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## 'They should come forward with the information': menopause-related health literacy and health care experiences among Vietnamese-born women in Melbourne, Australia

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### ABSTRACT

**Objectives:** Health literacy refers to an individual's capacity to access, understand, evaluate and use health information to make well informed health-related decision to maintain and promote optimal health. Low health literacy is linked with worse health outcomes and is more common in people from socio-economically disadvantaged backgrounds and from culturally and linguistically diverse backgrounds and among people with limited education. Peri-menopausal and postmenopausal health behaviour predicts health in later life. This qualitative study was conducted in Melbourne, Australia. The aim of this study was to explore menopause-related health literacy and experiences with menopause-related health care among Vietnamese-born women who had immigrated to Australia as adults.

**Design:** A qualitative study using semi-structured interviews was conducted with women aged between 45 and 60 years and who were either in the peri or postmenopausal phase. Transcripts were analysed thematically.

**Results:** A total of 12 women were interviewed. Participants viewed menopause as a natural event and obtained most of their menopause-related information from family and friends. Limited English language proficiency affected their capacity to access, understand, evaluate and use menopause-related health information. They identified their Vietnamese speaking General Practitioners (GPs) as a reliable source of health information, but 'shyness' prevented them from asking questions about menopause and they suggested that GPs need to initiate menopause-related health conversations.

**Conclusion:** Low menopause-related health literacy among Vietnamese-born immigrant women may limit their opportunities to access information about and benefit from menopause-related health-promoting behaviours. Access to menopause-related health information in relevant community languages is essential to support immigrant women to make well informed menopause-related health decisions.

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Immigrant; menopause; healthy aging; health literacy; health care; health promotion

## Introduction

The concept of health literacy has evolved and is now defined as the ability to access, understand, evaluate and use health information to make appropriate decisions regarding health behaviour and health care (Sørensen et al. 2012). The Integrated Model of Health Literacy proposed by Sørensen et al. (2012) situates this definition at the core and adds descriptions of factors that affect health literacy as well as pathways linking health literacy to health outcomes.

Low health literacy is associated with worse health outcomes and is more prevalent among people from socioeconomically disadvantaged backgrounds, migrants from non-English speaking backgrounds and those who have limited education (Australian Commission on Safety and Quality in Health Care 2014; Berkman et al. 2011). People with low health literacy are less likely to participate in health screening, more likely to use emergency care and are at greater risk of hospitalisation (Berkman et al. 2011).

A systematic review of health literacy-related research among migrants living in the European Union found 21 investigations. These explored health literacy in eight general contexts including, chronic disease management; disease prevention; health promotion and communication; maternal care; assessment and measurement of health literacy; ethnic inequalities; migrant health and rights; and culturally competent care. Most found that limited language proficiency, low levels of formal education, and low socio-economic status were associated with low health literacy and that this influenced health behaviour, self-management of disease, and lead to worse health outcomes (Ward, Kristiansen, and Sorensen 2019).

In Australia, population-level health literacy was assessed in 2006 using the Adult Literacy and Life Skills Survey (ALLS) which was part of an international study coordinated by Statistics Canada and the Organisation for Economic Co-operation and Development (OECD) to assess adult literacy and numeracy. The survey was supported by the Australian Government and the Australian Bureau of Statistics. The ALLS was a household survey where one person per dwelling was invited to complete the survey. 11,139 dwellings were included in the survey of which 8,988 individuals completed the survey. It found that 57% of the adult population had inadequate health literacy skills; both men and women had a similar level of health literacy; but older adults had lower levels of health literacy. The authors suggested that lower levels of health literacy among older cohorts may be due to lower levels of education rather than a decline in health literacy over time. Health literacy among migrants from non-English speaking background was below that of the general population where only 26% of people born in a non-English speaking country recorded adequate health literacy skills to enable well-informed health-related decisions (Australian Bureau of Statistics 2008).

