AN EXPLORATION OF THE MEANING OF MENOPAUSE AMONG GHANAIAN-CANADIAN WOMEN

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ABSTRACT

In spite of its biological universality, menopause is a complex phenomenon influenced by gender, identity and culture. The meanings of menopause and what it signifies for women vary considerably. They are shaped by social attitudes about aging and women's roles over the life course. Utilizing in-depth interviews, this study examines the meanings and experience of menopause for ten Ghanaian-Canadian women living in the city of Toronto.

For these women, the understanding of menopause transcends the narrow biomedical definition of menopause as a deficiency disease requiring pharmaceutical intervention. Instead, they view it as part of a normative aging process and recognize that it is accompanied by changes in health, social role and status.

This research contributes to the growing body of literature on women's health and aging as well as to our understanding of culturally-diverse approaches to menopause and midlife.

TABLE OF CONTENTS

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CHAPTER ONE

INTRODUCTION

Aging is a social as well as a biological process. However, the focus of attention within medical circles has been primarily confined to changes in the physical body, with emphasis placed on developmental stages characterized as infancy, childhood, adolescence and adulthood. One result of this is that the subjective experience of maturation and associated changes in human relationships are rendered overly peripheral (Lock, 1998:35). The focus on biological changes associated with aging is widely reflected in current Euro-American popular discourse; in particular that connected with female middle age.

The female menopausal body is the site of controversial debate in connection with both its representation and the medical practices that manage it. In biomedicine menopause is considered a deficiency disease that is commonly treated with hormones. However, by contrast many social scientists suggest that the experience of menopause is multifaceted; that it is an arena for the negotiation of women's status, identity, culture and resistance (Lock, 1993; Spitzer, 1998:1).

Most studies of menopause are based on white and upper class women. The few cross-cultural studies on menopause primarily focus on the differences in symptom reporting across cultures. Studies of menopause in Africa and among African women who have migrated to other cultures are scant. African

studies have focused on the age of onset of menopause and the symptomatic features of menopause (Kwawukume et al, 1993). These studies most often utilize quantitative analysis. The limitation with this kind of research is that reporting is inconsistent and it conveys selective information on the experience of menopause. Only women who experience particular symptoms and associate them with the aging process may report it (McMaster et al, 1997:3). Moreover, this type of analysis does not allow women to give voice to their own experiences. The meaning and interpretations of menopause for them are not known.

By contrast, this study explores the meaning of menopause for Ghanaian-Canadian women. I discuss how culture influences women's experiences of menopause and the extent to which Ghanaian-Canadian women's accounts differ from biomedical accounts of menopause. I also examine how biomedical and Ghanaian indigenous views on menopause interact and how Ghanaian–Canadian women understand the aging process.

This study is based on primary and secondary source data. I conducted in-depth interviews with ten Ghanaian-Canadian women in Toronto during the summer of 2002 and explored the key themes in their narrative accounts. Menopause was significant for some women because it marked the end of the childbearing years, and the beginning of another stage of life as elderly women. Menopause was also a time when there were changes in women's roles and health. During menopause women begin to understand their bodily processes

and begin to take over the management of their bodies. For some, this involves resistance to the dominant biomedical definition and treatment of menopause.

The aim of this thesis is to describe the meaning and significance of menopause for the Ghanaian-Canadian women interviewed. I examine menopause in the context of culture and the social location of the women interviewed. I explore how some aspects of the Ghanaian culture have influenced Ghanaian-Canadian women's perceptions and interpretations of the menopausal body. Specifically, I examine how indigenous Ghanaian views about aging, the status of women and power, influence Ghanaian-Canadian women's views about menopause. I argue that women negotiate the meaning of menopause in the context of their social and material conditions of life. I suggest that while Ghanaian-Canadian women are surrounded by a culture where menopause is medicalized, most do not view menopause as disease but rather as a normative life transition. This is in part due to the fact that they have a positive attitude towards aging.

Biomedical Explanations of Health

Biomedical knowledge emphasizes the physiological and biological aspects of illness. The focus is on the internal workings of the human body (Doyal, 1995: 15). Mishler (1989) outlines four key assumptions of biomedicine as follows:

(a) It defines disease as a deviation of normal biological functioning. The body is treated as a series of separate but interdependent systems,

whereby the failure of some part or more is deemed as illness (Doyal, 1995: 15);

(b) It assumes that each disease has specific etiology and causes (Mishler, 1989);

(c) It assumes that diseases are generic; that is, each disease has distinctive characteristics (typically called symptoms) that are assumed to be the same over time and across cultures; and

(d) Finally, the model assumes the scientific neutrality of medicine. The discipline not only adopts the notion of rationality, but also objectivity and neutrality. Therefore it assumes that objective scientific rules are unaffected by wider social, cultural and political forces.

Biomedicine is a powerful tool in describing much of the sickness afflicting individuals (Doyal, 1995: 15) and it has had a very powerful impact on Western medicine (Mishler, 1989). Although biomedicine has succeeded in curing many diseases, its orientation is mechanistic and individualistic, limiting its potential to deal with the broader social dimensions of health and illness. Diseases are described as the mechanical failure of some part or more of an individual's system that requires repairs to the damage done. Consequently, individuals are separated from their wider social environment. The complex interrelationship between the social and cultural context of individual lives is largely ignored (Doyal, 1995: 15).

Additionally, the accomplishments of biomedicine have led to the neglect of preventive measures and an over-reliance on the curative model to explain the

causes of diseases and the different ways in which they are experienced (Doyal, 1995: 16). It also fails to explain why some diseases are resistant to treatment and offers little help in understanding why some individuals or groups are more likely to suffer poor health than others (ibid). In particular it is limited in its ability to understand and treat psychological distress, especially among women. On the whole, biomedicine is narrow in its approach to diseases and it has been widely criticized for not taking into consideration the social and environmental factors, which influence patterns of health and illness.

Notwithstanding its inherent limitations, the biomedical model is widely perceived as having contributed significantly to improving the health status of populations over the past century and dominates health discourse in both the Western and developing world (Mishler, 1989; Avotri, 1997). Thus any analysis of health and illness must examine the role of biomedicine in shaping health beliefs and practices of both practitioners and clients.

Women and Biomedicine

Feminist perspectives on health are concerned with the way in which biomedicine and other healing practices assert and maintain gender differences on behalf of the elite (Spitzer, 1998). Biomedicine has shaped our understandings of gender, sexuality and health. Feminist critics highlight: the significance of differential access to resources and the varying impact of work on men's and women's health; the presence of a gender hierarchy in the health care system, the existence and distribution of gender specific diseases and gendered

notions of the body, as the ways in which these are poorly understood and addressed in biomedicine (Spitzer, 1998).

Biomedicine undoubtedly has had a powerful impact in shaping contemporary health practice, due to its effective and impressive means for treating particular dimensions of human suffering. However, it is also a *cultural system*, complete with the hallmarks of other ethnomedicine: magical ceremonies, mystical knowledge, performance codes, creeds of faith, specialized domains of interest and rituals for the preparation of practitioners.

Women's body processes in particular have been negatively influenced by biomedicine. Its credibility and power are located in its authority to label and sanction behavior as deviant or diseased. It does so by claiming expertise and giving medical meanings to certain behaviors or conditions which previously had not been regarded as medical matters (Riessman, 1989: 191). Medical practice has become a tool for eliminating or controlling experiences that are defined as deviant for the purpose of securing adherence to social norms (Riessman, 1989: 191). These meanings and labels are also reflective of social expectations, which conveniently classify difficulty (Spitzer, 1998: 14). Such medicalization can occur on two levels: when a medical vocabulary is used to define a problem; and when physicians legitimate a problem (Riessman, 1989:191).

Over the past century, there has been an increase in the spheres of life that have come under the medical gaze. For example it is now conventional to consult a physician on issues of sexuality, fertility, childhood behavior and aging. All aspects of women's lives have come under the medical gaze, from

menstruation and childbirth to the end of fertility-the menopause. Hence, a young woman who expresses anger is at risk of being regarded as suffering from Premenstrual Syndrome (PMS), African slaves who attempted to flee from their masters in the 19th century were branded as suffering from drapetomania (drapetomania an insane impulse to wander from home) (Szaz, 1994 in Spitzer, 1998: 14), and a middle aged woman who expresses discontent is at risk of being labeled as suffering from menopausal syndrome (Lock & Scheper – Hughes, 1990). These labels project meanings and notions of what constitutes "healthy" womanhood and dictate appropriate behaviors and social roles for women (Nettleton, 1995: 140). For menopausal women they project meanings and notions of appropriate behavior and responses to it (Spitzer, 1998: 15). Women are socialized to recognize the physical symptoms of menopause and the appropriate behavior for the menopausal women. North American women are advised that the loss of libido is a medical problem which needs to be treated with hormones, whiles Bengali women in India know that sexual activity in inappropriate for the menopausal woman. Differences in class and culture, and in economic and political power, all find their expression through the bodies of menopausal women (Kaufert and Lock, 1990:187).

Socio-Cultural Explanations of Health

The socio-cultural framework takes into consideration the broader social, cultural and environmental factors that produce and shape the experience of illness. This perspective posits that certain cultural and social factors expose people to certain health risks and shows how beliefs and practices of a particular

culture may affect health in particular ways. For example, it is assumed that women in developing countries have too many children due to their cultural beliefs about fertility, which lead to higher rates of mortality (Avotri, 1997). Additionally, certain cultural practices such as customary rites and rituals expose people to illness. Female genital mutilation, which is practiced in certain parts of Africa, exposes women to infections and hemorrhage (ibid).

A socio-cultural approach to health recognizes that the experience of health and illness has much to do with social forces. It emphasizes the importance of material disadvantage and inequality in shaping health and illness and shows how the social structures within which people live affect the choices that they make. It examines the relationship between health and social position and how this affects health and illness. Additionally, it examines the circumstances of people's lives such as their incomes, sex and gender, environmental pollution, poor living conditions and stressful or dangerous conditions of work (Avotri, 1997: 24). Social indicators such as social class, sex, marital status, age, ethnicity and area of residence are associated with illness. Social status, political power and social roles have been shown to account for differences in the prevalence and distribution of certain kinds of illness. Social and cultural explanations of disease have also been used to explain differences in symptom reporting and the experience of menopause among women in different cultures (Lock, 1993).

The socio-cultural approach places its primary emphasis on social and cultural factors, often neglecting the individual or her biology. It assumes that

social and cultural factors are external to the individual who has little control over them (Avotri, 1997: 27). In essence the individual has no hand in the conditions that make them ill. However, it is very important to take into account the individual's biological make-up, as well as the social and cultural factors that affect their health.

While the biomedical model places excessive emphasis on the biological and physiological aspects of illness, the social and cultural paradigm emphasizes the wider environmental factors that affect health and illness yet often ignores the biological. Using a combination of the two models will help us to more fully understand the issues surrounding health and illness. While individuals are shaped by biology, social and cultural factors also contribute to their experience of health, illness and the body. Moreover, each of these models is useful in explaining particular aspects of health and illness and has implications for the kinds of medical and social policies used to address health problems (Macintyre, 1986, quoted in Avotri, 1997: 28).

1.1 METHODOLOGY

Over the past two decades feminist researchers have challenged the traditional ways social science has analyzed women, men and social life (Harding, 1987:1). Traditional epistemologies have excluded "the possibility that women could be "knowers" or agents of knowledge" (Harding, 1987:3). Dorothy Smith (1989: 34) and Nancy Hartsock (1983, 1985) have argued for a "research starting from women's actual experience in everyday life" (in Denzin & Lincoln, 1998: 309).

Conventional social research based on a positivist epistemology has emphasized the importance of objectivity and value free research and has tended to reinforce dominant masculine values in the quest for knowledge. The result is that women and minority groups have been largely marginalized in research. Until recently, most studies of menopause were based on quantitative and descriptive statistical research using a biomedical model of the female body and health. The outcome was that women's experiences and interpretations of menopause remained invisible. The limited cross-cultural research, often derived from a Western norm, focused on the absence or presence of symptoms, in different cultures. Research on menopause from the perspective of immigrant women and Ghanaian women, in particular, is scant.

The purpose of this study is to allow Ghanaian- Canadian women to give voice to their own experiences of menopause. To accomplish this, I felt that a qualitative method was more appropriate for this study than a traditional quantitative approach. One advantage of qualitative over quantitative research is that respondents are able to express their views and thoughts on the research question.

Many researchers (Kaufman, 1986; Lock, 1993; Atkinson, 1998) have documented how life stories are used to obtain a deeper understanding of the experiences of people, especially women. Life stories are personal narratives that provide insight into the construction of identity, social relations and dynamics of power (Bertaux, 1981; Kaufman, 1986). They are therefore "representations of lives" (Lock, 1993: 77). Life stories are integral to the understanding of our lives.

They are entrenched with meanings of culture, gender, values, norms and power relations. According to Lock (1993: 77) narratives focus on certain incidents that have shaped lives, and often give a hint of how the narrators understand their experiences in relation to the larger society.

Sampling, Data Collection and Analysis

Through my personal contacts in the Ghanaian-Canadian community in Toronto, women were sought who were interested in taking part in the study. The sampling method I used was the snowballing technique. It entails starting with someone known to the researcher and asking that person to suggest others who might be willing to participate. I contacted a women's group leader of a church, who was also a counsellor, and asked her to suggest other women who had gone through menopause. The contacts she gave me were women she knew. Other participants were identified through family or friends and included in the study to allow for comparison. The time elapsed since the last menstruation for the participants ranged from one year to ten years.

Participants were contacted by phone, and I explained the nature of my study to them. An appointment was then made for the day and time of the interview. Each participant chose the time and location of the interview. Two of the interviews took place at participants' own homes, two at the premises of the church they attend, one at a participant's office and four were conducted by phone. While it was sometimes difficult for the participants to schedule time, each participant made a significant effort to have enough time for the interview.

Prior to the interviews, informed consent was obtained from the

participants by getting them to sign the consent forms (see Appendix 3) or by verbally indicating their consent on tape. The latter alternative was used in cases where the interview was conducted by phone or when the participant was unable to read.

To conduct the interviews, a semi-structured interview guide was used. All of the interviews were tape recorded, even in cases where they were conducted by phone. Most of the interviews were conducted in Akan, the most widely spoken local language in Ghana, and in English. Most participants felt comfortable expressing themselves in the local language, while some others could not speak English. When English was used, it was usually interspersed with Akan. While it was sometimes difficult to translate certain questions to the local language; care was taken to convey them as carefully as possible. The interviews lasted between forty-five minutes and one hour. Participants' demographics were obtained at the end of the interview.

My sample consisted of ten Ghanaian-Canadian women, all of whom perceived that they had gone through menopause. At the time of the interviews, they were all residents of Toronto and the Greater Toronto Area. Two of the respondents have been in Canada for over 30 years, five of them for over 20 years and three of them for the past three years.

Three of the participants are in their sixties, two are in their fifties and five are in their late forties. Five of the women are married, three are widowed, one is divorced and one is single. All but one of the participants has children and five are also grandmothers. Two of the participants have post-graduate education,

two have diplomas in nursing and have taken several additional courses, four have junior high school certificates and two have no formal schooling. At the time of the interviews one of the participants was a consultant, one was a counsellor, two were retired nurses, four were working in factories, and three were not in the paid labour force.

All of the participants are first generation immigrants. They were all born and raised and had at least some education in Ghana. All of the participants are members of the Akan group, which means they trace their descent through their mother's line. Of these two are Fantes, four are Ashantis, three are Akyems and one is from Brong Ahafo. These ethnic groups share a similar language, customs and beliefs.

Seven of the women have had a natural menopause while three had hysterectomies prior to menopause. Clinically, a natural menopause is defined as having ceased menstruation for one year. Women who have had a hysterectomy - that is where their womb has been surgically removed - have premature menopause, and may experience menopause differently. These women were included in the study to allow for comparison. The time elapsed since the last menstruation for the participants ranged from one year to ten years.

The tapes were transcribed directly from Akan into English using the participants' own words as closely as possible. In my analysis of the data, I looked for common themes, language used and other expressions that are relevant to the study. I have grouped these in clusters which form the subsequent chapters of this thesis. The central question in this research is: "How do

Ghanaian-Canadian women understand and interpret their experiences of menopause?

The themes I explored in the interviews include:

- What are their cultural ideas and constructions of the female menopausal body and aging? Do they see menopause as part of the normal developmental process, or as a disease, or health problem?
- How do biomedical and Ghanaian indigenous views of menopause interact?
- In what ways does the medical system influence Ghanaian-Canadian women's views and/ or how do they use the medical system for their benefit?
- How do they perceive femaleness, womanhood, and aging?
- What are the cultural and historical factors which shape women's views on menopause?

I began the interview by asking the women what their experiences of menopause were and what it meant to them. Using the interview guide I asked questions about menstruation and menopause, aging and general health, the use of physicians and the medical system and traditional herbal medicine in Ghana and Canada. (See Appendix 2 for the complete interview schedule).

Ethical procedures were followed in accordance with the Tri-Council guidelines adopted by Lakehead University. Participants were told that the study was being conducted for academic purposes and that they could decline to answer any question they didn't wish to. I introduced myself to them as a student

who was interested in learning about their experiences of menopause and the meaning they make of such experiences. Participation in the study was completely voluntary; as is previously noted participants' consent was sought before the study began. To preserve their anonymity, all of the participants in this study have been given pseudonyms in the text. Appendix 1 (which is included at the end of this thesis) lists respondents' demographic descriptors.

Limitations

This study reflects the experiences of ten Ghanaian-Canadian women resident in Toronto. Because of the small sample size, it is not possible to generalize the results of the study widely. The study was also limited by its time frame. Interviews were conducted during a brief stay in Toronto, between May and August of 2002. Most of the participants were very busy thus I could not schedule face-to-face interviews with some of them. Because of this it was necessary to conduct some of the interviews by telephone. However, I don't think this negatively affected the outcome of the study as the telephone interviews were lengthy and in depth. In addition, I had called some of the participants several times prior to the interviews to schedule an interview and talk with them. Some asked questions about my program of study and my family. This allowed me to build up a rapport with them even though I had not met them in person.

Significance of the Research

The aim of this thesis is to discuss the meaning of menopause for Ghanaian-Canadian women. I explore how Ghanaian-Canadian women

construct their experiences of menopause in their own language and concepts. It is my opinion that, it is important to allow women to give an account of their own experiences. The most significant finding of this study is that while most participants have been in Canada for a very long time, the influence of biomedicine is not considerable in shaping their ideas of health and in their accounts of and responses to menopause. This study contributes to the paradigm of bio-culturalism (as discussed in Chapter Two): which recognizes the interaction of biology and culture in human experiences. Menopause is a natural event that will be experienced by every woman at some point in her life. However, this experience is influenced by cultural and societal expectations. In the same way the meaning a society gives to old age influences its treatment of such a process. This study contributes to a broader socio-cultural understanding of menopause and challenges biomedical assumptions of a universal experience of menopause. Additionally, it will guide health professionals and social workers to develop more ethnically-sensitive health services for minority women.

Plan of the Thesis

The thesis is divided into six chapters. In the next chapter I explore the biomedical and socio-cultural perspectives on menopause in more depth and discuss their implications for the health and status of women. I examine some of the key theories that inform socio-cultural perspectives on menopause.

In Chapter Three, I situate the context of this research. I begin with the geographical, political and social structure of Ghana. I discuss the cultural and religious beliefs of the people of Ghana, and how these shape the socio-cultural

perceptions of women living in Ghana. I describe the Ghanaian community in Toronto, and the circumstances leading to their mass exodus to Canada. I also discuss the immigration and health issues of Ghanaian women and how these influence their experiences of menopause.

Chapters Four and Five are descriptive accounts based on the interview data. I give summaries of the women's accounts of their experiences and the meanings they give to menopause. Some of the main themes highlighted in the narratives include aging, health and power. Others include: how women learned about menopause; issues of gender identity and status at the end of childbearing years; and the significance of fertility in the status of Ghanaian women. To illustrate the thoughts of the women I use quotations from the narratives. I end these chapters with case studies to illustrate key themes coming out of their narratives.

In chapter six, the conclusion, I link the findings of this research together with the arguments in the secondary literature. I reflect on my findings and how they can contribute to questions of theory and methodology in analysing menopausal experiences. I also give suggestions for future research.

CHAPTER TWO

PERSPECTIVES ON MENOPAUSE

In this chapter I take a critical look at the many ways menopause has been described and understood. It is important to understand the historical and social settings that influence women's subjective experiences. The biomedical view of menopause suggests that the menopausal experience is problematic, universal and is the same across cultures. An alternative perspective that is brought forward by social scientists is that the menopausal experience is different across cultures due to factors such as anticipation of changes in women's roles and status and other influences such as culture and biology.

Historical Discourse on Menopause

A French physician, Gardanne, first coined the term "menopause" in 1821, and this came to be the medical term used to describe the period preceding and after the last menstruation (Lock, 1993: 308). Prior to the 19th century, in many parts of the world the menopausal woman was regarded as a wise elder, healer, educator and mediator (Page, 1987: 18). In ancient Greece, women took on a new identity, selfhood and a consciousness at mid-life and these were said to rest in the body as well as the mind. There was no recognized division between the mind and the body. Thus a woman would at menopause be going through the process of seeking the balance and the adjustment necessary for her future roles (Page, 1990: 19).

By the 19th century, the body began to be conceived of as analogous to a factory. Mind and body began to be seen as separate entities. The view of

menopause as a disease which gained prominence at this time can be traced to Freudian theory. In Freudian theory the meaning of a woman's life is based on her ability to bear children. A woman's life becomes empty once she loses her fertility (Kaufert and Lock, 1998). Freud viewed menopause as reinforcing and promoting anxiety neuroses. Helen Deutsch, writing from a Freudian perspective argues that women exist for their reproductive abilities. The disappearance of this ability means the disappearance of a woman's feminine qualities resulting in "her natural end-her partial death" (Kaufert and Lock, 1998: 192).

Nineteenth-century philosophers linked menopausal problems with wealthy life styles. They philosophized that middle class women have more menopausal problems than lower class women, prostitutes and black women because they are more prone to sensitive nervous systems because of their social position (Lock, 1993: 319). This view continued to be expressed even by some renowned feminist writers into the 20th century. For example, Simone de Beauvoir (1971: 575), one of the prominent writers of our time, describing this "dangerous age" surprisingly subscribes to the psychoanalytic and biomedical perceptions of women in mid-life. In describing the "crisis of the "change of life," de Beauvoir, like other writers notes that women who take on "heavy work", such as peasant women, have a relatively good experience of menopause, certainly better than women who have "staked everything on their femininity." She continues that women "feel the fatal touch of death" when they come face to face with the "degeneration" of their bodies and the "irreversible process" of menstruation. She notes the inability of women to try with "pathetic urgency to

turn back the flight of time." She argues that the menopausal woman becomes very dejected and will continue to experience difficulty until death (Beauvoir, 1971: 578).

