West African Journal of Physical & Health Education

Volume 13. 2009

WEST AFRICAN JOURNAL OF PHYSICAL and HEALTH EDUCATION

VOLUME 13 **July 2009**

EDITORIAL

The West African Journal of Physical and Health Educatic (WAJOPHE) is an interdisciplinary journal that publishes article research findings and position papers in physical and healt education, recreation, sports and dance. The journal was initial the innovation or brainchild of the Department of Human Kinetic and Health Education of the University of Ibadan, Nigeria. Today, serves as a forum where scholars in education, exercise, sport: recreation, dance, and other health professionals contribute toward the full development of man and his environment, especially wit regard to the entire West African subregion.

Among the articles in *Volume 13* are: geriatric social work epidemiology of disease causation and methods of diseas prevention and control; weight gain and weight loss measure adopted by martial arts athletes; community participation i primary health care; effectiveness of health education interventio on attitude towards strategies for reducing HIV/AIDS-related stigma and discrimination; personality traits of taekwondo athletes; healt promotion and wellness strategies as capacity building fo sustainable development; self-concept and academic performance o secondary school students; knowledge and methods of family planning; concept of human sexuality and changing sex role technology and sports delivery; the growing threat of non-communicable diseases in developing countries; among others.

I want to specially thank all the contributors, for making the publication of this volume possible and worthwhile. I also want to thank the efforts of Professor J.A. Ajala and those of the current head of the Department of Human Kinetics and Health Education, University of Ibadan towards the publication of this and previous volumes.

B.O. Ogundele
Managing Editor

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Sexual Practice and Belief System among Menopausal Women in Ibadan: Implication for Sexual Health

Asuzu C., Babalola E. and Agokei R.C.*

Abstract

This is a correlation cross-sectional study aimed at investigating the sexual beliefs and practices of menopausal women in Ibadan, Oyo State, Nigeria. A systematic random sampling of women within the menopausal age was used to select the respondents; 101 women were selected from schools, churches, civil service and markets. A self-constructed questionnaire was used to collect data. Focussed group discussion was also used. The ages of the women ranged between 41 and 65, with the mean age of 47. The results indicated that the three independent variables were potent predictors and accounted for 26.1% variance of sexual practices of menopausal women. However, only sexual beliefs had significant contribution to the criterion measure. Some women claimed that they had never enjoyed sex and they do not want to continue in the act; some were afraid, believing that sexual intercourse during this period could result in ill health. It was recommended that sexuality health education should be used to tackle the problem of ignorance in this respect, as it could lead to conflict in the family.

Introduction

Perhaps when all aspects of human development are considered, that of human sexuality signifies the basis of our existence and continuity would be a consensus. Sexuality is not defined by one's genital behaviour or interests. Rather, sexuality encompasses the

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sexual knowledge, beliefs, attitudes, values and behaviour of individuals. According to Asuzu and Asuzu (2007) human sexuality may be defined as the totality of all that is characteristics of human sexes – male and female – especially those that distinguish them most from each other. It also involves an individual's perception and practice of the qualities that are characteristic of maleness and femaleness (Barber, 1988). Notably, there is growing speculations that sexuality is not for the old, and has thus added to the negativities often associated with old age. Hence, the notion that sexuality is a lifelong process goes contrary to the thinking of some elderly people, their children, and healthcare providers (Kennedy et al., 1997). This may have accounted for the very little attention, until recently, targeted at sexuality among older adults (Spence, 1992) particularly menopausal women.

Menopause is a life change defined by biological alterations occurring in the context of important social changes (Milanifar, 2001; Loh et al., 2005). Specifically, menopause heralds a decline in ovarian function (and a consequent reduction in ovarian hormones) and changes in genital and reproductive anatomy. These changes can impact sexual desire both directly, via biological processes, and indirectly, via psychological mechanisms. These include dyspaurenia (sexual pain) or, less directly, by lowering a woman's body image or self-esteem. Menopausal symptoms (such as, hot flushes and headaches) can indirectly and adversely impact desire by causing insomnia, lack of energy, difficulty concentrating, anxiety and/or depression. Although menopause is a biological process which normally affects all women reaching a certain age, there is an increasing appreciation for the role of sexual function in menopause and its importance for a woman's health and wellbeing. To this end, menopause has been described as another starting point in life that can be promising, useful and efficient (Mehrabian, 2001)

Studies on menopausal sexuality have been difficult because of the physiological changes associated with the ageing process and illnesses, which are more common at this time of life. The common sexual problems among post-menopausal women include loss of libido, orgasmic dysfunction, dyspareunia, decreased sexual desire and sexual activity, compared with the pre-menopausal period

(Tungphaisal et al., 1991). What is established is that the pattern of sexual life before menopause and the quality of marriage (the relationship status) are important correlates of sexual activities and sexual satisfaction. Nevertheless, the abrupt gonadal hormone decline associated with the menopause does adversely affect sexual function, regardless of the age at which the menopause occurs.

