

THE EXPERIENCE OF
THE MENOPAUSE AND
CLIMACTERIC OF WOMEN
IN AUSTRALIA FROM A
NON-ENGLISH SPEAKING
BACKGROUND



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Master of Health Science-Nursing

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BACKGROUND**

submitted by

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The experience of the
menopause and climacteric of
women in Australia from a

*In May,
the leaves turn red...
and gently,
they fall ...*

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...

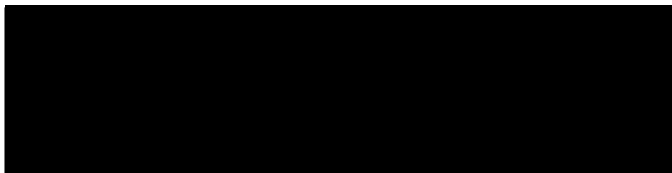
*Dedicated
to the Memory of
Raymond Francis English
1945-1995*

*My love
And my life...
My all...*



Statement of Authorship

I declare that this thesis contains no material published elsewhere or in part from a thesis by which I qualified for, or have been awarded another degree or diploma from any other college, institution or university. Furthermore, to the best of my knowledge and belief, no previously published material by another person has been used in the main text of the thesis except where due reference is made.



Carolyn English

December 1997

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ABSTRACT

Naturalistic inquiry was the method used in this qualitative study, examining the experience of the menopause and climacteric of women in Australia from a non-English speaking background. Women form over one-half of the Australian population, with 12% of this number being from a non-English speaking background country, and 14% of these women speaking a language other than English (LOTE) in the family home. These women seek health-care in a care system which was established and is maintained in the Anglo-Celtic tradition. As these women approach the menopause and the climacteric years, how culturally appropriate is our health-care service for these women? The study was conducted in the Western suburbs of Melbourne which has a higher percentage of people born overseas (34.6%) than the national or Victorian percentage of 22%. Data was collected by in-depth interviews with 33 women from the countries of Vietnam, the Philippines, China, Malta, Italy, Greece and Lebanon.

Issues explored and contained in the data included the women's difficulties with their own health at the time of menopause, the significant beliefs and practices about menopause in their countries of origin, availability of culturally relevant information and treatment in the health care system. Findings included negative attitudes to menopause and usage of hormone replacement therapy, cultural overtones in the women's beliefs about menopause, religion being a determinant in acceptance and coping with menopause and the climacteric, inadequate information provided by health-care professionals, and the unavailability of printed information in the appropriate language. The provision of Medicare was an important factor in the women's ability to access health care. As Australia is a multicultural country, it would appear from this study that the health-care system needs to address the issue of culturally congruent care.

THE EXPERIENCE OF THE MENOPAUSE AND CLIMACTERIC IN
AUSTRALIA OF WOMEN FROM A NON-ENGLISH SPEAKING
BACKGROUND

SUMMARY

In the Western Region of Melbourne, people from overseas countries formed 34.6% of the population, which is significantly higher than the national and Victorian rate of 22%. Of this number born overseas, 81% were born in non-English speaking countries, which is significantly higher than the 58% nationally (Australian Bureau of Statistics, 1991). The predominant countries of origin amongst the non-English speaking people were Italy and other Southern European countries (10%) and nearly 9% were born in countries of South-East Asia.

The aim of this study is to explore the cultural issues which surround the menopause and climacteric for women who are from a non-English speaking background (NESB). It is directed towards providing information for nurses, other health professionals and the health care system within which they work, so that culturally consistent care may be available for NESB women.

Questions framed to guide the research were:

- What is the experience of immigrant NESB women of menopause and the climacteric?

- What are the cultural beliefs, practices and myths, if any, of NESB women about the menopause and climacteric?
- Have the NESB women abandoned their cultural beliefs, practices and myths altogether and adopted those of their new country of residence?

A review of the literature indicates there is a gap in available information regarding non-English speaking women in Australia and their cultural beliefs and practices surrounding the menopause. Literature exists on the menopausal experience of women in many overseas countries, especially in the Asia-Pacific and North American countries. The majority of the studies examined were of a quantitative scientific nature, with symptomatology being the focus of the research. The information was not applicable to the Australian experience of NESB women or their cultural beliefs and practices. With the exception of one paper which reviewed the use of screening services by Italian and Macedonian women, the research which has been conducted in Australia selected only Australian-born women to be involved in the studies.

The study, entitled “The experience of the menopause and climacteric of women in Australia from a non-English speaking background”, is qualitative, using naturalistic inquiry, and conducted by in-depth interviews with six individual and three groups of NESB women exploring menopause and the associated issues as the women perceived them. Women who were involved in the study came from Malta, Italy, Greece, Lebanon, Vietnam, China and the Philippines.

The data for analysis included the full transcripts of all nine interviews with the NESB women. Some of the issues explored in this study and contained in the collected data for analysis were the women's difficulties with their own health at menopause, information available in their own language, family or partner support, the significant cultural beliefs and practices from their countries of origin, cultural relevance of any treatment received and cultural understanding of health workers.

Findings of the research included: negative feelings about menopause by the majority of the women; cultural overtones in the women's beliefs about menopause; religious faith, albeit of many different kinds, being a determinant in the woman's acceptance and coping with menopause and the climacteric; inadequacy of information provided by health care professionals including the inability to obtain printed material in the appropriate language. A large number of the women were positive about the level of care they received in the area of women's health within the public hospital system with Medicare being an important factor in their ability to access health care.

The structure of this thesis has been organised in a manner which reflects the particular methodology used, how the data was analysed and how and when the literature influenced the methods and analysis leading to the final conclusions of the thesis. This thesis comprises five chapters following this summary. Chapter One contains the introduction and the background to the research study. Chapter Two explains the methodology, data collection and the data analysis. Chapter Three contains the review of the

relevant literature. In Chapter Four are the results of the research findings, limitations to the study and future directions for research. Chapter Five contains the conclusion.

CHAPTER ONE

INTRODUCTION

Australia - a Multicultural Society

Australia is considered a multicultural nation and society (Manderson, 1990). It has been a country of migration since the first British settlers and convicts arrived in 1788, but more so since the Second World War. Post World War Two it was increasingly evident that this country required external sources of labour to remain economically viable. As a consequence large numbers of immigrants arrived in Australia and were either from southern European countries which had been devastated by the Second World War, or displaced persons living in refugee camps and who refused to return to their now communist country of origin (Jupp, 1990). Prior to this time, immigration to Australia was from the United Kingdom and Ireland, and this new shift in migrant intake created a change in the ethnic make up of Australia. The Australian Government's immigration policy, commonly known as the White Australia Policy, placed the onus on the immigrant to change his culture and to assimilate into Australian society. At the same time, there was no change to either the Australian culture or its society (Jupp, 1990; Mardiros, 1992). Since 1975 and the abolition of the White Australia Policy, migrants and refugees have continued to come to this country from the Middle East, Indo-China, Latin America, areas of Africa and of the Indian sub-continent (Jupp, 1990). The result of this migration is that Australia is now a nation which has up to 130 diverse migrant cultures.

Culture is defined by the Macquarie Dictionary (Delbridge, 1991) as pertaining to human behaviour, ideologies and social structures which are transmitted from one generation to another. Culture is shaped by virtue of shared understandings and expectations. It is dynamic, containing ritual and religious components, and changeable because of interaction with peoples from other cultures, intermarriage, trade amongst nations, hostilities between and within nations and of course, migration (Manderson, 1990). Many cultures now present in Australia endow the country with diversity of language, religions and lifestyles, contributing to the make-up of what is known as the Australian identity. Because the number of immigrants to this country has significantly increased over the last 40 years with great variation in the countries of origin, Australia has reached the point where 20% of the country's population was born overseas (Ferguson & Browne, 1991). Women form over one half of the Australian population, with 12% of this number being women from a non English speaking country, and 14% of these women speak a language other than English (LOTE) in the family home (Alcorso & Schofield, 1991).

The Australian Healthcare System

In Australia, the majority of health institutions are managed and staffed by Australian-born health professionals with specific cultural understanding and practices which are derived from the nation's Anglo-Celtic origins. It is monolingual and monocultural in its rules, regulations, policies, values and beliefs. The existing health system makes it difficult for the migrant person to receive care relevant to their culture, and even more for the Non English

Speaking Background (NESB) woman when care and service in the health system has been described as far from user friendly (Mardiros, 1992; Alcorso & Schofield, 1991; Idrus, 1988). Health practices and the structure of service delivery are culturally inappropriate for many NESB women, because of cultural beliefs which surround women-specific health problems such as birthing and birth practices, menstruation and menopause (Cape, 1993; Parsons, 1990; Ministerial Review, Health Department of Victoria [HDV], 1990). Leininger (1978) also claims Western countries impose their own culture on the country's health system, ignoring health values which exist from other cultures. Citing Chambers and Pettman (1986), Mardiros (1992) states that "...Australian immigration policy continued to place the onus on the migrant to change and assimilate, without concurrent change to the dominant culture and its institutions" (p. 27). Furthermore, Leininger questions the professional and ethical standards of imposing our health beliefs and practices on another culture especially when one considers that our own beliefs are not constant.

The National Non-English Speaking Background Women's Health Strategy (Alcorso & Schofield, 1991) expressed particular and distinctive needs relating to mental, emotional and reproductive health. In the 1970's ethnospecific health services were established to accommodate the needs of migrant women. However, in the 1980's a change in policy direction saw a move to combining these ethnic health services into the mainstream health services. With the changing trends of migration in the 1990's it has become necessary once again to develop health services which are ethno-specific and

incorporating ethnic health workers who are bilingual (Sonntag, Tomsic, Nash, Cheung, & Campbell, 1995; Garrett & Lin, 1990).

Health care should be relevant to all Australians regardless of ethnic background or cultural origins. For Australia to be a caring multicultural country it has an obligation to be responsive to the needs of its culturally diverse population (Garrett & Lin, 1990). There is great variation between cultures, and even within cultures, to the concept and perceptions of what exactly constitutes health. Health practices and attitudes need to change, recognising that ethnic groups have unique values which will influence their health behaviours and their ability and willingness to comply with treatment (Mardiros, 1992). According to Omeri & Nahas (1995), “consumers of health care are demanding that their cultural beliefs, values and caring modalities be incorporated in the mainstream health services” (p. 157).

Culture and Nursing

With the change in the cultural milieu in Australia, nurses need to be aware of and anticipate client differences in a wide range of areas including religion, family life patterns, dietary restrictions, beliefs and practices relating to health and illness. Unique sets of values will influence health practices and patient compliance with treatment (Tripp-Reimer, Brink & Saunders, 1984; Omeri & Nahas, 1995; Mardiros, 1992). As stated, the Anglo-Celtic style health-care system is inappropriate for many migrant people. Consequently, nurses are required to rethink their care in partnership with their clients to provide holistic nursing care that is “...culturally sensitive...culturally congruent,

sound and safe” (Omeri & Nahas, p. 157). Furthermore, nurses need to continue to acknowledge the Code of Nursing Ethics which states in Value Statement 1, that “nurses respect persons’ individual needs, values and culture in the provision of nursing care” (ANCI, 1993).

Australia’s Ageing Population

When a woman reaches the age of 50 years, she could expect to survive for at least another one-third to one-half of her present lifespan after the menopause (Burger, 1992; Gressor, 1994). Women’s life-expectancy has increased because of improvements brought about by the World Health Organisation (WHO), with the elimination or better control and management of many illnesses in Western society which were once fatal infectious diseases, improvement in environmental health measures, for example improved sanitation and water supply, and because of better medical treatment (National Women's Health Policy [NWHP], 1989). Over a period of time these factors have led to an increase in the number of post-menopausal women in Australia, whereby today, women account for just over half the total population of this country (Horvath, 1992). Older women are the largest, fastest-growing age group in Australia, such that in 25 years time they will form 35% of the Australian population (Anderson & Luxford, 1988).

Experience of Old Age

Experience of old age is dependent upon many variables. Amongst them are gender, education, class and culture. According to Nay (1992), “women, people from lower socio-economic groups and non-English speaking

backgrounds...suffer more problems and have fewer coping resources in old age" (p. 16). The percentage of population of NESB older persons in the Australian community continues to escalate at a rate that far outnumbers those who are Australian born. Nay states that in the 10 year period 1971 to 1981 "...Australian-born aged increased by 25% while those from NESB increased by 79%" (p. 16). According to the National Women's Health Policy (1989) it is believed that "ethnic aged women are seen to be in triple jeopardy: as women, as being older and of ethnic status" (p. 41).