By the early twentieth century, menopause had been "psychologized", partly due to the work of Sigmund Freud. Middle-aged women were seen as suffering from psychological and mental disorders. Such distresses at menopause were attributed to the decline and/or absence of endocrines. Other explanations given for the causes of physical and psychological disorders include "too much education, attempts at birth control or abortion, undue sexual indulgence, insufficient devotion to husband or children, or the advocacy of women's suffrage" (MacPherson, 1981: 101).

2.1 Biomedical Perspectives on Menopause

The medicalization of menopause began to be consolidated in the 1930s and 1940s with the beginning of research into sex endocrinology (Bell, 1982: 532). Since then research has indicated that many women as well as their physicians have regarded menopause as a deficiency disease which requires medical intervention (Salk, 1984 quoted in Page, 1990: 24; Kaufert, 1986). Kaufert's (Kaufert and Gilbert, 1986) study of 2,500 women in Manitoba found that 20% thought a physician would be helpful during menopause, but less than half reported symptoms to their physicians.

Women's views have been influenced directly or indirectly by the language found in the medical literature. Language is a powerful tool in the transmission of culture. Martin (1987) wrote extensively on the language used in

medical literature to describe women's normative bodily processes such as menstruation, childbirth and menopause. The imagery and metaphor of menopause in medical literature is that of the breakdown of a woman's system. Hence menopause occurs when the

> "ovaries become "*unresponsive*" to stimulation from the gonadotropins, to which they used to respond. As a result the ovaries "*regress*"...As a result of the "*withdrawal*" of estrogen at menopause, the hypothalamus begins to give "*inappropriate orders*" (Martin, 1987: 47).

As this quote indicates, the language of such accounts strongly reinforces the notion of menopause as the decline of a system and suggests the need for intervention and "repair."

Similarly, the World Health Organization (1994) defines menopause as "a time in a woman's life when ... ovaries stop functioning and the production of peptide and steroid falls" (WHO, 1994: 1). In the *International Classification of Diseases*, menopause is listed as an endocrine disease (Freund and McGuire, 1995:197). According to Page (1990: 24), the *Merck Manual of Diagnosis and Therapy* also "listed menopause under "Common Gynaecologic Problems", where menopause is defined as the psychologic cessation of menses as a result of decrease ovarian function.

Other popular materials such as articles and advertisements published in newspapers and paperback books typically portray menopause as a disease. These articles contain rules for management practices during the climacteric. Such representations are also commonly found in medical literature and pharmaceutical advertisement which portray the menopausal woman as depressed, anxious, nervous, and even suicidal. Thus menopause is described

as a time of decline and deterioration of the woman's system, which needs to be repaired (Lock, 1998: 44).

Menopausal Symptoms

A wide range of symptoms constituting the menopausal syndrome can be found in medical literature and research. According to Bantjes (1982) the symptom checklist used in a 1965 study of menopause by Neugatern and Kraines was based on symptoms found in medical literature (Bantjes, 1982: 6). In all they listed twenty-eight symptoms frequently reported to physicians. The symptoms are thought to be somatic, psychosomatic and psychological in nature. This list formed the basis of the Blatt Menopausal Index, "a weighted numerical index based upon the incidence and severity of eleven symptoms found to be highly indicative of menopausal disturbances" (Bantjes, 1982:6).

The somatic symptoms listed include hot flashes, cold sweats, and weight gain, rheumatic pains, and aches in the back, neck and skull. Others are cold hands and feet, numbness, tingling and breast pains, constipation, diarrhea and skin crawls. These symptoms are thought to be the result of hormonal changes in the body, mainly a decrease in hormonal activity. The psychosomatic symptoms include tired feelings, headaches, pounding of heart and blind spots behind the eyes. Psychological symptoms include irritability and nervous breakdown, feeling blue and depressed, forgetfulness, lack of concentration, insomnia, crying spells, feelings of suffocation, worry about the body, and feelings of fright or panic. Others are itching; desire to urinate, urinary inconsistency, irritability, constipation, diarrhea, nausea and vomiting, loss of appetite, resentfulness,

suspicion, erotic fantasies and fear of death (Davis, 1983:16). Other than the cessation of menses, hot flushes and night sweats are the only emblematic menopausal symptoms and they occur in about half of postmenopausal women. They are severe in only a quarter of women, with symptoms subsiding over the next year or two (Anand and Yusif, 2002: 357).

There is considerable disagreement among researchers about the etiology of menopausal complaints. As stated above some researchers are of the view that the withdrawal of hormones in the body is the primary cause of the menopausal syndrome. They argue that the symptoms occur "when evidence of ovarian failure such as atrophic changes of the accessory genital organs are present; and, symptoms are promptly relieved by estrogen therapy" (Davis 1983: 19).

Hormones for All

Due to the medicalization of menopause many consider Hormone Replacement Therapy (HRT) as the logical treatment for menopause. Physicians have been prescribing estrogens for several reasons. Among them are the alleviation of symptoms such as hot flashes, cold sweats and vaginal atrophy, which have been documented as the credible menopausal symptoms (Davis, 1996: 68).

The prescription of various estrogens (with, or without, progestin) has been conventional since the 1970s (Yusuf & Anand, 2002: 357). In the 1970s Hormone Replacement Therapy (HRT) was among the five most prescribed

drugs in the United States (Lock, 1998:42)[1]. In the mid 1970's HRT was linked to some "minor" side effects: endometrial cancer, gall bladder infection and blood clots in the legs (Yusuf & Anand, 2002: 357). There was also some concern that HRT could increase the risk of breast cancer. Its use therefore declined for a short while, as women became concerned about the risks associated with HRT. Then, researchers thought they knew what was missing-progesterone. Progesterone was therefore combined with estrogens to reduce the threat of cancer (Lock, 1998:42; Leysen, 1996:180). But there were still some problems with this therapy since postmenopausal women did not want to continue to menstruate.

Another rationale for the extended use of HRT emerged in the 1980's- preventing the loss of bone tissue and forestalling the possible development of osteoporosis. Women were advised they were at risk of developing hip fractures and falls as they age if adequate measures were not taken to protect themselves. Many clinicians believed that the benefits of taking HRT far outweighed the risk of not taking it (Williams, 1990: 708; Sheehy, 1992: 212; WHO, 1994). Women were therefore called upon to consider the immense benefits of the long-term use of estrogens.

The concept of risk holds individuals responsible for their own health and well being. Women are therefore made to take personal responsibility for their health. Those who fail to take responsibility for any fractures and falls might be

[1] Perhaps to the pharmaceutical companies' dismay, between 10-31% of Canadian women between 1990-95 and 38% of U.S. women in 2002 used HRT. In addition, it had one of highest non-compliance rates (up to 67%) of any prescription: meaning that physicians write out the

described as irresponsible and even lose claims for insurance in jurisdictions where preventive care is given a high priority.

In subsequent years the avoidance of coronary heart disease and cardiovascular disease were added to the list of benefits of using HRT. Hormone Replacement Therapy would save the American government millions of dollars (Williams, 1990: 708; Sheehy, 1992: 212; WHO, 1994). According to Williams (1990: 708), the "annual costs of medical and supportive care far exceed the entire National Institutes of Health research budget and are more than 100 times the amounts being invested on causes, prevention, and treatment of this condition [of hip fractures due to osteoporosis]."

Pharmaceutical companies vigorously advertise and heavily promote the prescription and use of HRT to both medical practitioners and consumers. They have also been actively engaged in funding research which demonstrates links between estrogen deficiency and osteoporosis. Advertisements promoting the use of HRT feature the menopausal woman on HRT as an active, dynamic middle class woman (Lock, 1998: 45). Those not taking hormones are usually depicted as very depressed and dejected. Their obvious message is that positive aging can be attributed to the use of hormone replacement therapy (Leysen, 1996:188). It is portrayed as solving the problems of old age, maintaining one's youthful appearance and maintaining a high level sexual activity.

Contrary to these claims, a recent study by the Women's Health initiative (sponsored by the American National Institute of Health Research) has

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prescription and women either does not bother to fill them or do not take them once filled. There is again a huge gap between the dominant discourse and practice.

established that the risks of HRT far outweigh the benefits. The aim of the study was to address the issue of benefit versus risks of the long term use of HRT. The study involved a total of 160 000 women between the ages of 50 and 79 years. The results of the study show that women using HRT are at a high risk of getting breast cancer, and major cardiovascular diseases such as coronary heart disease, stroke and pulmonary embolism (Yusuf & Anand, 2002: 357). The trials were halted because of an excessive number of breast cancer cases and major cardiovascular disease.

This study is a major victory for all women. It has also brought clarity to the controversy surrounding the use of HRT. HRT does not improve the quality of life of women contrary to popular beliefs. Though it may alleviate hot flashes, only a quarter of women suffer from severe hot flashes (Yusuf & Anand, 2002:358) and these generally don't last for more than a year. Amazingly, the study reported fewer cases of hip fractures (Yusuf & Anand, 2002:358) confirming early speculations that osteoporosis might not be caused by lower levels of estrogens but, rather a decline of calcium and magnesium (Van Wingerdin, 1996: 194). Some alternatives for the prevention of osteoporosis include exercises, adequate intake of calcium and minerals such as vitamin D and abstinence from smoking (Yusuf & Anand, 2002:359; Van Wingerdin, 1996: 194). Questions still remain though of how quickly prevailing protocols on the use of HRT will change, and whether physician prescribing patterns and patient's expectations will change in light of these new findings.

The widespread use of HRT is prevalent in North America and other western countries, but is not universal. While estrogen and psychotherapy are more likely to be prescribed for North American women, Japanese physicians typically prescribe herbal teas and provide counseling on the importance of cultivating hobbies (Kaufert and Lock, 1998: 190). Japanese physicians and their patients do not have much concern with osteoporosis, neither do they subscribe to the notion of the depletion of hormones as necessarily leading to illness. Prescription of estrogen for North American women is heavily influenced by the emphasis placed on youth and the imperative of women maintaining their attractiveness and femininity as they age. Not much is known about estrogen intake in Africa and Asia. Attitudes towards the use of estrogens and hormone replacement therapy are the product of the way a society expects women to behave as they age and society's view of the aging female body.

While the biomedical model dominates the discourse on menopause, not all physicians treat menopause as a disease. Recent reports that the risk of HRT far outweighs its benefits will make many physicians rethink their treatment options (See for example Yusuf and Anand, 2002).

2.2 Socio-Cultural Model

As noted above, anthropologists and sociologists reject the assumption of the universal physiological experiences of menopause. They look to culture to explain the differences in symptom reports in different societies. Anthropological and sociological studies view "culture as an organized system which attributes

meanings to reality, thus giving each natural phenomenon a particular meaning and significance" (Beyene, 1986: 49).

The social constructionist approach to menopause embraces the complexities of women's experience of menopause and focuses on the perception, formation, and expression of symptoms and their relationship to the wider socio-cultural environment (Davis, 1996: 72). Lock compared symptom reporting between two industrialized nations, Japan and North America (1998:48). Only ten percent of Japanese women, in contrast to between 31 and 35 percent of North American women, reported experiencing hot flashes. Among the Japanese sample, fewer than 20 percent reported ever having experienced hot flashes as opposed to nearly 60 percent of North American women. Night sweats were infrequent in Japan (4 %) yet experienced by 20 percent of menopausal women in Manitoba and 12 percent in Massachusetts. The most definitive symptoms (hot flashes and night sweats) in North America, do not apply to Japanese women. Lock argues that symptom reports are culturally constructed and that diagnosis is a social process. The Japanese do not even have a word for hot flashes in their everyday language; they use imagery to describe what is actually happening to them.

Other researchers have described similar findings (Davis, 1983; Freund and McGuire, 1995; Leysen, 1996). They report that symptoms accompanying menopause are not universal but vary across cultures. While in some cultures there is a high incidence of reporting of hot flashes and cold sweats, in others fewer symptoms are reported. Leysen (1996:175) suggests that there is a higher

rate of symptom reporting in most Western and industrialized countries than in developing countries.

Beyene (1989) has used bio-culturalism to explain the differences in symptom reports across cultures. Beyene (1989) conducted a comparative study among rural Greeks and the Mayan Indians of Yucatan Mexico. She notes that the only known physical symptom reported by Mayan Indians is the cessation of menses. However, Greek women reported symptoms of hot flashes and cold sweats. Beyene (1989) attributes the differences between the two groups to diet and fertility patterns. The Mayans have a high incidence of vitamin deficiency and anemia. They have little protein and have low intake of milk. Greek women, on the other hand, have a variety of nutrients in their diet. While Greek women marry later in life, practice birth control and have fewer children, Mayan women have early repeated pregnancies and may reproduce into their middle age. Beyene (1989) theorizes that the different menopausal experiences of Greek women and Mayan Indian women reflect a combination of biological as well as socio-cultural factors.

Still, other researchers have hypothesized that the social status and roles of middle-aged women in a particular society and culture influence women's experience of menopause (Bart, 1969; Flint, 1975; Brown, 1982; Kaiser, 1989; Robinson, 1996). They suggest that a woman's experience of menopause is related to the expectation of an increase or decrease of social status, and social roles.

Changes in Roles and Status

Women's experience of menopause is said to be related to the expectation of an improvement or decrease of social status, social roles, or with an increase in rewards (Bart, 1969; Flint, 1975; Brown, 1982; Kaiser, 1989). Women who anticipate an improvement in status, political power, and psychological well being for reasons such as freedom from menstrual pollution taboos; seniority in the domestic unit; new role opportunities; participation in the male domain of power; greater decision-making authority; respect and responsibility accorded to the elderly; and fulfillment of the social duty to bear and raise children (Bart, 1969; Flint, 1975; Brown, 1982; Kaiser, 1989) are expected to have a positive experience of menopause. In societies where they anticipate the loss of status, political power, lesser decision-making and little recognition of their past contributions in bearing and raising children their experience of menopause may be very negative. For example, in the case of North America and industrialized countries women may suffer depression, anxiety and be miserable during mid-life, due to the greater value placed on youth, attractiveness, and sexuality. The natural process of aging is denied or devalued and aging women face persistent stereotypes that reinforce images of the asexual, depressed middle-aged housewife (Kaiser, 1989). Where women are primarily valued for their procreative abilities, they feel less useful when this ability is lost.

By contrast, women in pre-industrialized and developing countries are thought to welcome the inception of menopause because they gain greater

status at mid-life. In some societies menstruation is viewed as a pollutant and dangerous, resulting in social restrictions in the form of taboos (Robinson, 1996: 455). At menopause women are freed from these restriction and taboos as well as other reproductive burdens. In Islamic countries, women are free from their purdah and can go out without a brother or husband having to accompany them. In some other countries different taboos may be to the advantage of the woman (Bernet, 1988).

Bart (1971) notes that strong ties to the family of origin; an extended family system where the woman continues to be the matriarch and has power and control; strong reciprocal ties between parents and children, such that the mother retains a great deal of power and control; institutionalized mother-in-law roles in which the mother-in-law acquires a new daughter whom she must train; or an emphasis on procreative rather than free sex with subsequent increased value of the maternal role, ensure that women maintain a strong valued status at the time of menopause(Bart, 1971, in Robinson,1996 :455). These factors prevent the loss of the mothering role thus impacting positively on the experience of menopause.

The assumption of these studies is that women in industrialized countries experience greater distress at menopause than women in non-industrialized countries. These assumptions are, however, problematic as Beyene (1986) notes that the findings with respect to role and status are expressions of Western values, which assume that "new roles for women such as participation in male activities" are a mark of status gain. Not all women in industrialized societies

express distress at menopause; nor do they consider male activities superior to female roles. In some cultures women do not necessarily equate status gain to participating in men's activities (Page, 1987: 41).

In her studies of menopause in a fishing village in Newfoundland, Davis (1983: 161) concludes that the high and unchanging status accorded to middle-aged women in Newfoundland does not decrease their negative views about menopause, neither is it associated with the absence of symptoms. Although the women saw menopause as a natural event, they showed a negative attitude towards it. She adds that research on the effect of status on the experience of menopause is not adequately evaluated on the symptom and attitude data (Davis, 1983: 162). Additionally, the women reinterpreted the symptoms accompanying menopause within their distinctive cultural framework in which blood and nerves are key signifiers of women's health status (ibid).

Barnett (1988) calls into question the importance of the presence of enhanced status and role in the experience of menopause. She suggests that women's experiences of menopause are related to satisfaction in their principal life roles (1988:51). She notes that such experiences are not dependent on the presence or absence of status loss or role gains and cannot therefore explain the empty nest syndrome. She argues that women do not suffer because their children are leaving home. Some women are satisfied if they perceive that their children are doing well and not that they are leaving home. This satisfaction varies across cultures. In the western world it may mean "Stacey" being on the moon rather than being a lawyer [preference of a particular career over another].

She goes on to explain that this role satisfaction may not necessarily be a reflection of the woman's status.

Lock (1986), in her study of Japanese women, notes that their attitudes toward menopause are different from that of their North American counterparts. More than half of the Japanese respondents were delighted with their relief from menstruation and fertility. They saw menopause as a process in a woman's life, not just a period before and after the cessation of menstruation. However, others also expressed sadness about concerns of growing old and losing their fertility. Almost a quarter expressed concerns that during menopause "one becomes a man" and "one loses the sacred function as a woman". Women who had difficulty at menopause were seen as having too much time on their hands. She concludes that differences in experiences may be accounted for by variations in class and occupation. While Japanese women were not concerned about working in male domains and women necessarily suffer, many noted that menopause is a threshold of aging and were therefore concerned about it.

In her studies of three immigrant communities in Canada, Spitzer (1998) notes that the meaning of menopause is flexible and dynamic, and that it is dependent upon cultural and personal meanings and life context (Spitzer, 1998: 148). Being in a new environment, migrant women grapple with unemployment, marital difficulties, oppressive gender roles and relations. Migrant women have to make sense of competing meanings and interpretations of menopause. However, these meanings extend far beyond the scope of biomedical definition and often include expectations regarding role change.

Migrant women have found new meaning by creating other identities through extending careers and employment opportunities, increased religious activity and taking part in community activities. As recent migrants, Somali women were still entangled in the immigration process, awaiting visas and approval. This was compounded by the absence of their family members, especially children. However, they found other meanings of menopause through spiritual activity and prayer (Spitzer, 1998: 158). Menopause allowed Somali women to be *dahir* on a continual basis: a state of being clean. They can devote their time to the reading of the Qu'ran and to praying. When menopause was associated with aging, the consequences were desirable. The feeling of "being *dahir* is personal and portable thus women cannot be segregated from this embodied notion of purity in menopause" (Spitzer, 1998: 158). Older women enjoy increased status and are recognized within the Somali community. Husbands are less demanding during this time, and this freedom from sexual activity is very much loved (Spitzer, 1998: 108).

Chilean women found opportunities to create new meanings and kept negative views at bay. They met together with other women to discuss issues that were once kept secret, and they found great joy and meaning in being with their families. They have also engaged in career and employment opportunities thereby pushing back the borders of age. Chinese women confronted the challenges they were facing by taking English as a Second Language classes to bolster their self-image.

Spitzer's findings show that the experience of menopause is not always problematic as is suggested in biomedical terms. Though immigrant women have to contend with existing ideas from the dominant culture, they do not necessarily subscribe to those ideas, instead they may find meaning by creating opportunities for self-fulfillment.

Studies of menopause on immigrant women are, however, still at the foundational stage. Studies on Ghanaian immigrant women are non-existent. This study explores, in particular, the meaning and interpretation of menopause for Ghanaian-Canadian women. As immigrant women in a new environment, what factors influence their experience of menopause?

In the next chapter, I describe the geographical and socio-cultural background of the respondents as a backdrop to the subsequent discussion of Ghanaian-Canadian women's narratives in the following chapters.

CHAPTER THREE

WOMEN IN GHANA

In this chapter, I describe the geographical and the socio-cultural contexts of Ghanaian women's lives. I begin by describing the characteristics of the various Ghanaian ethnic groups, and the economic and religious background of the country. I discuss the socio-cultural landscape of Ghana and its implications for the status of Ghanaian women. I go on to discuss the factors contributing to the immigration of Ghanaians to Canada, the make-up of the Ghanaian community in Toronto and the immigration of Ghanaian women.

The Country

The Republic of Ghana is a small West African country with a surface area of a little over 92,000 square miles. It is bordered to the north by Burkina Faso, Ivory Coast to the west, the Republic of Togo to the east and the Gulf of Guinea, which forms part of the Atlantic Ocean, to the south.

Ghana has a population of about 18 million. Women make up about 51% of the total population (2000 Ghana National Population Census). Ghana is an ethnically-diverse country with over a hundred distinct groups, who are categorized in part by languages spoken. There are five major ethnic groups in Ghana. The Akan, which form about 49.1% of the population, cover the southern half of the country. The Ewe on the easternmost part of the country make-up about 12.7% of the population and the Ga-Adangbe on the Eastern coast form about 8% of the population. The Northern tribes consist of the Mole-

Dagomba, the Gurma and the Grusi and they constitute about 16.5% of the Ghanaian population. Last, but not least, is the Guan, a small tribe on the hills of Akwapim and parts of the Central Region who comprise only 5% of the population (2000 Ghana National Population Census).

The most distinguishing characteristic of the various ethnic groups is kinship arrangement. According to Nukunya (1992), the kinship system prescribes statuses and roles to people, and it also determines the rules, duties and obligations of individuals and groups in all aspect of their lives (NuKunya, 1992: 2). A fundamental feature of the Akan is that they are matrilineal; that is they trace their descent through the female line. Additionally, inheritance and succession is through matrilineal descent. By contrast the Gur, the Ewe, and the Ga/Adangme are patrilineal; that is descent, inheritance and succession are traced through the male line. The inheritance system has changed in recent years due to social change and urbanization, and the introduction of new policies such as PNDC law 111, such that inheritance passes on from a father to a widow and her children. Succession to office, however, is still ascribed through the matri-clan (Nukunya, 1992:157).

