Quality of Life Among of Menopausal Women in Saudi Arabia

Hoda A. Elazim [1], Sahar M. Lamadah [2], Luma Gh. Al Zamil [3]

Abstract

Objective: to assess the menopause related symptoms and their impact on the women's quality of life.

Methods: A descriptive design was carried out in Obstetrics and Gynecological department at maternity and children hospital in Makkah Al Mukkarrmah. Convenient sample composed of 90 women at range of from 40-60 years were recruited in the study. Interviewing sheet that was designed by the investigators and Menopause Specific Quality of Life Questionnaire were used to collect the data.

Results: The present study showed that the most severe symptoms in vasomotor, psychosocial, physical and sexual domains were, hot flushes (29%), experiencing poor memory (48.3%), being dissatisfied with their personal life (44.8%), Low backache (41.9%), and change in your sexual desire (36.8%).
The overall scores of menopausal quality of life for each domain are indicated that the highest mean score in sexual domain (3.19± 1.99), following by psychosocial (2.94± 1.45) then vasomotor (2.55± 1.53) and finally physical symptoms (2.28± .749).

Conclusions: The present study concluded that most severe symptoms in vasomotor, psychosocial, physical and sexual domains were, hot flushes, experiencing poor memory, being dissatisfied with their personal life, low backache, and change in your sexual desire. The mean scores of physical and vasomotor domain were significantly more in postmenopausal (PM) group then menopausal transition MT group. While the mean scores of each domain suggest that menopausal symptoms were associated with decrease in women quality of life.

Keywords: Menopause - Menopausal symptoms- Quality of life – MENQOL.

(J Med J 2014; Vol. 48 (4):227- 242)

Received	***Accepted***
Feb. 10, 2014	*June 29, 2014*

Introduction

Today, with increasing life expectancy and life span, women spend one-third of their lifetime after menopause [1,2]. Menopause is an adaptation process during which women go

1. **Assistance Professor of Obstetrical and Gynecological Nursing, Faculty of Nursing-El Minia University, Egypt, Nursing College at Umm Al Qura University, K S A.**
2. **Lecturer of Obstetric and Gynecological Nursing, Faculty of Nursing, Alexandria University, Alexandria, Egypt, Nursing College at Umm Al Qura University, K S A.**
3. **Speech Language Pathologist, The University of Jordan, Bachelor's Degree Faculty of Nursing – Jordan University Scientific and Technology, Jordan, Nursing College at Umm Al Qura University, K S A.**

*** *Correspondence should be addressed to:* Luma Ghazi Al Zamil**
Phone No.: 0096656468721
Fax No.:0096625270000/4670, B.X:715-21955
E-mail :lumazamil@yahoo.com

through a new biological state. This process is accompanied by many biological and psychosocial changes [3]. Menopause is a normal physiological process which is characterized by the permanent cessation of menses in women as a result of reduced ovarian hormone secretion usually between the ages of 45 and 55 years. During this period women can experience many symptoms including hot flashes, night sweats, sleep and mood disorders, impaired memory, lack of concentration, nervousness, depression, insomnia, bone and joint complaints, and reduction of muscle mass. The duration, severity, and impact of these symptoms vary extremely from person to person, and population to population. Some women have severe symptoms that greatly affect their personal and social functioning, and quality of life[4]. Vasomotor symptoms, are common physical conditions experienced by midlife women in the transition through menopause and early post menopause [5,6].

Psychological symptoms frequently associated with menopause include fatigue, irritability, and anxiety. Some symptoms associated with changing hormone levels are directly linked with estrogen depletion. Hot flashes, night sweats, and vaginal atrophy resulting in vaginal dryness are correlated with changing levels of sex hormones[7]. Other symptoms, such as sleep disturbances, fatigue, anxiety, and weight gain, although common to the experience of menopause, are multi factorial in cause and occur in non-postmenopausal women as well[8]. Studies find that most women experience at least one or more of these symptoms as they transition through the postmenopausal stage of life[5].

The mean age of the menopause in Egypt is 46.7 years, which is low compared to many countries, but this age has been rising in the past few years in the west, probably because of the different 'sociocultural attitudes' towards the menopause in different communities. The western woman attitude towards the menopause is generally positive and about one third of them considers the menopause as 'a normal physiological change'. Nevertheless, the Egyptian women need an awareness campaign about menopause in order to educate them about this important stage of their lives[9].

Despite a majority of women experiencing multiple symptoms, the literature still presents a gap on whether clusters of symptoms consistently occur and what effect symptom clusters have on quality of life [5].Study in Saudi Arabia showed those 'hot flashes' and 'sweeting' (68.5%), 'vaginal dryness' (37.3%) and 'sexual problems' (30.7%) were the most common symptoms in menopausal women. In addition, the most severe symptoms were hot flashes and excessive sweating [10]. The frequency of symptoms can vary based on epidemiological characteristics of the population and the assessment tools used [11]. The effect of menopausal transition on women's lives is complex and includes changes in physical health, psychosomatic domains, and personal life. Health-related quality of life may be severely compromised in women with vasomotor symptoms. Up to 40% of women in Sweden experience vasomotor symptoms until the age of 64 years[12].

Quality of life is a broad, multidimensional concept that lacks a precise definition in the medical literature. The World Health Organization has defined quality of life as individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns[13]. Quality of life tends to decline in midlife women, and there is a need to

determine what role, if any, symptoms commonly associated with the transition to menopause and early postmenopausal play in this phenomenon [14, 15].Quality of life is an important outcome measure of health care, and understanding the impact of menopause on quality of life is a critically important part of the care of symptomatic postmenopausal women [16].The study of quality of life in the post-menopausal women has become an essential component in clinical practices. Most studies on quality of life of postmenopausal women were conducted in developed countries with different socio cultural realities, which may influence not only the perception of quality of life but also the experience of menopausal symptoms. Very little information exists about quality of life of postmenopausal women in developing countries[17].

