Exploring Urban Pakistani Muslim Midlife Women's Experiences of Menopause: A Focused Ethnography Study

By

Amynah Salim Mevawala

A thesis submitted in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

Faculty of Nursing

University of Alberta

Abstract

Midlife women experience physiological changes. These changes are mainly related to the pre-, peri-, and postmenopausal symptoms that have an impact on their physical and psychological well-being and their general quality of life. Midlife women from diverse cultures differ in behaviours, values, and beliefs related to their life experiences and in ways to manage menopausal symptoms. Along with accessing contemporary healthcare services, urban Pakistani women commonly use natural/traditional/home remedies comprised of ingredients such as honey, garlic, and ginger and practice mind and body therapies such as yoga, aerobics, meditation, and other exercises to manage their menopausal symptoms. A combination of modern medicine and self-care practices tend to be used to promote health and prevent disease. There is limited research in the Pakistani context (Anwar, Green, Norris, & Bukhari, 2015) of midlife women and their menopausal symptoms and strategies used to manage those symptoms (Baig & Karim, 2006; Nisar & Sohoo, 2010). My doctoral research explores urban Pakistani Muslim midlife women's experiences of menopause to acquire a deeper understanding of menopause and associated management strategies. A focused ethnography research methodology was used for this study. It guided and informed an understanding of the experiential knowledge of midlife women in a specific cultural context. Recruitment of 20 Pakistan Muslim women residing in urban Karachi was facilitated through women who were socially active at their workplaces or within their communities. Further recruitment used the snowball approach. Study data were gathered between December 2017 and March 2018. I conducted in-depth, semi-structured interviews with 20 women to develop a deeper understanding of the experiences related to the management of menopausal symptoms, the use of biomedical interventions, and self-care practices. Mandatory ethical considerations were

followed in the study. The data were managed using Quirkos qualitative data management software and I analyzed the data using qualitative content analysis to interpret and describe the women's experiences of menopause. The demographic characteristics of the participants indicated that the age of the study participants ranged between 40 and 59 years. All the participants were Muslim but belonged to different faith practices of Islam. Participants of the study were educated working women. Three main themes developed: perception of menopause, strategies for symptom management, and influencing factors. Cultural and religious understanding and practices were interconnected with women's overall perception and experience of menopause. The findings of this study have offered a novel perspective regarding providing a deeper cultural understanding of menopause and associated management strategies in the study population. In addition, it revealed the factors that contribute to shaping women's decisions and menopause-related experiences. The information acquired through this study are valuable for nurses and other health care professionals to provide culturally appropriate interventions to midlife Pakistani women. This study has generated significant information to direct further research in the context of Pakistani midlife women experiencing menopause.

Keywords: educated, experience, focused ethnography, Karachi, menopause, middle age, midlife, Muslim, Pakistani, professional, urban, women, working

Preface

This thesis is an original work by Amynah S. Lakhani (Mevawala). The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name “EXPLORING PAKISTANI, URBAN, MUSLIM, MIDLIFE WOMEN’S EXPERIENCES OF MENOPAUSE USING FOCUSED ETHNOGRAPHY”, No. Pro00074398, December 21, 2017.

In the name of Allah, the most Gracious, the most Merciful.

Praise be to Allah, Lord of the worlds.

The Most Gracious, the Most Merciful.

Master of the Day of Judgement.

It is You we worship, and it is You we ask for help.

Guide us to the straight path.

The path of those You have blessed, not of those who have evoked (your) anger, nor of those who have gone astray.

Holy Quran (Surah Al-Fatiah, The Opener)

Dedication

Meeting the challenges of a doctoral program requires great perseverance and dedication. This is not achievable by a single individual but needs a team of a lot of people with a positive attitude, moral and emotional support and understanding, and continuous unconditional love and encouragement. I dedicate my doctoral thesis to all those wonderful people of my life who stand by my side regardless. Most heartfelt thanks to my loving mother, Zarina Lakhani, for her continuous motivation, and lots of love and prayers. Special thanks to my husband, Salim Mevawala, for being patient, and supporting me to achieve my life goals. A big thank you to my two lovely sons, Alizain and Alishan, for their love and understanding during this endeavour, for boosting my morale when I was down, and for always being a source of energy and motivation for me. They also graduated from their programs over the course of my studies. I love you both more than I could ever tell. We sailed together through the multiple transitions of relocation to a new country, progressing in our academic careers, fulfilling work and other responsibilities, and surviving resiliently through the rough and tough days. Together we stood strong in the good and bad times. A huge shout out to my brother, Sadiq Lakhani, for always being by my side and encouraging me to reach the skies. A warm thank you to my caring sister-in-law, Shirin Lakhani, for believing in me and supporting me through my journey. Thank you also to my niece, Simran and nephew, Shehriyar, for giving me memories to cherish. Last, but not least, thanks to my father, Late Sadruddin Lakhani, who always aspired me to seek higher education. Words will fall short to express my love and gratitude to all my family, friends, and well-wishers; I will fondly reminiscence the moments shared. From the bottom of my heart, thank you all for being there for me!!

Acknowledgements

All praise be to Allah. I cannot thank God enough for igniting in me the inner light and motivation in the pursuit of knowledge. He grants me the strength and courage to stay on the right path and continue my quest for lifelong learning.

Thanks to His Highness Prince Karim Aga Khan for his vision and inspiration for nursing, higher education, meritocracy, pluralism, and other important domains. It helped me stay focused and follow his guidance.

I am indebted to many people throughout my doctoral journey, and particularly, in completing my final Ph.D. dissertation. I would like to extend my humble gratitude to my dissertation committee. A big thank you to Dr. Solina Richter, my Ph.D. supervisor, for her continuous encouragement, support, and guidance, and for confiding in me in accomplishing this milestone endeavour of my life. You intrigued me to work beyond my known capabilities. Thank you, Solina, for being an outstanding mentor and guide. I am grateful to Dr. Pauline Paul for her support when I needed it the most, much before she became my committee member. Thank you, Pauline, also for your detailed and prompt feedback in perfecting my thesis, you always encouraged me to stay positive. I would like to thank Dr. Kathleen Hunter for her expert feedback on my thesis. Thank you, Kathleen, for bringing clarity, and shaping my thesis the best way possible. Once again, a sincere thank you to all my thesis committee members who provided invaluable support and guidance throughout my dissertation process. You helped me develop my research and scholarship, enhanced my critical thinking and questioning skills, and contributed tremendously in attaining a high-standard work.

I would like to graciously thank Dr. Marilyn Evans, for agreeing to be my thesis external examiner at this time of turmoil of COVID-19. Thank you also for her thought provoking questions and valuable feedback. Thank you to Dr. Bukola Salami and Dr. Tanya Park for being on my examining committee, and for their intriguing questions and comments. Thank you also to Dr. Joanne Olson for agreeing to chair my final doctoral thesis defense, and for her guidance and encouragement. Additionally, thanks to all my study participants for devoting their time and sharing their valuable experiences to achieve the aim of my study. I am grateful to the Faculty of Nursing, University of Alberta deans, directors, faculty, staff, and everyone who contributed to my success. I would like to acknowledge the data transcriptionist for her due diligence in transcribing the data verbatim promptly and maintaining confidentiality at all times. I am also thankful to the language editors for picking up minor details to enhance the quality of my thesis. I would also like to recognize all the scholarship/funding support I received throughout the course of my endeavour. Thanks also to my community for being a source of encouragement in keeping me goal directed.

This arduous process of doctorate would not have been possible without the relentless efforts of all those involved in big and small ways. So, thank you to everyone who contributed to my triumph and for transforming me into what I am today!

Table of Contents

Table 4 List of Tables

List of Figures

List of Appendices

List of Acronyms

AJA	Azaad Jammu and Kashmir
CAM/T	Complementary and Alternative Medicine/Therapies
CIA	Central Investigation Agency
FATA	Federally Administered Tribal Areas
GDP	Gross Domestic Product
HCP	Health Care Provider
HRT	Hormone Replacement Therapy
KPK	Khyber Pakhtunkhwa
NPI	Non-Pharmacological Interventions
NWFP	North West Frontier Province
PPP	Purchasing Power Parity
TCM	Traditional Chinese Medicine
WHO	World Health Organization

Chapter One: Introduction

In midlife, women commonly experience a variety of physiological changes that are primarily related to the pre-, peri-, and postmenopausal symptoms. These changes may affect their physical and psychological health, as well as their overall quality of life (Nisar & Sohoo, 2009). The most common symptoms include hot flashes, night sweats, mood swings, fatigue, vaginal dryness, loss of libido, sleep disorders and psychological distress (Chattha, Raghuram, Venkatram, & Hongasandra, 2008; Daley, MacArthur, McManus, Stokes-Lampard, Wilson, Roalfe, & Mutrie, 2006; Khokhar, 2013; Yeh & Chang, 2012).

As a result of their life experiences, women in this age group vary in their behaviours, values, and beliefs, as well as how they manage menopausal symptoms. Besides various other factors, religion, culture, and social background significantly influence women's beliefs, understandings, behaviours, attitudes, and practices surrounding health and illness (Sluijs, Lombardo, Lesi, Bensoussan, & Cardini, 2013; Yosef, 2008). For instance, in Pakistan, urban women access modern healthcare services, but also use natural home remedies (Shaikh & Hatcher, 2005) such as honey, tea, ginger, garlic, turmeric, black seeds, cinnamon, cardamom, and a variety of herbs (Rizvi & Ali, 2016), and practice mind and body therapies such as yoga, aerobics, meditation, and religious/spiritual practices.

Urban Pakistani Muslim women tend to use a combination of contemporary medicine and self-care practices for health promotion and disease prevention. However, these practices are not well understood as there is a dearth of research in the Pakistani context (Anwar et al., 2015). Also, there is a paucity of literature about midlife Pakistani women, their menopausal symptoms, and the strategies they use to manage menopause (Baig & Karim, 2006; Nisar & Sohoo, 2010; Wasti, Robinson, Akhtar, Khan, & Badaruddin, 1993). This research aimed to explore urban

Pakistani Muslim midlife women's experiences of menopause to acquire an in-depth understanding of menopause and related management strategies. It would guide and inform an understanding of the experiential knowledge of midlife women in a specific cultural context. Knowledge generated through this study will inform nurses and healthcare providers, so that they could effectively care and advocate for Pakistani women[1] experiencing menopause.

Research Context

For a better understanding of the phenomenon under investigation, i.e. exploring Pakistani women's experiences of menopause, acknowledging the context in which the study was conducted is essential. The geographical location and sociopolitical, cultural, and historical backgrounds in which these women live have played a crucial role in influencing the menopause experiences of women in Pakistan.

Pakistani context. Pakistan is an independent country. It is predominantly an Islamic state, also known as the Islamic Republic of Pakistan.

Sociopolitical and historic overview. Pakistan came into being in 1947 as a sovereign state when British colonization ended in the Indian sub-continent. At that time, British India was divided into two distinct states, Pakistan, and Hindustan (India), based mainly on the people's religious affiliations, predominantly Islam and Hinduism, respectively.

Located in South Asia, Pakistan occupies an approximate area of 796,100 km^2 (The World Bank, IBRD, IDA, 2019; UN data: A world of information, n.d.). In addition to bordering the Arabian Sea, it shares its borders with India in the east, China in the northeast, and Afghanistan and Iran in the west (UNICEF, 2013). Pakistan is a developing nation that is

[1] Pakistani women in the context of this study refers to urban educated Pakistani Muslim midlife women.

divided into four major provinces, i.e. Sind, Punjab, Baluchistan, and KPK (Khyber Pakhtunkhwa) formerly known as NWFP (North West Frontier Province); and four federal territories, i.e. FATA (Federally Administered Tribal Areas), Gilgit-Baltistan, Islamabad Capital Territory and the State of AJA (Azaad Jammu and Kashmir). The capital city of Pakistan is Islamabad (UN data: A world of information, n.d.), it is situated in Punjab province. Karachi is the capital city of Sind province, located in the South, and is the largest city (Ziring & Burki, 2019).

The projected estimated population of Pakistan in the year 2018 was 207.8 million (CIA, 2019). About 37% of the country's total population reside in urban settings, and 63% live in rural areas. Currently, more rural to urban migration is happening that results in over-crowded cities like Karachi and Hyderabad. Pakistan's gross domestic product (GDP) in 2018 was estimated at US$ 1,462.0 per capita, with 5.7% as the annual GDP growth rate (CIA, 2019), and an estimated 29.5% of the population living below the poverty line in 2013-2014 (Pakistan Ministry of Finance, n.d.).