Australia is a multicultural society where more than a quarter (26%) of the population was born somewhere else in the world (Australian Bureau of Statistics 2016b). It has a two-tiered health care system. The Australian Government funds and administers Medicare which is the national public health insurance scheme. It comprises three components including visits to medical practitioners, subsidised pharmaceutical benefits scheme and treatment in public hospitals. In addition, publicly funded health screening programmes are delivered by state, territory and local governments. Individuals may also choose to

purchase private health insurance which offers additional services including treatment in privately owned hospitals, dental care and allied health services.

The reasons for migration vary and are often determined by economic and political drivers (United Nations Migration Agency 2018). The International Organisation of Migration defines ‘migrant’ a person who moves to another country to improve their economic and social position and improve the prospect for themselves and their families. For people who migrate for economic reasons, migration may be an empowering experience that improves their living situation. However, for those who are forced to migrate due to political unrest, migration is often characterised by social and economic disadvantage (United Nations 2016). Migrant women are particularly vulnerable, because they may have had limited choices in the decision to migrate as they often migrate under ‘family reunification’ programmes (Sarkissian 2014; United Nations Population Fund 2006). They are likely to be employed in lowly paid jobs; may have had limited educational opportunities in their country of origin; (United Nations Population Fund 2006) and have difficulties accessing culturally and linguistically relevant health resources and health care in their new country of residence (Higginbottom et al. 2015; Small et al. 2014).

Vietnam is the fifth most common country of birth among Australians born overseas (Victorian Multicultural Commission 2016). After the Socialist Republic of Vietnam was declared in 1976, many Vietnamese fled their country and by 1981 nearly 50,000 Vietnamese-born refugees had settled in Australia. A family reunification programme followed and by 2016 nearly 200,000 Vietnamese-born people were living in Australia (Australian Bureau of Statistics 2016a). In the state of Victoria, over 80,000 people were born in Vietnam of whom nearly 21,000 were women aged 45 years or older (Victorian Multicultural Commission 2016).

Every woman who reaches midlife will experience menopause. Menopause refers to the final menstrual cycle and is only known in retrospect 12 months after the event. The term ‘menopausal transition’ can be used synonymously with the term ‘peri-menopause’. It describes the stage in a woman’s reproductive life before menopause when menstrual cycles increasingly become irregular and the last normal menstrual period occurred within the previous 3–12 months. The postmenopause refers to the period 12 months after the final menstrual cycle (Utian 2004).

The menopausal transition which occurs between the ages of 45 and 55 years (Palacios et al. 2010) can be accompanied by a number of physical symptoms, most notably hot flushes and night sweats. Some women also experience psychological symptoms including mood changes (Freeman and Sherif 2007). Reporting of greater frequency and severity of menopausal symptoms has been associated with increased health care seeking (Avis, Crawford, and McKinlay 1997; Guthrie et al. 2003). In addition, health behaviour during and after the menopausal transition influence health in later life (Guthrie et al. 2004). After menopause, there is an increased risk of chronic non-communicable diseases (Davis et al. 2012; Roush 2011). Healthy lifestyles such as regular exercise and a balanced diet during the menopausal transition and beyond are crucial for a healthy postmenopausal life (Guthrie et al. 2004; Roush 2011). In order to make well informed health-related decisions during the menopausal transition and in the postmenopausal period women need to have robust health literacy skills.

A recent review of research investigating perceptions of menopause-related health, health behaviour and health care among migrant women found 19 peer-reviewed studies, most investigating experiences of menopause-related symptoms. Four studies Hunter

et al. (2009) Im and Meleis (2000), Komesaroff et al. (2002), and Remennick (2008) included questions exploring experiences with menopause-specific health care and three studies Im, Meleis, and Lee (1999), Komesaroff et al. (2002) and Liu and Eden (2008) included questions investigating self-management strategies. These studies suggest that migrant women report more vasomotor and physical symptoms and poorer mental health than women from the host country. The authors of the review concluded that more research is needed to better understand how migrant women manage their menopausal transition and how to provide culturally relevant menopause-specific health care (Stanzel, Hammarberg & Fisher 2018).

