular the cycles are (Jahanfar, 2012). These characteristics show the bio-medicalization of menstruation because the listed characteristics are all the standards that the medical community uses to determine the normality and functionality of the female body-machine.

The Xhosa and Zulu participants grew up in sociocultural contexts where their mothers paid careful attention before they started menstruation to monitor the girls' menarche and confirm their ability to conceive when they got married. As one participant said:

> If you became unfortunate and did not experience periods when you are expected to, and the family was not made aware, then you were not helped. You will have challenges bearing children when you get married. Because conception depends on menstruation, as you know, since you learn about it (Mamu Ntelwa over 60 years, Xhosa).

Biomedical research supports Mamu Ntelwa's point that failure t or delaying menstruation suggests infertility and health challenges (Jahanfar, 2012: 190). This dysfunction can start from adolescence throughout the reproductive phase, causing women physical and psychological ill-health.

In addition, the close monitoring of the girls' menarche afforded the mothers a platform to discuss with the girls the possibility of teenage pregnancy. As one participant stated:

> When you reported the onset of your menstruation as a girl to your mother or elders, they warned you about falling pregnant considering that you have reached the adulthood phase (Mamu Shwashwa, 73 years, Xhosa).

Mamu B (60 years, Xhosa), on the other hand, when she started menstruating, just got put on contraceptives without a discussion on pregnancy or even birth control. Her parent acted as an active contributor to the medicalization of her menstruation, which needed a pill to help avoid

pregnancy. She, on the other hand, was a passive participator. Moreover, her experience is like the experiences of the participants in the Padmanabhanunnia *et al*. (2018: 709) study. who were also placed on contraceptives when they reached the menstrual phase as a matter of must.

The ability to bear children as a woman is a significant part of the woman's self-concept and gender identity regardless of whether she ends up bearing the children (McPherson, 2002: 95). One participant reflected on why she desired to be a mother when she got married, she said:

> Umm, I don't know if I had thought through whether I wanted to or not. It was an expectation for every girl. You got married. You had babies. And so, I fell in love and married the love of my life. … And it wasn't even ever a question. I just know that I wasn't particularly fond of babies. I wasn't one of those girls who grabbed a doll around or anything. I mean, I was interested in reading and reading was my love, you know. But [….] I don't know if I was a particularly mothering kind of person, but certainly. I wanted to have a baby with my husband. I loved him dearly, and it felt like the right thing to do (Ms. Knowles, over 60 years, English).

This idea confirms the power of societies in programming our thinking, later constructing our lived experience – e.g., falling pregnant because of the expectation on a married woman. At times, we even neglect or take for granted what we genuinely want as individuals. As Ms. Knowles stated, bearing children was a societal expectation for every girl. Thus, it felt right for her to bear children for her husband regardless of whether she naturally desired to have children. In her case, it is not clear what beliefs shaped her thinking at that young age was.

Furthermore, people's ideas of when this expectation of bearing children as a woman should lift or lift differs. Two participants believe that the reproductive period could end between 35 and 40 (Mamu Ntelwa, over 60 years, Xhosa & Manu Ndamase, 63 years, Xhosa). According to them, menstruating beyond these ages is not common, but it is not necessarily abnormal. Mamu Ntelwa attributed menstruation over 40 years to a Xhosa healthy diet and way of living. She shared a story that her church leader who had attended a funeral in rural Eastern Cape had told her, that the leader was shocked by an elderly woman (around 50 years old) whom they saw breastfeeding at the funeral they had attended. Although Mamu Ntelwa was also shocked at a nearly 50-year-old woman breastfeeding, she, however, noted that seeing a woman around that age still menstruating is an exception reserved for rural villagers because they still maintain healthy living. Thus, their bodies function differently from those living modern lifestyles.

Mamu Ndamase (63 years, Xhosa), also attributed the continuation of menstruation beyond what they think should be a cut-off age to a healthy lifestyle (having a lot of blood) and

genetics. Moreover, Jahanfar (2012: 187) argues that genetics influence a woman's menstrual characteristics, but the "… inability to distinguish between the proportion of genetic and environmental influences clouds the conclusions." Literature is still limited in terms of distinguishing between the proportion of environmental and genetic influence given the multi-stranded nature of the menstrual cycle (Jahanfar, 2012: 188).

4.3.3 Menstruation and adulthood/womanhood

Most participants in this study associated menstruation with adulthood, particularly womanhood. They viewed menstruation as more or less an indicator of womanhood since it signals the readiness of a female to bear children, particularly in a marriage context. Furthermore, they consider a female to be fully human when she gets married and becomes a mother. This belief is informed by their different sociocultural contexts, especially because of the idea of rites of passage ceremonies like *intonjane*.

Furthermore, one participant spoke about the restrictions that especially married women are subjected to during their reproductive phase in their respective contexts (Mamu Ntelwa, over 60 years, Xhosa). The restrictions include dressing rules, and the kinds of food you eat especially when visiting the in-laws. It could be argued that most of these restrictions and taboos are founded based on negative perceptions about menstruation. Most rural communities in developing countries consider menstruation impure, which impacts women's menstrual experiences (Gómez-Sánchez *et al*., 2012: 374; Padmanabhanunni *et al*., 2018: 704). However, according to the Xhosa and Zulu participants' culture, these restrictions are set to protect women from having challenges in the marriage, especially reproductive-related challenges. Mamu Ntelwa (over 60 years, Xhosa) and Mamu Shwashwa (73 years, Xhosa) argued that there are consequences to face when and if a woman does not honor the restrictions given by her husband's family.

