

From Karolinska Institutet, Department of Public Health Sciences,
Division of Social Medicine, Stockholm, Sweden

**Chilean women in midlife;
aspects on health, sexuality, migration
and gender roles**

Implications for midwifery

Lorena Binfa



**Karolinska
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ABSTRACT

Aims: To explore effects of biological and psychosocial factors on climacteric symptoms in Chilean midlife women (I), - to assess the impact of menopause and sociodemographic variables on quality of life (QoL) (II) - to learn about Chilean women's reflection about womanhood, and sexuality during midlife and the possible influence of migration whether they lived in Sweden or in Chile (III) - to explore how Chilean immigrant women living in Sweden perceived and related their life situations and health status during midlife to their migration experiences (IV) and to find out what Chilean midwives and midwifery students regard being Chilean women's health care needs in midlife (V).

Material and Methods: Quantitative and qualitative methods were used to collect the data. The inclusion criteria for the studies were healthy Chilean women who accompanied patients to the Primary Health Centres (PHC) in Santiago (I-II), Chilean middle-aged women living in Santiago or who had lived in Stockholm for at least 15-20 years (III and IV). Chilean midwives working in PHC in Santiago and Chilean midwifery students in their last study years (4th and 5th year) (V). The quantitative data were collected in two cross-sectional surveys using face to face structured interviews (I-II); three validated scales and two questionnaires to collect data on biological, psychosocial and climacteric symptoms (I), one quality of life (QoL) questionnaire (II). The qualitative data was collected using Focus Group Discussions (FGDs) (III- V), in depth interviews with key informants (IV) and written narratives (V). Socio demographic data was collected in all the studies. EPI-INFO and STATA softwares were used for analysis of quantitative data (I-II). FGDs, in-depth interviews and written narratives were analysed using manifest and latent content analysis (III-V).

Results: Perimenopausal women had a significant increase of stress and climacteric symptoms and perimenopausal state was a risk factor for somatic and vasomotor symptoms (I). Menopausal women had worse quality of life scores than women still menstruating and menopause was the only variable found to cause a significant impairment in QoL (II). A major influential factor in the women's lives had been the strong influence of a gender imbalanced life since childhood. This was a fact whether the women lived in Stockholm, Sweden or Santiago, Chile. The experienced gender imbalance had made the women socially, economically and biologically more vulnerable to exploitation later in life (III). The Chilean women discussed about their struggle to gain social acceptance and position and they reflected about the discrimination they had met in the Swedish society and within the health care system along with health changes they had had during midlife. They connected some of their health related problems to their hardships of migration. Important for their way of coping with their own health seemed to be a recognition of their level of independence, need for an 'own space', self-acceptance and awareness of power relationships (IV). The midwives considered that women in midlife have special health care service needs; they considered themselves to be the most appropriate health staff to provide health care for women in midlife. Midwives recognized that they lacked communication skills and competences in assisting psychological, social and cultural health care needs of women in midlife such as violence, abuse and sexuality issues. The midwifery students remarked that many midwives focused their attention on fulfilling the biomedical requirements. Some students also questioned disrespectful attitudes by midwives especially towards poor immigrant women and women with psychosocial problems (V).

Conclusion: Gender issues, structure of power relationships and empowerment should be incorporated into and critically discussed during midwifery education, training and in clinical settings. More reflections about and attention to the quality of the client-provider relationship in clinical practice are needed.

Key words: Chilean women, health, midlife, sexuality, gender roles, midwifery.

LIST OF PUBLICATIONS

This doctoral thesis is based on the following papers, referred to in the text by their Roman numerals:

- I. Binfa L, Castelo-Branco C, Blümel JE, Cancelo MJ, Bonilla H, Muñoz I, Vergara V, Izaguirre L, Sarrá S. Influence of psycho-social factors on climacteric symptoms. *Maturitas*. 2004; 48: 425-431.
- II. Blümel JE, Castelo-Branco C, Binfa L, Gramegna G, Tacla X, Aracena B, Cumsille MA, Sanjuan A. Quality of life after menopause: a population study. *Maturitas* 2000; 34 (1): 17-23.
- III. Binfa L, Robertson E, Ransjö-Arvidson AB. Chilean women's reflections about womanhood and sexuality during midlife in a Swedish or Chilean context. *Health Care for Women International* 2009; 30: 1093-1110.
- IV. Binfa L, Robertson E, Ransjö-Arvidson AB. "We are always asked; "where are you from?" Chilean women's reflections in midlife about their health and experience of migration to Sweden. In press in *Scandinavian Journal of Caring Sciences*.
- V. Binfa L, Pantoja L, Gonzalez H, Ransjö-Arvidson AB, Robertson E. Chilean midwives' and midwifery students' views of women's health care needs during midlife in Chile.(submitted)

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LIST OF ABBREVIATIONS

AGI	The Allan Guttmacher Institute
CEPAL	United Nations Economic Commission for Latin America and The Caribbean (Chile)
CMPH	Chilean Ministry of Public Health
CNSI	Chilean National Statistics Institute
CNWS	Chilean National Women's Service
FGD	Focus Groups Discussion
FIGO	International Federation of Gynecology and Obstetrics
FMUCH	Faculty of Medicine University of Chile
FONASA	National Health Fund (Chile)
FRDLC	Federal Research Division of the Library of Congress (Chile)
HRQoL	Health Related Quality of Life
HRT	Hormone Replacement Therapy
HT	Hormone Therapy
ICM	International Confederation of Midwives
ICMER	Chilean Institute of Reproductive Medicine (Chile)
ISAPRE	Private Health Institution (Chile)
OR	Odds Ratio
PAHO	Pan-American Health Organization
PHC	Primary Health Care
QoL	Quality of Life
SCB	Statistics Central Bureau (Sweden)
SNBHW	Swedish National Board of Health and Welfare
STRAW	Stage of Reproductive Aging Workshop
UNFPA	United Nations Funds for Population
WHI	Women's Health Initiative
WHO	World Health Organization
WMA	World Medical Association

1 PREFACE

At the end of the 1990s, the Swedish Institute invited a colleague and me as representatives of the midwifery school, University of Chile, to study the midwifery programme at Karolinska Institutet (KI). The Swedish midwifery programme had undergone major changes after the 1979 higher education reform and midwives fulfilling the eligibility requirements could pursue doctoral education, which was not the case in Chile at that time. The midwifery programmes at KI and University of Chile got the opportunity to embark on a lecturer and student exchange programme with financial support from the Swedish Linnaeus–Palme initiative, Karolinska Institutet and the University of Chile, which has made it possible for eleven lecturers and sixteen midwifery students in total to lecture and study at a twin university. This exchange programme has also provided the necessary time to focus on midwifery research training in Chile and made it possible for me to get the opportunity to pursue PhD training at Karolinska Institutet, Stockholm, Sweden.

So far, little attention has been paid to the overall life and health situation and lived experiences of Chilean women in midlife. My clinical experience of caring for middle-aged Chilean women made me realise that there are many lifestyle and health-related problems and no systematic strategy to meet the health care needs of women in midlife. My professional role later led me to participate in the adjustment of midwifery education in Chile to meet the women's and society's need for midwifery care. Therefore, I became interested in deepening my knowledge about women's health needs in midlife for my PhD studies in order to better understand how the health care system and especially midwifery care and education, can contribute to improving quality of life for the women in midlife.

2 INTRODUCTION

In accordance with the definitions of WHO/ICM and FIGO, the professional responsibility of a midwife is to address sexual, reproductive and perinatal health in a life perspective (ICM, 1992). Following the demographic and epidemiological changes in Chile, midwives' professional responsibility has been extended. Added to their traditional role, the care of pregnant women, and sexual and non reproductive women's health throughout their life cycle have also become part of midwifery. This is explicitly described in the midwifery curriculum and in the Women's Health Programme (WHP)(CMPH, 1997). At present, Chilean midwives are the professionals that provide the majority of gynaecological and obstetric care at the primary health care level, while also attending most of the normal deliveries in the public health services (Segovia, 1998).

Women in midlife

Midlife is a period that encompasses many aspects during women's lifespan, and comprises a variety of definitions. Some definitions, like age boundaries or menopausal transition, are mainly seen as part of a biological process within the biomedical paradigm which has contributed to a fragmentation of women's health research, without considering social historical and cultural aspects that shapes women's health and illness experiences (Meleis & Im, 2002). Most of the research on women's health during midlife has, to a great extent, focused on menopause and the experience of menopausal symptoms (Beyene et al., 2007; Daukantaitė, 2006; Im & Meleis, 2001a), largely as a result of the medicalisation of this period in life (Kaufert & Lock, 1997). Studies of women during this period of life have reported an excess of morbidity and symptoms of illness behaviour, depression, anxiety and physical constraints, which may reduce their quality of life (Krantz & Ostergren, 2000; McDonough & Walters, 2001; Mellner et al., 2006; Tibblin et al., 1990; WHO, 2007). The classical statement "females are sicker but men die quicker" (Verbrugge, 1985), seems to be a paradox. Women, despite their increased frequency in symptom reporting and disease burden when compared to men, live longer than men (Oksuzyan et al., 2008; WHO, 2008). During the last decades, the relation between the health status of middle-aged women and their overall life situation is receiving increasing attention (Daukantaitė, 2006; Krantz, 2000; Mellner, 2004). For women in midlife and experiencing menopause, the body is much more than a biological or a physical entity (Boughton, 1997). A sociocultural approach considers women's midlife as a time of shifting roles, biopsychosocial changes, including the time around menopause i.e. menopausal transition, and fundamentally takes into consideration women's own definitions about midlife (Arpanantikul, 2004; Woods & Mitchell, 1997; Woods et

al., 1995). The term psychosocial is referred to as “pertaining to the influence of social factors on an individual’s mind or behaviour, and to the interrelation of behavioural and social factors (Oxford Dictionary). This definition is very important in health research, on the one hand because it implies that psychosocial factors can be modified by the social structure in which they exist, and on the other hand, because they should be seen as mediators between the social structure and the individual’s health (Krieger, 1999; et al., 2001; Martikainen et al., 2002). In western society climacteric and menopause have been permeated historically by negative symbols or ‘medical metaphors’ as described by Martin (Martin, 2001). Terms such as decline, deteriorate, decrease, failure or degenerate are commonly used. Such connotations affect the social constructions of middle-aged and menopausal women, with respect to medical, societal and women’s own views. According to Martin, the changes in the biological body at the time referred to as ‘midlife’ and menopause, remind women of their advancing age, and women are expected to conform and are supposed to become more invisible. As discussed by Boughton (1997), women’s ‘embodied experience of menopause’ showed that the body of a menopausal woman has mainly been related to biology, particularly in the discourse and praxis of health care (medical) professionals.

Menopause and Menopausal transition

In medical science menopause has been defined as an oestrogen-deficiency disease (WHO, 1981) and more recently as the permanent cessation of menstruation resulting from loss of ovarian follicular activity (WHO, 1996). By consensus natural menopause is diagnosed after 12 months of amenorrhea. After prospective self-reporting studies by women, it has been concluded that the mean age of menopause is 51.3 years, apparently without any secular shift in the age of onset of the menopause (Blake, 2006; Nelson, 2008).

Menopause is preceded by a menopausal transition, popularly known as the perimenopause or climacteric, characterised by changes in hormonal levels, irregular menstruations, and variable symptoms, the mean duration of the transitional phase is 3,8 years. For clinical and research purposes it has been of interest to define and categorise the different stages within the menopausal transition. According to the Stages of Reproductive Aging Workshop (STRAW) criteria (Soules et al., 2001), which also recommended the adoption of the term menopausal transition, instead of perimenopause or climacteric, in reference to this period, the following stages have been defined. Stage-2, early transition is characterised by changes in the normal menstrual cycle of > 7 days. Stage-1, late transition women experience two or more skipped menstrual cycles and at least one intermenstrual interval of 60 days or more. The menopausal transition ends after 12 months of amenorrhea (otherwise

unexplained), then followed by the postmenopause, early postmenopause set at 5 years, including the 12 months following the last menstruation. The latter years in women's lifespan are considered the late postmenopausal years (Blake, 2006). However, categorisation of stages has been questioned (Kaufert et al., 1986, 1987; Mansfield et al., 2004) and researchers are becoming aware of differences in the subjective experiences of individual women; the age-related changes are attributed to variations in psychosocial and cultural factors, layered over an invariant biological base. Avis et al., (2005) conclude after analysing findings from various population-based studies of menopause and symptoms, that cross-cultural differences in symptoms reporting argue against the existence of a "universal menopausal syndrome" (Avis et al., 2005a).

Women may encounter a number of somatic and psychological health-related problems, which may affect their quality of life or general wellbeing. Vasomotor symptoms (hot flushes and night sweats) and genital atrophic disorders are related to a decrease in oestrogen levels. With regard to other symptoms, such as headache, dizziness, muscle-joint-skeletal problems and mood disturbances, it is not clear if there is any relation with oestrogen decline (Li, 2003). A review of longitudinal studies has shown that menopausal transition is significantly associated with clinical manifestations such as vasomotor symptoms; vaginal dryness and sleep disturbances (probably associated with vasomotor symptoms), and several other symptoms are inconsistently associated with menopause (Nelson, 2008; Vesco et al., 2007; Woods & Mitchell, 2005).

Hormone therapy (HT)

During the 1950s, oestrogen replacement was promoted as an anti-aging agent additionally relieving menopausal symptoms, primarily vasomotor symptoms (Blake, 2006). In the 1970s, the standard choice to treat menopausal symptoms was to use HT. In medical research either, hormone replacement therapy (HRT) which implies the correction of an abnormal deficiency (Ekstrom & Hovelius, 2000) as well as HT are used when referring to this treatment. Many studies have until recently suggested that long-term treatments with HT have a protective effect against coronary heart disease (Stampfer et al., 1991, 1985). However, during the 1990s many randomised controlled trials were carried out showing that HT did not reduce cardiovascular events (Grady et al., 2002; Grodstein et al., 2001, 2006; Hulley et al., 1998). Furthermore, the National Institute of Health (NIH) "The Women's Health Initiative (WHI)" revealed that HT does not decrease the risk for coronary heart disease (CHD) and the WHI reported an association between prolonged use of HT and increased risk of thromboembolism, heart infarction and breast cancer (Rossouw et al., 2002), related to the proliferative effect in breast tissue when progestagen is added to

estrogen. A continuous combined HT treatment may increase the risk of breast cancer compared to treatment with estrogen alone (Soderqvist & von Schoultz, 2004). Findings from these studies accounted for two important consequences; clinicians reassessed the use of HT and the current consensus is that the HT is recommended only for treatment of menopausal symptoms, with the lower dose and the shorter time (Blake et al., 2002; Grady, 2003; Lemay, 2002; Shapiro, 2007), while alternative treatments should be sought for other age-related disorders (e.g. osteoporosis, atherosclerosis, etc). Several studies after the WHI revealed a decrease in HT use (Blumel et al., 2004; Ekstrom, 2005; Ettinger et al., 2003; Haas et al., 2004; Lawton et al., 2003). Recently, a Swedish study suggested that several gynaecologists stress that symptomatic treatment with HT during menopausal age over a period of about five years increases the quality of life (QoL) for women and that this has been neglected after the WHI study due to unwarranted anxiety over side effects and risk (von Schoultz, 2009). The 2007 American Heart Association (AHA) guidelines for preventing cardiovascular disease in women stated that HT and selective oestrogen receptor modulators (SERMs) are not recommended to prevent heart disease in women (Mosca et al., 2007).

