

'Not everybody is an internet person': Barriers for menopause-related health literacy among immigrant women from the Horn of Africa nations

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Funding information

Australian Government Research Training Program Scholarship; Finkel Professorial Fellowship; Finkel Foundation

Handling Editor: Sarah Ireland

Abstract

Issue addressed: Changes in health require new learning. There are increased risks of chronic noncommunicable diseases after menopause and positive health behaviour during the peri-menopausal years and beyond are crucial for a healthy postmenopausal life. In order to implement health promotion messages, women require adequate health literacy skills in order to achieve better health and access to appropriate health care.

Methods: This qualitative study explored menopause-related health literacy and experiences of menopause-related health care using semi-structured interviews with women from the Horn of Africa nations who had migrated to Melbourne, Australia.

Results: Participants viewed menopause as a normal life phase and did not see the need for accessing menopause-related information and care. Limited education, low literacy and being unfamiliar with the internet were barriers to health literacy. Participants' preferred health care providers who could converse in their first language, but regretted their lack of proactive engagement in providing menopause-related information.

Conclusion: Primary health care providers need to be aware that immigrant women from the Horn of Africa nations have poor health literacy and may be unaware of the benefits of positive health behaviours during and after menopause. Offering menopause-related health promotion opportunistically may lead to better postmenopausal health for this group of women.

So what? Health promotion and education programs codesigned with community stakeholders may be effective in engaging immigrant communities to improve menopause-related health literacy.

KEYWORDS

health behaviour, health literacy, health promotion, immigrant women, menopause, midlife

1 | INTRODUCTION

Menopause is a transitional life phase and most commonly occurs between 45 and 55 years of age.¹ After menopause the risk of noncommunicable diseases such as cardiovascular disease² and

osteoporosis³ increases. Ageing, changes in hormone levels and poor health behaviours contribute to this. Risk can be mitigated through health promoting behaviours. Hence, health behaviours around the time of menopause influence healthy ageing.⁴

In order to understand health promotion messages and apply health behaviours that promote optimal health in later life,

individuals need to have adequate health literacy skills. Sorensen and colleagues⁵ conceptualised the Integrated Model of Health Literacy. It consists of different components and determinants, and describes the pathways linking health literacy to health outcomes. The model defines health literacy as the capacity to access, understand, evaluate and use health information and services, which is needed to make well-informed health-related decisions. This capacity is at the core of the model and it is influenced by antecedents including situational determinants (eg individuals' use of media, physical environment, social support, and family and peer influences); personal determinants (eg age, race, gender, socio-economic status, education, occupation, employment, income and literacy) and societal and environmental determinants (eg demographic situation, culture, language, political forces and societal systems).

Inadequate health literacy has been linked to low participation in health screening and health promotion programs, increased use of emergency care and increased risk of hospitalisation.⁶ To improve health behaviours related to chronic diseases, health literacy interventions in primary care have been implemented. Taggart and colleagues⁷ completed a systematic review of 52 studies investigating interventions to improve health literacy relating to behavioural risk factors for chronic diseases. They found that both group and individual level interventions improved health literacy and health behaviours including smoking cessation, better diet and increased physical activity.

Furthermore, health literacy research shows that inadequate health literacy is more prevalent among people with limited education, from socio-economic disadvantaged backgrounds, and among immigrants from non-English speaking background.^{8,9} Yet, there are limited investigations evaluating interventions to improve health literacy among these vulnerable groups including migrant populations.¹⁰

Australia is a pluralist society. The 2016 Australian Census of Population and Housing data showed that 26% of the population was born in countries outside of Australia.¹¹

Migration is most commonly initiated for economic and political reasons. For those who migrate to improve their economic position, migration can be an empowering experience.¹² However, for those who are forced to migrate due to armed conflict, natural disasters or persecution in their country of origin, it is driven predominantly by needs for safety and survival.¹³