Islam is the main religion of Pakistan (Miaschi, 2019). More than 96% of Pakistan's population is Muslim (Miaschi, 2019; Pakistan Bureau of Statistics, Government of Pakistan, 1998) of various faith practices, including Shi'a and Sunni, with some divisions belonging to Bohra, Ithna'ashari, Ismaili, and others (Miaschi, 2019). The justice system of the country is also governed by Islamic principles (Ziring & Burki, 2019). Both English and Urdu are the official languages of Pakistan (Nag, 2019b). English is the lingua franca of the Pakistani elite and most government ministries (CIA, 2019). It is also the medium of instruction of the country's educational system, particularly higher education. Urdu is Pakistan's national language and Arabic is considered the language of religion, i.e. the language of the holy Quran

and Hadiths (the collective body of teachings and sayings of Prophet Muhammad - peace be upon him) (Nag, 2019b). Pakistanis have varied ethnic backgrounds. Twenty dialects exist throughout the provinces and federally administered regions. These include the four provincial languages widely spoken, i.e. Sindhi in Sind, Punjabi in Punjab, Balochi in Baluchistan, and Pushto in KPK province (Hakim & Aziz, 1998; Nag, 2019b). Pakistan's total educational spending in the year 2012 was approximately 2.1% of GDP (The World Bank, IBRD, IDA, 2019), which increased to 2.8% in 2017 (CIA, 2019). The literacy rate of Pakistani adults increased from 49.9% in 2005 to 57% in 2014 with an increase in male and female rates from 64% and 35% to 69% and 44%, respectively (The World Bank, IBRD, IDA, 2019). More illiteracy is found in the rural and tribal areas of the country, with female literacy below 1% in some regions, due to the dominance of traditional feudal systems that seek to preserve hegemony by keeping women ignorant. The private education system in Pakistan is better than the public system, but more expensive. Thus, the majority of people living mainly in rural or tribal areas, and some parts of the urban slums, are poorly educated, while the feudal ruling elite and a vast majority of affluent people residing in urban areas are well-educated. Children of the elite often choose to emigrate (The Economist Intelligence Unit - Country Profile: Pakistan, 2008). Data from mid-year 2019 shows that approximately 6.3 million Pakistanis have emigrated to other countries (Nag, 2019a).

Healthcare and related facts. According to Pakistan's constitution, its health sector is the provincial responsibility, but the federal and provincial governments administer healthcare delivery jointly, and districts take responsibility for its implementation (World Health Organization, 2007). The total health expenditure of Pakistan in the year 2018 was estimated to be 2.6% of the GDP (CIA, 2019; Dillinger, 2017) which is lower than in developed nations like

Canada and the U.S. where it is 17% and 22%, respectively (The World Bank, IBRD, IDA, 2019). However, it is comparable to other developing countries like Bangladesh and Sri Lanka, where it is 2.9% and 3.5%, respectively. In Pakistan, the healthcare system has public and private sectors, as well as non-government organizations (NGOs), and there are unregulated care providers too (Kurji, Premani, & Mithani, 2016). People of Pakistan commonly refer to homeopaths, herbalists, Greco-Arab healers, traditional/spiritual healers, and bonesetters for managing symptoms and treating minor ailments (Anwar et al., 2015). Over 75% of the total healthcare spending in Pakistan is private and less than a quarter is public-funded (The World Bank, IBRD, IDA, 2019).

In Pakistan, in 2015, regarding maintenance of hygienic conditions, about 65% of the population had improved sanitation facilities (The World Bank, IBRD, IDA, 2019) with an increase to 83% in urban and 51% in rural areas of the country in 2018 (CIA, 2019). Additionally, an estimated 94% urban and 90% of the rural population had access to improved potable water sources (CIA, 2019). The overall life expectancy of Pakistanis at the time of birth has increased from 66.4 years, with 65.5 years for males and 67.3 years for females in 2014 (The World Bank, IBRD, IDA, 2019) to 68.4 years, with 66.4 years for males and 70.5 years for females (CIA, 2019). The estimated birth rate of Pakistan in 2018 was 21.6 and the death rate was 6.3 per 1,000 people (CIA, 2019). In the year 2018, the total fertility rate decreased to 2.55 (CIA, 2019) from 3.8 births per woman in 2012 (The World Bank, IBRD, IDA, 2019). Of all pregnant women, 73% received prenatal care in 2013. And in 2018, almost 70% of the births were attended by skilled healthcare workers (The World Bank, IBRD, IDA, 2019). In 2018, the infant mortality rate of Pakistan was determined to be 50.4 per 1,000 live births; and the maternal

mortality rate to be 178 per 100,000 live births (CIA, 2019). In addition, in 2018, 34% of women aged between 15 and 49 years used contraceptives (The World Bank, IBRD, IDA, 2019).

Pakistan has a double burden of disease; it is challenged with both communicable and noncommunicable diseases (Naseem, Khattak, Ghazanfar, & Irfan, 2016). There has been a rise in the noncommunicable diseases in Pakistan such as diabetes, hypertension, heart disease, chronic lung disease and cancer (Nishtar et al., 2013). In Pakistan in 2010, noncommunicable diseases constituted the top ten causes of morbidity and mortality and were the reason for one in every four deaths in the country (Jafar et al., 2013).

In addition to the insufficient healthcare resources, there is inadequate planning and management of the existing facilities due to corruption, especially in the public healthcare sectors (Gul, 2007; Kurji et al., 2016). Due to the inadequate quality of healthcare services in the public sector, most of the people from the middle and upper socioeconomic status utilize private healthcare facilities. Socioeconomic status in developing context considers facilities such as housing, water, and sanitation, as well as education, work, and financial standing (Pradhan, Ali, Hasnani, Bhamani, & Karmaliani, 2018). In lower-middle-income countries, poverty may be indicated as living under $1 or $2 a day (Maselko et al., 2018). Quacks, faith healers, homeopaths, hakims (traditional healers) and other healthcare resources are commonly used by Pakistanis (Shaikh, Haran, & Hatcher, 2008; Wasti et al., 1993). In addition, it is common to find fake doctors who are running their clinics based on their working experience as drug dispensers, nurses, or physician assistants (WHO, 2007) or on the mere grounds of continuing to work as their ancestor's business.

Cultural and social influences on women's roles in Pakistan. In Pakistan, there is an enormous influence of Islam in almost all walks of life, including diet, education, marriage,

customs, and celebrations, as well as policies (Hakim & Aziz, 1998). Islam is a religion of peace. In Islam, seeking knowledge is obligatory for all Muslim men and women (Roomi & Parrott, 2008). There are numerous examples, in the Quran and Hadiths, of women scholars and leaders (Roomi & Parrott, 2008). Islam teaches equality among both men and women, and that it has never prevented women from working (Roomi & Parrott, 2008). Hazrat Khadija (R.A.), the wife of Prophet Mohammed (peace be upon him) who was a successful businessperson, is just one example out of many in the history of Islam. Since Pakistan is an Islamic Republic, it discourages gender discrimination at all levels; yet, gender discrimination exists more in the rural than urban parts of the country mainly due to illiteracy, tribal and feudal practices, and misinterpretations of Islam by fundamentalists (Awan, 2012). Rural women are more illiterate and homebound as compared to women in urban areas. The cultural and social setting of Pakistani society is largely patriarchal (Roomi & Parrott, 2008; Awan, 2012). Conversely, the nature and degree of domination vary across classes, regions, and the urban-rural divide (Awan, 2012). Hence, despite the Islamic teachings and principles in Pakistan, there exist the social seclusion of people based on their societal status. However, several factors other than the religion affect the social norms in the country (Awan, 2012). This includes the caste system based on gender and social class that had been prevalent in the Indian sub-continent, and that still has an impact on the people of Pakistan (Lee & Saeed, 2001).

The concept of nuclear families is found more in urban parts of the country, while the concept of joint families exists more in the rural areas (Hakim & Aziz, 1998; Rao & Hussain, 2019). Family is the fundamental economic and social unit in Pakistan (Hakim & Aziz, 1998; Saeed & Atta, 2018). A typical Pakistani family may include parents, grandparents, great-grandparents, children, grandchildren, siblings, cousins, nieces, nephews, and their families; all

living in one household or the same neighbourhood (Weiss, 2014). In most instances, since males are considered superior, the eldest male member of the family is an authority figure (Hakim & Aziz, 1998). He has the final word on all matters of the household and expects complete obedience from all the members as a societal and ethical obligation.

In Pakistani culture, both men and women observe their responsibilities since childhood. They are brought up to respect and obey their parents and elders (Hakim & Aziz, 1998). Boys are valued more; they are nurtured and trained to be authoritative since childhood (Rizvi & Ali, 2016). While girls are considered to belong to another house, the house of their prospective husband, and are treated as temporary visitors in the parents' house (Hakim & Aziz, 1998). In most families, children are expected to stay with their parents until they are married, after which boys take their parents' responsibility. Girls are expected to leave, and live and die in their husband's/in-law's house regardless of the circumstances. Daughters are mainly responsible for taking care of their husbands' families, particularly, parents-in-law (Hakim & Aziz, 1998).

Status of women. There is a profound influence of culture and religion on the status of women in Pakistan (Hakim & Aziz, 1998; Saeed & Atta, 2018). Originally, the Islamic laws were intended to improve women's status in society, since before Islam, there was tribal law in Arabia where women had almost no legal status; and Islamic teachings played a major role in improving women's situation (Hakim & Aziz, 1998; Saeed & Atta, 2018). Islam gives equal status and right to both men and women; including seeking education, working outside of the home, participating in economic and social matters; as well as placing a uniform standard on both genders for protecting their private parts by wearing decent clothing, not involving in extra-marital affairs and lowering their gaze (Hakim & Aziz, 1998; Saeed & Atta, 2018). However, over time there has been an enormous influence of culture and customs on Islamic societies,

including Pakistan (Hakim & Aziz, 1998; Saeed & Atta, 2018). These may vary widely in different Muslim countries, for example, strict laws in some Arab countries, against women driving a vehicle; whereas, in Pakistan and India, women, mostly educated and affluent, drive vehicles; while some Muslim families living in more developed parts of the world tend to be more open-minded. There are differences in the status of women noted in various faith practices of Islam; for example, Ismaili Muslim societies tend to be more liberal. Ismaili Muslim women are generally more educated and independent, work outside of the home, and have more gender equality. Such differences may be due to varied interpretations of Islam as well as rooted in the cultural and traditional practices (Hakim & Aziz, 1998; Saeed & Atta, 2018). There are instances where Pakistani Muslim women have not only been involved but have excelled in all spheres of life including business, arts, education, politics, science and technology, and training as pilots. Some of the well-known women political leaders of Pakistan include Begum Ra'aana Liaqat Ali, Fatima Jinnah, Shaheed Benazir Bhutto - the leader of Pakistan Peoples' Party and the first elected prime minister, Dr. Fehmida Mirza - first speaker of the national assembly; in addition, various ministries like social welfare and special education, information and broadcasting, health, foreign affairs, information and technology, and state minister for the national health services, are led by Pakistani Muslim women (Ahmad & Anwar, 2018).

Islam gives a higher value to women as mothers, and children are obligated to be obedient and respectful to them (Hakim & Aziz, 1998; Rao & Hussain, 2019). There is a well-known saying and belief both in the Islamic and cultural context of Pakistan that, heaven lies underneath the mother's feet (Hakim & Aziz, 1998; Rao & Hussain, 2019); which denotes the high importance placed in caring for and respecting mothers. Likewise, men in Islam are instructed to take care of and respect their wives (Saeed & Atta, 2018). According to Pakistani

culture and tradition, women are expected to be unselfish, calm, and compromising (Ahmad & Anwar, 2018; Qureshi, 2013). They are also expected to do most of the household chores and take care of the family and in-laws (Ahmad & Anwar, 2018). Women are widely considered as homemakers (Ahmad & Anwar, 2018; Roomi & Parrott, 2008), who are mainly responsible for reproductive activities related to childbearing and child-rearing, while men bear the financial responsibilities that are related to earning and spending, and carrying the family's name forward (Ahmad & Anwar, 2018; Hakim & Aziz, 1998). Early and more frequently, forced marriages of girls, more than boys, are common in Pakistan, often in underprivileged societies (Pal, 2017). In most instances, a spouse is chosen by the elders in the family, despite the right of a woman to be willing, and agreeing to marry a person, given in Islam (Pal, 2017). In Pakistani culture, women are considered an honor or prestige (izzat) of the house. She is the responsibility of the head of the family, usually father; or brother, husband, or even grown-up sons, or other male members of the family (Awan, 2012; Hussain, 2009). Often, the male members of the family make all her important and other life decisions, be it education, marriage, selection of a career or any other matter (Awan, 2012). Consequently, women in Pakistani society remain more dependent on men and face gender discrimination due to patriarchy (Awan, 2012; Rashid, 2011).