Little is known about how migrant women access, understand, evaluate and use menopause-related health resources and the barriers and enablers for adequate menopause-related health literacy. The aim of this study was to explore how Vietnamese-born women who migrated to Australia in adulthood manage the menopausal transition and their postmenopausal health; how they access, understand, evaluate and use menopause-related health resources; and their experiences with menopause-related health care.

## Methods

### *Study design*

Qualitative methods are used to gain a deep and fine-grained understanding of individual perceptions and experiences about which little is known (Hammarberg, Kirkman, and de Lacey 2016). In this study, data were collected using semi-structured interviews (Green and Thorogood 2009). In semi-structured interviews, an outline of topics to be covered is used as a guide but the participant's responses lead the course of the conversation. Semi-structured interviews allow interviewees the opportunity to comment on and express their lived experiences on all the topic to be explored (Galletta and Cross 2013).

### *Participants and recruitment*

Women were eligible to participate if they were: born in Vietnam, aged between 45 and 60 years, and peri- or postmenopausal.

Flyers in English and Vietnamese explaining the purpose of the study, eligibility criteria and the contact details of K.S. and T.N., a Vietnamese-born bilingual researcher, were distributed at food markets, community groups, and community and learning centres in areas with a high proportion of residents who were migrants from Vietnam. Women who wished to participate in the study were asked to telephone K.S. or T.N.

### *Conceptual model*

The Integrated Model of Health Literacy proposed by Sørensen and colleagues (2012) acknowledges that health literacy is a process requiring four types of competencies; accessing, understanding, evaluating and using health-related information. Access refers to the skill to search, find and obtain information. The next competency is understanding and refers to the ability to comprehend the obtained information. The capacity to evaluate the information means that the individual is able to interpret and judge the information

in relation to the trustworthiness of its source and content. The final step of the health literacy process is described as the ability to communicate and use the information that was acquired (Sørensen et al. 2012). The capacity to proficiently perform each competency enables individuals to make well informed health-related decisions.

### ***Data collection and procedure***

An interview guide was developed based on the published literature (Stanzel et al. 2018), the researchers' clinical and research experience in women's health, the research questions and the Integrated Model of Health Literacy (Sørensen et al. 2012). The interview guide covered three topics related to the research questions.

First, participants were invited to describe their menopausal experience, including self-management strategies and experiences with menopause-related health care.

Second, health literacy skills were gauged using Sorensen's Integrated Model of Health Literacy (Sørensen et al. 2012). Participants were asked if and where they searched for menopause-related information; whether they were able to find what they were looking for; whether the information was understandable and answered their question; how participants evaluated the trustworthiness of the source of the information; and whether the information was relevant and easy to use. Finally, the sociodemographic information including age, marital status, year of migration, level of education, and occupation was gathered at the end of the interview.

The interviews were conducted by K.S. in English at a place that was convenient for participants. Interviews were audio-recorded with permission. T.N. acted as interpreter in interviews with women who had insufficient English language proficiency to be interviewed in English. These were also audio-recorded with permission. To protect anonymity participants could either choose a pseudonym or a pseudonym name was chosen for them.

Approval to conduct the study was provided by the University's Human Research Ethics Committee (ethics approval certificate number 8128).

### ***Data management and analysis***

Audio-recorded interviews conducted in English were transcribed verbatim. For interviews conducted in Vietnamese and interpreted into English, the interpretation was transcribed verbatim. Excerpts of transcripts of interviews conducted with the assistance of the bilingual researcher were checked for accuracy by a second bilingual researcher. The transcripts were entered into Nvivo 11 for analyses. Data were analysed thematically as described by Braun and Clark (Braun and Clarke 2006). This method involves: becoming familiar with the data through transcription; repeatedly reading the transcripts; assigning initial codes inherent to the topics in the interview guide; grouping codes into original themes introduced by participants; refining the themes; and selecting quotes that illustrate the themes. The initial analysis was conducted by K.S. Findings and interpretation was discussed with the research team until consensus was reached. The findings are presented with illustrative quotes.