Experiences of the menopause vary across cultural and geographical zones (Gold, 2000). In a review of sex and ageing, Kaplan (1990) concluded that most physically healthy men and women remain regularly genitally or erotically sexually active well into advanced old age. Nevertheless, there is an increased tendency to assume less erotic activeness and erotic involvement, among older women particularly after menopause. In addition, there are added repressive and conservative dysfunctional beliefs and myths (such as 'sex is only for women under 30 years old'; 'female sexual life ends with menopause' and 'only normal women have orgasm whenever they have sex') (Heiman and LoPiccolo, 1988; LoPiccolo and Friedman, 1988; Hawton, 1985).

Ghazizadeh (2000) acknowledges that such beliefs can affect all the signs and traits of this period. However, physiological changes associated with the ageing process, coupled with the increasing prevalence of medical disorders in older age, could play a significant role in the pathogenesis of any observable sexual dysfunctions. Bloch (2002) reported that women having a negative consideration against menopause suffered more from the signs and symptoms of this period compared to the other women. As an issue yet unclear, this study is thus designated to determine the sexual practice and belief system among menopausal women in Ibadan, Nigeria.

Statement of the Problem

A woman's sexual function is a major part of her wellbeing and quality of life. However, at menopause, defined physiological and chemical changes within the body cause an initial estrogen deficiency, vaginal dryness, reduced blood flow to the clitoris, and decreased sensation in the genitals. The overall implication is often characterized by a reduction of sex drive among menopausal women with an inadvertent neglect for their spouses (husbands). Often in

an attempt to explore sexual freedom these spouses engage in extramarital sexual relationship with perceived younger females and, in many cases, women of lesser virtue. Infected persons may infect their wives when they eventually give in to sexual advances. In this manner, innocent menopausal women may contact sexually transmitted diseases, including HIV/AIDS. As people of these ages are less involved and carried along in the campaign for better sexual health practices, they may never know their condition until it is too late. To this end, it is not yet clear that sexual practices and belief systems held by menopausal women may make or mar their sexual health. In addition, little or nothing is yet to be done to include and carry along menopausal women in the healthy sexual practices campaigns. This gap in knowledge is what this study intends to fill.

Purpose of the Study

This study investigates the sexual belief and practices of menopausal women in Ibadan, Nigeria. It seeks to:

1. determine the relationship between the knowledge of menopausal women and their sexual practices and beliefs.
2. determine their knowledge of HIV/AIDS and its relatedness to their sexual life stage.

Research hypothesis

1. There will be no significant relationship between sexual beliefs, knowledge of menopause and knowledge of HIV/AIDS and sexual practices of menopausal women.
2. There will be no significant joint and relative effect of sexual beliefs, knowledge of menopause and knowledge of HIV/AIDS on sexual practices of menopausal women.

Methodology

The study employed the descriptive survey design in other to avoid alteration of data which occur naturally. The study was carried out with women in the age range of 40 years and above, who are currently experiencing the menopausal stage of their sexual life in Ibadan metropolis. A sample of one hundred and one (101) menopausal women were selected for the study from the population

of menopausal women in Ibadan metropolis using the availability sampling technique. The sampling technique was employed because of the sensitive nature and characteristics of the participants required. The sample was selected from government parastatals, schools, colleges, market squares, churches, mosques and the University of Ibadan.

The study employed a self-developed sexual belief and practice survey scale. The scale was specially developed for the study with regard to the typical and sensitive nature of its participants. The scale comprised five sections (A, B, C, D and E). Section A comprised of biodata information, such as age, educational level, religion, marital status and work/career. The other four sections contained forty items (10 items each) measuring knowledge of menopause, sexual beliefs, sexual practices, and knowledge of HIV/AIDS (sections B, C, D and E respectively). Each section was structured into the 5-point likert scale format, with responses rated from 1 (very much unlike me) to 5 (very much like me). Using a test-retest procedure on a different pre-test population, the scale reported a coefficient alpha of 0.71, 0.69, .0. 79 and 0.82 for each section and an overall alpha reliability coefficient of .93.

