Original Article

Midlife Women's Menopausal Transition Symptom Experience and Access to Medical and Integrative Health Care: Informing the Development of MENOGAP

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Abstract

Background: Individuals with a uterus experience menopause, the cessation of menses, on average at age 51 years in the United States. While menopause is a natural occurrence for most, over 85% of women experience multiple interfering symptoms. Menopausal women face health disparities, including a lack of access to high-quality healthcare and greater disparities are experienced by women who are black, indigenous, and people of color. Some women are turning away from hormone therapy, and some seek integrative health interventions.

Objective: Some menopausal women who seek healthcare do not receive it as they lack access to medical and integrative healthcare providers. A potential solution to this problem is a medical group visit (MGV), during which a provider sees multiple patients at once. The aims of this study were to gather women's opinions about the menopause, provider access, and conventional and integrative health interventions for later use to develop a menopause MGV.

Methods: We conducted a Community Engagement Session and a Return of Results (RoR) with midlife women to learn about their menopause experiences, barriers and facilitators to accessing health providers, and their interest in and suggestions for designing a future integrative MGV (IMGV). Thematic qualitative research methods were used to summarize session results.

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Results: Nine women participated in the Session and six attended the RoR. Participants were well-educated and diverse in race and ethnicity. Themes included: an interest in this topic; unfamiliar medical terms; relevant social factors; desired whole person care; interest in integrative health; barriers and facilitators to accessing healthcare. The group expressed interest in ongoing participation in the future process of adapting an IMGV, naming it MENOGAP.
Conclusion: These findings highlight the importance of stakeholder engagement before designing and implementing MENOGAP and the great need among midlife women for education about the menopausal transition, integrative self-care, and healthcare.

Keywords
integrative health, integrative medical group visits, medical group visits, health care access, menopause, menopausal transition, perimenopause, post-menopause

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Background

All individuals with a uterus experience menopause,[1] the cessation of menses, which is a natural occurrence experienced during midlife. In the United States, the mean age of menopause is 51 years.[1] The menopausal transition leads up to menopause and may last a decade. Even though menopause is a natural occurrence for most, over 85% of midlife women experience multiple symptoms that interfere with their quality of life and daily activities.[2] Individuals may experience irregular periods, vaginal dryness, sleep problems, mood changes, weight gain and slowed metabolism, thinning hair, dry skin, vasomotor symptoms (VMS) including hot flashes, chills and night sweats, or loss of breast fullness.[1,3]

However, symptom experiences varies, and multiple studies report greater menopausal symptom severity and bothersomeness among black, indigenous, and other people of color (BIPOC) women.[4,5] The Study of Women Across the Nation (SWAN) was launched to study physical, biological, and social changes experienced by African American, Hispanic, Chinese, Caucasian, and Japanese women.[6] The SWAN study is a multi-site, longitudinal, epidemiologic study designed to examine the health of diverse midlife women.[6] For example, this study informed us that African-American women are more likely to report heavy menstrual bleeding and to undergo hysterectomy and more severe VMS.[3] Notably, this study did not include American Indian/Alaska Native (AI/AN) women and very little is published about their menopause experiences.[7]

A common treatment for women experiencing bothersome menopausal symptoms is Menopausal Hormone Therapy (MHT). The Women's Health Initiative (WHI) conducted a study in 2002 about the safety of MHT and later conducted a risk/benefit analysis study of MHT in 2013, concluding that it is appropriate management for most women and contraindicated for women with estrogen-sensitive cancer or a history of coronary heart disease, blood clot, or stroke.[8] Data were re-examined in 2016, and MHT is listed as a first-line intervention to treat menopausal symptoms such as hot flashes, vaginal dryness, and mood changes.[1] Recent studies have indicated minimal to no contraindications to MHT being utilized by women younger than 60 without the contraindications mentioned above and during the 10 years after menopause.[9] MHT is a first-line treatment in The Menopause Society's hormone therapy position statement,[10] and even though it is indicated for most women, there is a gap in care as not all women can access or choose to take MHT. For example, the State of Menopause Survey conducted in 2021 with 1039 women aged 40-65 across the United States found that more than 72% of surveyed women were familiar with MHT, but 65% said they would not consider using it unless their provider recommended it (32%) or a new clinical study emerged proving its safety (29%).[11] Further, a systematic review of nine surveys reported that 50.5% of women reported using non-pharmacologic interventions specifically for their menopause symptoms.[12] Thus, the present study was informed by these trends in the utilization of evidence-based integrative health and self-care information. The study team sought to gather midlife women's feedback about the future process of designing an intervention that includes both medical and integrative healthcare interventions.