Menopause

Menopause is defined as the cessation of menstruation and occurs during the climacteric phase of life, the median age of the woman experiencing menopause being 50-51 years (Utian, 1976). Menopause occurs naturally when the ovaries gradually cease to produce hormones, or surgically if the ovaries are removed. The climacteric refers to the transitory period in the human female between the ages of reproductive and non reproductive ability. The climacteric is sometimes, but not necessarily always, associated with symptomatology, and is referred to as the climacteric syndrome (Utian, 1976). Common symptoms experienced include hot flushes, sweating, mood changes, poor sleep patterns, loss of interest in sex, dry vagina, and bladder problems (Gressor, 1994). The time of the onset of the menopause can occur during what can be a period of many life changes and stresses for a number of women, for example, children leaving home, lifestyle changes, new directions in employment and caring for aged parents or family members. However, although a normal life event, menopause is an emotive word, as it carries with

it the connotation of old age. Western society views the menopause as the ending of youth and the beginning of old age (van Keep & Humphrey, 1976; Abraham, Llewellyn-Jones & Perez, 1995). Menopause is also surrounded by a number of stereotypes such as, women are irritable, unattractive, gain weight, go crazy. These stereotypes need to be challenged and one of the ways this can be done is by community education (NWHP, 1989). Today, the informed menopausal woman anticipates to maintain a high quality of life during these latter years, expecting to be active, participate in the workforce as well as remaining feminine and sexually active (Nachtigall, 1994; Davis, 1994).

While it is true that the menopause is a universal female occurrence, is the way in which women cope with menopause and the climacteric phase of life universal? (Davis, 1994; Oddens, 1994; Boulet, Oddens, Lehert, Vemer & Viser, 1994). It appears the cultural background of the woman greatly influences the manner in which a woman copes and adjusts to the menopause (Davis, 1994). Different cultures have established varying connotations of menopause, that is, cultural gains and losses. For example, in some societies the woman is rewarded in one way or another for reaching the end of her fertile period, whereas in another the woman is punished for reaching the end of her youth. In India, women from certain classes, such as the Rahjput class, emerge from Purdah at the time of menopause. They acquire a higher status and are allowed to move around at will, free from the 'dangerous contamination' of the menstrual blood (Davis, 1994).

Contemporary Australia is of such cultural and ethnic diversity that NESB women comprise around 12 percent of the total Australian female population and they survive longer than Australian born women (Alcorso & Schofield, 1991). Therefore, it would be appropriate to explore the cultural issues surrounding the time of menopause and the climacteric for NESB women who now live in Australia. Exploring these issues would enhance understanding of their beliefs, attitudes and needs at this stage in their lives, especially when one considers that the present health-care facilities are of Anglo-Celtic origin and in some instances are not culturally suitable. The gathering of information from women of a non-English speaking background about the cultural beliefs and practices which surround the menopause and climacteric, would allow health professionals to provide these women with optimal culturally congruent care at this stage in their lives.

Menopause and the climacteric has been researched by a number of people (Ramoso-Jalbuena, 1994; Tang, 1994; Oddens, 1994; Boulet et al. 1994; Ismael, 1994; McCarthy, 1994). These studies were conducted in ethnic groups within the country of origin and showed that each culture has its own unique set of customs derived from its own unique set of circumstances. However, there has been little research relating to the woman who has migrated to Australia from a non-English speaking country and her cultural practices and beliefs at the time of menopause and in the climacteric.

CHAPTER TWO

REVIEW OF THE RELEVANT LITERATURE

There are shortcomings in knowledge of the cultural aspects of reproductive health and women from a non-English speaking background within the healthcare system of the Western Region of Melbourne (Morris & Hamilton, 1994; Robinson, 1995). Morris & Hamilton state NESB women had high levels of fear and anxiety when using health services and the majority of the women did not share either culture or language with the health practitioners. Furthermore, they suggest because of the two social worlds which exist within the hospital setting, one being that of patient and the other the health professional, with few links between them, that "...for women of NESB using services with inadequate language and cultural services there exists a double jeopardy" (p. iv).

What are NESB women's beliefs surrounding reproduction and especially menopause? What cultural practices do they have? Is the healthcare system meeting the health needs of these women when their cultural beliefs and practices are taken into consideration? In other words, is care culturally appropriate in order to enhance the outcome, and possibly lead to a better experience for the NESB women? Reviewing the literature revealed there was information on the menopause and the climacteric in many countries. This information is relevant to the country in which the research was conducted but it is questionable whether the cultural aspects are applicable to the woman

from a non-English speaking background in Australia who is experiencing the menopause or the climacteric.

The organisation of this chapter is such that the literature reviewed has been divided into two areas. Firstly, the literature which concerns multiculturalism and nursing, then secondly the reviewed literature which pertains to menopause. The literature relating to menopause has been grouped together by the regions in which the studies were conducted. These regions are the Asian-Pacific, the Australian and the North American. It is acknowledged Australia is often included in the Asia-Pacific region, but it has been a deliberate decision to keep the Australian studies separate because of the specific nature and focus of this research.

Multiculturalism and Nursing

As Australia is a multicultural society, nurses must be capable of working with patients from a wide range of countries, and in doing so, to give them care that is befitting to their culture. According to Tripp-Reimer et al. (1984) understanding "...specific factors that influence people's health behaviours..." (p. 78) allows nurses to better meet the needs of their patients. Furthermore, Tripp-Reimer et al. state cultural background accounts for differences in values, beliefs, both in religion and health practices, dietary habits and family life patterns, to name but a few. By making a cultural assessment, nurses can give meaning to behaviours which may otherwise be considered unusual and thereby leading to a better understanding of the manner in which a patient perceives illness or health. According to Tripp-

Reimer et al. cultural assessments "...identify patterns that may assist or interfere with a nursing intervention or planned treatment regimen" (p. 78).

Data to be collected for a cultural assessment according to Tripp-Reimer et al. should include ethnic alliance, preferred religion, dietary choices and specific ethnic health practices and beliefs.

Sonntag et al. (1995) also agree different ethnic groups have specific values which will influence health practices and compliance with treatment. Like Tripp-Reimer et al. (1984), these researchers also acknowledge the need for nurses to become familiar with other cultural values, behaviours and beliefs and incorporate them into assessment of the ethnic patient to allow for appropriate management of the patient. The acceptance of western health practices and the perceptions of health care among migrants are two areas which Sonntag et al. suggest require further research as "...a key order to raising awareness of the issues in the [nursing] profession..." (p. 125).

Mardiros (1992) writes "perceptions of 'health' vary between cultures, and are communicated through language" (p. 29). Furthermore, in order to better serve sick individuals requiring culturally relevant care "...Australian institutions must become responsive to the cultural diversity of the Australian community" (p. 29). Standard plans of care which are suitable for the caregiver or practitioner and not the consumer are the result of inadequate information gathering about culture contends Mardiros. According to Mardiros, what is required is an "...overall understanding of a culture in the context of its various constituent elements..." in order to allow health care providers to be "...reactive

and proactive” (p. 33). Like Alcorso & Schofield (1991), Mardiros too, makes the statement the health care system is dominated by traditions which do not take into account the multicultural nature of Australian society and suggests the nursing profession needs to look at meeting the consumer’s health goals by viewing the client “...in the context of their cultural heritage...” (p. 38) otherwise effective care will be ‘haphazard’.

Omeri & Nahas (1995) state it appears cultural nursing assessment “...is absent or limited in scope” (p. 153) after examining various nursing assessment tools. These authors believe the general information such as country of origin, religion, language and dietary needs are inadequate as this information does not provide an indepth or complete picture of the patient’s cultural background which could be a basis for planning health care needs. Omeri & Nahas believe health care consumers are demanding the inclusion of their cultural norms, values and caring modes into mainstream health services, in order to comply with treatment.

The Asian-Pacific Region

Lock, Kaufert & Gilbert (1988) noted the majority of research and information on menopause originates in Europe and North America where a stereotype of the menopausal woman has been created rather than a reflection of the menopausal experience by a majority of women. These researchers, states Lock et al., create models of menopause which are specific to western culture and include the western concepts of body, symptoms, ageing and women and their place in society. These models and concepts can be

deceptive when research is carried out in societies which do not support the same views. This was most evident in the Lock et al. indepth study on the menopausal syndrome in the Japanese society, where both medical personnel and individual women were interviewed. The mind/body dualism prevalent in Western medicine is "...alien to the Japanese traditional medicine and is still not widely accepted today" (p. 319). To complicate matters further, there was no exact word in the Japanese language equivalent to 'menopause'. Lock et al. admits the word used in their study was probably closer to midlife crisis or change of life rather than menopause, which underlines the difficulties of conducting research and interviews in a foreign language. They also state how the low incidence of vasomotor symptoms reflecting cultural, psychological or physiological differences, or a combination of all three, requires further examination. Differences were noted in the reporting of the degree of menopausal symptoms, especially those with vasomotor origins, in women from rural areas compared with those from urban areas. It was a common suggestion by the medical personnel interviewed that women "...could master their symptoms through the exertion of willpower" (p. 319). Women were still expected to show the stoic nature of their predecessors. The study reports menopausal symptoms are being seen by the medical profession as a 'luxury disease', a post war phenomenon, or belonging to the middle class where women have spare time on their hands. In making these comments, the medical participants were adding "...an essentially moral dimension to the diagnosis ..." (p. 319) of menopausal symptoms. The majority of women interviewed had similar ideas to those of the medical participants, where both groups described the stereotype of the woman with menopausal symptoms,

rather than the woman's own individual experience or those of the medical participant's patients. Crucial to the findings of the research by Lock et al. was the thorough knowledge of the culture of illness in Japan and the insights gained from the in-depth interviews with Japanese women and physicians, and the noting that research using Western language could be misleading as terminology needs to be culturally correct.

Oddens (1994) summarised a group of studies on menopausal women in various Asian countries known as The International Health Foundation South-East Asia study. Oddens comments the previously held views on negative attitudes in western countries towards ageing influenced the reporting of climacteric symptoms in western women and the non-occurrence or non-reporting of symptoms in non-western societies because of the social 'rewards' of being free from menstruation and the attaining of older age in those societies are no longer correct. In the summary, Oddens states the studies have proved symptoms are present in climacteric women in non western societies, but that it is to a lesser degree in some South-East Asian countries. This is attributed to the cultural values placed on menopause, the climate, dietary habits and lifestyles. In these studies of women in South-East Asian countries, despite the fact that considerable distress was experienced by some women at menopause, menopause was sometimes seen as a reward rather than a punishment. Oddens' (1994) summary included work by the following authors: Boulet et al. (1994), McCarthy (1994), Ismael (1994), Ramoso-Jalbuena (1994) and Tang (1994), whose work will now be discussed in further detail.

Seven south-east Asian countries were studied by Boulet et al. (1994) as part of the International Health Foundation South-East Asia study. This research confirmed that the climacteric was experienced in these countries, but in a milder form than in western countries. It noted that special care was taken to overcome language and cultural problems, and as much as possible the data was objective. The study by Boulet et al. noted that little research had been conducted in Asia on the climacteric or menopause, and its aim was "...to gain some clearer ideas on whether the symptoms associated with the menopause are experienced in South-East Asia and, if so, how are they perceived" (p.158). Among the exclusions of the study were Caucasian women, as the study was focussed on menopause and behaviour of Asian women. Boulet et al. acknowledges comments by Lock et al. (1988) regarding conducting research on the menopause in non-western cultures because of the problems and difficulties encountered with translation and the fact that concepts such as hot flushes and menopause have no equivalent in the language or the cultures. To overcome these barriers, translations were carefully checked and the interviews were conducted face to face by experienced interviewers. It was noted by Boulet et al. that a group of climacteric symptoms such as sweating, irritability, headaches, palpitations and anxiety were experienced by the women interviewed in the Asian countries. Also, there were a lower number of women experiencing hot flushes and night sweats than in western countries. However, the figures obtained were still higher than those reported by Lock et al. in their Japanese study. It was believed this could be attributed to the differing research methodologies. The study by Boulet et al. used face to face interviews, which they believe gave more reliable results, whereas Lock et al.

used a self-administered questionnaire. Diet was also believed to have contributed to the difference between the results of the Boulet et al. and Lock et al. studies, as the typical Japanese diet is high in phyto-oestrogens. In reaching their conclusion, Boulet et al. noted a type of stoicism played a role in the countries under study and that socio-economic factors and cultural background needed to be considered.

Despite a poor response rate of only 13.1% on a study of Singaporean women, McCarthy (1994) reached similar conclusions to Boulet et al. (1994) whereby menopausal symptoms have less impact on women's lives than in the West. McCarthy noted the low incidence of symptoms repeated in other South-East Asian countries may be related to cultural factors. McCarthy makes note how in their experience, stoicism is certainly present in delivery wards in Singapore when compared with the United Kingdom, and questions whether the woman who delivers her child without the expression of pain would be more likely to cope with menopausal symptoms without complaint or medication.

