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DOI: https://doi.org/10.3399/BJGP.2022.0569

To access the most recent version of this article, please click the DOI URL in the line above.

Received 15 November 2022
Revised 18 January 2023
Accepted 20 January 2023

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When citing this article please include the DOI provided above.
Primary care practitioners’ experiences of peri/menopause help-seeking among ethnic minority women.

Jennifer MacLellan*, RGN, MA, MSc, RM, PhD, Qualitative Researcher, Nuffield Department of Primary Care Health Sciences, University of Oxford. ORCID ID: 0000-0002-6872-5011

Sharon Dixon, Ma(hons) Cantab, MBBS, MSc, MRCGP, General Practitioner and NIHR Doctoral Research Fellow, Nuffield Department of Primary Care Health Sciences, University of Oxford. ORCID ID: 0000-0002-7469-6093

Sultana Bi, MSc ANP, BSc, RGN, NP, Advanced Nurse Practitioner, The Lister Surgery, Westbourne Green Community Health Centre, Bradford.

Francine Toye, PhD, MA (hons) Cantab, Qualitative Research Lead, Physiotherapy Research Unit, Oxford University Hospitals NHS Foundation Trust. ORCID ID: 0000-0002-8144-6519

Abigail McNiven, PhD, MA (hons) Dunelm, BA (hons) Dunelm, Senior Qualitative Researcher, Nuffield Department of Primary Care Health Sciences, University of Oxford. ORCID ID: 0000-0001-5041-2095

*corresponding author
Abstract

Background: Each woman’s experience of the peri/menopause is individual and unique. Research shows ethnic minority women often have different experiences from their white peers, and these are not being considered in conversations about the menopause. Ethnic minority women already face barriers to help-seeking in primary care, and clinicians have expressed challenges in cross cultural communication including the risk that ethnic minority women’s peri/menopause health needs are not being met.

Aim: To explore primary care practitioners’ experiences of peri/menopause help-seeking among ethnic minority women.

Design and setting: Qualitative study design in the primary care setting of England, with PPI consultations.

Methods: We sampled 46 primary care practitioners across 35 practices in England. Using an exploratory approach, we conducted online/telephone interviews and analysed the data thematically. We presented our findings to three groups of ethnic minority women, to inform our interpretation of the data.

Results: Practitioners described lack of awareness of peri/menopause among many ethnic minority women which they felt impacted their help-seeking and communication of their symptoms. Cultural expressions of embodied experiences could offer challenges to practitioners to ‘join the dots’ and interpret experiences through a holistic menopause care lens. Our groups of ethnic minority women illustrated the practitioner findings with examples from their own experiences.

Conclusion: There is a need for increased awareness and trustworthy information resources to help ethnic minority women prepare for the menopause, and clinicians to recognise their experiences and offer support. This could improve women’s immediate quality of life and potentially reduce future disease risk.

Key words: Primary health care, perimenopause, menopause, ethnic minority, communication.

How this fits in:

- Ethnic minority women may have different experiences of the peri/menopause from their white peers.
- Ethnic minority women may face language, inhibition and health literacy barriers to primary care.
• There is a need for increased awareness and trustworthy information resources to help ethnic minority women prepare for the menopause and advocate for their health.
• Resources, training and quality interpreter support are needed to help clinicians recognise ethnic minority women’s experiences and offer support, improving quality of life and potentially reducing future disease risk.

Background

The menopause is a natural stage in a woman’s life, and each woman’s experience is individual and unique. Research from the USA shows that different ethnic groups may have different experiences from their white peers, such as entering the peri/menopause at earlier ages\textsuperscript{1}, having longer transition periods\textsuperscript{2}, and emphasising different symptom experiences\textsuperscript{3,4,5}. Acculturation and the stresses of poverty and structural racism appear to play a complex role in menopausal symptomatology, with recommendations to clinicians that ethnicity should be taken into account when interpreting symptom presentation\textsuperscript{6,7,8,9}. Despite evidence of high menopausal symptom burden among ethnic minority women in studies from outside the UK, evidence of help seeking and HRT treatment are less common when compared with white women\textsuperscript{10}. In the UK, ethnic minority groups are over represented in the 20\% most deprived areas\textsuperscript{11,12}. Inequalities in HRT prescribing in the UK may reflect an unmet need in menopause care for women living in deprived areas, and requires further investigation\textsuperscript{13}.