Women face many health disparities, high mortality rates, and healthcare access concerns. These problems can partially be attributed to the poor education of medical residents.[13] Only 6.8% of surveyed medical residents indicated that they felt adequately prepared to manage the care of women experiencing menopause.[13] Within the medical and nursing educational systems, there is a demand for better trainee education regarding care for women in the menopausal transition.[14] Insufficient training translates to poor care: one survey of midlife women reported that one-third of women said they felt their doctor isn't comfortable talking about menopause, causing them to look elsewhere for support.[15] This could potentially be due to a lack of in-depth education of medical students. Approximately one-third of the surveyed residents opted not to offer MHT to a symptomatic, newly menopausal woman who did not have any contraindications to receiving MHT or to a prematurely menopausal woman

until the natural age of menopause, despite the overwhelming evidence that MHT is efficacious and safe for these two categories of women.[16] As previously discussed, MHT does not come without side effects, nevertheless, some medical residents are not providing what is currently the first-line treatment for symptomatic menopausal women. Few publications highlight the attitudes of Nurse Practitioners (NPs) and other healthcare providers toward managing various symptoms and conditions during the menopausal transition. Still, literature does exist to educate NPs about the care of women during the menopausal transition.[17,18]

Another barrier midlife women face is the miscommunication of menopausal terms. Some cultures refer to the perimenopausal term as "the change" or "a transition" instead of using a medical term. In Europe, menopause is referred to as the "climacteric stage".[19] In addition, high costs from the healthcare system, lack of insurance coverage, geographic location of residence, life priorities, and native languages are all barriers women may face to receiving adequate care.

There are numerous ways to decrease these health disparities. From a clinical standpoint, improving access to health care is a critical solution. Because of the potential negative consequences of MHT and health disparities, more women are turning away from MHT. Medical group visits (MGVs) are one efficient way to fill the gap in disparities in care so that whether a woman wants to take MHT or does not, she can receive medical care in a group setting.

MGVs, also known as shared medical visits, are medical appointments in which one to two providers deliver medical care for a group of patients with similar diagnoses or questions instead of a one-to-one medical appointment. MGVs are one potential solution to the shortage of providers because they allow for more individuals to be seen by a provider trained in concerns of the menopausal transition. MGVs allow individuals to be more easily seen by providers and create a community for the patients because they can meet others experiencing the same problems.[20] A qualitative study was performed on the delivery of MGVs, concluding that MGVs "successfully deliver on the promise of patient-centered care".[21] MGVs have been designed for women receiving antenatal care,[22] for patients with diabetes mellitus,[23] and for psychiatric patients[24] – and participants in all 3 types of MGVs reported a preference for the group format over a return to individual medical visits.

There is minimal literature on MGVs for menopause.[25] Of the few studies of MGVs for the menopausal transition, one study included annual examinations, follow-up menopausal concerns, hormone therapy, bone densitometry results, and osteoporosis treatment follow-ups. The authors concluded that shared medical visits increased physicians' productivity by 20% compared to individual appointments. The participants were surveyed afterward and responded, with the majority stating that they would prefer to go to another shared medical visit instead of the individual visit.[26]

The aim of the present study is to ask a sample of midlife women about their experiences of the menopausal transition, what medical attention they sought out when they had bothersome symptoms, and whether they were interested in MGVs with integrative health components and if their communities might find a MGV of interest. The present study is the first step in a planned series of studies to adapt a MGV for peri- and post-menopause and test it for efficacy. If found efficacious, future studies of effectiveness and implementation in health systems will be conducted. The results from this first study will inform the future detailed development of an intervention to bridge the gap in knowledge about whether midlife women would prefer MGVs and components of evidenced-based integrative health and self-care information.

Methods

Ethics Statement

This study was approved by the University of Utah Institutional Review Board and each participant provided informed consent before the start of the session.

Community Engagement Sessions

We conducted two sessions with the same community members: (1) a Community Engagement Session (similar to a focus group) and (2) a Return of Results. The Engagement Session ("Session") was designed to elicit community members' opinions about the menopausal transition and access to medical care and non-pharmacological interventions such as acupuncture, acupressure, massage therapy, and chiropractic. We also asked about their preferred evidence-based, non-pharmacological components and delivery format. Community Engagement Sessions provide a format for researchers to consult with community experts – people with expertise about a particular topic from their lived experience.[27] The Meharry-Vanderbilt Community-Engaged Research Core[27] has identified best practices for enhancing community engagement in community consultations: early input, researcher coaching, researcher humility, balancing power, neutral facilitator, and preparation of community stakeholders.[28] These practices are also used to increase participant participation, to include various viewpoints, and avoid conflation or squelching of any idea or voice. We incorporated these best practices into the conduct of the Session, the results of which are presented here.

