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Factors Related to Women's Quality of Life in The Climacteric Period

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Abstract

Quality of life is satisfaction on the physical, psychological, social, and environmental aspects in the climacteric period. Climacterium is the period of life from decreased activity to the end of ovarian function, which has an impact on the occurrence of climacteric syndrome. The purpose of this study was to determine the factors associated with the quality of life of women during the climacteric period. This research method was an analytical survey, with a cross-sectional design. The research was conducted in August 2022 at Padukuhan Karangnongko, Tirtomartani, Kalasan, Sleman. A sample of 90 people was selected by proportional random sampling. The research instrument used the WHOQOL-BREF questionnaire, data analysis used Kendall Tau. Factors that are not related to women's quality of life include age, education, occupation, parity, history of chronic disease, history of breast and cervical cancer screening. Factors related to women's quality of life are health insurance (p-value = 0.005) and physical activity (p-value = 0.036). Health insurance should be prepared early, and regular physical activity can improve the quality of life for women during the climacteric period.

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INTRODUCTION

Menopause is one of the stages in a woman's life cycle which is a sign of the end of the reproductive period. Hormonal changes during menopause can have an impact on physical, emotional, mental, and social well-being. Symptoms that occur during and after menopause vary quite a bit in women. Some experience mild symptoms, but some are severe enough to interfere with daily activities and quality of life (WHO, 2022). The results of previous study show that menopause has a negative impact on quality of life and is statistically significant. Some of the accompanying symptoms experienced by menopausal women due to decreased hormone levels and aging, which of course affect the quality of life (Chintya et al., 2019).

The number of postmenopausal women in the world continues to grow. By 2021, women aged 50 and over make up 26 percent of all women and girls worldwide. That's 22% more than 10 years ago (United Nations, 2021). Women also live longer. Globally, a woman who turns 60 in 2019, has an expectation of living to the next 21 years (United Nations, 2019). The popular belief in society is that menopause causes physical and psychological problems. Problems that arise in women are in almost all domains, both vasomotor, psychosocial, physical and sexual. Most women around the world experience this problem so it can't be ignored. Improving the quality of life is a challenge that needs to be faced today (Karmakar et al., 2017).

During the climacteric period, women experience several physical and mental changes that affect their health and reduce their quality of life. Most postmenopausal women complain of fatigue, decreased stamina, changes in appearance, skin texture or color, muscle and joint pain, memory loss, and sexual complaints. Apart from that some women suffer from anxiety and depression (Karma et al., 2018). Menopausal status, educational level, crowding and body mass indexes, marital status, smoking and alcohol intake were among the factors that were significantly associated with the frequency and the severity of menopause related symptoms (El Hajj et al., 2020). Previous studies have shown that the prevalence and severity of menopausal symptoms and reduced quality of life are significantly higher in postmenopausal women than in premenopausal women. Menopausal symptoms largely affect the quality of life of pre- and postmenopausal women (Rathnayake et al., 2019).

WHO defines quality of life as a person's perception of their position in life in terms of the culture, value systems in which they live and in relation to their goals, expectations, standards and concerns. It is an integral part of a person's physical health, psychological state, level of independence, social and environmental relations, and personal beliefs. This definition has the view that quality of life is a subjective assessment in a cultural, social, environmental context, and cannot be equated with the terms health status, life satisfaction, or mental well-being (WHO, 2012). Women's quality of life increases with healthy living behaviors and decreases with menopause, and is indirectly influenced by self-efficacy and social support (Ermawati, 2018).

Based on the results of previous studies, factors related to the quality of life of perimenopausal women include the severity of depression, self-reported health conditions, occurrence of menopausal symptoms, level of education, and marital status (Kanadys et al., 2016). In addition, exercise also affects the quality of life of menopausal women who live in rural areas, none of the 22 women who exercise regularly have severe complaints of menopausal symptoms (A. N. Sari & Istighosah, 2019). Sociodemographic variables such as the woman's age, marital status, education level, last menstrual period and menstrual cycle are statistically significant on the quality of life of peri- and postmenopausal women (Koirala & Manandhar, 2018).