Significance

The transition through menopause is a life event that can profoundly affect quality of life. More than 80% of women report physical and psychological symptoms that commonly accompany menopause, with varying degrees of severity and life disruption[1]**.** Few empirical studies, however, have examined the interrelated nature of symptoms associated with the menopausal transition and early postmenopausal and the effects of those symptom groups on quality of life[14]. Maintaining good physical functioning with age is a vital component of independence in later life [18,19,&20].

Identifying characteristics associated with poor physical functioning could contribute to prevention and management strategies that help older people to maintain their independence and also therefore their quality of life. Health-care providers play a more visible and instrumental role in continuously assessing menopausal women's needs as well as to implement appropriate health educational programs and to develop a new way to meet their demands [17]**.**

The Research Questions: Are the menopausal symptoms impacts on the women's quality of life?

Aim of Study

The aim of this study was toassess the menopausal related symptoms and their impact on the women's quality of life.

Subject and Methods

Research Design:

Descriptive study design was used in this study

Setting:

The study was conducted in Obstetrics and Gynecology department at maternity and children's hospital in Makkah Al Mukkaramah.

Subjects:

A convenient sample of 90 women at menopausal stage was recruited in the study according to the following criteria:

- Mentally oriented.
- Women of age 40 – 60.
- Don't uses hormonal replacement therapy.
- Minimum read and write is accepted.
- Free from medical conditions like diabetes, hypertension, cardiac disease and thyroid disorder.

Tools:

Tools for data collection were consisting of:

A-Interviewing sheet: was designed by the researchers and it includes data about women's socio demographic data: economic state,

occupation & educational level, menstrual status etc...

B-Menopause specific quality of life questionnaire (MENQOL). It is a self-report measure assessing the presence and severity of menopause symptoms and the degree to which they adversely affect women's life designed by **(Hilditch JR, Lewis J)**[21]. It consists of 29 items divided into four domains: vasomotor (three items), psychosocial (seven items), and physical (16 items) and sexual (three items), the vasomotor domain assesses hot flushes, night sweats, and sweating. The psychosocial domain evaluates the psychological well-being of the individual by including items regarding anxiousness, memory, and feeling "blue". The physical domain assesses items such as flatulence, bloating, pain, tiredness, sleeping, energy and weight gain. The sexual domain inquires about changes in sexual desire, vaginal dryness, and intimacy.

The systematic scoring for each of the four MENQOL domains is identical. The seven-point Likert scale used during the administration of the MENQOL is converted for scoring and data analysis. For each of the 29 items, this seven-point Likert scale is converted to an eight point scale, ranging from 1 to 8. A "one" is equivalent to a woman responding "no", indicating she has not experienced this symptom in the past month. A "two" indicates that the woman experienced the symptom, but it was not at all bothersome. Scores "three" through "eight" indicate increasing levels of bother experienced from the symptom, and correspond to the "1" though "6". The score by domain is the mean of the converted item scores forming that domain and ranges from 1-8. Severities of menopause symptoms scoring system as the following, Score range from 2-4 consider mild, score range from 5-6 moderate, and score range from 7-8 severe symptoms.

Validity and reliability

To measure content validity of the tools the researchers assure that items of an instrument adequately represent what are supposed to measure by presented it to 3 experts from obstetrics and Gynecology nursing) who conducted face and content validity of all item. All recommended modifications were performed. Also using ***Menopause specific quality of life questionnaire (MENQOL)*** is considering stander evidence support validity of the tools. The test–retest reliability for MENQOL questionnaires was good whether the interval between testing was one days. Domain internal consistency was calculated for each questionnaire using Cronbach's alpha and the degree of reliability alpha precision 88% of the study.

Administrative design

Needed permissions were obtained through appropriate channels. An official permission was obtained from the dean of the faculty of nursing at Umm Al-Qura University to the director of hospital requesting his approval for data collection.

Pilot Study

To assess the clarity, reliability and applicability of the study tools used in the study for data collection; a pilot study was conducted with a representative sample of ten women. The results of the pilot study helped in the necessary modifications of the tools in which omission of unneeded or repeated questions, adding missed questions was done. The women included in the pilot study were excluded from the study subjects.

Procedures:

The researchers attended the gynecological ward of the studied setting two days per week, from 9.00 a.m. to 1.00 p.m. The study was conducted during the period October 2013 to December 2013. The researchers introduced themselves and briefly explained the purpose of the study to approached women who met the criteria for inclusion in the sample. All women were informed that participation is voluntary. Oral acceptance of women to participate in the study was obtained. Modifications of the tools were done, accordingly. Data collection was carried out through interviewing with women; Time consumed for each interview ranges from 20 to 30 minutes with each woman using the previously mentioned tool. The researchers collect data related to socio demographic data, menstruation status, and menopausal symptoms.

Menopausal status was determined based on the reported length of time since last menstrual period. Women who reported still having normal menstrual cycles or with slight change in the length of cycle were classified as menopause transition (MT). While women whose last menstrual period occurred 12 months ago or more, were categorized as post menopause (PM). The experience of symptoms, as tested in Menopause Specific Quality of Life (MENQOL) questionnaire. Menopause Specific Quality of Life (MENQOL) questionnaire consists of 29 items. All items followed the same format. Each woman was asked whether she experienced the symptoms in the previous six months, if answer was no she was asked next item and if answer was yes she was asked to indicate how bothered she had been by the symptoms on a 7 point scale ranging from 0=not at all bothered to 6 extremely bothered. For analysis score becomes 1 for "No", 2 for "Yes" through to 8 for "Yes (Extremely bothered)". Grading the severity of the symptoms as; mild, moderate or severe calculated as score from 2-4 (mild), scores from 5-6 (moderate) and from 7-8 (severe). The tools of data collection were translated into Arabic by the researchers, tested and verified by bilingual persons.

Ethical consideration:

After approval of the ethics committee, an official permission was obtained from the dean of the faculty of nursing to the director of hospital requesting his approval for data collection and informed consent was obtained from each participant. The significant and purpose of the study was explained to them, confidentiality of any obtained information was ensured to them.