In the UK, research evidence exploring ethnic minority women’s experiences of the menopause is limited\textsuperscript{14} and largely confined to journalism, charities, and advocacy blogs from women in the ethnic minority community\textsuperscript{15,16,17}. These narratives stress how the specific and nuanced aspects of ethnic minority women’s experiences are not being considered in the conversations about menopause\textsuperscript{18,19}. In the UK, the majority of patients with peri/menopausal symptomatology will present and be managed in primary care, ideally placed for its accessibility and holistic approach\textsuperscript{20}. Literature shows that ethnic minority women face numerous barriers to help-seeking in primary care that include language, inhibition, and constraints in health literacy\textsuperscript{21,22}. Studies exploring the professional perspective focus on the challenges of cross cultural communication\textsuperscript{23}. In light of this, we aimed to explore primary care practitioner’s experiences of ethnic minority women’s help seeking for support with peri/menopause symptoms. We then reflected on our findings with ethnic minority women to better contextualise our understanding. We present their responses alongside, and sometimes in juxtaposition, to that of the healthcare providers.

Method

This study was part of a larger qualitative project exploring primary care practitioners’ experiences of supporting women’s health in primary care. As the research question was broad, we took an exploratory approach. Between March-September 2022, we targeted our sampling to primary care
practitioners in England working in areas of deprivation where health inequalities, multi-morbidity and GP retention challenges are keenly felt. Participants answered an invitation, accompanied by an information sheet and consent form, through the Clinical Research Network.

The original topic guide was developed by (AM, FT, SD) in response to a perceived gap in the women’s health strategy evidence base. The guide was piloted with two practitioners and used to create a broad structure for the interview, with flexibility for the participant to develop and expand on the topics/issues of particular importance or relevance to their context of practice. Data were collected through single episode, one-to-one interviews with fully informed consent recorded, conducted virtually online or by telephone by experienced qualitative researchers (JM, SD). Audio recordings were transcribed verbatim, checked against the original recording, and loaded into the data analysis software, NVivo 12.

We analysed the data thematically as data collection progressed. The primary researcher (JM) initially coded the transcripts, discussing the coding frame and results in regular analysis meetings with the wider research team (SD, SB, FT, AM). Not all participants had experience of consulting with ethnic minority women. However, the specific practice challenges relating to peri/menopause symptom help seeking and healthcare access among ethnic minority women began to emerge strongly from the data through the constant comparison of codes and new data. We purposively sampled practices serving highly diverse populations to clarify, check and confirm our findings. Analysis progressed to focused coding and development of core categories by JM before interpretation into themes in discussion with the full research team. Sampling continued until data saturation was agreed by the full team to have been reached.

Consulting with ethnic minority women with lived experience of the menopause

We presented our findings to three groups: one group identifying as West African women and two groups of South Asian ethnic minority women (one from an Urdu speaking community and one from a Bengali community) to hear their experiences and inform our interpretation of the data. We engaged with these women through a university ‘Diversity in research’ group and two community based organisations offering a range of health and wellbeing support to the local community. We held three meetings lasting between 1.5 - 2.5 hours, with 14 participants in total who had experience of peri/menopausal symptoms. One was conducted online in English (two women), and two were in-person with interpreter support (12 women). The in-person groups included five women who communicated only in their own language with interpreter support, three who spoke a mix of English and their own language, with four communicating primarily in English. All participants spoke the community language and participated fully in the lively discussions. Interpretation did not disrupt the flow of the discussion but was conducted discreetly for the researcher to keep up with the conversation and ask clarifying questions. Participants were reimbursed for their time. In this paper,
we present their perspectives alongside the clinician experience, weaving together research participant and women’s voices, with recognition that good healthcare must take into account both sets of experiences and address both sets of needs.

Results

We interviewed 46 primary care practitioners across 5 regions of England from 35 practices. The deprivation index and ethnic diversity of the practice postcode offer an illustration of the population context (Figure 1&2). Participant characteristics are recorded in Table 1. Interviews lasted from 19 to 60 minutes, with an average of 32 minutes. The analysis constructed three themes: knowing the problem, communicating the problem, and joining the dots (a holistic interpretation of presentation). Participants spoke candidly during the interviews with deep respect for patients and colleagues, often identifying challenges as system constraints.