## **Results**

Twelve women agreed to be interviewed. Five participants volunteered after reading the study flyer, the rest were recruited through snowballing. Of the 12 interviews, eight

were conducted with the assistance of the bilingual researcher T.N. All interviews were conducted face-to-face; ten in the participant's home and two in an interview room at the University. The socio-demographic characteristics of the participants are shown in Tables 1 and 2 and demonstrate the diversity of the sample.

Four themes emerged from the data.

### ***Menopausal experiences – it's natural, it's normal***

All participants described menopause and their menopausal experience as a natural transition and any symptoms they had were either minimised or simply accepted as part of this phase of life. Many respondents mentioned not understanding what the concerns were and why anyone would actually talk much about menopause.

I feel like we don't need to do anything, and just accept it and its normal ... I didn't worry [about menopause] just because I talked to other friends who used to experience it. And they told me already about it, that's why I think, that's normal. (Hien)

In fact, most participants who experienced emotional symptoms that they attributed to menopause laughed about how they affected them.

I feel uneasy and very easy to get angry with someone. If they talk to me [laughs heartily, and then laughingly says] leave me alone, don't talk to me too much. (Tara)

The underlying belief that menopause is part of a natural transition in life is further reflected in the self-care strategies participants employed. Exercise, dietary changes, and traditional herbs were mainly used to manage any symptoms and menopausal and post-menopausal health.

**Table 1.** Socio-demographic characteristics.

	Women (n = 12)
Age group	
45–49	3
50–54	2
55–60	7
Menopausal status	
Perimenopausal	3
Postmenopausal	9
Average age at menopause	48
Marital status	
Never married	1
Married	6
Widowed	1
Divorced/separated	4
Level of completed education	
Primary School	7
High School	2
Tertiary/university	3
Employment	
Employed (casual only)	3
Home duties	9
Years in Australia	
1–10	3
11–20	2
21–30	5
>30	2

**Table 2.** Individual participant characteristics ( $N = 12$ ).

Pseudo-nym	Menopause status	Year of migration	Interview with interpreter	Level of education	Paid employment
Thi	Peri-menopausal	1998	Yes	Year 7	No
Tara	Post-menopausal	1995	No	Year 12	No
Hanh	Post-menopausal	1998	No	Bachelor in pharmacy (Vietnam)	Yes-casual
Hien	Post-menopausal	2015	Yes	Bachelor in Finance (Vietnam)	No
Linh	Post-menopausal	2014	Yes	Year 12	No
Tien	Post-menopausal	2014	Yes	Completed primary school	No
Hanna	Post-menopausal	1991	No	Bachelor in Literature (Vietnam) Cert IV in Aged Care (Australia)	Yes – casual
Lani	Post-menopausal	1980	No	Some Primary School	No
Mingh	Post-menopausal	1999	Yes	Year 9	Yes – casual
Hung	Post-menopausal	1987	Yes	Year 6	No
Xuan	Peri-menopausal	1988	Yes	Year 9	No
Quy	Peri-menopausal	1995	Yes	Year 10	No

Sometimes I just go out for exercise [and] I just drink tea, some herb tea. That's what I learned and I apply [laughs]. (Hanna)

... because now I take a vitamin, ... and I eat a lot of fruit and veggie. Vitamin C, vitamin D, because they [doctor] said that with my age I have to do more D to support my bones. (Tara)

The perception of menopause as normal and transient was reinforced by advice and recommendations given by the Vietnamese-speaking general practitioners (GPs) participants had consulted, most of whom did not offer any medical intervention.

One day I asked my female doctor and she, she said to me that's normal, every woman has to go through the time. Some woman got difficulty [time], some woman get easy [time]. (Hanna)

On the occasions where GPs prescribed medications, participants were reluctant to take them. This applied equally to medication for menopause-related symptoms and other medications such as analgesia and sleeping tablets. Their reluctance was based on fears of unwanted side effects and the belief that the medication was not necessary.