The perception of women in Ghana differs depending on which ethnic group they belong to. For instance, male children are preferred where descent is traced through the male line (Amoah, 1990). On the other hand, giving birth to female children who would carry the matri clan is also encouraged. Despite the predominance of matrilineality, male children are mostly preferred over female children in Ghana.

In groups with matrilineal descent women have considerably more autonomy than women from patrilineal descent groups. They have more say in their education and finances, and more status in both the home and the public sphere. In old age, women from matrilineal clans can expect to have more status than women from the patri clan. Women in the matri clan can expect to become head of their lineage and sit in council with the men as will be discussed later.

History

Ghana has been in contact with other countries since the 1400s and was colonized by the British in 1800. Ghana was formally called the Gold Coast until its name was changed when the country established its independence from Britain in 1957. The first Prime Minister, then President of the country, Dr.Kwame Nkrumah helped develop the country into an industrial nation. But this transition was aborted when the country plunged into huge international debt. Disgruntled soldiers overthrew the government in a coup d'etat in 1972. Within 30 years of its independence the country has suffered three coups. The last coup was in 1981 led by Flt. Lieutenant J. J. Rawlings. The country now has a democratically elected government after more than ten years of military rule led by Rawlings and his supporters.

Religion

The power that religion has on women's lives cannot be overemphasized. There are three main religions in Ghana: Christianity, Islam and Indigenous Ghanaian Religion. Christians make up about 69% of the population, with

Moslems making up 15.6% and indigenous Ghanaian religion the remaining 8.5% (2000 Ghana National Population Census, culled from the Ghana Home Page).

Religion has a tremendous impact on the perception of women and determines, to a large extent, the way they are viewed and treated. Women have faced considerable discrimination in general and torture all in the name of religion. Christianity, Islam and traditional religion all have had an impact on the status of women in Ghana. Both Christianity and Islam have used scriptures to subdue women. Christian beliefs underline the secondary importance of women to their husbands, and Islam also promotes this male-female hierarchical dichotomy through its religious practices (Ofei-Aboagye, 1994: 48). Christian and Moslem women might have different experiences and understandings of menopause due to differences in religious beliefs. For example, the status of Moslem women changes at menopause, they can now pray together with the men in the mosque. However, there is no significant change in the status of post-menopausal Christian women.

The Perception of Women in Ghana

In Ghana, as well as other African countries, ideas about women determine how they are perceived and shape society's expectations of them (Avotri, 1997: 43). Some of these ideas are reinforced by religious beliefs and practices. These notions influence the way women are perceived and how they perceive themselves.

The image of the Ghanaian woman is ambivalent. Women are respected for their procreative and nurturing role, which enables them to contribute to the continuity of society (Avotri, 1997: 45). A childless woman is looked upon with pity. Klingshirn (1971) reports that for a young wife, the most difficult time is between the period of her marriage and the birth of her first child. After that everything becomes easier, "for her mother-in-law will see in her not her son's wife, but the mother of her grandchild and for the husband she is the mother of his child and as such was entitled to some respect in the family" (103). An unmarried woman with a child is more honourable and has more respect than a married childless woman.

Nonetheless, women are regarded as the polluters of the sacred (Hacket, 1994: 65). This is because "menstrual blood is considered so dangerous and potent that any direct or indirect contact with it is believed to render all powers impotent and inactive" (Amoah, 1990: 139). A menstruating woman is therefore considered unclean, and so does virtually nothing. Among the duties she is prevented from carrying out is the preparation of meals. And, if she is from a royal family, she is also restricted from entering the stool room[2]. Although some of these taboos have changed in the modern era, there is still some sense of shame and secrecy surrounding menstruation and menstrual blood.

Furthermore, women are generally considered a problematic social category in need of control and supervision (Ampofo 1993: 103). Women have been scapegoated and blamed for the economic and social ills of society. In

Ghana, the military government of the Armed Forces Revolutionary Council (AFRC), which took power in 1979, publicly flogged women and forced them to perform humiliating exercises in public. Their goods were seized and sold at ridiculously low prices and in some instances women who were accused of hoarding goods were raped (Ampofo, 1993: 104). Ampofo explains the philosophy of the government of the day:

> Although the origins of the coup which brought the AFRC to power lay in Ghana's economic crisis and the extreme corruption of the erstwhile SMC [military] government, the causes were perceived to centre around 'moral decay', not the least that of *kalabule* [this is a local term for corruption] women.

Ghanaian women who have been entering neighbouring Ivory Coast have recently come under attack from security forces, journalists and the general public, especially men. This attitude is reflected in their sporadic arrests, beatings and sometimes the raping and killing of prostitutes and "immoral" women in Accra ostensibly to cleanse society (Ampofo, 1993: 104).

There is also some mystery and fear surrounding women especially elderly women in Ghana. Many elderly women are branded witches and blamed for misfortune that happens in the family. An example is the Gambaga camp in northern Ghana. Women in this camp are mostly elderly women who have been accused of witchcraft and therefore driven from their homes. The women at this camp are destitute, without a family and friends. They survive by begging and or with the help of well wishers and Non-Governmental Organizations.

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[2] In Ghana the stool normally called the black stool contains the spirit of the ancestors. These stools are put in a room called the stool room. Libation and other rituals are performed in the stool room from time to time.

The concept of witchcraft in Ghana is an important one. Witches are persons, male or female, who are believed to possess inherent supernatural powers which they use, knowingly or unknowingly, to harm others or benefit themselves (Nukunya, 1992: 58). Practising witchcraft means using this evil to harm others (Klingshirn, 1971: 269). It may be inherited from a family member, for example, passed down from a grandmother to her granddaughter. A person may receive the evil spirit through food, or have it breathed into him, or the evil spirit may be put into a gift like money or jewellery (Klingshirn, 1971: 269).

Persons labelled witches are most often women even though children may also have these evil spirits (Klingshirn, 1971: 269). People with disabilities such as lepers, or those with protruding teeth, the poor or destitute, and older women are generally thought to be witches. Klingshirn (1971: 273) explained that women are frequently accused of witchcraft because of their social situation. In a traditional marriage, a woman's function is to bear and raise children. Where this function cannot be fulfilled because of infertility, a husband may choose a new, younger wife. There is therefore some tension between the two wives. If this happens, the younger woman may blame the older one for all of her misfortunes.

Witchcraft accusations are motivated by jealousy, hatred and envy, as well as fear. They are also caused by the necessity to account for unexpected or undeserved misfortune where it is not recognised that such a misfortune can happen by chance, or through natural causes (Nukunya, 1992: 58). Witchcraft is blamed for all types of illnesses, failure of children, miscarriages, unexpected deaths, failure of a business venture, bad crop, poor grades in school, a lorry

running into a ditch, loss of affection of one's partner, or any other misfortune that may befall a person (Klingshirn, 1971: 270). Basically, within Ghanaian culture a witch is blamed for anything that cannot be explained through other obvious reasons, or any strange thing that happens. It is interesting to note that even educated persons, and those who are Christians and Moslems, continue to believe in witchcraft.

Some older women in Ghana therefore would tend to blame witches for their distress at menopause if they do not understand what is happening to them as some of the accounts in this study show. My informants reported that in their moment of distress, their mothers blamed it on witchcraft because they could not explain what was happening to them. On the other hand, women who complain a lot during menopause can be branded witches as has happened in Gambaga.

Underlying Ghanaian traditional customs and practices is a strong gender dichotomy. The idea of male superiority and female inferiority is instilled into the psyches of boys and girls from birth onwards. These ideas and notions are reinforced by cultural beliefs and practices. During puberty rites, girls are taught the art of charming men. They are also taught to be submissive to their husbands (Amoah, 1990: 137-138). For example young brides are taught never, under any circumstances, to refuse their husband's sexual advances and also to consult them before they take any decision. Fertility and procreation are also stressed during these rites. Many of the symbols used in the rituals reinforce the importance attached to fertility and procreation (Amoah, 1990: 136). Infertility is considered to be one of the greatest misfortunes or calamities that can happen to

a woman. Infertility makes a woman no longer female, but androgynous. To be able to produce children is synonymous with being a woman. As such, a "barren" woman is considered an outcast and often ridiculed by society (Amoah, 1990: 142). This is so for women whether they are from a patrilineal or a matrilineal family tradition. Infertile women can adopt babies[3], but this cannot be used as a means to circumvent stigmatization of childless couple. Many women bring up or even adopt children of other family members as their own, but this is not enough for them to escape stigmatization.

Marriage gives a husband exclusive rights and claims over the woman's sexual and domestic services. The woman, by contrast, does not enjoy the same rights over the husband (Oppong, 1974; Avotri, 1997; Klingshirn, 1971: 93). In return for these rights a man has to show responsibility towards his wife and children; he has to look after their material well being including the provision of clothing, housing and food (Klingshirn, 1971: 93). It is unimaginable for a married woman to refuse sexual relations with her husband. Refusal of sexual relations with one's husband can lead to divorce and in some cases rape and sexual assault by the husband (Ampofo, 1993: 107-108). With marriage, the woman obviously loses control over her sexuality. These beliefs underlie most violent behaviours against women in Ghana.

One of the techniques of controlling women's sexuality is female genital mutilation. Although the current government has taken steps to abolish it, it is still practised by some ethnic groups in Ghana (Osei, 1998 quoted in Ardayfio-

[3] This is normally informal adoption, that is someone bringing another's person's child up, perhaps a friend or relative; adopting children from adoption agencies and social

Schandorf, 1990:403). The ideological assumption underpinning this practice is that women are sexually passive and are not supposed to express their desire or enjoy sex. The aim of female genital mutilation is to remove the latent sexuality among girls and to ensure that they remain virgins until they marry. Since women's genitalia are considered unclean it is viewed as purification rite[4] (Avotri, 1997: 48; Dolphyne, 1991: 34-40).

Work

In Ghana, the status and roles of women are socially, culturally and politically defined. Traditionally, work is based on a clear-cut division of labour along gender lines. Women are responsible for the maintenance of the home, raising and caring for children, and looking after their husbands and various members of the family including disabled and aging relatives. The woman is expected to be up and doing all of the household work. Failure to do this is seen as a sign of laziness and rebellion. Familial obligations consume much of the time and energy of women, leaving only a few hours for income generating activities (Ardayfio-Schandorf, 1993).

Most Ghanaian women are self-employed or work in family businesses such as agriculture, agro-based industries and trade (Manuh, 1994; 62). Women's participation in the formal labor force has increased over the years with greater opportunities in education for girls. Most are employed in the lower echelons of the labor force as nurses, teachers, and sales workers (ibid). Very

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service agencies is not very common in Ghana.

[4] I am aware that there is some debate about this. See for example Boddy's work on Sudan.

few women are employed in administrative and managerial work (Nikio, 1990:143). Women have traditionally dominated petty trading and other trade activities. Women's reproductive role and the sexual division of labor all constrain their productive activity and their health.

Education

The Education Act of 1961 made basic education compulsory for all children of school-going age[5]. One important promise of this campaign was the free textbook scheme. This practice came to an end when the government was overthrown in a coup in 1966. Enrolment in primary schools declined drastically especially for females (Ofei-Aboagye, 1994: 49). The law of compulsory basic education was resurrected again in the 1990's with the introduction of Free Compulsory Basic Education (FCUBE) for all children. The enrolment of females in schools is increasing, but the numbers are still small. The number of women who go on to higher education is very minimal. For example, on average girls comprised only 25% of students in all forms of higher education during 1970-75 (Ofei-Aboagye, 1994: 49). These numbers have increased slightly over the years. Still it is not uncommon in the event of limited resources for a male child to be sent to school instead of a female child.

The importance of education in a woman's life cannot be overemphasized. Higher education will certainly increase the status of women in Ghana. With increased education, women will be equipped for better jobs, thereby achieving financial security and in this manner supporting themselves. Education also plays

a major role in women's health status and health-seeking behavior. Women's health-seeking behavior to a large extent will determine how they will manage their menopausal bodies. In the next section, I explore health and healing in Ghana and the health-seeking behaviors of Ghanaian women in particular.

Women, Health and Healing in Ghana

Traditional medicine in Ghana was a blend of religion combined with physical treatment. Traditional healers in Ghana include:

> herbalists, who use mainly herbs in their healing practices, cult leaders, who deal with witchcraft and disasters in social living pertaining to their followers, fetish priests, who combine herbs, divination, possession and the calling of deity in healing and the leaders of syncretic churches who use prayers and other religious ritualization in healing their members (Twumasi, 1979: 349).

A herbalist will usually have sound knowledge of the healing qualities of herbs, which has been handed down to him through generations, or which he or she has acquired during his training at a shrine (Klinshirn, 1971: 254). The healers use simple instruments, they set broken bones, bandage wounds, and they give stimulants and sedatives (Twumasi, 1979: 349).

Due to acculturation and western influence, today health and healing in Ghana combines western and traditional methods of healing (Twumasi, 1979). The British built the first hospital - Korle Bu teaching hospital - in 1921. Like many developing countries, Ghana's health services are greatly inadequate. It is estimated that only 45% of the rural population has access to health services (Oxfam, 2002). In Ghana about 75% of the population lives in rural areas.

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[5] The orientation of Kwame Nkrumah's government was to make education and other social

Women are largely responsible for the health of their family members. They take them to hospital and then nurse them back to health. Women however do not get such services from other family members or their husbands when they are ill.

Research on Ghanaian women's health has traditionally focused on their reproductive health, which mostly defines them as wives and mothers. Recent work however has been able to capture Ghanaian women's health from another point of view. Psychosocial health problems such as "thinking too much" and "worrying too much" which result in headaches and insomnia were the major health problems reported by women (Avotri & Walters, 1999:1124).

Avotri and Walters (1999) observed that the health of women is influenced by their social and cultural conditions. Talking about their health the women emphasized their roles and social relationships. In addition to all their familial chores, the number of households headed by women is increasing steadily. This means that they have to constantly engage in various income-generating activities in order to take care of their children. This results in "their thinking" and "worrying too much" (Avotri, 1997), yet women's problems most of the time have been viewed in isolation from their life experiences.

The perceived cause of illness plays a major role in seeking treatment (Ofori-Atta & Linden, 1995). Women's health seeking behavior is normally dependent on the social structural as well as demographic factors, the availability of social network and social support system, beliefs, attitudinal and institutional factors (Fosu, 1995). Fosu (1995) analyzed the health-seeking behavior of

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amenities accessible to all Ghanaians after independence from Britain in 1957.

women for mental illness. He found that the belief system of women played a very significant role in seeking help for mental and physical ailments. Women are more likely to seek the help of traditional healers and herbalists if they perceive the cause of the ailment to be spiritual. In rural Ghana the perceived cause of disease plays a critical role in health-seeking behavior. Other factors which aid health-seeking behavior of women are their previous contact with medical institutions, and their health status.

Purchasing of drugs from drug peddlers, drug stores and herbal peddlers is very common among Ghanaians (Abdul-Hamid, H.; Accra City Health Project; 2001). Women are likely to purchase drugs from drug stores and pharmacies when they show signs of sickness and would only go to the hospital when there is no improvement. Other factors which may deter women from seeking professional help are attitudinal and institutional factors and poverty. Most women are poor and cannot therefore afford to seek professional help.

As my research study took place in Toronto, in the next section, I will take a look at the Ghanaian community in Toronto, the factors that contributed to their migration to Canada, their settlement and the migration pattern of Ghanaian women.

The Immigration of Ghanaians to Canada

Under The 1953 Canadian Immigration Act, national origin was the requirement of acceptability for immigrants. This favoured immigrants from France and Great Britain, Northern and Western Europe and the United States. This was altered in 1967, when family reunion and labour skills were given

priority. Amendments to the immigration act in 1978 added refugee status as a criterion for admission (Boyd, 1986: 46). These changes to the immigration act facilitated the arrival of immigrants from non-European countries: the Middle East, Asia, Africa and South America (Boyd, 1986: 46). The African groups of more recent vintage have arrived in smaller numbers compared to the Chinese and the Vietnamese (Opoku-Dapaah, 1993).

The influx of Ghanaians to Canada is a recent phenomenon. Traditionally, Ghanaians have migrated to other neighbouring West African countries such as Nigeria, the Ivory Coast, Togo and other parts of Africa. These countries were chosen for reasons of proximity, cost and ease of entry. Lack of adequate settlement possibilities led many Ghanaians to flee to Europe. However, the acceptance of refugees and asylum seekers in Europe was not encouraging as many countries adopted tough measures and tightened their immigration laws to discourage new claimants. The stringent measures adopted by these countries forced many Ghanaians to look to North America especially Canada as a migration destination (Opoku- Dapaah, 1993: 18).

The Ghanaian community in Toronto is composed primarily of recent migrants. Most migrated to Canada in the late 1970s and the early 1980s. Initially, Ghanaians arrived in Canada as refugees and not as migrants. Between 1981 and 1985, about 8,000 Ghanaians arrived in Canada and settled in the Toronto area. Of those who settled in Toronto, 78% were Akan, 15% were Ga and 2% were Ewe (Opoku-Dapaah, 1993). Today the Ghanaian community in Toronto is the largest African immigrant community in Toronto. The major force

behind their unprecedented mass departure was a combination of repression, and ceaseless harassment and intimidation by Ghana's regime at the time, the Provincial National Defence Committee (PNDC) (Opoku-Dapaah, 1993:16).

In December1981, the PNDC led by Flight Lieutenant Jerry John Rawlings seized power from the elected government of Dr. Hilla Limman. The new regime suspended the constitution and ruled through decrees. Public tribunals were set up to replace the courts and many government agencies were also suspended. There was no guarantee of freedom or rights (Opoku-Dapaah, 1993: 16).

The PNDC launched a reign of terror by crushing alleged coup plotters and conspirators. In 1982 it ushered the country into a new revolutionary era. In the early days of the regime citizens were mobilized into revolutionary organs such as People's Defence Committee (PDC), Workers' Defence Committee (WDC), Peoples' Militia, Mobilization Squads and Task Force (ibid). These committees acted as agents of political communication and informants of anti-revolutionary activities ibid)[6]. The tyrannical regime of the PNDC contributed to the flight of Ghanaians abroad.

The economic policies of the PNDC had a tremendous impact on the life of Ghanaians. The PNDC assumed power in a country where the economy was very poor due to corruption and years of mismanagement. The government instituted an Economic Recovery Program (ERP) under the auspices of the World Bank and the IMF. The condition reached under this agreement was the devaluation of the Cedi and the lay-offs or redeployment of workers. In just under

[6] The PDC's, WDC's, People's Militia and the Mobilization Squads and Task Force were all supported by the PNDC government, so that it was disastrous for anyone not to obey them.

18 months the local currency was devalued by 5.5%. This brought untold hardship on Ghanaians.

Workers' Unions, university students, professional bodies, teachers and traders rejected the hard economic policies of the government. The government reacted fiercely to its critics by imprisonment and military terrorization forcing them to seek refuge elsewhere. The PNDC began a reign of terror in Ghana with continuous attacks on property owners, merchants, industrialists, investors and traditional nobles. The Citizens Vetting Committee was established in 1982 to try people suspected of profiteering, corruption, evading of tax and hoarding (Opoku-Dapaah, 1993: 17). Women did not escape the terrors of the PNDC rule. Many women were stripped naked and beaten in public for hoarding goods. Makola, the heart of Ghanaian trading, was burned down and much of its merchandise destroyed by fire. Under the PNDC law 4, the Preventive Custody Law, people who were thought to have engaged in activities not in the interest of national security were arrested and detained indefinitely. The press too was stifled under oppressive laws so that they could not report anything negative about the government. The intimidation, frequent arrest and detention of many people, coupled with the precarious economic situation in Ghana, between 1981 and 1991, forced many Ghanaians to flee the country.

Between 1985 to 1991, about 7,464 Ghanaians claimed refugee status in Canada and settled in the Toronto area (Opoku-Dapaah, 1993). More than15% own their homes, and the remainder live in rental housing and apartment complexes. The settlement of Ghanaians in Etobicoke residential areas was due

to its proximity to Toronto's industrial district where most of them worked. Rental costs were another factor that influenced the choice of relocation. Most Ghanaians live in shared accommodation (Opoku-Dapaah, 1993: 34).

The Ghanaian community in Toronto is a well-established community. Most people belong to one or more ethnic associations. These ethnic associations are groups formed by people of the same ethno-cultural background. These associations serve as family for new immigrants and also as a support network in times of trouble. They also emphasize pluralistic values in ceremonies and cultural display.

Religion is also a very important feature of Ghanaian-Canadians life. There are many churches in Toronto with a parent church in Ghana. People who go to the same church in Ghana start to meet and get other followers. They then invite the founder, or the senior pastor, of that church in Ghana to come for a meeting or a conference. The church in Toronto then becomes a branch of the parent church in Ghana. The method used in their services is almost the same as that used in Ghana, that is: clapping, dancing, drumming and singing. Some of the churches use the Ghanaian local language in their services. Women make up more than 60% of the members in these churches.

Most of the Ghanaians in Toronto have at least a high school diploma. Despite the higher education of these refugees, many of them are under-employed. In a survey of Ghanaian immigrants in Toronto in 1993, many of the Ghanaian refugees worked in factories and as taxi drivers and couriers (Opoku-Dapaah, 1993; 8). The result of this under-employment was the development of

petty traders in the Ghanaian community. This is very crucial for self-employment and the development of small businesses, which form part of the Ghanaian community (ibid). It is not uncommon to find Ghanaian grocery shops, beauty shops, financial institutions, private medical practitioners and law firms in Toronto. Despite these modest achievements of the Ghanaian community in Toronto, many of the women still work in factories and are under-employed or unemployed.

Ghanaian Women and Immigration

The migration experience of Ghanaian women has been largely ignored in research. Women are more often than not deemed to migrate primarily to join their husbands (Boyd, 1986; Spitzer, 1998; Brydon, 1992). Most of the studies on migration in Ghana (and West Africa) have been concerned with the migration of men (Caldwell, 1969). In the early part of the century, population movement in Ghana was largely from rural area to rural area where men moved to work on cocoa farms or as caretakers (Brydon, 1992). When women moved, it was either to join their husbands, or to be married off to a suitor in a nearby village. Those who moved to urban locations went to work in the lower echelons of the colonial government sector in various capacities such as domestic workers and office administrators (ibid).