Statistical Design:

Data was collected, coded, tabulated and analyzed, using the SPSS computer application for statistical analysis. Descriptive statistics was used to calculate percentages, frequencies, Mean and standard deviations, Chi Square (X2), T. test are used to estimate the statistical significant differences. A significant P-value will be considered when P less than 0.05 and it will be considered highly significant when P-value less than or equal 0.01.

Results

The results of this study are presented under the following three heading demographic characteristics of the women, menopausal symptoms, and quality of life scores among menopausal women.

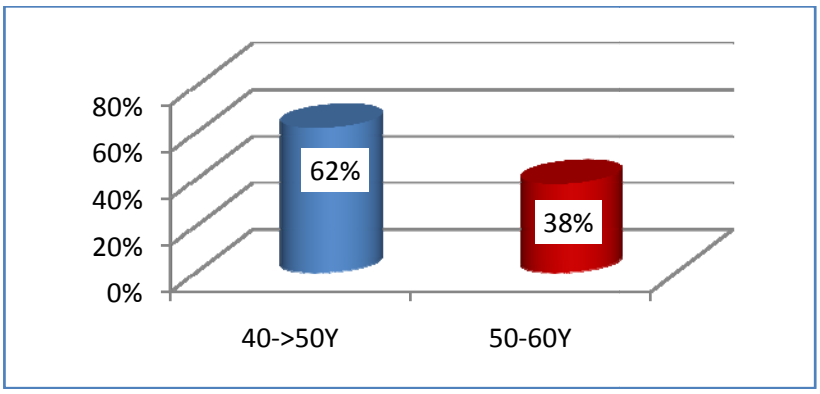

Figure1: Distribution of the women by their age

As regards to demographic characteristics of the sample, **Figure (1)** shows that (62%) of the women's age ranged between 40->50 years.

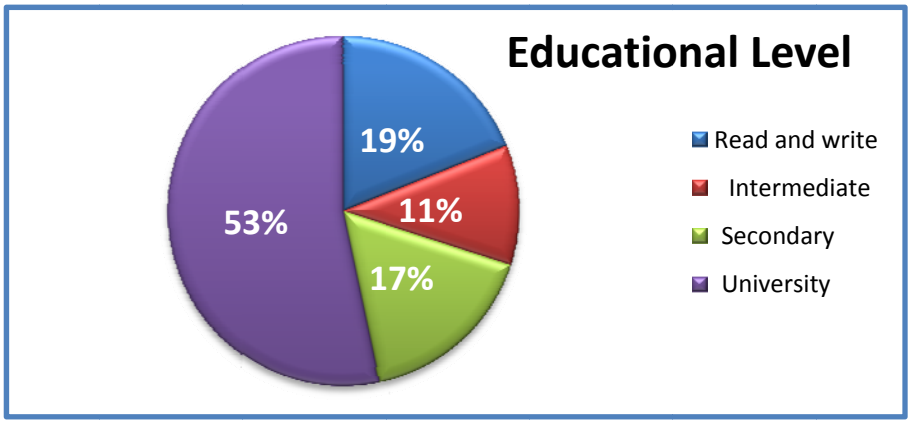

Figure 2: Distribution of the women by their educational level

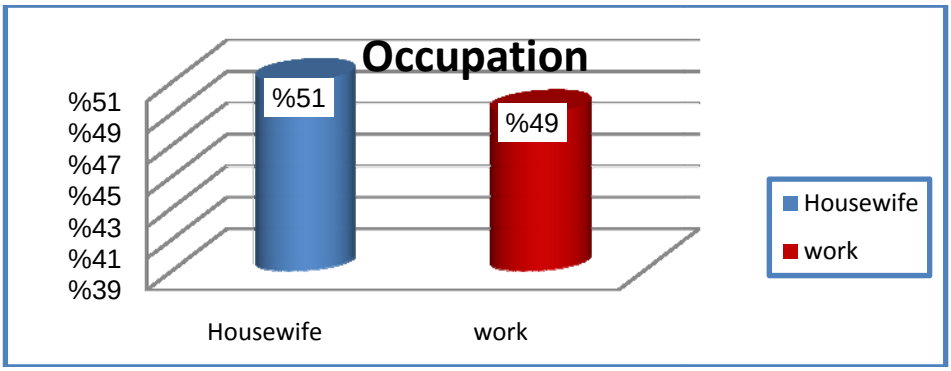

Figure 3: Distribution of the women by their occupation

Figure (2) illustrates that, the percentage of women who received formal university education was (53%), while (11%) of the women had intermediate education.

Figure (3) shows that 51% of the women were housewives and 49% were working.

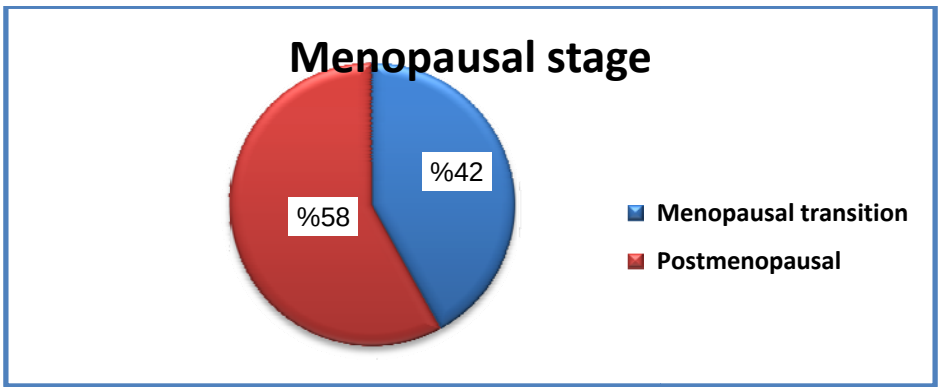

Figure 4: Distribution of the women by their menopausal stages

Figure (4) illustrates menopausal stages of the women, it was found that 58% of the women at post-menopausal women. While 42%menopause transition.