To convey the severity of not following such restrictions, one participant shared a storyline of a Xhosa novel titled *Ukuba ndandazile* (Had I known which tells the story of a woman who experienced heavy abnormal menstrual bleeding because she had eaten forbidden food at her husband's home (Mamu Shwashwa, 73 years, Xhosa). In my opinion, cases like this one are reasons why the medicalization of any phenomenon should include other medical branches beyond the medical profession, for instance, such cases consider spirituality to accurately help the woman.

Interestingly, Mamu Ntelwa (over 60 years, Xhosa) proceeded to suggest that women no longer experience consequences that would come with dishonoring such restrictions because of the protection and immunity the Christian faith (believing in Christ) provides. Mamu Shwashwa (73 years, Xhosa) shared similar sentiments. She proceeded to suggest that such protection and immunity, however, does not spare one's children. In that the ancestors will place demands for the disobedience of the parent on the children when they come of age, failing which they will endure the punishment their parent escaped. Mamu Shwashwa (73 years, Xhosa) further alluded that apart from the influence of the Christian faith, some of these restrictions are only consequential when the married woman has not given birth or reached menopause. For instance, Mamu Ntelwa (over 60 years, Xhosa) shared that it is not the time that she follows the rules on dressing because as one who has moved from the reproductive phase and has children, there is nothing she fears would get in the way of her conception as per the social expectation. So, both participants appreciated menopause because they had paid their debt in fertility, and they no longer lived in fear or worry of what could go wrong in their marriages.

Mamu Ndamase (63 years, Xhosa) on the other hand, did not make any connection between menstruation and womanhood/motherhood. Womanhood and motherhood are used interchangeably in this paragraph to convey a clear meaning of her argument since in her isiXhosa argument, she used *ubumama,* which refers to motherhood, but the translation of her text to English demanded that the term be interpreted to mean womanhood to make sense. She believes that nothing can make a woman more or less of one than she already is by being female. She further argued that a woman needs to affirm herself of such an identity. As she explained:

> You are a complete woman; you do not look down on yourself. You need to affirm yourself that I am a complete woman, and I will forever be. For instance, though this is not related to the discussion, my husband is no more, he died last year in May. I do not wish for people who see me to pity me and see me as vulnerable. The woman who took me through a workshop as a widow told me to be a woman who is sure of her womanhood. Who does not undermine herself because the husband is no more? You are a woman whenever! However, you need to be sure of that.

She internalized the idea of womanhood with which she was socialized into being a widow. Moreover, upon pondering the issues that arise in marriages because of the cessation of menstruation, she argued that menstruation does not build a marriage or a home, nor is it the reason for two people to be together. Finally, the two different perspectives on what menstruation means show that many factors shape people's understandings of menstruation like

any other social phenomenon as per the argument of social constructionism. Individuals assign meanings to concepts and those meanings will determine the value and importance of those concepts to the individuals. For instance, motherhood is more important to some of the participants in the current study (e.g., Mamu Shwashwa, 73 years, Xhosa; Mamu Ntelwa, over 60 years; Ms. Knowles, over 60 years) than to Mamu Ndamase (63 years, Xhosa).

4.3.4 The secret event

A common finding in this study is that some of the participants, although they were from different sociocultural backgrounds, experienced the onset of their menstrual phases at a point when it was a significantly sensitive subject to discuss. As one participant shared her story on how her mother had not prepared her menstrual phase:

> My mom did come into the bathroom once when I was there and say, 'Have you ever found blood on your pajamas?' I had no idea what she was talking about. I said no, I don't think so. Why? And that was it. And then she gave me a little book to read on about rabbits and things, but that tried to give the sex cycle clearly. She was a little bit embarrassed about it. Anyway, I don't think I heard. I was taught about it at school. There was a girl who I was friends with, who was much more developed than anyone else, you know, and we were quite envious of her (Ms. Knowles, over 60 years, English).

Mamu B (60 years, Xhosa) shares Ms. Knowles' experience, as she noted that when was young, she and her friends were frightened when one of them started menstruating because they did not anything about it. They were also afraid to tell their parents or be seen by their brothers or others at school. Again, like Ms. Knowles' experience, she and her friends only learnt about menstruation when they witnessed a menstruating girl at school. She noted that after such occurrences, a female teacher explained what was happening. This is also similar to a study's finding in rural India which found that participants were taught about menstruation by their teacher (Deo & Ghattargi, 2005: 2).

Another reason for the lack of knowledge was provided by Mamu Ntelwa (over 60 years, Xhosa) who said that certain community members prevent their pre-menarche children from playing with girls who have started menstruation. They tell their children to "leave those girls because they are older than you" (Mamu Ntelwa, over 60 years, Xhosa). The parents of younger girls were afraid that the older girls would learn about menstruation outside of the home.