Our participants were recruited through referrals with The University of Utah's Clinical and Translational Science Institute's (CTSI) Community Collaboration and Engagement Team (CCET). This team is expert at conducting Sessions. Recruitment involved flyers, existing community partnerships, word of mouth, social media, and referrals

from past participants. Screening of eligibility to participate was conducted by telephone and email. Potential participants were considered for inclusion if they were female, self-described, other, or prefer not to disclose sex/gender; had an intact uterus; within the ages 40-55; report poor menopause-related quality of life (≥3 on a 0-6 scale) and experiencing hot flashes (severity ≥3 on a 0-10 scale) lasting for 6 or more months; were willing to provide menstrual history which indicates either late transition (1+ missed periods in the last year) or early post-menopause stage (within 1 year of the final menstrual period); and were able to provide informed verbal consent.

The following questions were asked in the Session:

1. What interested you in this discussion?
2. Are the terms perimenopause, menopausal transition, and post-menopause familiar?
3. What is your experience with the menopausal transition?
   a. What age is relevant to this topic?
   b. What about social changes or social pressures? Are there any social aspects relevant to your experience of the menopausal transition?
   c. Are there any healthcare aspects to your experience of the menopausal transition?
4. What are the barriers to accessing healthcare providers (e.g., primary care providers, gynecologists, etc.)? What are the barriers to accessing integrative health providers (e.g., acupuncturists, massage therapists, chiropractors, etc.)?
   a. What helps you access healthcare providers? What helps you access integrative health providers?
   b. Where should resources for the group intervention be posted?
5. What are your feelings about the proposed group intervention?

These questions used lay language and were open-ended when possible. The questions were written to avoid negative or positive bias and allowed for any amount of detail and self-disclosure. Participants received a short verbal description of the Session and the proposed group medical intervention and were emailed the Session questions at least a week before the Session.

The Session was held on September 28, 2021, and was led by a CCET staff member experienced in facilitating this type of group and is independent of the research team. During the 2-hour Session, a facilitator led a discussion of the questions with the aim of eliciting responses from all Session participants; an experienced CCET scribe summarized the discussion on large paper as part of the facilitation. Several members of the research team observed the discussion. Session participants were provided with a $75 gift card to compensate them for their time.

Data Analysis

Conventional content analysis, an inductive method of qualitative research,[29,30] was used to analyze the Community Engagement Session results. The Session was audio-recorded and transcribed. The de-identified transcription was read and re-read, after which coding was performed to identify themes and subsequent sub-themes by the first and second authors, with recoding until consensus was achieved. Participants' comments are direct quotes, except that they were edited for brevity while maintaining the original meaning. Descriptive statistics, performed on de-identified data, were used to analyze the participant demographics using SPSS Version 27.[31]

Return of Results

We conducted a Return of Results (RoR) to review the data tables with Session participants. This was an opportunity to obtain feedback from women about whether the identified themes were accurate and whether community members would suggest any additions, deletions, or changes to the data analysis.

Results

Twenty-two individuals were screened, and nine met the inclusion criteria to participate. All nine women chose to attend the session, and six attended the Return of Results session. Participants ranged in age from 41 to 55 years. Most had completed a higher education degree (associate through doctorate) and lived in an urban area (55%). There was broad diversity in race and ethnicity: five of nine participants (55%) were leaders in their respective communities, representing Black/African American, American Indian/Alaska Native (AI/AN), Hispanic, Refugee, and Pacific Islander communities. For reference, the state of Utah is 23.3% BIPOC.[32] Other demographic data are listed in Table 1.

Participants' responses to the session questions are summarized in Tables 2–9. We anticipated that the question "*What interested you in this discussion*?" would elicit participants' desire to learn more about the menopausal transition based on the literature.[33-36] This was the case; in addition, participants indicated that they felt alone and would like to talk with other women in addition to learning more about the menopausal transition (see Table 2).

Are the Terms Perimenopause, Menopausal Transition, and Post-menopause Familiar?

Several views were presented concerning terminologies such as perimenopause, menopausal transition, and post-menopause (see Table 3). Several women reported that they had not heard of various terms before attending this session. Women also noted that, for example in a Latino

Table 1. Demographics of Engagement Session Participants.