The recent history of the Horn of African nations (Eritrea, Ethiopia, Somalia, South Sudan and Sudan) is marked by war, civil unrest and environmental crises. The war between Eritrea and Ethiopia; between Sudan and Somalia; and recurring droughts and famine in this region have resulted in millions of people being internally and externally displaced.¹⁴⁻¹⁶ Many live in refugee camps in neighbouring countries for years before being resettled in countries such as Australia under the Refugee and Humanitarian visa program.¹⁷ Women are particularly vulnerable in situations of forced migration.¹⁸ In 1989, the Australian Government recognised the unique gender-based risks for women who were unaccompanied by a male relative, and introduced the 'Women at

Risk' program which prioritises unaccompanied refugee women for resettlement.¹⁷

In the Horn of Africa nations life expectancy for women currently ranges from 58.3 years in South Sudan to 67.8 years in Ethiopia.¹⁹ There are no reliable data on life expectancy of women who were born in the Horn of Africa nations and migrated to Australia. Some studies report improved health status in migrants who migrated from low- and middle-income countries to high-income countries. This is thought to be the result of having better access to health care and health promotion and screening programs which are uncommon in lower income countries where health care systems largely focus on cure and interventions rather than prevention for noncommunicable diseases.²⁰⁻²³

Little is known about menopause-related health literacy among immigrant women, including how they access, understand, evaluate and apply menopause-related information and care.²⁴ The aims of this study were to describe how women who were born in the Horn of Africa nations and migrated to Australia in adulthood experience and manage their menopausal transition; how personal, situational, societal and environmental factors influence their health literacy skills; and explore their experiences and satisfaction with menopause-related health care.

2 | METHODS

2.1 | Study design

Qualitative research methods provide fine-grained knowledge about individual experiences. This study used semi-structured interviews to gain deep understanding of menopause-related experiences of women in midlife.

2.2 | Setting

The study was conducted in Melbourne, Australia where 28.4% of residents were born overseas.¹¹ The 2016 Australian Census of Population and Housing reported that nearly 21 000 people living in Victoria were born in Horn of Africa nations and had arrived in Australia either under the Refugee and Humanitarian or the Family Stream Migration program since the 1990s.²⁵

2.3 | Participants and recruitment

Women aged between 45 and 60 years, who were born in one of the Horn of Africa nations, migrated as adults and were peri- or postmenopausal were eligible to participate. Flyers providing information about the purpose of the study, eligibility criteria for participation and contact details of the researcher were distributed widely to community health services, community learning centres and community groups in areas with high proportions of residents who had migrated from the Horn of Africa nations. Community leaders were

contacted to secure their support for the study and permission to attend community meeting places.

2.4 | Data collection and management

An interview guide was developed based on the published literature,²⁴ the investigators' clinical and research experience in women's health, and study aims. Three broad topics guided the interviews: participants' experiences and management of menopause; their capacity to access, understand, evaluate and use menopause-related information; and their experiences of menopause-related health care.

Once eligibility had been established interviews were scheduled and conducted at locations convenient to participants. An accredited interpreter assisted in interviews with women who had insufficient English language proficiency to be interviewed in English. Written informed consent was obtained before the interview. Interviews were audio-recorded with permission. The audio-recorded interviews were transcribed and entered into NVivo for data analysis. In interviews that were conducted with the assistance of an interpreter, only the English interpretation was transcribed. To protect anonymity participants were given a pseudonym.

2.5 | Data analysis

Data were analysed using thematic analysis as described by Clark and Braun.²⁶ This method involves six phases: familiarisation with the data by transcribing and repeated reading of the transcripts; development of initial codes based on the topics of the interview guide; grouping of codes into preliminary themes; refining of the preliminary themes into final themes; and generating a report. The initial analysis was conducted by KS Findings and interpretation of the data was discussed with the research team until consensus was reached.

2.6 | Ethics approval

The study was approved by Monash University Human Research Ethics Committee (MUHREC 8128).

3 | RESULTS

Eleven women agreed to be interviewed. All interviews were conducted face to face either in the participants' homes or in a private room at a community centre. Four interviews were conducted with the assistance of a qualified interpreter. The socio-demographic characteristics of the participants are shown in Tables 1 and 2.