Islam emphasizes modesty, which is often perceived as purdah (Roomi & Parrott, 2008) i.e. the seclusion or hiding of women from men (Hakim & Aziz, 1998). The extent of purdah varies according to its interpretation. It may include covering the face (except eyes); covering the upper body, or whole body from head to toe in a veil (burqa or abaya) (Awan, 2012) with only a small piece of netted cloth in front of the eyes, and having high walls and curtains in the house; to covering only the head and wearing decent clothes that cover most parts of the body. This may also include certain restrictions on communicating with the opposite gender, and the

physical behaviours like touch of the opposite gender, especially, stranger men or the ones that are not part of the family or close relatives *'na-mahram'*, with certain exception of close family members/relatives (mahram) (Awan, 2012). Due to the influence of rigid mind-set and centuries' old sociocultural traditions, as well as political influences, women are often kept suppressed and homebound *'chadar aur char dewari'* in less educated, and lower socioeconomic class (Bari, 2000; Rashid, 2011). They face a high amount of domestic and inter-partner violence (Awan, 2012). In extreme cases due to tribal and feudal practices, more frequently in some of the underprivileged and rural parts of the country, if a woman is found guilty of crossing specified rules of the village/tribe, she is condemned with strict punishments (Awan, 2012; Bari, 2000). In extreme cases, this may include stoning or beating to death, disfiguring with acid on the face or other body parts, or other inhumane and cruel punitive treatments or acts. This imposes restrictions on women's participation in educational, social, and economic activities (Hakim & Aziz, 1998). Hence, working outside of the home is not acceptable in some communities (Roomi & Parrott, 2008). However, when the family is in need or cases when male members of the house are not earning due to reasons like addiction or simply laziness, women are allowed, and sometimes forced to work to earn, to support the family (Hussain, 2009). However, literate, and professional women have more freedom to make an independent decision about whether to work or not. For example, in large cities like Karachi, women's rate of seeking education and working in non-traditional fields other than, for instance, teaching, are increasing (Hussain, 2009). Nevertheless, there are certain legal restrictions and gender inequalities found in the country, related to marriage, divorce, child custody, inheritance and serving as a legal witness (Hakim & Aziz, 1998). In many parts of the country, there are additional restrictions on

women that are not based on religious sanctions but rather, on local customs (Hakim & Aziz, 1998).

In Islam, sexual relations of both genders are restricted to the person they are married to since marriage is highly valued (Saeed & Atta, 2018). The rate of divorce in Pakistan is exceptionally low due to the Islamic practices as well as the social stigma attached to it. Divorce is also under-reported since it is considered shameful (Hussain, 2009), especially for women. There is huge familial and matrimonial pressure on Pakistani women regardless of where they live (Rodriguez, 2007; Saeed & Atta, 2018). Especially, educated working women are expected to be a homemaker at least as good as less literate non-working women, if not better (Khurshid, 2016). This is due to gender inequality that puts women in an increasingly responsible and vulnerable position to cope with the cultural norms and expectations (Ahmad & Anwar, 2018; Roomi & Parrott, 2008).

Women usually learn about womanhood, gender roles, responsibilities, privileges, and restrictions much early in their childhood (Rizvi & Ali, 2016). However, this gender divide and inequality widen with puberty (Ali, Azam Ali, Waheed, Memon, 2006). Puberty in both male and female adolescence brings huge changes in societal perception and interpretation. Adolescent boys get to enjoy more freedom and privilege, while girls experience more restrictions (Ali et al., 2006). In addition, menarche and menstruation are mainly viewed and experienced negatively by girls (Burrows & Johnson, 2005). Some of the negative perceptions include feelings of disgust, shame, embarrassment, vulnerability and susceptibility to diseases, and something to be hidden (Burrows & Johnson, 2005), in addition to being stigmatized (Rizvi & Ali, 2016). Menstruation is not perceived as a normal event, and menstruating women are considered impure (Bhartiya, 2013). Likewise, women experience and sometimes hold negative

views about different phases of their life related to their reproductive and gender roles. Consequently, notable events in a woman's life like pregnancy, childbirth, and menopause hold similar cultural perceptions and challenges (Rizvi & Ali, 2016).

Research Problem

Little is known about the experience of menopause of urban Pakistani Muslim midlife educated working women. It is important to study women's perception of menopause and how they manage menopausal symptoms in the Pakistani context. It is also vital to identify the influencing factors that guide their decision on how to manage menopause. The above understanding will help healthcare providers to acquire in-depth cultural understanding about menopause and its associated factors when providing care to Pakistani women experiencing menopause.

Research Questions

The broad question for my study was:

What are the urban Pakistani middle-to-upper socioeconomic status Muslim midlife women's experiences of menopause? This was further divided into 3 main questions that guided my study:

- How is menopause perceived by middle-to-upper socioeconomic status urban Muslim midlife women in Karachi, Pakistan?
- How do urban Muslim midlife women manage symptoms associated with menopause in Karachi Pakistan's cultural context?
- What are the various sociocultural, religious, familial, and other factors that influence Karachi, Pakistani women's experiences related to menopause?

Purpose of the Study

The purpose of this study was to explore urban Pakistani middle-to-upper socioeconomic status Muslim midlife women's experiences of menopause and to acquire a deeper cultural understanding of menopause and related management strategies in the Pakistani context.

Significance of the Research

This study explored the experiences of urban Pakistani Muslim midlife women of menopause. Limited literature is available on this topic in the Pakistani setting. The investigation was the first of its kind to explore educated urban Pakistani middle-to-upper socioeconomic class Muslim midlife women's experiences of menopause and gain an in-depth understanding of menopause and related management strategies using a focused ethnography approach. It has helped guide and informs an understanding of the cultural experience of midlife women in the Pakistani context. This study has developed knowledge for nurses and healthcare-associated professionals/providers to care and advocate for Pakistani Muslim women experiencing menopause. In addition to knowledge development in nursing, it is significant to facilitate and help people in a culturally appropriate means to benefit the process of health promotion and wellbeing (De Chesnay, 2014). Consequently, findings of the study are helpful for the health care practitioners to better assess, develop and implement health promotion strategies and health education material, guide health policies, and to meet the holistic health care requirements that are culturally congruent with Pakistani women. This also informs further research needed. Knowledge developed through this study also supports the holistic health care needs that are culturally congruent with the midlife Muslim women living within Pakistan as well as in other parts of the world to some extent such as in Canada and the U.S. More specific studies are, however, needed in diverse contexts.

Since caring for patients in a culturally competent way is important in the discipline of nursing, it will be facilitated by the application of the knowledge obtained by this research endeavour. For example, in Pakistani culture, reproduction is considered a major and vital role of women (Ahmad & Anwar, 2018). Hence, menopause affects women's value in a society that may lead to a difficult life transition and psychological distress in females in menopausal age. Moreover, women experiencing life challenges associated with menopause, require culturally congruent care keeping in mind several important measures like affordability and the wide use of complementary/self-care practices prevalent in society. Therefore, it was extremely important to conduct a study to explore how Pakistani women managed menopausal symptoms; as this has remained a neglected area in healthcare research in Pakistan.

Midlife women from diverse cultures vary in values, beliefs, and ideas around their menopausal experiences and strategies to stay healthy (Hunter & Rendall, 2007). My investigation was significant in understanding the practices used by Pakistani women to manage menopausal symptoms as an embodied experience; since not much is known or has been studied in this part of the world. Pakistani women's menopause experience and management strategies were more embodied in terms of their multiple influencing factors related but not limited to, their cultural, religious, familial, and other factors. By studying the variability in the cultural beliefs of these women, nurses can avoid stereotyping and support client-centred interventions relevant to the women they serve (De Chesnay, 2014). Culturally congruent care contributes to culturally appropriate research planning and implementation, and health policies and compliance to interventions, are more successful (Ross, 2014).

Chapter Two: Literature Review

In this chapter, I discuss menopause and its physiology, common symptoms midlife women experience during menopause, strategies midlife women use to manage menopausal symptoms, sociocultural perception of menopause, and perceptions of menopause in the Pakistani cultural context. The perception of menopause and strategies to manage menopausal symptoms are greatly influenced by several factors that include women's social, cultural, and religious training and beliefs. Women's age at menopause and symptoms experienced are also contingent upon their race, parity, lifestyle, health status, level of education, height, weight, socioeconomic status, and other conditions (Adhi, Hasan, Shoaib, & Tauheed, 2007). Nurses and health care providers (HCP) need to understand how these factors affect women's perceptions about menopause, and their ideas and desire for managing its symptoms, so that they are able to work effectively with women to manage the symptoms of menopause. It is imperative to recognize that we should not stereotype women's experiences of menopause, which are unique to every individual woman (Karim et al., 2013; Khokhar, 2013). In some cultures, women present varying degrees of distress related to menopause, while in other cultural settings, menopause may or may not be perceived as a stressful life event (Hall, Callister, Berry & Matsumura, 2007; Khokhar, 2013).

The search terms used for this literature review were: "menopause*" OR "climacteric" AND "women" AND "middle age*" OR "midlife" AND "Pakistan*" AND/OR "Islam" OR "Muslim" OR "Asia*" AND "experience*" OR "symptom*" OR "knowledge" OR "attitude" OR "perception" AND "urban". Databases and search engines used were Google Scholar, Medline, PubMed, CINAHL, Sociology, Medical Humanities, EBSCO Host, Int'l Economic Stats, Government Information, Anthropology Plus, Google, JSTOR, and Discovery Service for

University of Alberta libraries. Librarians' assistance was used frequently throughout the process and some of the online chat transcripts were also saved.

Menopause and its Physiology

Menopause is defined as the permanent cessation of the menstrual period for 12 consecutive months (Adhi et al., 2007). Menopause may occur naturally, or artificially due to reasons including surgery (hysterectomy and oophorectomy), chemotherapy or radiotherapy (Baig & Karim, 2006). The time before final menopause in a midlife woman is referred to as pre-menopause; the period of the variable menstrual cycle during midlife is termed as perimenopause, and the period after complete amenorrhea for a year is known as post-menopause. The term menopausal transition is given to the period of transition of women from a reproductive to a non-reproductive stage of life (Elavsky & McAuley, 2009).

Menopause occurs due to the decreased ovarian sensitivity to gonadotropin stimulation, because of follicular attrition (Friedlander, 2002; Greendale, Lee, & Arriola, 1999). Throughout a woman's life cycle, oocytes in the ovaries undergo atresia. As a result, there is a decrease in the quantity and quality of follicles. Due to the shrinkage of follicles during the menopausal transition, there is a fluctuation in the menstrual flow and length of the menstrual cycle (Friedlander, 2002; Greendale et al., 1999). The process leads to an absence of ovulation and irregularity in the menstrual cycle, fluctuation in gonadotropin and steroid hormone production, and a decrease in estrogen and luteinizing hormone (Friedlander, 2002; O'Neill & Eden, 2014). Consequently, there are periods of amenorrhea before the complete stopping of menstruation. It is known that the vasomotor and peri-menopausal syndromes in midlife women are due to sympathetic arousal, resulting in raised catecholamine and cortisol levels (Chattha et al., 2008). Midlife women are also considered to be at elevated risk for conditions like osteoporosis, and

cardiovascular illness (Gutiérrez et al., 2015) most possibly due to the coincident escalation in insulin resistance and related atherogenic changes (Innes, Selfe, & Taylor, 2008). Due to the physiologic changes in response to gonadotropins and its secretions as characterized by varying hormonal levels, midlife women commonly experience a variety of symptoms.

Common Symptoms Experienced by Midlife Women during Menopause

During midlife, women generally experience physiological changes related to pre-, peri- and postmenopausal symptoms. These have an influence on their physical and mental well-being as well as their quality of life. Some of the common symptoms women frequently experience during this time may include but are not limited to hot flashes, weight gain, fatigue, aches and pains, psychological distress, vaginal dryness, loss of libido, sleep disturbance, night sweats, mood swings, vasomotor instability, urogenital complaints, memory loss, insomnia and depression (Adhi et al., 2007; Chattha et al., 2008; Daley et al., 2006; Khokhar, 2013; Yeh & Chang, 2012). Menopausal age and symptoms, however, may vary depending on several factors, including socioeconomic status, race, lifestyle, parity, health status and level of literacy (Adhi et al., 2007).