In the reviewed Padmanabhanunni *et al*. (2018: 708) study, the majority of their participants stated that being unprepared for the onset of their menstruation caused them to experience fear, shock, and confusion when they started menstruating. Strangely, Mamu Ntelwa (over 60 years,

Xhosa) said that withholding of menstrual education in some families is deliberate so that when the girls' menarche appears, they will be frightened, and this will cause them to tell their parents. She continued her strange reasoning by stating that having too much knowledge about menstruation will lead to pregnancy. When it appears, they will clean themselves up and continue looking after themselves without the help of the parents, which to the parents means risking pregnancy. As such, Mamu Ntelwa believes that menstruation should still be hidden from the girls who have not yet experienced it.

4.3.5 Should menstruation be kept a secret?

Most participants shared that growing up menstruation was a sensitive subject that was kept a secret even from girls who had not yet started menstruating. Moreover, participants shared different views on whether menstruation should remain a sensitive subject to be spoken and taught about. For instance, Mamu Ntelwa (over 60 years, Xhosa) argued that although it is hard to talk to one's children about the subject of menstruation it should no longer be kept a secret from everyone including boys. However, she suggests that women who fear the embarrassment that comes with discussing the subject with other children like her should at least teach other children who are not their own. Moreover, she expressed a level of relief from the burden of teaching her children about menstruation because of her fear of embarrassment because of the role television plays in bridging the gap by not hiding things on subjects like menstruation. However, she still thinks that teaching both girls and boys at home helps make them responsible children. Furthermore, this perspective shows what has previously been discussed about how different generations perceive reality differently because her fear of embarrassment is uncommon in our younger generation.

Mamu Sihlobo (74 years, Zulu) shared a similar fear of embarrassment with Mamu Ntelwa. She expressed that she is someone open and loves talking, but she finds it difficult to teach one's children about menstruation. However, her fear of embarrassment stems from a different point of view. The difficulty, in her opinion, is the extent to which the menstruation subject should go which can blur the lines to the children, making them disrespectful. She believes that other topics that would have come up in the discussion would change or affect the dynamics of the mother-daughter relationship, such that the mother cannot even warn the child about teenage pregnancy because in this generation the child dares to remind the mother of her teenage pregnancy. Conclusively, Mamu Sihlobo sees no point in hiding anything about menstruation because television already shows everything.

On the other hand, the value system Ms. Knowles (over 60 years, English) uses does not allow her to hide anything from her children. She expressed that as a single parent, she wanted to raise liberal individuals, as she said:

> They knew everything about everything. You know, as soon as they asked a question, I would answer it, you know, and so and they would ask difficult questions like, "what is rape mom?" And then I will explain. I just had to because I wanted them to feel like they had agency over their own actions, you know. And that they knew what was happening to their bodies. … I think we had become more aware about bodily integrity of children and how that needed to be protected. And so, yeah, I gave them all the information, and I think, I think previous generations, my parents' generations and many mothers, my generation, there was just an embarrassment (Ms. Knowles, over 60 years, English).

Similarly, Mamu B (60 years, Xhosa) noted that she does not hide menstruation from her children. Moreover, Mamu Ndamase (63 years, Xhosa) sees it as a good idea to educate both girls and boys about menstruation, especially those in primary school. She argued that they need to understand that menstruation is a natural process that happens to girls. She argued this based on what her grandchild had shared, that they had witnessed their grade 4 classmate having her first menstruation in class. Mamu Ndamase's grandchild further shared with her that her classmates laughed at the girl when they saw that she had messed herself up.

Mamu Shwashwa (73 years, Xhosa) however, thinks that information on menstruation must be kept a secret from boys. In her opinion, the two genders are different for a reason, as such each needs to keep to what they were socialized into as well as the experiences peculiar to their gender. Therefore, she sees no point in men knowing what is happening with women's bodies, and vice versa.

4.4 Conclusion

Menstruation, like menopause, is a complex biological process that demands a more nuanced approach to understanding it. The participants had different meanings and levels of value attached to the menstruation experience. Some participants' cultures contributed to their views on menstruation. Some of the meanings and values attached to menstruation overlapped with meanings of different concepts of women's stages of maturity. Furthermore, there is relatively little reference to the accounts of the participants' experiences of menstruation. Mamu B's brief shared experience with starting her period is linked to medicalization in which her mother actively participated. Her experience lets us into other ways of medicalizing the menstruation process, i.e., introducing a girl to birth control pills to avoid her falling pregnant. Moreover,

she was passive in this context. Contrary to how her mother approached her menstruation experience, some of the participants' parents who would warn them about pregnancy left it to the participant to be responsible. Furthermore, these different approaches to dealing with menstruation were to some extent influenced by different contexts. Different parents interpret and respond to things differently. Ms. Knowles' mother took her daughter's announcement of her period differently than all the other shared views. Therefore, how girls or their surroundings react to menstruation, especially menarche, depends on their awareness and knowledge about the transition (Deo & Ghattargi, 2005: 2).

Finally, contrary to what most of the reviewed literature found, this study's participants did not reveal any superstitious mythical ideas about menstruation. Furthermore, the restrictions that some of the participants associated with menstruation were more to protect them than to oppress them. South African research on women's maturing process like menstruation needs to account for the context's diverse meanings and understandings of this process as well as the motives behind the restrictions that come with this reproductive phase. This will contribute to a broader understanding of the female body in traditional or rural communities, as Padmanabhanunni *et al*. (2018: 704) suggest that such literature is important.