Demographic Topic	N (%)	Range
Number of participants	9 (100%)	
Age (years)	--	41-55
Race/ethnicity		
Not reported	0 (0%)	
African american	2 (22%)	
Alaska Native/American Indian	1 (11%)	
Asian	1 (11%)	
Caucasian	5 (55%)	
Hispanic	2 (22%)	
Pacific Islander	1 (11%)	
Multiple reported	(Yes)	
Religious affiliation		
Agnostic	2 (22%)	
Atheist	1 (11%)	
Christian	3 (33%)	
Muslim	1 (11%)	
Other	2 (22%)	
Approximate household income		
Prefer not to disclose	0 (0%)	
<$10,000	0 (0%)	
$10,000-$24,999	1 (11%)	
$25,000-$39,000	3 (33%)	
$40,000-$49,000	0 (0%)	
$50,000-$74,000	2 (22%)	
>$75,000	3 (33%)	
Educational level		
Not reported	1 (11%)	
High school or equivalent	1 (11%)	
Some college	0 (0%)	
Associate's degree	2 (22%)	
Bachelor's degree	1 (11%)	
Master's degree	1 (11%)	
Doctorate degree	3 (33%)	
Number of members in the household		
Not reported	0 (0%)	
Lives alone (1)	1 (11%)	
One other person (2)	1 (11%)	
Two other persons (3)	1 (11%)	
Three other persons (4)	4 (44%)	
Four other persons (5)	2 (22%)	
Five other persons (6)	0 (0%)	
Geographic area		
Rural	0 (0%)	
Suburban	4 (44%)	
Urban	5 (55%)	

communities, the terminology is less important than having conversations on the topic while in a Polynesian communities, the change of life is a term that is used, but not really talked much about so it was difficult to know what age(s) were relevant. It was noted that in the Somali language that there was not a word for menopause. Women noted terms such as 'change of life' or 'transition' were helpful.

Tables 4–7 include the following four topics: 1) women's experiences with the menopausal transition; 2) ages relevant to this topic; 3) social dimensions; and 4) healthcare dimensions.

What is Your Experience With the Menopausal Transition?

Concerning experiences, participants reported experiencing headaches, hot flashes, irregular menstrual periods, loss of memory, changes in mood, sleep disturbances, and vaginal dryness, as well as having no symptoms being experienced and being unsure about experiences. See Table 4, which also includes perceptions, or appraisals, about the various symptom experiences.

What Age is Relevant to This Topic?

Participants also mentioned age dimensions. Six of nine women commented about age as related to this topic. Some women reported that they had irregular periods in their late 30s and 40s and had problems with mood and sleep. Some women also reported that they did not have particular symptoms in their 40s and did not have the symptoms they thought they would in their 50s (see Table 5).

Are there Any Social Aspects to Your Experience of the Menopausal Transition?

Social dimensions reported by women (see Table 6) included being in the "sandwich generation," trying to confide in friends but finding they were not also in the menopausal transition, basing anticipated menopausal experiences on their mother's experiences, and that communication was needed about the transition.

Are there Any Healthcare Aspects to Your Experience of the Menopausal Transition?

Participants reported healthcare dimensions (see Table 7) such as unhelpful care from a provider, helpful care from a provider, the sex of the provider being relevant, and interest in whole person care vs pharmacologic treatments.

What are the Barriers to Accessing Healthcare Providers (e.g., Primary Care Providers, Gynecologists, etc.)? What are the Barriers To Accessing Integrative Health Providers (e.g., Acupuncturists, Massage Therapists, Chiropractors, etc.)? What Helps you Access Healthcare Providers? What Helps you Access

Table 2. What Interested you in this Discussion?.

Themes	Example Quotes (Edited for Brevity)
Interested in this topic	*The journey into menopause is very new to me, and I would like to be a part of this important conversation*
Learn more	*Want to learn ways to get through symptoms and menopause in general* *Want to understand what [my) body is doing* *Something that she does not know a lot about*
Would like to talk with women	*I am going into menopause, and I don't know who to talk to other than an MD* *Wanted to be in a space where I could freely talk to other women and share experiences*
Interested in integrative health (IH) interventions	*I am interested in integrative and western medicine and headed into menopause* *Heading into the area of menopause and I do not usually use traditional medicine health care systems*
Not talked about/taboo	*My community and society, in general, does not talk about this* *This is a taboo subject in my community and I wanted to step out and learn more and to help out my community*
Self-help	*I am looking forward to this group for self-help options and acupuncture*
Feeling alone	*Stage in our lives where we feel awkward. Want to hear that I'm not the only one that this is happening to* *It's nice to hear from women who are also experiencing the same thing*

Table 3. Are the Terms "Peri-Menopause" and "Post-Menopause" Familiar?.