Participants were diverse in terms of age, menopausal status, country of origin and level of education. Most participants had

TABLE 1 Participants' socio-demographic characteristics

	Women (n = 11)
Country of birth	
Eritrea	2
Ethiopia	3
South Sudan	4
Sudan	2
Age group	
45-49	5
50-54	3
55-60	3
Menopausal status	
Peri-menopausal	7
Postmenopausal	4
Average age at menopause	48
Marital status	
Never married	1
Married	3
Widowed	1
Divorced/separated	6
Level of completed education	
No schooling-illiterate	2
Primary School	4
High School	5
Tertiary/university	0
Employment	
Employed	5
Home duties	6
Years in Australia	
1-10	0
11-20	9
21-30	2
>30	0

resettled in Australia in early 2000 after having lived in refugee camps in countries bordering their country of origin in order to escape famine, ongoing civil and political unrest.

Four themes emerged from the data.

3.1 | Menopause and midlife—a welcomed life phase

Menopause was a welcomed life phase and represented normal physiological changes. It was predominantly described as a release from the reproductive role and the inconveniences caused by monthly menstruation.

No, because it [menopause] is normal for us, you know, we used to be tired washing pads every months and you will be happy, yeah you can see your time is it. Yeah

TABLE 2 Individual participant characteristics (N = 11)

Pseudo nym	Menopause status	Year of migration	Interview with interpreter	Level of education	Paid employment
Mena	Postmenopausal	1994	No	Year 9	Yes-business owner
Yenu	Peri-menopausal	1997	No	Year 12	Yes-business owner
Salina	Postmenopausal	2002	No	Year 12	Yes-health care industry
Aamira	Postmenopausal	2005	Yes	No schooling-illiterate	No
Nafiza	Post menopausal	2004	Yes	No schooling-illiterate	No
Kazima	Peri-menopausal	2002	No	Year 12	No
Muhsina	Peri-menopausal	2003	No	Years 12	Yes-self employed
Duaa	Peri-menopausal	2004	No	Some Primary School-illiterate	No
Sabeen	Peri-menopausal	2003	No	Year 12	Yes – community sector
Hyiab	Peri-menopausal	2000	Yes	Year 7	No
Fofu	Peri-menopausal	2003	Yes	Primary School	No

[menopause] good thing for us. And you no more getting babies because you expect to get babies.

(Aamira)

We don't like period, it's very annoying.

(Duaa)

Midlife was described in a social context as a life phase where women gain greater social standing and are highly regarded for their wisdom and maturity within their community. This respect is heavily reliant on women's achievement as wife and mother as highlighted by Salina's reflection.

Respect comes from status and in Ethiopia status comes from family. You get married and have children these are all things, you gain status.

(Salina)

You become top in your family and even in your community. Especially in my age, I would be happy at home. I would be like ... everybody would come and ask me 'ah Sabeen we need to do this' and then I would give ideas. So everybody would go and do it and I would be respected all the time.

(Sabeen)

flushes, muscular-skeletal pains and tiredness. Most reported limited understanding about women's health and menopause specifically.

I don't know anything about menopause.

(Muhsina)

At first, I didn't know. I was feeling hot and sweating all the time. I thought I had an infection and wanted to see my doctor.

(Yena)

Some attributed their lack of knowledge about women's health to having had limited educational opportunities and having spent most of their lives in remote areas.

Most of us, we were born in the cattle care, in the village, far away from the city.

(Aamira)

... but you know especially women they don't think that much about women's health, especially the woman in the village. They don't care about the ... you know ... menopause or whatever. Maybe they can feel tired but they don't think ... this is like ... changing menopause or all this stuff. They just notice it and then that's it.

(Kazima)

3.2 | Limited education linked to knowledge about menopause and women's health

When asked about their personal menopause-related experience, all participants described the changes of their menstrual cycle and most said that they experienced some physical symptoms including hot

3.3 | Political and societal environment linked to health literacy

Information gathering can be from formal or informal sources. Health care providers and reputable websites are regarded as formal and

more trustworthy and family members, friends or the popular press are regarded as informal and less trustworthy sources of information.