The results of a preliminary study at Padukuhan Karangnongko, Tirtomartani, Kalasan showed that 4 out of 5 respondents had a moderate quality of life, even though climacteric complaints/syndromes were in the mild category (40%) and even very mild (60%). Complaints experienced included vasomotor (40% hot flushes and sweating), psychosocial (80% felt skills decreased and decreased than usual), physical (80% felt tired/weak quickly, 80% felt reduced physical ability, 80% decreased stamina), 60% felt less energetic), sexual (20% experienced changes in sexual desire, vaginal dryness, and avoided intercourse).

Although there are many studies on quality of life, research on factors related to quality of life in climacteric women in Sleman is still not conclusive. This study aims to identify factors related to the quality of life of climacteric women in terms of sociodemographic factors and health risk factors.

METHODS

This type of research is an analytic survey with a cross sectional approach. The research was conducted in August 2022. The sample of this research was women aged 40-60 years who were married and their husbands lived in the Padukuhan Karangnongko, Tirtomartani Village, Kalasan, Sleman, DIY, totaling 90 people, who were selected by proportional random sampling technique. The inclusion criteria in this study were not currently on hormone replacement therapy, experiencing at least 1 complaint during the climacteric period. The independent variables in this study include sociodemographic factors and health risk factors. Sociodemographic factors consist of age, education, occupation, parity, and health insurance. Health risk factors include history of chronic disease, history of breast cancer screening, history of cervical cancer screening and physical activity. The dependent variable in this study is quality of life.

Research data collection was carried out by 6 research enumerators. The enumerator researchers had previous apperceptions related to research objectives, research instruments and data collection techniques. Data collection techniques by visiting selected samples to their homes. This method was chosen because it is not possible to collect respondents at one time. The door to door method will also provide full opportunity for respondents to answer questions more freely. The instrument used to measure quality of life is the WHOQOL-BREF which is a summary of the WHOQOL-100 consisting of 26 questions. To assess the quality of life, there are 4 domains that are combined, including the physical, psychological, social and environmental domains. Data were analyzed using the Kendall Tau test. This research has gone through an ethical due diligence test and is declared to have fulfilled the ethical principles Number: 096.3/FIKES/PL/VII/2022.

RESULTS

Table 1: Respondent characteristics

No	Variable	Frequency	Percent (%)
1.	**Age**		
	< 45 years old	28	31.1
	45-60 years old	62	68.9
2.	**Parity**		
	Nullipara	5	5.6
	Primipara	13	14.4
	Multipara	71	78.9
	Grandemultipara	1	1.1
3.	**Level of Education**		
	Basic Education	29	32.2
	Middle Education	43	47.8
	Higher Education	18	20.0
4.	**Job Status**		
	Housewife	65	72.2
	Work	25	27.8
5.	**Health insurance**		
	Don’t Have Health Insurance	19	21.1
	Have Health Insurance	71	78.9
6.	**History of Chronic Disease**		
	Don’t Have History	55	61.1
	Have History	35	38.9
7.	**Physical activity (Sport Habits)**		
	Never	25	27.8
	Seldom	44	48.9
	Often	21	23.3

Continued Table 1: Respondent characteristics

No	Variable	Frequency	Percent (%)
8.	**History of VIA/Pap Smear test**		
	Never	76	84.4
	Ever	14	15.6
9.	**History of clinical breast examination (CBE)**		
	Never	82	91.1
	Ever	8	8.9
10.	**Menopausal status**		
	Menopausal transition	51	56.7
	Post menopausal	39	43.3
	Total Respondents	**90**	**100**

Source: *Primary Data*

Based on table 1 it is known that most climacteric women are in the age range of 40-50 years (58.9%), multiparous (78.9%), secondary education (47.8%), housewives (72.2%) , have health insurance (78.9%), no history of chronic disease (61.1%), rarely exercise (48.9%), have never had an VIA/Pap Smear test in the last 3 years (84.4%), have not have had CBE in the last 3 years (91.1%), and are in the menopausal transition stage (56.7%).