Knowing the problem

The practitioners we spoke to describe a significant increase in the overall numbers of women attending consultations looking for support for symptoms of peri/menopause in recent years, largely credited to recent campaigns on mass media. However, this surge was not perceived to be equally reflected among ethnic minority groups in the population:

I see white women with menopause. There’s so many other ethnicities in [North England city] that we don’t see as much of, and I’m sure they’re suffering the same symptoms. (PC08, Clinical Pharmacist)

Cultural sensitivity surrounding the discussion of reproductive health and its embodied experience, within families and the community, was suggested as a factor limiting women’s attribution of their symptoms to the hormonal changes in their body. Consequently, practitioners reported that while ethnic minority women often had an awareness of the menopause as the end of a woman’s periods, associated symptoms surrounding the transition to and beyond this life stage were less well understood.

I say “Oh, do you get sweats and things?” and they’ll say, “Oh yes, I do get them,” and I’ll say, “Oh, do you think you might be going through the menopause?” But they’re like, “Oh, but I’m still having periods.” The idea that there might be a perimenopause and actually that this is a transition, I don’t think is something that [all] people really particularly [understand]. (PC14, General Practitioner)

Participants said that many consultations about the menopause involved educating women across
population groups about potential symptom presentation, as a prerequisite for treatment or self-care options available to them. While there has been a welcome increase in the availability of English language resources, a particular constraint mentioned by practitioners was the lack of educational resources in the different languages spoken by their practice populations, and accessible routes of delivery.

We should be producing leaflets about the menopause in Urdu, Punjabi, all these different languages so that women can access that. (PC20, General Practitioner)

One of my friends, she’s a doctor in a different region where there’s a very large Asian population, and she did this radio show where she would talk about different health concerns [...] tailored to the population, and she spent quite a lot of time talking about women’s health and periods, menopause, sexual health, contraception, and she said there’s really good engagement. (PC21, General Practitioner)

Participants felt that the provision of accurate information for women was extremely important to ensure understanding of the symptoms they were experiencing and their relation to the changing hormones in their body. Not knowing that symptoms may be related to peri/menopause and that treatment or self-care choices were available to help alleviate symptoms was seen as a barrier to help-seeking for some women.

**Reflections from our Lived Experience group:**

We shared these findings with 14 ethnic minority women with lived experience of peri/menopause, and asked for their reflections on how this resonated with their perspectives. Our group described the menopause as ‘when your periods stop’. The majority of the group described how women in their community would feel embarrassed to talk about symptoms, that the menopause is a natural phase of a woman’s life and they must ‘just get on with it’, or ‘if you can manage it, then don’t speak about it’. One participant mentioned how some women do not want to accept they are getting older and no longer able to have children.

When asked how awareness of peri/menopause could be addressed in the community, the Bengali women specifically advocated for visual messaging through links to video clips from the GP or health messaging on the local TV channel. Accessing a written resource from the healthcare professional, or independently at the GP surgery that they could take home and read or ask their family to read, was requested from all groups, alongside opportunities to share experiences and talk with experts in the menopause (face to face or in online communities). While visual representation in health messaging was not considered important among the South Asian women we spoke to, it was for the Black
African women. These women described how if they did not understand the symptoms or see people like them in health messaging with these symptoms, they describe it as a concern for ‘white people’ and normalise/manage the symptoms they are experiencing. The younger women in both South Asian women groups, who were confident in English, advocated for an accessible checklist of symptoms that women could read and take with them to the doctor to ask if their symptoms could be the menopause, giving them confidence to discuss their embodied experiences with the professional.

**Communicating the problem**

Communication of bodily experiences was felt to be constrained by incongruence between the language used by healthcare professionals and women. Primary care practitioners felt a lack of awareness of the potential whole body symptom experiences surrounding the peri/menopause could impact how women describe what they are feeling. For example, a bilingual participant, who often consults in the first language of the woman attending, described how:

[Ethnic minority women may] explain things in different ways to somebody who’s grown up being western, who’ll say, “I’ve got hot flushes, […] I think I’m going through ‘the change’”’; they might not understand that’s what ‘the change’ can cause. Sometimes they’ll say things like, “There’s heat coming from my tummy,”… or, “The pain goes up to my head.” […] Their symptoms just don’t always make sense, medical sense, to us [healthcare professionals]. (PC16, Advanced Nurse Practitioner)

Awareness of symptoms of the peri/menopause and health literacy may act as a barrier to the communication of symptoms. This can be compounded by a lack of clinician awareness of the potentially different presentations of peri/menopausal symptoms in different ethnic minority groups.