Quality of life

According to Utian (2007) the WHO 1993 definition of QoL as “an individual’s perception of one’s life situation in the context of the culture and value systems in which one lives and in relation to one’s goals, standards and concerns” (Utian, 2007) can be utilised for women during the menopausal transition. Health-related quality of life (HRQoL) refers to the effects of the personal, physical and emotional health status on the overall quality of life (Schneider et al., 2008). This concept has been the prevailing criteria and during midlife it has been usually referred to menopausal symptoms that affect women’s QoL, rather than accounting for more general aspects of QoL. In line with this, a literature review on the assessment of HRQoL showed that most of the instruments used for this purpose are based on a list of symptoms and feelings (Zollner et al., 2005). Menopause is not a disease, and QoL is related to more than health. Findings from studies of quality of life during menopause are not conclusive; some indicated impairment in women’s QoL, others showed improvement, while others found no association (Matthews & Bromberger, 2005; Nelson, 2008).

Social Support

Social support has been classically considered to be a protective factor against occupational stress, and to act as a buffer protecting against health risks. Social support is considered one of the social determinants of health (Marmot & Wilkinson,

1999); belonging to a social network makes people feel cared, loved, valued and esteemed, which has a strong protective effect on health and can also promote healthier lifestyles. The concept of social support is described by Schaefer et al., as comprising three dimensions; material support, emotional support and informational support, and their association with stressful life events, physical fitness and psychological symptoms (Schaefer et al., 1981).

The family acts as a very important support system, Caplan (1976) suggested that family provides different support roles for its individual members. Family can also support with problem-solving guidance and mediation, and also provide practical and specific aid such as financial support, help with childcare or technical support. The most important role of the family is protecting its members; family can be a place where you are accepted no matter how the outside world is reacting to you (Caplan, 1976). However, family can also be a source of conflict and a threat for its members; domestic violence, considered a type of interpersonal violence (WHO, 2002a), affects women and their children in all aspects of their lives. The perpetuation of violence, rooted in inequalities contributes to the perpetuation of inequalities limiting women's opportunities of work, mobility, access to information, self-care and self-esteem, thereby resulting in lack of autonomy and independence (Garcia- Moreno, 2000).

Gender and midlife women's health

All societies are based on a gender system corresponding to the societal structure of human activities and relationships based on the 'sexes', leading to the societal division of privileges and burden between women and men. While 'sex' refers to the biological characteristics recognised as unchangeable factors differentiating women and men, gender refers to the social, cultural and economic grounds seen as changeable factors contributing to women's and men's disparities (Lerner, 1986). Consistent among most gender researchers is that gender contributes to structures that support a dichotomy in work, characteristics and behaviours between women and men, and that there is an asymmetry in the relationship with power unequally divided into male superiority and female subordination (Connell, 1987; Montecino et al., 2003; Rubin, 1975). Gender role expectations and behaviour vary between place, time and culture, just as gender relationships vary within and across societies, in relation to the social structure of power and authority (Krieger et al., 2001; Wamala & Lynch, 2002). Gender, together with class and race, occupies a central place at the macrosocial level in the distribution and allocation of resources in a hierarchical society (Gomez, 2000).

It is accepted in public health that gender imbalance can act as a damaging health determinant among women; disadvantages in power, resources and influences are generally related to poor health (Annandale & Hunt, 2000). A critical point related to

women's health under a feminist view is the underlying male-centred assumption model as the norm in which results and conclusions for women are drawn (Im & Meleis, 2001b; Wood et al., 2006). In order to understand women's health, a multisectorial approach with a gender perspective is required (Ostlin et al., 2006) as well as a gender sensitive theoretical framework which does not reduce women's health and illness experience into a disease or health problem (Im & Meleis, 2001b). Additionally, it is necessary to study and analyse the interconnections between ethnicity, gender and class as power relationships affecting women's health which are interdependent rather than independent (Weber, 2006).

Stress and gender roles

Stressors involve demands that can tax or exceed the individual's adaptive resources. The stress experience may produce short-term responses, manifested as behavioural (e.g. smoking), physiological (e.g. high blood pressure) or psychological (e.g. sleep disturbances) outcomes. Social and psychological circumstances can cause long-term stress. The cumulative effect of such psychosocial stressors over time may increase the risk of poor mental health and premature death. Today stress is considered one of the social determinants of health (Marmot & Wilkinson, 1999). Individual factors such as coping strategies or social factors like having access to material resources or social support, appear to act as modifiers of the relationship between stressors, short-term responses and long-term health outcomes (Schulz et al., 2006; Steptoe, 1991). Women are still responsible for the traditional roles of childcare and home duties, independent of their work position, and these responsibilities have been considered to be a source of overload, conflict and stress (Sorensen & Verbrugge, 1987), affecting women's health and the development of symptoms (Gore & Mangione, 1983; Krantz & Ostergren, 2000; Rosenfield, 1989). It has been suggested that women are favoured when achieving different roles because of better financial resources, social support and economic autonomy, as well as other opportunities for increasing their self-esteem (Sorensen & Verbrugge, 1987). However, the effects on health from the multiple roles depend on the context in which these roles are carried out; combining paid employment and family roles depends on job characteristics, personal and family attributes, partner support, age of children and educational/occupational level (Bartley et al., 1999; Hibbard & Pope, 1993). In the Latin American context the 'machismo' represents a cult around masculinity and exercising domination which strongly influences gender relationships (Mones & Guzman, 1998). Among Latin Americans' traditional female role, womanhood is confirmed through marriage and childbearing and the gender roles of wife-mother are central to the cultural value of 'familialism' providing a strong attachment, loyalty and identification with the family (Marin & Marin, 1991). In Chile, Montecinos (1997) described the existence of a 'Conservative

modernisation´ by accepting the incorporation of the women in the public sphere however, maintaining the traditional role in the familiar aspects (a present mother and absent father) (Montecino, 1997). Furthermore, a new concept `neomachismo´ has been introduced. This means that Chilean men should be egalitarian in a modern society in which it is not possible to be seen as `machista´; however, they have rarely adopted the new complementary roles required by contemporary society (Montecino et al., 2003).

Sexuality

Sexuality is a fundamental aspect of a human being both for women and men. The way in which women perceive and experience sexual function, pleasure, and desire is affected substantially by context. Fausto-Sterling (2000) used Russian nesting dolls as a metaphor to illustrate how history, culture, relationship, psyche, organism, and cell are each appropriate components to study the meaning and development of sexuality and gender. It refers to the requirement for the integration of knowledge i.e., human sexuality cannot be well understood unless we consider all of these components (Fausto-Sterling, 2000). Social structures and constructions of power divisions, gender, race, class and heterosexual dominance play an important role as all these aspects are internalised at the deepest intimate level and feelings become part of the human personality itself (Ross & Rapp, 1997).

Sexual health is defined as a state of physical, psychological and social wellbeing as related to sexuality. The definition of sexual health and sexuality encompasses a broad number of issues, such as gender identity and roles, sexual orientation and reproduction, and cultural beliefs norms and values, as well as the rights related to prevention of STDs and sexual violence (WHO, 2006).

Many models have been developed in the past decades (Kaplan, 1979; Masters & Johnson, 1966) to explain the human sexual response as a complex biopsychosocial process. Usually the domains included in these models, which are also used for studying sexual function, are desire, arousal, frequency of activity (mostly sexual intercourse), orgasm, satisfaction, and pain. Low sexual function and personal distress components for each of the domains are current definitions of female sexual dysfunction in these models (Basson, 2000). However, these models have been criticised for not being sensitive enough to capture women's experiences of sexuality and called for a more women-centred, interpersonally, and socioculturally focused model (Tiefer, 1991).

Feminist scholars have scientifically argued against and criticised the biomedical research on women's sexual desire (Wood et al., 2006), by situating sexual desire as isolated at the individual level and separated from several contextual interacting

factors (Tiefer, 2000). Sociocultural research, in contrast, has focused more on contextual factors, women's overall situations and life events affecting women's sexual desire (Mansfield et al., 1998).

Sexuality of women in midlife

The relationship between menopause and sexual function has been of particular interest in biomedical research because of physiological and psychosocial changes most women experience during midlife. Therefore, in the 1960s, women's sexuality was articulated as to be one of the menopausal problems which must consequently be medicated (Ramirez, 2006; Tiefer, 2000; Tiefer, 2002). Sexual complaints are among the health concerns reported by women attending menopause clinics, therefore clinical experience is biased by a small group of self-selecting women who are probably not representative of most women. As suggested by Avis et al., (2005) research conducted in general populations of women does not show clear and consistent associations between menopause and different measures of decline in sexual function (Avis et al., 2005b).

During the menopausal transition, many women appear to experience changes in their sexual desire and most research has related it to a decrease in sexual desire (Basson, 2005; Dennerstein et al., 2003; Mansfield et al., 1998). Biomedical research has been particularly interested in studying sexual desire because it is one of the components of the sexual function believed to be most affected by steroid hormone changes and this has raised the conception of sexual desire as disease-oriented consequently labeling women who do not meet the "normal criteria" as pathological or dysfunctional (Wood et al., 2007). However, there remains a certain ambiguity related to the definition, conceptualisation and operationalisation of sexual desire when related to women (Basson, 2002; Wood et al., 2007). Furthermore, a recent review concluded that further studies are needed to clarify the relevance of sex steroids to women's sexual function (Nappi et al., 2005).

Many studies suggest that contextual - including psychosocial and cultural- background, relational variables, i.e. dissatisfaction with intimate partner, as well as socioeconomic and health status, have a greater impact on most aspects of sexual functioning than the transition to menopause (Avis et al., 2000, 2005b; Dennerstein & Goldstein, 2005; Dennerstein et al., 2005; Graziottin & Leiblum, 2005; Lewis et al., 2004; Mansfield et al., 1998). A study showed that 60% of women in midlife did not report any change in their sexual responsiveness, and in their sexual relationship the women described the importance of physical closeness, tenderness and intimacy with their partners (Mansfield et al., 1998). Findings from other qualitative studies

revealed a different perspective of women's perceptions about sexuality in midlife diverging from expert representations (Davila, 2005) and shaped by gender roles (Ramirez, 2006) and finally manifested in the different way in which women 'negotiate their sexual agency' (Wood et al., 2007).

Sexuality and violence

The term 'sexualised violence' has been used to refer to an overarching concept stated both at an individual level in couple relationships as well as structural violence through pornography, prostitution and trafficking (Risberg et al., 1999; Rönnberg & Hammrström, 2000). This means not only individual men's violence against women, but also how cultural representations of masculinity are constructed and the way this level interacts. The WHO concludes that women, in most cases, are victims, resulting from a lack of power to avoid being targets of sexual violence (WHO, 2006). Among Swedish students, verbal abuse is a predominantly masculine practice (Eliasson et al., 2005).

Among Latinos, although Latin America is not homogenous, generally a discussion of sexuality is taboo, therefore manifested as sexual silence. Further, a study conducted in a Hispanic community revealed that among Latina women, it is desirable to be naïve about sexual knowledge, thus perpetuating sexual silence and increasing their risk for unsafe sexual practices (Marin, 2003). In addition, sexuality among Latinas is influenced by the traditional gender roles, perceived as men being highly sexed and often proving their masculinity and exerting sexual coercion over women (Marin, 2003). The 'machismo' includes women's subordination and limits their self-determination and own decision-making concerning sexuality and reproduction (Mones & Guzman, 1998). The double standards also permit more flexibility among men to act as sexual agents. These cultural and social constructions shape Latino life, increasing women's risk for STDs and sexual abuse. The WHO states that the double standard in sexual morality is one of the risk factors for the spread of human immunodeficiency virus (HIV) and other sexually transmitted infections (WHO, 2006). It is fundamental both for women as well as for society, to develop effective intervention programmes for male perpetrators of violence against women (Eliasson, 2004).

Migration and Ethnicity

Migration and resettlement is a long standing process which affects all aspects of a migrant's existence and the generations to follow, in both sending and receiving countries (Castles & Miller, 1993). Migration involves a new beginning, often

including the acquisition of a new culture and language, usually followed by changes and related adjustments regarding lifestyles, social status, income level, and social isolation (Meadows et al., 2001). In migration research, there are different ways for looking at causes for migration whereas one discusses the tendency of people to move from low to high income areas, labour demand, better economic choices or political freedom (Jackson, 1969). However, different views of migration have been criticised because of its incapacity to explain actual migratory movements or to predict new ones (Sassen, 1988). Migration processes can be seen as the result of the interaction between macro-structures related to the extent of institutional factors and micro-structures involving individual characteristics of the migrants themselves to cope with migration hardships and resettlement (Castles & Miller, 1993).

The long-term effects of migration are focused in the last stage of the migratory process; permanent settlement. This stage can vary significantly depending on the actions of the state and population of the host country, moving from one extreme of openness and acceptance of cultural diversity allowing the creation of ethnic communities and the formation of a multicultural society, to the other side -the opposite- in which immigrants are excluded and marginalised leading to the formation of ethnic minorities (Castles & Miller, 1993).

Ethnicity is frequently seen as a characteristic of minority groups, there is consensus that everybody understands ethnicity as a sense of group belonging, sharing a common history, culture and a collective sense of common origin. Ethnicity leads to identification with a specific group, however, visible markers such as language, culture, religion, behaviour and phenotype can be used as a parameter for exclusion by other groups (Castles & Miller, 1993). Becoming an ethnic minority is not directly associated with migration, but can be a consequence of special mechanisms of marginalisation; further, it can be seen as threatening to the dominant group, therefore discrimination, harassment and violence as different manifestations of racism are reproduced (Castles, 2000).

Women's migration

Today, it has been reported that almost 95 million of the world's migrant population are women, representing half of the whole migrant population, and it is only now that there are concerns from the international community about the impact of migration on women's health, and the challenges they have to afford during the migration process (UNFPA, 2006). Studies indicate that women are the most vulnerable group among the migrant population (Ritsner et al., 2001; UNFPA, 2006). Traditionally, women's migration has been related to family reunification, thus women have been seen as dependent subjects, therefore largely invisible in migration research. Political

instability coupled with economic stagnation in a number of countries, with consequences such as uprooting and displacement will probably continue and contribute to even greater public health problems. It has been documented that women have been under-represented as asylum-seekers and among refugees admitted for resettlement, indicating that gender roles influence policies in receiving countries (UNFPA, 2006).