Table 2: Quality of Life

No	Variable	Frequency	Percent (%)
1	Bad	3	3.3
2	Moderate	62	68.9
3	Good	22	24.4
4	Very Good	3	3.3
	Total Respondents	90	100.0

Based on table 2, it is known that most climacteric women have a moderate quality of life (68.9%).

Table 3: Quality of life in Each Domain

No	Domain	Very Bad		Bad		Moderate		Good		Very Good		Total Respondents	
		f	%	f	%	f	%	f	%	f	%	f	%
1	Physical	0	0	23	25.6	55	61.1	12	13.3	0	0	90	100
2	Psychological	1	1.1	2	2.2	63	70	22	24.4	2	2.2	90	100
3	Social	0	0	1	1.1	61	67.8	20	22.2	8	8.9	90	100
4	Environment	0	0	4	4.4	50	55.6	29	32.2	7	7.8	90	100

Based on table 3, it is known that the majority of the quality of life for climacteric women in each domain is moderate, but the highest is in the psychological domain (70%). In addition, it can be seen that in the poor/bad quality of life, climacteric women have the highest percentage in the physical domain (25.6%).

Table 4: Relationship Between Sociodemographic Factors and Quality of Life

No	Variable	Kendal Tau (p-value)
1	Age	0.690
2	Parity	0.051
3	Level of Education	0.083
4	Job Status	0.082
5	Health insurance	0.005

Table 5: Relationship Between Health Insurance and Quality of Life

No	Health Insurance	Quality of Life										Total Respondents	
		Very Bad		Bad		Moderate		Good		Very Good			
		f	%	f	%	f	%	f	%	f	%	f	%
1	Don't Have Health Insurance	0	0	0	0	18	94.7	1	5.3	0	0	19	100
2	Have Health Insurance	0	0	3	4.2	44	62	21	29.6	3	4.2	71	100

Based on tables 4 and 5, it is known that from sociodemographic factors, there is only 1 variable related to quality of life, namely health insurance ownership (p-value = 0.005). In the group of women who do not have health insurance, only 5.3% have a good quality of life, while in the group that has health insurance, 29.6% have a good quality of life.

Table 6: Relationship Between Health Risk Factors and Quality of Life

No	Variable	Kendal Tau (p-value)
1.	History of Chronic Disease	0.068
2	Physical activity (Sport Habits)	0.036
3	History of VIA/Pap Smear test	0.419
4	History of clinical breast examination (CBE)	0.359
5	Menopausal status	0.534

Table 7: Relationship Between Health Insurance and Quality of Life

No	Physical activity (Sport Habits)	Quality of Life										Total Respondents	
		Very Bad		Bad		Moderate		Good		Very Good			
		f	%	f	%	f	%	f	%	f	%	f	%
1	Never	0	0	2	8.0	19	76.0	4	16.0	0	0	25	100
2	Seldom	0	0	2	2.3	30	68.2	10	22.7	3	6.8	44	100
3	Often	0	0	0	0	13	61.9	8	38.1	0	0	21	100

Based on tables 6 and 7, it is known that from health risk factors, there is only 1 variable related to quality of life, namely physical activity (p-value = 0.036). In the group of women who never exercised, only 16% had a good quality of life, while in the group who rarely exercised, 22.7% had a good quality of life. In the group that often exercised, 38.1% had a good quality of life. This shows that physical activity improves the quality of life.

DISCUSSION

1. Respondents Characteristic

Based on the results of the study, it was found that women aged > 45 years (68.9%) and had menopause were 36 people (40%), while women aged < 45 years (31.1%) were only 3 people (3.3%) who had menopause. This is in accordance with what was conveyed by (WHO, 2022) where the regularity and length of menstrual cycles varies throughout a woman's reproduction, but the normal age of natural menopause for women worldwide is 45-55 years.