Certainly in my patients who are maybe first or second generation Bangladeshi or Indian or Pakistani, menopause will often present as pain, […] it’s all, “Oh, I’m aching, I’m aching,”... so it’s a very different presentation. (PC27, General Practitioner)

A lot of them [ethnic minority women] do present with things like aches and pains, and low mood, and a lot of it gets attributed to physical ailments and it’s quite common. A lot of them start complaining in early 30s and I think, by the time they hit the menopause age, it probably does get missed that it’s actually menopause rather than something musculoskeletal. (PC40, General Practitioner)

If the practitioner felt unable – through communication or time constraints – to unpick these
presentations, there was a risk that women would receive sub-optimal care.

A good menopause consult cannot be done in 10 minutes. I mean you struggle to do it properly in 20 minutes, but you're lucky if you get 20 minutes (PC45, General Practitioner)

Participants felt that at this stage in the help-seeking journey, if the woman is unable to advocate for herself, the knowledge and time available of the clinician significantly impacts on what is achievable within the consultation, and ultimately on patients’ perception of the quality of care experienced.

**Reflections from our Lived Experience group:**
Hot flushes were common across the group, with one woman describing waking in the night soaked in sweat. This had been going on for 12 years but she ‘doesn’t know what to ask for’. Other common symptoms were vulval itching, fatigue, joint pains, forgetfulness, low mood, irritability, anxiety, insomnia, bloating and dyspepsia, and headaches. Heavy bleeding and anaemia before their periods stopped were common across the groups.

Most of the women had consulted the GP about one or more of these symptoms at various times but felt no one had suggested that they might be linked to the menopause. Some of the women described being told it was normal for their age and to manage it. Others described being given medicine for depression, blood pressure (dizziness and palpitations), and thrush. Many women in the South Asian women’s group were living with diabetes and were told their vulval itching, unresolved by anti-fungal pessaries, was due to their diabetes, highlighting the challenges for them (and clinicians) of unpicking symptoms in the context of multiple health concerns and possibilities. None of these women had discussed the other symptoms they were experiencing, such as hot flushes, low libido or low mood, or had been offered an examination. All the women who attended a GP with symptoms described feeling they were not listened to, and felt they had to attend multiple times. This reduced their trust in the clinician and the health system.

Many of the women described feeling embarrassed to talk about their symptoms, as they did not realise other women may also share these experiences. When asked which was most sensitive to talk about – periods or mental distress around menopause – the resounding answer was mental distress. Mental distress was described as being denied within the family and wider community, making it difficult for women to seek help. There was a prevailing attitude across the groups of ‘getting on with it’, trying to keep busy or seeking comfort in their faith.

**Joining the dots: Taking a holistic approach to care**
When practitioners were able to hear and interpret the woman’s experience and propose their origin as
the peri/menopause, they found this communication of knowledge was well received.

Some of the women that I've spoken to about [...] the menopause, I think they found it a real revelation, it's not that there's something wrong with them. That it's a natural part of life and of aging. (PC21, General Practitioner)

However, participants felt it takes time, often over more than one consultation, alongside knowledge of different peri/menopause presentations by the practitioner to assess the woman holistically in light of her symptoms and age profile.

I think previously women’s symptoms were dismissed as depression, or anxiety, or it’s just a cultural thing, it’s stress, it’s lots of other things, but they are coming forward, they are complaining of hot flushes and sleeplessness and anxiety symptoms, which we say to them, “Oh, it’s age-relevant, we’ve got to look at your age, this could be causing your symptoms,” and rather than treating each symptom, you’ve got to treat the root cause, and they are coming forward. (PC16, Advanced Nurse Practitioner)

Despite the availability of training for practitioners in primary care, participants felt women’s health, including the peri/menopause, rests largely with female practitioners by default as they are seen by patients to offer a more holistic approach.

My male colleagues say, “We don’t feel we have the vocabulary or confidence to ask some of the questions when thinking about menopause whereas female doctors naturally do”. (PC33, General Practitioner)

My two male colleagues haven't done any British Menopause Society updates so they're not the right people to see, they can do the very basic[s], but if something needs a more layered approach, they haven't got the-, it’s not their area of interest or skill. (PC27, General Practitioner)

Female practitioners we spoke with expressed concern that if no female practitioners are available for ethnic minority women to consult with, this could further impact their care.