Further women's subordination, which is even worse among immigrant women often employed as domestic workers with insecure or lack of labour contracts, face an increased risk of being exploited and sexually abused especially among undocumented women (Castles & Miller, 1993; Macklin, 2008; UNFPA, 2006).

Following the return of democracy in 1990, Chile had experienced sustainable economic growth (Worldbank, 2004). Due to this and the global mobilization of the work force, Chile has become a country with an increased number of immigrants, especially from border countries (Argentina, Peru, Bolivia and Ecuador) whereas those coming from Peru constitute the largest group of female immigrants (Martinez, 2003). Further, most of the female immigrants are mothers (85%) with economic responsibilities influencing their decision to migrate as a family strategy rather than an autonomous decision (Cortes, 2005). Little is known with regard to health implications of this population.

The feminisation of migration enhances the possibility to open new spaces for the family and society, as well as more flexibility in gender division of work and changes in gender roles. However, it also hides the risk of affecting women's life projects by reinforcing asymmetric gender structures and women's subordination thereby depriving them of their rights and dignity (CEPAL, 2007).

Migration to Sweden and health

In Sweden, 1.2 million inhabitants are foreign-born i.e. immigrants (SCB, 2005). In the last decades, Sweden has had a significant migration movement supported by governmental policies (Castles & Miller, 1993). However, in 1989, the Swedish government, probably influenced by the European tendency decided to restrict rules concerning refugees, showing signs of detrimental immigration policies leading to a 'culturalist construction' of new forms of discrimination (Alund & Schierup, 1991).

Because of the increased number of immigrants, health research conducted in Sweden has investigated the association between ethnicity, migration process, acculturation and health outcomes, demonstrating a strong association between ethnicity and poor self-reported health (Lindstrom et al., 2001; SNBHW., 2001; Wiking et al., 2004). This research also suggests that immigrants are at higher risk of adverse mental health status (Blight et al., 2006; Sundquist et al., 2000), self-reported longstanding

psychiatric illness and intake of psychotropic drugs (Bayard-Burfield et al., 2001), and higher rates of hospital admissions for mental disorders (Westman et al., 2006). Even though few studies have been done in Sweden in which researchers specifically investigated foreign-born women in midlife, some studies report limiting and longstanding illnesses among foreign-born women (Robertson et al., 2003a), as well as an increased use of health care services (Malmstrom et al., 1998) and an increased risk of psychiatric hospital admission among foreign-born women (Robertson et al., 2003b). Further gender assessment and the incorporation of socio-demographic factors in the analysis are suggested (Westman et al., 2006).

Chilean migration to Sweden

In September 1973, the military coup headed by Pinochet overthrew Allende's socialist party causing the greatest exodus of people in Chilean history. Thousands of Chilean men and women were forced to leave the country during 1973-1974 as political refugees. A law decree in 1973 made a legal procedure to expel political opponents from the country. In the beginning of 1975 up to 1979 another law decree gave political prisoners the possibility to exchange their imprisonment for the exile option, a military strategy to expatriate the political left which was also in response to international pressure (Tollefsen-Altamirano, 2000). The migration trend decreased in the 1980s and 1990s, but there were still episodes of political or economic migration. Figures about the Chilean exile vary between 160.000 to 250.000 or 300.000 (Llambias-Wolff, 1993). The National Return Office (NRO) estimated that there were about 200.000 Chileans in exile during 1993. All social classes were affected, and refugees were found on every continent. Due to gradual political change and liberalisation in Chile, there has been a return migration to Chile since the 1990s (Klinthäll, 2007). Many Chilean people came to Sweden who assisted, especially in urgent cases. During 1987 there were almost 14,000 political refugees living in Sweden (Sznajder M & Roniger, 2007). Exile is defined as being sent away from one's native country or home to another, mainly for political reasons; a forced absence (Oxford Dictionary). In the exile memory there are two strong and consistent images described by people in exile. One is about the experience of living in two worlds - 'here and there' - and the other is that of a space hung on time (Stern, 2001). Therefore, not belonging to any place and living the life of another on borrowed time, both are the expression of a fracture and the negative view of exile. However, there are some convergent positive images among a specific group of professional middle-class women highlighting what they gained in autonomy and independence (Rebolledo, 2006).

Chile



Population (2007): 16.598.100 (growth rate: 0.8%); density per sq mi: 21 inhabitants.

Capital and largest city: Santiago

Language: Spanish

Ethnicity: European background 95%, indigenous 5%

Religion: Roman Catholic 89%, Protestant 11%, small Jewish population.

Source Chile Information (infoplease.com)

The Republic of Chile is situated in the extreme southwest of South America bordering Peru to the north and Cape Horn to the south. Bolivia and Argentina are to the east, and the Pacific Ocean to the west. About 85% of the population lives in urban areas and 40% lives in Santiago and its surroundings. According to the last population census (2002), almost 5% of the total population belongs to indigenous group, with Mapuche being the largest group (4%) (CNSI, 2002). The major religion is Roman Catholic.

Chile was originally under the control of the Incas Imperium. In 1541 a Spanish soldier founded Santiago. Chile won its independence from Spain in 1818.

According to the governmental system, Chile had a parliamentary era (1891-1925) which was later followed by a presidential republic (1925-1973). Chilean society preserved the essence of the stratified colonial social structure, family politics, and the influence of the Roman Catholic Church.

Chile is undergoing a demographic transition characterised by low birth and mortality rates with increasing life expectancy. Aggregate social and economic indicators for

the country show clear improvements, expressed in a reduction of poverty levels from 38.6% in 1990 to 18.8% in 2003. However, inequality between social groups and regions persists. At the end of 2000, 10% of the wealthiest households captured 40.3% of the income, while the poorest 10% obtained just 1.7% (PAHO, 2007).

Chile today is a unitary state with a democratic government. The country is divided into 15 political-administrative regions. Since the return of democracy in 1990, the country has established a record of committed economic reform, proactive social investments, clean, transparent public sector management, and stable, consensual governance. Chile's main industries are copper mining and agriculture (Worldbank, 2004).

In 1970 Salvador Allende became the first socialist president freely elected on a Marxist program in a non-communist country. In September 1973 Allende was overthrown by a military coup ending a 46-year era of constitutional government in Chile. The military coup was led by a four-man junta headed by General Augusto Pinochet who eventually assumed the presidency. Pinochet's dictatorship led to the imprisonment, torture, disappearance, execution, and expulsion of thousands of Chileans.

Chilean women from all social classes assumed very important roles in defense of democracy against repression as leaders for human rights movements and also socioeconomic organisations such as popular gardens, and kitchens as well as other survival strategies to protect families in the poorest neighborhoods. They also played an important role in recovering democracy by participating in different political and social movements that finally brought a return to civilian rule in 1990.

In 1989 Pinochet lost a plebiscite on whether he should remain in power. In 1990 he stepped down in favour of Patricio Aylwin representing a centre-left coalition. In 2006 Michelle Bachelet became the first female president of Chile (Encarta, 2008). The participation of the women has been crucial first, in recovering democracy and later in the process of state modernisation through working actively against forces that are resistant to generating the necessary changes to resolve the dichotomy between public and private, eliminating gender hierarchies and by developing new forms of relationships between production and reproduction (Guzmán, 2002).

Reproductive rights in Chile

Only recently in 2004, Chile approved a law permitting divorce, despite strong opposition from the Catholic hierarchy's to the legalisation of divorce. Chile was one of the last countries in the world to legalise divorce. Beforehand, there was a law that allowed marital separation under certain conditions but without dissolution of the conjugal union. There is still a sentence included in family law about whether

"women should obey their husbands", which is supposed to be read (although it is frequently omitted) to Chileans during their marriage in a civil ceremony at the registry (FRDLC, 1994).

Although contraceptive methods of all types are widely accepted, Chile has a high rate of adolescent pregnancies (ICMER, 2004). Abortion is not legalised and this is without exceptions. In 1931 therapeutic abortion was introduced in the sanitary code and it was permitted only in case of complicated pregnancies putting the mother at risk of death. This law was derogated in September 1989 at the end of the military dictatorship therefore stating prohibition for any type of abortion (law N°119). Although illegal, abortions are commonly performed in Chile. Studies carried out in recent decades showed that Chile has one of the highest rates of induced abortion in Latin America (ICMER, 2004). International estimates report that almost 150.000 women undergo induced abortions every year in Chile and most of them face risks for complications that are uncovered by the health system (PAHO, 2003). Researchers on Chile have consistently estimated that about one third of all Chilean women have one or more induced abortions during their childbearing years (AGI, 1994).

Inequalities of power between men and women are seen as one of the main causes of violence against women. During recent years, violence against women; mainly domestic and sexual, has been of central interest, and many laws and recommendations have been approved. A Chilean study related to domestic violence concluded that 25% of housewives suffered from physical and 30% from psychological violence (CNWS, 2001). Another interview study revealed that in Santiago 50.3% of the women experienced intimate partner violence at some point in their lives; psychological (16.3%) or physical and/or sexual (34%) (CNWS, 2002). A major problem of statistics is related to underreporting of cases due to women's fear or because of legal insecurity. During 1995 a law against domestic violence was approved (law N° 19.325), and in 1999 modifications in the penal code were introduced in relation to sexual abuse (law N°19.619). These improvements in law regulation increased legal protection, favoured socialisation among the general population, and also encouraged women to report cases of violence.

Chilean Health System

Since the return to democracy, Chile is undergoing a process of health reform, known as the General System of Health care Guarantees, which established the Universal Access Plan with Explicit Guarantees (AUGE). Its purpose is to guarantee the right to health for all Chileans, without discrimination; to improve their levels of health; and to reduce socioeconomic and geographical inequities. The Ministry of Health is responsible for the formulation and establishment of health policies, development of

general standards plans, supervision, monitoring, and assessment of compliance with them. The health system is mixed in terms of financing, health insurance, and service delivery. All the workers, by law, are required to pay 7% of their monthly wages into a public insurance provided by the National Health Fund (FONASA) or private insurance provided by Private Health Institutions (ISAPREs). In addition FONASA receives transfers from the Government to cover indigents and to develop public health programmes. FONASA covers 68,3% of the Chilean population. The rest of the population is either covered by the ISAPREs (17,6%), by other private plans (14,1%), or has no insurance at all. Health care is regulated by rules that form part of the Ministry of Health's programmes, defining coverage, frequency of contact between users and services providers, and the responsibilities of the different levels in the system. Today, according to the health reform, the sanitary authority (Under Secretariat of Public Health) is separated from the health care provision (Under Secretariat of Health Care Networks) and priority is placed on primary health care and the family and community health teams have been strengthened (PAHO, 2007, 2008).

Midwifery education in Chile

Midwifery education in Chile started in 1834 with the first course for midwives supervised by Dr. Lorenzo Sazie, a French obstetrician who was contracted by the Chilean Government to teach in Chile. Dr. Sazie was also the first Dean of the Faculty of Medicine, University of Chile, created in 1842 (FMUCH, 2009). In 1896 there was a relevant change to midwifery education when the Ministry of Education gave tuition responsibility to the Rector of the University of Chile thereafter recognising midwifery education at the University level. From the beginning midwifery education was under medical supervision and direction. It was a two-year direct entry study program stating a requirement to be admitted as 'being a healthy and educated woman'. During 1930 the programme was extended to three years including one year of internship in maternity care. In 1959 the attainment of a bachelor's degree was required to apply. It was not until 1960 that the first course for lecturers in midwifery was developed by the WHO-PAHO and sponsored by the Faculty of Medicine at the University of Chile. This made it possible for the first midwife director of the school to be nominated in 1968 and during her leadership in 1971 the study programme increased to a four-year programme (Tupper, 2004). Since 1995, it has been a five-year programme leading to a 'licentiate degree'. Currently, after a five year academic programme, trainees take the responsibility for enhancing and improving women's health and quality of life along their life-cycle. Newborn health is also a core task for our profession. Interventions aimed at improving their health include family and community. To accomplish these tasks, activities such as

prevention, promotion, treatment and rehabilitation are constantly performed. Therefore, the active role played by midwives inside the health team is within an ethical, legal and management framework (SMUCH, 2009). So far, little attention has been paid to research education of midwives and to addressing the gender and cultural aspects on youth sexual and reproductive health and the health care needs of women in midlife in Chile.

At present there are eleven midwifery schools in Chile and about three hundred midwives qualify every year (Universia, 2009). Qualified midwives are mostly Government employed and work mainly in Obstetric and Gynaecology wards in hospitals but also in the PHC clinics. Chilean midwives also work in private clinics and are eligible to run their own clinics.

Health aspects of Chilean women in midlife

Although life expectancy for people in Chile is high, 81,5 years of age for women, and 75,5 years for men (CNSI, 2005), health and quality of life need to be addressed as the demand for health care among the middle-aged group is high. Statistics reveal that major and increasing health problems among the adult Chilean population are related to cardiovascular diseases (CMPH, 2003). The First National Health Quality of Life Survey (HQLS) was introduced by the Chilean Minister of Public Health to obtain a baseline for the creation of health plans and programmes for health promotion, and for the development of the sanitary objectives for the decade 2000-2010. This survey revealed that Chilean women had a negative perception about their health status which increased with age and lower socioeconomic level (CMPH, 2006). According to the last population census (2002), Chilean women do not have paid work to quite the same extent as men; almost one third of the women are in gainful/paid employment. Of the men, 70 % are in paid employment, compared with 35.6 per cent of the women, one of the lower rates in Latin America. The salary for women is on average/hour 20 % lower than the salary for men, and today about 25% of women are single mothers therefore assuming all the responsibilities of her family. Additionally, almost 30% of the working women are non skilled or blue collar workers (PAHO, 2003).

3 AIMS

Overall aim

The overall aim of this thesis was to investigate Chilean women's aspects of health in midlife, their sexuality, experience of migration, and gender roles and their implications for midwifery in Chile.

3.1.1 Specific aims

- To analyse the effects of biological and psychosocial factors on climacteric symptoms (I).
- To assess the impact of menopause and some sociodemographic variables on quality of life (QoL) (II).
- To learn more about Chilean women's reflection about womanhood and sexuality during midlife and the possible influence of migration whether they lived in Sweden or in Chile (III).
- To explore how Chilean immigrant women living in Sweden perceived and related their life situations and health status during midlife to their migration experiences (IV).
- To find out what Chilean midwives regard as being Chilean women's health care needs in midlife. The aim was also to explore Chilean midwifery students' views on the clinical care provided to women in midlife (V).

4 MATERIAL AND METHODS

Quantitative (I and II) and qualitative (III-V) methods were used for data collection. In order to explore the biological and psychosocial factors influencing women's midlife situation, validated psychometric instruments were used. Further, to capture Chilean women's lived midlife experiences, and Chilean midwives and midwifery student's view of women's health care needs in midlife, a qualitative method was chosen to collect the data (Polit & Beck, 2008).