4.5 Menopause

Information about menopause has recently been available and accessible, and the primary focus has been on the biological shift that women experience during this transition (McPherson, 2002: 54). However, this study's reviewed literature has shown that efforts to ensure that menopause is understood and recorded as a multi-stranded phenomenon that needs a more nuanced approach to understanding it are made. This section relates the participants' understanding of the menopause phenomenon, including their perceptions and cultural beliefs about it. Women's meanings of the menopause transition can influence how their embodied experiences will be constructed as per the previous discussion (Ussher, Perz & Parton, 2015: 456). Under this theme, we look at various meanings that participants attach to the phenomenon, their source of information, their experiences, and their views on preparing the younger generation for this phase. The participants' understandings and views on the menopause transition were both diverse and alike to some extent.

4.5.1 What is menopause?

All participants understood menopause as a natural transition that happens when a woman ceases to menstruate and to reproduce. Although the participants use the medical framework's definition of menopause, some of them understand the transition to be a phenomenon that goes

beyond the biological shift from a reproductive to a non-reproductive phase. They associate the transition with the process of aging, and some participants used menopause and aging interchangeably.

There is no existing clear marker of the beginning of the menopause transition (McPherson, 2002: 55). This is based on the idea that even the commonly used *biomedical discourse*'s definition of menopause talks of a period of a woman's life or final cessation of menstruation, which does not mark the exact time of the beginning of the transition (Hvas & Gannik, 2008: 178). This not-so-clear marker of the exact beginning of the menopause phase makes it understandable when some women associate menopause with the process of aging. For instance, one of the participants noted that menopause is the permanent cessation of menses that cannot be reversed or stopped using traditional rituals or ceremonies like other cases do (Mamu Ntelwa, over 60 years, Xhosa). In her cultural context families perform traditional ceremonies to counter or treat any kind of cessation of menses that may occur to a woman who is still in her reproductive phase, an interesting distinction. Cases like the abovementioned suggest the broadness of the conceptualization of medicalization. Hence, the need for the debate on medicalization to be broadened enough to acknowledge the work other branches of medical knowledge continue to do in medicalizing social phenomena. Furthermore, menopause does not always occur naturally, it can be surgically induced due to various health problems.

4.5.2 Menopause and aging

Participants in this study associated menopause with the process of aging. It can be argued that this association is because menopause usually occurs during the aging process, which involves physiological and psychological shifts, as well as social changes like separation from family and friends in Western societies (McPherson, 2002: 68). Two participants in this study expressed being unpleased with changes like their adult children who had left their homes for work and settled in places far from home with their own families (Mamu Shwashwa, 73 years, Xhosa & Mamu Ntelwa, over 60 years, Xhosa).

Moreover, as older citizens in their community, they have taken it upon themselves to mother every other child in the village. Furthermore, Mamu Shwashwa (73 years, Xhosa) noted that an older woman in a community is responsible for playing the role of being a mother beyond her household, especially when her children have left home. Mamu Ntelwa (over 60 years, Xhosa) noted that since they are close to leaving this world, they should play their part in society while they are still alive. Therefore, the two participants associate aging with an

extended role of mothering children outside their household, a role that no one assigns to them but stems from an inward conviction to be responsible.

Another interesting finding in this study is that all the participants did not express a fear of losing their physical attractiveness, which is contrary to what other studies found (Hvas & Gannik, 2008; McPherson, 2002; Utz, 2011). As a result, Ms. Knowles (over 60 years, English) confidently expressed that she still considers herself to be quite attractive. Mamu Ntelwa (over 60 years, Xhosa) and Mamu Shwashwa (73 years, Xhosa) only expressed great concern about the increasing rate of teenage pregnancy and cohabiting. This was alarming to them since their generation in their sociocultural contexts was more socialized into abstaining from sexual intercourse until they got married, and all their children were conceived in marriage. Mamu Sihlobo (74 years, Zulu) is also opposed to teenage pregnancy, as such, she extended some advice to me to study, work, be financially stable, and then have a child, in that order.

Finally, other studies have found that menopause puts an extra burden on women, whose bodies are already experiencing age-related physical health problems (Fenercioğlu, 2017:152; Hvas & Gannik, 2008; Moral *et al*., 2018; Ramkuela *et al*., 2008). Contrary to that finding, none of the participants in this study complained about age-related or physical burdens due to menopause. Two of the participants, Ms. Knowles and Mamu B are still professional workers. Moreover, all the participants noted that they were still doing household chores. For instance, when I went to interview Mamu Shwashwa (73 years, Xhosa), she was clearing and cleaning her yard. Mamu Ndamase (63 years, Xhosa) was also busy with household chores when I went for our interview. Furthermore, the 74-year-old Mamu Sihlobo was about to wash her car by herself even though she lives with two adults, a daughter, and a granddaughter who she can ask to wash the car. All these household chores show that the women have relatively good physical health.