Term Used	Example Quotes (Edited for Brevity)	Culture (if Stated)
"Peri-menopause"	*I had never heard of perimenopause until joining this group*	--
	I feel that it encompasses the pre, actual, and post	--
	I'm in health research and I've never come across that term [perimenopause] before	
"Post-menopause"	*Post menopause: I am not familiar with that term at all*	--
Which terms to use	*The terms are not as important as the conversation*	--
	One is not better; they're all important	Latino
"The change of life"	*Almost like a timeline. Although it isn't really talked about, so I'm still trying to figure out what age is the timeline*	Polynesian
"Transition" or "Transitioning"	*I like it because I am becoming something else, although there are a million different ways we transition, and one term does not acknowledge this uniqueness*	--
"The change"	*Feels like a colloquial term*	--
No word for it	*Familiar as in hearing about the [terms], but what do they mean? We do not have a word for menopause in our language*	Somalia

Integrative Health Providers? Where Should Resources for the Group Intervention be Posted?

Participants provided detailed comments regarding barriers and facilitators to accessing health care – both conventional healthcare providers and integrative healthcare providers, such as acupuncturists, chiropractors, and massage therapists (see Table 8). Concerning accessing Integrative Health care providers, participants noted that location and availability were an issue and a lack of awareness about what acupuncture or massage could be used to treat. With respect to accessing conventional care, COVID-19-related concerns were noted, as well as issues with the location and availability of the provider, the need for childcare, lack of information about going in for preventive care, and finding that providers were reactive and not preventative. General limitations were noted, such as time and finding a provider they liked. A frequency count of barriers is included in Table 8, with the physical location being the most frequently mentioned barrier.

Facilitators to accessing healthcare providers (both conventional and integrative) included word of mouth, having insurance coverage, education about the insurance plan, doing their research, and having easily accessible public information (along with suggestions as to where we could post information about the proposed integrative medical group visit, IMGV).

What are Your Feelings About the Proposed Group Medical Visit Intervention?

Participants' perceptions of the proposed IMGV are listed in Table 9. They indicated several *positives* about the proposed IMGV, such as a safe and designated time and place to talk

Table 4. What is Your Experience With the Menopausal Transition?.

Theme	Experience	Perception
Headache	Headaches started coming since hot flashes	--
	Experienced headaches	Are others having headaches?
Hot flash	Have had hot flashes	--
Irregular period	Skipping and intermittent periods	Not knowing what to expect or when, that can be stressful
	Weird flow changes, weird consistency, more clumpy	--
	Last period was 7.5 weeks long	Feeling is a loss of control; I feel crazy, it's so hard to cope with complete extremes
	More inconsistent	It's been frustrating
	Changes in menstrual period	--
Memory loss	Lately having trouble communicating because of forgetting certain words	--
	Feel like losing her memory	--
	Forgetfulness all the time	--
Mood change	PMS is getting more severe; feeling unraveled	Overwhelmed, it's unpleasant
	Sometimes crying, having feelings of loneliness and nobody loves her	It's difficult; not knowing why it is so difficult
	The feeling is a loss of control	It is so hard to cope with --
	Anxiety and quick to be unnerved	
Sleep disturbance	Have to take 5HTP and melatonin to shut off her brain	--
	Usually comes home so tired, and sleeps on the way to bed	--
	Lack of sleep	--
Vaginal dryness	Experienced some vaginal dryness	--
No hot flashes experienced	Never once had a hot flash and if anything felt colder	No idea what that's like
	Never experienced a single hot flash	--
Unsure about experiences	--	Something is weird, something is going on Don't know what is going on basically
	--	Going to be 50 and not having the symptoms that were anticiapted
	--	Did not relate these symptoms to menopause
	Mood and sleep problems	What is this, what is going on? Why are there mood and sleep problems, plus hot flashes?

Table 5. Age Dimensions.

Age	Onset of Symptoms
39	Intrauterine device removed, and periods have been irregular since
Early 40's	Skipping and intermittent periods
41	Having troubles with mood and sleep
42	Never experienced a hot flash, so maybe it's on its way?
Mid 40's	Period stopped
50	I'm going to be 50; I haven't had the symptoms I thought I would

about the menopausal transition, desire for a follow-up session, excitement about the IMGV, and that it is a whole person approach. Another expressed theme was that women feel unheard and unseen at this age and in this transition and that the IMGV would give acknowledgment to women. Several *barriers* were described, such as midlife women being very busy and lacking time to devote to a multi-session intervention, that childcare may be needed, and that perhaps the IMGV would need to be tailored for various cultures (and delivered in various languages), and that the IMGV might be overwhelming with many different components such as journaling and healthy eating. The name of MENOGAP was proposed and discussed, with the idea of the IMGV filling a GAP in MENOpausal women's healthcare. Suggested formats included online, either synchronously or asynchronously, with a learning management system such as Canvas or via discussion boards.