The earliest study of Ghanaian women as international migrants was the work of Niara Surdarkasa (1977) and was mostly drawn from the 1960 Ghana census. Surdarkasa suggests that women moved largely in relation to marriage,

either to accompany, or to join their husbands. Anarfi's (1990) work on Ghanaian women's migration to Abidjan, the capital of Ivory Coast, gives a clear indication that economic motives play a very strong role in women's international migration. In similar work among the returnees to Ghana, (that is women who had returned to Ghana from Nigeria in the early 1980's when the government of that country expelled all illegal immigrants most of whom were Ghanaians), Brydon (1992) indicates that most women had left Ghana for economic reasons. The women she interviewed had gone to Lagos alone, sometimes without knowing anybody there. They stressed that good work and decent remuneration were not available in Ghana, so they had traveled to Nigeria and other neighboring countries where they found good jobs and reasonable pay. Some of the women in Brydon's sample had at least elementary school education. However most of the women were traders and others worked in the lower ranks of the public sector. Men far outnumbered women at the time of the influx of Ghanaian refugees to Canada (Opoku-Dapaah, 1993). Reasons for this disparity are not known. However the ratio of Ghanaian women to men now is similar.

In this chapter, I have described the geographical and the socio-cultural characteristics of Ghana. I have also described the cultural and religious beliefs of the Ghanaian people and women's place within it. Generally, the beliefs and practices of the Ghanaian people reinforce strong gender dichotomies. Women in Ghana have relatively low status in their younger years. This lack of status is compensated for, as they get older, for in old age, elderly women's status equals that of men. Ghanaian women generally have low education and lower paid jobs.

They are responsible for the health needs of their families. Their health-seeking behavior is influenced by the perceived cause of illness. The most common self-perceived illnesses affecting Ghanaian women are psychosocial in nature, such as "worrying too much" and "thinking too much", emanating from the social and material conditions of their lives.

This chapter has provided a background context for the subsequent chapter in which I summarize key narratives from my interviews with Ghanaian-Canadian women.

CHAPTER FOUR

WOMEN'S EXPERIENCES OF MENOPAUSE

This chapter is descriptive in nature. I present the summaries of the interviews and give detailed accounts from the respondents which illustrate key themes arising from of the interviews. Ghanaian-Canadian women's views of menopause fall into two categories; a vast majority of the women view menopause as a normal event, with a few regarding it as an iilness. Their perspectives varied according to whether the participant had natural menopause or hysterectomy, participant's age, education, medical history and life experience. While some of the participants accepted the medical model of menopause, there was resistance to this model from several of the women. I end this chapter with illustrative life stories from two of the women, which include a brief biographical description, their experiences of menarche and menopause and how they make sense of it.

Menarche: An Introduction to Shame

As menopause signified the end of menstruation, participants' experiences of menstruation and what it meant to them were also discussed. Women's attitudes and experiences of menstruation, as well as their interpretation, formed the basis of their interpretation of menopause in later years. Menstruation was imbued with many meanings for the women. For some it was overlaid by secrecy and shame, yet for others it meant achieving normalcy and was an important marker of the transition to womanhood.

Menstruation was something that was rarely discussed between mothers and children. Only a few of the participants in this study learned about menstruation from their parents. When asked if her mother discussed menstruation with her before she went through it, Araba said:

Yes, my mother told me about it. She sat me down and told me... (Araba)

Kukua learned about it at school in her hygiene class but not from her mother.

> At that time we learned during Gold Coast Hygiene [Ghana used to be called the Gold Coast] all about menstruation. So we talked about it with our friends but never with our mothers or other persons. (Kukua)

Most of the women thought menstruation was something that was secret and shameful. Several of them did not inform their parents when they had their first menstrual period. When asked why most said that they were shy to tell their parents.

Mansa sums up the thoughts of several of the participants:

> Eih...it is shameful. You see that in Ghana we don't talk with our mothers about these things. So when something like that happens, you're afraid to tell them (Mansa)

Pokua also felt it was a shameful thing:

Even in Ghana you feel so much ashamed you don't tell anybody. (Pokua)

Those who reported that they told their mothers about their first menarche said they were shy and ashamed when they were telling their mothers. Menstruation was hidden from both parents: mothers and fathers were both equally avoided. When asked if they knew why it was shameful and kept a secret, some said they had no idea. Others said their parents would worry about them getting pregnant and might restrict their activities. Mansa notes:

> Because we have heard that when you menstruate and you sleep with a man you'll get pregnant. You're afraid to tell your mother that you've menstruated; she will prevent you from going out. So you don't tell your mother so that you are not prevented from going out. If there's a concert in town you will not be allowed, because they know that when you go something bad will happen. Maybe as a child you're not thinking about those things. (Mansa)

Fosua told of an embarrassing experience when she reached puberty:

> One day I was standing and chatting with a guy when my father came from nowhere and slapped this guy. He warned him never to talk to me again and he took me in his car and drove me home (Fosua).

Since these women felt ashamed and embarrassed to let their parents know about their first menarche, they tried to hide it. Only a few of the participants in this study reported their first menstruation to their mothers. Some told their friends while others tried to manage it themselves. Here is what some of the participants had to say:

Nyame:

> What I remember was that we were six girls, we were in Kumasi, we were babysitters for some whites [expatriates]. We were staying with the whites. In the evenings while they meet at the clubhouse...we also gather somewhere with the kids playing with them. I was there when I felt something warm coming out of me. So I went to look and I realized that it was blood. So I called one of my friends and told her...eih Adwoa, this is what I've seen. So she said...the elders say it is menstruation maybe that was it. I didn't tell anybody apart from my friend. So the older girls who have reached that stage taught me what to do. (Nyame).

Others who lived in big households learned it from older girls in the family. They therefore did what they had seen the older girls do when they got their menses.

> When you're going to urinate you'll see that there is something in your pants. You'll realize that the moment has finally arrived. So I didn't tell anybody and controlled it myself. So I realized that what the older girls in the house were doing-sending you to go and buy a toilet paper and pads

were all about-so when the time came and I saw the sign I controlled my thing. I didn't tell anybody (Mansa).

Frema also reported being scared when she had her first menses because she didn't know what it was.

> I remember I was sixteen years. I got up one morning and saw blood in my panties. So I run to my stepmothers' room and told her that blood was coming out of me. She told me it was nothing, that I have reached "mmaa mu" [womanhood]. (Frema)

As much as these women tried to hide their menarche from their mothers, they were eventually exposed. Their mothers eventually found out that they had reached puberty.

Aba said:

> If you live with your mother in the same house, she'll eventually find out. They always watch our movements. So my mother confronted me about it and I told her the truth. (Aba)

What the women recognized when they reached menarche was that they had reached womanhood. They had made the transition from childhood to adulthood. These women were not certain how to assume the responsibility of adulthood, and therefore tried to hide it. Puberty rites were performed for several of the women, though not publicly. Only one participant reported having a public puberty rite. The others reported that their "mouths were touched" [ano nka][7]. The rite consists of feeding a mashed yam with palm oil and eggs to the "young women". This rite is the same in all instances-both public and otherwise. Serwaa told of her experience as a neophyte:

[7] Normally, in Ghana puberty rites consist of outdooring girls in public when they reach puberty rites. Some parents may choose to not outdoor their girls, but will give them the ceremonial food which consist of mashed yams with palm oil and eggs called "nka ano", which means touching of mouth.

> They [mother and aunties] sat me on a stool and gave me mashed yam with palm oil and eggs. They told me to swallow the eggs without chewing it or scratching it. They said that if I chew the eggs, I wouldn't have any children. So I swallowed the eggs...they said if you chew the eggs it means you're chewing your children. (Serwaa)

In all cases it was explained to the women that they had reached "mmaa mu" literally meaning they have now entered the midst of women.

Araba's mother says to her:

> Right now you have become a woman, [obaa]...if you hadn't menstruated you are not yet a woman, you can get pregnant...you can give birth. If you go and take a man right now you can get pregnant. Once you have your period, you are a woman...no matter what age you are, you can get pregnant. So you must take care of your self at school...you must take care of yourself... (Araba)

Nyame was also told that she had entered womanhood:

> They told me that, "now you have entered "maamu" [reached womanhood], we are outdooring[8] your "bra" [menstruation]. If you play with boys, you can become pregnant. (Nyame).

When asked whether their status changed as young girls, the women responded negatively. Although they might not recognize any status change when they reached puberty, the women reported that they were under the constant watchful eyes of their parents (see Fosua's account above). They were introduced to the normalcy of having children and a family: hence the warning to swallow the eggs and not chew or scratch them.

The term for menstruation in the Akan language is "bra" meaning "life", or "mfikyere ko" meaning "go to the back of the house". However there is no cultural rite in Ghana to mark the menopause or to usher women into the next stage of

life. At puberty, fertility is glorified and infertility is frowned upon. As young women, they were introduced to the notion that the role of a woman is to bear and raise children. It is always viewed a shame when a woman fails to fulfill this role. Consequently, the end of menstruation meant that their role of child bearing and child raising had come to an end. Interestingly, several of the women in this study were not unhappy that this role had ended. Moreover, since the women thought menstruation was something that was secret and shameful, they were delighted that they had emerged from the concealment and embarrassment that surrounded their lives as women.

Determining Whether Menopause has Begun

Since menopause is defined as passing twelve months without menses, the experience of menopause can only be known retrospectively. I asked the participants how they recognized they were going through menopause or had gone through it. Looking back, several of the women noted that at the beginning they did not know what was happening to them. When asked how she knew she was going through menopause, Frema said:

> I had no clue... honestly...I had no clue. I don't think I even picked up a paper to read. I had no clue. (Frema)

Many did not know that they were beginning menopause. The majority expressed the fear of being sick with a strange disease, while others thought they might be pregnant. Since these women had no idea what was happening to them, they suspected something terrible and some consulted their family

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[8] The significance of the outdooring ceremony is to announce to the community that the girl has

members for help. Mansa and Aba suspected that they were sick and called their sisters:

Mansa:

> I had a sister in Europe... so I called her, and told her my problem...I took it so serious that something strange was happening to my body...my mind was on something else...so she said it was nothing...so she said "go to your doctor and tell him what you are telling me now". (Mansa)

Aba also thought that she was sick and consulted her sister:

> I was in Ghana in 1996. I was having some fever. I thought it was the change of weather. My sister was a nurse at the Central Hospital, and her husband was a pharmacist...so I went to them. (Aba)

Serwaa also thought that she was pregnant and consulted her doctor:

> I thought I was pregnant, but it was not pregnancy. So when the doctor said that it was" it" [menopause] I believed it. (Serwaa)

For others, the realization that menopause had begun came from observed bodily changes. Irregular menstrual cycles also provided a clue as to whether menopause had begun. Kukua says,

> I had a reduction in my monthly periods. It came and went away for six months and then stopped. I also had periods of hot flashes. I then knew that I had reached menopause. (Kukua)

Araba knew when:

> The periods stopped for two months...three months... and the flow started again...then you know, a couple of months it starts deteriorating...then I didn't know if it was two months or three months...(Araba)

Those who were no longer menstruating because they had had a hysterectomy knew they were going through menopause by the physiological changes that took place. Pokua describes how she knew:

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now moved from childhood to womanhood.

> After my womb was removed, I began to experience severe hot flashes. I went to see my doctor and he told me I was going through menopause. (Pokua).

Since the stage at which menopause begins is not precise, some of the participants were not certain if menopause had really begun. Araba asserts that although she knew that menopause begins between the age of forty-five and fifty she was not sure when hers started. Oforiwaa was also not sure when she had entered menopause. She had this to say:

> First I didn't have my periods for three months. So I thought...oh...after my first-born was born, I didn't have my periods for three months. In fact all of them (children)...I didn't take any birth control. It was seven years. I wasn't doing any family planning before my third. The fourth one too was three years. I was thirty-two years then. So when I started menopause, I said...wow...Old lady pregnant...? (Oforiwaa)

When I asked the participants how they definitely knew they were going through menopause, the majority of them said that a visit to the doctors' office made them aware of it. This is what Oforiwaa who was a nurse by then and knew about menopause had to say:

> ...But still I went to see my doctor for advice. He explained the whole thing to me, which I already knew. (Oforiwaa)

Araba also visited her doctor:

> ...It just came at a time when I didn't have my period for a month and two months...it was going on. When I went to see my gynecologist that is when it dawned on me that this is what I was going through. (Araba)

Frema also knew about menopause only after a visit to her doctor.

> It was after I saw my doctor that I knew I was going through menopause. (Frema)

The power of the medical model is evident in the participants' knowledge of menopause. For most of the participants a physician's opinion was the definitive authority on whether menopause had commenced. However, a few others relied on their own understanding of their bodily processes such as changes in menstrual cycle and physiological change, while a few others drew on the experience of other family members.

Learning about Menopause

One of the observations of this study is that the majority of women interviewed had little knowledge about their body processes such as menopause. I asked the women whether they were familiar with menopause before they experienced it. Most of them were not. The two women who had knowledge about it had learned about it as part of their profession (as nurses and counselors). Oforiwaa who is a retired nurse had this to say:

> You see I am a nurse so I knew about these things. I would have women come to me and say to me, "this and this and that" and I will tell them that it is not a sickness but menopause" (Oforiwaa).

Araba, who is a counselor, learned about menopause in the context of her employment and she also did some research on her own.

> I had enough information about it, and I read about it, and I had clients that had gone through it. I kind of expected such a thing, and I knew such things were going to be happening... (Araba)

Some also learned about it by watching women's shows on television, such as the Oprah Winfrey show. Others picked up information on menopause through brochures and magazines which they read in clinics. What was most evident is that none of the participants had learned about menopause from the

experiences of other family members[9]. The general consensus was that their mothers did not know anything about menopause and so they never talked about it. Frema sums up the views of the other participants like this:

> Our mothers didn't talk about it... they thought it was witchcraft. My grandmother and mother didn't say anything about it. (Frema)

It was only after participants had gone through menopause themselves that they realized that their mothers must have gone through similar experiences.

> My own experience of what was happening to me made me aware that the same thing happened had to my mother... when she was suffering. For them... everything is blamed on the witch. It was later that I realized that she was going through the same thing. (Mansa)

Pokua also did not know about her mother's experience until later:

> Yea...my mother was like this...sometimes when we are in the room, she'll be sweating, but I didn't know what it was. It was later when I came here, that I heard about menopause. I also heard it from the news. (Pokua)

Additionally none of the women reported learning about menopause from their friends. It was something they never talked about or discussed. When this study began some of the participants began to talk with their friends about it.

Kukua says:

> We never talked about it with our mates. It's something you don't discuss with your friends. People think it is their private lives and not anybody's business. It was only when Effe called me to ask if I could do it (take part in the study) that we talked about it. (Kukua)

Serwaa remarks:

> The other day I talked to you, I told my friend that you wanted to talk to me about menopause. And she said that she had the same problems. (Serwaa).

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[9] It is interesting but not uncommon, that mothers do not discuss menopause with their children. Suggs' study in Botswana and the older Somali Women in Sptizer's study talked only about menopause with age mates.

Women were more likely to talk about menopause with their sisters and cousins than with friends. Some of the participants reported discussing menopause with sisters who had already gone through the experience or who are now going through it and needed information. Mansa called her sister in Europe to talk to her about what was happening to her, and Aba also talked to her sister who was a nurse while she was in Ghana. (See above quotations). Pokua also had her twin sister and elder sister call her from Ghana to ask her what was happening to them.

> My twin sister, she has called me. She says her bones are weak...she has swollen breasts. So I told her what was happening to me. I told her it was menopause. (Pokua)

In order to understand what was going on and also to make their own decisions, some of the women in this study got more information on their own. Frema did her own research on menopause:

> Then...I started reading about it, got some books from the library, and did my own research. (Frema)

Pokua read some pamphlets that were given to her at church:

> We were given some pamphlets at church. It was then that I realized I was going through. (Pokua)

Araba also read some more about the subject even though she already had some knowledge on menopause.

> I read a lot and got a lot of pamphlets, women's pamphlets-you'll get it from the hospital. The doctor also gave me lots of materials to read, to know what is available. (Araba)

In Ghana, issues of a sexual nature are not a subject for discussion; thus, it is not common for parents to discuss them with their children. Sex and reproduction are cloaked in secrecy. It is not surprising that menopause is rarely discussed or talked about with family and friends. Just as menstruation was barely discussed between parents and daughters, menopause is also a taboo subject. One reason menopause is not discussed with family members, especially mothers, is the secrecy and shame surrounding menstrual blood as noted above.

While the older generation has the tendency to accept what their doctors tell them, the younger generation is more apt to seek information about what was happening to them. Some of the participants were unconcerned and did not go looking for information; however, several others took the initiative to seek their own information in an attempt to understand what they were going through. This difference in approaches reflects age at which menstruation stopped, level of educational status, and in some instances indifference. The older women in this study who spent most of their lives in Ghana explained that it is only the doctor who has knowledge about the body. They therefore accept whatever the doctor tells them. Some of the more educated participants made an effort to get more information about menopause, while others did not.

Several of the women acknowledged that there is a lack of information available to women and indicated that women would be better off if they had more information about their bodily processes.

Attitudes towards Menopause

Ghanaian-Canadian women's attitudes toward menopause were largely shaped by the nature of their personal experiences of menopause. The majority of the participants had a positive attitude towards menopause. Those who had a negative attitude were in the minority. Several of the participants did not have preconceived concerns or expectations of the menopausal experience primarily because they did not have any prior knowledge about it. Fosua sums up the thoughts of several of the women by saying:

> I had no knowledge about menopause before I went through with it. I therefore didn't have any concerns...because I didn't know what it was. (Fosua)

The few participants who were knowledgeable about it in advance also had a positive attitude towards it. When asked about what they think of it now Aba had this to say:

> I never thought about it because I know that this is not a disease. It is part of the normal growing process that everybody goes through, so I didn't think about it. (Aba)

Those who had the most negative attitude towards menopause were women who experienced great discomfort when going through the transitions of menopause. These women believe that menopause is a disease.

For example, Mansa exclaimed:

> Eih...as for this it is a disease (Mansa).

Pokua also believes that menopause is a disease:

> It is [menopause] not good. It is a very bad and dangerous disease. It can even kill you (Pokua)

The experience of menopause was very unpleasant for some of the women. They complained of hot flashes, spells of dizziness and decreased sexual libido. They believe that the onset of menopause triggers other diseases and discomforts, which they did not experience beforehand. Yet, only two women in this study believe that menopause is a disease. The vast majority of my respondents believe it is part of the normal process of life. It is note worthy that the women who experienced more discomforting symptoms at menopause tended to have a more negative attitude than women who did not experience so much discomfort.

Women's Experiences of Menopause

As I noted above, menopause is still primarily defined in terms of its physical symptoms. Several of the women in this study reported going through some physical and emotional changes which brought them to an understanding that they were going through menopause. However, they approached menopause with expectations of the normal age of onset as described by Mansa and Pokua. For Mansa, menopause did not happen at the "right time":

> I have not reached the stage that I should have menopause, but the surgery that I had made me menopausal. (Mansa)

Although Mansa was 47 years when she had hysterectomy, she believes that she had menopause at a time she was not supposed to. She compares herself to her elder sister in Europe, who also had hysterectomy, who she assumes had her menopause at the right time.

> ...my sister, she had hers when she was supposed to, her womb was also removed, but it did not affect her like me. She didn't have burning sensations like me. (Mansa)

Mansa echoes the thoughts of Frema and Pokua who also had hysterectomies. For them, menopause happened prematurely and this affected their experience of menopause. They think that their experience is different from all others and describe it in negative terms.

Frema describes her experience in this manner:

> The reason mine is severe is I had partial hysterectomy. I don't know whether that's why...that is making it so bad. (Frema)

Others such as Araba felt that menopause happened at the right time. Araba says,

> ...So I knew it was coming, but at what age mine will start, that I didn't know. But I guess the women in my family-my aunt, my mother-they [menopause] came late in their late fifties, that's when they started their menopause. So I think the women in my family, they have it late...so I had knowledge of how mine was going to be. (Araba)

Several of the women in my study reported having excruciating hot flashes.

Araba explains how she felt:

> The hot flashes, all of a sudden I am wet...and my heart start beating faster as if I am being frightened...I become very hot and the next minute I feel like taking my clothes off. (Araba)

Fosua sometimes feels as if she has engaged in a strenuous job when she gets hot flashes.

> When I get the hot flashes, my whole body will be so hot and wet, sometimes I feel like taking my clothes off, and the next moment I feel cold as if nothing happened. (Fosua)

Mood swings were also part of the experience of menopause for some of the participants. Several of them reported having short tempers when going through menopause. Fosua reports:

> Sometimes I feel angry at very little, little things. I always consider myself to be a nice person but now I easily get angry. (Fosua)

Mansa said:

> Oh yes...it makes me hyper. It makes me angry easily...if I think about it, I cannot understand it. Sometimes you don't need to get angry but you do. (Mansa)

Some of the women reported symptoms other than the hot flashes and the cold sweats. Serwaa and Nyame who had their menopause in Ghana reported having a different experience. Serwaa expressed her distress as this:

> I felt uncomfortable [me ho yeraw me] my stomach was burning, my thighs were burning; my head was aching. (Serwaa)

Nyame also reported not having any hot flashes but rather pains in the legs:

> My feet were burning and I had swollen knees, and I couldn't walk. And my whole body was "hodwoo" [ached] (Nyame).

Aba also reported pains in her legs.

> Sometimes my feet burn when I am walking as if I am walking on coals. I felt faint and dizzy, I felt so uncomfortable. And it was as if I am hearing so many voices in my head, as if some things were going on in my head. (Aba)

Going through menopause was very unpleasant for some of the participants. Hot flashes were a big concern for some of them. Frema describes how she feels when she has hot flashes:

> I sat on a board, when I was a judge at the...when it [the hot flashes] comes, it makes me nervous, if you feel very hot... I am thinking the

> lawyers are thinking you're either nervous or doing stuff. So some of the people...like the other judges I sat with, and they were women who were going through menopause..."oh...they would say, it's only one of her flashes" (Frema).

It was difficult for me to ask participants about their sexual relations when they were going through menopause because of my own beliefs about privacy. However, surprisingly some participants talked about sexual issues without being asked and others made brief references to it. The onset of menopause brought changes in the sexual life of many of the women. While some reported increased sexual activity during menopause, others experienced a decline. A few also reported no change in their sexual activities. Oforiwaa's husband was working in another part of Ghana so she did not see him very often. Menopause increased her sexual life because she would not have to worry about her periods when her husband came home or when she went to visit him. In Ghana, it is not uncommon for a couple not to indulge in sexual relations when the woman is in her period.

> You don't worry when you're traveling. You can enjoy (sexual relations) anytime you like. Me like this my husband was staying somewhere, sometimes my husband will come and I am not free... (Oforiwaa)

Pokua's, sexual relations with her husband changed for the worse.