The majority of climacteric women in this study were multiparous (> 2 children). The results of previous studies showed that the majority of mothers had multipara parity, namely 22 people (68.8%) and a small number had nulliparous parity, namely 1 person (3.1%). From the results of the analysis it can be concluded that on average a menopausal woman has 2-4 children. There is a significant relationship between parity and age at menopause. Mothers who have never given birth enter menopause earlier (early menopause) because menstruating women who do not experience fertilization cause ovarian follicles to degrade or decrease in number (Nurdianti et al., 2018).

Most climacteric women (47.8%) have middle education, and 20% have higher education. The results of previous studies indicate that there is a relationship between education and attitudes towards menopause. A person's education influences the way of thinking which ultimately determines the person's

attitude to be positive in the life he lives (Estiani & Dhuhana, 2015). Women with low education increase the risk of anxiety at menopause compared to higher education (Setiyani & Ayu, 2019).

When viewed from employment status, it is known that most women (72.2%) are housewives/not working, and only 27.8% are still actively working. The results of previous studies stated that working women are very vulnerable to experiencing work stress. There is a significant relationship between work stress and the onset of menopause. If work stress increases, the onset of menopause is faster/earlier (Arditya et al., 2017).

78.9% of menopausal women already have national health insurance (NHI), but there are still 21.1% who don't have it yet. The results of previous studies stated that the implementation of National Health Insurance in Indonesia is still considered very bad, NHI activities are only curative and rehabilitative, not yet preventive and promotive. This might be the cause of women not having NHI (Mustikasari, 2021).

Judging from the history of chronic disease, the majority (61.1%) of climacteric women did not have chronic disease. Only 38.9% had chronic disease. The most chronic disease is hypertension (18.8%), diabetes mellitus (7.7%). Before menopause, women are protected from cardiovascular disease because they have the hormone estrogen which plays a role in increasing high-density lipoprotein (HDL). High HDL is a protective factor that prevents atherosclerosis. During premenopause, levels of the hormone estrogen begin to decline with age (Riyadina, 2019). Late menopause was significantly and positively related to diabetes (OR = 1.611, 95% CI: 1.142, 2.274) (Fu et al., 2016).

Physical activity such as regular exercise should be done regularly during the climacteric period to increase endurance. This study found that only 23.3% of women regularly exercise at least three times a week. The results of previous studies showed that there was a difference in the decrease in menopausal symptoms before and after muscle and bone strength training. Age-appropriate physical activity with a frequency of three times a week and a duration of 30 minutes each exercise must be done and continued (Simangunsong & Wahyuni, 2020). This is also in line with previous research which showed that 86% of respondents without menopausal symptoms regularly exercised at least once a week, while only 1% of respondents with menopausal symptoms regularly exercised. Exercise has many benefits and relieves many of the discomforts experienced during menopause. Not exercising regularly affects the physical and mental adjustments of menopausal women, so that menopausal women experience discomfort due to a decrease in the hormone estrogen (Widjayanti, 2021). Menopausal women are at risk of experiencing reproductive health problems including breast cancer and cervical cancer. Routine screening is very important and recommended to do. In this study, it was shown that 84.4% had not done an VIA/Pap Smear and 91.1% had not done a clinical breast examination in the last 3 years. This is in accordance with previous studies, namely as many as 92.3% of women of reproductive age did not take an VIA test in the last 3 years (Wantini & Indrayani, 2019). 90% of women have not had a clinical breast exam in the last 3 years (Wantini & Indrayani, 2018). The factors related to early detection of cervical cancer are knowledge, attitude, access to information, and husband's support. The most dominant factor influencing women's participation in early detection is husband's support (OR = 46.69) (Fauza et al., 2019). The results of other studies show that a person's lack of knowledge about breast cancer and CBE examinations can lead to a lack of interest in carrying out CBE examinations (Nurhayati et al., 2019).