An observational cross-sectional study conducted on 212 midlife women in Karachi, Pakistan, found hot flashes as the most frequent symptom experienced by menopausal women (Adhi et al., 2007). Other symptoms reported by participants included: palpitation, sweating, headaches, extreme fatigue, feelings of loneliness, anxiety, depression, and decreased levels of concentration, which may be comparable to other contexts but with varying frequency and severity. No significant negative impact of menopause was found on libido in this study (Adhi et al., 2007). A population-based cross-sectional study of 960 middle-aged women conducted in Karachi, Pakistan, reported somewhat similar symptoms with added symptoms like urinary

incontinence, hair loss, and memory loss (Baig & Karim, 2006). Another study conducted on 650 midlife women residing in Karachi, Pakistan, also noted similar symptoms, with the addition of irritability, dyspareunia, and frequency of micturition (Wasti et al., 1993). Yet another cross-sectional study conducted on 202 midlife women in Hyderabad, Sindh, Pakistan reported stress incontinence and growth of facial hair in some women, in addition to the above symptoms (Nisar & Sohoo, 2009). In another study, some women in Karachi reported skin changes and decreased vision in addition to other symptoms during midlife (Karim et al., 2013). A study conducted on 870 middle-aged women in Hyderabad, Pakistan, indicated that urban versus rural women experienced increased frequency and severity of symptoms (Khaskheli, Baloch, & Sheeba, 2009). The researchers further added that rural women compared to the urban, had higher comfortability and acceptance about menopause; and manage its symptoms in a better way (Khaskheli et al., 2009).

Strategies Midlife Women Use to Manage Menopausal Symptoms

Women of menopausal age manage their symptoms differently, depending on numerous influencing factors. Besides various other factors, country of origin, religion, culture, and societal background have a major influence on women's beliefs, behaviours, understandings, attitudes and practices toward health and illness (Sluijs et al., 2013; Malik, 2008; Yosef, 2008). There is an overall dearth of research in developing countries including the Pakistani context (Anwar et al., 2015; Anwar, Green, & Norris, 2012). Anwar and colleagues (2015) explored the management of symptoms and minor illnesses experienced by Pakistani people, in everyday life; however, menopausal symptoms were not included in the lists generated by participants in this study. A limited number of studies have been conducted with midlife women, their perceptions, menopause symptoms and strategies for coping with those (Adhi et al., 2007; Baig & Karim,

2006; Wasti et al., 1993). Urban Pakistani Muslim midlife women tend to use a combination of modern medicine and self-care practices for health promotion and disease prevention purposes (Wasti et al., 1993).

Strategies midlife women use to manage menopause-related symptoms vary in different parts of the world, however, the biomedical view of menopause in the U.S. is spreading worldwide at a fast pace and is becoming the dominant way to manage menopausal symptoms (Hall et al., 2007). For most of the second half of the 20th century, menopause was considered a debilitating condition that needed to be treated with hormone replacement therapy (HRT) (Chattha et al., 2008; Daley et al., 2006; Reynolds, 2002). HRT was believed to be the most effective and safe treatment for 'curing' menopausal symptoms. Due to the medicalization of menopause, women have been widely treated with HRT consisting of estrogen and progesterone for their menopausal symptoms. Estrogen was portrayed as a wonder drug that brought back women's youth and beauty (Reynolds, 2002). It, however, was suggested in the latter part of the 20th century, that those menopausal women being treated with estrogen and progesterone were at a high risk of coronary heart disease, stroke, breast cancer and venous thromboembolism (Daley et al., 2006; Dog, 2007; Hall et al., 2007). Nonetheless, in some cases, midlife women are still prescribed low doses of hormone therapy in cases of moderate to severe menopausal symptoms, after excluding any contraindications of its use (Dog, 2007).

Due to the multiple risks and adverse effects, HRT is not considered the best management strategy; women and HCPs are searching for risk-free and effective complementary and alternative medicine/therapies (CAM) and non-pharmacological interventions (NPI) to manage menopause-related symptoms (Cheema, Coomarasamy, & El-Toukhy, 2007). Globally, there has been a revival of interest in CAM and self-care practices (AlRawi, Fetters, Killawi,

Hammad, & Padela, 2012; Butt, Sultan, Butt, & Iqbal, 2009; Hunter & Rendall, 2007). Complementary and alternative therapies are now widely used globally and in a variety of ethnicities and genders. The gap in strategies for managing menopausal symptoms that developed as HRT was discredited, has led to exploring the effectiveness of alternative therapeutic possibilities, which have shown some positive results in improving these symptoms (Chattha et al., 2008).

Some of the CAM/T modalities include medicinal herbs, traditional Chinese medicine (TCM), Ayurveda, spiritual healing, acupuncture, homeopathy, naturopathy, and traditional healing, biological-based therapies and dietary prescriptions such as chelation therapy, herbal and non-vitamin supplements, special diets; manipulative and body-based therapies like biofeedback, energy healing therapy, hypnosis, relaxation techniques, and mind-body practices like yoga, tai chi and qi gong (Davis, West, Weeks, & Sirovich, 2011). CAM modalities are widely used either to complement conventional medicine or for treatment or simply for health promotion and self-care (Davis et al., 2011). A narrative review of 110 articles, conducted by Bishop and Lewith (2010), that focused on demographic factors, including gender, age, income, education, and ethnicity, to look at the use of CAM, indicates that more midlife women than men use CAM. The review also concludes that midlife women users of CAM belong to higher income groups and are well educated (Bishop & Lewith, 2010).

Researches, both in the eastern and western contexts, suggest that traditional mind-body practices like yoga, tai chi, and qi gong could propose safe and cost-efficient approaches. They help in decreasing insulin resistance syndrome-related risk factors for cardiovascular diseases in menopausal women, elevating their mood, well-being, and sleep, and reducing sympathetic stimulation, and augmenting cardiovagal function (Innes et al., 2008; Yeh & Chang, 2012).

Mind-body therapies are proven to decrease autonomic arousal, resulting in a perceived improvement of QOL in midlife women; while coupled with physical exercise, this improvement could occur through the increased circulation of beta-endorphins and possibly as a diversion from stress and worries (Posadzki, Ernst, Terry, & Lee, 2011). Due to the increasing benefits and minimal risk, midlife women are now turning to CAM/NPI at a faster rate to ameliorate their climacteric symptoms (Daley et al., 2006). Some of the common CAM/T and NPI indicated in the literature, as used by women for their menopause symptom management, are diet and nutrition, yoga and exercise, relaxation and stress management, and naturopathic and homeopathic remedies. A significant number of women reported these to be efficacious (Daley et al., 2006).

Among other CAM, yoga, one of the oldest modalities, developed thousands of years ago, is currently gaining popularity as a form of mind-body medicine (Pilkington, Kirkwood, Rampes, & Richardson, 2005). Yoga has demonstrated tremendous efficiency in perceived stress, fatigue, anxiety, sleep disturbance, depression, and lower back pain reduction; while providing overall health, energy, and quality of life improvement (Chattha et al., 2008; Kelly, 2009). There are documented pieces of evidence that propose a reduction in neuro-hormones and electrophysiological changes of sympathetic arousal after the practice of yoga (Streeter et al., 2007). Furthermore, studies suggest that the depressive symptoms of menopause may decrease with yoga practice, by increasing GABA (gamma-aminobutyric acid) levels in the brain (Streeter et al., 2007; Pilkington et al., 2005). A randomized controlled trial (RCT) conducted by Chattha et al. (2008), in Indian women of menopausal age, confirmed that the practice of yoga is a common modality. The authors indicated that CAM is gaining more popularity, with over 15 million people practicing it while increasing numbers of women are practicing it in the U.S.

Numerous other types of physical activities practiced by midlife women have also demonstrated improvement in climacteric symptoms. The frequency and duration of these practices has a direct relationship to the improvement of menopausal symptoms (Chattha et al., 2008).

Some midlife women use aromatherapy and massage therapy for managing their menopause-related symptoms. An interventional study found that the utilization of aromatherapy using different essential oils topically in the form of massage on the abdomen, back, and arms, was effective in reducing the total menopausal index in Korean climacteric women; more specifically it reduced hot flashes, pain, and depression (Hur, Yang, & Lee, 2008). In a similar investigation, aromatherapy was found to help reduce blood pressure in menopausal women (Hur et al., 2007).

Midlife women in Pakistan, frequently use a combination of complementary and self-care modalities as well as religious practices and rituals in their everyday lives (Qidwai, Samani, Azam, & Lalani, 2012; Shaikh & Hatcher, 2005). They also use gems and consume vitamin supplements; those are widely believed to be fundamental in avoiding harm and to keep well (Qidwai et al., 2012). Eighty percent of midlife women in Karachi were found to be knowledgeable about menopause, while only 13% were knowledgeable about HRT, 29% consulted a physician, and only one woman was taking HRT (Khokhar, 2013). A study conducted in Hyderabad, Pakistan, reported that 60% of well-educated working midlife women consulted HCPs, and only 5% were aware of HRT (Memon, Jonker, & Qazi, 2014). Pakistanis generally consider traditional healing, natural and home remedies, and other CAM as an inherent component of their society and culture (Shaikh, Malik, James, & Abdul, 2009). One of the most common self-care practices found in Islamic believers is spiritual healing, i.e. by reciting and following the teachings of the Quran and Prophet Muhammad (PBUH) (Anwar et al., 2015).

Performing spiritual meditation (AlRawi et al., 2012) is believed to triumph the health and healing of the body and soul. Religious and spiritual healing plays a crucial role in Muslim women's overall self-care practices (AlRawi et al., 2012). Recitation of selected verses from the holy Quran on individuals both sick and well for vitality, especially the first few verses, that are considered the 'verses of cure' (Anwar et al., 2015), and wearing amulets (Farooqi, 2006) are a few examples that Muslim women practice. In addition, natural ingredients like honey, cinnamon, ginger, garlic, turmeric, black seeds (kalonji), and olive oil have a great value and are commonly used by women, due to the vast benefits of some of these mentioned in the Quran and Hadiths (AlRawi et al., 2012). In Pakistan, religious ways of healing are a predominant domain. Since non-conventional, traditional, complementary and alternative therapies, and home remedies are engrained in the daily life of Pakistani women with minimal awareness of their scientific benefits and uses, they are often not noticed or reported. A study on midlife working women holding a minimum of a graduate degree, in Pakistan, indicated that none of them had any knowledge about available alternative therapies to manage menopausal symptoms, they, however, expressed the desire to seek more knowledge (Memon et al., 2014). Another study conducted on midlife Pakistani women found that about a quarter of the participants frequently used herbs and supplements (Nusrat, Nishat, Gulfareen, Aftab, & Asia, 2008).

There is a need for safe, economical, wide-ranging therapies that minimize menopausal symptoms with minimal to no negative health consequences, promote adherence and lower the risk of major chronic conditions linked with menopause. There is an increased need for management strategies, due to the rise in the overall life expectancy, more women are expected to spend about one-third of their life in the perimenopausal to postmenopausal phases (Khokhar, 2013). It is recommended that despite inadequate scientific evidence of the effectiveness of

CAM and self-care practices, its use should not be discouraged if women personally find it beneficial and it poses little to no harm (Dog, 2007). Several other self-care and CAM/T practices like acupressure, acupuncture, music therapy, Reiki, color therapy, mindfulness-based stress reduction, guided imagery, and numerous other therapies are vastly utilized by midlife women due to their multifaceted benefits.

Sociocultural Perception of Menopause

Women's experiences and perceptions are primarily based on their cultural influence and their way of living. In various cultural settings, values, beliefs, customs, and practices are carried forward from one generation to another. People's lifestyle reflects those of their predecessors, and they are least affected by other cultures. In this section, I have addressed various perceptions of women about menopause based on their situation and sociocultural influence.

Authors of a study in Iran report that midlife women in the rural context, have a more negative perception of menopause compared to the urban women, mainly due to losing the ability to conceive; they view menopause as a step towards aging and do not welcome this life change (Khademi & Cooke, 2003). They often fear to lose their youth and childbearing characteristic that gives them a sense of vitality and worth in society. Literature reports that women who are approaching the menopausal age perceive more anxiety about the symptoms than the ones who are already experiencing it (Sampselle, Harris, Harlow, & Sowers, 2002).

Some educated working midlife women view menopause as an opportunity to enjoy freedom from the monthly menstrual cycle and pursue their professional endeavours (Stotland, 2002). While some women mainly from low-income groups are too busy balancing their life and work, menopause and its symptoms are less significant to them (Im, 1999). For example, some

midlife women have a lot to do, i.e. work to support their family financially as well as do household chores, take care of the family, children, and elderly at home. In the process of managing the busy schedule of life, these women are left with no or less time to think about their menopause as they have other priorities in life that take most of their time and attention (Khademi & Cooke, 2003). Conversely, educated women are better aware, able to recognize, and manage their menopause symptoms because they possess the knowledge through literature, mass media, healthcare providers and educated social groups (Awan, 2012; Vanwesenbeeck, Vennix, & Van De Wiel, 2001).