Based on the sensitive nature of the study, participants who were willing to participate in the study were provided with copies of the questionnaire to fill and return. The participants were met one--on-one and summarily informed of the confidentiality of every data provided. Completed instruments from the willing participants were collected and the participants at each time were thanked for their cooperation. These actions in a way encouraged the respondents to have the confidence to express themselves and not hold back any important information from the researcher.

Lastly, a focussed group discussion procedure was also adopted and organized to enable respondents interact on menopause, HIV/AIDS and sexual beliefs and practices among them. This was an avenue for them to learn from each other and proffer solutions to problems they face as menopausal women/ couples. The data obtained in the study were summarized and analyzed using simple frequency descriptive, Pearson Product Moment Correlation and Multiple Regression analysis.

Results

The ages of the respondents ranged between 41 and 65 years. Of these, 46-50 years range had the highest percentage of 39%, while the age range of 61-65 had the lowest percentage of 1%. The data also showed that Christianity has the largest number of respondents (76/ 75.2%) while Islam has 25 (24.8%).

Table 1: Descriptive statistics and correlations among variables

Variables	*Mean*	*Standard Deviation*	*Sexual practices*	*Sexual beliefs*	*Know. of Menopause*	*Know. of HIV/AIDS*
Sexual practice	18.57	3.819	1			
Sexual belief	17.8	4.118	.472**	1		
Knowledge of Menopause	33.5	6.156	.424**	.550**	1	
Knowledge of HIV/AIDS	33.92	6.251	.360**	.374**	.438**	1

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

The respondents with tertiary education were the majority (85/ 84.2%), while those with primary level of education had the lowest percentage (2%). Th data also showed that civil servants constituted the highest number of participants (60/ 59.4%), while accountants were the least by job group (3/ 3.0%). Married respondents had the highest number (94/ 91.1%) while the divorced had the lowest number (2/ 2.0%). In addition, the data revealed that respondents practising the monogamous type of marriage were the majority in the study, with a population of 83 (82.2 %), while polygamy had 18 (17.8 %). Table 1 indicates that there were statistical significant positive correlations between all the variables investigated.

Table 2: Result of multiple regression analysis between predictor variables and sexual practices

Predictors R	R^2	Adj	R^2	F-Ratio	Beta	t	Sig
Combined effect	.532	.283	.261	12.750			
Sexual beliefs	.311	2.970	.004				
Know. of menopause	.181	1.680	096				
Knowledge of HIV/AIDS	.164	1.690	.094				

The result presented in table 3 indicated that the three independent variables (sexual beliefs, knowledge of menopause and knowledge of HIV/AIDS), jointly yielded a linear analytical coefficient of multiple regression (R) of 0.532, a multiple correlation square (R^2) of 0.283 and an adjusted multiple correlation square (R^2) of 0.261. This shows that 26.1% of the total variance in sexual practices of the participants is accounted for by the combination of the three independent variables. Furthermore, the analysis of variance of the multiple regression data produced an f-ratio value which was significant at 0.05 level [$f(3,97)= 12.750$, $p<0.05$]. The findings thus, confirm the potency of sexual beliefs, knowledge of menopause and knowledge of HIV/AIDS as predictors of sexual practices among menopausal women.

Each of the independent variables contributed to the prediction of sexual practices in varying weights. The results indicated that the following beta weights which represented the relative contribution of the independent variables were observed and presented in order of magnitude: sexual beliefs (β =.311, t=2.970, p<.05), knowledge of HIV/AIDS (β=.164, t=1.690) and knowledge of menopause (β =.181, t= 1.680).

Discussion

The multiple regression analysis in table 2 shows that sexual beliefs, knowledge of menopause and knowledge of HIV/AIDS could significantly predict sexual practices of the participants. The magnitude of this relationship in predicting sexual practices among menopausal women is reflected in the values of coefficient of multiple (R^2) of 0.283 and an adjusted multiple (R^2) of 0.261. Thus, it can be said that 26.1% of the total variance in the sexual practices among menopausal women is accounted for by the combination of sexual beliefs, knowledge of menopause and knowledge of HIV/AIDS. The f-ratio value [$f(3,97)=12.570$, $p<0.05$] which is significant at 0.05 level further attests to the fact that the predictive capacity of the independent variables are not due to chance factors.