4.5.3 Menopause and Sexuality

Menopause and sexuality were another interesting finding in this study. Participants expressed different views on and different experiences of the subject. Two participants expressed that they had a low sexual desire from the start till the end of their transition (Ms. Knowles, over 60 years, English & Mamu Ndamase, 63 years, Xhosa). The tone of voice with which Ms. Knowles expressed the lack of sexual desire did not suggest that she was bothered by it. She has accepted and embraced it as part of the menopausal transition. When asked if menopause had affected her relationship with her partner, she noted that she was not in a relationship when the transition started. Moreover, she had this to say about the change in her sexuality:

> I just was less interested. So, I do kind of think that, for me, it (menopause) affected my libido. And I was so relieved to be on my own, and I've never felt I am longing for sex. I loved sex. I loved it. But it kind of went away, you know? And now I'm happy for other people to have it, but not me. I'm sorry. Don't. I'll Hug, I'll dance, and I'll be affectionate. But uhm, and yes, and I'm like that too. And I like being single. I absolutely love being single. So, you know, but I think because I embraced whatever the path was to see what happens (Ms. Knowles, over 60 years, English)

On the other hand, another participant explained that lack of sexual desire might have been a result of her being diabetic rather than menopausal:

> In my case, when I was still menstruating, I got attacked by sugar diabetes. Sugar diabetes kills certain things in one's body. Sexual feelings died, dying in me as a woman with a husband. It is, of course, not going to be nice when it is only the husband who is willing to be intimate when you are not. You need to let him know, as we are taught at the hospital that when you have diabetes, the degree of engaging in certain activities will decrease (Mamu Ndamase, 63 years, Xhosa).

In this case, Mamu Ndamase's husband was somehow affected by her lack of sexual desire. As has been noted that sexual dysfunction impacts both the partner and the one bearing the symptom on a sexual, emotional, and interpersonal level (Scavello *et al*., 2019: 15). Mamu Ndamase, as noted above acknowledged the possibility of her sexual dysfunction symptoms to bring problems in her marriage, so she made her husband understand her state of health. As a result, the window for problems or conflicts to occur as a result of lacking sexual intimacy was closed. Therefore, she suggested that women should talk with their partners and educate them about the cause of their lack of sexual desire whether it is menopause-related or diabetes-related to lessen the chances of conflict to occur. Since the couple will work together to find ways to adapt to their new reality. Moreover, she believes that couples must discuss matters like menopause and the symptoms that could occur before marriage to help prepare each person for the journey ahead. Because sexual dysfunction is a medical condition considering that in such a state the body-machine is not functioning according to the medically expected and accepted normality standard. It is with disturbances like this from how the body is naturally expected to function that the medical community comes in and medicalizes a phenomenon to come to rescue the one who is being victimized by the phenomenon.

Another part of menopause that was found in this study is premature menopause which has a more complex impact on a woman's sexuality than on old women:

> The younger the woman, the less she realizes the different key goals of her life cycle (falling in love, having a satisfying sexual life, forming a stable couple, getting married,

> having a family) and the more pervasive the consequences on her sexual identity, sexual function, and sexual relationship can be" (Graziottin, 2012: 254).

From the above suggestion, it could be argued that the idea or thought of premature menopause is the worst case. Mamu Ndamase (63 years, Xhosa) experienced premature menopause at age 35. She was already experiencing low libido due to her chronic illness (diabetes) when she started menopause. Interestingly, to her surprise, she fell pregnant with her lastborn immediately after the onset of her menopause. She had seven children when her shift to the non-productive stage started. Therefore, her case was different the those of women who battle with sexual identity, feelings of wounded or lost sense of self, sexual attractiveness, and femininity due to the dying potential to bear children (Graziottin, 2012: 255).

Furthermore, a study found that a significant percentage of women with low libido experience feelings of frustration, concern, unhappiness, disappointment, hopelessness, shame, bitterness, low self-esteem, insecurity, feeling less feminine, feeling like she is letting down their partner, and that she is a sexual failure (Nappi & Lachowsky, 2009: 140). This finding is contrary to Mamu Ndamase's (63 years, Xhosa) experience, she even noted that she had a beautiful and healthy relationship with her late husband despite the lack of sexual intimacy and inability to conceive anymore:

> You should have seen me and my husband. My husband was way older than me. You would see us together and see two beautiful people who love one another, but when it comes to us sleeping at night, nothing is happening. We just hugged each other like siblings, and it was nice. It was very nice in our household because we had ironed out these physical intimacy issues. I was diabetic, and he got testosterone cancer later, yet it was very amazing. I would go to church, leaving him lying on the bed, and hug and kiss him goodbye. A home is not a home because of physical intimacy but because of love between the two partners (Mamu Ndamase, 63 years, Xhosa).

It could be argued that not every woman has a similar fortunate experience to Mamu Ndamase. Moreover, her experience is supported by Ussher *et al*. (2015: 461), who found that some women develop a focus on non-genital intimacy such as cuddling, massage, touching, and kissing. Furthermore, like Mamu Ndamase, the women involved in this kind of renegotiation of intimacy find it consistently good (Ussher *et al*., 2015: 461). Therefore, people need to be made aware of the many possibilities menopausal women have, like hormone replacement therapy to deal with sexual dysfunction if it becomes a significant issue (Hirsch, 2023). Because the medicalization of menopause has made sexual abstinence cease to be an inevitable consequence of the menopause phase for women who would not want it (Nappi & Lachowsky,

2009: 138). Menopausal women's husbands or partners influence how the women perceive and manage their menopausal symptoms. As seen in the case of Mamu Ndamase. Furthermore, a woman in another study expressed being distressed about her menopausal transition because her husband desperately wanted a child (Grazziottin, 2012: 255). Therefore, her feelings of distress were due to the pressure she received from her husband. Thus, recent research argues that men have an important role in assisting their partners navigate the challenges that may come with menopause (Agunbiade & Gilbert, 2019: 509).