Women, who have migrated globally, or within a country or geographical boundary, may perceive menopause differently. Most immigrant women in a study conducted on Korean women did not have a positive outlook towards menopause (Im & Meleis, 1999). Women reported that they were healthier, energetic, and more productive in their home country compared to their current situation, where they felt more depressed and weaker. They also indicated that it was related to the numerous challenges of immigration, which were making them aged faster. Due to the multiple transitions that migrant women go through, it is hard to differentiate their feelings of menopause with those caused by the migration experience (Hall et al., 2007). Immigrant women do not widely talk about their perception and experience of menopause (Im & Meleis, 1999). In addition, their menopausal symptoms greatly depend on their life situation, coping ability, literacy level and socioeconomic status (Adler et al., 2000). Greek women living in Australia reported aggravated symptoms and negative opinions about menopause, mainly due to coping with multiple stressors of immigration (Komesaroff et al., 2002). Some Pakistani immigrant women living in non-native countries face comparable problems and do not hold a positive outlook about menopause (Qureshi, 2013). These women

generally see menopause as getting older quickly; while they still have to raise children, progress in careers, and gain financial stability in a new setting (Im & Meleis, 1999). In contrast, well-educated, employed Filipino midlife women residing in the U.S. informed a more positive outlook and better coping with their menopause experiences (Berg & Lipson, 1999). However, both native and Russian immigrant women living in the U.S. reported high levels of depression (Miller, Sorokin, Wilbur, & Chandler, 2004). Thus, the experience and perception of menopause are greatly contingent upon midlife women's social, religious, cultural, environment, familial, economic, and multiple other factors.

Perception of Menopause in Pakistani Cultural Context

In this section, I highlight how menopause is perceived in Pakistani culture. Due to the dearth of research in the area, perception of menopause in comparable countries and contexts and pertinent tacit knowledge are included, as necessary.

Family is the most important unit of Pakistani society, each member of the family has a significant and culturally defined role to play (Saeed & Atta, 2018). In Pakistan, the primary role of women, as physiologically given by nature, is widely considered related to childbearing and child-rearing (Saeed & Atta 2018). Although, such perception is stronger in rural or poorly educated communities than urban and literate families (Adhi et al., 2007; Awan, 2012; Hakim & Aziz, 1998; Qureshi, 2013). Pakistani women have high societal expectations to care for their families, especially their husbands and in-laws (Ahmad & Anwar, 2018). These findings also coincide with other similar cultures (Rasmussen, 2000). In addition to the huge pressure on Pakistani women to bear children, they are expected to give birth to male children (Hakim & Aziz, 1998; Stotland, 2002). Sons are believed to be the strength of the family who would take care of their parents in their old age, and carry-on the heredity of the family; thus, having more

male children is looked upon positively (Awan, 2012). For women, having more sons means bearing higher prestige and power, and acquiring daughters-in-law (Stotland, 2002). Thus, giving birth to male children raises women's status and gives them value and respect in the family and society (Hakim & Aziz, 1998). In the hope and intent of bearing a male child, Pakistani couples usually keep trying for multiple pregnancies up to 12-14 or more in some parts of the country. In Karachi, less educated midlife women from poor families reported having five children on an average; while the maximum parity was 13 (Malik, 2008). In some instances, Pakistani women continue to give birth to children late in their lives, while in other instances, it is a taboo if a woman is expecting in her middle age. Having active sexual relations at menopausal age is hence, looked upon negatively in some communities (Carolan, 2000).

Women experiencing menopause, sometimes view themselves as old and incapable of conceiving anymore. Results of a study in Karachi show that 36% of the middle-aged women were happy, while almost 33% were unhappy with the cessation of menstruation (Khokhar, 2013). Menopause is sometimes perceived as a threat by midlife Pakistani women since they fear that their husbands may abandon them for younger women. This is highly prevalent in societies where women are physically, materially, socially, and financially dependent upon their male partners (Aaron, Muliyil, & Abraham, 2002; Khademi & Cooke, 2003). Perception about menopause, however, greatly varies based on several factors including, women's level of literacy and dependence on men, and socioeconomic status. When inquired from less educated women from low socioeconomic status in Karachi, approximately 72% of them viewed menopause as natural, while 28% believed it was a disease (Khokhar, 2013). Findings from a study conducted in Karachi, that involved poorly educated middle-aged women from the low socioeconomic class showed that majority of them had either positive (47%) or neutral (39%) attitude towards

menopause; and perceived it as independence and freedom from the monthly menstrual cycle (Malik, 2008). In some developing countries like Pakistan, women do not give much attention to menopause. Women either do not see it as a problem since they perceive it as a natural occurrence, or view it as a luxury of life for those who have time for themselves or they have multiple other roles and responsibilities, and problems to attend to than menopause (Malik, 2008; Im, Meleis, & Lee, 1999; Winterich & Umberson, 1999).

There also exists a taboo to be an older woman, which is connected to women in their menopausal age. Instead of being called non-productive, inactive, old, and ugly (Stotland, 2002), to being called young and to maintain their status in society, women in Pakistan frequently choose to hide their actual age. Their spoken age often differs from that of their documented age (Adhi et al., 2007). Women tend to under-report their age and they are usually a few years older than what they say they are (Baig & Karim, 2006). However, women from poor education and socioeconomic background may sometimes find it difficult to perceive menopausal changes and to prepare for it at the right time, since they may not even know their age at menarche or their age according to their actual date of birth (Adhi et al., 2007). In Karachi, the average age of women at menopause, as per their documented age, was reported in a study as 44.5 years (Adhi et al., 2007). However, the average age of menopause in less literate midlife women from lower socioeconomic backgrounds in Karachi was stated as 47.4 years (Malik, 2008). And the mean age at menopause indicated by midlife women from three socioeconomic classes, i.e. lower, middle, and upper, in urban Karachi, was 47 years (Wasti et al., 1993). Due to limited literature in developing countries on age at menopause, in practice, 40 years is used as the arbitrary cut-off point for natural menopause (Adhi et al., 2007).

In some cultures, women bear higher status, power, and more independence after menopause. While in some patriarchal societies like in parts of Pakistan, India, and Korea, women sometimes do not experience an increase in status when aging, nor can they talk about their views and suffering related to menopause with their husbands or family. Instead, they are expected to stay silent and tolerant (Aaroon, Muliyil, & Abraham, 2002; Ahmad & Anwar, 2018; Qureshi, 2013). Some women appreciate the fact that after menopause they will be relieved from recurring birthing as due to illiteracy and misinterpretation of Islam, using family planning methods is perceived as inappropriate (Hakim & Aziz, 1998). However, menstrual irregularity in midlife may sometimes be stressful and confusing, as women cannot figure out if it is related to menopause or another pregnancy (Carolan, 2000).

For some women, midlife is the time to redefine their roles such as taking care of the elderly and grandparents or grandchildren (Carolan, 2000). Sometimes it is a choice of women to play with and take care of their grandchildren, while at other times, it may be preferred or necessitated by their children and other members of the family (Stotland, 2002). Women's roles in midlife may shift to becoming mother-in-law and grandmother from the earlier roles of daughter-in-law and mother (Stotland, 2002). Such responsibility and role change also correspond to a study conducted on midlife women in Japan, who are primarily responsible to look after their grandchild and daughter-in-law (Zeserson, 2001).

As the educational level of women influences their attitude towards menopause, 87% of the literate professional middle-aged women in Hyderabad, Pakistan informed that they had a positive attitude towards menopause, and most of them had a feeling of easier and calmer life (Memon et al., 2014). In a study on women in three different cities of the Punjab province of Pakistan, it was found that higher education and good socioeconomic status were significantly

related to positive perception, better knowledge, and management of menopause (Mallhi, Qadir, Khan, Khan, Adnan, 2014).

In educated Pakistani families, a limited number of children, in most instances two or even one is considered enough, regardless of the gender of the child, as opposed to lower literacy and socioeconomic group. In such families, women perceive menopause as part of the aging process and welcome this life transition (Wasti et al., 1993). They view menopause as the time to enjoy their life, get more involved in their professional growth, and give more independence to their children in their life choices, besides practicing various strategies for coping with menopausal symptoms (Wasti et al., 1993). Moreover, these women feel free to discuss their menopausal experiences and management strategies with their family, friends, colleagues, and HCPs (Memon et al., 2014; Wasti et al., 1993), though preferably with females in most instances. They have more opportunities and exposure to mass media and the internet, which have a significant impact on women's perception of menopause (Memon et al., 2014). As stated earlier, the impact of the medicalization of menopause, i.e. the use of HRT and CAM are perceived as effective ways of managing symptoms of menopause by some midlife women (Moyad, 2002; Reynolds, 2002). Most educated, urban midlife women try to make healthy lifestyle changes, maintain self-esteem, and embrace this life process; as was reported by midlife urban Iranian women (Khademi & Cooke, 2003).

There is yet another significant cultural aspect to the perception of menopause, particularly in Pakistan. Due to some Islamic misconceptions as well as cultural beliefs, menstruation imposes some limitations on women (Bari, 2000; Rizvi & Ali, 2016). For example, they should abstain from offering prayers or fasting particularly, when they are menstruating (Mumtaz, Sivananthajothy, Bhatti, & Sommer, 2019; Rizvi & Ali, 2016). According to some

interpretations, women are considered unclean or *'na-pak'* during these days and are refrained from participating in religious activities, (Rizvi & Ali, 2016). This includes loud recitation of verses from the holy Quran, touching the holy book, or performing other rituals both alone and in religious congregations (Rizvi & Ali, 2016). Women can only continue with these practices once they are clean or *'pak'* (Rizvi & Ali, 2016) or relieved from menstrual bleeding, and after they have taken a complete shower once their monthly menstruation is over (Mumtaz et al., 2019). However, some interpretations argue that women during menstruation are given relief in Islam (Rizvi & Ali, 2016). For example, offering prayers include multiple times bowing, bending and prostration, which may be uneasy and difficult and may increase the menstrual flow; similarly, fasting from dawn to dusk may be challenging and may compromise women's health as they require better nutrition during this time (Rizvi & Ali, 2016). Hence, women are excused, so that they could regain their health and take a break from the religious practices including the obligatory *'farz'* ones when menstruating (Rizvi & Ali, 2016).

Hence, there exists a divergent viewpoint of women about menopause in the religious and sociocultural context of Pakistan (Wasti et al., 1993). Women perceive it as a freedom to practice all the religious rituals and activities without the imposed restrictions as in menstruation. They can offer prayers every day and do not have to miss any more fasts and then make up for the missed days later. They can recite the Quran and touch the holy book any time they wish, as they have no restrictions. Since it is prohibited in Islam to perform sex during menstruation, some women and men feel relieved as, after menopause, they can fulfill their sexual desires at any time.

In addition, there are several cultural myths related to menstruation such as, not trimming nails or drinking and eating foods that are thought to be hot or cold in nature or effect, and not

eating or handling pickles during menstrual days (Rizvi & Ali, 2016). Since midlife women also perceive menopause as an indication of aging, they get more involved in religious practices and spiritual search, and less active in worldly matters since menopause is thought to be a sign of getting closer to their death and the Day of Judgment. A similar perception of menopause is found in midlife Iranian women (Ayatollahi, Ghaem, & Ayatollahi, 2005). Women from some cultures, who observe purdah can undo their veils when they reach menopausal age because they are perceived as old and experienced, not young and productive. These women view menopause as gaining more freedom to talk to men, travel alone and do things without the company and permission of men, which was earlier restricted (Mumtaz et al., 2019).

In summary, women's roles, and perceptions of menopause in Pakistani cultural contexts vary widely based on factors such as urban and rural settings, socioeconomic status, and level of education. The perceptions may range from viewing menopause as a positive or natural phenomenon to negative or disease related. In Pakistan, there is an increased concept of extended family, and bearing male children is valued in some families. In such communities, midlife women are viewed as old and incapable of reproducing. This may be one of the reasons why women usually hide their age; while some women from less educated backgrounds may not know their actual age. Since menopause is generally considered women's private matter, most women in Pakistan do not discuss menopause openly as they are expected to stay silent about this (personal) life experience. However, due to access to print and electronic media, educated professional/working women may discuss their menopause experience, preferably with female family members, friends, colleagues, and health professionals.

There is limited literature available on menopause in the Pakistani context. Studies focusing on the in-depth exploration of women's experience of menopause, such as conducting a focused

ethnography study in the area or exploring the cultural understanding of menopause has, however, not yet been found in the literature.

Chapter Three: Methodology

The purpose of my study was to understand Pakistani women's experiences of menopause. Since I had not experienced menopause, I was asking the question as an outsider trying to understand a worldview that was hidden from me. During my doctoral studies, I learned the significance of appreciating an individual's values, beliefs, understanding, and experience concerning their cultural and societal perspectives. I came to understand that menopause is a phase for women that is influenced by their circumstances and impacts their lives. I created a glossary of the research terms using the definitions most relevant and applicable to the study and to its context and my perception about menopause (Appendix A). To appreciate women's experience of the phenomenon, it was significant to gain an in-depth understanding by listening to women who have experienced it in a specific sociocultural and religious context.