I go to see the doctor. And the doctor went after checking and she said that everything functioned well. So she ask about my age and she think that I may have menopause and she prescribed some medication for me, [but] I didn't take it, I didn't care for it ... (Linh)

I went to the family doctor and he tell me about like is difficult to sleep and he give me some medication. When I take the medication, I sleep so well. But I think if I take the medication I, it will reduce my memory it makes the symptoms more severe. That's why I didn't use it. (Tien)

### ***Influence of culture on the experiences of menopause***

Participants were asked about how they thought their culture of origin affected their experience of menopause. They did not elaborate whether there are any cultural differences in perceptions of menopause between Australia and Vietnam because they were unaware of how people born in Australia view menopause. However, participants' reflections indicated that their experience of menopause was influenced by both Vietnamese and Australian culture.

Most participants reported that their personal experiences are similar to their contemporaries in Vietnam; they seek support from friends and family and mainly use traditional therapies to manage any bothersome menopausal symptoms.

When I used to work in Vietnam, I had some colleagues, some were younger and some were older than me. Some of them they experienced menopause and they talked to me about the experience and now like I expected what will happen and that's why I find it easy to overcome, that I don't have any shock ... [A] few years ago I had a friend who is younger than me and she got menopause some symptoms, and I can advise her and ... [I said] it is common don't worry about it. (Hien)

In Vietnam the people use Chinese herbal, Vietnamese herbal to treat the menopause. (Hanh)

Participants reflected that there are few health services and little health information for women in Vietnam and no menopause-related health care and health information. This was perceived partially due to a lack of government policies and health care funding.

I don't know if now they have changed, but I think that they not um concentrate on the ... people's health. They don't talk about menopause, yeah, ... they don't think that this is important with them the woman's um you, you have to take care of yourself. (Tara)

Hanh, reflected on how the lack of health promotion programmes in Vietnam influences people's health behaviour. She believed that this is the reason why people born in Vietnam do not engage in health promotion and only seek medical care for illnesses.

Like most of [Vietnamese] people just feel pain, feel something wrong with the body [and then] go to GP straight away. [They] no worry about the future or worry about information about that sickness or something ... (Hanh)

All participants had embraced the Australian health care system, and many attended cervical and breast-screening programmes which are offered free of charge to women in Australia. Some sought information from their GPs about menopause-related symptoms.

I will follow the recommendation and guidelines in Australia, the medical um Western approach. I hope that I can, when the symptoms are more severe I will go the family doctor and ask her advice how to improve it. (Quy)

### ***Barriers for menopause-related health literacy***

When asked about when, why and how participants sought information about menopause it was apparent most used the experiences of their peers or female relatives as their main source of information.

I didn't search for any information just talking to friend and they share some experience. (Tien)

Few searched for menopause-related health information from other sources. Those who did accessed it from a Vietnamese language website or the local library. Both sources had perceived limitations. The internet only offered general health information and the menopause-related books in the library were in English and participants reported that their ability to understand and apply the knowledge was limited.

I am ... not very well in English that's why I checked reading about information. When this one I understand and I apply for me. And this one I don't understand so I leave it. (Hanna)

In addition to the apparent difficulties in accessing and understanding information, participants showed limited ability to evaluate the health-related information they had accessed. Information was judged based on whether it suited the individual's life philosophy as demonstrated by Tara

[You] have to read the book to know is it a good book or not. So I think that people who recommend to me but I still believe in the... [looking for word] um, my thinking, my reading and my trusting.

Appraising health information offered on the internet poses particular challenges for individuals with low health literacy as it is difficult to filter, judge and evaluate the quality of the information and the trustworthiness of its source.

Participants who had accessed information from Vietnamese language websites and from YouTube were asked how they knew that these sources were trustworthy. The websites were judged as reliable because participants believed that they were hosted by the Vietnamese government. Although the information gathered from YouTube had been published by lay people, some participants had implemented the recommendations. They were aware that it was difficult to determine the reliability of this source. But because the recommendation they had followed related to eating specific foods, they believed that this could not be dangerous and therefore judged it as safe as indicted by Tien:

Like it's just food. It's not harmful it's ... you can try.