Few participants had ever looked for or accessed menopause-related information. They reflected that seeking health information was uncommon in their country of origin. They explained that due to poverty, war and political unrest health services were very basic and the concepts of patient education unfamiliar.

South Sudan it's not like a first world ... there is a doctor, but you know ...

(Kazima)

You know we are in the war, we don't have um, go to hospital.

(Aamira)

In addition, women's health, including menopause, is rarely discussed in their communities and therefore they had not sought menopause-related information intentionally.

Huge difference [compared to Australian culture] in our culture. Menopause is secret, nobody talks about thing like that. We don't discuss it and we struggle with it.

(Salina)

The few participants who sought information about menopause accessed it mainly through informal sources such as close female friends, family members or occasionally from older women from their community.

My period sometime is you know, is coming every 2 weeks. And sometimes is very heavy and sometimes only one day. And when I tell her [older female community member] they said 'oh my baby your period you know is going to be stopped'.

(Mena)

Only few used the internet as a source of information. Salina reflected on her experience when seeking information about menopause symptoms, 'actually when I get hot flushes and periods got heavy, I googled it.'

Finally, participants who were unable to read in their native language as well as in English identified this as a barrier for being able to access menopause-related information.

I don't know how to read.

(Nafiza)

Oh the one thing I will tell you, I don't know how to read. And I don't know how ... to go and look about healthy things.

(Duaa)

3.4 | Perceptions and experiences of menopause-related health care

All participants had been resettled in Australia more than 10 years ago. Despite having arrived under the Refugee and Humanitarian Program,²⁷ having experienced abject poverty, war, lengthy periods in refugee camps, having had limited formal education, and having limited English language proficiency all women accessed primary health care. Many participants reported positive relationships with their general practitioners (GPs) describing their care as thorough and caring. They preferred GPs who spoke their first language because that helped them fully understand the information provided during their health consultation.

Yeah is good doctor. The reason we go to the um, Arabic doctors is because, is not because we don't like Australian doctors, it is because of the language. Because we want the language that we can understand. That is why we go to this Arabic doctor who can speak my, our language.

(Hyiab)

I also saw a lady doctor in Moonee Ponds and she (participant indicated that the doctors touched her arm) said 'we do this together'. This was lovely, very lovely [laughs]. When I need to have a very detailed conversation, I go to a doctor in Werribee. He is from Ethiopia, sometimes there are still words that are difficult to describe.

(Salina)

Participants with limited English proficiency who consulted English-speaking GPs were either accompanied by family members who acted as interpreters or offered a telephone interpreter service.

Some participants who saw their GPs for menopause-related care were disappointed by the lack of information provided and some felt misunderstood and that their concerns were dismissed.

The doctors, they don't listen. Still I feel sweats and I don't know how long [they will last]. Maybe they think I know, but he didn't ask. Doctors should tell, not everybody is internet person.

(Yena)

I feel nervous a bit because you know ... when you go to the doctor, it's just ... [dismissive gesture] ah that's ... take some Panadol and that's it. But they don't actually give an explanation.

(Kazima)

In response to a follow-up question about how health services could be improved most participants reflected that the GP needed to

be proactive and provide more health information and suggested that regular community talks about women's health would be beneficial.

4 | DISCUSSION

To our knowledge this is the first study investigating menopause-related health literacy among immigrant women born in the Horn of Africa nations. We found that this group of women welcomed menopause as a normal, positive life phase. They had limited knowledge about menopause and lacked the health literacy competencies necessary to be able to make well-informed menopause-related health decisions. While many perceived their health care providers in Australia as caring and competent, they wished that GPs would be more proactive in providing menopause-related health information and that community-based health education were available.

This study identified three barriers to accessing menopause-related health information.