4.1 STUDY SETTINGS

Studies I-II and V were carried out in Santiago, Chile. Part of study III was carried out in Santiago, Chile and the other part in Stockholm, Sweden, and study IV in Stockholm, Sweden.

Santiago

Santiago has a population of about 6,3 million and 12 % are women 40 to 64 years of age (CNSI, 2005). In this age group, 64% of the women attend the Chilean National Public Health System. In Santiago, Primary Health Care (PHC) is structured and technically delivered in six Metropolitan Health Services (Northern, Southern, Western, Eastern, Centre and South-Eastern). The administrative responsibility for primary health care has been decentralised into the municipalities (PAHO, 2008). Study I was performed in one PHC centre belonging to the Eastern Metropolitan Health Service. At the time of the study, an estimated population of 3.987 women in the age group 40 to 59 years attended this health care centre for health control, medical care or menopause-related complaints. Study II was carried out in four PHC centres belonging to the Southern Metropolitan Health Service during 2001. This study area provides health care service for an estimated population of 60.000 women in the age group 40 to 59 years.

Stockholm

Stockholm has a population of about 1,9 million and 16 % are women in the age group 40-64 years and within this group about 23% are foreign-born women. In 2005, there were 6.175 Chilean women age 40 and 64 who lived in Sweden (SCB, 2005), all of whom were eligible to attend the Swedish National Health Care System. The responsibility for providing health care has been decentralised into the county councils and in some cases to the municipalities (SNBHW, 2008).

4.2 STUDY PARTICIPANTS AND SAMPLING

The participants in all the studies were Chilean middle-aged women, and Chilean midwives and midwifery students.

Study I and II.

The inclusion criteria were healthy women, 40 to 59 years of age, who accompanied patients coming to the PHC centres in Santiago de Chile. Thus the participants were not seeking medical care for themselves. The exclusion criteria were women using Hormonal Therapy (HT), and hormonal contraceptives, or women with hysterectomy and/or oophorectomy. A convenience sampling procedure was used. Using the statistical software (EpiInfo version 6.04) to calculate a sample size for a population based on about 4.000 women who had sought medical care at PHC and an expected frequency of symptoms of 30%, a sample size of 300 women was recruited to the study based on the results of the power calculation (I). Using the statistical software (EpiInfo version 6.04) to calculate a sample size for an estimated population of 60.000 women and an expected frequency of symptoms of minimum 50%, and a maximum acceptable error of 5%, a sample size of 382 women was obtained. A total of 481 women were recruited for the study (II).

Study III - IV

Included were Chilean middle-aged women living in Santiago or who had lived in Stockholm for at least 15-20 years. A purposive sampling procedure was utilised for the recruitment of participants. This procedure relies on the selection of subjects judged to be particularly knowledgeable of the topic of interest or typical members of the population under study (Polit & Beck, 2008). A Chilean woman in Sweden recruited participants of the Focus Group Discussions (FGDs) held in Stockholm. In Santiago, midlife women were recruited by a Chilean woman who belonged to a nongovernmental organisation (NGO) working with women.

Study V

Chilean midwives working in PHC in Santiago were informed about the aim and methodology of the study and invited to participate in the study; those who accepted the invitation were distributed randomly in four FGDs. Further, midwifery students in their last study years (4th-5th years) from the School of Midwifery at the University of Chile were invited to participate: Those who returned their written narratives were included in the study.

4.3 DATA COLLECTION

Study I and II.

Three validated scales, two questionnaires were used to collect data on biological, psychosocial and climacteric symptoms (I), one quality of life questionnaire (II). The quantitative data were collected in 2 cross-sectional surveys conducted in Santiago, using face-to-face interviews, according to structured data collection instruments. All the interviews were carried out by medical students specially trained for that purpose. The data collection process was supervised by the principal investigator (LB) and one assistant for validity and reliability of the data collection procedure. In both studies sociodemographic data was collected (I-II).

Study III - V

The qualitative data was obtained through FGDs. In study III and IV three FGDs were held in Stockholm and two in Santiago. In addition three in-depth interviews with key informants were held in Stockholm. In study V four FGDs were held with midwives working in PHC centres in Santiago, Chile. Further, thirteen written narratives were obtained by midwifery students in Santiago. Sociodemographic background characteristics of the participants were collected, such as age, marital status, level of education, and work history.

4.3.1 The Greene Climacteric Scale (I).

The Greene Climacteric Scale (Greene, 1998) is a self-evaluated scale of intensity of climacteric symptoms rated as “not at all” (0) “a little” (1) “quite a bit” (2) and “extremely” (3). The scale contains 21 questions grouped into 5 symptom domains: anxiety (questions 1-6) e.g. feeling tense or nervous; depression (questions 7-11) e.g. loss of interest in most things; somatic (questions 12-18) e.g. headaches; vasomotor (questions 19-20) e.g. hot flushes; and sexual domain (question 21) e.g. loss of interest in sex. This scale has been widely used for the assessment of climacteric symptoms. In this study we used a validated Spanish version (Blumel et al., 2001). The internal consistency measured with the Cronbach alpha coefficient was 0.85.

4.3.2 The Cooper Stress Symptoms Checklist (I).

The Cooper Stress Symptoms Checklist was developed by Cooper to be used for the assessment of symptoms of stress (Cooper, 1981). It includes 22 statements about experiencing physical symptoms of stress e.g. back or waist pain, and questions about psychological symptoms of stress e.g. feeling irritable or impatient. In the present

study we used a Spanish version validated by Trucco et al. (1998, 1999) (Trucco & Valenzuela, 1998; Trucco et al., 1999). Statements are rated as “hardly ever” (0), “some of the time” (1) and “most of the time” (2). The internal consistency measured with the Cronbach alpha coefficient was 0.89.

4.3.3 The Smilkstein’s Family Apgar Test (I)

The Smilkstein’s Family Apgar Test was developed for the assessment of family dysfunction (Smilkenstein, 1978). It is a 5-item Likert scale for assessing the individual’s perception about satisfaction with his/her family, comprises the assessment of five dimensions of family function; adaptability, partnership, growth, affection and resolvment. The Smilkstein Family Apgar Test is widely used in Primary Health Care Centres adopting the Family Health Care Model in Chile as a screening test for detection of family dysfunctions. The test is recommended to be used as a baseline and in later follow-up assessments. Questions are evaluated as “hardly ever” (0), “some of the time” (1) and “most of the time” (2). The scores can vary from 0-10. In this study we used the Spanish validation developed by Bellon-Saameño et al. (Bellon Saameno et al., 1996) (I). The internal consistency Cronbach alpha coefficient was 0.75.

4.3.4 The Duke-UNC Functional Social Support Questionnaire (FSSQ) (I).

The Duke-UNC Functional Social Support Questionnaire (FSSQ) developed by Broadhead et al. (1988) (Broadhead et al., 1988) is an 11-item questionnaire to measure social support, including affective support reflecting a more emotional form of support and caring e.g. love and affection and confident support which reflects a confident relationship where matters of interest in life are discussed and shared e.g. useful advice about life. The individual responds according to how much he/she feels it would like to be, from “less than I wish” up to “as much as I wish”, assigning a corresponding score from 1 to 5. In this study, we used the Spanish validation developed by De la Revilla et al. (1991) (de la Revilla Ahumada et al., 1991). This questionnaire has been widely used in patients attending Primary Health Care centres especially in Spain (Bellon et al., 2007; de la Revilla et al., 2007). The internal consistency Cronbach alpha coefficient was 0.87.

4.3.5 The Life Events Scale (I).

The Life Events Scale was developed by Israel et al., and is used for identifying negative life events (1989) (Israel et al., 1989b; Israel et al., 1989a). It contains 13 items comprising events such as personal, familiar or close friend’s economic/job

problems, diseases, death, injuries or loss of items of value. The participant must respond yes or no whether or not they had experienced some of these events in the past six months. In this study we used an adapted questionnaire validated to Spanish by Trucco et al., (1998, 1999) (Trucco & Valenzuela, 1998; Trucco et al., 1999) The Cronbach alpha coefficient for the internal consistency was 0.70.

4.3.6 The Menopause-Specific Quality of Life Questionnaire (QoL) (II).

The Menopause-Specific Quality of Life Questionnaire (QoL) was developed by Hilditch et al., (1996) (Hilditch et al., 1996) and is used for measuring quality of life. It is a 29-item self-evaluation questionnaire which measures four domains of QoL: vasomotor (questions 1-3) e.g. hot flushes; psychosocial (questions 4-10) e.g. being dissatisfied with personal life; physical (questions 11-26) e.g. weight gain and; sexual domains (questions 27-29) e.g. avoiding intimacy. The participant should report whether or not she has experienced this problem in the last month and if the answer is yes, the participant rates, in a range from 0-6, the extent to which a problem bothers her from “not at all”(0) up to “extremely bothered” (6). As no validated version in Spanish was found, an expert committee from a healthcare centre for menopause in Santiago (PROSAM) translated the questionnaire from English to Spanish, and thereafter translated it back into English using a native speaker of English (Polit & Beck, 2008). This new version was again translated into Spanish (backward-translation technique), the internal consistency of the four components studied (physical, vasomotor, psychosocial and sexual) in the translated test, were measured using Cronbach alpha coefficient (values over 0.80 for all the tested domains were found). This translation was first tested in a pilot study with women attending the same health care centre.

4.3.7 Focus group discussions (FGDs) (III-V).

Focus group discussions (FGDs) are especially recommended for data collection to obtain the viewpoints of several individuals. The interaction of the members potentially leads to rich and deep insights and information about the topic under discussion (Polit & Beck, 2008). FGDs are often used when the group is made up of people with similar backgrounds and common interests, and when the discussions centre on a specific topic; these conditions facilitate interaction between participants and enhance the data generated by group interactions (Berg, 2007). One disadvantage of the FGD is that some people can feel uncomfortable about expressing their points of view in front of others or inhibit individual expressions especially with some sensitive topics. However, the moderator plays an important role in obtaining input from all group members by not leaving a few people dominating the discussion and

by creating a permissive atmosphere for the expression of personal and conflicting points of view, in which case group interaction may facilitate expression of viewpoints usually not accessible (Polit & Beck, 2008). The purpose of the FGD is not to reach consensus from the group, or solutions to the issues under discussion, but to bring forth different points of view (Kvale & Brinkmann, 2009).

In study III and IV, a total five FGDs was conducted during the study period. A Chilean woman in Sweden recruited the first participants, i.e. a snowball sampling technique. The rest of the recruitment was done through a purposive sample procedure (Polit & Beck, 2008).

The FGDs were held in separate rooms in community locations accessible and comfortable for the participants. The discussions were informal in style and lasted for about one and a half hours. All the FGDs were coordinated by a moderator (LB) who is trained at managing the dynamics of focus groups and who has experience in menopause research work in Chile. A Spanish-speaking researcher (ER) facilitated FGD 1, 2 and 3 in Sweden, and a Chilean teacher facilitated FGD 4 and 5 in Chile. With permission from the women, the discussions were tape-recorded. An assistant note-taker kept record of the group process during the FGDs.

In study III and IV the FGDs started with one opening question: “Can you please tell what experience/reflections you have on womanhood and sexuality in midlife?” In study IV the introductory question was, “Can you please tell me about your experiences of midlife situation and health?” The women were asked to freely discuss and express their personal views, experiences, perceptions, and knowledge about the topics. Rephrasing the women’s statements and the use of probing questions were often necessary to gain further insight into the discussions. Each FGD lasted between 60 and 120 minutes. In order to assess the quality of the interviews and to collect guidelines for the next FGD, the tape-recorded FGDs were transcribed verbatim and translated into English by the moderator and facilitator as soon as possible after the FGD. One of the FGD texts was translated back into Spanish to check the quality of the translation, which was found to be appropriate.

In study V the midwives who consented to participate were randomly allocated to four tape-recorded FGDs, held in four different health centres, in separate rooms. The principal investigator (LB), trained in FGD methodology, moderated all discussions, and a facilitator (LP) took notes of the FGDs dynamic. A discussion guide was used during the FGDs. The introductory question was: “Can you please tell me about health care needs by women in midlife?” The midwives were encouraged to talk freely about this topic. Follow-up (probing) questions were asked to clarify or deepen the answers. After the FGDs, the midwives completed a questionnaire about their sociodemographic background, year of midwifery degree, and work-related factors.

All FGDs were tape-recorded, transcribed verbatim and translated into English. One of the FGD texts was translated back into Spanish to check the quality of the translation, which was found to be appropriate. An assistant note-taker kept record of the group process during the FGDs.

4.3.8 In- depth Interviews (IV)

In-depth interviews were performed with three Chilean immigrant women to obtain more profound insight into the effect of the migration process. These face-to-face interviews were held with members of the social and cultural group in the research context in order to capture experiences that could have been more difficult to explore with FGDs; being a political refugee and immigrant, and coming to and living in Sweden. This technique gives participants the freedom to respond in their own words, provide as much insights as they wish and offer the possibility of deeper explanations (Fontana & Frey, 2005). This can be seen as a form of triangulation of data to enhance greater credibility (Polit & Beck, 2008). Each interview lasted between 60 and 90 minutes, and was audiotaped and transcribed verbatim.

4.3.9 Written Narratives (V)

Written Narratives were obtained from midwifery students in their 4th and 5th study year, asking about their particular view or significant aspect, as a self-disclosure about individual experiences (Chase, 2005) based on their clinical observation while experiencing a midwife/woman in midlife encounter during their clinical training.

This kind of contact with the students was considered appropriated to avoid any degree of pressure to take part in the study, respecting their wish/freedom to participate, also their privacy while writing. The midwifery students who returned their signed consent form were included in the study, and were asked to write down their reflections and significant experiences.

4.4 DATA ANALYSIS

4.4.1 Analysis of quantitative data

All the statistical analysis was computed with the EPI-INFO version 6.04 and STATA software programmes. Differences between groups were tested with analysis of variance (ANOVA) or Student's *t* test. Percentage differences were tested using χ^2 (I and II). Least-squares difference and Bonferroni comparisons were tested for differences between groups, and associations between exposed (peri- and

postmenopausal women) and non-exposed (premenopausal women) were expressed in odds ratios (ORs) (II). Logistic regression was used to assess the simultaneous influence of different variables on the risk of suffering climacteric symptoms or stress (both were considered as dependent variables) and history of family dysfunction, life events, poor social support, premenstrual syndrome and perimenopausal status (independent variables) (I), and to assess the simultaneous influence of different variables in QoL; the four domains included in the questionnaire were considered as dependent variables, and menopause and sociodemographic variables as independent variables (II). The entry of the variables into the logistic regression models was considered with a 20% significance level, and the stepwise procedure was applied (I and II). A significance level of $P < 0.05$ was established.