Another interesting finding in this study is the links participants make between menopause and sexuality. One participant, for instance, thinks that it is the lack of sexual intercourse that induces menopause (Mamu Ntelwa, over 60 years, Xhosa). It could be argued that her perception is because of her interpretation of her doctor's questions upon her diagnosis of menopause. It has been argued that how people think or talk about menopause, even in casual conversations, influences how the woman will perceive the transition (Hvas & Gannik, 2008: 177). Below is what she recalled about her interaction with the doctor she had visited:

> The doctor asked if I still had a husband. Maybe because of the health condition that he was seeing (menopause). He asked the last time I had my period, and I told him that it was five years ago. He further asked the last time I engaged in sexual course. and I said in 2009 (Mamu Ntelwa, over 60 years, Xhosa).

Mamu Shwashwa (73 years, Xhosa) made a similar link between the two concepts as Mamu Ntelwa. Although it was not clear what could have made her think that way. Similarly, Mamu Sihlobo (74 years, Zulu) made a similar link. She also thinks that hot flushes cause low sexual desire. She believes that every woman naturally has hot flushes. She alluded that they only get noticed during menopause because of the cessation of menses which would normally be a way to secret them together with all the body's filth that would be released during one's period. Thus, she believes that hot flushes can only be managed with sexual intercourse since a woman discharges fluids during intercourse of which hot flushes become part. Furthermore, she believes that it is only the honest and trustworthy doctors who advise elderly women to be sexually active to manage their hot flushes. Mamu Sihlobo further attributed many health challenges like arthritis, osteoporosis, and abdominal pains in elderly women to low sexual activity. She believes that sexual intimacy stretches a woman's body and gets rid of harmful fluids: "Not engaging in sexual intimacy at old age makes you sick and grumpy" (Mamu Sihlobo).

As a Zulu, Mamu Sihlobo suggested that polygamy becomes a problem for a woman's sexuality during menopause. She shared that there is a traditional ceremony that the Zulus and the Pedis perform for older women in polygamous marriages to plead with the ancestors to cease the first wife's sexual desire. This is done so that the woman will not fall ill from lack of sexual intimacy, because by that time the husband's gaze is on younger ladies, and the first wife is deprived of physical intimacy (Mamu Sihlobo, 74 years, Zulu). Agunbiade and Gilbert (2019: 503) also note that menopausal women in polygamous marriages suffer under unequal and, at times, unhealthy conflicts that arise from competing for their husbands' attention with younger wives. Mamu Sihlobo argues that when this happens the older women start dating younger men.

4.5.4 Learning about menopause

There are initiatives and interventions aimed at educating women on the scientific/biomedical understanding of menopause. For example, printed pamphlets and other resources are distributed through public healthcare clinics, community groups, and churches in Harare and Bulawayo in Zimbabwe, and in Soweto, Johannesburg, South Africa (Drew *et al*., 2022:16). One participant stated that she has accessed information on several ailments, including menopause at the clinic. As she said:

> We do not teach about menopause because each individual has her own experience unlike during the appearance of one's menarche, where you report your experience and then be taught about it. Menopause is different. If one experiences irregular menses and they are not pregnant, they need to go to the clinic and get tested; do not just ask around. We are taught these things in clinics when we go on pregnancy check-ups. There are many things we are taught about (Mamu Shwashwa, 73 years, Xhosa).

In her statement, Mamu Shwashwa shows that healthcare centres in other contexts have done well presenting the assistance the profession can offer women in their menopausal transition. Such that, her trust in the medicalization of menopause makes her believe that no one can offer anyone any form of assistance besides medical professionals who have the knowledge and equipment to test and find out ways to help the individual. She also supports the earlier thought on women seeking medical assistance during their pregnancy journey.

Besides the information provided in clinics, two participants (Mamu Ntelwa and Mamu Ndamase) mentioned that their doctors told them about menopause upon their diagnosis of it. Moreover, this shows the extent to which menopause has been medicalized, in that doctors have the necessary tools to dictate even the start of the transition. This seems to be very helpful, to say the least, as it not only dictates the onset of menopause but also creates a platform to educate women who may not know about it. Mamu B (60 years, Xhosa) noted that she got

information about menopause from books and nurses from her church. She noted that the nurses would conduct question-and-answer discussions on menopause. Therefore, she was not alarmed by her menopausal symptoms like irregular menses and vaginal dryness. This is a third instance showing healthcare professionals sharing their expert knowledge on the subject to equip menopausal women and those who are yet to experience it. Meaning that the profession's medicalization of menopause continues to spread and the acceptance of it is increasing. Finally, Mamu B also got some help during this phase from her older sister's friends. Similarly, Ms. Knowles stated that she got some of the information about menopause from learning from her mother and aunt about their own experiences.