When asked whether the information was easy to use and relevant to participants' values Tara commented:

If something [is] useful I write it down and follow it if I can. And if not, if I could not follow it maybe just a little bit follow [laughs].

A follow-up question to ascertain what additional sources of information participants accessed revealed that most identified their GP as a trustworthy and reliable source of information and consulted her or him when they experienced health concerns which they believed were menopause-related.

### ***Barriers and enablers for optimal menopause-related health care***

Although participants' perception that menopause-related health care is not a priority in Vietnam and most had learned about menopause from female family members or friends, they had taken up the opportunities for health screening offered by the Australian health care system. Some had also consulted their Vietnamese-speaking GP about menstrual changes and others had used consultations for non-menopause-related health problems to ask about menopause.

I go to the family doctor not for the menopause purpose, I just wanted to have a screening test ... the Pap test. And then I asked the family doctor, I only have worries about whether if we have menopause after 50 years old is good for your health. And she said is okay if you are 48, the normal range. That is why she only answer the question, and she didn't give any further information. (Minh)

Participants expressed regret that GPs did not discuss the implications of menopause for their health. They reported that in Vietnam doctors have a high standing in the

community and they were therefore ‘shy’ about asking their GPs menopause-related questions. To allow Vietnamese-born women to be educated about midlife health and menopause participants suggested that GPs need to initiate conversations about menopause.

I think the, the doctor have to welcome, has to ask, invite question. They [women] silent, in you know in my culture. We respect, high respect doctor. Maybe they [doctors] decide to ask her [patient] about that [menopause]. But they [women] say okay, okay, they just say yeah, yeah, they not show, show emotion, they keep inside. Like me, they [do] not ask important questions with [the] doctor, or they don’t want to answer any questions. And they [women] shy and [that’s the] reason why women that were born in Vietnam are unlikely to come out and straight up [say or ask] what they need and what they want and what worries them. That’s the point, I think the main point. (Hanna)

She [the doctor] didn’t give any further information. I would hope to receive the advice from the doctor, she explains further about the symptoms, the problems, the health problems as well, not only menopause and um, give advice what to do but actually like according to our Asian culture. [But] we are more likely to be shy and the doctor just don’t say. So the doctor should come forward with the information and not wait for the person to ask. (Minh)

Participants described their preference to consult with female health care practitioners and the difficulties in finding a female Vietnamese-speaking GP.

No, I will not trust a male doctor because I prefer a female doctor to check over my general health. (Xuan)

He is a man and off course he is Vietnamese so he can understand what I said. But he is a man so it’s difficult for me to share some woman’s problems. So I am looking for a female doctor who can speak Vietnamese, but it’s hard. (Linh)

Many participants described their GPs as time poor and rushed and some even felt that they were only interested in writing a prescription and were not inviting questions.

The GPs are not much help because they have less time for any patient. They just have about 5 or 10 minutes for one patient and so that’s not enough time for us to ask anything. They just check, uh ... how do you feel and she writes a prescription. (Tara)

Finally, language competency was the most commonly identified barrier for access to health care. Eight of the 12 participants were unable to converse in English and the remaining four recognised the limitations in their English proficiency and as a result chose Vietnamese-speaking GPs.

I think all Vietnamese, especially Vietnamese no speak English, because we go, normally, we go to the Vietnamese doctor. And she check with us, [in] my language. (Hanna)

One participant recounted her experience of having a mammogram. Because she was able to follow the simple mammogram procedural instructions the health practitioner assumed that she also understood the more complex follow-up instructions. However, this was not the case and she felt inadequately informed about what she was expected to do next. The language barrier theme was recurring and anecdotes highlighted how it hampered access to optimal care.