Table 1. Distribution of the women regarding to severity of menopausal symptoms

Symptoms*	*Mild*		*Moderate*		*Severe*	
	No	*%*	*No*	*%*	*No*	*%*
1. Vasomotor-						
• Hot flushes	**20**	**41.7**	**14**	**29.2**	**14**	**29.2**
• Night sweats	**26**	**54.2**	**13**	**27.1**	**9**	**18.8**
• Sweating	**27**	**56.3**	**14**	**29.2**	**7**	**14.6**
2. Psychosocial-						
• Being dissatisfied with my personal life	**12**	**41.4**	**4**	**13.8**	**13**	**44.8**
• -Feeling anxious or nervous	**15**	**51.7**	**3**	**10.3**	**11**	**37.9**
• Experiencing poor memory	**12**	**41.4**	**3**	**10.3**	**14**	**48.3**
• Accomplishing less than I used to	**12**	**41.4**	**7**	**24.1**	**10**	**34.5**
• Feeling depressed, down or blue	**12**	**41.4**	**6**	**20.7**	**11**	**37.9**
• Being impatient with other people	**13**	**44.8**	**4**	**13.8**	**12**	**41.4**
• Feelings of wanting to be alone	**13**	**41.4**	**4**	**13.8**	**12**	**41.4**
3. Physical-		**68.4**	**3**	**6.3**	**15**	**26.3**
• Flatulence (wind)or gas pains	**39**	**59.5**	**7**	**9.6**	**23**	**31.1**
• Aching in muscle & joints	**44**	**55.6**	**9**	**12.5**	**23**	**31.9**
• Feeling tired or worn out	**40**	**67.5**	**4**	**7.7**	**13**	**25**
• Difficulty sleeping	**35**	**62.0**	**11**	**12.2**	**16**	**17.8**
• Aches in back of neck or head	**44**	**48.4**	**6**	**19.4**	**10**	**32.3**
• Decrease in physical Strength	**15**	**54.8**	**4**	**12.9**	**10**	**32.3**
• Decrease in stamina	**17**	**48.4**	**7**	**22.6**	**9**	**29**
• Feeling a lack of energy	**15**	**61.3**	**6**	**19.4**	**6**	**19.4**
• Drying skin	**19**	**41.9**	**7**	**22.6**	**11**	**35.5**

• Weight gain	**13**	**67.7**	**8**	**25.8**	**2**	**6.5**
• Increased facial hair	**21**	**51.6**	**10**	**32.3**	**5**	**16.1**
• Changes in appearance, texture or tone of your skin	**16**	**32.3**	**14**	**45.2**	**7**	**22.6**
• Feeling bloated	**10**	**38.7**	**6**	**19.4**	**13**	**41.9**
• Low backache	**12**	**35.5**	**12**	**38.7**	**8**	**25.8**
• Frequent urination	**11**	**38.7**	**11**	**35.5**	**8**	**25.8**
• Involuntary urination when laughing or coughing	**12**					
4. Sexual						
• Change in your sexual desire	**23**	**60.5**	**1**	**2.6**	**14**	**36.8**
• Vaginal dryness during Intercourse	**21**	**55.3**	**10**	**26.3**	**7**	**18.4**
• Avoiding intimacy	**23**	**60.5**	**5**	**13.2**	**10**	**26.3**

* Multiple responses

Table (1) illustrated the severity of the menopausal symptoms among the studied subjects. It can be observed that, the most severe symptoms in vasomotor, psychosocial, physical and sexual domains were, hot flushes (29%), experiencing poor memory (48.3%), being dissatisfied with their personal life (44.8%), Low backache (41.9%), and change in their sexual desire (36.8%), while the mild symptoms in these domains were night sweats (54.2%,), sweating (56.3%), feeling anxious or nervous (51.7%), Flatulence (wind) or gas pains (68.4%), difficulty sleeping (67.5%), Increased facial hair (67.7%), change in their sexual desire (60.5 %) & Avoiding intimacy (60.5 %).

Table 2. Relationship between the severity of menopausal symptoms and menopausal stage

Symptoms	**Mild**		**Moderate**		**Severe**		**Total**	**X**	**p. value**
	No	***%***	***No***	***%***	***No***	***%***	***No (%)***		
*** Menopausal stage**									
• Menopausal transition.	12	25	7	14.5	4	8.33	23(47.9)	9.489	**.009**
• Post-menopausal	4	8.33	7	14.5	14	29.16	25(52.1)		

Table (2) showed that (29.16%) of postmenopausal women experienced severe symptoms as compared to only (8.33%)of women in transition menopausal. There was a statistically highly significant difference between the severity of menopausal symptoms and menopausal stage (X=9.489 at P<.0.009).

Table 3. Relationship between the severity of menopausal symptoms and demographic characteristics

Symptoms	Mild		Moderate		Severe		Total	X	p. value
	No	*%*	*No*	*%*	*No*	*%*	*No (%)*		
Age-									
-40 ->50	10	20.83	11	22.91	6	12.5	27(56.3)	6.930	**.031**
-50- 65	6	12.5	3	6.25	12	2	21(43.7)		
Education-									
• Read and write	3	6.25	1	2.08	2	4.16	6 (12.5)		
• Primary/Intermediate	2	4.16	2	4.16	3	6.25	7(14.5)	8.107	N.S
• Secondary	6	12.5	2	4.16	1	2.08	9(18.8)		
• University	5	10.41	9	18.75	12	25	26(54.2)		
Occupation-									
• Working	6	12.5	5	10.5	10	20.8	21(43.7)	1.641	N.S
• House wife	10	20.8	9	18.8	8	16.66	27(56.3)		

Table (3) shows that there was a statistically significant difference between; the severity of menopausal symptoms and current age (X=6.93 at P= 0.031). However, there were no significant differences between; severity of menopausal symptoms and level of education and occupation.

Table (5) shows that the overall scores of menopausal quality of life for each MENQOL domain. It is showed that the highest mean score in sexual domain (3.19± 1.99), following by psychosocial (2.94± 1.45) then vasomotor (2.55± 1.53) and finally physical symptoms (2.28± .749).