Ismael (1994) studied menopause in 400 women in Malaysia. The three major ethnic groups of the population, Chinese, Malays and Indians participated. The research noted menopause comes as a blessing to Muslim women as it means they may now participate in some religious activities. A large portion of the study group (more than 70%) reported not having experienced symptoms such as hot flushes, sweating or palpitations. Where women sought medical attention for disturbing symptoms almost half of these women decided not to comply with the prescription given. Embarrassing

problems were not discussed with the doctor, and consequently women rated their health overall as good. The final conclusion of this study by Ismael was menopause was a biological phenomenon which is not spoken about in Malaysia at this present time.

Ramoso-Jalbuena (1994) noted there is little information on climacteric Filipino women because the symptoms experienced are not considered life-threatening. The Filipino woman had a positive perception of her health status, and Ramoso-Jalbuena suggests the Filipino woman is better able to cope with the menopause than her western counterpart, because she generally accepts the discomforts of menopause as a part of the normal life cycle. Ramoso-Jalbuena raises the possibility of some menopausal symptoms such as sweating and raised body temperature being masked by the tropical climate of the Philippines. As about 70% of all Filipinos live below the poverty line, with diminished resources, plus a religious and cultural upbringing that make the women think of their families first and themselves last. As a consequence they do not seek medical attention for menopausal symptomatology. Ramoso-Jalbuena believes the many Filipino women who have been prescribed Hormone Replacement Therapy (HRT) and can afford the cost, fail to take the medication as they are concerned with the incidence of cancer and its relationship to the taking of HRT.

Tang (1994) comments on the paucity of information in relation to the climacteric in her study on Chinese women in Hong Kong. Only anecdotal reports exist. Tang states of knowledge of Chinese women who are

menstruating are prevented from certain religious practices such as burning incense when praying to gods or ancestors. Tang questioned the woman's social status when she stops menstruating. Is she 'clean' because there is no more blood? Is her social status elevated? Is there correlation between attitudes towards menopause, cessation of menses and the absence or presence of menopause symptoms? As in other studies in this literature review, the climate was again questioned as a reason for the women reporting few vasomotor symptoms. Working and living conditions were harsh for this group of women, and Tang suggests this diverts attention from any symptoms of the menopause.

Punyahorta (1996) studied the experience of Thai women and the menopause also noting that Asian women have less complaints with menopausal symptoms than their western counterparts. She admits there are areas where information is lacking, for example genetics, environment and diet, which may hold the key to the differences experienced by women. Punyahorta notes that health interventions may need to be different to those used with western women, because there is a need to understand the way in which Asian women explain, describe and even experience the menopause. In Thailand, a woman's position is enhanced as she approaches mid-life. There are "...fewer restrictions, the right to exert authority over particular relatives [such as daughters-in-law], and the opportunity to achieve beyond the household setting" (p. 5). Punyahorta further states menopause is seen as "...the change" in Thai society" (p. 5). Findings of the research showed Thai women were physically active, with a great number working in the fields, and

most women believing menopause was a natural occurrence. The women's knowledge of menopause came from friends, relatives and self-experience, and abnormal menstruation and headaches were the main reported symptoms. The low intake of alcohol and of cigarette use are questioned as contributing factors to the low incidences of menopausal health problems. Punyahorta reports Thai beliefs and behaviours are shaped by the Buddhist faith which has the concept of "...impermanence of life..." (p. 8) and thereby the women accepting "...the declining of body functions that come with age" (p. 9). Furthermore, states Punyahorta, the notion of maintaining attractiveness and youth after menopause is unusual amongst rural middle-aged Thai women. The low incidence of hot flushes was similar to other studies on Asian women, such as Lock et al. (1988), but Punyahorta mentioned the hot climatic conditions as a probable cause for this low rate of reporting.

Similar findings were reported in another study in Thailand where Chirawatkul & Manderson (1994) concluded menopause is regarded as a simple and natural biological event for village women, but amongst health professionals it is regarded as a medical problem necessitating treatment. This paper draws attention to the diverse perceptions and understanding of menopause among contemporary Thai women.

The Australian Region

Abraham, Llewellyn-Jones & Perz (1995) studied the perceptions and symptoms before and after the menopause with 60 women in Australia. The study showed the majority of women had a positive attitude to menopause both before and after the menopause. At both times women perceived there was little information available in the media, and doctors had no concepts of what menopause meant to women nor did they provide the women with sufficient information. The women recruited to this study were considered to be better educated and more likely to be employed in a professional position than women from the general community, a fact which has been associated with positive approaches to menopause. The findings of this research suggested health professionals needed to inform women of menopausal symptoms, and provide them with more information and discussion time about the menopause. Abraham et al. noted preconceived ideas of menopause "...significantly predicted the overall menopause experience described by the women" (p, 121). Although this is one of a small number of Australian studies, it is noted the participants in the study were Australian women and ethnic or cultural values were not included as part of this study.

The study by Dennerstein, Smith & Morse (1994) was limited to urban, Australian-born women. The aim of the study was to determine whether well-being in mid-life was related to menopausal status, social circumstances, health status, interpersonal stress, attitudes and life-style behaviours. The questionnaire used was similar to that of Avis & McKinlay (1991) and the modified version used by Lock et al. (1988). It was suggested that the well-

being of mid-life women was not related to the endocrine changes of menopause, but rather to their current health status, psychosocial and lifestyle events.

A further study by Dennerstein (1996), on the association between well-being and current health status, psychosocial and lifestyle variables, states there is a variation of symptoms across cultures, with the Asian women reporting less symptoms than their counterparts in North America and Europe. In this paper, Dennerstein looks at menopause from a social science perspective, noting most research on menopause has a medical focus. Furthermore, she states qualitative research provides additional important data, unobtainable in surveys, because of the interaction at the interview process where there can be clarification and responsiveness to issues raised. Difficulties are discussed in relation to differences between surveys and qualitative research, in both presentation and publication of material attained. Dennerstein notes that there are domains from which surveys cannot acquire information, for instance, sensitive areas such as sexuality. Dennerstein records symptoms and experiences of Asian women in the higher socio-economic classes as experiencing more symptoms than women of lower classes, this being exactly the opposite of women in Europe and the United States of America. Women from Melbourne had similar symptom patterns to women from Europe and the United States reports Dennerstein, who suggests a need for research which blends the two methodologies of quantitative and qualitative research and explores the issues of well-being and symptomatology in menopause.

A literature search reveals only one example of a study conducted in Australia with a cross cultural theme. This study, by Gifford (1990), was with Italian and Macedonian women living in the western suburbs of Melbourne, Victoria, looking at their experiences and expectations during and after the menopause and their use of screening programs. Both groups of women viewed the menopause in a negative light, or as being a time of decreasing health. Their convictions are related to beliefs about the function of blood during the time of reproductive years, and the perceived problems which can arise after the menopause when menstruation has ceased. The monthly flow of blood is linked to health, and that no blood flow equals poor health. The Macedonian women expressed the view that intercourse should stop when the periods ceased, as there is no flow of blood to either clean out the uterus or any semen deposited in the vagina. Both the Italian and Macedonian women believed the symptoms experienced in the menopause such as headaches, hot flushes and 'nerves' are caused by "...too much blood or blood that was too strong" (p. 822). Gifford says it may be a cultural norm for women from these countries to expect diminished health at menopause, thus differing from Anglo-Australian women who seek to maintain or even improve their health as they grow older. Italian and Macedonian women indicated they tend to prefer using services based at hospitals rather than community based services, believing they are better equipped to deal with 'women's problems' and there are usually interpreters available. Consequently, Gifford suggests a number of strategies to increase the utilisation of health and screening services by ethnic women. The suggestions include developing culturally appropriate health education

programs during and after the menopause and sensitising health care professionals to cultural beliefs and notions about health.

In another paper written from the same study source, Gifford (1994) writes that the Macedonian and Italian women tend to avoid the usage of two words: menopause and cancer, as they "... 'terrify' and represent changes in life which women can do little about" (p. 299). However the women are accepting of menopause as a normal and inevitable part of the aging process. Gifford (1994) believes their experiences surrounding menopause and their thoughts regarding cancer are related to the change in social status as older immigrant Italian women and to the grieving process of leaving a life and a home far away from Australia. The women in this study were housebound, unable to speak English and fearful of the possibility of lack of family support in their old age. Gifford (1994) contends "...older migrant women occupy one of the least privileged positions in Australian society" (p. 316) and in order to practically and adequately address the health needs of immigrant women, society needs to "...take into account other social inequities they experience as they age" (p. 316).

The North-American Region

The Massachusetts Women's Health Study (MWHS) was a large study of 2,565 women by Avis & McKinlay (1991) surveying women's attitudes towards menopause. The results suggested that the so-called menopause syndrome may be more dependent upon personal characteristics rather than on menopause itself. Avis & McKinlay state that within the United States of

American menopause is seen as a major negative life-event, as emphasis is placed upon youthfulness and sexuality and reproduction viewed as “...evidence of personal success and fulfilment” (p. 65). The study sets out to explore three areas: how attitudes are related to menopause and how those attitudes change as menopause is experienced; how mental and physical health variables and socio-demographic factors influence attitudes towards menopause; and finally, prior attitudes towards menopause and symptom reporting during the menopause. Results of Avis & McKinlay’s study showed women reported relief or neutral feelings about the cessation of periods. The figures for women reporting relief were only slightly higher than those obtained by Lock et al. (1988) in the Japanese study. Furthermore, the study by Avis & McKinlay showed there was a direct correlation of negative attitudes towards menopause prior to experiencing menopause and the reporting of menopausal symptoms, supporting the notion of a “self-fulfilling prophecy” (p. 78).

Dickson (1994) writes “Menopause is seen as a hormone deficiency disease...” and “...is the result of extant “scientific” research modes...that promotes cause-effect explanations” (p. 118). She also believes biomedical menopause research has menopausal symptoms as its focus, whereas the sociocultural research model has sociocultural variables as the focus. In these models of study, the symptomatology as established in the medical model is expressed as a behavioural phenomenon of Western cultures. For example, in cultures where women's roles are valued, or diets are different, symptoms as described by the western woman are not known. Quality of life for older women is described by Dickson as being of prime importance, and nurses can assist

women in making informed choices at this time in the women's lives. It is noted in Dickson's study the women interviewed did not talk with their mothers or daughters about menopause although some had memories of their mothers passing through the menopausal transition stage. Partners were noted as not always knowing what was going on, and information on menopause was obtained from and shared with other women such as sisters and friends. Dickson states "...the rich description of the menopausal stories and the essential themes identified can be used as a basis to provide knowledge for nurses in helping to understand the experience" (p. 150). Dickson firmly believes nurses have a helping role in affirming and supporting women who are in the menopausal transition stage and beyond.

In summary, while a number of studies relating to menopause have been carried out in various countries, the majority of these studies look at the symptomatology of the menopause and not at the cultural practices and beliefs of the women. However, what part do the religious beliefs of the women play in their approach or attitudes towards menopause? Are they able to practice their religious beliefs or is there some restriction, or are the restrictions lifted? What are the myths passed from one generation to the next with regard to menopause? Are there dietary beliefs during menopause? On reading the available literature, some of these questions have been partly answered. Apart from the work by Gifford (1990 and 1994), the Australian studies which were reviewed did not include women from a non-English speaking background. There appears to be no research on the cultural beliefs and attitudes towards the menopause and the climacteric of NESB women who have migrated to

Australia. Furthermore, the literature also reveals the need for nurses to be more aware of the cultural diversity of this country. Doing so will allow the client in the health care system to receive care that is culturally congruent with their values, beliefs and practices.

It is appropriate for this study to be conducted to add to the body of knowledge and to bridge the information gaps existing in the current literature considering that: Australia is a multicultural nation with an aging population, the majority of whom are female; our health care system is Anglo-Celtic orientated and dominated; and Dennerstein's (1996) comments on the need for more qualitative research, to explore, clarify and seek additional information on the experiences of women at menopause.

CHAPTER THREE

THE RESEARCH DESIGN

This section will describe the research process, the procedures and the strategies which were used in establishing the research project and defining the research question, the selection of the participants, the collection of the data, and the data analysis, see Figure1.