2. Quality of Life

The quality of life of postmenopausal women is the satisfaction of menopausal women with the physical, psychological, social and environmental aspects of their lives. Quality of life is divided into four domains, namely the physical, psychological, social and environmental domains (WHO, 2012). Quality of life in this study is included in the moderate category in each domain. The results of this study are not in line with previous research which showed that the majority of menopausal women respondents in the Wonosari Village, Semarang, as many as 41 respondents (53.2%) had a good quality of life (A. S. Sari & Susilawati, 2021). The quality of life in this study based on the environmental domain has the highest percentage of good quality of life compared to the domain, which is 32.2%. Environment related to freedom, security, opportunity to obtain information, participation/opportunity for recreation, home environment. Meanwhile, the poor quality of life is mostly found in the physical domain, namely 25.6%. Physical changes/physical complaints related to menopause can certainly interfere with daily activities, mobility, discomfort, rest/sleep, work

capacity, including drug dependence and medical treatment so that the quality of life decreases.

If menopause is associated with the dimensions of quality of life, it is clear that the quality of life has decreased. This is because during the menopause phase all these dimensions change. This phase occurs gradually due to decreased ovarian function. Therefore, entering the age of 40 to 50 years is a scary thing for women. Psychologically, this worry can originate from the thought that one will become unhealthy, unfit and not beautiful. This condition is not pleasant for women (Marettih, 2012).

Factors related to the quality of life of women in this study are health insurance ownership and physical activity. This is consistent with research which states that subjective quality of life tends to be better in postmenopausal women who do regular exercise (Putri et al., 2014). The results of the analysis of previous studies show that there is a significant relationship between exercise and the quality of life of postmenopausal women living in rural areas. As many as 22 out of 50 women (44%) who exercise regularly, none of them have serious complaints about the symptoms of menopause they are facing (A. N. Sari & Istighosah, 2019). Exercise is effective in relieving menopausal symptoms. Nearly half of the participants (45.4%) had low levels of physical activity, which correlated significantly and inversely with the MENQOL subdomains including vasomotor, psychosocial, physical and sexual (El Hajj et al., 2020).

Ownership of health insurance in this study was above 75%, meaning that many people are aware of the importance of having health insurance. Ownership of health insurance is also significantly related to quality of life. The results of previous studies also show the same thing, where most have national health insurance. Health insurance also significantly influences the overall quality of life domain. Health insurance will facilitate access to health services when there is a decline in health status and continuous health monitoring, especially for those with chronic diseases (Sinaga et al., 2022). The results of other studies also show that the health status of elderly people who have health insurance is better than those who do not have health insurance (Gu et al., 2017).

CONCLUSION

The quality of life for women during the climacteric period is in the moderate category and factors related to the quality of life are health insurance and physical activity/sports. Women's quality of life will improve if women have health insurance and exercise regularly.

SUGGESTION

Efforts are needed to improve the quality of life of women during the climacteric period by increasing regular physical activity/exercise at least 3x/week and having national health insurance in order to obtain protection benefits in meeting basic health needs. Future research is suggested to develop efforts to improve the quality of life of women during the climacteric period.

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CONFLICTS OF INTEREST

The data collection process in this study was carried out by enumerators, so there was no conflict of interest between the researchers and the respondents. All respondents had previously conveyed the aims and objectives of the research, and were consciously willing to become respondents. Research funding and publications are fully provided by PPPM Universitas Respati Yogyakarta as grants for lecturer research activities, and there is no conflict of interest from any party.

AUTHOR CONTRIBUTIONS

Nonik Ayu Wantini was responsible for conceptualizing research, monitoring research implementation, processing data, writing research articles, and writing correspondence. Lenna Maydianasari was responsible for apperception to research enumerators, input of research data, writing and revising manuscripts. Jacoba Nugrahaningtyas Wahjunung Utami was responsible in writing and revising the manuscript.

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