Table 4. Score for each MENQOL domain

Domain	Total Scores*	
	Mean*	± SD
Vasomotor	**2.55**	**1.53**
Psychosocial	**2.94**	**1.45**
Physical	**2.28**	**.749**
Sexual	**3.19**	**1.99**

* MENQOL, menopause-specific quality of life questionnaire; Scores ranged from 1-8

Table 5. Mean distribution for each MENQOL domain scores by menopausal stage

Domain	Menopausal transition. NO (52)		Post-menopausal NO (38)		t.	p. value
	Mean*	± SD	Mean*	± SD		
Vasomotor	**2.32**	**1.48**	**2.86**	**1.56**	**1.66**	**.09**
Psychosocial	**2.77**	**1.50**	**3.17**	**1.36**	**1.30**	**NS**
Physical	**2.14**	**.72**	**2.48**	**.75**	**2.11**	**.03**
Sexual	**2.92**	**2.01**	**3.55**	**1.92**	**1.47**	**NS**

* MENQOL, menopause-specific quality of life questionnaire; Scores ranged from 1-8.

Table (5) represents the scores of four domains by menopausal status. The scores of physical domain were significantly more in postmenopausal (PM) group (t=2.11 at P< 0.03) and the scores of vasomotor domain were high in post-menopausal (2.86 ± 1.56) as compared to (2.32 ± 1.48) in menopausal transition. There is no statistically significance difference as regarding to psychosocial and sexual domains.

Discussion

Menopause has emerged as a prominent issue in the women's health. Aim of the present study was to assess the menopausal related symptoms and their impact on the women quality of life. Results of the current study answer the research questions that menopausal symptoms impacts on the quality of life of menopausal women.

As regards to the demographic characteristics of the study sample, it was found that more than half of the women's age ranged between 40-50 years. This result is similar with the results of the Study done by **Al-Oleyat & noor(2010)** [10]. In this cross – sectional study a sample of 233 Saudi women from 45 to 55 years old. Also study done by **Gehad and Galila (2010)** the mean at menopause was 46.35 +_ 4.8 years in Egypt and mean age in Saudi Arabia was 49.9 +_ 2.23[22]. In addition study done by **Elsabagh and Abdullah (2012)** indicated that women age ranged from 40-70[23]. However, comparing our findings with previous researcher, ours still fall between the normal ranges of menopausal age.

As regards to the educational level, it was found that, more than half of the women had university education this is reflected upon women cooperation. In relation to occupation 51% of the women were housewives and 49% were working this result is supported by the results for the study carried out by **Elsabagh E and Abd Allah ES. (2012**) they indicated that less than two thirds (58.3%) of them were house wife and the rest of them were worker. As will as the same study revealed that 32.0% of women have primary or preparatory school while 25.1% among the studied sample were illiterate [23].

As regards to the severity level of menopausal symptoms, the most severe symptoms in vasomotor, psychosocial, physical and sexual domains were, hot flushes, experiencing poor memory, being dissatisfied with their personal life, low backache, and change in their sexual desire, while the mild

symptoms in these domains were night sweats, sweating, feeling anxious or nervous, flatulence or gas pains, aches in back of neck or head, increased facial hair and avoiding intimacy. This may correlates with fluctuating levels of estrogen in the blood from premenopausal to postmenopausal period. These results are accordance with the results of many studies reported that 'hot flashes' and 'sweeting' were the most common and severe symptoms in menopausal women[10, 24]. **Chim, et al (2002)** [25] in a Singaporean are contradicted the results they indicated that the frequency of hot flashes and night sweats was 17.6% and 8.9%, respectively. In addition in United States, [17] African-American women reported hot flushes most frequently (45.6%) followed by Hispanic (35.4%), Caucasians (31.2%), Chinese (20.5%) and Japanese (17.6%). Vasomotor symptoms are usually related to hormonal changes during menopause periods so this difference may have been due to genetic or socio-cultural diversity and also differences in diet, especially the consumption of phytoestrogen foods.

As well as In Malaysia, **Jahanfar et al. (2006)**[26] who reported that the most common symptoms were found to be joint and muscle discomfort (84.3%), followed by anxiety (71.4%), physical and mental discomfort (67.2%), hot flushes and sweating (67.1%). These differences in frequencies of symptoms may be associated to differences of race, life style, culture, genetics and diet. In the study conducted by **Waidyasekera et al. (2009)**[27]they reported that the joint and muscle discomfort, physical and mental exhaustion and hot flashes were the most prevalent menopausal symptoms. This similar with **Gharaibeh et al. (2010)**[28] they found that vasomotor symptoms were reported to have the highest scores as hot flushes and night sweating. In addition **Ashrafi et al. (2010)**[29] showed that night sweats, joint and muscle pain and hot flashes are the most common symptoms associated with menopause in Iranian women. These findings were also noted by **Rahman et al. (2010)**[30] emphasized that the frequency of sexual problems, bladder problems and vaginal dryness were experienced mainly by premenopausal and postmenopausal group of women and it was also significant statistically in comparison to other menopausal status.

The most prevalent psychosocial symptom in the present study was; poor memory that agrees with results of many studies, which indicated that the most common and severe symptom that was reported by women was poor memory[25, 31, 32]. These contradict with the results of the study done by **Kalahroudi MA et al. (2012)**[33] they revealed that the most prevalent psychosocial symptom was accomplishing less than I used to, but the most severe symptom was feeling anxious or nervous is contradicted with results of our study.

Regarding physical domain, our study showed that most of the women had a complaint of severe low backache while study done by **Kalahroudi MA et al. (2012)**[33] report that feeling a lack of energy is the most complain and the most severe symptom was aching muscles or joints while somatic and psychological symptoms are not related to menopausal status because these symptoms are multi-factorial, rather than due to hormonal imbalance and middle-aged women usually experience these symptoms due to health problems related with aging. In addition **Nisar N. and Ahmed S N., (2009):**[17] they stated that the frequency of physical and sexual symptoms was 99% and 66% respectively, similar findings were reported from China[33].