Firstly, the influence of their culture on perceptions of menopause limited participants' understanding of the links between menopause and later life health. In Western societies, menopause is viewed as a marker of ageing and a time when health behaviour is linked to health in later years.⁴ Health care providers are encouraged to remind women of the importance of positive health behaviour to reduce the risk of developing chronic noncommunicable diseases later in life.²⁸ On the other hand, based on some anthropological observation, Flint²⁹ argues that in traditional cultures menopause is predominately perceived as a time of liberation when women gain greater social privileges and control. However, there is little contemporary evidence about the experiences of menopause among women in traditional cultures to support this assertion. Nevertheless, the women in this study viewed menopause as a normal, positive life phase associated with greater social position and they did not see the need to seek menopause-related health information and care. This may in part be because the health care system in their countries of origin focuses on curative rather than preventive care and as a result, there is no tradition in seeking health-related information.²¹⁻²³ Consequently, participants' apparent unawareness of the increased risks of chronic noncommunicable diseases postmenopause leaves them vulnerable to missing out on menopause-related health information and the opportunity to adopt health promoting behaviours during and after menopause.

Secondly, barriers to health literacy were identified. Sorensen and colleagues⁵ refer to health literacy as the capacity to access, understand, evaluate and use health-related information. The ability to access health information is foundational and the stepping stone to the subsequent competencies. If this first competency cannot be completed successfully it follows that the remaining health literacy competencies cannot be achieved. In contemporary high-income settings the internet is a primary source of health information.³⁰ Since most online health information is text based, it is only accessible to people who are literate and able to use the internet. As demonstrated in this study migrants with limited education and low

literacy may be unfamiliar with the internet and are therefore unable to seek and use online information. This in turn means that they may miss out on information that would enable them to make positive menopause-related health decisions.

Thirdly, in the absence of the capacity to access menopause-related information participants relied on their GPs to provide this. Health literacy is assisted by a health care system that considers and acts upon factors influencing health literacy. Higginbottom et al³¹ investigated health care experiences among immigrant women in Canada and found that communication difficulties and lack of health information in relevant community languages were two of the most commonly cited barriers to health care. Participants in this study had seen GPs and many had overcome language challenges by consulting GPs who conversed in their native language. However, the lack of proactive engagement by their GPs in providing menopause-related information was a barrier to receiving menopause-related health care and the opportunity to act on health promoting information.

Study strengths include that participants were diverse in terms of menopausal status, age, duration of residence in Australia, marital status and educational status. Furthermore, volunteers with insufficient English language proficiency were able to participate with the assistance of a qualified interpreter, all of whom were female and of similar cultural background to participants.

Nevertheless, we acknowledge some limitations. Cross-cultural and cross-lingual research poses unique challenges.³²⁻³⁴ Some interviews required interpretation, which always carries the risk that subtleties and potentially relevant information may be lost.³⁴ There were no participants who had been born in Somalia. It is possible that perceptions and experiences of women from Somalia may not be identical to those of participants from other Horn of Africa nations. Overall, however, we believe that the strengths of the study outweigh its limitations and that the findings help us understand the barriers and enablers of menopause-related health literacy among women from these nations who have migrated to high-income countries.

5 | CONCLUSION

In summary, our study suggests that menopause-related experiences and health literacy among immigrant women from the Horn of Africa nations are linked to both previous experiences in their country of origin and current experiences in the country of immigration. Understanding the factors that influence health literacy among immigrant women from this region allows us to think creatively about ways to improve their access to information about health behaviours that reduce the risk of noncommunicable diseases postmenopause.

6 | IMPLICATIONS AND FUTURE RESEARCH

Women who have migrated from the Horn of Africa nations perceive the menopausal transition as a normal, positive life phase and are

unlikely to seek menopause-related information. It might be beneficial if primary health care providers adopt a proactive approach to assessing menopausal status and discussing menopause-related health in their encounters with immigrant women during their midlife. Any primary health care consultation offers an opportunity to assess menopause-related health knowledge, recommend relevant health screening and provide health promoting information.