When I went to the hospital and my children took me there. She [daughter] just helped me with the administration information and with the officer there. And when I go inside [clinical room] they just stay outside and I work with the doctor. Luckily it’s a female doctor, and um

because she said to me you can take of your coat and I understand it. And she said that like just sit, sit close to the machine or she just helped me to do this. So I think she [health care practitioner] maybe [think] she don't need interpretation because of that. But the limitation is, I just can have a medical check-up of my body but when I want to ask information, I don't understand English, so yeah that's the problem. (Linh)

## Discussion

The findings of this study are that women born in Vietnam who had migrated to Australia perceive menopause as a natural phase of life that does not require specific health care; rarely seek menopause-related health care or health information and want GPs to opportunistically initiate discussion of menopause and provide menopause-related health information when they consult them. Women who had sought menopause-related health information found little information available in Vietnamese and described lack of English language proficiency as the greatest barrier to accessing, understanding, evaluating and using health-related information. Taken together, the findings of this study suggest that important opportunities for women to learn about health behaviours associated with healthy ageing are missed.

Adequate health literacy is linked with optimal health outcomes (Berkman et al. 2011; Kreps and Sparks 2008). Sørensen and colleagues' (2012) model of health literacy has mostly been examined in quantitative surveys using questions with fixed response options. Pleasant, McKinney, and Rikard (2011) identified gaps in health literacy research, including the lack of comprehensive health literacy measures. They suggested that in order to gain a thorough understanding of people's health literacy, investigations need to explore how people access information; and what the barriers and enablers are to understand, evaluate and use health information to make well-informed decisions. This study addressed this gap by using qualitative methods to generate in-depth understanding of experiences and perceptions about which little is known (Hammarberg, Kirkman, and de Lacey 2016; Malterud, Siersma, and Guassora 2016).

Furthermore, Aldoory (2017) identified a lack of community-based health literacy research. She argues that health literacy research outside of the health care setting is needed to explore health behaviours in order to prevent and reduce chronic conditions and diseases. This study addressed this gap by recruiting participants in community setting and conducting the research outside the health care context. Further strengths of the study include that participants were diverse in terms of menopausal status, age, length of time in Australia, marital status and educational status; and that volunteers who did not speak English were enabled to participate with the assistance of a bilingual, bicultural co-researcher. Cross-cultural and cross-lingual research pose unique challenges (Jones and Boyle 2011). As qualitative interviews rely on participants' verbal accounts, some pivotal information may be lost in interpretation, particularly if the interpreter is unfamiliar with the cultural context of the study (Jones and Boyle 2011). To minimise this risk the research team included a Vietnamese-born researcher who is fluent in Vietnamese and English and familiar with Vietnamese culture.

Access refers to the ability to 'seek and find' health-related information. Our data suggest that culture influences access to menopause-related health information. In high resource countries, health care providers are accepted as primary sources of health advice. If women discuss menopause-related issues with their female peers it is mostly done after

consulting a health care provider and in order to process the information (Guthrie et al. 2003; McCloskey 2012). This contrasts with Vietnamese-born women living in Australia, who primarily seek advice about menopause-related symptoms from older female relatives and friends and only occasionally use health care providers, the internet and printed material as sources of information. This may in part be explained by cultural practices in the country of origin where the initial source of health information is family and friends. Bennett Kimbrough (2007) made similar findings when she reported that migrants from East Asia, Africa, South and Middle Americas living in the US believed that health and illness were private matters and therefore the initial source of health information was trusted family members and peers. Our data indicate that participants had limited knowledge about how and where to access information. The inability to access information leaves individuals vulnerable as it increases the likelihood of learning through informal sources which may provide incorrect and potentially harmful information.