In this chapter, I describe the research design that I used for my exploration; strategies for recruiting participants; and the collection and analysis of data. I also describe how I ensured rigour and maintained ethics throughout the research process.

Design

Research is conducted to answer questions and gain new knowledge. Qualitative studies emphasize words, statements, and individuals' knowledge, perception, and experience. In addition, qualitative studies are conducted to understand the complexity of the lived experience of people from those who live that experience (Schwandt, 1994). There are several ways of conducting qualitative studies depending on the researcher's epistemological and philosophical underpinnings as well as the purpose of the study (Boadu & Higginbottom, 2014). For some

researchers, nothing is more compelling than to discover the cultures and lives of people (De Chesnay, 2014).

Ethnography is one of the qualitative research methodologies that originated from early anthropology (Cruz & Higginbottom, 2013; Milgate, 2006). It is the study of people in relation to their rich cultural context (McFarland, 2014). In addition, caring for people is the essence of nursing and nursing knowledge influences practice (Keen & De Chesnay, 2014). In a broader sense, ethnography as a research design is of relevance to nursing since it is intended to study a specific culture and the way people live their lives in that culture (De Chesnay, 2014). A plethora of ethnographic research studies have been conducted in recent years. The most common types of these ethnographic studies include focused ethnography by nurses (Keen & De Chesnay, 2014). Nursing scholars conduct these focused ethnographic studies in diverse settings, namely in the area of inpatient, community, academic, and long-term care settings (Keen & De Chesnay, 2014). Many of these nurses conduct focused ethnographic inquiries in previously known settings or their home countries (Keen & De Chesnay, 2014). Diverse ways of living mainly derive from the cultural or ethnic backgrounds of people or their country of origin, nature of work or profession, or other life conditions (De Chesnay, 2014). As nursing is an applied field of study and practice, this methodology is significant for knowledge development in the field of nursing as well as to add to the understanding of cultural safety and cultural competence in nursing (De Chesnay, 2014).

I chose to undertake this endeavour with a qualitative perspective using a focused ethnography approach. It was the most suitable study design to answer my research question: "What are urban Pakistani Muslim midlife women's experiences of menopause?" The design provided me with the focus and flexibility to understand women's perception and experience of

menopause in the Pakistani context. I employed both emic and etic perspectives for the study. I used a semi-structured format for this exploration that allowed freedom for the women to share their experience of menopause and its potential influencing factors. My effort was to become cognisant of the cultural understanding that health professionals need to appreciate and address when working with Pakistani women experiencing menopause.

Assumptions of the study. The study design has the following assumptions that are congruent with a constructivist approach:

- There is no single or static truth, rather there exist multiple realities, and that knowledge is continually evolving.
- Knowledge is constructed. Mutual interaction among human beings and their environment plays an important part in knowledge construction.
- Knowledge development is influenced by objectivity; both theoretical knowledge and observation are value laden.
- Truth is constructed based on the social and environmental context, people's values, beliefs, and understanding, and human interaction and experience.

This focused ethnography inquiry is the first nursing study conducted within the specific population of Pakistani context with a focus on urban Muslim midlife women's menopausal experiences. My investigation aimed to explore the experiences of a specific group of women (educated, working women from the middle-to-upper socioeconomic status who were Muslim and were living in Karachi, Pakistan). Since I had a predefined purpose; the study was well focused; the setting was known to me as the principal investigator of the study; and the study could be conducted within a specific period, it made a good fit to conduct a focused ethnography (Higginbottom, Pillay, & Boadu, 2013).

Nursing being a practice-oriented profession, I believe that it was significant that the focus of the research was to apprehend people and their interactions with the environment and the social and cultural structures they lived in. There is a strong influence of the traditional values and beliefs of people on their health and illness behaviour (McFarland, 2014). Suffice to say that such experiences are not quantifiable, thus, nurses need to conduct qualitative investigations to gain understanding and insight into those experiences to enhance health care approaches in increasingly culturally congruent ways of nursing care (Ross, 2014).

Ethnography. Ethnographic studies are significant qualitative designs for nurses to gain insight into people's health belief systems and values to be able to develop effective services in culture-specific ways (McFarland, 2014). In nursing, ethnography started to be used as a research design in the second half of the twentieth century (Munhall, 2007). It is used to study people's behaviour in relation to their culture. Culture primarily refers to the learned set of values, beliefs, and attitudes that affect behaviour patterns of a group of people (McFarland, 2014; Ross, 2014). The word ethnography is derived from the Greek words: 'ethnos' meaning 'the people' and 'graphis' meaning 'to write' (McFarland, 2014). Hence, ethnography is a research methodology to study people's beliefs, values, and customs by immersion in that culture. In other words, it is the process of learning about people from the people (Higginbottom et al., 2013; McFarland, 2014; Roper & Shapira, 2000). Cultural knowledge is both explicit, meaning overt or obvious, and implicit, meaning covert or concealed (Higginbottom et al., 2013). Ethnographers understand that knowledge about a culture is socially constructed. For instance, tacit knowledge is implicit or covert (Higginbottom et al., 2013). It is not obvious or easily learned; and to obtain and infer such knowledge a variety of data collection techniques are required to be used by the researcher. An ethnographic researcher also tries to comprehend the

meaning people give to the artifacts, symbols, and events (Speziale, Streubert, & Carpenter, 2011). Ethnographic designs help unravel from an emic perspective the tacit knowledge of people that is embedded in their cultural and social values, beliefs, and practices, from an emic perspective.

Ethnographic techniques have further developed over time into highly adaptable methods to serve the diverse purpose of investigations (De Chesnay, 2014). Some of the types of ethnography include traditional, focused, visual, auto-ethnography, critical, cognitive, disrupted, performance, deconstructed, reflexive, specialist, and practitioner ethnography (De Chesnay, 2014).

Focused ethnography as an approach to inquiry. Focused ethnography originated in the field of sociological ethnography and is rooted in classical anthropological ethnography (Boadu & Higginbottom, 2014). The design was initially introduced and described by Hubert Knoblauch and was published in the English language in 2005 (Wall, 2015). There is, however, limited literature regarding focused ethnography as a research methodology (Wall, 2015). The design is commonly used as a pragmatic and efficient way by professionals who belong to applied fields or practice-based disciplines such as nursing, computer design, and engineering to study specific cultural perspectives and to practically use that knowledge (De Chesnay, 2014; Wall, 2015). It is an effort to understand a group of people, subculture, or phenomenon through culturally relevant information (Keen & De Chesnay, 2014).

Focused ethnography is a valuable type of ethnographic research design through which people's norms, beliefs, actions, and opinions can be studied (Knoblauch, 2005). Focused ethnography thus profoundly deals with the tacit knowledge of a certain group of people in relation to their specific culture and practices of daily living, like my study aim. It is an in-depth

investigation of a specific question to be answered in relation to its cultural context. In focused ethnography, the researcher often knows the context under study. Hence, the researcher is not a stranger to the people or culture being studied, as opposed to in traditional ethnography where the ethnographer studies an unfamiliar context by immersing in the environment for a longer period. In traditional or conventional ethnography, the researcher encounters strangeness, while in focused ethnography the researcher confronts alterity (Knoblauch, 2005). Alterity is when the researcher possesses shared knowledge with the study participants, but at the same time also may encounter new knowledge. The new ideas and perceptions gained from the research participants are comprehensible to the researcher due to the presence of shared commonality and enable the researcher to recognize variation during data gathering (Knoblauch, 2005).

Because of the specific and focused nature and purpose of the study, it is referred to as focused ethnography. Thus, focused ethnography is conducted in a setting where a group of people share similar characteristics, interests, values, beliefs, and actions, for instance, in a city or geographical boundary, religious group, organization, hospital or hospital unit. In summary, it is an intense study design with periodic and purposeful visits rather than continuous participant observation and broader fieldwork as in traditional ethnography (De Chesnay, 2014). In focused ethnography, key members of the culture are interviewed in depth (De Chesnay, 2014). The interviewees or the study participants who agree to participate must be knowledgeable in the phenomenon being studied and be willing to share their knowledge and experience around the narrower research question. The interviews may be structured, semi-structured, or unstructured, depending on the nature and purpose of the study.

Basic philosophical, ontological, and epistemological tenets of focused ethnography. According to the philosophical derivation, ethnography is an anthropological research design that

dates back to the late nineteenth and early twentieth centuries (De Chesnay, 2014; McFarland, 2014; Wall, 2015). The methodology was initially used by anthropologists to study primitive cultures. However, over time it has been adopted by educators, nurses, sociologists, and other social and human scientists who are interested in studying cultures/subcultures and societal interactions of the groups of people and organizations (De Chesnay, 2014; Wall, 2015).

Ontology is the nature of reality or the study of truth or being (Crotty, 1998). Its assumptions are based on what constitutes reality (Scotland, 2012). The ontology of ethnography is believed to be culturally constructed. Cultural knowledge is both explicit and implicit. In ethnographic studies, culturally congruent knowledge is gained by physical presence or immersion in the culture being studied. A better understanding of the people or culture is accomplished using a variety of data collection techniques and making relevant inferences to gain culture-specific knowledge.

Epistemology is concerned with the nature and forms of knowledge and the possibility and scope of knowledge or truth (Crotty, 1998). It provides the philosophical basis for deciding the possibility of the kinds of knowledge possible and how we can ascertain its adequacy and legitimacy (Crotty, 1998). Its assumptions are based on how knowledge is generated, obtained, and communicated, or simply, what it means to know (Scotland, 2012). Ethnography is grounded on the epistemology of constructivism. Ethnographers believe that there is no one truth, but there are multiple truths, facts, or realities. Since epistemology is axiological (Carter & Little, 2007), focused ethnography is fundamentally rooted in constructionist epistemology that is founded on the assumption that meaning is not discovered but instead is constructed through social interaction, environment, and historical and cultural patterns that are the part and parcel of people's everyday lives (Boadu & Higginbottom, 2014). My philosophical paradigm is, hence,

based on the post-positivistic, constructivist epistemological perspective (Spiers et al., 2014) that acknowledges the existence of multiple truths and realities rather than just one truth as in a positivist paradigm (Boadu & Higginbottom, 2014).

Conducting the study in the natural setting of the people, in my case in the Pakistani Muslim context, was congruent with the interpretivist theoretical perspective, particularly that of naturalistic inquiry where I looked for historically situated and culturally derived interpretations of the people's social life-world (Boadu & Higginbottom, 2014). This was achieved by obtaining the tacit knowledge of the people. Tacit knowledge is implicit, which is not readily available and requires multiple means to collect the required data. An ethnographer utilizes various data collection techniques to access and make inferences of the tacit knowledge. For attaining relevant data, focused ethnography as a methodology employs anthropological research methods like in-depth interviews, field notes, and observations to study targeted cultural groups' values, beliefs, customs, behaviours, and perceptions to address specific issues and to generate specific knowledge regarding a particular health process or condition (Boadu & Higginbottom, 2014; Cruz & Higginbottom, 2013).

An alternative to learning people's cultures completely in all the different dimensions as in conventional ethnography, focused ethnography explores the cultural factors within a narrower and more focused scope of inquiry (De Chesnay, 2014). My impetus to explore the experiences of urban Pakistani Muslim midlife women of menopause was well suited to a focused ethnography design. Using focused ethnography, I relied essentially on the in-depth, semi-structured, audio-recorded interview data with 20 midlife women, until I reached saturation. This means that I continued to collect data until rich data was obtained that was adequate to answer my inquiry and I created field notes to reveal the cultural elements of interest

(Knoblauch, 2005; Higginbottom, 2011). Data saturation was reached when there was no new knowledge being added by the participants and the information being given was redundant.

Characteristics of focused ethnography relevant to my research. Qualitative research designs have some common characteristics. These include fieldwork, researcher as an instrument, and the cyclical nature of data collection and analysis. However, some characteristics are unique to ethnographic studies such as the emphasis on culture, the researcher's immersion in the culture, and reflexivity. In the classical or traditional approach, the researcher aims to study all aspects of a culture. A traditional ethnographer enters the field with minimal prior knowledge and without a specific issue to focus the study and immerses in the environment for an extended period. Alternatively, focused ethnography is particularly appropriate for conducting applied social research since it can be conducted in a previously known setting with a specific study focus for a limited time (Knoblauch, 2005). The following characteristics of focused ethnography were pivotal in the decision to select it as the most suitable method of investigation to serve the purpose of my study.