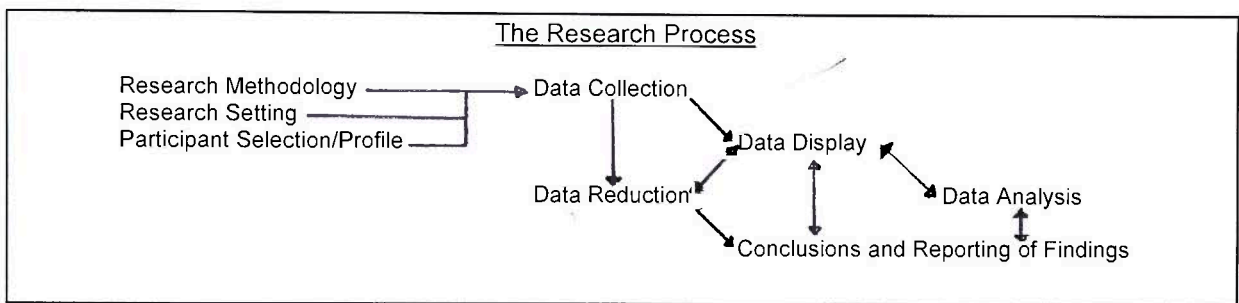


Figure 1. The Research Process.

The information will be organised under the following sub-headings:

- the research methodology
- the research setting
- participant selection and profile
- data collection
- data analysis.

Although the use of these headings gives some structure to this section, and describes the research process, it does not necessarily reflect the sequencing of the research process itself. Some processes occurred concurrently.

The Research Methodology

The research was qualitative using semi-structured taped interviews with both individuals and groups of non-English speaking women.

Naturalistic inquiry was the qualitative method chosen as it gives the opportunity to gather information in a setting that is not contrived and affording a close and searching account of the normal details of an everyday event. In other words, this method seeks to establish the informant's experience of a particular event, that is, menopause and its cultural aspects in the woman from a non-English speaking background. Naturalistic inquiry achieves the overall goal of collecting the richest possible material that is descriptive and potentially insightful, and to acquire social knowledge (Lincoln and Guba, 1985; Morse and Field, 1995; Polit and Hungler, 1995; Lofland and Lofland, 1984). As Lofland and Lofland state, the epistemology of naturalistic inquiry is that "...face-to-face interaction is the fullest condition of participating in the mind of another human being..." and "...you must participate in the mind of another human being...in order to acquire social knowledge" (p. 12).

The human is the instrument of research in naturalistic inquiry. It alone has the characteristics capable of dealing with the complex nature of the human phenomena. The human characteristics include:

- *responsiveness* - to sense and respond to any personal and environmental signs that are present. By responding to the cues presented, the human can interact with the situation and make them known.

- *adaptability* - despite human imperfections, the human is extremely adaptable at assessing more than one factor at any time. This contrasts with the research instrument which only assesses one factor at any given time.
- *opportunity to clarify and summarise and the opportunity to explore atypical responses* - the human instrument is capable of immediate summation of data given, feeding it back to the interviewee for clarification or correction. Atypical responses can be responded to and explored further (Lofland and Lofland, 1984; Lincoln and Guba, 1985).

The primary sources of data in naturalistic inquiry are the words and actions of the persons being interviewed. Intensive interviewing is "...a guided conversation..." eliciting from the interviewee "...rich, detailed materials that can be used in qualitative analysis..." (Lofland & Lofland, 1984, p.12) and captures the participants' point of view. In most cases, the researcher is not only asking and listening, but also observing. Group interviews were conducted along with individual interviews. Lofland and Lofland suggest that group interviews may prove productive in situations where the topics are not of a sensitive nature. However, in the case of this study, the subject being studied was of a sensitive nature, and group interviews proved successful. The participants were agreeable to be involved in a group interview, but not as individuals. Group interviews have the advantage of allowing time for reflection, the recalling of experiences and the triggering of opinions. Differing opinions provide further discussion. Furthermore, because of the nature of group interviews where

there are times of not talking, there is time to reflect, and if necessary, to change or qualify information that has been shared (Lofland and Lofland).

The research setting

The research was carried out in the Western and North-Western suburbs of Melbourne. The West is an area that is characterised by a high migrant population, social disadvantage such as high unemployment, job losses, and lower incomes as employment has been in industries that have been affected by the recession or exploitation, such as “outworking”. A significant proportion of new arrivals and refugees reside in the Western suburbs because of their wish to live with already established ethnic communities (Robinson, 1995).

In 1991, the Western region of Melbourne had 34.6% of the population born in overseas countries. This compares with the national and Victorian rate of 22%. Migrants were predominantly from Southern European and South-East Asian countries. A language other than English (LOTE) was spoken in 36.5% of homes, again higher than the national average of 22%. The number of women from a non-English speaking country in the Western region of Melbourne was 13.8%. (Australian Bureau of Statistics Census, 1991).

The research project was welcomed and affirmed by Women’s Health West (formerly The Women’s Health Service for the West), who, in endorsing the project, especially noted the gap in the literature concerning NESB women’s experiences of the menopause (see Appendix A). Women’s Health

West was established in 1988 as a regional women's health service to address the issues identified in the report "Why Women's Health. Victorian Women Respond. 1987". The service provides information to individuals and groups, promotes activities such as workshops and self-help groups, establishes and sponsors projects, provides opportunities for worker training and targets women in the community who are the most marginalised, those with disabilities and women of NESB.

Participant Selection

Professional networks in the Western Region of Melbourne were used to make contact with facilitators of NESB women's groups. These groups are conducted at Migrant Resource Centres or Community Health Centres in the Western and North-Western suburbs. Contact with the group facilitators provided both individual and group participants. There was a snowballing effect in the recruiting of some participants, especially in the group situations where the women were reluctant to be interviewed as individuals but quite agreeable to being part of a group interview. Personal contact with a local medical officer provided further individual participants. In all, six individual and three group interviews were conducted, totalling 33 women participating in the study.

The interviews were conducted at Migrant Resource Centres, and a Community Health Centre for the group interviews, and in the participants' homes in the case of the individual interviews. An attempt was made to recruit only women who had enough command of the English language to avoid the use of interpreters. However, this was not possible and it was necessary to

use three interpreters. Where this was the case, interpreters were made available at no cost from the Community Health Centre or the Central Health Interpreting Service. Interpreters were used for the Greek women's group, the Lebanese women's group and the Chinese woman.

Profile of Participants.

Individual women interviewed were from the following countries: Vietnam, Malta, Italy, China and two individuals from the Philippines. The groups of women were from Lebanon (nine women), Greece (ten women), and Italy (eight women). For a detailed profile of the individual and group participants in the study see Appendix B.

There was a wide range in the women's ages, from the late 30's to 70 plus. Their backgrounds were a mixture of rural and city dwellers in their countries of origin. Educational levels varied from never completing primary school to secondary level with one woman having completed a University degree.

Of the 33 women involved in the study, three were peri-menopausal, the remainder being menopausal of whom five had experienced a surgical or chemotherapy induced menopause. Menopause had occurred in the women at ages ranging from 40 to 55 years.

There was a wide variation in the length of time living in Australia. It was stated to be from 18 months (in the instance of one Lebanese woman), to 40 years for some of the women in the Greek and Italian groups.

Data Collection

Data for analysis was collected over a period of six months. Purposeful sampling was carried out, to obtain credibility in the findings of this research project, not representativeness. Purposeful sampling is a strategy used to understand something about a specific case or event without the necessity to generalise in each and every case. It provides a small sample of great diversity providing information that is detailed and unique, and having some shared patterns (Lofland & Lofland, 1984).

The analysis of data was commenced whilst awaiting the completion of the interview processes. This practice is common in qualitative research. Concurrent data collection and analysis helps to inform and drive each process. It leads to further revision, modification and clarification of the research questions as concepts are revealed in the previously collected data, or in other words, a refining of the interview process (see Figure 2).

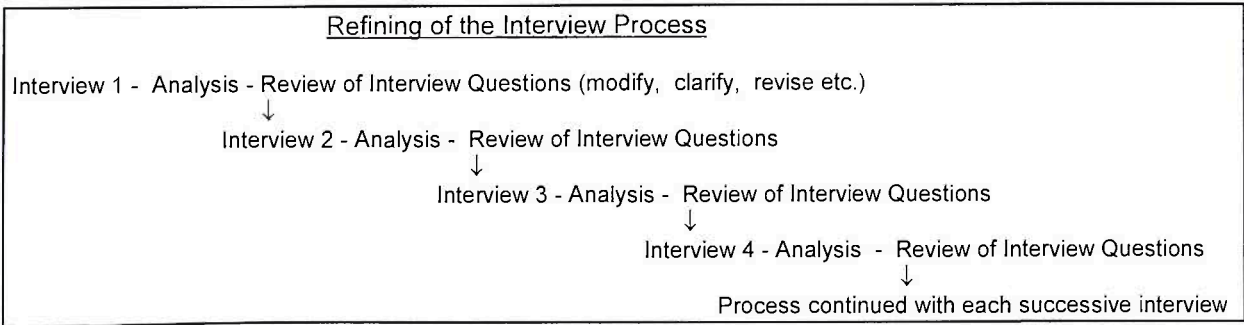


Figure 2. Refining of the Interview Process.

The participants were given a brief verbal outline of the research to be conducted and invited to ask questions relevant to the interview process. They were informed they could refuse to answer any questions, stop the interview where necessary or withdraw from the study at any time without prejudice. For those who agreed to take part in the project an informed consent form was signed (see Appendix C).

Participants in the research project were interviewed using open ended questions for a period of about 30 to 45 minutes with the interview being tape-recorded. Each person or group was interviewed on only one occasion with the exception of the group of Lebanese women. A preliminary non-recorded interview was held with the Lebanese women to explain the nature of the research and the type of questions that would be asked. This session was conducted at the suggestion of the interpreter because of the sensitive nature of the subject. The interpreter was present at this preliminary interview.

Interpreters present at the interviews did not have input into the interviews. They interpreted directly what the participant or the researcher was saying, clarifying information as required by either party.

Exploratory questions were asked, which sought to describe the situation or understand the event of menopause in the woman's life, and especially any beliefs or cultural practices and their origins which the woman carried out during her menopause (see Appendix D). Questions asked included:

- What do you understand by the term menopause?
- Would you please describe your cultural background.
- What are the values/myths/religious beliefs or practices that surround menopause in your country of origin?
- Do you carry out those practices now that you live in Australia? If not, why not?
- Was information on the menopause appropriate to your culture?
- Could you find information in your own language?

Thus questions were asked about the woman's menopausal experience, her attitude to menopause, what were her cultural beliefs and practices in relation to menopause, if living in Australia had changed her beliefs, and whether available information was culturally correct and in her own language. Notes were taken during the interviews as part of the data collection, recording details such as body language, facial expressions and any other relevant information which could enhance the data analysis. After each interview, more extensive field notes were made to summarise the interview and to record the researcher's impressions and intuitions about the interview itself and the information provided.

The transcribing of all the interview tapes was done as soon as possible after the interviews were conducted whilst the information and the interview process was still fresh in the mind of the researcher. A copy of the transcribed interview was forwarded to the participants for confirmation of accuracy of the record of interview and for the adding or clarification of further information. A

self-addressed stamped envelope was provided to the participants for return of the copy of interview and any further information provided.

Data Analysis

Inductive data analysis is the process of making sense and meaning of the information (the data) which has been gathered in the field (Lincoln & Guba, 1985). Analysis of data collected involves the processes of coding data, developing themes and finally, reporting on the findings. In this research study the following steps were undertaken to analyse the data in order to reach meaningful findings:

- immersion in the data
- noting initial impressions
- coding major themes
- categories established
- matrix of major categories
- highlighting common terminology
- collapsing of major categories
- writing of category statements
- summation of each category.

The data consisted of verbatim transcripts of six individual and three group interviews, each interview being approximately 30 to 45 minutes in duration. Further data was available from the field notes and observations recorded at the time of interviews.

- Immersion in the data

Immersion in the data as a whole enables reflection and clarification to take place and was achieved by the replaying and listening to the taped interviews on a number of occasions. It was supplemented by the reading and re-reading of the transcribed interviews. This provided a detailed intimate knowledge of the interview. It allowed reflection on the interviewee and the information which she was sharing. The concurrent use of field and observational notes helped to further focus reflection on the data at hand. With the replaying of the tapes of the group interviews, it was an occasion to further enhance the transcriptions as women talked over one another and at times made it difficult to hear clearly what was being said. The process of being immersed in the data provided the opportunity to capture the essence and the meanings of what the women were saying and the manner in which they were saying it.

- Initial impressions

Initial impressions were noted with each interview using both transcriptions and observational /field notes. For example:

Negative view of the menopausal process. Quite worried that she is unable to have intercourse as often as her husband wishes. Has told me more than she tells her Doctor! A rather depressed woman.

[Malta].

and another initial impression of an interview:

Things aren't too good at present, but she hopes that they will get better in the future. Very optimistic lady. [Italy].