**Reflections from our Lived Experience group:**

There was a general feeling of distrust towards medical care among the groups, despite complementing primary healthcare staff on being ‘very good’. Eight of the women said they had not felt listened to when speaking with a male clinician, even if he spoke Urdu (the Bengali women of the
group were also fluent in Urdu), but access to a female clinician could be challenging. Three women specifically mentioned no-one explaining the symptoms they may experience following hysterectomy. Consequently, they described not understanding when they experienced changes in their skin and hair, hot flushes and extreme irritability that caused discord within their family. They struggled and ‘just got on with it’.

**Discussion**

**Summary**

Literature shows that ethnic minority women may present with symptoms of menopause that are different, or described differently, to their white peers. Our study has shown a communication gap in the consultation, rising from lack of awareness of peri/menopausal symptomatology in some ethnic minority women which does not allow them to advocate for their health, compounded by a lack of knowledge or confidence in some primary care clinicians to interpret and connect symptom presentation with a holistic menopause care lens.

**Strengths and limitations**

Our study uniquely explores the communication and knowledge constraints of primary care practitioners’ in meeting the peri/menopause needs of ethnic minority women in parallel to the nuanced experience, presentation and understanding of symptomatology among a small group of ethnic minority women. The principal limitation of our study is the restricted range of our public consultation (14 participants from three communities). We were able to activate existing links with two South Asian community groups and the University’s ‘Diversity in Research’ public involvement group, but were unsuccessful in making new connections with community based organisations supporting other ethnic minority women. While our public consultation is not reflective of the diversity of women living in the UK, it has given a small selection of women an opportunity to voice their experience and interpretation of our research findings. The dominance of female practitioners in our interview sample (40 versus 5 male practitioners) may have impacted the nuanced sensitivity of our data to ethnic minority women’s experiences, and this is a complex area for further research. However this purposive sampling approach is a strength of the methodology to achieve data saturation.

**Comparison with existing literature**

The complexity and interdependence of women’s health experiences place primary care as ideally suited to support women seeking help for the peri/menopause exactly because of its holistic, integrated, multi-morbid expertise, and universal accessibility. However, despite a rise in peri/menopause training among primary care clinicians, there is still a knowledge and confidence gap
in practice. A lack of training in medical schools and reliance on self-directed education once in general practice is unsustainable in a service struggling to meet patient demand. Furthermore, guidelines, training and structural support for cross cultural communication consultations exist but their implementation is ad hoc. Experience of complex and inflexible service arrangements, inconsistent language support, and varying levels of health literacy among the population presenting to primary care amplify the challenges facing women’s experience of healthcare.

**Implications for research/practice**

Training priorities in the pressured services of primary care polarise expertise in practice, reinforcing the gendered distribution of consultations and further deskilling of practitioners. Presentation of peri-menopause symptoms across the population should be incorporated into core and update primary care training as recommended by the APPG on menopause. Both clinicians and our Lived Experience group of women requested educational resources in non-European languages. This would help bridge the gap by supporting the awareness raising of peri-menopause experiences in ethnic minority communities, to inform help seeking and communication of embodied experiences of the peri-menopause, and as a prerequisite for decision-making about treatment options and self-care.

Given the complex nature of connecting menopausal symptoms and the inter-relationship with other chronic conditions, the availability of accurate and trusted interpreter support during the consultation is necessary for this complexity to be explored safely and thoroughly in a conversation between the woman and practitioner.

The higher risks experienced by ethnic minority women, when compared to their white counterparts, of cardiovascular disease, osteoporosis and diabetes, increase as a consequence of the hormonal changes of the menopause. If the communication and knowledge gap surrounding ethnic minority women’s experiences of the menopause can be bridged comprehensively, there is also scope to improve women’s immediate quality of life and potentially reduce future disease risk.

**Funding:** This study is funded by the National Institute of Health and Care Research (NIHR) Policy Research Programme (NIHR202450). The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

**Ethical approval:** This study has received ethical approval from the Health Research Authority (ref 22/HRA/0985).

**Competing interests:** The authors have no competing interests to declare.

**Acknowledgements:** We would like to acknowledge the contributions of our Public Involvement participants and express our thanks for the insights they shared with the research team.
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Table 1: Participant characteristics
Figure 1: Population Diversity of GP Practice Postcode

(If greater than 86% of the population is white = Low Diversity
If less than 86% of the population is white = High Diversity)
Figure 2: Multiple Deprivation Index of practice postcode