> When it gets to that stage you don't even think about men. That one is out. You don't feel anything. For me when I sleep... it got to a time when I don't even want any contact with my husband. I sleep far away from him as I can. I went to see my doctor and he gave me some pills. But it didn't work... It was that serious. You have a husband but you cannot do anything. (Pokua)

Some of the participants were frustrated because their friends and family did not appreciate the problems they were going through. Others just made a joke of their experiences with their colleagues at work. Frema was very angry when some of her friends seemed not to appreciate her problems but was happy when others did.

> But what gets me angry is sometimes, even people who know I am going through will say, oh...remove your clothes and you will be all right. You see they went through menopause, but I don't think they have the experience as I have. . I don't think if I take my clothes off I'll be better off...it has nothing to do with this shirt [pointing to her shirt]. The hot flashes...I could still sit here naked and it will come. And that's the part that makes me angry. Your own friends want you to take your clothes off. (Frema)

Pokua also reported not getting any help from her husband.

> No, for him he thought I did it intentionally. Things like that they don't know. They feel you intentionally don't want to sleep with them. (Pokua)

Later in the interview I asked the participants how it felt to be going through menopause. Several of them were happy that they would not have to think about menstrual periods or the threat of being pregnant again. While Araba expressed relief Kukua show indifference to her experience.

> At the beginning I said hallelujah, I don't have to think about monthly periods, I don't have to think about buying pads, I don't have to think about monthly, monthly...and think about it, you know, I won't be miserable for five days, so it wasn't a big deal. (Araba)

> When you reach menopause, you become a child once more. You forget about pads, pregnancy and stuff like that. Menopause is one of the things that happen, you are neither here nor there. You're neither happy nor sad. I just carried on with my life. (Kukua)

The women expressed their experiences of menopause primarily in physiological terms. The most common symptoms reported were hot flashes,

cold sweats, bouts of dizziness and decreased sexual libido. Others reported having some burning sensations in the thighs, stomach, feet and swollen knees. Despite relaying their experiences of menopause in physiological terms, the majority of the women did not simply subscribe to a biomedical definition of menopause as a deficiency disease. Only two of the participants considered menopause a disease. The majority of the women think that it is a part of the normative aging and developmental process.

End of Fertility/ Childbearing Years

Physically and symbolically menopause signals the end of childbearing and fertility. When I asked the women in this study what menopause meant to them, several of them said it meant the end of the childbearing years. Several of the women had stopped giving birth before they reached menopause and noted that it is unusual for women to have children at that time. Araba calls this "Menopause surprise":

> Yes, it's a marker that you're aging; you're falling out of the childbearing age. At the time that it [periods] goes on and off, you can have what they call menopause surprise[10], because on and off, you don't know when your period is going to come, you can get pregnant within that time. Actually, our last-born was a surprise, because she [her mother] didn't know she was pregnant..."emera na me twa bra na menyin sen yi"[I have stopped menstruating, how can I become pregnant]. (Araba)

Some expressed mixed feelings about the end of childbearing while others expressed relief. Serwaa who already has seven children received the news that she was menopausal with mixed feelings:

[10] The source of this term is not known. The participant might be referring to something she has heard or something that women talk about.

> If it was pregnancy, I would have been happy with it. But since it was menopause I accepted. I was an only child. I wish I could have more children. (Serwaa)

Serwaa elaborates the benefits of having more children:

> You don't know which of your children will take care of you...I have many children but only one of them takes care of me. He brought me here [Canada]. Some of my children have never called to see how I am doing since I came here. (Serwaa)

For Nyame, a good mother is one whose children have turned out well. She gives this advice to new mothers:

> Anyone, if you reach womanhood-for children it is God who gives children-so when you begin to give birth to children you have to take care of them. If you give birth to children you have to take care of them so that they have a good future. That's why today we don't give birth to many children. If you think you can take care of them, give them good education; today education is very expensive... (Nyame)

Mansa had been practicing birth control for sometime prior to menopause and had had a hysterectomy. However, the fact that her womb has been removed appears to be hard on her. Mansa remarked:

> It shows that right now, even if your womb is not removed, if you reach that stage, you will never give birth again. If you are a woman and you cannot menstruate, it means you can also not give birth... (Mansa)

Then later she adds:

> For a woman, this motor [womb] in us makes us complete, but if you don't menstruate, you don't do anything...and this thing has been removed from you...its difficult. (Mansa).

The significance of menopause for the women in this study varied greatly. The related factors may be history of birth control, number of children one has and expectations of self. Several of the women in this study had been practicing

birth control prior to the onset of menopause. To these women menopause meant freedom from pregnancy. Although several of the women recognize that menopause means the end of the childbearing years, they are not unhappy about it. In fact, some indicated they would have been surprised if they had another child. Mansa however, describes the removal of her womb as a death sentence. She will never have children again.

Language of Separation of Menopause from Self

Several of the women talked about menopause as if it was separate from themselves. They talked of "the menopause" as "it" or "the thing".

Pokua says:

> **It** [menopause] brings frustrations...**it** brings problems...people don't realize that it's **the** menopause.
>
> And
>
> **This thing!** My aunt, she's also sick, because of **the menopause.** (Pokua)

Mansa also says:

> **This thing...**it has so many symptoms. (Mansa)
>
> And
>
> As for **this thing,** people have different experiences. (Mansa)

Some of the participants talked about menopause as if something foreign was happening to their bodies. This is similar to conclusions reached by Weideger (1976) and Martin (1978). They suggest that women have the tendency to view menstruation and menopause as something that is not part of a woman's life, thereby denying the reality of the experience.

Experiences of Women in Ghana

To explore whether Ghanaian-Canadian women's experiences of menopause would be different from women in Ghana, participants were asked if their experiences of menopause were different from that of their mothers. As noted above, there is no word in the Ghanaian language that designates the term menopause. It is designated as "bratwa" which means the end of menstruation. Women in Ghana might refer to this vaguely as the change of life. And most of them do not have any knowledge about menopause and its symptoms. Almost all of the participants said that their mothers did not talk about these things. As previously noted, this might be due to the sense of secrecy and shame surrounding menstrual blood, or that they have no idea why they behave the way they do during certain points of their lives. Many of the participants alluded to the latter suggestion. Most women reported that their mothers thought it was the act of witchcraft or juju. This is what Mansa had to say about the issue:

> In Ghana, a lot of people, they know that people stop menstruating, but they don't know that when you stop menstruating you go through such terrible pain. They don't know that it has symptoms. In Ghana they don't know that when you're about to stop menstruating you suffer like that. Even my own mother made me aware of it. When she was about to stop menstruation she didn't know that it was menopause. My own experience of what was happening to me made me aware that the same thing happened to my mother, when she was suffering. For them, they blame everything on the witch. It was later that I realized she was going through the same thing. For my mother, her heartbeat increased, sometimes she felt that her whole body is burning her, and her head also burns her. So she shaved all her hair, oh, she really suffered...because back home they don't have any knowledge about it. Even if you go to the hospital, I don't think they'll even get estrogens for you. So when she's hot, she uses some herbs to rub herself. They admitted her to the hospital for some time but the doctor said he couldn't find anything wrong with her. The doctor too didn't know it was menopause. When it [menopause] comes they wouldn't ask you about that. (Mansa)

Pokua also describes her mother's experience:

> Even back home they don't have a name for it. For my mother she was always complaining that she's very hot, and she used to sweat a lot. They don't know what it is. My mother was just sweating like that, so she went to see her doctor. (Pokua)

Pokua suggests that her parents' divorce was due to her mother going through menopause. She compares her decreased sexual activity and her moodiness with what her mother experienced. She is going through the same experiences as her mother.

> My parents were married for thirty-four years. But can you believe that a young girl snatched my dad from my mother's hands...because my mother was my age when my dad divorced her. (Pokua)

She also made mention of how her sisters back home have been complaining about being sick and did not know what was wrong with them.

> My sister called me; she says that her bones are weak. So I told her what was happening to me and to others and told her that it is the menopause. She says I should buy some vitamins for her (Pokua) .

Aba did not see her mother going through menopause but knew a friend who did.

> I had a friend who had gone through this situation. And she blamed it on their rival. Some people who have it think that it is their rival who has bewitched her. Many women think that it is their rivals who have performed some magic on them. (Aba)

Oforiwaa who was a nurse in Ghana until her retirement throws more light on some of the experiences of women in Ghana.

> ...Yes, some of them may have waist pains; even some have pains in their ankle. As a nurse some people come to me with all sorts of problems and I counsel them. (Oforiwaa)

Araba also talked about her mother's experience in this way:

> Very funny, if you see that they're always cranky, you see that they remove their cloth and put it around them; we say...oh, old lady is going through the change of life. But they didn't know what that change of life was...when you get to a stage you stop menstruating, but they don't explain that when you get to that stage, this is the effect that you get after you stop menstruating. (Araba)

According to my respondents, women in Ghana do not have a different experience of menopause from Ghanaian-Canadian women. Just as with many of their Canadian counterparts, few women in Ghana have prior knowledge of menopause, or menopausal symptoms. They also have little knowledge about medical intervention. To describe hot flashes, they use the term "sheshe" which translated means burn. They may have some burning sensations but not necessarily hot flashes. Those participants who do not know the medical term use this term "sheshe" which is different from "ahororow" which might mean hot in English.

Men Going Through Menopause

Several of the participants thought that men also go through menopause. When I said that technically men do not menstruate, so I wondered if they can go through menopause, they argued that in midlife men go through the same problems as women; the only difference is that they do not experience hot flashes and cold sweats.

Araba says:

> They[11] don't menstruate but they go through it in a different way. Sometimes, you look at that cranky old man, you know, they get cranky in

[11] The participant here is referring to something she heard from somewhere, she is not sure where.

> their old age. We used to say it but didn't know that it is also their way of going through menopause. So it hasn't been anything new (Araba).

Pokua also believes men's behaviors change when they reach menopause:

> You see when men go through menopause they tend to chase young, young girls (Pokua).

Others like Mansa expressed doubt about men going through menopause.

> They say that men also go through menopause but I don't know about that. I think it is part of aging. I've heard that men go through it but I've not seen how men go through it. My husband has not complained about anything like that. (Mansa)

Aba does not believe that men go through menopause either:

> I don't believe that. Men don't menstruate, so how can they have menopause. (Aba).

Oforiwaa looked at the issue in terms of reproduction. She argues that women stop reproducing (sic) when they reach menopause but men can reproduce for a very long time.

> A ninety year old man can produce, they are different; they can produce. But fornwomen as soon as you reach that stage you stop producing. Unless they [men] are weak and they can't, not all men. (Oforiwaa)

It is interesting to note that Ghanaian women recognize that at menopause certain things change in a woman's life, which may not necessarily be physical changes. They recognize that there are emotional changes and social transitions as well and that similar experiences may be found among men. Pokua for instance made mention of her father leaving her mother and going to marry a young girl who might be her age, and Araba also made mention of men

who get depressed when in their middle age. Below are the life stories of two of the women to illustrate the themes I have discussed above.

Life Stories

ARABA (Interview # 9)

I was born in 1940 in the port town of Takoradi in the Western region of Ghana. I have three children and five grandchildren. I went to high school and then worked a little bit with the government of Ghana. I left Ghana at age 28 and went to Great Britain with my husband for further studies. When he was done with his program we decided to get a little bit of experience and so we ended up in Canada. My husband did computer programming-the old type of computer programming-so when we came we couldn't find a job here. We worked in the factory for two years, so I decided to go back to university. When I finished my program I was recruited to the Social Board where I worked for 15 years.

I worked a little bit in Ghana, and was involved in union activities: in the Western Region of Ghana; it is called the TUC (Trade Union Congress). When I came to Canada and was working in the factory, I got involved with other women workers. I did a little bit of organising and was involved with the Canadian Labour Congress before I went back to university. After university I went to the Canadian Labour College came back and started working with women until the education wing was moved, then I started working with the unemployed. I tried to train them so they can get a better job. I used my part-time hours teaching and training new immigrant women housekeeping, how to use the healthcare system and taught English as a second language. When we came here it was very difficult getting a

job, I [now] train new immigrant women who come here so that they can get a job.

I didn't menstruate till I was 15 years old. My mother had told me about it but I didn't know when it was coming or what to expect. When I first had my menstrual period, my mother took a pail of water and took me to the bathroom to have a bath. She then gave me something to put on, and sat me down and said, "this is what is happening now, right now, you have become a woman. If you have not menstruated, you would not be a woman. You can get pregnant; you can give birth. If you go and sleep with a man right now, you can become pregnant. Once you have your period, you're a woman. No matter what age you are you can become pregnant so take care of your self". I didn't have any problems when my periods came. Some people have cramps and other problems. I had an easy menstrual period that is why I think I had an easy menopause.

Menstruation for me did not change my social status. It did not change till I was 20 years. Whenever I go out my mother would be like "young woman, where are you going? You have to be careful. You have to wait till you finish with your schooling and then you can do whatever you want". If you have a mother who is frank, you think they talk too much. But if you have a mother who will sit you down and explain to you that whatever happens to you is normal, it is not something to be afraid of, and something to be shy of, and then you'll not be shy of it. On the other hand if you have a mother who is so strict, they put a lot of fear

into you and make you think that it is dirty, and once you have it you're going to be a flop. That is why a lot of girls hide it from their mothers.

When I started menopause my periods came and went away for about two months, three months and then it didn't come for about six months. So I went to see my doctor and told him what was happening. He confirmed my suspicions and said I was going through menopause. I experienced hot flashes, mostly in the night. All of a sudden I become hot and wet with sweat, I feel like taking my clothes off, and then my heart starts beating faster as if someone has scared me, it just goes away the next minute. I knew I was going through menopause. I knew I was not physically, physically ill; it was just a change of life. I did not take any medication. The doctor gave me the choice to either go on HRT or not. I decided not to go on HRT, I just regulated my diet. After I knew I was going through menopause, I read a lot of pamphlets; I got it from the women's hospital. From what I read, I did not like the side effects of HRT. So I tried the less risky one: I regulated my diet.

My mother was always cranky when she went through menopause. She used to take her clothes off and put it around her. She always complained of being hot. She knew she was going through the change of life, but didn't know that when you stop menstruating these are some of the experiences that you have to go through.

I think of menopause is part of the life process. It means that I should not think about monthly periods. At the beginning I said 'hallelujah.' I don't have to think about buying pads, you know, I won't be miserable for five days; it's not a

big deal. I think menopause is a marker that you're falling out of the childbearing age. During that time you can have what is called the menopause surprise. During the time when the period is on and off, you do not know when you are ovulating, and you don't know when the period is coming, so you can get pregnant within that time. Actually my mother's last born was a surprise, because she did not know she was pregnant. Actually, I don't have any concerns about aging. The only thing is I cannot dress as I used to, I have to let down the hems and wear it in such a way that it covers my knees...that kind of stuff. Other than that I think it's a natural process everybody will go through. So whether we like it or not, it's not the "if" but the "when", it's a process.

I don't personally think about it (aging). It may be that I am healthy; maybe if I had pains and aches, then I will think about it. I am aching, I feel dizzy, and I can't walk. But I don't do all of this. The only thing is when I look at somebody I knew years ago or movies then I realize that, oh I am aging myself, that kind of thing. But inside I don't feel that I am old, it doesn't bother me, I still do things the way I used to and I am still active. To keep myself healthy, I take time to being active and looking at life positively. When things come by I see them as part of life, thinking about it; what I can change and what I can improve, that is my thinking.

In Ghana we treat the elderly much better; we take care of them till they die. Even when there's an elderly person in the house and she does not have children of his/her own or the children are dead, the family still takes care of him/her. I'd prefer to retire back home in Ghana.

POKUA (Interview # 3)

I have been in Canada for about twenty years now. I came to join my husband; we have two daughters. I lived in Koforidua, which is an urban town in Ghana. I went to school in Ghana, up to the elementary level.

I had my first menstruation at the age of 15 years. My mother never told me anything about menstruation. I think that the reason being they did not know anything about it themselves and such things were not discussed. I lived in a big household with a lot of family members. I noticed that the girls in the house put cotton wool in their underpants during certain times of the month (at that time we didn't have pad). I was going to take my bath one day when I saw blood in my underpants. So I also went and bought a cotton wool and put it there. I never told my mother about it. I felt so much ashamed to tell her. Now they teach the kids at school about these things. My daughters just tell me as soon as it (menstruation) comes and I buy the necessary things they need for them. I had so much pain during my menses; sometimes I have to take painkillers to relieve me of the pain. My last born has the same problem; she goes through a lot of pain when she gets her period. Sometimes I am scared she will have a difficult menopause.

After giving birth to my last born, I was told I had hepatitis B. I was told that if I ever had a child again the baby would be a sick child. So I said I would not have children again. So my tubes were tied. Then I later developed fibroid as a result of my tubes being tied. I was 34 when my tubes were tied and at 42 my womb was removed. My womb was removed that early. The doctor told me to expect menopause soon, he did not explain what it was or what to expect. I

reported to him (doctor) when I started experiencing hot flashes. He then told me I was going through menopause.

The biggest problem I got during menopause was the hot flashes. Sometimes I sweat profusely and I cannot even sleep. You would think that I have been running a marathon or doing some difficult task. Sometimes I sleep with the air conditioning on, together with a fan. And I have to put my legs on pillows just to get relief. It (menopause) is not good. It is a very dangerous and bad disease. It brings a lot of diseases. So the doctor put me on some drugs (HRT), it was 60 grams. It was not helping so I checked with the doctor again and he put me on 120 grams, so I was taking six tablets a day. I stopped taking the HRT when I saw on TV that is causes cancer. I am really suffering now since I stopped taking the HRT. I take a lot of peanuts; it reduces the sweat and slows down my heartbeat. For four years now I have been going to a Chinese herbal clinic in Hamilton where a friend took me. The herbs are mixed together and made into tablets. I have not worked for the past 11 years now because of a problem I had in my neck and shoulders. My neck was in a cast for all those years. It all happened when I removed a tooth. And last two years I nearly suffered a stroke. I am now better because of the herbs I am taking. I only go to my doctor for check up.

It got to a time when I did not even want to have any contact with my husband. I sleep far away from him as much as I can. It is very serious. You have a husband but you cannot do anything. Some even commit suicide. It (menopause) does not make you function well (sexually). When you see a

man...I mean the moment I see him...I will be in the room when he enters...he has not even come close to me but I will be angry. He thought I intentionally do not want to have anything to do with him. Things like that they do not know, they think you intentionally do not want to sleep with them.

I believe that marriages can break because of the menopause. My parents were married for thirty years; I believe the marriage was destroyed because of the menopause. My mother would sometimes take off her clothes because she was sweating profusely. But I did not know what it was. I only learnt about menopause when I came here and was going through the same problems. She was always complaining that she was feeling hot. She went to see the doctor, but the doctor even did not tell her it was menopause. With my own experience, I realise that she was at that time also going through menopause.

I believe that menopause is a sign that you are aging. However I do not have any concerns about aging. Because you know that whatever happens, you will hit that stage, either you grow old or get young. My only concern is I did not know that menopause was that difficult. It also shows that you have passed the childbearing years.

Conclusion

In the narratives above, menopause was viewed as a natural occurrence, and as a disease. While Araba had natural menopause, Pokua had hysterectomy prior to menopause. The difference in attitude towards menopause is due to the age at which menopause began and the level of education of participants. Araba had menopause in her fifties whiles Pokua's happened in her forties. Women

who had menopause in their fifties were already past the child bearing years, while women who had menopause in their forties still consider themselves young. The former are more likely to recognize menopause as the beginning of aging than the end of childbearing years. They therefore recognise menopause as a natural occurrence than women who have had hysterectomy.

Araba's level of education and career have exposed her to feminist views about the body and health and she is more likely to see menopause in a different light than Pokua who has had little education and did not have prior knowledge about menopause before her hysterectomy. There were however other women in this study who had little education and yet had a positive attitude towards menopause.

In the next chapter, I continue with the description of women's accounts of the meaning of menopause in the context of their lives, their encounters with the medical system in the treatment of their menopausal bodies, and the links between menopause and Ghanaian-Canadian women's views of health and aging.

CHAPTER FIVE

HEALTH AND AGING

This chapter is primarily descriptive in nature. I give an account of the women's health concerns and their experiences with the medical system as they relate to menopause. Detailed statements from the women are used to illustrate how in some instances they attempted to take control of their own bodies by making their own decisions, taking a more holistic approach to their health and finding alternatives to orthodox medicine. In other instances, the women left the management and control of their bodies in the hands of their physicians. I end this chapter with the life story of one woman to illustrate her account of menopause and her attempt to take over the management of her menopausal body.

Women's Experiences with the Medical System

As discussed in Chapter Two, the biomedical definition of menopause as a hormone deficiency disease shapes its management in most medical settings. Conventionally, women going through menopause who are experiencing discomforting symptoms, and increasingly even those who are not, are encouraged to take estrogen supplements. Physicians generally do not hesitate in prescribing Hormone Replacement Therapy to menopausal women.

In this study several women resisted the biomedical definition of menopause, while others accepted it. Several of the physicians the women

visited routinely prescribed HRT for them. Pokua's doctor did not hesitate to prescribe HRT as soon as she was "diagnosed" with menopause.

> My doctor wrote some drugs for me. The gram was 62.5. It was not helping. So I went back to the doctor. So he checked my blood and he put me on 120 and it helped me. So the thing that before I was taking 62.5, I now take double... (Pokua)

Mansa's doctor told her that there was no other alternative to alleviate the "menopausal symptoms" than to take HRT

> Mine was pink. So the medicine he gave me was all he had. He told me that the estrogens were all he had. So that's all that I take. (Mansa)

Frema's doctor told her that if she took the estrogens the hot flashes would go away.

> And so when I went, the first doctor was like...oh, you have to take these medications and you know all the hot flashes will go away. So he gave them to me. (Frema)

Frema's doctor got angry with her when she went back to him for an alternative.

> I took them and realized I was bloating too much. I went back to him and asked, is there anything I can do about this because I don't think I am being helped by this. So he said, what do you want from me? He started screaming at me. So I said ok, so I left him and went to see another doctor. (Frema)

Frema's second doctor also prescribed the same thing for her.

> And then she (doctor) also decided to prescribe the same thing for me but at a lower dose. I took it for about two months and I realized I had the same problem.

The women's accounts indicate that most of their physicians prescribed Hormone Replacement Therapy without fully explaining the side effects to them. Araba is among the few whose gynecologist allowed her to make her own decision whether to take the estrogens supplement or not.