4.4.2 Outcome variables

The Greene Climacteric Scale: The score obtained from each symptom domain was analysed separately. The mean score for each symptom domain ranged from 0-3. For the multivariate analysis the score was further dichotomised defining a mean score \geq to the mean in each symptom domain as the exposure category (I).

The Cooper Stress Symptoms Checklist: The total score ranged from 0-44. For the multivariate analysis the score was dichotomised with a mean score \geq to 19 to be classified as the exposure category (I).

The Menopause-Specific Quality of Life Questionnaire (QoL): For each domain, the score was the following: If the answer was NO = 1, YES and 0 = 2, YES and 1 = 3 and so on up to YES and 6 = 8. The mean score for each domain range from 1-8 and each domain was analyzed separately. The scores were further dichotomised for the multivariate analysis i.e. having a score \geq to the median for each domain was considered as exposure category (II)

4.4.3 Explanatory variables.

Age, marital status, number of children living at home, level of education, work, health system insurance, stage of reproductive health, premenstrual syndrome (PMS), health status, family function (Smilkstein's Family Apgar Test), social support (Duke-UNC Functional Social Support Questionnaire), negative life events (The Life Events Scale).

Age groups were classified into: 40-44, 45-49, 50-54 and 55-59 years of age.

Age in midlife women was 40-64 years of age (III-IV).

Marital status comprised four groups: married/cohabiting, single, separated and widowed (I-IV).

Number of children living at home: comprised whether or not the women had children living at home (II-IV).

Level of education: The respondents were classified into three groups according to their attained level of education (1) *basic:* comprehensive school level, ≤ 9 years of education; (2) *medium:* at least four years of secondary school, 10-12 years of education; and (3) *high:* more than four years of secondary school or university studies, >12 years of education (I-IV).

Work comprised two groups: paid work and unpaid= housewives (I-IV).

Health system insurance comprised two groups: women belonging to the National Health care insurance or private health care insurance (I-III).

The stage of reproductive health: was defined as: premenopause (regular menses), perimenopause (irregularities > 7 days from their normal cycle) and postmenopause (amenorrhea > 12 months) according to The Stage of Reproductive Aging Workshop (STRAW) criteria (Soules et al., 2001) (I).

The stage of reproductive health: for defining the menopausal status (II): women were classified as premenopausal (experiencing regular cycles), perimenopausal (experiencing irregular cycles) and postmenopausal women, further divided into postmenopausal less than 5 years ago, and postmenopausal for five or more years. (Punyahotra et al., 1997) (II)

The antecedent of premenstrual syndrome (PMS) was evaluated according to the questions of the menstrual cycle problems: Self-Care Flowcharts of the American Academy of Family Physicians (AAFP, 1996) which consider dysmenorrhoea, emotional problems, oedema, mood swings, changes in mental alertness or ability to concentrate, tiredness and sleep disturbance in the premenstrual period, a case was defined when the answer was positive to all these questions (I).

Health status was defined as a condition compatible with the performance of routine activities and no clinical history (I-II).

The Smilkstein's Family Apgar Test: The score were further dichotomised for the multivariate analysis defining a mean score \leq to 7 as the exposure category. The test's total score ranges from 0-10 (I).

The Duke-UNC Functional Social Support Questionnaire (FSSQ): The total score for the questionnaire ranged from 0-55. The score was calculated by summing the item scores. For the multivariate analysis the score was further dichotomised defining the exposure category as having a mean score \leq to 29 (I).

The Life Events Scale: The total score range was 0-13. A scale score was calculated by summing the item scores. The scores were further dichotomised for the multivariate analysis as having experienced \geq to 4 events as the exposure category (I).

4.4.4 Analysis of qualitative data

Qualitative data (III -V) were analysed using a thematic manifest and latent content analysis of narrative data, performed to structure and categorise the data, and to identify themes and patterns among data. Manifest content analysis focuses on the most obvious and straightforward meanings of a text, while latent content analysis is extended to an interpretative reading and captures the deep underlying meaning of the text (Berg, 2007; Graneheim & Lundman, 2004; Hsieh & Shannon, 2005). To understand each FGD and interview as a whole, to obtain a sense of the whole content, and to discover essential contents within the text, the analysis process started with a so-called *naïve reading* of the raw text several times—in which the text was reviewed line by line in order to find patterns. Women’s experiences were the focus of the manifest content analysis (III-IV). Afterwards the *meaning units*, including words or phrases, were identified and grouped into topics relevant to the aim of the study. Data were reduced, shortened to break down the data into smaller units which were coded and named according to which content they represented, and later grouped in categories based on shared concepts (Graneheim & Lundman, 2004; Polit & Beck, 2008). The text was evaluated by questions such as ‘what is the meaning of this statement and what is it about?’ In the next step, the text was read again and open coding was conducted. Data were condensed and shortened and coded while still preserving the core of the text and latent content analysis was extended to an interpretative reading in order to capture the deep meaning of the text. Afterward analysis data were grouped in main themes, which were critically discussed and compared within the research team; this can be seen as a form of triangulation to enhance data credibility. The units of analysis were the group transcriptions rather than individuals’ perspectives. In order to assure trustworthiness and authenticity (Lincoln & Guba, 1985), summaries of the FGDs were returned to some women of the focus groups (member checking).

The transcriptions of the FGDs and students’ narratives (V) were read several times to get a sense of the whole, then the text was reviewed line by line in order to identify meaning units, including words or phrases. All meaningful text was coded and placed into topics relevant to the aim of the study and put into a coding list (open coding). The list of codes was grouped into subcategories, categories, and themes (Graneheim & Lundman, 2004). The categorising method was critically discussed and compared

within the research team for validity of the method (Lincoln & Guba, 1985). In the first step four categories emerged from the FGDs with the midwives. A second step was then done, adding the written narratives by the midwifery students' reflections about midwifery care of women in midlife during their clinical training in PHC (Chase, 2005) . The narratives were first coded and analysed according to manifest analysis, and then, together with the FGDs of the midwives, analysed with latent content analysis, where three main themes emerged.

A summary of study designs, study populations, settings and data collection methods is presented in Table 1

Table 1. A summary of study designs, study populations, settings and data collection methods

Studies Period of the study	Design	Population	Study setting	Methods and data collection
I January- February 2002	Quantitative Cross-sectional survey	300 women aged 40-59 years of age	The Primary Health Care Centre Carol Urzua Santiago-Chile	Face-to-face interviews. Structured questionnaires and scales.
II May-October 1997	Quantitative Cross-sectional survey	481 women aged 40-59 years of age	The Primary Health Care Centres: Sor Teresa; Sta. Anselma; San Joaquin and Dr.J.A.Pinzon Santiago-Chile.	Face-to-face interviews. Structured questionnaire.
III May-2005 March 2006	Qualitative design Content analysis, manifest and latent	Middle-aged Chilean women(16) and Chilean immigrants (21)	Stockholm-Sweden. Santiago-Chile.	Three FGDs in Stockholm Two FGDs in Santiago
IV May 2005- July 2006	Qualitative design Content analysis, manifest and latent	Middle-aged Chilean immigrants (24)	Stockholm Sweden.	Three FGDs and three in-depth interviews
V November 2008- April 2009	Qualitative design Content analysis, manifest and latent	Chilean midwives (22) and midwifery students (13)	Santiago- Chile	Four FGDs and thirteen written narratives

4.5 ETHICAL CONSIDERATIONS

Ethical approval to conduct the study was given by the research ethics committees at Karolinska Institutet and Medical Faculty, University of Chile. All the women were informed about the aim and methodology of the study and were enrolled in the study after informed consent. Participants were reassured that the information would be treated with strict confidentiality, and that neither they nor their place of work would be identifiable in any later report (WMA, 2004).

5 RESULTS

5.1 SOCIODEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS IN THE QUANTITATIVE STUDIES (I AND II)

The mean age of the participants was 48.1 ± 5.9 (I) and 49.5 ± 5.8 (II). Most of the women were married/cohabitants 75.7% (I) and 59.7% (II). More than half of them had completed basic education 60.6% (I) and 53.2% (II). Most of the participants were housewives (>65%) and almost one third (30%) were paid workers, figures that are in accordance with the Chilean national rates (CNSI, 2005).

The main findings of the five papers are summarised according to their respective research questions.

5.1.1 Results of quantitative studies (I and II)

Study I

Are there any associations between psychosocial, reproductive and sociodemographic factors with menopausal symptoms and psychosomatic symptoms of stress during the menopausal transition among Chilean women?

Women in the perimenopausal stage had significantly increased scores (means) of stress and climacteric symptoms when compared with women in the pre- and postmenopausal stage although there were no significant differences in the mean scores for psychosocial factors (frequency of negative life events, family dysfunction or poor social support) among the women in the compared groups (Table 2).

Table 2. Mean scores of Greene scale (climacteric symptoms), Cooper Questionnaire (Stress symptoms), Smilkstein's Family Apgar Test (family dysfunction), Duke-UNC Questionnaire (social support), and Vital Events Scale (life events) according to women's reproductive status.

Variables	Number (%)	Stress Symptoms (Mean)	Climacteric Symptoms (Mean)	Life Events (Mean)	Family Dysfunction (Mean)	Social Support (Mean)
Premenopausal	142 (47.3)	19.7 ± 8.8	0.90 ± 0.56	2.9 ± 1.9	7.5 ± 2.7	37.4 ± 11.4
Perimenopausal	46 (15.3)	23.4 ± 9.3	1.14 ± 0.66	3.2 ± 2.4	7.6 ± 2.6	35.5 ± 11.8
Postmenopausal	112 (37.4)	19.8 ± 9.9	0.97 ± 0.62	2.9 ± 2.1	7.4 ± 2.7	37.1 ± 10.0
Fisher test		3.0	2.9	0.3	0.03	0.5
P value		0.05	0.05	NS	NS	NS

Data are given as mean \pm S.D.

Total mean score for each domain of Greene scale range from 0-3. The total score for: Cooper stress checklist: 0-44; Life events scale: 0-13, Family Apgar Test: 0-10 and Duke UNC Social Support scale: 0-55

Women with a history of premenstrual syndrome showed an increased odds ratio [OR: 3.6 (CI: 1.5–9.0)] for climacteric symptoms when compared with women without a history of PMS.

Women reporting negative life events showed increased odds in three domains of the climacteric scale when compared with women without negative life events:

- Anxiety symptoms [OR: 7.5 (CI: 2.9–20.5)]
- Depression symptoms [OR: 7.5 (CI: 2.6–23.4)]
- Somatic symptoms [OR: 2.6 (CI: 1.1–6.1)]

Women relating family dysfunction implied increased odds in two domains of the climacteric scale when compared with women without family dysfunction:

- Depression symptoms [OR: 3.4 (CI: 1.6–7.3)]
- Sexual symptoms [OR: 2.6 (CI: 1.1–5.8)]

Women reporting poor social support showed increased odds in one domain of the climacteric scale when compared with women relating good social support:

- Depression symptoms [OR: 2.4 (CI: 1.1–5.2)]

Women in the peri-menopausal stage showed increased odds in two domains of the climacteric scale when compared with women in the other reproductive stages:

- Vasomotor symptoms [OR: 2.5 (CI: 1.2–5.2)]
- Somatic symptoms [OR: 2.6 (CI: 1.2–5.2)]

The multiple logistic regression analysis showed that women with a history of premenstrual syndrome showed higher odds ratio for climacteric symptoms [OR: 3.6 (CI: 1.5–8.5)] after adjusting by age, marital status and level of education than women without premenstrual syndrome (OR=1).

Furthermore, women in the peri-menopausal stage showed increased odds ratios for climacteric symptoms [OR: 2.9 (CI: 1.4–6.0)] than women in the premenopausal stage. Women reporting negative life events had increased odds for climacteric symptoms [OR: 2.3 (CI: 1.0–5.3)] compared with women without negative life events.

An unexpected result was that a significant number of premenopausal women with regular cycles suffered from vasomotor symptoms (64.1%) and these women had

higher scores in all domains of the Greene and Cooper scales compared with premenopausal women without vasomotor symptoms (Table 3).

Table 3. Mean scores of climacteric symptoms (Greene Scale) in premenopausal women with vasomotor symptoms

Vasomotor Symptoms	N	Climacteric (Mean)	Symptoms (Mean)	Domains (Mean)	(Greene (Mean)	Scale) (Mean)	Stress Cooper (Mean)
		Anxiety	Depression	Somatic	Vasomotor	Sexuality	
No	51	0.5 ± 0.4	0.7 ± 0.5	0.6 ± 0.4	0.0	0.7 ± 0.8	14.8 ± 8.3
Yes	91	0.9 ± 0.6	1.2 ± 0.7	1.2 ± 0.6	1.2 ± 0.7	1.3 ± 1.0	22.3 ± 8.1
T-test		4.0	4.1	6.4	11.3	3.6	5.2
P value		0.0001	0.0002	0.0001	0.0001	0.0005	0.0001

Total mean score for each domain of Greene scale ranged from 0-3

Total score for Cooper stress checklist ranged from 0-44

Study II

Are there any associations between menopausal status, sociodemographic variables and impaired quality of life (QoL) during the menopausal transition among Chilean women?

Impaired QoL was associated with age and the different stages of the menopausal transition.

- A gradient was shown between age of the women and increased scores for the vasomotor, physical and sexual domains of QoL ($p < 0.001$) (Table 2 in article)
- The same gradient was observed in the mean scores of the women through the different stages of reproduction for all the domains of QoL. The Bonferroni test for multiple comparisons revealed that only the premenopausal stage differed significantly from the other stages ($P < 0.0001$) (Table 4).

Table 4. Effect of menopause on Quality of Life

Menopausal Stage	Vasomotor (Mean)	Psychosocial (Mean)	Physical (Mean)	Sexual (Mean)
Premenopausal	1.53 ± 0.89*	2.45 ± 1.34*	2.27 ± 1.03*	1.97 ± 1.52*
Perimenopausal	3.31 ± 1.86	3.44 ± 1.60	3.43 ± 1.37	3.45 ± 2.10
Post menopausal				
< 5 years	3.28 ± 1.83	3.33 ± 1.45	3.42 ± 1.20	3.48 ± 2.13
≥ 5 years	3.23 ± 1.90	3.69 ± 1.56	3.85 ± 1.1	3.81 ± 2.50

Total mean score for each domain of the QoL questionnaire ranged from 1-8

* $P < 0.001$

Women in the peri/postmenopausal group (this group was made up of three groups: peri-menopausal women, postmenopausal < than five years and the postmenopausal women> five years) showed increased odds ratios (ORs) for impairment of the four QoL domains compared with the premenopausal group (premenopausal women) ($P<0.0001$).