It is widely known that any ethnographic study is conducted in the natural setting of the culture under study (McFarland, 2014). In addition, there is relevance and legitimacy in conducting focused ethnographical research in cases of time and funding constraints where specific questions need to be answered and where the inquirer possesses the necessary background knowledge of the specific cultural group to be studied (Boadu & Higginbottom, 2014). Focused ethnography did not require me as a researcher to immerse myself in the setting over a longer period. Instead, a more frequent and episodic yet intense investigation took place to be able to gather rich data pertinent to the investigation to answer specific questions (Rashid, Caine, & Goez, 2015), due to the advantage of a prior knowledge of living in the milieu (Cruz, &

Higginbottom, 2013). The aim of the study was achieved through interviews as the main means of data collection with its key participants through an agreement of the researcher and the researched regarding the time and place of interviews.

As discussed earlier, focused ethnography is conducted in the country or the cultural and subcultural context where the researcher belongs or has lived (Keen & De Chesnay, 2014). My country of origin is Pakistan; I was sufficiently knowledgeable and acquainted with the cultural, religious, political, linguistic, and societal contexts of the study setting and participants. This gave an insider perspective to my research. However, I also had outsider perspectives to the study. Both the insider (emic) and the outsider (etic) accounts had their benefits and drawbacks on my investigation. The emic and etic perspectives in ethnography and specific to my study are discussed separately in more detail in the next sections. Moreover, in focused ethnography as in any qualitative study, the researcher is the primary instrument of data collection.

My skill as an investigator enabled and empowered participants to feel comfortable and open to reveal and express their beliefs, practices, and experiences in the required detail (Ross, 2014). This was achieved by establishing rapport with the participants through effective communication skills and interview techniques; disclosing accurate and complete information about the study; explaining about the privacy and confidentiality of the study; answering all questions or queries participants had, at their level of understanding; sharing contact details and being open and accessible to be contacted for concerns related to the research; and ensuring a comfortable and safe environment for the interviews with the consensus of participants.

The required ethical considerations were continually followed and were crucial, especially as the participants were women (Ignacio & Taylor, 2013) in a highly patriarchal society (Murshid, & Critelli, 2017).

Emic and etic perspectives in ethnography. Emic refers to the insider perspective or position of participants' reality where the researcher shares some common characteristics or experiences with the participants (Dwyer & Buckle, 2009). Etic refers to the outsider view of the researcher's observation and the scientific explanation of that reality, where the researcher does not share the commonality of roles, characteristics, or experiences (Dwyer & Buckle, 2009). In other words, emic is more subjective of what people say or the meaning they give to their actions, whereas, etic is more objective of what people do based on the researcher's abstraction or reasoning. Hence, the information ascribed to a phenomenon is the emic view and the information derived or extracted from the behaviour related to that phenomenon is the etic view. The focus of emic view is on the cognitive aspects, i.e. values, ideas, and actions, while the focus of etic view is on the behavioural aspects, i.e. the observed behavioural patterns of a context or culture in an ethnographic study. Despite that the data gathered through emic and etic perspectives may not necessarily coincide with each other, they contribute to significant knowledge and understanding of the phenomenon under study. This enables the ethnographer to comprehend people's behaviours in relation to their culture and draw significant interpretations toward the aim of the study. To obtain vital information, an ethnographer utilizes multiple sources of data to validate the study findings. An ethnographic study primarily includes participant observation and interviews. Additionally, the researcher may consider reviewing relevant documents and collecting physical evidence, also known as artifacts, for richer data and better comprehension of the issue (Speziale et al., 2011).

In an ethnographic study, the researcher may have an emic or an etic orientation to the context or the phenomenon under study. For example, if a researcher is studying reproductive health in women in Pakistan but does not possess the cultural knowledge of Pakistan, the

researcher's analysis will be from an outsider or etic view. If the researcher belongs to the Pakistani culture and is studying a similar phenomenon, the researcher will have an insider or emic perspective to the interpretation of the study findings. However, whether the researcher is an insider or outsider to the study is variable. Since at any given time the researcher holds multiple identities depending on his/her citizenship, the field of study, gender, age, and religion, etc., these influence their emic and etic perspective. In some instances, an ethnographer may possess both emic and etic perspectives.

Since my chosen research methodology for my study was focused ethnography out of the wider qualitative genre of ethnography for understanding the menopause experiences of urban Pakistani Muslim midlife women, I will concentrate further discussion around this design. There were several reasons why focused ethnography was chosen as the most appropriate method for this exploration; some of the salient ones are discussed here.

Emic and etic perspectives pertinent to my study. In addition to the broader insider and outsider accounts, there were some specific emic and etic perspectives to my study. Having lived in the milieu for several years allowed me acceptability and easy access to the participants in the study setting as an insider. Due to my familiarity in the given setting with the people, their culture, religion, languages, and practices, I was perceived as an insider. I was able to communicate directly with the participants comfortably and confidentially. My acceptability in the community was rapid and easy (Dwyer & Buckle, 2009). For the purpose of the study, I approached working women from the urban context. These women were literate working women; they valued the importance of research and fully participated and welcomed this research endeavour. I was also an outsider due to living in Canada for the last few years and not possessing the age-related experience of menopause (Dwyer & Buckle, 2009). My absence from

the context for the past few years posed a possibility of putting me in a stranger position in some aspects of the culture as there may have been recent changes and developments that I was not aware of. I realized that having lived in a Canadian culture may have unintentionally affected my accent, my perspective and approach to life, and my lifestyle, which may have contributed to putting me in an outsider position. Also, approaching women as a researcher from a foreign university may have posed some hindrance as an outsider.

My research aimed to study a culturally sensitive women's issue that was considered personal and private. A benefit to this design of inquiry was that in my study, the gender of both the researcher and the researched was female. This was positive for the gender-related comfortability in my cultural context that added to the credibility of the data (Ross, 2014). Since my setting of the investigation was more conservative, female-related issues were not talked about openly. Being from the same gender as the participants gave me an advantage. It enabled the participants to be more at ease and elaborative in discussion and, therefore, allowed me to gain maximum knowledge of this less spoken women's issue in the given context. This was a significant consideration in ensuring the rigour of a qualitative study where the interviewer and interviewee's gender difference may have resulted in limited, missed, or misinterpreted vital facets of data (Ross, 2014). It was, however, not free of challenges.

Study setting. The proposed research was conducted in the metropolitan city of Karachi, Pakistan. One of the most populous cities in the world, it is Pakistan's largest and most populated city, as well as is the commercial and financial hub of the country and the capital city of the Sind province (Karachi Population, 2019). It is also famous as the "City of Lights" and "The Bride of the Cities" (Karachi Population, 2019). In 2019, the city population of Karachi was estimated to be 15.7 million (Karachi Population, 2019).

Population. My study participants were women who fulfilled the inclusion criteria. All women were Pakistani Muslims. Since Pakistan is a predominantly Muslim country, most people follow some fundamental teachings of Islam. For example, belief in the oneness of God, Quran as the holy book, and Prophet Mohammad (peace be upon him) as the last prophet of Allah. The participants belonged to various faith practices of Islam, including Shia, Sunni, and Ismaili. Despite some differences among them, they followed the preaching of the holy Quran and Hadiths. Most people of Pakistan share some common values, beliefs, and practices, like eating halal meat (only of permitted animals, slaughtered in a prescribed manner) and abstaining from the consumption of alcohol and pork. In addition, my study participants were educated urban working midlife women residing in Karachi, who were willing to participate and share their experience of menopause.

Sampling and recruitment. I employed purposive and snowball sampling methods to recruit midlife women. The purposive sampling method is most often used in qualitative studies to achieve an in-depth understanding of the phenomenon under study (Etikan, Musa, & Alkassim, 2016). The method was consistent with the assumptions and objectives of my study and, it placed special emphasis on the saturation of the data (Etikan et al., 2016). Using this sampling method, I received rich and valuable information from the participants.

Inclusion criteria. The main inclusion criteria for the study participants consisted of women, who were:

- from any faith practice of Islam
- experiencing natural menopause
- educated to a minimum of post-secondary level
- professional/working

- living in Karachi, Pakistan
- proficient and comfortable in the English language
- interested to participate in the research, and
- willing to share their experiences related to menopause.

I initially recruited my study participants through three pre-identified women. Based on my previous social contacts, these were working women who were socially active and had a good network with women from various parts/communities in the megacity of Karachi, Pakistan. One of the women worked at a sports center as a personal trainer. People of all ages and gender including women from various parts of the city were members of the center and visited the place regularly. She mainly conducted training for women; I had attended some of her workout sessions while I was in Pakistan earlier. In addition, she provided individual training to women on a freelance basis. The other woman intermediary worked at a bank. She was an acquaintance and a friend of my friend, who had a good network with working women as she had been working in different capacities at various banks in Karachi, for several years. The third woman was the owner of a beauty salon, whom I knew before coming to Canada. She had been working for several years and had many women clienteles. All these women acted as intermediaries for recruiting participants for my study. I provided them with all the necessary information about the study to share with potential participants. They verbally shared the study information with midlife women in their contact. Script for verbal information giving was provided (Appendix B). They spoke to potential participants who were willing to take part in the study or the ones who needed further information and took their written consent to be contacted by the researcher. The consent to contact form was provided (Appendix C). In addition, they emailed the study information to eligible women in their contact. The information sheet for email circulation was

provided (Appendix D). They also posted a poster at their workplace (Appendix E). The above strategies allowed interested participants to contact me directly if they wished to participate in the study. I had included three intermediaries for the recruitment of study participants as it was good to have more than one gatekeeper. In case, if one was not available for some reason, I still had the other two intermediary women to begin the recruitment process. After the initial recruitment of study participants, a snowball approach was used for recruiting more participants in the study. Snowball is a good technique for participant recruitment. In that, the current study participants suggested and identified other potential participants who met the inclusion criteria and were interested and willing to participate in the study. Before any participant was recruited, they were briefed about the necessary information of the study and all questions answered to their level of understanding and satisfaction.

I confirmed that the recruitment was based on the specific inclusion criteria of the study as mentioned above. The reason for selecting participants from Karachi was because they shared similar values, beliefs, and practices, and were familiar to me as the researcher. In addition, my study participants were educated working urban midlife women who were experiencing natural menopause and were living in various parts of the city. The reason for recruiting educated working women from the middle-to-upper socioeconomic status was that the middle class in Pakistan is among the largest in the world and is ranked 18th worldwide (Alam, 2015). In addition, not much literature is available on the experiences of menopause in this group of women in Karachi, Pakistan. Menopause is thought of as a woman's private matter; less-educated women from lower socioeconomic class avoid discussing their experience of menopause. They are less knowledgeable about the changes related to menopause due to limited resources, both time and material. While most educated working women belonging to the

middle-to-upper socioeconomic status were well-aware of this life stage. Based on my personal experience of the context, I anticipated that these women would be more comfortable talking about such experiences due to their level of understanding, network with other professional/working women and healthcare providers; and exposure to print, electronic and social media, and awareness about this physiological life process. They were also more independent in choosing to participate in the study at their own will. As mentioned elsewhere in the thesis, menopause occurs naturally, or artificially as a result of surgery like hysterectomy and oophorectomy, or chemotherapy and radiotherapy. I focused on recruiting women who were experiencing natural menopause; practicing Islam; educated to at least post-secondary level; working; residing in Karachi; comfortable in communicating in the English language; showed interest in participating in the research and willing to share their experience of menopause. Women experiencing menopause other than natural reasons were excluded from the study. However, age at natural menopause varied in midlife women due to several reasons. Based on the available literature and tacit knowledge of the context, it is common that most women in Pakistan do not disclose their correct age (Adhi et al., 2007; Baig & Karim, 2006). Hence, midlife women who were experiencing natural menopause were selected for the study. Since there is no mandatory retirement age in some public and private sectors of the country, there were women who were working over 65 years of age.

While recruiting participants, it was important to ensure that the number of participants recruited was enough to answer the research question. In a qualitative inquiry, the number of participants mainly relies on obtaining in-depth and rich data, and on reaching data saturation. That is when new ideas or information stop emerging from the data, or there is more redundancy or repetition of information obtained from participants. I recruited 20 women; the number of

participants was based on reaching the required saturation and richness of data as mentioned earlier.

Research Data Collection

Multiple strategies of data collection are desirable in focused ethnography studies. A combination of different data gathering strategies for my study helped elucidate, corroborate, and develop insights into the phenomenon under study. The use of more than one source of data collection facilitated a better understanding of the phenomenon from multiple angles. The data obtained from one source complemented and confirmed the data gathered from another source. Data collection through different methods contributed to the trustworthiness of the study. For my study, I used semi-structured interviews and a field journal, in addition to a demographic data sheet completed by each participant.

All the study participants filled a demographic data questionnaire that included information like age, marital status, occupation, etc. (Appendix F). It helped obtain participants' basic background information for having to know participants well, which resulted in a better understanding of their experience.