Return of Results Session

We conducted a Return of Results Session on May 19, 2022, and 6 of 9 participants attended. The research team reviewed the data tables presented here with the midlife women. Participants provided input regarding clarifications and confirmed the identified themes in each of the tables.

Table 6. Social Dimensions.

Themes	Example Quotes (Edited for Brevity)
Participants in the "Sandwich Generation"	*I'm taking care of my elderly parents and my kids are in middle school*
Participants trying to confide in their friends	*They have no idea what I am talking about*
	Friends do not know anything about menopause. They make fun of me and may say things like, "Oh, you're old."
	I currently do not have friends who are experiencing any symptoms and I do not really have anyone to talk to about this
Anticipating menopausal experiences from mothers	*My mom had a hysterectomy in her 40s, and she did not have perimenopause either. Her [menopausal transition] was immediate*
Communication about the menopausal transition	*Communication is needed in my community and between community people and their providers*

Table 7. Health Care Dimensions.

Themes	Example Quotes (edited for brevity)
Unhelpful care from a provider	*My doctor never associated my symptoms with menopause*
	My doctor thinks my symptoms have something to do with my medication
	It's frustrating to listen to my doctor when I go in. It seemed like a 15-minute office visit with my doctor because of symptoms, then blood work, and the doctor said that I was fine. Yet I felt "crazy."
	The doctor has not associated my symptoms with menopause or had a conversation with me and I'm 50 years old
Helpful Care from a provider	*The Nurse Practitioner was profoundly different than being with a male gynecologist, it was helpful, and she treated me as a whole person*
	The gynecologist I saw was great, but only had "medical fixes."
	I appreciated that my male healthcare provider immediately asked if I was having irregular periods regarding my symptoms of trouble sleeping and mood changes
Sex of the provider	*I'm more comfortable talking to women providers that are within the menopausal range versus those in their 20's or being male*
	A male doctor ran bloodwork for me and said I was not in perimenopause even though I had many symptoms
Pharmacologic fixes vs whole person care	*Am I in need of a change of dose or a change in medication?*
	There should have been a discussion before giving me a different medication
	I just thought I needed a change of medication
	This is not just about the medication or prescription; it is about helping me as a whole woman through this process

Feedback on Table 4 included that after the discussion in the fall, women's thinking changed, and that hearing other women's perspectives changed their own perspective. Several women mentioned that they had sought care from a healthcare provider; one participant found a menopause group on Facebook and found the discussion online helpful. Participants mentioned that having community and culturally specific tailoring to the IMGV would be appropriate and that the biggest identified need is education for midlife women about this topic because every woman will someday go through menopause.

Discussion

The Community Engagement Session with nine midlife women and Return of Results (RoR) session with six women yielded important information about their lived experiences during the menopausal transition and provided valuable advice about the future development of MENOGAP. Participants were diverse in terms of race/ethnicity and had various levels of post-secondary education. Fifty-five percent were black, indigenous, and people of color (BIPOC) compared to the state of Utah which is 23.3% BIPOC.[32] Themes included an interest in participating in this conversation; medical terms were unfamiliar and less important than having a conversation; this sample of midlife women experienced many symptoms; many social factors affected participants; receiving unhelpful and helpful healthcare; a desire for whole person care; a need for information about what conditions Integrative Health interventions can treat during menopause; and barriers to accessing both conventional and integrative care were identified. The group expressed great interest in the proposed IMGV model but expressed barriers such as a lack of time available and needing childcare. Women indicated that an online format may be helpful to overcome these barriers. Participants also indicated that cultural and linguistic adaptations of MENOGAP may be needed, so it could be culturally relevant for a specific community and offered in languages besides English. These findings highlight the importance of extensive

Table 8. Barriers and Facilitators to Accessing Healthcare.