- Vasomotor [OR: 10.6 (CI: 3,5-26.8)]
- Psychosocial [OR: 3.48 (CI: 1.8-8.0)]
- Physical [OR: 5.72 (CI: 3.0-23.3)]
- Sexual [OR: 3.24 (CI: 2.2-14.3)]

Furthermore the univariate analysis showed that:

- Women caring for more than two children had impaired scores [$3:30\pm 2.03$ vs. 2.77 ± 1.74 ($p<0.0004$)] of the vasomotor domain than women without children to care.
- Women reporting lower level of attained education showed increased scores [3.37 ± 1.59 vs. 2.67 ± 1.22 ($p<0.002$)] of the psychosocial domain than women with higher education.
- Being housewives showed increased scores of the four domains of QoL, Vasomotor [$(3.11\pm 1.90$ vs. 2.57 ± 1.71 $p<0.007$)], psychosocial [3.44 ± 1.59 vs. 2.92 ± 1.45 ($p<0.003$)], physical [$(3.45\pm 1.36$ vs. 2.96 ± 1.20 $p<0.0004$)] and sexual [$(3.63\pm 2.23$ vs. 2.49 ± 1.95 $p<0.0001$)] than women with paid work (Table 5).

Table 5. Effect of paid work on Quality of Life

	Vasomotor	Psychosocial	Physical	Sexual
Housewives	3.11 ± 1.90	3.44 ± 1.59	3.45 ± 1.36	3.63 ± 2.23
Paid work	2.57 ± 1.71	2.92 ± 1.45	2.96 ± 1.20	2.49 ± 1.95
P<	0.007	0.003	0.0004	0.0001

The multiple logistic regression analysis showed that women in peri- and postmenopausal stage had increased odds for vasomotor symptoms [OR: 12.06 (CI: 5.61-25.91)], psychosocial symptoms [OR: 4.2 (CI: 2.26-7.81)] and physical symptoms [OR:4.16 (CI: 2.22-7.78)] domains of the QoL than women in the premenopausal stage. However the women in peri- and postmenopausal stage had decreased odds for the sexual domain [OR: 0.5 (CI: 0.26-0.96)] than women in the premenopausal stage.

5.2 SOCIODEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS IN THE QUALITATIVE STUDIES.

Study III and IV

Participants had similar sociodemographic backgrounds; the mean age for both groups was 53 years although differences were observed in level of education, which was found to be higher in the Chilean women who had immigrated to Sweden. 52 % of the Chilean women in Sweden had university studies compared to only 37% among the Chilean women living in Chile. A higher proportion of the women who resided in Chile had children living at home, as it is common in Chile for children to first leave their homes upon completion of their higher education or when getting married. There was no proportional difference regarding their occupational position and the use of hormonal therapy (HT) during some period in midlife between the Chilean women living in Sweden and those in Chile.

Study V

The mean age of the midwife participants was 38 years (range from 23-64), and having experience from 1 to 42 years working in PHC (mean: 11,6) in 10 different primary health care settings. The participant's educational formation in the midwifery programme varies from studying three years (until 1968) to four years (until 1995) up to the five year midwifery programme until today. The 13 students participating were from the fourth (8 students) and fifth (5 students) year of study, the mean age of the students was 25.7 (range from 22-37). Few male midwives and students participated in this study, which in fact represents the predominance of female midwife professionals in Chile.

5.2.1 Results of qualitative studies (III-IV)

Study III

What are the Chilean women's reflections about womanhood and sexuality including their gender roles during midlife and possible influence of migration whether they lived in Sweden or in Chile?

Reflections on societal expectations on women

Participants had been brought up with the common opinion that the main role in a woman's life is to become a mother. This was shaped by the strong influence of the social norms and views on gender roles. The mother was viewed as holy and pure and should dedicate her life to their family. However, the Chilean women living in Sweden had also taught their daughters a broader perspective- the importance of being independent and managing by themselves.

Missing a female family encounter

The Chilean women who had immigrated to Sweden expressed that throughout their lives in a foreign country they had especially missed their female family members, and they felt that this longing and feeling of loneliness had influenced their own lives.

Perceptions about sexual relationship

Changes in sexual life

The women expressed concerns about physiological and psychological changes during midlife and how these changes had affected their sexual life and sexual relationship. For some women sexual relationship was an obligation and an accepted sexual act and relation just to avoid problems or due to fear of losing their husband. Other women enjoyed their sexuality even more than before, having a caring, or a new partner was seen as favourable for sexual activity.

Cultural influence on sexuality

The women reflected on the influence of the strict sexual morals in Chile both when they were young and during their adult sexual life, and how this had affected their views of themselves and their sexual rights. Chilean women had been taught to have one sexual relationship in their lives.

Participants also discussed the consequences when there was lack of contraceptive services in Chile. They expressed concern about the double standard in Chilean society regarding sexual morality and sexual behaviour. Some behaviours are accepted for men, but not for women, and some topics were considered “taboo” and hidden such as premarital sex. The Chilean women living in Sweden reflected on the strict anti-abortion law in Chile.

“In Chile abortion is illegal, you cannot even talk about it, but it does not mean that there are no abortions in Chile” (FGD2).

Social stigmatisation of midlife women

“Vieja menopausica” Menopausal bitch

The women reflected on stigmatisation of women in midlife in media and society, and the influence of gender roles and sexism towards women. This could also be expected from the medical system, assuming middle-aged women to be full of health problems that need to be medically controlled and treated. Women themselves were hiding and denying menopausal symptoms because of stigmatisation. Menopause usually is considered as a “bad stage” and women are represented as “*furious, bitter, angry and hysterical bitches*”. There were also reflections on the importance of accepting what you have had in life and looking positively ahead.

Study IV

What are the perceptions of Chilean women living in Sweden about their health situation during midlife and the possible influence of migration?

Chilean women’s reflections on migration and resettlement.

Most of the women came to Sweden for political reasons. Some of them had experienced trauma and torture and many were forced to leave Chile suddenly. Often members of the same family had been separated, and some families were threatened. The Chilean women discussed about different hardships they had faced upon arrival to Sweden, especially the heartbreaking loss of family and networks. Some women felt solidarity from the Swedish people, however, others expressed concern about the ignorance among the Swedish authorities regarding their status as political refugees. Women referred to the fact that no treatment for trauma or psychological support was available.

Women felt that they were seen as foreigners and they experienced discrimination; they were always seen as “others”. One challenge they faced was with language

proficiency. They also had problems validating their degrees, examinations, and certifications in order to find work in their profession, and most of the women felt as if they had been deskilled. Their husbands experienced an even more difficult transition because they had also lost their socioeconomic position and authority. Some women recognised that they gained a better position in Sweden and were aware of the civil rights and equality before the law for women in Sweden. Most of them assumed the main responsibility for their family, and work; leaving no time for them to think of their own needs and health. Women's improved position and men's subordination in Swedish society had caused many men to lose power, authority, and control over their women. This had affected marriages and relationships and could partly explain an increased divorce rate among immigrants.

Health during midlife; perceptions of Chilean women living in Sweden

Concerns about physical and psychological health-related symptoms affecting their daily lives were discussed relating it to the extent to which migration possibly affected them. Carrying the main responsibility made them ignore their own health until their inevitable symptoms affected their daily lives, limiting their working capacity. Some women related these symptoms to their emotional and social burden. Some felt so overwhelmed with problems (concerning their health, their relationships with their husbands and children, and the economy), that they were in deep depression. Some of these women had been prescribed antidepressants. They saw life as impossible to change and they talked about themselves as being victimised. The importance of having one's own time and interests, and adopting a healthy lifestyle was perceived as having a positive impact on health.

“Everything is a big deal; this situation in addition to other things ended up with me in a severe depression” (Interview 3).

Participants reflected on their needs for health and self care during midlife, expressing confusion concerning contradictory health information and about their disappointment in the Swedish health care system particularly the way in which Swedish physicians manage health problems and symptoms. They felt a lack of attention and missed having a trusting relationship with caregivers.

Strategies to manage their life and to gain social acceptance and position

The women reflected on their struggles to settle in Sweden and to gain acceptance in Swedish society, and consequently how those struggles affected them and their families. Some women expressed it as choosing between two alternatives: giving up or taking control. Some of these women expressed that they focused on their families'

needs, trying to fulfil their needs and wishes. When problems arose different ways to face them were discussed; some women said that they tried to take control of their lives, other women tried to ignore them, while some others lost control. This could be due to a combination of reasons; socioeconomic insecurity, lack of social networks, and little or no access to knowledge. The women discussed these situations which had led to a feeling of helplessness and even paralysis.

All the women had been back to Chile; either to visit or some went to live but later came back to Sweden. For them, being in Chile had given them feelings of not belonging anywhere. Some women reflected that their main reaction to being in Chile was shock. Surviving their crises had made some of them stronger, but some of them also had health consequences in midlife. Some of them felt that their main purpose in life was to fulfil the needs of others, while others addressed their own needs, put limits on other people, and give themselves space and opportunities.

Study V

What do Chilean midwives and midwifery students regard as being Chilean women's health care needs in midlife?

A shift in the care of women in midlife

The midwives reflected generally on women's health needs in midlife and discussed how the focus of the health care system has changed from previously having special resources and interest in menopausal transition, to not having enough resources for treating women and having nothing to offer them today. The midwives also discussed the changed focus after published studies about side effects of HT, and how this affected women's attitude in midlife.

Health of 'different kinds of women'

The midwives described 'different kinds of women', those with high socioeconomic position, the poor and marginalised, immigrants, and minorities. Women from a low socioeconomic position were seen by the midwives as paying less attention to menopausal symptoms because they have many other problems to solve, contrary to women with a higher socioeconomic position.

The midwives also discussed immigrant women and minorities, in particular the families of Mapuche origin, who were seen as generally hiding their ethnic roots. Most of the midwives argued that independent of ethnicity or cultural background,

they treat all women equally; however, they talked about the immigrant women as knowing and demanding their rights and taking advantage of them. The midwives also complained about their husbands as they were deciding everything when coming into consultation with their wives.

Relation to husband, sexuality and violence

The midwives reflected on the fact that husbands were often absent and did not support women, that their relationship seemed to be based on aggression and power, i.e. physical and psychological violence, and that they use economic pressure to manipulate and subordinate the women.

The midwives also recognised their own weaknesses, lack of resources to address the complexity of sexual problems frequently connected with violence, drug abuse and alcohol consumption. Some midwives found it uncomfortable to talk about these matters. Some midwives expressed that they became irritated and lost patience with recurrent visits of some women who repeatedly talked about their problematic life of violence and abuse.

“Some women come repeatedly telling the same problem, they do not advance, then you have to say “this will be the last time I listen to you, because you just tell the same story...and how long are you going to live with this”, I do not know if this is very pedagogic, but it is important, one has to learn to put limits (1.1)”

Midwives representing ‘holistic care’

The midwives talked about themselves as important people generally in the health care system and especially in the PHC. Most of them referred to themselves as being the most qualified professional to attend to women’s health during midlife as they represented a more ‘holistic care’. But the midwives felt that they lacked competence in social and communication skills in order to be able to deal with the psychosocial aspects affecting women’s lives.

To fulfil the biomedical and health care system requirements

Most of the students perceived that the midwives still focused their attention on fulfilling the biomedical requirements. Even knowing the findings from recent research about menopause and HT, the midwives did not include it in their counseling; therefore, this could lead women to confusion and difficulty in resisting the stigmatisation of ageing as deterioration and illness. The students connected the focus on the biomedical requirements with the Health System’s organisational level; the time schedule was too limited so it would stay clear for the women that they have

to be precise comprising the exact purpose of the visit. It can be seen as the midwives rejecting their own responsibility for the lack in the given care, victimising themselves in the system.

To be prepared: Midwives competencies and skills

The students had doubts about midwives' skills in relation to communicating and sensing women's particular needs, as well as showing the ability to answer questions other than those with a biomedical focus. The midwives themselves commented on their competencies and skills, working environment, and the given care. They also commented that the women were urging too much, that they had insufficient time and energy to consider or talk about more complex subjects, and they avoided their responsibility by doubting if it belonged to their assignment.

To respect: Midwives' attitudes and prejudices

Contradictory meanings came up when talking about different women's needs and the importance of establishing limits. The students questioned the disrespectful attitude towards the caretakers with comments such as;

“We have to attend this woman quickly if not, we will never finish”

“Typically these old ladies tell you their whole life”

“You do not need to listen to them so much; these ladies take a lot of time”

The students also questioned whether the midwives had less prejudice towards minorities, immigrants and the psychosocial problems of women than the population in general and they saw a difference in the quality of care given to women from minorities and immigrants. The students questioned the limited or lack of self-criticism among many midwives in relation to their practice.

5.3 SUMMARY OF MAIN RESULTS

5.3.1 The quantitative studies (Paper I and II) showed that:

Women in the perimenopausal stage had a significant increase in stress and climacteric symptoms when compared with women in the pre- and postmenopausal stage. Women in the perimenopausal stage showed increased odds for somatic and vasomotor symptoms (I).

Women in the peri- and postmenopausal stages had impaired quality of life scores than women in the premenopausal stage. Housewives had worse QoL scores than women with paid work. The menopausal stage was the only variable found to cause a

significant impairment in quality of life. Peri- and postmenopausal women also demonstrated a higher risk for suffering impairment in the sexual area of QoL (II)

5.3.2 The qualitative studies (Paper III-V) revealed that:

A major factor in the women's lives had been the strong influence of a gender imbalanced life since childhood. This was a fact whether the women lived in Stockholm, Sweden or Santiago, Chile. The experienced gender imbalance had made the women socially, economically and biologically more vulnerable to exploitation later in life (III). The Chilean women discussed their struggle to gain social acceptance and position, and reflected on the discrimination they had met in the Swedish society and within the health care system along with health changes they had experienced during midlife. They connected some of their health-related problems to their hardships of migration. Important for their way of coping with their own health seemed to be a recognition of their level of independence, need for an "own space", self-acceptance and awareness of power relationships (IV). The midwives considered that women in midlife have special health care service needs; they considered themselves to be the most appropriate health staff to provide health care for women in midlife. Midwives recognised that they lacked communication skills and competencies in assisting psychosocial and cultural health care needs of women in midlife such as violence, abuse and sexuality issues. The midwifery students remarked that many midwives focused their attention on fulfilling the biomedical requirements. Some students also questioned disrespectful attitudes by midwives especially towards poor immigrant women and women with psychosocial problems (V).

6 DISCUSSION

6.1 DISCUSSION OF RESULTS

The findings in this thesis have been analysed following the same journey that I followed as a researcher. I was educated and trained as a midwife and as a researcher within a quantitative and biomedical health care context. I feel that during my research training I gained a wider perspective, a more complex, interdependent approach to studying and reflecting on women's health situation and needs in midlife. The following discussion is based on the findings of the studies and connected with the midwifery perspective addressing the women's perceptions of their health needs with the midwives and the midwifery students' views. The major discussion points are: 'A shift in the care of women in midlife'; 'Societal expectations of women'; 'Sexuality and violence'; 'Different kinds of women' and 'Representing 'Holistic care' (midwifery role and education)'.