- Coding of the major themes

After reflection on the data obtained, themes, concepts, revealing statements, descriptive words and passages in the transcripts were identified and marked in the margin of the pages of transcribed data. Like themes, concepts, statements and passages were marked and then clustered together. These formed a major theme which again was marked in the margin of the page.

- Categories established

Major categories were established in two ways. Firstly, by using questions which were common to each interview, such as the definition of menopause in the woman's own terminology. Secondly, by using the major themes already decided in the previous step. For example, cultural beliefs surrounding menopause in country of origin, and what women do at time of menopause in country of origin were classed as major categories by the clustering of themes and statements. Using these two criteria, a total of 12 major categories were established. There was valuable data which did not readily fit into the established categories, but was seen as important to the research outcomes, so it was given its' own category of "other", thereby making a total of 13 categories. These 13 categories formed the basis for the construction of a large matrix.

- Matrix of major categories

A large matrix of the major categories was constructed on paper. It consisted of the nine individual or group names on the Y-axis and 13 revealing questions or topics on the X-axis (see Appendix E). The categories included:

- definition of menopause.
- learnt that information from?
- cultural beliefs surrounding menopause in your country of origin?
- difficulties experienced at the time of menopause?
- attitude to taking of hormone replacement therapy? Do you use HRT?

The information relevant to the established categories for each individual or group was put in the appropriate category box either by cutting up the transcribed interviews or by writing in longhand. There was an overlapping of data as some of the information obviously fitted into more than one category. In some instances there was no data applicable to the category, in which instance that category block was left blank.

- Highlighting common terminology

On the large matrix, common terminology, words or statements in each category for each group or individual were colour coded and any obvious or significant differences were highlighted. For instance, in the category, “definition of menopause”, where the reply included the words “cessation of periods” or similar, the words were circled in a specific colour, such as red, which was allocated to that term or word right across the matrix. Using the example of the definition of menopause, it revealed that in seven of the nine

replies the words “periods stop”, “menstruation ceases”, or “no more bleeding” occurred in that category. In the remaining two replies, the “stopping of periods” was in another category, where it was subsequently circled in red. This process revealed the commonalities in each category and highlighted the differences in replies to specific questions. Furthermore, in all but three replies, the definition of menopause also contained a long list of difficulties or symptoms of menopause. The colour coding allocated to each of these symptoms was repeated in the category relating to the difficulties the women experienced at menopause. That is, the pink circle used for “hot flushes” in the definition category was repeated for “hot flushes” in the symptoms category. By examining this common terminology it emerged that the women viewed menopause as symptomatology with negative connotations, rather than as a stage of life.

- Collapsing of major categories

It became obvious there was too much data to handle successfully in the 13 categories which had originally been established. It was necessary to reduce the number of categories. Categories were deleted where there was little data indicated by a number of blank areas in the matrix for that particular category, or where information was so little that no firm conclusions could be drawn. Two or more categories were merged to form one where the data was similar. By way of illustration, “cultural beliefs surrounding menopause in country of origin” and “what women do at time of menopause in country of origin” were combined as there was a large overlapping or repetition of data and recoded under the category of “cultural background, beliefs and practices”.

This process of collapsing and recoding reduced the categories by six to finish with a total of seven categories. (See Appendix F).

- Writing of category statements.

An attempt was made to summarise what each interviewee was saying in each category. To illustrate, for “the definition of menopause or change of life”, the raw data is:

Well, I understand about, I am not feeling very well at the moment, and like, headache, blood pressure, backache, and sort of like you can't sleep, and you feel many things in your body. But I can handle it, you know. I can handle it at the moment. I wish in the future I can feel better. [Italy]

The category statement written was:

I am not well at present with a few problems, but I can handle it and hope to feel well in the future.

A summation of the raw data was carried out in the seven categories for each individual and group. This summary was written on a small card and taped on one side over the raw data. This allowed access to the raw data underneath as well as to the data summation. This summation of each data category was an attempt to compact the information further, making it easier to view as a whole, and was used as a preliminary guide for selection of themes for discussion

- Summation of each category

Using both the raw data and the summation of each answer, an overall summary was made of each category, drawing together the similarities and the differences. For example, to the theme “What advantages are there in living in Australia at this time in your life?” similar replies were:

[In] Greece...[healthcare]...not as good as in Australia. Healthcare for women is much more appropriate and much easier to get here in Australia, with Medicare. [Greek women's group, via interpreter].

Better medical care out here in Australia. [Italian group].

...the health officers here are so concerned about the health of the people. And there is this Medicare. You don't have to pay the total amount you are supposed to pay to the doctors. [Filipino 1].

and also:

...and when you are in Australia you are also really entitled to free Medicare... [Chinese].

The summation for this category was:

*Australia has good medical care, we have Medicare which means that we don't have to pay for the Doctor
Better than country of origin because cannot afford care in that country, too costly, healthcare not readily available
Rural areas are worse
No health education.*

This was the process carried out with each category, reducing the data further to now manageable dimensions. This summarised data was viewed as a whole and the issues were selected which will be discussed fully in the following chapter.

Ethical Considerations

Permission was granted from the Victoria University of Technology Human Research Ethics Committee to conduct the research in accordance with the Victoria University of Technology Code of Conduct for Research and the Code of Professional Conduct for Nurses in Australia.

There are no names or other identifying information on any of the data collected in the form of notes, tape recordings, transcripts or computer disks, so as to protect the confidentiality and anonymity of the participants. The individuals have been referred to as V, I, P 1, P 2, C and M, and the groups as G, L and IG. However, for clarity in discussing the results of this research, the participants have now been recoded according to their country of origin, that is, V is Vietnam, I is Italy, P 1 is Filipino 1 and so on.

The collected data, which includes tape recordings and computer disks, will be stored in a locked file. It will be retained intact for 5 years following the completion of this research project in accordance with the Victoria University of Technology protocols. The data may be revisited for secondary analysis in future projects.

In the three instances where interpreters were used, they were required to observe the tenets of confidentiality and anonymity with the information shared and their individual identity.

CHAPTER FOUR

DISCUSSION OF FINDINGS

This chapter discusses at length the main findings of the research, the limitations to the study and the directions for further research. Data collection provided much rich material. There were many issues which were revealed in this study but unfortunately they all cannot be examined in depth in this thesis. Full discussion was not possible on some sensitive topics especially where the issues were raised within the groups as the intention was not to embarrass the women involved. Recommendations have been made to explore these matters in further research.

The findings of the research which will be discussed in detail are:

- attitudes towards menopause
- cultural practices during the menopause and climacteric
- information on menopause, sources and sharing
- use of hormone replacement therapy
- the place of religion in menopause and the climacteric
- provision of healthcare.

These findings which will be discussed have been chosen because they were issues raised by the majority of the women in the study and provided a great depth and variation of information.

Attitudes Towards Menopause

It was obvious the women experienced a wide range of emotions and symptoms at both the time of menopause and in the climacteric. Women from Greece and Lebanon knew menopause as “the change” or “the change of life”. No matter which term was used, emotions varied from frustration, confusion, to embarrassment and disappointment. As Malta, aged 48 years said:

I don't understand why you have to go for a long time through the menopause. I used to think it would be for maybe a month or two. I was talking to my doctor and she said it can go on for ten years or so. I don't know why. I am still confused....Why do we have to feel so sick - like, every day you feel yucky! You know, sometimes you feel like you don't want to talk, or you get pains here and there and everything is wrong. Lots of times I get depressed...but I start on the hormone tablets...but what I don't understand is why I still have the periods, like normal...because...I had no problems with the periods [before menopause] and no other problems. It's just that I am going through the menopause. I don't know why. [large sigh]

and as one lady from the Italian group said:

I feel very sick because I've got aches in the bones. Sometimes I stop in bed. I can't walk for one week.

One woman, Filipino 2, described her disappointment when she discovered she was menopausal and her fertility was gone. After working for some years to establish the family in Australia and having 3 sons, she resigned from work deciding to have another baby. The opportunity had now gone. For her it became a time of loss and sadness for what was to have been, but it also became a time of acceptance of the children she had already borne and that her desire to try for a female child was no longer a reality. At the same time, she was also hoping for a miracle for her periods to return.

I was almost at the end of my 42 years old, turning 43. [with a look of disappointment on her face and shaking her head]...too early. Just slowly, I noticed that my menstruation is only up to one or two days, and really, really small, or just like spotting, and totally stopped. Well, of course I was disappointed, because I wanted a little girl,

you know. But what can I do? But I was thinking that I might have a miracle and my period come back. Because my mother was in her late fifties when she had her menopause. Because there are 14 in the family...most of my brothers and sisters have got lots of kids. You know, I am the only one in the family who had early menopause.

It is interesting to compare the responses of the women from the Mediterranean countries with their counterparts from the Asia-Pacific region when asked for a definition or their understanding of the term menopause. Mediterranean women's definition of the term menopause meant a long list of negative events, such as: hot flushes, joint pains, headaches, aching all over the body, unable to sleep at night, depression, "too many nerves", sex "dropping off" (that is sexual activity either decreasing or even ceasing), feeling many things in the body (emotions), swelling up in the stomach (weight gain), generalised weakness. It was evident the women were describing their symptoms of menopause, although as the conversations continued, the words "periods stop" were mentioned. The consensus from the group of Greek women was the menopause was a time of not feeling good and was for one woman:

a time of nerves... too much nerves, too nervous all the time, but you can get tablets for that...a time of when there was no more sex...

and for another from the same group:

you get sick, you have hot flushes...lots of sweats, too much sweating, you don't sleep at nights, it is a time of no more sex, a time when you worry too much

One Italian woman spoke of:

pains in the joints, that causes a lot of trouble when you work [in paid employment]...a lack of energy...and pain all over the body

and another as:

a time of not being well. Yes.

With the group of Lebanese women, menopause meant “changes in the body” such as:

...a big difference actually in the body....[such as] hot flushes, all the time... headaches...swelling of the abdomen [demonstrating with hands to indicate weight gain around the girth] ...when the periods stop the body changes in that the woman is not being as active as normal

The reality of menopause was totally different to the perceptions held by Malta prior to her menopause. As she explained:

Well, I used to think that your period stops and that's it. And maybe feel like to have no more sex, like you know, "sex off". But that's all. That's the only thing I think. I never used to feel things that you going to feel a lot of stuff, you know like depression and that. I never used to think about depression. But perhaps my thinking was too naive. I used to think that the period stop and I used to be happy because don't have to wait for the period every month. And I used to say, then once the period was finished you be off sex. That's the only thing. I'm stupid, aren't I?

Not only was Malta struggling with the unreality of her preconceived ideas, but also with depression, for which she was taking prescription medication, and a loss of sexual libido coupled with a husband who could not understand her lack of interest in sexual activity. Dennerstein et al. (1994) believed well-being at mid-life was related to current health status and lifestyle events rather than endocrine changes of menopause. This was true for Malta, as her health was compromised by her depression, her diabetes and recent surgery for removal of the gall bladder, and her lifestyle ruined as the family had become bankrupt in the preceding year. Malta had not adjusted to the changes in her lifestyle.

The preconceived perceptions of menopause as expressed by Malta did not align with the reality in her situation. This would be contrary to what Abraham et al. (1995) stated, a belief that preconceived ideas significantly predict the overall menopausal experience.

A number of the women who came from countries in the Asia-Pacific region had quite different ideas and attitudes to menopause and the climacteric than those from Mediterranean countries. They believed it was a natural life event occurring in all women at some time in their life and there was no point in worrying about it.

I read from the paper...that after I have reached the menopause...maybe I will get sick or I might get headache...to me, nothing happen to me in that way. I am just very normal. Because I am very normal, so is nothing that makes me look special or different, so nothing at all...I am just lucky I don't have that symptoms...

This is how the woman from mainland China, now aged 64 and menopausal at 52 years, explained her experience of menopause. It was a symptom-free time with her only concern being whether she would still be able to have sexual intercourse with her husband once she had reached the climacteric, especially if he was still sexually active.

Hot flushes and irritability in the early days after the menopause were problems which faced Filipino 1. The hot flushes eventually stopped, but occasionally she experienced periods of being quite irritable. As she said:

actually it is only the stopping of my periods. [In the timespan of] two years and two months my period it happened only three times and then I stopped altogether....it is natural for every woman to have it [menopause] sooner or later. It is only how we take it. We should be

prepared when that time comes. Anyway, our life will be a mess if you don't accept it....if it's stopped, it's stopped.

For Filipino 2, menopause was premature, but she was symptom free. Although the menopause was a surgical one at the age of 49, the Vietnamese woman too was symptom free, saying how:

I don't think I had any difficulties because I couldn't find any symptoms.

Each of the women from China, the Philippines and Vietnam believed menopause was considered a natural event in their countries of origin and did not receive much attention although there was information available. However, most of the information listed menopausal symptoms. It was stated by the Vietnamese woman how the educated person living in the city may be more aware of menopause, but not so for the women in the rural districts where:

It just happens, and they have to cope with it.