4.5.5 Experiencing menopause

The ability for women to determine the beginning of menopause is important as it can help them to prepare ways to navigate the transition. Irregular menses were a standard indicator of the onset of menopause for some of the participants, like the study I conducted in 2022 (Makalima, 2022).

Participants all had varied menopausal symptoms, with hot flushes being the most common symptom. As earlier noted, one of the participants (Mamu Shwashwa, 73 years, Xhosa) had a hysterectomy due to cervical cancer. After she had her last born, she experienced prolonged heavy, painful, and smelly bleeding. When she went to the doctor who ordered a Pap smear test, she tested positive for cervical cancer. Her active participation in the medicalization of the female's reproductive health returned with a great benefit of health and prolonged life. Even though surgically induced menopause is said to 'suddenly deprive a woman of total ovarian hormone production,' it leads to a rapid impact on both her sexuality and well-being (Graziottin, 2012: 255). Moreover, others have also found that women who had their menopause surgically induced were at a higher risk of emotional and psychological distress due to sexual dysfunction (Nappi & Lachowsky, 2009: 140). Due to the sensitivity of the matter, I could not find out what the impact was for Mamu Shwashwa. Furthermore, the benefits like relief from pain and worry, as well as prolonged life due to medical interventions are among the reasons medical initiatives and interventions should be extended to many rural and poor urban communities (Drew *et al.*, 2022). This further suggests that women are not victimized by the bio-medicalization of their bodies as the feminist critiques may suggest.

As earlier noted, one of the participants (Mamu Ndamase, 63 years, Xhosa) was diagnosed with diabetes before the onset of her menopause transition. Therefore, she experienced health-related problems before menopause. Hot flushes were her only new concern. Furthermore, 28

years later the hot flushes are milder and bearable than before. Although she experienced severe hot flushes, she never consulted a doctor to request treatment to manage them because she believes that God's nature must be allowed to be. This way Mamu Ndamase showed active rejection of the medicalization of menopause. Moreover, Ms. Knowles shared similar sentiments with Mamu Ndamase on treating the symptoms. She also experienced severe hot flushes, but she declined getting HRT as a colleague had advised. Ms. Knowles 'wanted to embrace whatever her body was bringing her way.' She was happy she also declined HRT:

> I'm very glad I didn't go on hormone replacement therapy. I didn't want to, you know, I kind of felt I didn't want to medicalize something that was normal, that was something women go through. I didn't want to make it into pathology, into something that needs treatment. I wanted to go, 'I'm embracing this next phase of my life' (Ms Knowles, over 60, English).

Ms. Knowles only experienced irregular menses and hot flushes. Furthermore, she narrated that she felt excited when hot flushes started because they reminded her of the feeling she would get when she used opioids. However, with time, hot flushes started irritating her because they deprived her of sleep. Lack of sleep at night and going to work in the morning made her feel insane. Her rejection of HRT in the name of not wanting to medicalize something natural led her to endure severe hot flushes like Mamu Ndamase. Moreover, the two participants' rejection of HRT seemed to be due to their internalized meaning and idea of the transition, rather than their contexts. Furthermore, Ms. Knowles further argued that she considered sleeping pills than HRT, which she does not recall taking at all. So, she found a way of reorganizing her sleeping time and avoiding spicy food which tended to trigger the hot flushes. Conclusively, she positively embraced the phase. She even felt uncomfortable referring to changes that come with menopause as *symptoms but* prefers to call them *manifestations*.

Like other participants, Mamu B's (60 years, Xhosa) onset of the menopause transition started with irregular menses. Her menopause experience, however, was smooth sailing except for vaginal dryness. She consulted a doctor who prescribed vaginal cream, which is recommended as a first-line treatment used in hormone-dependent cancer survivors, or when a woman only experiences mild to moderate vaginal dryness (Scavello *et al*., 2019: 11). She showed herself to be an active participator in the medicalization of menopause.

Finally, Mamu Ntelwa (over 60 years, Xhosa) said that she never experienced any challenges during her menopause. She does not even know when the onset of her menopause was because her last menstruation cycle was before her last pregnancy. She did not immediately consult a

doctor when she was not menstruating because she thought it was due to breastfeeding. Therefore, she was shocked when she found out from the diagnosis that she was already in menopause.

4.5.6. Menopause: "the pause from men"

Nearly all participants had positive feelings about menopause, and this is an intriguing finding given the value that is placed on childbearing in most rural communities, which Mamu Shwashwa (73 years, Xhosa) and Mamu Ntelwa (over 60 years, Xhosa) mentioned. For example, Ms Knowles (over 60 years, English) referred to this phase as a "pause from men," since she believes it freezes the attention a woman gets from men during her youth, ending the male gaze. She is very glad that she is no longer subjected to the male gaze. As she explained:

> I don't see myself as a wildly attractive person, but I've always got attention. So, when we were having party days, you know I would get attention and people wanting to buy me drinks or, dance, etcetera. And I did find that the older I got, the less visible I became walking around, you know. So, men making eye contact with me or chatting to me, or whatever doesn't happen anymore. Which yay! What a relief. And it kind of gives you a different sense of freedom not to have that male gaze on you all the time. So, you move out of the realm of where men's gaze is because it's always much younger females than themselves. And so, when I moved into my 40s into my 50s, I mean, I think I'm still a beautiful woman, and I think I've got energy and attractiveness, but it doesn't need a man to validate it or to make me feel that way. I mean I truly was unprepared for how happy I would be not to have a man in my life (Ms. Knowles, over 60 years, English).