Healthcare Setting	Barrier	Example Quotes (Edited for Brevity)
Accessing acupuncturist, massage, chiropractor?	Location and availability	*There is a chiropractor who focuses on women's health, and to get into her is a 3-7 months wait, depending on when you call*
	Unaware	*We never talk about anything like that [referring to acupuncture]. No one would even think of doing it. We just see it on TV. As far as a Chiropractor, it is only if it is really needed. Massage is just looked at as a luxury*
	Lacking information	*I never would have thought acupuncture could help with perimenopausal symptoms*
Accessing healthcare provider, primary care provider, gynecologist?	COVID-19	*I just went for my annual exam it was hard to get an appointment. Then one of my other visits I went to, I was automatically put in a virtual slot without being told that was going to happen*
	Location/availability	*Any which way, it's a 2-3 hour drive, just for the healthcare or that referral*
	Financial	*Copays for gyn and acupuncture things can be anywhere from $20-60. Do we pay a bill, put gas in the car, or do we feed the family? Of course, everything else will come before [copays]*
	Childcare	*They only allow a patient to come in or a child patient and a parent. If you have babies or grandkids, what do you do?*
	Lacking information	*In our community, it seems that nobody really takes their health seriously, until they are about to die. They don't really have a lot of outreach to come into our communities, and let us know, hey, you need to do this and this and this*
	Reactive, not Preventative	*If you say "I'm going to the doctor" the first thing you're asked "is everything ok, are you ok?" and that is the first thing asked*
Healthcare in general	Time Limitation	*A lot of people I know don't even have the time to get a yearly physical check, let alone maintenance visits like massage or chiropractic*
	Disliking change in healthcare providers	*I am also someone who does not like change*

	Barriers	Frequency
	Physical Location	4
	Time Limitation	3
	Financial Limitation (lack of insurance)	3
	Finding a provider one liked	2
	Unaware of options	2
	Childcare	2
	COVID-19	2
	Reactive, not preventative	2
	lacking information	1
	Limited Availability	1
	Facilitators	
What helps you access healthcare and integrative healthcare providers	Word of Mouth	*There are a lot of providers out there… It is hard to know which providers are good or bad*
	Insurance Coverage Education	*I'm finding out new things about my insurance and I've been with the company for 7 years*
		Knowing what is on your insurance, and what's covered, that is important
	Research	*I do a lot of Google searches for my healthcare first*
	Easily Accessible Public Information	*Information needs to be accessible. Where are those places we naturally inhabit so the information can be easily accessible - as it is for young moms?*
		Newsletters within our communities
		How about the gym?

Table 9. Perceptions of the Proposed IMGV Model.

Themes	Input About IMGV (Example Quotes are Edited for Brevity)
Positives	*We have this designated area to talk, and it's safe. It is nice to hear that others have similar or different experiences. Having a designated area and time to set aside to do this seems like a fantastic idea*
	I like that there is actual maintenance after. I could spend a lot of time through a program and often that is on your own. I like that aspect
	When you started talking, all I could think was, 'Can I sign up today'?! That is the most profound thing
	I like that is a whole person approach that addresses a wide variety of needs. But most importantly, women are actually being seen. That is the key, in a lot of spaces, we are not feeling seen. When almost all the women go through this in their lives. So a huge part of the population never feels seen and addressed
	The most valuable thing that this program seems to be addressing, is that acknowledgment. The value of having space for a discussion
	It's in-depth teaching and amazing. I am grateful that it is going to be something available for a lot of us
	I am definitely getting lots of different ideas that could be possibilities that I could integrate in our community. I've had ideas in just in the couple of hours that I have experienced tonight
Barriers/ Additions	*Definitely, lack of free time is a barrier, and it's an investment we will need to figure out – but I will do whatever I can to be there*
	Many women have small children. Maybe add childcare somehow. Then you could get a lot of women interested in having 2-3 hours of space without having to worry. If barriers were removed, I think women absolutely could participate and would want to
	Maybe add different languages and reach out to different cultures. That would be wonderful
	I feel a little bit overwhelmed by it. … To find time, journaling, and trying to eat healthy and all of that. Just to me the whole thing I kept thinking, 'would I even have time to do all that??' I would love to join it but I don't know if I could really commit to it
Format for IMGV	*I love online. If I have to travel, bad weather, construction, traffic… I like zoom*
	Maybe a/synchronous, alternating may be beneficial
	Canvas would be a terrific online format
	Discussion boards: done on your own time, in your own space. Not live

engagement with potential stakeholders before the future design and implementation of MENOGAP. We plan to continue engagement with this group of community members, forming a Community Advisory Board (CAB), to collaboratively design an IMGV called MENOGAP.