> I didn't take any medication. The doctor gave me a choice; either I take medication-the HRT or some other things I could try. I didn't take the medication. I just regulated my diet. (Araba)

Most of the women who started HRT ceased taking it after some time.

One major reason why they stopped was a concern with side effects.

> I used to take double (estrogens) till I heard that it causes breast cancer. I saw it on TV. So I stopped using it. Since then I've not taken any of those tablets. But now am really suffering (Pokua).

Frema decided to stop after finding out that it has side effects.

> ...I started reading about it. I got some books from the library, and did my own research. And I realized that the medications they were giving me at some point, there are such side effects that I stopped and decided ... to use the natural [products]... (Frema)

Araba did not even try to start on HRT after she learned of the risks associated with it.

> From what I read, I didn't like what...the side effects of the medication. So I decided to try the less risky, and if it did work... Then what the doctor said...sometimes you have no option...then you go to the medication. So I decided to try the less evil one. But if I was really, really hard pressed to take, then I'll take the HRT. So I tried the alternate first. (Araba)

Several of the women rejected the biomedical definition of menopause. They asserted that menopause was a normative occurrence and therefore did not take any medication. Asked why she did not take any medication, Kukua said:

> I didn't take any medication whatsoever. I knew what it [menopause] was so I was expecting it. (Kukua)

Araba did not think it was a disease:

> I knew I wasn't physically, physically ill. It was just the change of life. That was what was happening. (Araba)

Fosua also did not take any medication because she thinks menopause does not have any cure.

> I didn't take any medication. Because I don't think it has any cure. (Fosua)

Others such as Serwaa, Nyame and Aba who went through menopause when they were in Ghana did not take any medication because their doctors did not prescribe it.

> I didn't take any medication...it does not have any medication...the doctor told me that. So he gave me some pills (painkillers) to take. (Serwaa)

Aba was also not given any medication by her physician.

> She didn't give me any medicine. I didn't take any medication. (Aba)

Some of the women in this study think that it is not necessary for all women to take hormone replacement therapy.

> Personally...maybe it's my personal opinion. I don't think so (it is not necessary for women to take estrogens) (Araba).

Oforiwaa notes that it is necessary for women to know about menopause and that knowledge about it will affect their use of medication.

> I think that if it is explained to women, it's better than women taking medication. It is better that things are explained to women. (Oforiwaa)

Others think that HRT should only be given in extreme cases.

> But if it's severe then they can take it. (Oforiwaa)

At the time of the study, only one of the women interviewed was on hormone replacement therapy. She thinks that it is inevitable that women would take the supplement to avoid greater consequences in the future.

> If you don't take it [HRT] menopause will cripple you. It cripples you a lot. The estrogens help...if you don't take it, you'll be crippled. (Mansa)

Several of the women interviewed took an active part in managing their menopausal bodies. Several rejected the biomedical practice of taking hormone replacement therapy because they do not view menopause as an illness. Others did not take it because of concerns with its side effects. Others left their doctors to manage their bodies for them.

Traditional Herbal Medicine

In Ghana as well as in many parts of the world, women have turned to alternative forms of medical treatment. These usually include the use of herbs, leaves and barks of trees. Traditional herbal medicine is sometimes used for preventive as well as curative purposes.

More than a few of the women in this study use traditional forms of medicine to prevent fevers, or to cure other diseases. A number of them used traditional medicine as an alternative to estrogens. Frema used Chinese and Mexican herbal medicine as an alternative to hormone replacement therapy.

> I decided I would start...use the natural...the Chinese. I went to the Chinese shops...there is this drug, "don quai", I got that, I got some instructions... natural medications, Chinese herbs, and none of it helped...so at some point...in June, 1999, I said ok...I'll try some of the natural medication...there's this Chinese... no Mexican something drug. I was looking for it, I took the pills, I did all sorts of stuff. (Frema)

Pokua also used traditional medicine after she stopped using estrogens.

> When I sweat like that, do you know what I do? I take peanuts. It helps me a bit. I take lots of them, and it reduces the sweat and the heat, which is burning. (Pokua)

Araba also decided to use alternative medication instead of Hormone Replacement Therapy.

> I just regulated my diet. (Araba)

Pokua has been using herbal medicine since she was a girl.

> Yes, when I was in Ghana, I used to drink "dudu" (mixture of herbs). I used to vomit when I was young. So my madam used to prepare some for me. I also used to have "asa" [enema]. I mix it with ginger and use them. (Pokua)

She turned to herbal medicine as her primary source of health care. She had been battling some health problems for eleven years now. A friend of hers directed her to a Chinese herbal clinic in Hamilton and she has been going there ever since.

> Yes I go to a Chinese herbal clinic. I've gone through a lot of pain. For eleven years now I've never worked. I went to remove a tooth and I got some problem. So they told me that my neck and shoulder have been damaged. So they gave me lots of injections... Then someone who said I have helped her sometime ago told me about a Chinese man in Hamilton. It is herbal medicine. They have made it into pills. It's plenty. Now I have to take lots of them when I get home. Now that's the place I go whenever I am sick. I only go to my doctor for check ups. I've been going there for the past four years. (Pokua)

Araba makes tea from some spices. These she uses for both preventive and treatment purposes.

> For me what I use is ginger, a bit of black pepper pods, the seeds not the powder, "wisa" [white pepper]. I boil it, let it cool down, and put it in bottles, and I drink a small glass of it everyday. That's my medicine. It cleanses my whole system, and then I drink lots of water. And that I've been drinking for, how many years now? It cleanses me so I don't take laxatives, like people take laxatives and Advil, I don't take those things. (Araba)

Mansa prefers herbal medicine to orthodox medicine.

> For me when I am at home [Ghana], I like using the herbs, there are some sicknesses I wouldn't take to the hospital to waste my time. I'll use herbal medicine when am in Ghana, I like the herbal medicine. You know that these "abrofo aduro" [orthodox medicine], if you take it you will become fat. (Mansa)
>
> If there were some here I would have used them. Whenever I go back home, I bring back some. Some I boil like tea, some others, control fever, it makes you urinate very often, and I boil them also. (Mansa)

Aba also says that she likes herbal medicine:

> I also feel that the herbal medicine is good, it cleans the body. I use it to keep myself healthy. (Aba).

By contrast Nyame had a bad experience with native doctors and has vowed never to use herbal medicine again. Below is an account of an interesting experience she had with indigenous doctors.

> We went for mother's funeral at Prang, [home town]. I was complaining at the funeral that my legs were burning and I couldn't walk. So my mother's [aunts] suggested that Kwaku [the herbalist] who plugs leaves [herbs]. At that time he was also around. So they called him to come and have a look at my legs. So he went outside and got some leaves. He asked for a calabash [small bowl made from gourds] and water. So when he was given the calabash and water, he mashed the leaves in and rubbed it on my legs. After rubbing it on my legs, he left the leaves in the water. Then he poured the water away, after which there were, nails and broken bottles in the calabash. He then told me that there things inside my legs, and that was causing all the pains. So I told him that if those things were really in my legs, I should have been dead by now. I also told him that if those things are in your body, it is tetanus, and I would have been dead. So what he's saying is not true. He told me that it is true. So I said "no, no, no, I don't believe you, I don't believe in your medicine." So he got angry and left the funeral grounds, and my mother was angry too. He was just trying to get some money from me. But I told him that I don't have any belief in that. So I am not going to pay him anything. I had no faith in the medicine. I didn't have any faith in his medicine so I went to see the doctor. I didn't intentionally go to see him [herbalist] at that time (Nyame).

Instead Nyame would like to take her children to hospital as soon as they are sick.

> No, I didn't use any herbal medicine; I never used it. I go to the hospital immediately when any of my kids or I am sick. Whenever you see me using herbal medication, then it's for a boil, such as "tinkalo" [a type of medicine used for boils that is rub it against a smooth surface with water] and put it on the boil. Using herbal medication such as boiling the leaves or use it for "asa" [liquid gotten from mashed leaves and use it for enema], I never use it... If you do this herbal medicine and something happens, they'll tell you that if you had taken him to the hospital, nothing would have happened. For me, I don't take herbal medicine like that. I don't like it. (Nyame)

Serwaa uses herbal medicine together with orthodox medicine, but stopped after an unpleasant experience of using the wrong medication. Serwaa goes to the hospital as soon as any of her children or she is sick. Below is her story:

> I used to. There was a time I had constipation. So I mixed soap and water to have an "asa"[enema]. I had so many problems in my stomach. I felt so uncomfortable that I didn't know what to do. And I was bleeding too. So my husband took me to the hospital...I don't like using herbal medicine because anytime I use it I bleed or have problems. There was blood all over the chair I was sitting on. I bought the concoction from a drug vendor in a car. I always go the hospital when am sick. (Serwaa)

A few of the women turned to herbal medicine when conventional forms of cure failed them. The majority indicated that they would want to use herbal medicines as a supplement to conventional medicine if they were available. Some of the common herbs used are natural spices such as ginger, and black and white peppers for tea. Others get their supplies of mixed herbs when they go back to Ghana for a visit. Nyame and Serwaa who have had a bad experience with traditional healers using the wrong type of medicine have vowed not to use

them again. None of the women were aware of practising Ghanaian native doctors in Toronto.

Women's Health

Women's health involves emotional, physical and mental well being. In this section, the women describe how they restore and maintain their health. Several of the women in this study reported chronic sicknesses that they are battling. Serwaa, for example, describes the general weakness of her body:

> My health is deteriorating. My whole body is burning, and my body is very "hodwo' [feels very weak]. I can't eat [lost appetite]. My stomach is also burning. Sometimes I have to remove my dress because I feel very uncomfortable. (Serwaa)

When asked if she thinks it is the menopause which is causing these discomforts, or whether they are part of aging, Serwaa thinks that both menopause and aging have contributed to her woes. Several of the participants complained of a reduction in their strength, which they attributed to the onset of menopause.

Nyame says:

> Now I have some weakness. I don't know if it is that [menopause]. The blood is not coming out any more and this is causing problems. My strength has reduced; my waist. I can't even get out of bed. I used to be very strong. I could run and walk very fast. I think old age is also to be blamed: menopause is also to be blamed. Things change when you're growing. (Nyame)

Additionally, Nyame suffers from chest pains and eye problems. Mansa also reports that menopause has affected her health.

> It affected my health. It does not make you as strong as you used to. For that, you'll never get strength. (Mansa)

Aba also complained of a reduction in her strength:

> When you get to a point where your knees and joints hurt so much. The kind of work that you used to do when you're young, when you grow old you cannot do that kind of work any longer. Because you get tired easily when you do a little job. When I look at how I was when I was young, I see a difference in it, because when I do a little thing, then I become tired. Recently, I climbed some staircase, for about three days, I couldn't get up. I am on the 8th floor. When I climbed for a week, I was grounded in this house. It was later that I realized it was the staircase that I climbed. I was even climbing with some kids, but they were running and playing on the staircase. When you're growing your body becomes that of a child again. (Aba)

Aba attributes the decline in strength to weakening blood:

> When you get to that stage your blood becomes weak, especially those women who bleach [chemicals used on the skin] themselves... (Aba)

Though having some health problems, Araba sees herself as a healthy person.

> Its just a few months ago that my blood pressure went up, as I had soon come from Ghana. So far, if not for that, I'll say that I am healthy. (Araba).

Kukua also thinks she is healthy because she does not take any medication.

Despite aches and pains, Mansa sees herself as a healthy woman.

> Oh yes, I am controlling the menopause, it gives me pains at the joints and my body aches. But I think that I am healthy. (Mansa)

Fosua and Aba also see themselves as healthy women because they do not have any health problems. To keep herself healthy, Araba regulates her diet and engages in active pursuits.

> I think positive thinking; take time being active and looking at life...when things come by, you see it as part of life. Thinking about it, what you can change and what you can improve. If you cannot change, or you cannot do anything to improve it, then let it go. That's my thinking. Let go, what, I can sit down all day, I spend the next morning, and it will be the same. And I also regulate my diet. (Araba)

Nyame takes a walk most evenings to keep herself healthy.

> I go for walk every evening. I also distribute newspapers, and these are also forms of exercise. (Nyame)

Oforiwaa laments that she can no longer take her walk every evening because she has to baby-sit her grandchildren. To keep herself healthy she tries to regulate her diet.

> I watch my diet. I don't get time to take a walk because of the children. I have to take care of them when they [her children] are not there. (Oforiwaa)

Although all of the participants have been on ill occasionally, they consider themselves generally healthy. The women were aware of decreased strength at the onset of menopause. Some were unsure whether the onset of menopause brought about a decrease in strength, or whether this decline is part of the aging process. All of the women were aware of the benefits of a healthy diet and regular exercise to keep mind and body healthy.

Hysterectomy

The literature on menopause suggests that women who have had hysterectomies experience menopause differently[12]. This is because menopause is surgically induced. Three of the participants had hysterectomies for various reasons. Pokua had a fibroid:

> When I had my last born, I was told that I had hepatitis B, I didn't know. I was told that if I ever had a child again, that child would be a sickler [sick baby]. So I said I would not have children again. That is why my tubes

[12] I am aware that there is a literature on hysterectomy, but since this is not the principal focus of my research, I would not discuss it centrally here. What is of relevance to my work is the way the women represent their experience of menopause.

were tired [tubal ligation]. Later on I got fibroid and then my womb was removed. I was 42 years old when my womb was removed. (Pokua)

Frema describes her reasons for having a hysterectomy as follows:

> I had fibroid... and I had an operation, so I had partial hysterectomy. (Frema)

Mansa explains the reason for her hysterectomy:

> They performed an operation and removed my womb. My womb was weak. When I have my periods I bleed a lot, so they had to remove it. My doctor told me that they had to remove it; it was giving me problems. So they told me that it is time better if it is removed. So I allowed them to remove it. (Mansa)

Each of these women recognized that they might have had an early menopause because of the hysterectomy. At the beginning of the interview Mansa said:

> For mine, I got it early. I hadn't reached the stage that I should get it. But it is because of the operation that I had that has made me get menopause. (Mansa)

However, each also indicated shock and surprise when they started experiencing problems after the procedure. Their doctors did not explain to them the consequences of the hysterectomy. They were not informed what to expect and few details were given. Mansa reported that she had to call her sister in Europe when she started experiencing menopausal symptoms. (See above). Her sister advised her to see her doctor, explaining that she might be going through menopause.

> I use to have my periods before the operation. It was after the operation...even up to today I never saw blood again. So after the operation, for about six months I felt that my body was burning, it was

> burning [me ho sheshe me, esheshe sheshe me] I didn't know what it was I have a sister in Europe who...they did to her what was done to me [also had hysterectomy] So I called her. When I called her I told her my symptoms... (Mansa)

Frema was also unaware that she could go through menopause after her partial hysterectomy. While her doctor told her that she could go through menopause any time soon, Pokua did not have enough information to prepare her for what was ahead.

> For me because my womb was removed. The doctor told me that because of my age, and the fact that my womb was removed, I should expect something like that to happen...I didn't know it was that difficult. (Pokua)

Mansa also thought something strange was happening to her (see above).

Each of the women reported great distress at menopause. They eventually came to the conclusion that the great discomforts they experienced at menopause were due to their hysterectomies.

> The reason mine is severe is I had partial hysterectomy. I don't know whether that is making it so bad. (Frema)

Mansa:

> I feel that it's because of the surgery that I am suffering like that. (Mansa)

For the women in this situation, menopause was premature and a surprise to them. They indicated that if their doctors had taken time to explain to them what to expect after a hysterectomy, they would not have been as frightened when they started going through menopause.

In this section, I have shared women's health concerns as it relates to menopause. For some their health has taken a downward trend with the onset of

menopause. Others are also of the view that both menopause and aging have brought general weakness. Most women however turned to other sources for their medical needs. They take a holistic approach to their health, such as having a positive attitude, regulating one's diet and taking walks.

Aging

One of the major characteristics of menopause is that it is a marker of aging. Almost all of the participants identified menopause as a marker of aging. They noted that the end of menstruation means one is on the road to growing old. However for women who experienced early menopause due to hysterectomy, it signifies the end of childbearing years rather than a marker of aging.

> Yeah, it is a marker that you are aging; you are falling out of the childbearing age. (Araba)

Aba:

> For me I know that when you get to that time, it means you are growing. By 45 to 50 you are just growing. (Aba).

Contrary to the belief that most women are anxious about aging, the women in this study expressed no concerns with growing old. Several of them think that there is nothing one can do about growing old, so they just accept it when it comes. Pokua explains that:

> Whatever happens, you'll hit that stage, either you grow old or young. I was not concerned. (Pokua)

Nyame was philosophical about aging:

> No I was not worried. As a human being who has been brought into this world, you are just going forward (growing), you never go back [grow young] (Nyame).

Aba was just thankful that she has reached that stage in her life:

> I was happy that I was going through menopause, in the sense that I was on the way to growing. I've reached middle age. To get to that stage is an achievement...some people when they get to that stage, they get sick or get some chronic disease. (Aba)

Some of the participants expressed delight in becoming the wise old woman. They look forward to their children and grandchildren coming to them for advice. Oforiwaa expresses her desire to be an old woman when she says:

> Young people come to you for advice. They need you... you help them. You share your experiences with them...you get a lot of respect from them. (Oforiwaa)

What seemed to bother several of the participants is not being able to do what they used to do. Some of them mentioned loss of strength and general body weakness as some of the unpleasant things that happen at old age.

> I don't have any concerns...hmm. The only thing is your strength is not like it used to be...you get tired easily (Fosua).

Araba was not happy because she cannot wear the kind of clothing she used to wear when she was young.

> It's no concern. That was what I was saying that you couldn't do what you want to do. When I wear certain dresses and I stand in the mirror, I say, if I take this out, people will say that "an old woman putting on this kind of dress!" this minor thing. Then you take it off and lower the hems and then you wear the one that will cover you...that kind of stuff. Other than that to me I think it's a natural process you will go through. (Araba)

Oforiwaa and Frema wish they could get more respect as elderly people.

> Here, they'll just call you Oforiwaa. Everyday these children [some children she was baby sitting] call me Oforiwaa, but I tell them to call me grandma, because I like it. So here they will call you by your name, it's not good. You have to respect your elders. (Oforiwaa)

Some of the women also thought of the need of their children to take care of them in their old age. Nyame talked about the need to take care of one's children so that they will in turn take care of them in their old age. See similar views by Serwaa above.

> So if God willing you get only two to three [children] that you think you can take care of, you go ahead, you don't have any problem. If you help them and they lead a good life, in your old age they will take care of you. That is what everybody is looking forward to; that their children will also take care of them. They [parents] take care of them, so that they [children] will take care of them in the future. (Nyame)

Asked whether they prefer growing old in Ghana or Canada participants had different opinions on the subject. Several of the participants prefer growing old in Canada because of good medical care. Fosua sums the views of several of the participants when she says:

> Here the advantage of growing old is that the elderly have been provided for...that is why I said that our medical system is not good. Here as an elderly, whether she is at home has a home care, at a nursing home or old age home, as soon as she is sick, amnesia or whatever, the doctor will come... (Fosua).

For others, it does not matter where they grow old. They would prefer to grow old in Ghana because the weather there is good for them, at the same time they would want to spend their retirement in Canada due of good medical system. They note that once they have money they can stay back home and get good medical care. Kukua says:

> For me it does not really matter whether I stay here or go back home. (Kukua)

Some of the participants want to return to Ghana once they reach retirement and pension. Some acknowledge that man is also spirit and they do not only have to think about material things. Others fear being put in a nursing home and would like to go back home after retirement.

Others like Mansa would like to grow old in Ghana because she will have lots of people around.

> It is good to grow in Ghana. Here if you're old, who cares about it? Here if you're old they will put you in a home. Back home, if you're growing old you still live with your family. So you don't see anything. But here they will put you in a home and nobody come to visit. The stress causes you to die early. It's not good. (Mansa)

Life Story

FREMA

I was born in 1948. I started school in Accra, Ghana's capital but moved to Techiman (in the hinterland) after my father had accepted an appointment at the chieftaincy secretariat. There I had my high school education. I then came to Canada in 1978 to join my husband. Things were difficult when we came here (my husband and I), finding a job was difficult. I then went to university, had my bachelors' degree and then went on to do my masters in Social Psychology. After my program, I teamed up with some people and then we formed an organisation called Canadian Women, to help immigrant women to settle down. We trained them in English, and provided settlement programs for them.

I had menarche when I was 14 years old. I did not know anything about it, so when I saw blood in my underwear one morning I did not know what it was. My parents were divorced by then so it was my father, my stepmother, my

siblings and I. So I told my stepmother about it and she gave me cotton wool and showed me what to do. Because I come from a royal household, they performed puberty rites for me, together with other girls. In the morning, I was dressed in beads and kente cloth (traditional Ghanaian cloth) and they took us to the queen mother who was going to initiate us. But I did not follow the program because my mother and stepmother were fighting over me. I did not know what transpired at the ceremony because of the confrontation. But what I remember is that they were going to give us some mashed yams and eggs, I ended up not taking part at all in the ceremony. Women who were in their monthly period were not allowed into the stool room (a small dark room where stools- sat on by chiefs at ceremonies- are kept) and the main compound of the chief's household. I was in a boarding house and was not at home during most part of the year,(in Ghana most children leave home for high school and stay in dormitories) I therefore did not really have any restrictions.

I went through menopause at the age of 46. I had had hysterectomy prior to that. I had fibroid and then had a partial hysterectomy due to that. I was having hot flashes and I thought I was sick. I did not know what was happening to me until I talked to my doctor. I had no clue what was happening to me. Our mothers didn't talk about it, they thought it was witchcraft. My grandmother and mother did not say anything about it. It was after I saw my doctor that I knew I was going through menopause. He told me I needed to take medication (HRT). My first doctor was like..." oh, you have to take these medications and you know all the hot flashes will go away". He gave me the medication and I took them. After two

months I realized I was bloating too much. I went back to him and asked, "is there anything I can do about this because I don't think this medication is helping me". And he said, "what do you want from me", and he started screaming at me". I said okay and left him for another doctor. She also decided to prescribe the same thing for me (HRT) but at a lower dose. I took it for about two months and I realized I was having the same problem.