Concerning sexual domains current study results showed that 60.5% of women had a change in sexual desire, and avoiding intimacy', but a 'change in sexual desire' was more severe in 36.8 % of women than other sexual related symptoms. While in the study done by. **Rostami A, et al. (2004)[35],** they indicated that 92% of women reported avoiding intimacy. Also in Ecuadorian women this rate was76.5%[31], in Korean women the most common symptom was a change in sexual desire' that was severe in 27.1%of cases[36]. In Singaporean women the most common and severe symptom was avoiding intimacy[25]. Also, other investigators[10, 37] stated that the prevalence of 'change in sexual desire' was approximately 30.7%. Also results of the study done by **Greenblum CA. et al. (2012)[8]** indicated that the most commonly experienced symptom was hot flashes, with 73.2% of women currently experiencing that symptom[8]. In decreasing order, the remaining frequencies were as follows: fatigue (58.0%), sleep disturbances (56.3%), anxiety (53.6%), irritability (51.8%), weight gain (51.8%), vaginal dryness (48.2%), and urinary incontinence (32.1%).

Results of the present study showed that the severity of menopausal symptoms had a highly significant association with; menopausal age (X=6.93 at P= 0.031), however, there were no significant differences between; severity of menopausal symptoms and level of education and occupation. This contradicted with the study done by **Kalahroudi MA et al (2012)[33]** reported that menopausal symptoms had a significant association with working status, educational level, exercise activity, exercise frequency and duration of menopause. Several studies have shown that women who had longer education, reported milder menopausal symptoms[39, 32]. But one study in Taiwan showed that educated women had more menopausal symptoms compared to less-educated women[35].

Results of a study in Singapore also demonstrated that there was no association between level of education and menopausal symptoms[25]. Several studies have also shown the impact of working status on the severity of menopausal symptoms[25, 40, 2].As regard to menopausal stages the current study showed that, less than one third of the postmenopausal women experienced severe symptoms because they had more time to adapt to the menopausal changes. This study finding is similar to studies by Lee et al.[36, 38, 39]

According to quality of life scores among menopausal women, the current study revealed that the scores of physical domain were significantly more in postmenopausal (PM) group than menopausal transition MT group (t=2.11 at P< 0.03) and the mean scores of vasomotor domain were high in post-menopausal (2.86 ± 1.56) as compared to (2.32 ± 1.48) in menopausal transition while there is no statistically significance difference as regarding to psychosocial and sexual domains. This results are accordance with **Nisar N and Ahmed N (2009)[17]** they indicated that PM woman had significantly higher scores in physical domain then MT group P<0.002, while the scores of psychological domain were significantly high in MT group then in PM (p < 0.003). A study from Thailand showed many symptoms to be significantly related to MT stage (such as hot flushes, upset stomach, insomnia, and urinary symptoms) only night sweats and joint aches and pains were significantly associated with PM stage[17]. Other studies reported that vasomotor complains were more prevalent in MT woman whereas psychological complains were more in PM women.

As regards to the overall scores of menopausal quality of life for each MENQOL domain, the results of current study showed that highest mean score in sexual domain, following by psychosocial then vasomotor and finally physical symptoms. **Greenblum et al. (2012)[8]** concluded that the symptoms found to most significantly affect quality of life were sleep disturbances, fatigue, and anxiety.

Conclusion

The current study concluded that the most severe symptoms in vasomotor, psychosocial, physical and sexual domains were, hot flushes, experiencing poor memory, being dissatisfied with their personal life, low backache, and change in their sexual desire. The mean scores of physical and vasomotor domain were significantly more in postmenopausal (PM) group then menopausal transition MT group. While the mean scores of each domain suggest that menopausal symptoms were associated with decrease in women quality of life.

Recommendation

The current study recommended that

1. Health care providers need to play a more visible and instrumental role in continuously assessing menopausal women's needs as well as implement appropriate health educational programs for women about the menopausal period and how to pass it safely.
2. Further research addressing women's health needs is also essential for improving the quality of life of menopausal women in Saudi Arabia.

References

1. McKinney ES, Ashwill JW, Murray SS, James SR, Gorrie TM, Droske SC. Maternal-Child Nursing. St. Louis: Elsevier Science Health Science Division. 2012.
2. Speroff L, Fritz LSMA. Clinical Gynecologic Endocrinology and Infertility: 7th ed. Philadelphia: Lippincott Williams and Wilkins, 2005.
3. Bernis C., and Reher D. S. "Environmental contexts of menopause in Spain: comparative results from recent research," Menopause, 2007, 14 (4): 777-787.
4. Williams, R E., Levineb B K., Kalilani L b., Lewisc J., and Clarkd RV., Menopause-specific questionnaire assessment in US population- based study shows negative impact on health-related quality of life, Journal homepage: www.elsevier.com/ locate/maturitas. Maturities, 2009, (62), 153-159.
5. Lewis V. Under treatment of menopausal symptoms and novel options for comprehensive management. Cur Med Res Opin; 2009, 25: 2689-2698.
6. Thurston R, and Joffe H. Vasomotor symptoms and menopause: findings from the Study of Women's Health Across the Nation. Obstetric Gynecology Clin North Am, 2011; 38:489-501.
7. Ford K, Sowers M, Crutchfield M, Wilson A, and Jannausch M. A longitudinal study of the predictors of prevalence and severity of symptoms commonly associated with menopause. Menopause;2005. (122): 308-317.
8. Greenblum, CA., Meredeth A. Rowe, Neff DF., and Greenblum, GS., Midlife women: symptoms associated with menopausal transition and early postmenopause and quality of life. Journal of the North American Menopause Society, 2012, 20, 1.
9. Sallam H, 232 Galal AF. and Rashed A .Menopause in Egypt: past and present perspectives, The Suzanne Mubarak Regional Center for Women's Health and Development, Egypt, 2006, 6 (9): 421-429.