Our findings are in alignment with existing literature – most of which is conducted with White women – on women's experiences of the menopausal transition. Yet, our work is also aligned with studies focusing on a specific community. For example, a qualitative study asking Black women about their menopause and weight gain concerns reported that their sample was unprepared for changes experienced during menopause and were interested in receiving information about menopause.[37] Unfortunately, the same concerns expressed by a focus group conducted over a decade ago were echoed in the session we conducted: lack of support and confusion about symptoms attributable to the menopausal transition, as well as difficulties in obtaining helpful care from healthcare providers.[36] Midlife women want reliable information and opportunities to discuss the menopausal transition with (preferably female) health professionals is another theme from the present study that aligns with prior literature.[38]

Although the Session provides important preliminary information about midlife women's beliefs about perimenopause, the menopausal transition and post-menopause, symptoms experienced, and access and barriers to medical and integrative care, there are several limitations associated with our study. We had a slightly younger sample that was highly educated (compared to general US and Utah rates), and we did not have any participants who were post-menopausal. We also had a relatively educated sample living in urban and suburban areas. Thus, results may not be representative of women living in rural or frontier areas, as well as those with less education. Further, we did not ask about menopausal hormone therapy (MHT) directly, which negated our ability to discern interest in MHT as well as integrative health, or separately. Perhaps most importantly, we conducted the study with a small group of women, thus results of the study must be taken with caution as they may not be reflective of women's experiences in other regions of the country and may lack external validity. While a conversation was had among women of varying races and ethnicities, this study did not take a "deep dive" into any one community's experiences of menopause. There is a risk of potential bias of minimizing experiences due to a lack of information. However, only so much depth may be obtained during a 2-hour focus group, and that is indeed a limitation of the present study. One step we did take to increase rigor was to conduct a follow up session, a RoR, in which results were presented back to participants for clarification, change or improvement.

Our study suggests the great need for education about the menopausal transition for midlife women. A novel finding is that a whole person health perspective to managing menopausal transition and post-menopausal symptoms is of great interest to midlife women who participated in the study. Future research can be informed by one finding from our study, to develop interventions in different languages and reach out to different cultures: we recommend that future interventions be developed with appropriate cultural

and linguistic adaptations to be relevant to various cultures. For example, some communities have long-standing traditions of herbal or tea consumption and massage. We recommend that providers discuss natural folk remedies that are culturally relevant but also have safety data, and ideally, efficacy data. For example, Black Cohosh has been used by American Indian/Alaska Native women for centuries[39] and is likewise evidence-based.[40] Further, information provided in interventions should include symptoms commonly experienced, the timing of symptoms during the stages of the transition (late reproductive, early and late transition, early and late post-menopause), and variability in symptom experience (symptoms may last for years for some women while others are asymptomatic or experience minimally bothersome symptoms). Education could include self-care symptom management tips, pharmacological and non-pharmacological care, and information that is culturally relevant and tailored. Our participants repeatedly stressed that the social nature of the session was helpful and that women felt reassured they "weren't going crazy" because other women in the group expressed having similar experiences. This points out the need for information and support for midlife women in the menopausal transition. The social support, education, and self-care included in an IMGV may provide much-needed care during this natural, but sometimes problematic, life transition experienced by everyone with a uterus.

The information gained from this qualitative data contributed to plans to engage in the future adaptation of an IMGV called MENOGAP, designed to fill these gaps in menopausal women's care. Session participants expressed interest in joining a Community Advisory Board (CAB) to provide ongoing collaborative design of the MENOGAP intervention. Mixed-methods and application of the Meharry-Vanderbilt Community Engaged Research best practices[28] will be used to assess participant feedback in an iterative fashion to adapt MENOGAP to suit midlife women's preferences for health education about menopause ("menopause 101"), pharmacological and non-pharmacological treatment options, and evidence-based self-care for behavioral change and improving patient activation and self-efficacy. Just as MGVs are preferred over individual visits by patients with diabetes, psychiatric disease, and women receiving antenatal care, we anticipate that MENOGAP may be acceptable, and perhaps even preferred to one-on-one visits, by some midlife women as social support has been identified as being beneficial to midlife women,[41] women report high levels of satisfaction[42] and appreciating the group medical visit format.[43]

Summary Sentences

This study engaged midlife women before the design and implementation of MENOGAP, a proposed multi-component intervention with group medical visits and evidence-based integrative healthcare information. Participants reiterated the great interest in a whole-person health intervention and the need among midlife women for education about the menopausal transition, self-care, and healthcare.

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Note

1. While menopause is typically discussed as a cisgender women's health topic, not all people identify as cisgender women who experience menopause. Therefore, in this article we use the terms "individuals experiencing menopause" and "experiences" in addition to "symptoms" to avoid pathologizing/medicalizing menopause.

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