I started reading about menopause, I got books from the library, and did my own research, it was then that I realized that the medication they (doctors) were giving me had some bad side effects at some point in time; that it increases the risk of cancer. So I discontinued its use and decided to use natural methods. I went to the Chinese shops...there is one drug called "don quai", I got that, got the instructions and started taking that. However, none of them helped me. I still get my hot flashes. Mine is extreme, very extreme. When it comes (the hot flashes), my whole body and palms become wet, and I feel so dizzy. My daughters call me "the showers". I have to open my bedroom windows, especially in the summer, at the same time have the air conditioning on. Honestly, I am really suffering now. In 1999 I decided I will try the Chinese or the Mexican medication again but it did not work. I have given up now. I sat as a judge on a board, and I felt so nervous whenever I got the hot flashes. I always think the lawyers will think that I am scared of them. Some of the women judges I sat with and were going through the same problem will say..."oh, it's only one of her flashes, don't pay attention to her". So it became something like a joke, I rest for a while and then continue with my work. Now that I am on the other side and

represent clients, I tell them..."listen, I am having one of my flashes"...then I take a paper and fan myself, then I continue with my work. But unfortunately, if you are at a function and you are the guest speaker and it (hot flashes) comes on very badly-and mine is very bad, it seems as if I have just come from the gym, it is very scary-I have avoided wearing polyester shirts. What gets me angry is that some of my friends, who did not have the same experience as me, tell me to take my clothes off, which I think would not stop the problem.

Despite all this I do not think that menopause is a disease. One of my friends thinks it is a disease, but I always tell her it is not true. It is something that all women will go through one day in their life. It is a marker of aging. The realization just hits you that "wow, I am now getting to old age. But that is okay. I do not have any concerns about growing old; the only problem is I wish I could get a lot more respect around here.

Conclusion

Frema's story illustrates the dilemma many of the women in this study faced at the time of menopause. Her doctor told her that taking Hormone Replacement therapy was the only way out for her. She challenged that view and sought information for herself. She sought other means of dealing with the hot flashes, namely taking herbal medicine. Frema's story like many of the other women I interviewed suggests that women want more information about their bodily processes to enable them to make informed decisions about their management of menopausal symptoms.

Participants' awareness that they were growing old came with the onset of menopause and others' responses to them. The women generally had a very positive approach to aging. Several expressed delight at taking on the status of the wise old woman and look forward to others perceiving them in that way. Family and friends are also very important in the lives of participants as they age. In view of this most said they would love to return to Ghana after their retirement to be surrounded by family and friends. The onset of menopause led to decreased health for some of the women, and most were concerned with maintenance of their health over time. They are not sure whether menopause decreases strength or failing health is part of the normative aging process. The fact that menopause is viewed as natural and in non medical terms seems closely linked to the women's positive approach and lack of fear of aging.

CHAPTER SIX

THE MEANING OF MENOPAUSE

According to Jones (1994: 51) the "experience" of menopause reflects a time-limited, biological event, whereas the "meaning" of menopause has to do with what it represents or symbolises in the women's lives. In this study, a group of Ghanaian-Canadian women have voiced their experiences and the meanings they attribute to menopause, in other words what the event symbolises or represent in their lives. Relief from menstrual periods, the end of fertility, and changes in sexuality, aging and health are some of the issues they highlighted. There was some resistance to the biomedical model of menopause and aging among my respondents. The data from this study has both theoretical and methodological implications for the study of menopause. In this chapter, I try to bring these together with the arguments I have made in the previous chapters.

Emerging Portraits of Menopause

The term menopause refers to one year after the last menstrual period of a woman and this generally happens between the ages of forty-five to fifty-five. Ghanaian women usually go through menopause at age forty-eight and above (Kwawukume, Ghosh & Wilson, 1993: 153). The age at menopause for women in this study was between forty-two and fifty- five. Some aspects of the experiences of menopause reported by the Ghanaian-Canadian women were similar to those reported in western literature. Some women experienced hot flashes, and only one woman reported cold sweats. There was no report of night

sweats and sleeplessness. Several of the women, however, reported swollen feet, pains in the knees, burning of the whole body and in the stomach region and bouts of dizziness. Others also reported pains in the waist area.

The term menopause was not known in Ghana until recently. In Ghana the term designated for menopause is *bratwa. Bra* in the Akan language means life, and *twa* translated means end or cease. *Bratwa* literally translated means "end of life". This is similar to Lock's (1993) study in Japan. The Japanese term *konenki* is vaguely used to refer to menopause. In the medical literature, menopause is said to occur with a decrease in estrogen levels in the woman's body. Ironically the Ghanaian woman knows that there is an end to menstruation but she does not know what the "symptoms" that herald that stage are. In Ghana menopause is not marked publicly with rituals as menstruation is.

It is interesting to note that the term the women used to describe their distress is *sheshe*; this is different from *oshew* or *ahurow*, which would vaguely mean hot flash in the English language. There is no precise translation for hot flash. I observed that women who were familiar with the literature on menopause are able to express their experiences in medical terms. Those who are not familiar with menopausal literature describe their experiences differently. There was no difference of expression between the respondents who are medically trained and the non-medically trained.

Another observation that I made is the differences in the experience of women who had their menopause in Ghana and those who had theirs in Canada. The women who experienced menopause in Ghana reported of swollen and

knees, burning sensations of the body and stomach region and waist pains. Expressions of distress normally rest in the body. People would normally say that they are experiencing pains in their whole body. Women would normally complain of pains in their waist, while older women would normally express pains in their joints, normally their knees. This is consistent with other studies where the idiom of expressing distress is culturally-shaped, for example *nerva* or nerves among Greek women (Dunk, 1989)

It is obvious that knowledge of menopause plays a role in the experience of symptoms. This has been reported elsewhere (Jones, 1994; McMaster et al, 1997: 9). Most of the women in the study did not understand why they were experiencing the symptoms. They know that when a woman gets to a certain age, she ceases to menstruate but they do not know what heralds this event. A number of women in this study had not heard about menopause, therefore they had no idea what was happening to them. Some expressed the fear of being sick and others thought they might be pregnant.

For most of the women in the study, menopause means a change in sexual interest. This change may be an increase or a decrease in libido. This has been documented by other studies, for example, Jones (1994), McMaster et al. (1997), and Davis (1987). There was no mention of vaginal dryness and shrinking of the genitals. None of the women mentioned painful sex. Most of the women reported a decline of sexual interest, however, one woman whose husband was working in another town reported a new sense of freedom with

menopause and that she could now have sexual relations at anytime when she visits her husband.

There is some ambiguity surrounding sexual relations at old age in Ghana. Other researchers such as Van der Geest (2001) have reported this ambiguity. In a study about sex and old age in Ghana, Van der Geest (2001) found that most elderly people reported a decline in "strength", which in most cases appeared to be a euphemism for a decline in libido. Most women in her study reported they have less strength to engage in sexual activity. Some of her respondents, however, conceded that if their husbands wanted sex they could not deny it to them. It is, however, not clear what causes the decrease in sexual libido as its etiology is still very complex.

In all, Ghanaian- Canadian women saw menopause as a natural occurrence, one that all women will go through. This is evident in their knowledge of the age at which women stop menstruating. Most noted that menopause starts between the ages of forty-five to fifty-five; hence the assumption that a woman who still menstruates past fifty-five is ill. Similarly, they note that some people can start as early as thirty years, but they would likely think that this individual is malnourished or sick.

Role Changes

Traditionally, the role of the Ghanaian woman has been that of childbearing and childrearing, taking care of their husbands and the needs of other family members. For most of the women issues relating to the mothering role may become significant at this time of their lives.

If the role of the woman evolved around childbearing and childrearing, as it has for many of the women in this study, then that role may come to an end with the onset of menopause. However, if the woman did not engage in that role, the onset of menopause may be the time to contemplate the meaning of motherhood. With the exception of one woman, all of the women in this study engaged in the mothering role at one point in their lives.

In Ghana, the onset of menopause was a time a woman could anticipate becoming a grandmother, a mother-in-law and an elder of their families. It may also be a time when Ghanaian women could lose interest in sexual activity, and experience marital instability and the onset of aging. This is not to say that elderly Ghanaian women are devalued and shunned by society. In Ghana older women gain a lot of status and respect. The status of women at menopause is dependent on educational background and rural and urban roles for women. Urban educated women may anticipate retiring at this time, and if they continue to work, may rise to managerial positions in their careers; they may become opinion leaders in their villages and queen mothers. If she is from a matrilineal clan, a woman may become the head of the extended family.

In this study a few of the women, for example Mansa, Pokua and Frema, did not experience any role change because they still have their children at home. Others were enjoying their role as grandmothers and were taking care of their grandchildren. Barnett (1988) notes that women who were successful in their principal role continue to identify with it despite any changes in role performance. They still considered themselves as mothers. Some of the women

did not miss their mothering role because their children turned out so well. Mansa went on tell me about the benefits of having more children, and Serwaa enumerated the benefits of practicing birth control so that one can take good care of the children you have.

Almost all of the women in this study had at least two children. In a society where childless women are looked upon with malicious pity, most women in this study can look back with satisfaction that they have fulfilled their duty as mothers and can therefore look forward to the next stage of their lives.

Another role that accompanies the mothering role is that of housekeeper. It is uncommon for men in Ghana to do house work. This is devalued by society and is very unrewarding for women as some of the comments made by the women show. Some of the women in this study commented that they would love it if their men helped them with the housework. Women took care of the health needs of their children. Some saw it as their duty while others thought that men could help. For women with children still at home this role is likely to continue.

Women are engaging in paid jobs in increasing numbers, most of them for economic reasons. Almost all of the women combined their mothering role with paid jobs. While some are retired, others are still engaged in the work force. Araba and Frema have been involved in the women's labour movement both in Ghana and Canada. They have also been involved in organisations that help new immigrant women to settle down in Canada. They have both found great fulfilment in their roles as mothers and as career women. Ninety percent of the women in this study have engaged in dual roles, both as mothers and as career

women. Kukua who is childless and career oriented says she finds fulfilment in her work as a nurse. She has a lot of nephews and nieces who she regards as her own which allows her to connect to the mothering role as well.

Menopause and Aging

One of the major themes that came out of this thesis is the link between the quality of the menopausal experience and conception of aging. Menopause is the symbol that marks the division between the young and the old. For several of the participants in this study, menopause meant that they were no longer young, but growing older. However, others such as Mansa and Pokua who were in their forties did not equate menopause with aging.

For women, menopause may be the time that the body begins to show signs of aging. It has been reported elsewhere that many women are concerned with their body changes at this time (Jones, 1994). The women in this study showed signs of resisting society's ideal of the perfect youthful body. There were no complaints of weight gain or other body appearance issues, however loss of strength was a complaint voiced by several women.

Many of the women saw aging in a positive light. In fact they felt that there is nothing one can do about aging but to accept it. Rather, they looked forward to becoming wise old women and grandmothers. While a young woman has little or nothing to say either in the home or in the public sphere, this position changes when she is old. Her position may rival that of a man and her voice does not go unheard (Klingshirn, 1971: 116). Women in Ghana can expect to gain status and

respect as they grow. In the Akan language the elderly are addressed as *opanyin*, which means, "past growing". This term can be used for both men and women. The *opanyin* is someone who is wiser, more careful, respected and accomplished in life (Van der Geest, 1998). A woman becomes an *opanyin* when she stops menstruating. An *aberewa* is a term used for an old woman, when she cannot take care of herself and can no longer go to the farm or visit.

Several of the women were looking forward to becoming *mpanyinfo* in their various families. The women bemoaned the lack of respect for the elderly in the Canadian society. The respect accorded to the *opanyin* in Ghana is shown by giving up of seats in buses for them, addressing them with the proper name such as *opanyin* or *maame* [in Ghana, one does not address anyone who is older than him or her with their first names], and helping them with their loads and assisting them in any way possible.

Ghanaian-Canadian women also think that Canadians are less caring of their elderly. Most women look forward to going back home because they are afraid to go into nursing homes. In Ghana, the traditional extended family system made it possible for the elderly to be cared for in their old age. In a typical family house in Ghana, one expects to find adults, elderly persons, young people and children (Apt, 1996: 18). Therefore, the elderly can sit back, relax and enjoy life and his or her family. According to Van Geest (1998), the idea of dependency of the elderly is not that of failure as it is seen in industrialized societies, but of success. Most women look forward to being reunited with their family, to being taken care of and to being enjoyed by them.

As noted by Nana Araba Apt (1996) and the women interviewed, modernization and industrialization are disintegrating the traditional family system. Nana Apt argues that urbanization and modernization of economies have placed strains on the extended family system and the signs are that this traditional social welfare system no longer offers the customary social protection that they once enjoyed.

Although financial insecurity is a concern for both men and women as they age, for women who never worked in the paid labour force, this might be a more dramatic issue. Some of the women in this study reflected on what will happen to them in their old age. They saw the need for their children to take care of them. Serwaa and Nyame have no pension because they did not engage in paid labour in the public sphere. In Ghana only those who are employed by the government or big private companies get pensions after they retire. Although a woman may be engaged in productive labour, she will not get any pension because she is unlikely to have worked in the public domain. Old people therefore have to rely on their children and relatives when they grow old. Having many children becomes a security in one's old age.

This fear of long-term security explains why Serwaa wished she had more children after menopause even though she already had seven of them. She explained that it is better to have more children because one does not know which of them will take care of you in old age. At the end of the interview with Nyame, I asked her if she had anything more to add to what we had discussed. She went on to talk for more than ten minutes about the benefits of practicing

birth control so that one can have the number of children she can manage to take care of. Her belief is if you can take good care of your children, they will in turn grow up to become good and responsible adults who will take care of you in your old age.

The aging process is associated with many changes and has different meanings for the women in this study. For some, it meant changes in roles, for example, from mother to grandmother, and becoming an *opanyin.* Others have to grapple with problems of financial insecurity.

Menopause and Health

Menopause also signaled a change in health for some of the women. Changes in health status at menopause have been reported in other studies as well (Jones, 1994; McMaster et al, 1997). Some of the explanations given for the causes of health were related to blood. Davis (1986) and Gifford (1994) also found in their studies that a change in health was related to blood. Nyame reported of loss of strength and general weakness. She attributed this to the fact that the blood has stopped flowing. Aba believes that the blood becomes "weak" as one grows, and this brings about loss of strength and general weakness.

There is a difference between the explanations given in Gifford and McMaster et al.'s (1997) studies. In Gifford's (1994) study of Italian-Australian women, menopause was linked with ambivalence about immigration, where women were grieving for a home and life lost in Italy. In Australia the roles and status of women are less positive, therefore women experience menopause as a time of loss. In McMaster et al.'s study, women were happy that they were no

longer losing blood through periods and childbirth, and noted that they felt stronger after menopause.

For some women the changes in health were more connected with aging than with menopause. Quite a few of the women reported a decline in strength. In a study of old age in Ghana, Van Geest (2001) noted that strength [ahooden] was the most frequently mentioned word. Women need a lot of strength for the tedious labor they engage in. They need strength to be able to continue working, they need strength to take care of the needs of their family, and they need strength to have a sexual relationship with their husbands. When women complained about loss of strength in my study, they meant reduced energy to continue to work in the factories, reduced energy to go to the farm, and reduced energy to take care of their husbands and children.

For a few of the women, however, it seems that menopause meant a change to better health. There was no mention of nerves as was reported in Davis' (1986) study of Newfoundland women.

Overall, the women did not see menopause as a disease, but as a marker of general weakness and reduction of strength. A few of the women also reported forgetfulness and short temper. To gain their strength back, the women exercise daily, attempt to be active, engage in positive thinking, and regulate their diets.

Menopause and Power

The influence of the medical system on women, both in practice and in discourse cannot be underestimated. However, women are not always passive in their health care negotiations. They try to resist and exert their own power in their

everyday dealings with the medical system, however subtle. The notion of free choice entails that people have no limitation on their actions. Women's choices are however limited by their lack of knowledge as well as other social factors.

As was observed in this study and noted elsewhere (Jones, 1994) women lacked knowledge about physical body processes. This lack of knowledge has serious implications for their health. If women do not understand the changes that take place in their bodies, they cannot make informed decisions. For most of the women in this study, the "diagnosis" that they were going through menopause was made by their doctors. Additionally, as noted by Jones (1994: 62) without adequate knowledge normal physiological processes are often medicalized and the women are at risk of dangerous, expensive and unnecessary medical interventions.

The dominant discourse on menopause in North America is the biomedical model which constructs menopause as a physiological event and a disease, which requires treatment. For most women the medical discourse formed their initial understanding of menopause. However, most of them did not simply turn their bodies over to their physicians. For instance, Araba weighed the benefits and risks of Hormone Replacement Therapy (HRT) before making her decision. Frema and Pokua stopped using HRT and turned to the use of herbs when they realized that the risks outweigh the benefits.

At the time of this study, only one participant was taking HRT. She seemed unaware of its potential risks. The only side effect she knew of was some rashes that appeared on her face. The other women in this study, however,

rejected using HRT. Most believe that since menopause is not a disease, it does not warrant medical intervention. Some of the women are familiar with traditional healing practices and use herbal medicines to treat particular health concerns. However there was no known traditional medicine for menopause. Only one woman tried using herbs in place of HRT. None of the women recall their mothers using HRT; the existence of HRT in Ghana is very vague. One woman remarked that: *I didn't see my grandmother taking them, neither did I see any of my mothers take anything therefore I didn't take anything.* Ghanaian–Canadian women embraced the traditional view that menopause is part of the developmental phase, and does not warrant the use of herbs to control it. The perceived cause of menopause has played an important role in its management.

An example of the influence and authority and control of the medical system on women's lives is illustrated by the stories of Frema and Mansa relating to HRT. Frema's doctor got angry with her because she asked if there was any other alternative for HRT. In Mansa's case, she stopped taking the HRT. Her doctor found out by running some tests on her and indicated his disapproval. Her reaction was that you cannot hide anything from your doctor. You must do whatever he or she tells you. To her, the physician is some kind of absolute authority.

Though their initial descriptions of menopause were primarily focused on physical changes, several of the participants included other symbolic interpretations in the course of the interviews. In the biomedical perspective

menopause is a time of deterioration and a time limited event. By contrast, the women saw menopause as an ongoing event, part of the normative life cycle.

The findings of this study challenge the biomedical literature that treats menopause as a disease, and the view that most menopausal women should take HRT. However, it supports the socio-cultural model, which recognizes that the experience of menopause is a function of social factors such as status and roles.

How do the results of this study compare with the outcome of other studies on immigrant women? George (1985) and Spitzer's (1998) studies on immigrant women show that they were able to maintain indigenous meanings of menopause in a highly pluralistic society. George's (1985) studies amongst the Sikh in Vancouver notes that the women were protected from the dominant biomedical views of menopause. The women sought solidarity from one another, which enabled them to maintain their indigenous ideas of menopause. Spitzer's (1998) work among Chinese, Chilean and Somali women had similar findings. The women of Somalia, the least stable community, sought the company of other women to engage in the study of the Qu'ran and to devote time for prayer. The Chilean women also sought the solidarity of other women, which allowed them to maintain indigenous beliefs about menopause, though the Chilean community is relatively small. The Chinese women said they spoke freely with their peers and husbands about menopause.

In this study however, Ghanaian-Canadian women do not speak freely with other women about menopause and only a small number of the women in

this study received support from their spouses, though the Ghanaian community in Toronto is relatively large. The size of the Ghanaian community in Toronto indirectly may have served as a buffer against the biomedical model of menopause. Most of the activities engaged in by the Ghanaian community in Toronto are similar to those done in Ghana; some of these activities are funeral, marriage ceremonies and naming ceremonies. These activities help maintain the Ghanaian culture and also serve as an avenue where women meet other women to discuss issues concerning their lives. Ghanaian-Canadian women also have a positive attitude towards menopause because they anticipate the benefits of old age and an increase in status.

A significant finding from this study is the negative impact of hysterectomy on the experience of menopause. The women who had gone through hysterectomy and had a surgically induced menopause had a significantly different experience from those who had gone through natural menopause. They expressed more distress than women who had natural menopause. The problems they experienced seemed to be greatly exacerbated by the lack of information from their physicians. None of the women anticipated that having a hysterectomy would result in immediate menopause and they were not prepared to deal with it. The other studies on menopause did not isolate cases of women whose menopause was initiated by hysterectomy. There is the need for more studies in this area as well as research on the impact of patient education on the experience of menopause by women who have undergone hysterectomy.

Future Directions

This study is a small scale preliminary study that is geared towards finding how Ghanaian-Canadian women interpret the experience of menopause. With the exception of three women, all of the participants in this study have spent at least ten years in Canada. The women reflected on their experiences of menopause and what it meant to them. This study also gives a brief glimpse of the menopausal experience of women in Ghana through the women's accounts of other family members. A comparative study of women in Ghana would present a better hint of the experiences of women in Ghana. Such a study would also be useful to assess the impact of biomedicine on Ghanaian immigrant women.

The impact of religion on women's experiences and understanding of menopause cannot be overestimated. This study was conducted with women from predominantly the Akan tribe, belong to Christian religion. A study with Ghanaian women that included women from other tribes and other religions would help to assess the influence of other religious beliefs on women's experiences and understandings of menstruation and menopause. Most of the women in this study saw menstruation and menopause as natural events as they are arranged by God.

Women in this study have recognized that both men and women undergo some transitions in their lives at midlife. A few of the women in this study believed that men also go through menopause. They note that a woman's menopause is more obvious because she takes care of the needs of the family, and any changes that inhibit her duties are readily noticed. Additionally women

go through physical changes such as cessation of menses. Future research should explore the experiences of men at midlife. A gender studies analysis of the differences between men and women at this stage of their lives would provide interesting data on the comparative social dimensions of aging for Ghanaian men and women.

Conclusions

The purpose of this study was to explore the meaning and interpretation of menopause for a small group of Ghanaian–Canadian women. Women's own voices have been heard through this qualitative study. The study was limited by the short time frame and also by the sample size. However this did not affect the relevance of the study as this is only an exploratory study and does not seek to generalize to the Ghanaian-Canadian population as a whole.

For the past few decades, research on menopause has been along two lines: the biological model and the socio-cultural model. The biological model conceptualizes menopause as a disease, while the socio-cultural model views menopause as a socially framed developmental process. Additionally, the biomedical model assumes that distress at menopause is the norm for women in Western countries, while the socio-cultural model often depicts non-Western women as having a symptom-free experience because they gain greater social or political status after menopause.

The diverse views given in this study indicate that there is no universal way of experiencing menopause. Cultural, social, religious and life experiences,

age at which menopause began, and the meanings of aging for women, all influence the experience of menopause.