10. Al-Olayet AY, Al-Qahtani IF, Al-Essa DI, Al-Saleek FH, Al-Moutary Al-Mudimeg LM . Severity of menopausal symptoms, and knowledge attitude and practices towards menopause among Saudi women. Sci Res Essays, 2010, 24 (5): 4077-9.
11. Heinemann K, Ruebig A, Potthoff P, Schneider HP, Strelow F, Heinemann LA, et al., The Menopause Rating Scale (MRS) scale: a methodological review. Health Qual Life Outcomes; 2004, (2): 45.
12. Mishra G, and Kuh D. Perceived change in quality of life during the menopause. Social Sci. Med, 2006, (62): 93-102.
13. Catherine A, Meredeth A., Donna F. and Jesse S. Midlife women: symptoms associated with menopausal transition and early postmenopausal and quality of life. Menopause, 2012, 20 (1).
14. Avis NE, Assmann SF, and Kravitz HM. Quality of life in diverse groups of midlife women: assessing the influence of menopause, health status and psychosocial and demographic factors. Quality Life Res; 2004, (13): 933-946.
15. Ham O. Predictors of health-related quality of life among low-income midlife women. West J Nurse Res; 2011, (33): 63-78.
16. Col N, Haskins A, Ewan-Whyte C. Measuring the impact of menopausal symptoms on quality of life: methodological considerations. Menopause, 2009; (16): 843-845.
17. Nisar N. and Ahmed S N., Frequency of menopausal symptoms and their impact on the Quality of life of women: a hospital based survey, J. Pak Med Assoc, 2009, 59 (11): 752-756 .
18. Cooper R, Kuh D, Cooper C, et al. Objective measures of physical capability and subsequent health: a systematic review. Age Ageing. [PMC free article] [PubMed], 2010.
19. Cooper R, Kuh D, Hardy R, Group MR. and Teams FaHS. Objectively measured physical capability levels and mortality: systematic review and meta-analysis. BMJ.. [PMC free article] [PubMed], 2010; (341): c4467.
20. Studenski S, Perera S, and Patel K, et al. Gait speed and survival in older adults. JAMA. [PMC free article] [PubMed], 2011; (305): 50-58.
21. Lewisa J E., Hilditcha J R., and Wongb C J. Further psychometric property development of theMenopause-Specific Quality of Life questionnaire and development of a modified version, MENQOL-Intervention questionnaire. Maturitas. 2005, (50): 209-221 .
22. Gehad M, Samia A and Galila S. Effect of Menopausal Symptoms on Women's Quality of Life in Benha City (Egypt) and Arar City (Kingdom of Saudi Arabia). Med. J. Cairo Univ., 2010, 78 (1): 319-330,
23. Elsabagh E and Abd Allah ES. Menopausal symptoms and the quality of life among pre/post-menopausal women from rural area in Zagazig city. Life Science Journal, 2012; 2 (9).
24. Rachel. Williams, Kristen. Levine, Lind a Kalilani, Jacqueline Lewis, Richard V. Clark. Menopause-specific questionnaire assessment in US population-based study shows negative impact on health-related quality of life. Maturitas. 2009, 62: 153-159 .
25. Chim H, Tan BH, Ang CC, Chew EM, Chong YS, and Saw SM. The prevalence of menopausal symptoms in a community in Singapore. 41Maturitas. 2002; 4: 275-82.
26. Jahanfar Sh, Abdul Rahim bA, Shah Reza b K, Nor Azurabt I, Sharifah Nora bt S A D, Siti and Asma' bt AR Age of Menopause and Menopausal Symptoms Among Malaysian Women Who Referred to Health Clinic in Malaysia. Shiraz E-Medical Journal; 2006, 7: 1-9.
27. Waidyasekera H, Wijewardena K, Lindmark G, and Naessen T. Menopausal symptoms and quality of life during the menopausal transition in Sri Lankan women. Menopause; 2009, 16: 164-170.
28. Gharaibeh M, Al-Obeisat S, and Hattab J. Severity of menopausal symptoms of Jordanian women. Climacteric, 2010, 13 (4): 385-394.
29. Ashrafi M, Ashtiani SK, Malekzadeh F, Amirchaghmaghi E, Kashfi F, Eshrati B .Symptoms of natural menopause among Iranian women living in Tehran, Iran. Int J of Reproductive Medicine, 2010, 1 (8): 29-32.
30. Rahman SASA, Zainudin SR, and KarMun VL. Assessment of menopausal symptoms using modified Menopause

Rating Scale (MRS) among middle age women in Kuching, Sarawak, Malaysia. Asia Pacific Family Medicine, 2010, (9): 5.

31. Chedraui P, Hidalgo L, Chavez D, Morocho N, Alvarado M, and HucA. Menopausal symptoms and associated risk factors among post-menopausal women screened for the metabolic syndrome. Arch 275 Gynecol Obstet. 2007; (3): 161-8.
32. El Shafe K, Al Farsi Y, Al Zadjali N, Al Adawi S, Al Busaidi Z, and Al Shafaee M. Menopausal symptoms among healthy, middle-aged Omani women as assessed with the Menopause Rating Scale. 18 Menopause. 2011; (10): 1113-9.
33. KalahroudiM A., Mahboubeh T., Sadat z., Saberi F3, and Karimian Z., Prevalence and Severity of Menopausal Symptoms and Related Factors Among Women 40-60 Years in Kashan, Iran, Nurs Midwifery Stud. 2012: 1 (2); 88-93. DOI: 10.5812/nms.8358
34. Chen Y, Lin SQ, Wei Y, Gao HL, and Wu ZL. Menopause- specific quality of life satisfaction in community-dwelling menopausal women in China. Gynecol Endocrinol; 2007, 23: 166-72.
35. Rostami A, Ghofranipour F, and Ramazanzadeh F. The Effect of Health Education Program on Quality of Women's Life in Menopause. Daneshvar Med. 2004.
36. Lee MS, Kim JH, Park MS, Yang J, Ko YH, and Ko SD, et al. Factors influencing the severity of menopause symptoms in Korean post-menopausal women. J Korean Med Sci. 2010; (5): 758-65.
37. Askari F, BasiriMoghadam K, BasiriMoghadam M, Torabi S, Gholamfarkhani S, and Mohareri M.Age of Natural Menopause and the Comparision of Incidence of Its Early Complications in Menopause Transition stages in Women From Gonabad City. OfogheeDanesh. 2012.
38. Gharaibeh M, Al-Obeisat S, and Hattab J .Severity of menopausal symptoms of Jordanian women. Climacteric. 2010, 4 (13): 385-394.
39. Lee Y, and Kim H. Relationships between menopausal symptoms, depression, and exercise in middle-aged women: a cross-sectional survey. Int J Nurs Stud. 2008; 12 (45): 1816-22.
40. Delavar MA, and Hajiahmadi M. Factors Affecting the Age in Normal Menopause and frequency of Menopausal Symptoms in Northern Iran. IRCMJ. 2011; 3 (13): 192-8.