The women from the Asia -Pacific countries believed there was minimal symptom reporting, particularly in the rural areas of their countries, as women were getting on with daily living, which in some cases included hard physical work. Although there are variations in each of the women's menopausal experiences, it could be seen how the women who came from the Mediterranean regions expressed negative attitudes towards menopause. That is to say, their definition of menopause was a list of the symptoms they had or were experiencing. This negativity agrees with the views expressed by Gifford (1990) when she explored the issue of menopause with Macedonian and Greek

women. Gifford noted the menopause was seen by these women as a time of diminished health with hot flushes, headaches and nerves and an avoidance of intercourse.

The positive attitude and non reporting of symptoms as displayed by the women who came from the Asia-Pacific countries is in accord with Lock et al. (1988), McCarthy (1994), Ismael (1994), Tang (1994), Punyahorta (1996) and Chirawatkul and Manderson (1994). The attitude as displayed by Filipino 1 are akin to those of Filipino women described by Ramoso-Jalbuena (1994) who stated the discomforts of menopause are part of the normal lifecycle.

Therefore, from the information gathered at interview and with the reviewing of the literature, it could be assumed in Australia this group of menopausal NESB women have the same attitudes to menopause as do women in their country of origin.

Cultural Practices During the Menopause and Climacteric

Although some women saw menopause and the climacteric as a time of decreasing health, loss of sexual activity and possible domestic violence, for one woman from Lebanon it was a time of being "old", not in the sense of years but as "wise and respected", and from whom family members sought counsel and guidance. As she shared her situation through the interpreter:

The woman actually is considered pure once the period is gone; really pure....the older women in Lebanon play with the children, looking after the children...because she don't have the period, she was considered pure and she used to say to all the women [when she was in Lebanon] "I wish you had the same thing. It's really good for you" It's something you really look forward to. She is considered

an old woman, but not in age, but wise....the woman is considered really wise - and there is a lot of respect [interpreters' translation].

The change of status for this Lebanese menopausal woman would appear to be similar to the example described by Davis (1994) where the women in India from the Rajput class attain a higher status in life after menopause.

Similarities also exist with the example given by Punyahorta (1996) describing the elevation of the position of the woman in the household in Thailand. In this case the menopausal woman has "...the right to exert authority over certain family members..." (p. 5), for example daughters-in-law, and to be involved in activities outside of the family home.

Domestic violence was believed to have been a problem in the past, said Italian women, inferring when the women reached the menopause and were unable to conceive and have further children, the husbands found difficulty in accepting that reality.

Some men want more children and when the menopause comes, they can't have any more children and for some men that is tragic....maybe not now because of the times, but before. Lately, no, because things change. But there used to be problems. The ladies claim men start to hit them. Why? Some men, I don't know if men go through menopause too! [general laughter from the group]

Likewise, in some sections of Lebanese society, men wish their wives to be able to bear children. At the time of interview with the Lebanese group, the peri-menopausal women shared how the prospect of menopause provoked a sense of trepidation for the future, that is, "what does the future hold for me with my husband when I am menopausal and can no longer have children?" A member of the Lebanese group explained how:

[respect for the older woman depends]...*In some families, in some settings, it depends on the family. In some families, the husband would not like the idea [of respecting the older woman] because his wife is not really good, like. Responding like [sexually], and take a younger one [wife]....you can have two wives, sometimes three wives.*

These women took comfort from their religion because the Koran was quite explicit in the reasons for a man taking another wife, and the way the wives were to be all treated equally. It was a possibility it could happen to any of the peri-menopausal women in the group, although it was clearly stated this was not a generalised occurrence in Lebanon, it depended on regions, families and even within families. It was said that:

some families they don't; they marry for life; others they keep doing that. For some women it is good, for other women, not good.

The Lebanese women spoke of marital infidelity on the part of the husband during the menopause and climacteric rather than divorcing or taking another wife. It would appear therefore, the menopause and climacteric could be a time of relationship difficulties and domestic violence within the marriage for some women from certain ethnic groups. However, these beliefs of the Italian and Lebanese women should not be generalised across the whole of the ethnic population.

Menopause did not come naturally to all women. For five women it was the result of a hysterectomy, and for two women the result of chemotherapy for cancer. For those women who had a hysterectomy, it came as a blessing as they had been experiencing menorrhagia. These women described being menopausal as "a relief". Despite all the negative feelings and symptoms

experienced, the majority of women were still able to speak of being menopausal in positive terms. It was a time of no longer worrying about periods, no more fears of becoming pregnant, and of being able to spend more time with grandchildren. Some women expressed loneliness and felt disappointment as the family had grown up and no longer needed them, in other words, “the empty nest syndrome”. Being positive, they remarked the grandchildren now received their attention. Furthermore, it was viewed as a time of being able to help other people because there was more time available, or as one Italian woman from the group interview put it:

When they no work anymore or the children get bigger, the person reach menopause feel a little bit neglect or a little bit depressed and all these problems, but if they stay too much [at] home and all day work [at home] they [should be] busy for other people. Forget our problems. Do something for others.

and another followed with:

to serve others, forget about yourself and to keep occupied.

Greek women thought the climacteric was a time for family activities and being involved in other pursuits but one of these women expressed her positive feelings about menopause as a time of feeling “clean”, that is, no more menstrual blood. Filipino 1 explained when asked the benefits of being menopausal:

one thing is that you don't have to worry about washing your things [panties] when you have a period.

Thus, for a few women, being menopausal was positive because of the small things that affect everyday life. Italy, aged 54, had some difficulties but was approaching her life with a positive attitude with the comment:

...I am not feeling very well at the moment, like headache, blood pressure, back ache...you can't sleep, and you feel many things in your body. But, I can handle it you know, I can handle it at the moment. I wish in the future I can feel better ...I think life is wonderful and it should be happy, you know?...I think I can survive like this. That's what I think, that's what I believe.

Quality of life at menopause and in the climacteric seems to be an important issue for some of the women in this study. In recognising this, the women have sought other activities, more involvement with family and other people. Dickson (1994) also noted in her study that quality of life was of prime importance to the older woman. Furthermore, the attitudes of relief on reaching menopause as expressed by the women in this study correlate to those in the study by Avis and McKinlay (1991) wherein they stated women reported either relief or neutral feelings at the cessation of periods.

Information on Menopause, Sources and Sharing

The women agreed menopause, or any matter relating to reproduction, was “something secret”, a subject that was “taboo” in their countries of origin. The Greek women felt ashamed to discuss such matters as reproductive health. They were continuing the same tradition with their children just as their mothers had before them. One Greek woman told of:

asking her daughter to refrain from discussing reproductive matters with her children [woman's grandchildren] in front of her ..it was alright to do so when she was not around, but not in front of her [through interpreter]

A second Greek woman related the story of how:

her mother , when she thinks about it now, was obviously pregnant with her younger [sibling] and when she asked her mother why she was getting fat, her mother just said “oh, I just get fat, don't you worry about it”. But she noticed that when the baby came her mother wasn't fat anymore [through the interpreter].

and this woman treated matters relating to reproductive health in the same manner - with secrecy.

Reproductive health was also a “taboo subject in Malta”. As the Maltese woman described:

...Actually I used to hear people talk and I used to say what the hell they talk about this menopause thing. And I mean I was married and everything! I used to believe that not everybody gets it, goes through this menopause....I know my mum...she was from the old generation and she never talk about anything. Never ever talk to me about sex or anything like that. I'm getting married and I still don't knew nothing...it's terrible that. I was upset later on in life when I find out that my mum told me nothing...because I was very naive...because they never used to talk about our period...

Lebanese women through the interpreter explained their situation like this:

...you don't talk about it [menopause] because you don't want them [husbands] to know you are getting old...because you are frightened of him leaving....and you don't discuss things like that [reproductive health matters]. Not to the husbands.

However, one of these women has chosen to speak to her children about reproductive health as she recounted:

For girls, yes. I talk to my daughter. For boys, their father's left to do it. My son ask me, why you not fast. I tell him, he's 15 years old now. They know about these things from school. They tell them everything at school now.

Asia-Pacific women fared no better when it came to matters of reproductive health. These women described similar experiences to the women from Mediterranean countries. In China, it was explained only magazines or newspapers will discuss reproductive issues, and rarely between two people.

In Chinese society, they usually don't talk about personal subject, certainly not something like this subject [menopause], hardly discuss that.

The Filipino women interviewed shared differing ideas about reproductive health information and in particular information about menopause. As Filipino 2 summarised it:

[I learnt my information from] reading and hearsay....from women who had already experienced menopause in our country. I do not think any women think about menopause really [in my country] because they have so many children to raise up, you don't have time to think about it. Too busy doing something.

Filipino 1 lacked information on reproductive health and believed:

It is a taboo. It only came out about this sex thing when they give sex education to elementary people [that is, school]. That's all. But we are not allowed even to say anything about sex....When I was growing up, there was just one thing I wasn't clear about, that is somebody, if a boy kissed a girl, I think the girl becomes pregnant. My mother should have told me that it is not that so....No [reproductive things not spoken of in the Philippines]....it is more open here [in Australia].

For a few of the women, learning about reproductive health came at an early age, having to act as interpreters at medical consultations for older mothers who did not speak English. As an Italian woman from the group related:

I interpreted for my mother at the doctors' and that is how I learnt about it all. I was 14 when my mother had menopause. Myself [for me], the doctor said, she's going through the menopause. I went red in the face trying to tell her about it.

Another explained her situation as:

My mother got it [menopause] when I was 10....I learnt an awful lot by having to interpret for my mother, about the facts of life. Even though I didn't understand a lot of it, it was a case of, you tell me and I'll tell the doctor. She had headaches and a lot of bleeding before that. I didn't understand why. But, it saved mum explaining to us...I learnt a lot, I did a lot of reading.

Information gained at interview shows reproductive matters were not discussed openly, considered a cultural taboo, and in the case of the Italian group, learnt as a result of acting as interpreter for their mothers in consultations with health professionals. Ismael (1994) noted in Malaysia women did not speak of menopause, and Punyahorta (1994) comments Thai women gained information on menopause from friends, relatives and self-experience. Furthermore, Dickson (1994) states women in her study did not talk with their mothers or daughters about menopause, although some had memories of mothers going through the menopausal transition, and that women shared menopausal information with other women such as friends or sisters. This was certainly the example with the women in this study. For some, like the Greek women, they have not discussed the menopause or any reproductive health matters with their daughters, let alone their male children. These women stated they were too embarrassed to discuss such a personal subject. Dickson further states partners were often unaware of what was happening. Likewise with this study, women seemed to have been reluctant to share with their partners the fact that their periods had stopped and that they were now menopausal, as the following vignettes show:

My husband noticed I was not buying pads at the supermarket any more [Filipino 1].

My husband had his own problems with his health at that time, I did not want to bother him so I coped with it on my own. He eventually died [Italian group].

many husbands work long hours, or spent time in the "coffee shops" and did not contribute much to family life or in the home [Greek group, via interpreter]

I am afraid to talk too much about it, my husband may want more

children, and so he may take another wife to have kids with
[Lebanese group]

and from Italy, an exception, who spoke about her menopausal problems with her husband, daughter and female friends:

[my husband] he understand....sometimes you don't say much to your husband....I can talk with my daughter very often. I can talk with my friends - I have got very good friends. So, I think I am lucky....If I discuss with a friend I feel much better You can talk more with a woman like you [indicating interviewer] or discuss it with your daughter. They tell you the advice because they understand the culture better than me. And that's it.

A common problem experienced by the women in the research was the apparent lack of information on menopause in their own languages. One woman said it needed to be culturally correct, but she could not fully explain what she meant on further exploration. The women agreed some form of printed information would have been helpful at the time they reached menopause. Even now, it would be useful to supplement knowledge deficits. The Lebanese group of women said they had attended a day seminar on menopause, but felt their husbands had not been happy as the menfolk thought the seminar was education which could induce the women to turn from traditional family ways. One Lebanese woman believed it was a “male control thing” on the part of her partner. The comments by the women in this study on the lack of information provided by health care workers and in printed or other forms would appear in part to substantiate Abraham et al. (1995) who stated in their study of menopausal women in Australia how health professionals need to provide more information to women regarding menopause.