'A shift in the care of women in midlife'

The midwives discussed the Chilean women's special health problems and health care needs during midlife and a shift from "before to after", referring to a changed focus in the health services for women during midlife. The change coincided with the publication of studies on the side effects of HT. Some midwives felt that most women consider menopause as just another normal phase in the life cycle. However, the midwives expressed that it is important to prepare women about the menopausal transition (V).

When midlife women were answering questionnaires about stress and climacteric symptoms, it was found that during the perimenopausal stage, women experience a significant increase in these symptoms when compared with women in the pre- and postmenopausal stage (I). This is consistent with findings reported in other studies (Duche et al., 2006; Freeman et al., 2007; Igarashi et al., 2000). Findings also showed increased odds for climacteric symptoms among women in the perimenopausal stage when compared with women in the premenopausal stage (I). Similar findings were described by Duché et al., (2006) among middle-aged non-menopausal French women (Duche et al., 2006).

An extensive review carried out by Avis et al., (2005) concluded that despite overlapping risk factors for symptoms, vasomotor symptoms are more related to menopausal status than the psychological or physical symptoms, and suggested that future research should be conducted in order to clarify the interrelation within symptoms and identify vulnerable groups for symptom reporting (Avis et al., 2005a). It has also been suggested that there is a need to elucidate the significance of these

symptoms for women in midlife, which remains unclear, and the way, if any, that these symptoms affect wellbeing, daily activities and quality of life (Woods & Mitchell, 2005).

When midlife women were answering the specific QoL questionnaire, it was shown that women in the peri- and postmenopausal stages had impaired quality of life (QoL) scores when compared with women in the premenopausal stage, and increased scores for the vasomotor, physical and sexual domain of QoL (II). Similar findings were reported among healthy Japanese women (Satoh & Ohashi, 2005). Another study reported significantly more early perimenopausal women than premenopausal women as having impaired QoL in unadjusted analysis, that disappear when adjusting for other covariates (Avis et al., 2003). Other studies did not find any association between the menopausal transition and QoL (Cheng et al., 2007; Schwarz et al., 2007), suggesting that the differences among women during the menopausal transition can be explained by lifestyle, sociodemographic and psychosocial factors (Schwarz et al., 2007), being married, and ethnicity (Avis et al., 2004).

Additionally, the menopausal stage was the only variable found to cause significant impairment in quality of life (II). Recently, a study interviewing Latin American women found impaired scores of QoL among them; Chilean women reported the highest prevalence (80.8%) followed by women from Uruguay (67.4%) (Chedraui et al., 2008). Chilean QoL surveys revealed that Chilean women had a negative perception about their health status regarding income level, physical condition, mental and emotional wellbeing, leisure time, sexual life and health status. Furthermore, women were overloaded with duties and reported more symptoms of stress than did men (CMPH, 2006).

The women in the FGDs (III) were aware of physical and physiological health-related symptoms, but most women related these symptoms to the ageing process. Similar findings were described by Lindh-Astrand et al., (2007) (Lindh-Astrand et al., 2007), women also related these symptoms to their emotional or social burden rather than to the menopausal transition. Participants further discussed how they seek different alternatives, including changes in lifestyles, to manage and take control of their lives. Similar findings are described by other qualitative studies (Arnold, 2005; Bertero, 2003). For some women, bodily acceptance and control by doing exercises provided a very strong strategy – not only for fitness but also for physical and mental wellbeing (Jeng et al., 2004).

The Chilean midwives expressed a concern that there were not enough resources for any treatments, that they had nothing to offer the women; furthermore, they perceived no interest in health education or promotional activities. They further discussed that the physicians seemed to no longer have an interest in the health of women in midlife.

The midwifery students also remarked that many midwives focused their attention on fulfilling the biomedical requirements. They argued that they did not experience the midwives referring to sexuality and quality of life outside the biomedical perspective and did it in a very stereotypical way. Even if the midwives had knowledge of recent research on menopause, they had difficulties in approaching and including it in their counselling (V). Foley and Faircloth (2003) reported similar findings in which midwives demonstrated knowledge and used a medical discourse as a way of legitimating midwifery therefore control and power (Foley & Faircloth, 2003).

A biomedical perspective does not often take unclear symptoms into consideration, or it develops separate interpretations for their relation to health. It means that unclear symptoms are seen as independent rather than interdependent (Weber, 2006). Health care providers might not always have enough insight into women's sociocultural and medical lives to contextualise symptoms (Malterud, 1987a, 1987b).

'Societal expectations of women'

The Chilean midwives mentioned the overwhelming roles women are playing, and that they admired women's capacities to fulfil all their duties, especially women with low socioeconomic position who have the overall responsibility for their families with very little time to take care of themselves (V).

Chilean women participants, whether they lived in Sweden or Chile, mentioned that they had, since childhood, been strongly influenced by societal and cultural expectations to dedicate their lives to fulfilling the needs of their husbands, children and families, as well as the influence of societal expectations and views of "the mother as holy" and a person who should sacrifice herself (III, IV). Similar findings among Mexican American women were described by Davila (2005) (Davila, 2005). Women living in Chile and migrating to Australia perceived gender roles to be determined by social norms and values which restrict changes, promote a strict work division and behaviour shaped by a 'machista' culture (Dawson & Gifford, 2003).

The participants in both Sweden and Chile were strongly influenced by medical and hierarchal views in society and gave examples of the many mixed feelings they had about their lives, including confusion about their roles in the family, in society, and also concerning sexual norms (III, IV). This has been interpreted by social scientists as consequences of patriarchal dominance and societal views highlighting the complex interaction between gender, race and class (Mulinari, 2001; Mullings et al., 2001; Weber, 2006). Interestingly, women from all over the world describe similar feelings of being marginalised in a society that is gender-divided, making women economically and socially insecure, experiencing in the same jobs lower pay, prestige and decision-making power than men (Gomez, 2000; Meleis, 2005; Mones, 1997).

Participants felt stigmatised concerning the ageing, i.e. `vieja menopausica`^menopausal bitch´ in society, by the health care system, and even by their own families (husbands and children). Some women even expressed fear of ageing and of becoming a burden for their children and their families (III, IV). Montecino (2003) questions the fact that the female body is defined in medicine and society as `deficiencies´ (hormonal, psychological or physical) throughout life, i.e. when passing menarche, giving birth and even moreso when passing through menopause (Montecino et al., 2003).

Chilean midwives discussed their own views of women’s status in the family, and talked about midlife as a time of deterioration, the bodily changes in midlife, and how women could keep the feeling of being a “real” or valuable woman (V). According to Boughton (1997), a negative “embodied experience” of menopause can affect the women’s self-esteem and identity (Boughton, 1997). Some students reflected that as a consequence, women could feel confused and stigmatised because of ageing, illness, suffering and be more vulnerable to dysfunction. They also expressed that some midwives took their time to help with limited resources and skills, but often just in a biomedically-restricted way that sometimes put the woman into a victimised position rather than supporting her by giving counseling or promoting empowerment (V). These findings illustrate how healthcare personnel themselves, influenced by gender roles in western society, treat women in midlife (Kaufert & Lock, 1997; Ramirez, 2006).

Chilean midwives saw themselves as the most qualified professionals to attend to women’s health care needs during midlife; however, they recognised their inability to address psychosocial factors affecting women’s health during midlife and their lack of communicational and psychosocial skills (V). Woods (1999) questioned the traditional medical `deficiency model´ by failing to address the psychosocial factors that influence women’s health (Woods, 1999), and revealed a conflicting perspective between health care providers and women’s view of their own health during midlife (Ballard, 2002; Hvas et al., 2004; Walter & Britten, 2002). These findings indicate a lack of awareness and training on the psychosocial health care aspects.

‘Sexuality and violence´

Chilean midwives stated that it was difficult for women to talk about sexuality and violence, they referred to the fact that several of the midlife women complained about absent husbands who did not support them, or that their relationships were often aggressive with strong power differences between men and women. Both physical and psychological violence, combined with economic hardships, were used to manipulate and subordinate the women (V).

During FGDs the women expressed concerns about physiological and psychological changes during midlife and how these changes had affected their sexual life and sexual relationship (III). According to Bachman & Leiblum (2004), these physiological and psychological changes can affect women's self-esteem, self-image and may lead to a decrease in sexual desire and responsiveness (Bachmann & Leiblum, 2004). These bodily changes which women undergo in midlife, as commented by Grosz (1994), are seen as a deterioration and as contributing to stigmatisation of women (Grosz, 1994).

Some women stated that they enjoyed their sexuality even more than before. They related that having a caring or a new partner was seen as favourable for sexual activity (III). Similar findings were described by Mansfield et al., (1998). In this study, researchers inquired about the qualities midlife women wanted in their sexual relationships; terms such 'physical closeness and intimacy', 'sweet warmth and tenderness' were seen as desirable. Ramirez (2006) concludes that for some women in midlife, having a companionable rather than a sexual relationship was desirable, also some women did not perceive decreased sexual desire as problematic (Ramirez, 2006).

The strict sexual morals of the Chilean society as well as the double standard with regard to sexual behaviour, were criticised by the Chilean women living in Sweden, who discussed how this had affected their views of themselves and their sexual rights (III). Mexican American women described that there was a 'sexual silence'; that they avoided talking about sexual matters within their own families as well as with their intimate partners (Davila, 2005). Internalised messages concerning the appropriate place for sexuality in women's lives constitute a strong force in shaping women's capacity to negotiate their sexual agency (Wood et al., 2007) as well as in forging their sexual behaviour and comprehension of sexual health risks (Dawson & Gifford, 2003).

Some Chilean midwives also talked about women's unworthy situations, which made the women devalue themselves and their sexual desire, just fulfilling their "duties" in relation to their partner's sexual needs. The midwives also stated that sexual problems is one area of concern because of its close relationship with intimate partner violence, as well as alcoholism and drug abuse which was recognised as an extremely complex problem to be solved (V). A Swedish study showed that verbal abuse among students is a predominantly masculine practice (Eliasson et al., 2005), illustrating how cultural representations of masculinity are constructed and contribute to 'sexualised violence' (Rönnberg & Hammrström, 2000).

The midwives recognise their own difficulties when facing women with these problems. They raised a concern about their limited competencies during education and training but continued to focus mainly on the biomedical aspects (V). An obvious strategy to assist threatened and abused women is educational programmes for health professionals (Eliasson, 1999). However, a study showed that despite the fact that education has addressed health staff competencies with regard to this topic, health care givers are still unable to act when facing domestic violence and few abused women who consult them are identified (Rönnerberg & Hammarström, 2000). Furthermore, some midwives felt that they did not have anything “to offer” to the women. Some midwives expressed that they got irritated and lost their patience with recurrent visits of some women who repeatedly talked about their problematic life with violence and abuse. It has been suggested that in prevention programmes for violence against women it is fundamental to act to avoid a “victim-blaming” attitude (Hamzeh et al., 2008).

‘Different kinds of women’

The midwives stated that independent of ethnicity or cultural background they treated all women equally. However, many midwives expressed several prejudgments about different kinds of women depending on their socioeconomic position, cultural background and ethnicity (V). Researchers have concluded that stereotyping women according to their ethnic origin continues to influence the health care service that immigrants receive and they do not always receive equity in care (Blackford & Street, 2002; McCourt & Pearce, 2000).

Chilean women in Sweden gave their views of being an immigrant. Their experiences were embedded and influenced by stressful events – migration, resettlement; feeling discriminated against by the Swedish society and within the health care system. Many women felt torn between gaining social acceptance or position, and taking care of their families, therefore ignoring their own wellbeing until their health problems became obvious (III, IV). Also among displaced women for whom their economic situation and home responsibilities were the main factors limiting their access to health care (Mogollon Perez & Vazquez Navarrete, 2006), the survival needs of the family unit are a primary concern and the women’s own needs become secondary (Caballero et al., 2008; Meadows et al., 2001; Mendias et al., 2001).

The Chilean women who had migrated to Sweden discussed that it might be easier for women than men to cope with the subordinate role of an immigrant (IV), because in all societies women are subordinated and take the main responsibility for their families’ needs and health (Jones et al., 2003; Meadows et al., 2001). Furthermore, some of the participants were aware of the gender benefits they gained in Sweden when compared with their Chilean counterparts (Rebolledo, 2006). Dawson and

Gifford (2001) draw the same conclusion after studying life-stories of Chilean immigrant women (Dawson & Guifford, 2001).

The findings also highlight the importance of social networks and social support and how participants connected their health and depressive symptoms to their life histories, for some being a political refugee and for others being a foreigner/an immigrant and losing the social network and support (I, III, IV). However, it has been shown that despite difficulties after migration, women mobilised several personal and family resources to cope and gain strength and resilience against migration hardships (Ahmad et al., 2004; Jones et al., 2003; Mullings, 2006).

The Chilean women living in Sweden talked about women's civil rights and equity by law in Sweden and expressed confusion as to how health care providers responded to them when expressing their rights in care-related situations. Some women described these reactions as discrimination (IV), consistent with findings from another study relating this situation to discrepancies between their cultural views of health and the prevailing biomedical perspective of the host country (Weerasinghe & Mitchell, 2007). Similar reactions were reported by the Chilean midwives when attending immigrant women. However, the midwifery students stated that they had seen a difference in the quality of care given to women from minorities and immigrants as opposed to Chilean women, and remarked on the stereotypical care for the poor immigrant women given by the midwives. The students also questioned if the midwives held less prejudice towards minorities, immigrants and the psychosocial problems of women than the population in general (V). Montecino (2003) described great differences among Chilean women; poor women often suffer from marginalisation, unemployment, and lack of opportunities especially among minorities who additionally suffer from discrimination and subordination (Montecino et al., 2003).

These situations suggest the need for health care providers to be culturally sensitive to the particular health care needs of the immigrant women whom they attend (Markova et al., 2007). The findings further suggest the need to incorporate into the health care praxis gender sensitivity and gender-based explanations of health and illness (Im & Meleis, 2001b).

'Representing 'Holistic care'- midwifery role and education'

Despite the fact that Chilean midwives saw themselves as representing a more 'holistic care', the students considered the midwives to still be focused on the biomedical model (V). The concept of holistic care is based on the belief that all aspects of the person should be addressed. As discussed by Boughton, despite this discourse of holism, health care has remained focused on the care of the physical

body rather than the person as a whole (Boughton, 1997). A more holistic way of midwifery practice and a more optimal decision-making process for the women was reflected in a study about “making midwifery a sensible practice”. Embodied knowledge can be regarded as an inner source of power both for midwives and women (Parratt & Fahy, 2008).