Increased awareness among health care providers and health educators about the cultural influences on the experiences and perceptions of menopause and the personal, situational, societal and environmental determinants of health literacy may help overcome the barriers to accessing menopause-related health information identified in this study. Targeted professional education programs codesigned by community stakeholders may increase their ability to engage vulnerable communities in health promotion programs and activities.

Health information is largely internet based and consequently inaccessible for migrant women with limited literacy and internet skills. Community-based health information programs delivered by bilingual health educators in community settings such as community health centres, existing social or community groups allows the use of diverse information dissemination strategies and may provide an alternative in promoting menopause-related health literacy.

A possible area of future research is to investigate how people with low literacy access health information, and what approaches they use to overcome access barriers. This would inform strategies to reaching people with low literacy with preventive health messages. Furthermore, primary health care providers are in ideal position to complete opportunistic health assessments and provide recommendations to promote optimal health in older age. Research investigating potential knowledge gaps, learning needs and barriers to providing menopause-related care to immigrant women is warranted to inform health care practice and policies.

ACKNOWLEDGEMENTS

We thank the women who participated in this research project for their generous contribution. Karin Stanzel is supported by the Australian Government Research Training Program Scholarship. Jane Fisher is supported by the Finkel Professorial Fellowship, which is funded by Finkel Foundation.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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REFERENCES

- Palacios S, Henderson VW, Siseles N, Tan D, Villaseca P. Age of menopause and impact of climacteric symptoms by geographical region. *Climacteric*. 2010;13(5):419–28.
- van Dijk GM, Kavousi M, Troup J, Franco OH. Health issues for menopausal women: the top 11 conditions have common solutions. *Maturitas*. 2015;80(1):24–30.
- Daly RM, Dalla Via J, Duckham RL, Fraser SF, Helge EW. Exercise for the prevention of osteoporosis in postmenopausal women: an evidence-based guide to the optimal prescription. *Braz J Phys Ther*. 2019;23(2):170–80.
- Guthrie JR, Dennerstein L, Taffe JR, Lehert P, Burger HG. The menopausal transition: a 9-year prospective population-based study. The Melbourne Women's Midlife Health Project. *Climacteric*. 2004;7(4):375–89.
- Sørensen K, Van den Broucke S, Fullam J, Doyle G, Pelikan J, Slonska Z, et al. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health*. 2012;12:80.
- Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Crotty K. Low health literacy and health outcomes: an updated systematic review. *Ann Intern Med*. 2011;155(2):97–108.
- Taggart J, Williams A, Dennis S, Newall A, Shortus T, Zwar N, et al. A systematic review of interventions in primary care to improve health literacy for chronic disease behavioral risk factors. *BMC Fam Pract*. 2012;13:49.
- Australian Commission on Safety and Quality in Health Care. National Statement on Health Literacy. Sydney, Australia: Australian Government; 2014. Available from: <https://www.safetyandquality.gov.au/search/health+literacy>. Accessed September 5, 2016.
- Mantwill S, Schulz PJ. Does acculturation narrow the health literacy gap between immigrants and non-immigrants: an explorative study. *Patient Educ Couns*. 2017;100(4):760–7.
- Fernandez-Gutierrez M, Bas-Sarmiento P, Albar-Marin MJ, Paloma-Castro O, Romero-Sanchez JM. Health literacy interventions for immigrant populations: a systematic review. *Int Nurs Rev*. 2018;65(1):54–64.
- Australian Bureau of Statistics. Census of Population and Housing: Australia Revealed, 2016: Australian Bureau of Statistics; 2016. Available from: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/productsbyCatalogue/63230DE0557F3B83CA2581470023C559?OpenDocument>. Accessed May 14, 2018.
- United Nations Population Fund. State of World Population: a passage to hope. Women and International Migration. Geneva, Switzerland United Nations Population Fund, 2006.
- United Nations Migration Agency. World Migration Report 2018. Geneva, Switzerland: The UN Migration Agency, 2018.
- Browne P. The Longest Journey: Resettling Refugees from Africa. Sydney, Australia: University of New South Wales Press, 2006.
- United Nations High Commissioner for Refugees. Assistance to refugees, returnees and displaced persons in Africa - Report to the Secretary General. Geneva: Switzerland, 2007.
- Mwangi E, Wetterhall F, Dutra E, Di Giuseppe F, Pappenberger F. Forecasting droughts in East Africa. *Hydrol Earth Syst Sci*. 2014;18:611–21.
- Australian Government. Getting Settled-Women refugees in Australia. Canberra, Australia: Australian Government, 2013. Available from: <https://immi.homeaffairs.gov.au/settlement-services-subsite/files/getting-settledwomen-refugees-in-australia.pdf>. Accessed May 23, 2018.
- World Vision. Girls on the move. Nairobi, Kenya: World Vision International, 2018.
- United Nations Development Programme. Human Development Report - Global Human Development Indicators. Geneva: Switzerland, 2018.
- Adanu RM, Johnson TR. Migration and women's health. *Int J Gynaecol Obstet*. 2009;106(2):179–81.
- Global Health Workforce Alliance. Health workers for all and all for health workers-South Sudan Geneva, Switzerland: World Health