According to some of the women, cultural beliefs and practices did not exist in their countries of origin in relation to menopause and these included the more recent arrivals in Australia, Vietnam, Filipino 1 and 2 and China. However, Filipino 2 believed that her country, being the only Christian country in Asia, was one of many influences. These influences were thought to be a variety of religions both democratic and authoritarian in style, a Spanish influence from its early settlement by the Spaniards and more recently an American one because of its Naval bases. All of these contribute to the cultural make-up and beliefs of the people of the Philippines. Although Filipino 2 could not specifically name any cultural beliefs surrounding menopause, she thought “they might exist”. The Italian group explained some customs that they knew existed within the Italian community. They included:

when you've got your periods you're not allowed to bottle the tomato sauce. It will go off [ferment]. [when you are menopausal] you can bottle tomato sauce every day.

they believe the preserves do not keep if you have your periods

and also with the wine. It won't ferment while you've got a period. Not allowed to go near the wine vats.

The women in the group laughed at these comments, but when questioned on their practices about this information, a number of the women admitted to having followed these practices. They could not explain the rationale behind their behaviour. Their reply was “did it because....?” with a shrug of the shoulders, and no reason could be given. Obviously this information had come down through generations and had not been questioned at any stage by these women. It was considered a cultural norm to follow these practices.

Lebanese women believed at menopause the diet must contain special foods such as:

one or two eggs a day....makes you strong [strong bones]....they eat liver....drink olive oil....a cup full a week....cup of coffee [every day]....they eat honey [through interpreter].

These women carried out these practices because they believed it would make them look younger. The women had already spoken of the raising of the status of the menopausal woman. It would appear from this research study that women are not aware of cultural practices in their countries of origin, or if they are, what is the exact rationale behind the practices and beliefs that are carried out. One would have to question the place of cultural norms and values in a woman's practices and beliefs at menopause and in the climacteric.

Researchers have stated that more information is required on the cultural influences on women at menopause (Punyahorta, 1996; Dennerstein, 1996; Dickson, 1994; Gifford, 1994; Boulet et al. 1994).

Use of Hormone Replacement Therapy

All the women had heard of hormone replacement therapy, but a number saw it as a cancer causing agent, therefore definitely not to be taken. Among the remaining women there was a wide range of views concerning the taking of hormone therapy. Some believed that hormones were not necessary, or should only be taken for a short time. Others, such as a number of women in the Italian group, were taking herbal substitutes instead. It was apparent that for women who had previously or were currently taking hormone

replacement therapy, most did not have sufficient information about the medication. One Greek woman explained:

[she] was prescribed HRT by local medical officer, I did receive some information but not much. My daughter-in-law who is a pharmacist explain the benefits of HRT so I continue to take it. She says, mum it's good . Good for your body and you should take it. So I do. It is good for my bones, it keeps my bones strong. And it helps [her] skin, and it helps with hot flushes and [she] doesn't feel so nervous. [She] is not going to stop taking it [interpreters' translation].

Another, Filipino 2 had taken hormone replacement therapy for five years and then ceased.

Because, well, from reading, that the longer you stay on the pills the more complications you have....because you are taking the pills. Anything that goes into your body, I am sure there is an after effect. You just watch your diet. What you eat. How you think. How you do your everyday behaviour You don't really need pills unless you really badly need for sickness.

There was no indication to cease the hormone replacement therapy but Filipino 2 made the decision to take it for that specific length of time only. A woman from the Italian group tried it at the suggestion of a hospital medical officer, but it did not agree with her causing many problems. She explained it this way:

Increase my size, I tend to feel very heavy. I don't feel no good. Then I went to the [hospital] and saw a woman doctor and she said, "oh, you don't need them. You'd better stop this one". I was glad....I take Herbalife....but I find the Herbalife, it's helping me. But the doctor say use the [vaginal hormone] cream, the doctor he insist. I say, all right, I try. I try for a few days. Come back again. All my problems I had before. So I stop for one week and I try again. It's the same. Sorry doctor, no, I can't take any more.

China made the statement:

...more of that [hormone replacement therapy], more of that , you look younger ...I do not think it is necessary.

Vietnam had reasonable knowledge about the risks and benefits of HRT. It had been partly explained by the doctor whom she visits on a regular six monthly basis, but a considerable amount of her information was gleaned from attending information evenings on the menopause, reading books and other literature. This woman realised some of the benefits of taking hormone replacement therapy as she clearly stated:

I know about like this, that when I take the hormone, it then helps my body work as normal and hormones can help me receive or to use the calcium that I take in - that is good for my bones

but she still had one unanswered question, because:

....once I asked a Vietnamese doctor ..to explain for me how the hormone replacement help my body, and he hesitated to tell me, so I got the feeling that he avoided to tell me about the benefits of the hormone replacement may help the sexual activity, so I doubt about that - I don't know if the hormone replacement can help me to keep the sexual activity as normal

Other women believed there was no need to take HRT as they did not experience any menopausal symptoms. They were unaware of the other possible health benefits of hormone replacement therapy. Although two women, Italy and Malta, took hormone replacement therapy as prescribed by their local medical officer, they were not fully cognisant of the rationale for its usage. Malta told how:

I don't know. Sometimes I don't know if they help me or not...I was only on [drug name] before but now she [medical officer] gave them to stronger...what they really do to you, I don't know. Because they say that you have the hormone everywhere. I don't know that it is essential or not, so I don't know if they're helping much or not [Malta].

and from Italy:

...she [doctor] said take it, feel better in emotion. I am very emotional person, before maybe make a mistake for nothing but now maybe make me bit strong....my doctor said to take, I take, you got

to replace your hormones, fair enough, but not that I feel bad though, I feel alright....I don't know maybe no good, but what can I do? I can't change anymore....I feel alright, but because it's something inside, I don't know what's going on [Italy].

Obviously some of the women are aware of some of the benefits of hormone replacement therapy and are willing to take it, whilst others are firmly of the belief that it is a carcinogenic agent, or worry about the long term effects, and are therefore not interested in taking hormones. Some have tried natural therapies as an alternative with reasonable success. Others have made or added lifestyle changes such as exercise and diet and joining activities outside of home such as walking groups and ballroom dancing. The addition of dairy products to supplement the calcium intake, plus the benefits of soy products were mentioned by women in the course of their interviews as dietary measures that they had undertaken. Dickson (1994) mentions in her study that the women had mixed feelings about hormone replacement therapy, with some of the women in her study choosing to refrain from taking them, using diet and lifestyle changes instead.

The Place of Religion in Menopause and the Climacteric

Religious faith, albeit of many different kinds, was a determinant in the woman's acceptance and coping with the menopause and the climacteric. The Greek women discussed how a couple of their number had spoken to their priest about their state of health and feelings. According to the Greek women, the priest (from the Greek Orthodox Church) told them:

it is God's will that these things happen to you, you just have to bear it....[they] did not question what the priest had to say, they accepted it as God's will for them [via interpreter].

Filipino 2 explained her attitude not only to life in general but specifically menopause this way:

Probably because you are so religious, you believe, come what may, that God will always help us....It's just happy with life and thankful to God and I am happy....The main thing is you believe in God - that's number one, and number two, believe in yourself, and number three you still have your family who loves you.

She further believed religion influenced women in the Philippines, especially if they came from rural areas and belonged to a strict religious sect which restricted lifestyles of followers. Italy firmly stated:

Like, I believe that you got to have faith too sometimes. If you have faith, then whatever is to come - [like when] you die [shrug of shoulders].

As Vietnam explained, in her country of origin:

Vietnamese people are often influenced by many sorts of civilisations - like Confucianism, and Taoism and Buddhism and later Christianity, and so they accept it [these religions] and then they use it - these religions, these beliefs and because of that they can accept it [menopause]

and went on further to explain:

that if someone knows about it [these religions] someone at the hospital can help them [if] they are willing to use it [the hospital].

It was Vietnam's belief that knowing the religious philosophy of some of the religions to which Vietnamese people adhere would enable health care workers to better care for Vietnamese women within the health system. In other words, Vietnam is expressing the need for appropriate cultural care. Vietnam explained according to Confucianism, people can live a good life only in a well disciplined society. Family is part of that, and for the sake of their families, Vietnamese women are taught about self-sacrificing; to think of themselves is

selfish. Further, Buddhism states that life is suffering because of the inability to satisfy the human desires and which Vietnam believed included sexual desires, so people need to control themselves. Vietnam believes that these religions have influenced Vietnamese women's way of thinking about the menopause. Punyahorta (1996) too, believed that Buddhism affected Thai women's attitudes to menopause and the aging process which includes accepting the decline of body functions.

Lebanese women of the Muslim faith have more religious freedom after menopause. Whilst they are perimenopausal, there are restrictions on their religious practices and obligations. When a Muslim woman is bleeding she is unable to go to the Mosque to pray, to handle the Koran, to fast on Holy Days, to have any sexual relations with her husband. A ritual cleansing has to be carried out after any bleeding.

...when we have a period, we don't have sex, we don't pray, we don't fast....she is not clean....actualiy with Muslim women, especially when they have the period, they don't just wash with soap. They actually have very sacred prayers they say three times when they wash....and they don't touch the Koran, the book itself....if she doesn't say the sacred prayer three times she is not clean....the woman actually is considered pure [clean] once the period has gone [through interpreter].

Consequently, for these Lebanese Muslim women, not only is there a change in their religious observations, but she becomes elevated in status as discussed previously in this paper. One Palestinian Christian woman in the group stated how some Christian women in the Middle East are unable to attend Church whilst menstruating and consequently menopause brings changes in this groups' religious practices. For these Lebanese women, this is

the plus of menopause. Similarities exist with these Lebanese women and those in the study by Tang (1994), who speaks of religious influences in a Chinese woman's life whereby the woman is unable to burn incense to pray to gods or ancestors when she is menstruating, and the information provided by Davis (1994) about the women from the Rajput class in India who emerge from Purdah at menopause. When interviewed, China stated that she did not hold any such beliefs and inasmuch as she was aware, she did not know of any religious practices or beliefs as discussed by Tang.

Provision of Healthcare

The availability of Medicare was considered an important factor in the provision of health care to a number of women interviewed. It was stated by some individuals and groups the standard of health care in Australia was far superior to that of their home countries, and was affordable by the using of their Medicare card to access doctors and medical treatment or operations within the public hospital system. The women spoke in glowing terms of care and treatment received at large metropolitan public hospitals.

There's a [hospital] here....better medical care out here in Australia....I've been here in Australia 40 years and I've been to hospital three times for operations and I have been very satisfied [Italian group]

when you are in Australia you are also really entitled to free Medicare [China].

healthcare is much easier to get here in Australia....health is far better than our counterparts in Greece [Greek group via interpreter].

They spoke of the lack of facilities in their home countries, both in the cities and in the rural areas. Poverty in some instances in their country of origin precluded adequate health care and they contrasted this situation to Australia where income did not determine the eligibility for health care because of Medicare as was said:

if you don't have the money, you just go [to the doctors using Medicare card, Lebanese group].

In two instances, the women spoke of the political situations in their home country as being a stumbling block to adequate health care. The Vietnamese woman noted her country had been at war for many years prior to the end of the Vietnam War, and that had taken its toll on the country's infrastructure. Also, the Lebanese women believed the war in Lebanon had drained much needed funds from the Government's resources, and health was one of the services which had suffered. The women were most emphatic they considered themselves extremely fortunate to be living here in Australia; for them it was "the lucky country".

One woman summed up quite succinctly what menopause meant to her:

...life is beautiful....Menopause? I am proud to be - I am proud to tell them that I am already menopause. They say "You are menopause?" I say "Yes, I am." "You don't look [it]!" I say "No. I don't look, but I am proud I am already...7 years I am menopause. I just say, I should have to look after your diet, that is the main thing. If you have a good night's sleep, I am sure my skin will be alright, but sometimes you have a late night, and all this going out, but, if you are menopause, just accept it. Be positive, then it is more likely it is not the end of the world [Filipino 2].

It has not been possible to discuss all the issues which were raised by the women within the constraints of this thesis. However, from the analysis of

the data obtained, it could certainly be seen there are a number of similarities with the literature and there are gaps in knowledge about some aspects of menopause in women from a non-English speaking background. The negative attitudes to menopause by women from Mediterranean countries and positive attitudes by Asia-Pacific region women are certainly congruent with the literature which has been reviewed. The findings of lack of information provided by the health care system, the taboo of speaking about reproductive health matters, and attitudes to use of hormone replacement therapy have similarities in some areas to the literature. It is important to note that the findings of this research cannot be generalised for all women from a non-English speaking background because as it was so clearly pointed out in an interview:

“not all these things happen to everyone from our country, it is different between regions, between families, and even within families” [Lebanese group].