One student reflected that many women in midlife mature and develop deeper dimensions of their personality that are interrelated with the psychosocial aspects; however, the midwives did not consider these aspects (V). For women in midlife, there are strong motives to influence their own lives, find themselves vital and happier, be embodied, resist subordination, and have a rich sexuality (Woods, 1999). Human sexuality cannot be well understood unless we consider different sources of knowledge, as illustrated by Fausto- Sterling (2000) with the metaphor of the Russian nesting dolls. It includes a need for knowledge from multidisciplinary sciences and an awareness of limitations when working with human sexuality in a single discipline (Fausto-Sterling, 2000).

Some midwives expressed how hard it was when they tried to solve the women’s different and often complex health problems. The students also expressed that generally midwives tried to solve the women’s problems. Despite, midwives reflecting that there had to be a change made by the women themselves, they complained about lack of resources, and short time which limited care to simple advice (V). It is important that midwives are aware of and able to individually support and advise each woman they meet. However, with a lack of awareness and knowledge about gender issues, and midwives’ own need to empower themselves both privately and personally as women and professionals, it can be questioned how they are able to support and counsel other women. These reflections are also illuminated in studies by (Im & Meleis, 2001b; Woods, 1999). Furthermore, this attitude, by urging the need to solve women’s problems, is a way of “doing for” instead of “being with” (Oudshoorn, 2005) and also interrupts the process of the women’s own decision-making (Murtagh & Hepworth, 2003b). As commented by Barclay, midwives, because of their burden of work and responsibilities, scarcely criticise and question their practice and personal professional development (Barclay, 2008). However, it seems fundamental to reflect on these aspects for addressing a consistent practice, formation, and philosophy of care (Lange & Kennedy, 2006).

6.2 METHODOLOGICAL CONSIDERATIONS

6.2.1 Studies I and II

Internal validity as a property of a causal inference (Polit & Beck, 2008) will be discussed as concerns of causality and sampling procedures (selection bias).

Reliability issues will be discussed as concerning the use of questionnaires (Polit & Beck, 2008; Polit & Hungler, 1999; Ruiz & Morillo, 2004). Cronbach Alpha coefficient was used to assess internal consistency reliability (Polit & Beck, 2008).

Causality: these were cross-sectional surveys, therefore the interpretations of explanatory factors is complicated since both the outcomes and the exposure were measured at the same point in time, and it is impossible to establish the direction of the associations. However, due to time sequencing when studying some of the sociodemographic and psychosocial factors, it was possible to formulate some statements of causality, although it had to be done with caution (Polit & Beck, 2008).

Sampling (selection bias): Despite the fact that samples were non-probabilistic and a convenience procedure for sampling was used, the inclusion of healthy women who accompanied patients coming to the health centres instead of patients (proxy to general population) was used as a criterion to avoid selection bias. Additionally, all the women participants were distributed homogeneously with regard to the main sociodemographic variables representing the study population. Participants included in the studies were only from Santiago, and urban populations, thus findings cannot be generalised to the entire population of women in Chile. Furthermore, high rates of response (over 90%) were observed in both studies. Potential confounders were controlled during analysis, changing crude estimations only to a limited extent (Polit & Beck, 2008).

Use of questionnaires: These surveys utilised validated self-reported questionnaires (SRQ) for data collection, alpha coefficient was estimated for the assessment of internal consistency and high scores of correlation were found. These structured closed-ended instruments have well known limitations (Polit & Beck, 2008; Polit & Hungler, 1999; Ruiz & Morillo, 2004), especially when related to sensitive or behavioural questions, which in fact represent the subjects to be explored in these two surveys. Although all these instruments were designed to be self-applied, in these surveys the use of face-to-face interviews by trained interviewers was considered more appropriate to improve response rate and to assure the quality of data. The battery of tests utilised to measure the outcome variables in which women, instead of the physician, were asked to rate the extent to which symptoms affected them, has been found to be more precise to report their health status because medical assessment is also dependent on their particular perception and views (Wiklund,

1998). Although women were included in the surveys after signing an informed consent, the extent to which women could feel obliged to respond might be questionable (Clifford, 2008).

The limits of using questionnaires could be reflected as not taking into account the complexity and diversity of subjective and individual processes. It was only later, when using a qualitative methodology as a complementary approach that it was possible to increase understanding by acknowledging that even when women were aware of reported symptoms and were preoccupied about them, most of these women were also introducing changes in their lifestyles or using alternative treatments to cope with their symptoms. However, it was impossible to address this through structured questionnaires. This fact might partly explain why findings from qualitative studies show a conflicting perspective between health care providers and women's view of their health and health care in midlife (Hvas et al., 2004; Murtagh & Hepworth, 2003a; Woods, 1999; Woods et al., 1998).

6.2.2 Studies III-V

Trustworthiness (reliability and validity) of qualitative studies will be discussed according to the criteria developed by Lincoln and Guba (Lincoln & Guba, 1985).

Credibility: To assure the quality of the data, all interviews were transcribed by the moderator and facilitator as soon as possible after the interview in order to collect useful guidelines for the next interview (Polit & Beck, 2008). Also, an assistant note-taker kept record of the group process during the FGDs. One of the FGD texts was translated back to Spanish in order to check the quality of the translation. One disadvantage of the FGDs is that some people can feel uncomfortable about expressing their points of view in front of others, especially about some sensitive topics. Therefore, to complement the FGDs, in-depth interviews were held with three key informants (IV) and the midwifery students' narratives (V).

Additionally, during FGDs, despite all midwives being encouraged to freely express their points of view, we realised that a few young midwives kept more silent than others. Afterwards they were contacted by the research team in order to ask them about possible reasons for their silence. They mentioned that it was partly because of their inexperience and some expressed having particular problems in their workplace: i.e., both reasons reflect fear regarding power structures within the PHC and the midwives involved (V). This is also an important finding that we have to be aware of when doing research—the limiting effect of existing power structures (Oudshoorn, 2005). Despite previous limitations, the strength of these studies was the rich reflections given by the participants in the FGDs, in-depth interviews and narratives.

This gave a deeper understanding and contextualisation of the focus of this study, contributing to enhance the study's credibility.

Triangulation: The use of multiple referents aimed to obtain validating conclusions by avoiding bias coming from single-methods was addressed through the separate participation of all researchers during the process of data analysis. This was done in order to assure neutrality and to ensure that findings and conclusions are based on the data and reflect the participant's reality. During data analysis, similar codes were grouped into sub-themes and later into themes and critically questioned and compared within the research team. Also, summaries of the FGDs were returned to some women of the FGDs (member checking), in order to assure trustworthiness and authenticity (Lincoln & Guba, 1985).

Transferability: Although findings from qualitative research should not be generalised, similar findings from other qualitative studies made us suggest that findings from these studies also reflect the views of other Chilean women in midlife therefore findings can be more or less generalisable.

6.2.3 Methodological Conclusions

Complementary Approach

In this thesis, methodological and research paradigms have evolved from the traditional positivistic and quantitative, to a more subjective, naturalistic and interpretative way for exploring women's health care needs in midlife.

Using both the quantitative and qualitative approach, a better understanding of women's midlife experiences emerged. Findings from the quantitative data reported increased rates of climacteric and psychosocial symptoms among women during midlife; furthermore, they showed that menopause caused a decrease in QoL independent of age and other sociodemographic variables. These findings are consistent with the biomedical paradigm raising biological explanations as the base for understanding symptom reporting. However, its weaknesses is its limited explanatory capacity mainly at a single level of explanation to try to understand a complex phenomenon. The qualitative approach allowed us to deepen these experiences beyond the biomedical approach and gave us the possibility to understand women's perceptions of their health care needs in midlife, as well as gender roles, sexuality, and migration and how these aspects had been influenced by their own lived experiences from childhood and cultural influences and their own life circumstances. The qualitative findings also enhance evidence of the importance of awareness of power relationships and communication skills in health care in order to promote patient empowerment, and the need for complementary approaches to the

biomedical paradigm to expand the understanding of the health situation among midlife and immigrant women.

6.2.4 Conclusions and Implications for midwifery education and training

The findings of this thesis revealed that the midwives considered that women in midlife have special health care service needs. The midwives also considered themselves to be the most appropriate health staff to provide health care for women in midlife however, they recognised that they lacked some competencies in assisting the psychological as well as social health care needs of women in midlife, consistent with the participants' perceptions related to confusion about the health care given and sometimes a relationship of mistrust with health care providers/midwives. Therefore, midwives need more education about women's health care needs in midlife, and more focus should be placed on the psychosocial and sociocultural aspects of midwifery. More reflections about the quality of the client-provider relationship, including communicational skills in clinical practice, are needed. Gender issues, violence, midlife women's sexuality, structure of power relationships, and empowerment should be incorporated into and critically discussed during midwifery education and training, as well as in clinical settings.

In order to expand the understanding of health care needs and inequalities, as well as providing evidence-based interventions/programmes for health staff, clinical training in continuing education, further development of multidisciplinary and complementary approaches in health care practice and research are needed. Women's perceptions and opinions about the given care and their health care needs have to be considered and incorporated into health practice.

A conflictive position among Chilean midwives between discourse and praxis emerged which was clearly perceived by the midwifery students who raised a concern about the role modelling they are meeting during their clinical training. Therefore, promotion of a more interactive process between clinical midwives (clinical field) and teachers (academy) as well as with students is needed.

There are also questions about the consequences for the women, students, and midwives of the unawareness of the power relations, although they were clearly outspoken in the hierarchal biomedical health care organisation. A space for a reflexive and multidisciplinary practice and education is needed; students, women, and younger colleagues should be systematically considered as a critical lens to be taken into account. There is a need for women's leadership and advocacy concerning the influence of gender, sexuality, psychosocial and cultural aspects of women's

health in midlife that should also aim to empower women and promote gender equity in society.

7 RESUMEN EN ESPAÑOL

Propósito: El propósito de esta tesis fue explorar el efecto de factores biológicos y psicosociales en los síntomas climatéricos en las mujeres Chilenas entre 40 y 59 años de edad (I) – evaluar el impacto de la menopausia y algunas variables sociodemográficas en la calidad de vida de mujeres en ese mismo rango etareo (QoL) (II) – aprender de las reflexiones de mujeres Chilenas que viven en Suecia o en Chile respecto su experiencia como mujeres, roles de género, su sexualidad en esta etapa de la vida e indagar respecto la posible influencia de la experiencia de migración (III) – explorar como las mujeres Chilenas inmigrantes a Suecia perciben y relacionan su situación de vida y estado de salud durante esta etapa de su vida (edad mediana) con su experiencia de migración (IV) finalmente conocer la percepción que tienen las matronas Chilenas y los estudiantes de Obstetricia respecto de cuales son las necesidades de salud que tienen las mujeres en esta etapa de su vida (V).

Materiales y Método: Para la obtención de los datos se utilizó una combinación de métodos Cuantitativo y Cualitativo. Los criterios de inclusión para los estudios fueron mujeres Chilenas sanas acompañantes de usuarios en diferentes centros de salud de Atención Primaria (APS) en Santiago (I-II), mujeres Chilenas en edad mediana que viviesen en Santiago o que vivieran en Estocolmo al menos por 15-20 años (III and IV). Matronas Chilenas que trabajaran en centros de APS en Santiago y estudiantes de Obstetricia de la Universidad de Chile en sus dos últimos años de estudio (4^o y 5^o año) (V). Los datos cuantitativos fueron recolectados a través de dos encuestas poblacionales en las que se utilizaron cuestionarios estructurados previamente validados (I-II); tres escalas y dos cuestionarios para la recolección de datos respecto síntomas climatéricos, biológicos y psicosociales (I), un cuestionario específico para evaluar calidad de vida en la menopausia (QoL) (II) todas fueron realizadas por encuestadores previamente entrenados. Los datos cualitativos fueron recogidos a través de Grupos Focales (GFs) (III- V), entrevistas en profundidad con informantes claves (IV) y narrativas escritas (V). Adicionalmente se recolectaron antecedentes sociodemográficos para todos los estudios. Los programas estadísticos computacionales EPI-INFO y STATA se utilizaron para el análisis de los datos cuantitativos (I-II). Los datos cualitativos fueron a analizados utilizando analisis de contenido; manifiesto y latente (III-V).

Resultados: Durante la perimenopausia las mujeres presentaron un aumento significativo de síntomas de estrés y climatéricos, la perimenopausia es un factor de riesgo de presentar síntomas somáticos y vasomotores (I). Las mujeres con menopausia revelaron peores puntajes de calidad de vida respecto los puntajes de las mujeres que seguían menstruando (ciclos regulares). Finalmente la menopausia fue la

única variable responsable de causar un empeoramiento significativo de la calidad de vida (II). Las mujeres participantes en los GFs consideraron que un factor relevante para ellas ha sido la fuerte influencia, desde su infancia, de la desigualdad de género. Este fue un hecho tanto para las mujeres que viven en Santiago, Chile, así como para las mujeres Chilenas que viven en Estocolmo, Suecia. Las participantes reflexionaron respecto a que esta desigualdad de género las ha hecho más vulnerables tanto biológica así como económicamente (III). Las mujeres Chilenas que migraron a Suecia discutieron respecto sus experiencias y dificultades para ser aceptadas en la sociedad Sueca y poder lograr una posición social. También reflexionaron respecto la discriminación social que ellas encontraron a su llegada a Suecia, también con respecto a la atención de salud y sistema de salud Sueco. Las mujeres Chilenas conectaron algunos de sus problemas de salud con las dificultades de haber migrado. Parece ser muy importante para ellas el darse cuenta de cómo cada una afronta los problemas de salud y como esto se relaciona con su nivel de independencia, de autoaceptación, con tener un espacio para si misma, y con reconocer las relaciones y estructuras de poder (IV). Las matronas Chilenas consideraron que las mujeres tienen en esta etapa de su vida necesidades especiales de salud y necesidades de cuidado. Las matronas se consideran como los profesionales más apropiados y calificados para brindar la atención de salud a estas mujeres. Sin embargo, las matronas reconocen que carecen de habilidades comunicacionales y competencias para atender los problemas y necesidades psicológicas y socioculturales de las mujeres en esta etapa de su vida tales como violencia, abuso y aspectos relacionados con su sexualidad. Los estudiantes de Obstetricia señalaron que muchas matronas focalizaban su atención en cumplir fundamentalmente con los requerimientos biomédicos. Algunos estudiantes cuestionaron ciertas actitudes de parte de las matronas de falta de respeto hacia algunas mujeres, especialmente inmigrantes o mujeres con problemas psicosociales (V).

Conclusión: aspectos de género, estructuras de poder y empoderamiento debieran ser incorporados y críticamente analizados en los programas de formación de las (os) estudiantes de Obstetricia, y en sus prácticas en los campos clínicos. Se requiere dedicarle mayor reflexión y atención a la calidad de la relación usuario-proveedor.

Key words: Mujeres chilenas, salud, edad mediana, menopausia, sexualidad, roles de género.

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