Contrary to Ms. Knowles' reality, Ussher *et al*. (2015: 457) argue that the expectations women have about menopause are mainly negative such that they become surprised when their experiences contradict with their prior expectations. Furthermore, Ms. Knowles' perception demonstrates that an individual is at liberty to exercise her agency and not conform to the expected contextual standards. Finally, Ms. Knowles' view differs from other women who get consumed and overwhelmed with feelings of being less desirable and losing their confidence (Ussher *et al*., 2015: 458).

4.6 Conclusion

Participants associated menopause with the process of aging because there is no precise clear marker of the onset of the transition. While some participants assumed the role of mothering their community since their children are adults who live in their own homes. The process of aging and the menopausal version of their bodies does not really bother the participants. Another interesting finding is the participants' understanding of a woman's sexuality in the

menopausal stage of life. The participants' perceptions on and experiences of sex was varied, some had no interest in sex due illness, while others were bothered by it. The healthcare sector played a huge role in making some of the participants aware of their maturing/menopausing bodies. As, reviewed literature points to some benefits from the medicalisation of menopause. Although some participants rejected HRT because they understand menopause as a natural process, which should be embraced as it comes. Finally, none of the participants held significant negative views of menopause.

Chapter 6: A study conclusion

Menopause is a complex transition from a reproductive to a non-reproductive phase that every woman experience. It comes naturally, but it can also be surgically induced. The transition is characterised by onset of physical and emotional changes, which impacts women's social lives. Therefore, understanding it demands an approach that appreciates both the biological and sociocultural aspects of the process. The biomedical discourse is used to understand the biological shift and the medicalisation thereof. Since the biological shift sometimes come with burdensome symptoms, such as hot flushes, the medical community has medicalised menopause, and prescribe HRT, which benefits women. However, there are many criticisms against medicalising natural conditions such as menopause. For this reason, some participants in this study advocates for the use of HRT when menopause symptoms are severe.

How women understand or perceive this transition is significantly influenced by wider sociocultural factors, as well as the biomedical discourse on menopause that they have internalized. This means that the experience of menopause is a social construct. This why women understand and experience menopause differently. Furthermore, some women's cultural attitudes toward menopause need to be challenged as these ideas not based on scientific knowledge on menopause. In some cultural contexts, menopause is a taboo and sensitive subject, and this may put women at risk if they have health conditions such as cervical cancer.

Menopause comes with a biological shift, as well as a social shift. This shift is informed by the medical and social meanings attached to the transition, especially ideas about femininity that the women were socialized into before the transition. This also includes how menopausal women are viewed in their communities. Furthermore, it is these meanings that also inform the women's menopausal self-identity. This means that menopausal women should continuously deal with the tension between conforming to the social definition of womanhood and an identity that may not be determined by gender anymore. As such the post-structuralist feminist theory emphasizes the need to pay attention to the meanings that women have internalized, and any social force that may challenge their agency to look for knowledge gaps and their ability to bridge these gaps.

Despite this study's participants' acceptance of menopause, women still need to be equipped with accurate knowledge about the symptoms they experience, what they mean, and how they can be treated. For example, one participant believes that hot flushes cannot be treated with any medication but can be alleviated by engaging in sexual intercourse. The most important

finding on the menopausal biological shift is that all participants have been managing or managed their symptoms without intervention, which suggests that menopause does not always lead to negative physical and psychological symptoms. Finally, there was minimal impact on on the participants' social roles as most of them still carry on their household chores, and two are professional workers.

6.1 Limitations and recommendations

The study's limitation is that the findings cannot be generalised, given the small sample size. Furthermore, the age gap between the participants and the researcher limited the extent to which she could ask probing questions. Since this is a mini thesis, it does not allow the topic to be explored fully. There is need for further research on the sociocultural aspect of both the menopause transition and menstruation process in the South African context, particularly around cultural beliefs. Furthermore, restrictions due to menstruation and the consequences of not honouring them need to be researched to broaden our understanding of the female body among rural communities. Finally, research needs to be done on how some of the women who refuse to get help to ease severe symptoms because they view menopause as a natural condition. The findings can inform health policy on awareness campaigns on reproductive health and menopause.

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Interview questions:

Introductory remarks.

1. Can you tell me about the very start of your menstruation process? How was the experience like?
2. What was going on in your mind when you realised the change?
3. How did telling your parents?
4. What are your thoughts on teaching both girls and boys about menstruation?
5. Now, take me through the time you realised that menstruation had ceased, and you were now entering the menopause transition? How did you find out?
6. What was going on in your mind when all this was happening?
7. What information did you have about menopause that made you realise that you were entering into it?
8. What would you say is your culture's idea of menopause? How is menopause viewed in your culture?
9. How did the transition impact your relationship with your husband/partner?
10. Were there changes in your social environment, like assuming new roles by virtue of transitioning to a non-reproductive phase?
11. What would you advise a young lady to do to fully prepare for this phase?

Concluding remarks.