Limitations of the Study

In the process of the participant selection and data collection for this research, the following were limitations of the study:

- language,
 - lack of understanding by women’s group workers, and
 - confidentiality of the participant.
-
- Language

Although some group facilitators were willing to speak to their groups about the research, interpreters were not readily available. The cost to use

interpreters from outside agencies was prohibitive. The interpreters who were available were provided as staff members of the Community Health Centre or employed by the Resource Centre from Central Health Interpreting Service. Interpreters used did not provide input to the interviews. It was a disadvantage being unable to speak the language of one group, as they were exchanging information between one another very quickly. Even the interpreter had difficulty in “keeping up” with the exchange of information and it is acknowledged that good material was lost during that interview. At one stage the interpreter had to stop the conversations and take information on a point by point basis.

Group interviews were difficult to control as the women all wanted to talk at once. However the group interviews promoted the expression of a wide range of views and produced much rich data. It was a difficult task to be the gatekeeper for information flow. The transcribing of these tapes was made more difficult because of the women all talking at once or over one another. This caused the loss of some data as did laughing at information being given whilst the woman was still talking.

In the transcribing of the tape recordings, the accents of the women caused misunderstanding of some words which often resulted in distortion of the whole context of the discussion. Different accents also made it impossible to discern exactly what word was being used. In one case, it was not possible to recheck personally part of the transcribed tape due to the interviewee being

unavailable. The same woman did not return the copy of interview despite further requests to do so.

- Lack of understanding by women's group workers

Women's health workers were reluctant to ask the women in the groups they facilitated if any members were interested in taking part in the study. The workers showed a lack of understanding of the research process. To illustrate, it was considered by the health workers that the subject of menopause was too personal and the women in the group would not talk about it in public. In other words, the worker spoke for them. In situations where personal access was possible and an opportunity was given to describe both the research and the requirements of participants, the response from those women was positive.

- Confidentiality of the participants

The quality of information gained and possibly confidentiality was compromised during two of the interviews. The women's husbands came and sat in the room. This limited the personal searching questions in one instance because of the husbands' attitude. In the other case the husband started to interject and make comments or would answer questions until he was asked to refrain from doing so by his wife. He subsequently left the room. Both of the participants had informed their partners of their involvement in the interview process prior to the time it occurred.

Future Directions

Because Australia is a multicultural society, the health-care system needs to accommodate its population. To do so, health professionals require substantial knowledge of different cultures, openness and sensitivity towards the cultural milieu of this country, and a willingness to integrate other cultures' practices into our care system. In order to meet the apparent needs of the non-English speaking woman at the time of menopause and in the climacteric, further research and action on the part of healthcare professionals is necessary. Healthcare professionals are in a position to disseminate correct information to eliminate confusion, thereby providing the means for women to make decisions which relate to and enhance the quality of life such as the use of hormone replacement therapy, the maintaining of a healthy lifestyle and promoting positive attitudes towards menopause. In order to enable healthcare professionals to provide culturally congruent care to the health consumer, in this case the non-English speaking women at menopause, additional research is required into the following areas:

- further exploration of the cultural aspects of menopause
- the providing of information on menopause which is language specific and culturally correct.

Furthermore, the issue of the loss of libido or the ceasing of sexual activity at menopause was not fully explored at interview, as it was not the intention to embarrass the women, especially in the group setting. The decrease of sexual activity was mentioned at all interviews with the exception of two. It would appear that there is a variation in sexuality for different cultural

groups. This issue should be researched in further detail as it may be a key to some of the negative attitudes that women have concerning the menopause and the climacteric.

CHAPTER FIVE

CONCLUSION

This qualitative study, using naturalistic inquiry, and conducted using in-depth interviews, examined the experience of the menopause and the climacteric in Australia by women from a non-English speaking background. The study was carried out in the Western Region of Melbourne which is an area with a high proportion of non-English speaking population. In all, a total of 33 women contributed to the study. Individual women came from the countries of Vietnam, China, the Philippines, Malta and Italy. Three groups of women participated: from Greece, Italy and Lebanon, the latter group being a mixture of Palestinian, Muslim and Christian women.

This research has been directed towards providing information for nurses, other health professionals and for the health care system in which they work so they may give culturally congruent care to menopausal non-English speaking women. The research has shown culture is more than just a country of origin. Culture which is shaped by shared understandings and expectations, encompasses beliefs, values, ritual and religious components which are changeable and variable, both between and within ethnic groups and families. In order to answer the questions initially framed to guide the research, the areas which were explored in the study included: the NESB women's attitudes towards menopause, the use of hormone replacement therapy, the place of religion in menopause and the climacteric, sources of menopausal information

and the provision of health-care that was culturally appropriate. It further sought to explore whether the women still followed their cultural beliefs and practices or if they had relinquished those practices since living in Australia.

Whilst it is true the menopause is a universal female occurrence, this research has found the way in which women cope with menopause and the climacteric phase of life is not universal. This qualitative study suggests that negative attitudes towards menopause prevail in the non-English speaking woman, cultural taboos exist even in Australia when speaking about reproductive health, and menopause and climacteric information sources were few and not in the appropriate languages. The NESB women's attitudes to hormone replacement therapy were wide ranging, from a fear of cancer if hormone therapy was taken to not being necessary at all. For some groups of ethnic women there was a raising of their status within their society and subsequent changes in their religious practices. These were two cultural practices not relinquished by the women since their migration to Australia. It was also evident from the interviews that the issue of sexuality was of great importance to the menopausal NESB woman. With a few variations between different cultural groups, loss of libido and cessation of intercourse at menopause were considered to be the norm with some of the women, and it is postulated that this, in some way, may influence the negative attitudes that the women held towards menopause. Further research may shed some light on this issue.

Nurses and healthcare professionals need to recognize and accept that our orientation in healthcare is western dominated. Optimal healthcare encompasses the whole person and respects the individual. This should include their cultural beliefs and practices in relation to events and experiences in the person's life. Spreading knowledge about menopause will help to disipate some of the taboos which exist about menopause, and so promote a healthy attitude to this lifestage. Embracing these changes in healthcare practices will result in the provision of care that is appropriate and beneficial for the NESB menopausal woman in Australia.

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APPENDIX A

Women's Health Service for the West

60 Droop Street, Footscray, Victoria, 3011.

To whom it may concern,

Re: Research into the experience of Immigrant Non English Speaking women of the menopause and climacteric.


The Women's Health for the West (Women's Health West) welcomes the proposal by Carolyn English to undertake research into the experiences of women of NESB of the menopause.

Women's Health West works on innovative projects centred on women's health concerns, which aim to provide direct services to women, and also to effect change in mainstream health services to enable them to become more responsive to women's health needs. The Service particularly targets women of NESB, as well as low income women, and women with disabilities, as population groups who are marginalised in the mainstream.

There is a strong need for qualitative research in this area of women's health, as there is a vast gap in the literature concerning women's experience of the menopause. The value of this research is further enhanced in terms of its focus on exploration of the cultural issues surrounding the menopause and the climacteric from women of non English Speaking backgrounds, who are now living in Australia, as there is little formal recognition or knowledge of their beliefs and needs.

We urge your endorsement of this research proposal.

Yours sincerely,


Debby Smith, B.A(Hons), RN, RM, Grad Dip, Women's Health
Women's Health Worker, on behalf of Women's Health West

Tel (03) 9689 9588, Admin (03) 9689 7028, Fax (03) 9689 3861



APPENDIX B

Detailed Profile of Participants.

Nationality and relevant data on the participants in the research study:

Vietnamese, surgical menopause at aged 49, now 55 years old, from a provincial city in Vietnam and of ethnic Vietnamese origin, came to Australia in 1991. Has completed a University course since arrival in Australia.

Maltese, menopausal at 45, now aged 48, from a main town on Malta. Completed primary education only.

Italian, menopausal at 51, now aged 54, from a very small rural town in Italy. Educated to primary level.

Filipino (1), menopausal at 48 years, now 55, from a main city in the Philippines. Arrived in Australia in 1987. High school education.

Filipino (2), menopausal at 43, now aged 50, from a main city in the Philippines. Arrived in Australia in 1979. High school education.

Chinese, menopausal at 52, now aged 64, from a moderately large city in China, born of Chinese parents in Indonesia and went to China at age 16 years for her education. (It was the custom in those days to return to China for education.) Arrived in Australia in 1991. University education as a teacher.

Lebanese group of 9 women, some menopausal (6), remainder peri-menopausal (3). 2 of the women were Palestinian, 7 were Muslim, 2 were Christians. Ages ranged from 38 to 80 and they had been in Australia for periods ranging from 18 months to "many years". They were from a mixture of rural towns and larger cities. Education levels ranged from "never completed primary school" to high school education in the younger women.

Greek women's group of 10 women, aged from 60 to 70 plus. They had arrived in Australia between the years of 1957 to 1970. One woman came from a major city, the remainder were from small rural towns. All were menopausal at ages ranging from 40 (2, one of which was a surgical menopause) to 55 years. The majority of the women only completed primary schooling.

Italian group of 8 women, ages ranging from 42 to 60 plus. 3 women had a surgical menopause, 1 was for uterine cancer, 1 other woman was menopausal as a result of chemotherapy for stomach cancer. Another woman was already menopausal when she was treated for breast cancer. These women from various regions in Italy classified themselves as "middle-class" in Australia. Education levels were a mixture of primary and secondary schooling.

APPENDIX C

The purpose of this research is to examine the cultural beliefs and values regarding the menopause and climacteric of women from Non-English speaking backgrounds (NESB) who now reside in Australia.

The interview conducted will last approximately one hour. Where necessary, a follow-up interview may be conducted.

During the interview, questions will be asked regarding your cultural beliefs and values surrounding the menopause and how you have coped with this time in your life.

There will be no direct benefits to you in participating in this research project, but it may lead to more culturally appropriate health care for NESB menopausal women.

CONSENT FORM

I,.....consent to be interviewed, and that interview to be tape-recorded by CAROLYN ENGLISH who is a Master of Health Science student at the Victoria University of Technology. I have had the nature of the research being undertaken explained to me by Carolyn English. I understand that any information I give will be in confidence and that I will not be identified by name in any written material coming from this interview.

I also understand that should I wish to clarify or obtain further information regarding the interview I may contact Carolyn English at.....(home address).....or by telephone at.....(phone number).

I further understand that I may withdraw my consent and terminate my participation from this study at any time without any penalty attached.

Participant.....

Researcher.....

Date.....

APPENDIX D

Outline of Prompt Questions for Interview

- 1 What do you understand by the term menopause/change of life?

 Where did you gather this information from?
- 2 Would you say that you have reached Menopause, and if so, what age were you?
- 3 Would you explain your cultural background.

 What are its values/myths/beliefs/practices regarding menopause?
 Religious significance, any increase of status of the woman?
- 4 Can you tell me the sort of difficulties that you encountered at the menopause?

 How did you resolve these issues, or didn't you?
- 5 In light of what you have explained regarding your difficulties, do you believe that your cultural beliefs had any bearing on those difficulties or the way in which you "tackled" the menopause?
 If that is the case, please explain.
- 6 Where did you seek help/advice for your difficulties/problems? Use of cultural women's groups or organisations in your area? Do you know if they exist?

 If no help, why not? Is that culturally linked?
- 7 Did you have any contact with a Local Medical Officer during the menopause? Was the care culturally appropriate and did you get answers to your questions?

 What amount of time was afforded you if you used the services of LMO?
- 8 Describe the level of support you had from your partner and family at the time of menopause.
- 9 So you gathered your information on menopause from.....(Where did you get information on the menopause?)

 Do you feel you had enough information at the time of menopause?

10 If the information gathered was different to your cultural beliefs, what did you do?

Did you accept it, or seek culturally appropriate information?

11 If you did not have enough information, what more would you have preferred?

Do you have any suggestions in view of your cultural beliefs?

Do you feel that culturally appropriate information by members of health professional teams would be good for women of your nationality?

12 Do you believe that there is a change of thinking within your culture in relation to the menopause of women from your country who now live in Australia?

13 Do you believe that you have changed your cultural beliefs regarding menopause now that you live in Australia?

What do you believe has caused that change in attitude?

Do you have any regrets in that change of attitude?

APPENDIX E

13 revealing questions or categories on the X-axis of the matrix.

Definition of the menopause.

Learnt that information from?

Cultural background.

Cultural beliefs surrounding menopause in your country of origin.

What women do at time of menopause in country of origin?

Difficulties experienced at the time of menopause.

Country of origin compared with Australia - any differences for you?

Family support at menopause.

Information required or what would have been of benefit including language.

Attitude to taking of HRT. Do you use HRT?

Health maintenance.

Any advantages living in Australia at this time in your life?

Other information.

APPENDIX F

7 questions or topics on the X-axis of the matrix after reduction and recoding of the categories:

Definition of the menopause.

Learnt that information from?

Cultural background, beliefs and practices.

Difficulties experienced at the time of menopause.

Attitude to taking of HRT. Do you use HRT?

Any advantages living in Australia at this time in your life?

Other information.