Findings from the semi-structured interviews suggest that limited English language proficiency and lack of accessible information in the Vietnamese language are significant barriers for Vietnamese-born women's ability to understand and evaluate menopause-related information. Sørensen et al. (2012) define 'understanding' as the capacity to comprehend health-related information and 'evaluation' as the processing and judging of information. The 'understanding' and 'evaluation' component of health literacy have been described as the ability to derive meaning from words and numbers in the medical context (Peerson and Saunders 2009). Killian and Coletti (2017) argue that health professionals' vernacular act as a barrier for patients to understand and evaluate health-related information. To promote better health information communication, health literacy recommendations have been established to guide health care organisations and health care providers in improving the health literacy environments. The recommendations include implementing policies and systems at an organisational level; integrating health literacy into education of both consumers and health care professionals; and ensuring effective communication by providing directions for the development, review and improvement of written information (Australian Commission on Safety and Quality in Health Care 2017). Despite this, studies conducted in the United States and Australia on the readability of health-related information indicate that the content of most health information websites (Charbonneau 2012; Cheng and Dunn 2015) and printed material exceed the reading level of the average person (Charbonneau 2013). In addition, the inability to communicate proficiently in the dominant language adds a further barrier. Investigations exploring migrant women's experiences with health care services reported that lack of health information in community languages and limited access to interpreter services have been cited as significant challenges for accessing health care, and understanding and evaluating health-related information (Higginbottom et al. 2015; Mengesha, Dune, and Perz 2016; Morris et al. 2009; Tsai and Lee 2016). Understanding of health and illness is influenced by culture (Andrews and Boyle 2008; Shaw et al. 2009). Kreps and Sparks (2008) suggest that cultural beliefs and values inform perceptions about health and illness including causes and treatment of diseases. They argued that this may account for the low participation rate in health screening programmes among migrants. In addition, cross-cultural studies investigating experiences of menopause indicate that negative attitudes towards menopause are linked to reporting negative experiences. However, in cultures where menopause symbolises wisdom and maturity, menopause is

experienced as a positive natural life transition (Flint 1975; Stewart 2003). The Vietnamese-born women in this study perceived menopause as a natural life phase, and consequently rarely consulted their GPs about menopause-related physiological changes. Those who accessed menopause-related information independently or consulted their GPs about menopause-related matters followed these recommendations only if they aligned with their culturally influenced health beliefs. As a result, Vietnamese-born women may miss out on the benefits from menopause-related health information relevant to healthy aging.

Individuals' health literacy is facilitated by a health care system that understands and acts upon the interrelated factors influencing health literacy. In their systematic review of experiences among migrant and refugee women in accessing sexual and reproductive health care in Australia, Mengesha and colleagues (2016) found that difficulties navigating the health care system, including lack of multilingual resources, were significant barriers in accessing care and information. These findings are consistent with our data where Vietnamese-born women were unable to access menopause-related health information in their language. To overcome these language barriers participants consulted Vietnamese-speaking GPs which was possible due to a large number of Vietnamese-speaking GPs in their local community. However, when participants attended screening programmes for the general population it became apparent that participants were missing out on information and the opportunity to ask questions about procedure, results and follow up.

### **Implications for policy, practice and research**

Improving access to health information and other resources in the relevant community language is required to improve migrant women's knowledge about peri-menopausal and postmenopausal health. Furthermore, resources should be developed in consultation with relevant stakeholders from the community, provided in a variety of mediums including written, visual and audio resources and promoted through public awareness campaigns in multicultural settings.

Routine health care consultations with primary health care providers offer the opportunity to actively screen and discuss health behaviours and make recommendations to foster optimal health outcomes in later life. Research identifying barriers and enablers for primary health care practitioners to initiate discussions about health behaviour at the time of menopause and after to meet the menopause-related health information and care needs of migrant women is essential to inform health care policies and practice.

### **Conclusion**

This investigation has examined how migrant women born in Vietnam manage the menopausal transition and their postmenopausal health, their menopause-related health literacy skills and their perceptions and experiences with menopause-related health care. Our findings suggest that Vietnamese-born women perceive menopause as a natural phase of life, and therefore rarely seek information or consult authoritative sources about the health implications of menopause. As a result, they may miss out on health-promoting opportunities that enable well informed health-related decision during the peri-menopausal and postmenopausal phase and ensure optimal health outcomes in later life.

## Disclosure statement

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