جودة الحياة للسيدات في سن اليأس

هدى العزم،[1] سحر لمادة، [2] لمى الزامل، [1]

1- أستاذ مساعد، كلية التمريض النسائية والتوليد، جامعة المنيا، مصر؛ وكلية التمريض، جامعة أم القرى، السعودية؛
2- محاضر، تمريض النسائية والتوليد، كلية التمريض، جامعة الإسكندرية، مصر؛ وكلية التمريض، جامعة أم القرى، السعودية؛
3- أخصائي النطق، الجامعة الأردنية وكلية التمريض، جامعة العلوم والتكنولوجيا، الأردن؛ وكلية التمريض، جامعة أم القرى، السعودية.

الملخص

الهدف: اليوم ومع ارتفاع متوسط العمر المتوقع، تقضي السيدات ثلث حياتهم بعد سن اليائس. وسن اليائس هو عملية تكيف تمر من خلالها المرأة بتغيرات بيولوجية جديدة، هذه العملية تصاحبها العديد من التغيرات الحيوية والنفسية والاجتماعية. أظهرت دراسة أجريت في المملكة العربية السعودية أن التوهج الحراري والتعرق كان بنسبة (68,5%)، الجفاف المهبلي (37,3%)، والمشاكل الجنسية (30,7%)، هما أكثر الأعراض شيوعا لدى السيدات في سن اليائس، وكان التوهج الحراري والتعرق أكثر حده في التأثير. عرفت منظمة الصحة العالمية جودة الحياة على أنها إدراك الأفراد لحياتهم من حيث الثقافة والقيم التي يعيشون من خلالها وعلاقتها بأهدافهم وتوقعاتهم واهتماماتهم. الانتقال إلى سن اليأس حدث يؤثر على جودة الحياة. أكثر من 80% من السيدات يعانين من أعراض جسدية ونفسية واجتماعية تصاحبهن أثناء سن اليأس بحيث تؤثر على حياتهم بدرجات متفاوتة.

تهدف هذه الدراسة إلى تقييم الأعراض المرتبطة بسن اليأس وتأثيرها على جودة الحياة للسيدات.

الطريقة: أجريت هذه الدراسة بشكل وصفي وتم أخذ عينة مكونة من 90 امرأة تتراوح أعمارهن من 40-60 سنة بقسم أمراض النساء والتوليد في مستشفى الأمومة والأطفال بمكة المكرمة. واشتملت طرق جمع العينات التي استخدمت في هذه الدراسة على: إجراء مقابلات مع النساء واستبانة يقيس جودة حياة للنساء في سن اليأس. وقد أجريت هذه الدراسة على مرحلتين: مرحلة الإعداد ومرحلة التنفيذ حيث كانت مرحلة الإعداد هي أخذ الموافقات الرسمية لإجراء الدراسة والدراسة التجريبية، أما مرحلة التنفيذ كانت متعلقة بالتعرف إلى الأعراض الخاصة بسن اليأس وتأثيرها على جودة الحياة للسيدات.

النتائج: كشفت الدراسة أن أكثر من نصف النساء (62%) تتراوح أعمارهن بين 40-60 عاما. كما تشير النتائج إلى أن أكثر الأعراض حدة هي الوعائي، نفسية حركية والنفسية والاجتماعية والجسدية والجنسية. وكانت نسبة التوهج الحراري (29%)، ونسبة النساء اللواتي يعانين من ضعف الذاكرة (48.3%)، ومن النساء غير الراضيات بحياتهنَّ الشخصية (44.8%)، ومن النساء اللواتي يعانين من الآلام أسفل الظهر (9.41%)، وتغيير في الرغبة الجنسية (36.8%). أظهرت النتائج أن متوسط درجات جودة الحياة عند النساء في سن اليأس كانت أكثر سلبية في النواحي الجنسية (3.19± 1.99)، تليها الناحية النفسية والاجتماعية (2.94± 1.45)، تليها الوعائي نفسي الحركية (2.55± 1.53)، تليها الجسدية (2.28± 749.).

الاستنتاجات: تستنتج من خلال هذه الدراسة أن الأعراض الأشد حدة هي الوعائية الحركية والنفسية والاجتماعية والجسدية والجنسية. التوهج الحراري وضعف الذاكرة وعدم الرضا عن الحياة الشخصية، وألام أسفل الظهر والتغير في الرغبة الجنسية. متوسط درجات جودة الحياة كانت في المجالات الجسدية والوعائي نفسي الحركية بشكل ملحوظ بعد انقطاع الطمث. في المجمل العام أوضحت الدراسة أن أعراض سن اليأس مرتبطة بضعف جودة الحياة عند الأمهات في سن اليأس.

وكانت التوصيات للدراسة الحالية هي كالآتي:

1- مقدمي الرعاية الصحية بحاجة إلى أن يلعبوا دوراً فاعلاً في تقيم احتياجات المرأة بعد انقطاع الطمث، وكذلك تنفيذ البرامج التعليمية الصحية المناسبة.

2- الحاجة إلى مزيد من الدراسات لمعالجة الاحتياجات الصحية للمرأة و لتحسين جودة حياة السيدات بعد انقطاع الطمث في المملكة العربية السعودية.

الكلمات الدالة: سن اليأس، أعراض سن اليأس، جودة الحياة.