Menopause represents the end of the menstrual years, and for some women this can result in either an improvement or a decline in health; it can also mark the beginning of aging which can be accepted or feared. Menopause means the end of the childbearing years, and for some, it may signify the end of child rearing years. Menopause may be a time when women assert power over their bodies and resist mainstream Western society's ideal of youthful women. Overall the women I interviewed did not see menopause as a disease that required medical intervention. As stated by Martin (1987) women's accounts of their bodily processes often differ from the biomedical accounts of menstruation, childbirth and menopause.

This study included women who went through natural menopause and those whose hysterectomies initiated their menopause. I noted that the two groups experienced menopause differently. Those whose menopause was brought on by hysterectomy were not prepared for the changes they experienced. There is therefore the need for greater education of women who are contemplating a hysterectomy to ensure that they are aware of its impact on generating menopause and the type of discomforting symptoms they may suddenly experience. With advanced knowledge, women who have hysterectomies will understand the changes they are experiencing and be able to make informed decisions about the management of menopause in the same

fashion that women who experience a natural menopause have demonstrated here.

APPENDIX 1

PROFILE OF PARTICIPANTS

Serwaa is sixty-seven years old and a mother of seven children. She is a widow and has no formal education. Serwaa was born and raised in Nkawkaw, a marketing center in Ghana. Serwaa who has been in Canada for 3 years now was sponsored by one of her sons. Serwaa's menstrual cycle became irregular for about two months after the birth of her last child. She was fifty years old then. She went to see a doctor as she thought it was pregnancy. Serwaa did not take HRT and is currently any.

Kukua is a 64-year-old retired nurse. She left Ghana 41 years ago for the United Kingdom. She left the United Kingdom 3 years later to migrate to Canada and has been here since. Kukua grew up in Cape Coast, which is an urban center. Inhabitants of this town were the first to come into contact with Europeans in the 17th Century. Abigail was 45 years when she reached menopause. Kukua experienced hot flashes and night sweats but did not go on any medication. She is currently not on HRT.

Pokua is a 48-year-old woman who grew up in an urban town. She came to Canada twenty years ago to join her husband. She has two daughters. Pokua has extensive medical history including hepatitis B, had a tubal ligation at the age of thirty-eight, a hysterectomy at forty-six and nearly suffered a stroke two years ago. Pokua experienced hot flashes, night sweats, dizziness, irregular heartbeats, and loss of libido and bouts of depression. Pokua stopped taking

HRT when she learned of the side effects. She is currently taking Chinese herbal medicine.

Nyame is a 62-year-old woman with nine children. Nyame who was sponsored by her son has been in Canada for five years now. Serwaa who has no formal education is originally from a farming town in the Brong Ahafo region of Ghana. She has been in Canada for five years now at the invitation of her son. She lived all of her life in Ghana and was a baker. She has no education. Nyame was 52 years old when she went through menopause. She experienced hot flushes, pains in the legs, bones and had a swollen knee. She did not take any medication as she thinks menopause is a normal part of the aging process and that the symptoms will go away after some time.

Mansa is a 49-year-old woman and lives with her husband and their four children. She is an Akan and comes from a rural town in the Ashanti region of Ghana. Mansa had hysterectomy at age 46 on the advice of her doctor, because she had a weak womb and was bleeding in-between her periods. Mansa had a fair share of night sweats, hot flashes and burning sensation in her legs and still experiences them. She thinks menopause is a disease.

Aba was 47 years old when she went through a natural menopause. Some of the problems that she experienced were some burning sensation in her feet, dizziness and general weakness. Aba did not go on any medication. Aba hails from the coastal town of Cape Coast in the Central Region of Ghana.

Oforiwaa is a 54-year-old retired theatre [operating room] nurse who comes from the farming town of Begoro in the Eastern Region of Ghana. She has four children, three of whom are resident in Toronto. Her children sponsored her to Canada five years ago. Oforiwaa did not go on any medication and is currently not on HRT.

Araba is a 63-year-old widow with four children and five grandchildren. She left Ghana at age 28 with her husband to go to England. From England they came to Canada and have been here for the past 30 years. Araba who has a postgraduate degree hails from the coastal urban town of Cape coast in the central Region of Ghana. Araba began menopause when she was 54 years and experienced hot flashes and cold sweats; however she did not go on HRT.

Frema is a 54-year-old divorced mother of two and is a resident of Toronto. Frema is from a farming town of Brong Ahafo in Ghana and comes from a royal family. Frema holds a postgraduate degree and has her own firm. Frema underwent a hysterectomy at age forty-four because of a problem with fibroids. Frema started taking HRT but decided to stop when she learned that it could cause cancer. She is currently taking Chinese herbal medicine to reduce the bouts of hot flashes she has been experiencing.

Fosua is 54 years old, a mother of three children, and has four grandchildren. Fosua joined her husband in Canada and has been living here for twenty years since. Fosua is an Ashanti but was raised in Ghana's capital city of Accra. Fosua

went into menopause when she was 50 years old. She experienced hot flashes, cold sweats and dizziness; however she did not take HRT.

APPENDIX 2

INTERVIEW SCHEDULE

A. Demographics

1. Name of participant
2. Age
3. Marital status
4. Number of children
5. Place of birth
6. Ethnic group in Ghana, city of origin, language spoken
7. Time migrated to Canada, length of stay
8. Occupation in home country, occupation in Canada
9. Highest level of education

A. General Questions

1. Tell me about how you migrated to Canada
2. Tell me about your living conditions in Canada, how do they differ from your living conditions in Ghana?
3. Tell me about your working conditions, how do they differ from your working conditions in Ghana? (If applicable).
4. Any family in Toronto?
5. Household pattern (different or similar to the traditional Ghanaian context)
6. Belong to any (Ghanaian) group or organization?
7. Language spoken at home
8. Type of food eaten

B. HEALTH

1. How is your overall health?
2. If you are ill, what do you do?
3. If you or a member of your family is ill, what do you do?
4. When was the last time you saw a doctor?
5. How do you find the medical system in Canada?
6. Do you like your doctor?
7. Any chance of herbal medicine?
8. Who's responsible for your family's health needs?
9. How was your health in Ghana? Different from that of Ghana?
10. What do you to keep yourself healthy?

C. MENSTRUAL HISTORY

1. Age at menarche
2. Where did change your status, social role and relationship with the opposite sex?
3. How was it viewed?
4. Any problems at menarche?
5. What was your experience of menstruation?

D. MENOPAUSE

1. Age at menopause
2. What is menopause? When does it occur?
3. Are you aware of any physical or emotional changes that occur at menopause? If yes, what are they are they, and when do they occur?
4. How should a woman behave during menopause?
5. Taking any medications now?
6. Are you taking any Hormone Replacement Therapy (HRT)?
7. Do you think it is necessary for women to take HRT of any medications?
8. What was your experience like? Was it different from others you know?
9. Was it different from the experiences of other women in Ghana?
10. Was it different from your mother's experience?
11. Did you have any concerns or worries before going menopause?
12. Were those concerns realized?
13. Does menopause mean anything to you?
14. What significance does it have?
15. Is your different from what it used to be before reaching menopause?
16. Is it viewed differently in Canada than in Ghana?
17. If so how?
18. Do you see menopause as a sign of aging? If so how?
19. What does it mean to grow old
20. Any concerns over aging?
21. Did going through menopause change anything about your status as a woman, or your sense of who are as a woman? How do others respond to you?
22. How do men see menopause? Is it different from women?

APPENDIX 3

CONSENT FORM

I, _____ have agreed to take part in research on the topic An Exploration of the Meaning of Menopause for Ghanaian-Canadian Women, being undertaken by Ms Fidelia Donkor of the Department of Sociology, Lakehead University. I have read and understood the information in the covering letter as it has been discussed with me.

I understand that the study will not pose any physical and psychological risk to me. I also understand that the study will require me to answer some questions that I am free to withdraw from the study at any time and I can decline to answer any questions I don't feel comfortable with. I am aware that a report on the study can be requested from the Department of Sociology, Lakehead University when the project is completed.

_____

Signature of Participant Date

APPENDIX 4

INTRODUCTORY LETTER

Dear Respondent,

My name is Fidelia Donkor and I am a Master's student in the Department of Sociology, Lakehead University working under Dr. Pam Wakewich. I am interested in learning about the health of Ghanaian women between the ages of 45 to 70 who have migrated to Canada within the last twenty years. In particular I am interested in the experience and meaning of menopause for Ghanaian-Canadian women. I hope that the outcome of this research will be to help health professionals and social workers to develop ethnically sensitive health services.

The study consists of an interview, approximately one to two hours in length. This research will not be of any risk to you; however you are free to opt out at any time, or decline to answer any question you are not comfortable with. With your consent, the interview will be tape-recorded and later transcribed for analysis. The identity of all interviews will remain anonymous. I will store the tapes and the transcriptions for seven years after which they will be destroyed.

A consent form is attached to this letter for you to sign if you agree to take part in the study. Your name and all other identifying information will remain confidential. I will give you an assumed name in all the documents and papers in my possession. A final report can be requested from me upon completion of the study.

Please feel free to contact or call me at or my supervisor, Dr. Pam Wakewich at the Department of Sociology, Lakehead University at , if you have any questions or concerns at any time.

Sincerely yours,

Fidelia Donkor

REFERENCES

Abdul-Hamid, H. (2001) Accra City Project. Unpublished Manuscript. Accra, Ghana.

Apt, N. A. (1996) Coping With Old Age in a Changing Africa: Social Change and the Elderly Ghanaian. Avebury, England: Aldershot .

Amoah, E. (1990) "Femaleness: Akan Concepts and Practices" In J. Bercher (Ed) Women, Religion and Sexuality: Studies on the Impact of Religious Teaching on Women. Geneva: WCC Publishers.

Ampofo, A. A. (1993) "Controlling and Punishing Women: Violence Against Ghanaian women." Review of African Political Economy, Number 56: 102-110.

Anarfi, J. (1990) "Female Migration Occupation and Disease Linkages- The Abidjan Case Study." Paper Presented at the Informal Workshop on Researching Sexual Networking in West Africa, Ibadan, 22-23, March

Ardayfio-Schandorf, E. (1993). "Household Energy Supply and Women's Work in Ghana." In J.H. Momsen & V. Kinnaird (Eds) Different Places, Different Voices: Gender and Development in Africa, Asia and Latin America. London, U.K.:Routledge.

Atkinson, R (1998) The Life Story Interview. Qualitative Research Method Series. Volume 44. Thousand Oaks, California: Sage Publications.

Avotri, J. Y. (1997). "Thinking too Much" and "Worrying too Much": Ghanaian Women's Experiences of their Health Problems. PhD Dissertation, McMaster University, Hamilton.

Avotri and Walters, V (1999) "' You Just look at Our Work and See if You Have Any Freedom on Earth': Ghanaian Women's Accounts of Their Work and Health." Social Science and Medicine, Volume 48:1123-1133.

Bantjes, J. E. (1982) Some Social and Cultural Aspects of Menopause. Masters' Thesis, University of Saskatchewan.

Barnett, E. A. (1988) "*La Edad Critica*: The Positive Experience of Menopause in a Small Peruvian Town." In P. Whelehan (Ed) Women and Health: Cross-Cultural Perspectives. Bergin and Garvey Publishers.

Bart, P. (1969). "Why Women's Status Changes in Middle Age." Sociological Symposium, 3: 1-18.

Bell, S. E. (1982) "Changing Ideas: The Medicalization of Menopause." Social Science and Medicine, Volume 24: 535-542.

Berkow, R. (1987). The Merck Manual of Diagnosis and Therapy (15th Ed). Rahway, N. J.: Merck.

Bertaux, D. (ed). (1981) Biography and Society: The Life History Approach in the Social Sciences. Beverly Hills, California: Sage Publications.

Beyene, Y. (1989) From Menarche to Menopause: Reproductive Lives of Peasant Women in Two Cultures. Albany: Suny Press.

Boyd, M. (1986) "Immigrant Women: Language, Socioeconomic Inequalities and Policy Issues." In S. Halli, F. Trovato &L. Dreiger (Eds) Ottawa: Carleton University Press.

Brown, K. J. (1982) "A Cross-Cultural Exploration of the End of Child Bearing Years." In A. M. Voda, M. Dinnerstein & S. R. O' Donnell (Eds) Changing Perspectives on Menopause. Austin: University of Texas Press.

Brydon, L. (1992) "Ghanaian Women in the Migration Process." In S. Chant (Ed). Gender and Migration in Developing Countries. Belhaven Press.

Caldwell, J. C. (1969) Africa, Rurual Urban Migration: The Movement to Ghana's Towns. Canberra: ANU Press.

Conrad, P. & Schneider J.W. (1982). Deviance and Medicalization: From Badness to Sickness. St Louis: CV Mosby.

Davis, D. L. (1983) Blood and Nerves: an Ethnographic Focus on Menopause. St John's Newfoundland: Institute of Social and Economic Research, Memorial University of Newfoundland.

Davis, D.L. (1996) "The Cultural Constructions of the Premenstrual and Menopausal Syndromes." In C. F. Sargent & C. B. Brettel (Eds) Gender and Health An International Perspective. Upper Saddle River, NJ: Prentice-Hall, Inc.,

De Beauvoir, S. (1971) The Second Sex. New York: Knopps.

Denzin, N. K. & Lincoln, Y.S. (1998) The Landscape of Qualitative Research Theories and Issues. Thousand Oaks, California: Sage Publications.

Deutsch, H. (1945) The Psychology of Women, Volume 2. New York: Grand and Stratton.

Dolphyne, F. A. (1991) The Emancipation of Women: An African Perspective. Ghana: Ghana Universities Press.

Doyal L. (1995) What Makes Women Sick? Houndmills and London: Macmillan Press Ltd.

Dunk, P. (1989) "Greek Women and Broken Nerves in Montreal". Medical Anthropology, Volume 11:29-45.

Flint, M. (1975) "The menopause: Reward or Punishment?" Psychosomatics, 16:161-163.

Fosu, G. (1995) " Women's Orientation Towards Help-Seeking for Mental Disorders". Social Science and Medicine. Volume 40 (8) 1029-1040.

Freund, P. E. S. and M. McGuire (1995) Health, Illness and the Social Body: A Critical Sociology. Englewood Cliffs, N.J.: Prentice-Hall.

Gail, S (1992) The Silent Passage: Menopause. New York: Random House.

George, T. (1985) There is a Time for Everything: A Study of Menopause/Climacteric Experience of Sikh Women in Canada. Unpublished PhD Dissertation, University of Utah.

Gifford, S. M. (1994) "The Change of Life, the Sorrow of Life: Menopause, Bad Blood and Cancer Among Italian-Australian Working Class Women." Culture, Medicine and Psychiatry, Volume 18 (3) 299-319.

Hackett, R. I. (1994) "Women in African Religions". In A. Sharma (Ed) Religion and Women. State University of New York Press.

Harding, Sandra (1987) "Introduction: Is there a Feminist Method?" Sandra Harding (Ed.) Feminism and Methodology. Bloomington: Indiana University Press.

Hartsock, Nancy (1983) "The Feminist Standpoint: Developing the Ground for a Specifically Feminist Historical Materialism". In S. Harding & M. B. Hintikka (Eds.), Discovering Reality. Amsterdam: D. Reidel.

Hartsock, Nancy (1985) Money, Sex and Power: Towards a Feminist Historical Materialism. Boston: Northeastern University Press.

Jones, J (1994) "Embodied Meaning: Menopause and the Change of Life". Social Work in Health Care, Volume 19: 43-65.

Kaiser, K. (1990) "Cross-Cultural Perspectives on Menopause." In M. Flint, F. Kronenberg & W. Utian (Eds) Multidisciplinary Perspectives on Menopause. New York: New York Academy of Sciences.

Kaufert, P. & Gilbert, P. (1986) " Women, Menopause and Medicalization." Culture, Medicine and Psychiatry, Volume 10 (1) 7-21.

Kaufert, P. & Lock, M. (1998). "What are women for? Cultural Constructions of Menopausal Women in Japan and Canada" In D'Arcy Carl, Torrence & George M (Eds) Health and Canadian society: Sociological Perspectives. Toronto: University of Toronto Press.

Kaufman, S.R. (1986) The Ageless Self: Sources of Meaning in Late Life. Madison: University of Wisconsin Press.

Klingshirn, A. (1971) The Changing Position of Women in Ghana. Inaugural Dissertation. Marburg/Lahn.

Kwawukume, T.S. & Wilson, J.B. (1993) "Menopausal Age of Ghanaian Women." International Journal of Gynaecology and Obstetrics, Volume 40 (2) 151-155.

Leysen, B. (1996) "Medicalization of menopause: from 'Feminine Forever' to 'Healthy Forever'." In Lykke, N & Braidotti, R. (Eds) Between Monsters, Goddesses and Cyborgs. Feminists Confrontations with Science, Medicine and Cyberspace. London. Zed Books.

Lock, M. (1993) Encounters with aging: Mythologies in Japan and North America. Berkeley: University of California Press.

Lock, M. (1998) "Anomalous Ageing: Managing the Menopausal Body." Body and Society Psychosomatics, 27:266-73.

Lock, M. & Scheper-Hughes, N (1990) "A Critical Interpretive Approach in Medical Anthropoplogy: Ritual and Routines of Discipline and Descent. In T. Johnson, & C. Sargent (Eds) Medical Anthropology: A Handbook of Theory and Method. New York: Greenwood Press.

McMaster, J. Pitts, M. & Poyah, G (1997) "The Menopausal Experiences of Women in a Developing Country: There Is a Time for Everything: To Be a Mother and a Granny." Women and Health, Volume 26 (4) 1-13.

McPherson, K. I. (1881) "Menopause as Disease: The Social Construction of a Metaphor". Advances in Nursing Science Volume 3 (2) 95-113.

Manuh, T. (1994) "Ghana: Women In the Public and Informal Sectors Under the Economic Recovery Programme." In P. Sparr (Ed) Mortgaging Women's

Lives: Feminist Critiques of Structural Adjustment. London and New Jersey: Zed Books Limited.

Martin, E. (1987) The Woman in the Body: A Cultural Analysis of Reproduction. Boston: Beacon Press.

McCrea, F.B. (1983) "The Politics of Menopause: The "Discovery" of a Deficiency Disease". Social Problems, Volume 31 (7) 111-123.

Mishler, E. G. (1989) "Critical Perspectives on Medical Model." In Brown, P. (Eds) Perspectives in Medical Sociology. Belmont, California: Wadsworth Publishing Company..

Nettleton, S. (1995) The Sociology of Health. Cambridge, Mass. Polity Press.

Nikoi, G. (1990) "Women's Access to Credit in Africa." In Women and Credit: Research Series. United Nations International Research and Training Institute for the Advancement of Women. Santo Domingo.

Nukunya, G. K. (1992) Tradition and Change In Ghana. Ghana Universities Press, Accra.

Ofei-Aboagye, R. A. O. (1994) Ghanaian Women: Equity and Empowerment. PhD Dissertation. York University, North York, Ontario.

Ofori-Atta, A.M. L. & Linden, W. (1995) "The Effect of Social Change on Causal Beliefs of Mental Disorders and Treatment in Ghana." Social Science and Medicine, Volume 40 (9)1231-1242.

Opoku-Dapaah, E. (1993) Adaptation of Ghanaian Refugees in Toronto. North York:: York Lanes Press, Inc.

Oppong, C. (1974) Marriage Among a Matrilineal Elite: A Family Study of Ghanaian Senior Civil Servants. London: Cambridge University Press.

Page, L. (1990) The Change: Women's Construction of the Meaning of Menopause- A Group Process. Unpublished Masters Thesis. University of British Columbia.

Robinson, G. (1996) "Cross-Cultural Perspectives on Menopause." Journal of Nervous and Mental Disease, Volume 184 (8) 453-458.

Riessman, C. K. (1989) "Women and Medicalization: A New Perspective" In Phil Brown (Ed) Perspectives in Medical Sociology. Belmont California: Wardsworth Publishing Corporation.

Rossman, G. B. & Rallis S.F. (1998) Learning in the Field: An Introduction to Qualitative Research. Thousand Oaks, CA: Sage Publications.

Rubin, L.B. (1979) Women of a Certain Age: The Midlife Search for Self. New York: Harper and Row.

Salk, H. Sanford, W. Swenson, N. &Luce, J. D. (1984) "The Politics of Women and Medical Care." In Boston Women's Health Book Collective. The New Our Body, Ourselves. New York: Simon & Schuster.

Seidman, I. E. (1991) Interviewing as Qualitative Research: A Guide for Researchers in Education and the Social Sciences. New York: Teaching College Press.

Singer, M. & Baer, H. (1995) Critical Anthropology. Amityville, N.Y. Baywood Publishing Company.

Smith, D. (1989) "Sociological Theory: Methods of Writing Patriarchy." In R. A. Wallace (Ed.) Feminism and Social Theory. Newbury Park, CA: Sage.

Spitzer, D. L. (1998) Migration and Menopause: Women's Experiences of Maturation in Three Immigrant Communities. PhD Dissertation. University of Alberta.

Surdarkasa, N (1977) Women and Migration in Contemporary West Africa. In Women and National Development: The Complexities of Change. The Wesley Editorial Committee. Chicago: University of Chicago Press.

Twumasi, P. A. (1979) "A Social History of the Ghanaian Pluralistic System". Social Science and Medicine, Volume 13B: 349-356.

Yusuf, S. & Anand, S. (2002) "Hormone Replacement Therapy: a Time for Pause". Canadian Medical Association Journal, Volume 167 (4) 357.

Van der Geest, S. (2001) "'No Strength': Sex and Old Age in a Rural Town in Ghana." Social Science and Medicine, Volume 53: 1383-1396.

Van der Geest. S. (1998) "*Opanyin:* the Ideal Elder in the Akan Culture of Ghana". Canadian Journal of African Studies, Volume 32 (3) 449-493.

Van Wingerdin I. (1996). "Postmodern Visions of the Menopausal Body: The Apparatus of Bodily Production and the Case of Brittle Bones." In N. Lykke. & R. Braidotti (eds.) Between Monsters, Goddesses and Cyborgs. Feminists Confrontations with Science, Medicine and Cyberspace. London: Zed Books.

World Health Organization Technical Report Series. (1994) Research on Menopause in the 1990s.

Williams, T.F. (1990) "Osteoporosis and hip fractures: Challenges to Investigators and clinicians." Journal of American Medical Association, Volume 263(5) 708.

GhanaHomePage:http://www.ghanaweb.com/GhanaHomePage/ghana/gh_general.html.27/11/2002 2:16pm