Concerning the extent to which each of the three independent variables contributes to the prediction, it could be ascertained that sexual beliefs was the only significant predictor among the variables

studied. Thus, the data from this study partially supported the importance of sexual beliefs and practices as vulnerability factors for the development of sexual problems among menopausal women. Data (not tabulated) showed that 88 (87.1%) of the respondents refused the sexual demands of their spouses. Among the participants, 57 (56%) agreed that this behaviour created a wide gap between them and their spouses, while 23 (22.8%) were indifferent and 22 (20.1%) disagreed. Again, 58 (58.5%) agree that refusal of women to their husbands' sexual demand could result in extramarital relationships, while 28 (27.8%) disagreed and 18 (17.8%) were indifferent.

As evidenced in table 1, there is a relationship between sexual beliefs and sexual practices of menopausal women. This affirms the adage that people practise what they believe. Focussed group discussions with the participants revealed that menopausal women's sexual beliefs are not different from reports of prior studies (Heiman and LoPiccolo, 1988; LoPiccolo and Friedman, 1988; Hawton, 1985). A majority of the women consider sexual interactions as insignificant, and would rather expend their energy on stabilizing their children's growth. They also consider female sexual life to end with menopause and that sex is only for younger women. For them, sex is believed to be for childbearing only. Some other women claimed that they have never enjoined sex and they do not want to continue in the act. Some claimed they were afraid and believed sexual intercourse during this period may result to ill health. It is to this end that Ghazizadeh (2000) acknowledged that such beliefs can affect all the signs and traits of the menopausal period.

There were also significant statistical relationships between the knowledge of HIV/AIDS and sexual practices and knowledge of HIV/AIDS and sexual beliefs. This implies that there is a relationship between what menopausal women know about HIV/AIDS and their sexual beliefs and practices. Notably, the knowledge of HIV/AIDS is usually associated with stigmatization. However, one possible way HIV/AIDS could be introduced into the relationship with their spouse is via extramarital relationship. This becomes more possible when it is considered that 88 (87.1%) of the respondents refused the sexual demands of their spouses. In

addition, only 58 (58.5%) agreed that refusal of women to their husbands' sexual demand could result in extramarital affairs. This intensifies the fear that many menopausal women may be ignorant of the possible ways their sexual practices could cause them to be infected with STIs/STDs, including HIV/AIDS. Therefore, this finding of a statistical relationship between knowledge of HIV/AIDS and sexual beliefs/practices of menopausal women is germane to women's health and should be examined further.

The findings also showed significant statistical relationships between the knowledge of menopause and sexual practices and knowledge of menopause and sexual beliefs. The findings indicate that knowledge of menopause plays a significant role in the sexual practices and beliefs of menopausal women. Expectedly, general knowledge of sexuality at menopause reflects a domain whereby an individual is not only aware but also maintains the ability to manage the information acquired towards positive beliefs and practices. It was evident from the focussed group discussions that as knowledge about sexuality at menopause increase, beliefs probably changed positively. This in turn informs a more positive sexual practice among the participants

Conclusion

Certainly, the menopausal transition and the ageing process bring about physical and psychological changes that could impair sexual functioning. However, this study has shown that sexual functioning still occurs among menopausal women and their spouses. The study also revealed the danger associated with menopausal women when they refuse sex with their partners as a result of their sexual beliefs. It is therefore recommended that education should be used to eradicate types of ignorance that could lead to conflict in the family. With proper planning, health personnel should inform women in menopause about their completion with the passage of age and reaching to menopause period, and the importance of sexual desire in people. From the study, it can be argued that the elderly could still be victims of sexual infections and diseases; hence, the elderly should be informed and carried along in the HIV/AIDS and STD/STI control programme.

Furthermore, sexuality is not just genital stimulation. Sexuality, particularly with the elderly woman, is a complex phenomenon affected by the interaction of physical, psychological and socio-cultural factors. It encompasses the entire realm of human contact and communication and it is the way of life and a way people define and present themselves. Hence, sexuality remains exceptionally important throughout a person's lifetime and has important implications for enhancing self-esteem, a positive self-image and overall quality of life. Based on this, training programmes, workshops and symposiums should be organized targeting at educating menopausal women towards developing positives beliefs on sexuality and sexual functions particularly in the absence of genital stimulation, thereby aiding and enhancing sexual beliefs and practices of menopausal women.

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