- Organisation. Available from: <https://www.who.int/workforcealliance/countries/ssd/en/>. Accessed May 31, 2018.
22. Global Health Workforce Alliance. Health workers for all and all for health workers-Sudan Geneva, Switzerland: World Health Organisation. Available from: <https://www.who.int/workforcealliance/countries/sdn/en/>
 23. Global Health Workforce Alliance. Health workers for all and all for health workers-Eritrea Geneva, Switzerland: World Health Organisation. Available from: <https://www.who.int/workforcealliance/countries/eri/en/>. Accessed May 31, 2018
 24. Stanzel KA, Hammarberg K, Fisher J. Experiences of menopause, self-management strategies for menopausal symptoms and perceptions of health care among immigrant women: a systematic review. *Climacteric*. 2018;21(2):101–10.
 25. Victorian Multicultural Commission. Community Fact Sheets; 2016. Available from: <https://www.multicultural.vic.gov.au/population-and-migration/victorias-diversity/community-fact-sheets>. Accessed June 19, 2017.
 26. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(3):77–101.
 27. Australian Government. Community Summary Information. Canberra, Australia: Community Relation Section of DIAC, 2012. Available from: <https://www.homeaffairs.gov.au/trav/life/multicultural/community-informationsummaries>. Accessed June 4, 2018.
 28. Murtagh M, Hepworth J. Narrative review of changing medical and feminist perspectives on menopause: from femininity and ageing to risk and choice. *Psychol Health Med*. 2005;10(3):276–90.
 29. Flint M. The menopause: reward or punishment? *Psychosomatics*. 1975;16(4):161–3.
 30. Cheng C, Dunn M. Health literacy and the Internet: a study on the readability of Australian online health information. *Aust N Z J Public Health*. 2015;39(4):309–14.
 31. Higginbottom GM, Safipour J, Yohani S, O'Brien B, Mumtaz Z, Paton P, et al. An ethnographic investigation of the maternity healthcare experience of immigrants in rural and urban Alberta, Canada. *BMC Pregnancy Childbirth*. 2016;16:20.
 32. Eide P, Allen C. Recruiting transcultural qualitative research participants: a conceptual model. *Int J Qual Methods*. 2005;4(2):44–56.
 33. Sixsmith J, Boneham M, Goldring JE. Accessing the community: gaining insider perspectives from the outside. *Qual Health Res*. 2003;13(4):578–89.
 34. Jones EG, Boyle JS. Working with translators and interpreters in research: lessons learned. *J Transcult Nurs*. 2011;22(2):109–15.

How to cite this article: Stanzel KA, Hammarberg K, Fisher J. 'Not everybody is an internet person': Barriers for menopause-related health literacy among immigrant women from the Horn of Africa nations. *Health Promot J Austral*. 2020;00:1–8. <https://doi.org/10.1002/hpja.326>