I gathered further data for the study through a face-to-face, in-depth semi-structured interview with each of the 20 participants. I conducted the interviews in English. The reason for conducting interviews in the English language was that English is one of the official languages of Pakistan, as well as, it is the medium of instruction for higher education. Since the study participants were working/professional, literate women, they were well-acquainted and proficient in the English language. I prepared the interview guide in consultation with my supervisor (Appendix G). Two of the examples from the list of semi-structured questions are: "What do you know about the permanent cessation or stopping of the monthly menstrual cycle, also known

as menopause?" or "Tell me about your experience of menopause." While some of the probing questions asked to get more detailed information about the phenomenon under study were: "What do you mean by that?" or "Could you please elaborate on that?" or "Why do you think so?" Such questions provided a deeper understanding of the participants' thoughts, ideas, emotions, and actions related to the topic. Each interview lasted for approximately one hour. The length of the interviews was contingent upon the amount of information each participant was willing to share, as well as further probing required to obtain more elaboration on the information provided by participants. All interviews were audio-recorded. I noted participants' body language and gestures during the individual interviews. It complemented, substantiated the obtained data, and increased the credibility of the interviews. While conducting the participant interviews, non-verbal communication, body gestures, facial expressions, observed feelings, and the environment were noted for later reference. Written field notes were maintained throughout the data gathering process. A reflective log was written and maintained on an ongoing basis to ascertain the rigour of the study. It was important to note my feelings, ideas, perceptions, anxiety, surprises, disappointments, or any other reflections regarding what was spoken by the participants. I wrote the participants' reactions and any informal communication that took place throughout the data collection. I maintained these logs immediately or as soon as possible after each interview. This helped minimize possible biases in the analysis of the findings.

Data Management and Analysis

Translation, transcription, and data cleaning. Soon after the interviews had been conducted, the audio-recordings were transcribed verbatim. Translation and transcription of interview data may be complex and challenging (Davidson, 2009). Since the participants were proficient in the English language, most data were in the English language, except some words

or phrases that were spoken in Urdu. I did the necessary translation of the words or phrases spoken in Urdu since I am well-versed in both Urdu and English languages. I gave the translations to a translator (Davidson, 2009), who was proficient both in the English and Urdu languages, to do the back translation of the words or phrases. Forward and backward translation of some data was done to ascertain the accuracy of the obtained information to preserve the meaning of the participants' verbatim. While translating and transcribing the data I made sure that if the participants used Urdu words that have cultural significance, they were translated consistently the same to maintain the originality and essence of the meaning.

Once the interview data was transcribed in English by a professional transcriber, I did the required data cleaning by going through each interview audio-recording and transcription. Data cleaning was required to check the accuracy of the interview transcription with the audio recording and fill any missed pieces of information. This helped validate that the interview data had been transcribed fully and allowed filling in any gaps in the data. Immediately after data cleaning, I proceeded to data analysis.

Data analysis. I commenced with analysis as soon as my first interview was transcribed. I collected and analyzed data concurrently (Richards & Morse, 2013). I looked for similarities, differences and needed clarifications from the obtained data (Agar, 1996). Preliminary findings directed further interview questions. Conducting data collection and analysis simultaneously contributed to the rigour of the study. After completing the intended in-depth gathering and transcribing of data, I proceeded to the data management. I used Quirkos computer software, to organize and manage the datasets generated.

Data were analyzed for themes, patterns, meanings, and understanding, using Roper and Shapira's strategies of data analysis (Roper & Shapira, 2000). To analyze and synthesize the

obtained data, the process of coding, categorizing, and conceptualizing were used. After receiving the transcription of each interview, I started coding to reveal broader preliminary categories or themes. The process of data analysis mainly involved three steps, i.e. open coding, categorizing, and developing themes and sub-themes.

Firstly, I listened to each interview recording multiple times to comprehend and fully immerse in the data. Secondly, I read and re-read the transcripts to gain insights. I paid special attention to the repeated use of words or phrases in the text. I wrote key words and ideas in the transcripts and made notes on anything that drew my attention. At this stage, I proceeded with applying codes to the important pieces of information. I combined similar codes within and between interview scripts to reveal some major categories. I then went through all the categories to identify themes and patterns. I continued to organize the categories containing similar meanings together into main themes. I revisited the data to examine similarities and differences in patterns to gain an understanding of the participants' experiences. At all stages of data analysis, it was vital to understand and acknowledge the cultural meaning and significance attached to the participants' words and actions. Data analysis was a continuous, cyclical, and repetitive process. I went through the gathered data several times, and I went back and forth to review and reconsider the data until a satisfactory completion was achieved.

Throughout the process of data collection and analysis, I was in constant contact with my supervisor. I connected with her regularly on Skype for any discussion or guidance. I also sent a copy of transcripts along with the extracted themes to my supervisor for her suggestions and advice. Being the subject-experts, I confirmed my final themes and categories with my supervisor and committee members. This helped ensure that the analysis of the data reflected the

experiences shared by the participants and was able to answer the research questions. Table 1 illustrates the steps of my data analysis.

Table 1

Steps of Data Analysis

Activity	Analysis done
Attending and listening to the participant interviews	Familiarizing with and immersing myself in the data
Listening to the tape-recorded interviews	Making sense of the data
Reading the transcripts and reflective logs	Figuring out the general picture from the data
Drawing codes using Quirkos, qualitative data management computer software	Extracting codes and categories, and identifying themes and forming patterns
Consulting thesis supervisor and committee members;	Validating analysis from experts for suggestions/advice
Reviewing literature and	Referring to the literature for themes and patterns
Going back to the participants	Gaining further clarification/information by meeting with participants
Carrying out the above activities simultaneously on a continuous basis	Achieving better analysis for the intended results by answering the research questions more comprehensively
Revisiting and refining themes to attaining desired meaningful analytical description of the experiences of urban Pakistani Muslim midlife women of menopause.	

Rigour

Rigour is a way to demonstrate the validity and integrity of the research that is necessary for a qualitative study. Validity is defined as the level of accuracy of the research to which it refers (Porter, 2007). The responsibility to ascertain the rigour of a study lies both with the readers as well as the writers (Porter, 2007). In that, the responsibility of readers is to interpret the research report to convince if the writer has demonstrated rigour and the writer to ensure that the study has maintained the required rigour and trustworthiness (Porter, 2007). To maintain and confirm the rigour of a qualitative study, there are certain criteria given in the literature. There is

a group of criteria with the acronym TAPUPAS that encapsulates assessing the overall rigour of qualitative study (Pawson, Boaz, Grayson Long, & Barnes, 2003). This includes the *transparency*, to see if the process of knowledge development is open to external examination; *accuracy*, to see if the claims made in the study are correct and suitable; *purposivity*, whether the method is appropriate to the aim of study; *utility*, to see if the knowledge claims fulfill the practical needs; *propriety*, if the study has fulfilled the ethical and legal considerations; *accessibility*, if the findings are disseminated to reach the appropriate audience; *specificity*, whether the developed knowledge maintains the source-specific criteria (Pawson et al., 2003). For the purpose of maintaining trustworthiness and rigour in my study, I included credibility, which is comparative to the internal validity in a quantitative approach; transferability, which is comparative to the external validity; dependability that is comparative to reliability; and confirmability that reflects the objectivity (Lincoln & Guba, 1985; Krefting, 1991). Authenticity and credibility are of primary concern in qualitative studies including fieldwork since a major part of data collection are based on the subjectivity of the researcher and the ones being researched.

Credibility and trustworthiness. I assured the credibility of the research by fully immersing myself in the research process. I conducted all the interviews, maintained a reflective journal, wrote field notes, and performed data cleaning after the transcription of the interview verbatim. Since the audio-recordings of interviews were transcribed by a data transcriptionist, I obtained from her a confidentiality agreement of the data. I then listened to the audiotapes, read and re-read the transcripts and field notes, and performed the analysis. In other words, I ensured the truth value of my study by going through the research documents (transcripts, field notes, and reflexive logs) multiple times and by triangulation of data. Data triangulation involved

validating the study information from different methods. I performed data triangulation by examining information obtained from one method to confirm the information gathered from the other method (Creswell & Miller, 2000). In my study, it was participant interviews, reflective journal, and field notes. Triangulation confirmed the credibility of data by ascertaining information from more than one source of data collection. By using multiple data gathering methods, I maintained transparency during the interview process as well as at the analysis stage. Maintaining a reflective journal helped me get cognisant of my values, beliefs, opinions, and biases. In addition, the on-going expert opinion of my supervisor and thesis committee members contributed to ascertain the credibility of my study findings. I also worked on their guidance and opinion in refining categories and themes.

Transferability. Transferability is referred to as the possibility and scope of research data to be transferred to other settings (Lincoln & Guba, 1985). Transferability in qualitative studies is a comparable concept as generalizability or external validity in quantitative studies (Krefting, 1991). The aim of my study was not to achieve generalizability since it is inapplicable to a qualitative study. I tried to be as thorough as possible in discussing my research findings to help the readers appraise transferability in my study. I took appropriate measures to ensure that the study findings suitably fit to represent the context and population studied.

Dependability. Dependability reflects the replicability of the study findings. Triangulation of data was also used to ensure dependability in a naturalistic inquiry. I ensured a trail of record-keeping of the study that included maintaining interview transcripts, field notes, and coding schemes to keep them available for review by my supervisor (Creswell & Miller, 2000). This made the process more transparent with pieces of evidence available and accessible for the decision-making process about study findings. As part of ensuring dependability, I

initially reviewed the interview transcripts and field notes independently. And later, I discussed them with my supervisor to ascertain the similarities, and to work on the differences in the corresponding analyses.

Confirmability. Confirmability is referred to as the objectivity or neutrality of the data. Confirmability is important to ensure that the study has been conducted in a non-judgmental way. Since the researcher is the research instrument in a qualitative study, it will consciously or unconsciously be influenced by the researcher's values, beliefs, and ideas. However, it can be delineated through the research documents like a reflective journal (Creswell & Miller, 2000). In my study, I kept a reflexive journal to establish confirmability that directed as well as documented the process of data interpretation and analysis. I also maintained field notes soon after each interview to keep a note of the context of data collection.

To maintain the rigour of the study, I was more responsive and used multiple verification strategies. I ensured responsiveness by using purposive and snowball sampling strategies, listening to the participant interviews, using appropriate skills and knowledge to extract more information and to analyze the data.

As part of rigour, I maintained the methodological consistency of the study. I ensured that the research design, methods of data collection and ways of analysis were all congruent with the aim of the study. Also, the epistemological and philosophical assumptions were consistent with the research question and objective.

In addition, I carried out a concurrent process of data collection and analysis. This allowed me to analyze the data gathered previously and identifying additional questions from the gaps in information to generate new knowledge. Further related questions could be asked from

the participants for the purpose of the study. This forward and backward process of data collection and analysis contributed greatly to the rigour of the study.

Lastly, I maintained constant contact with my supervisor at each stage of my study. Any advice or suggestion from my supervisor, being a research expert, helped ensure the rigour of the study at each of its phases of data collection, interpretation, and analysis.

Ethical Considerations

There were several ethical considerations that I kept in mind while conducting this study. I sought approval from the Health Research Ethics Board (HREB) (No. Pro00074398) of the University of Alberta. I did not require an ethics approval from Pakistan since I did not recruit my study participants from an institution or workplace; rather, I inducted Muslim women living anywhere in Karachi based on the study inclusion criteria.

Before conducting the actual study interviews, I conducted a mock or practice interview. I asked a trusted friend to assume the role of study participant for the practice interview. This practice allowed me the opportunity to rehearse the explanation of study information and consent. It allowed me to check if my guiding questions and probes were enough to obtain in-depth and rich data. I reviewed the audio recording to pay attention to improving my interview skills with participants.

Information letter and consent. I provided a printed copy of the detailed information about the research to the midlife women who agreed to participate in the study (Appendix H). I obtained a written consent on the informed consent form from each participant (Appendix I). Before beginning the interview, I gave time to the participants to ask any questions they may have related to the study.

I commenced the interview of each participant after they had read through the information sheet, I provided them with answers to any questions or concerns they might have and obtained consent. I obtained participants' signature on two copies of the consent form. I gave one copy to the participant and filed the other for my record. I decided the day, time, and venue of individual interviews in consensus with the participants once they showed interest and willingness to participate in the study. However, the time and venue had to be decided thoughtfully, depending on the city's law and order situation; to make sure that it was safe and comfortable for the participant and me in terms of travel and the duration of the interview. At the beginning of the interview, I introduced myself to the participants, gave them a brief overview of the study, explained the use of the findings, and ensured confidentiality. I audio-recorded all interviews with the permission and consent of participants.

Rights, benefits, and risks. I recruited all the participants. The intermediaries, however, helped initially to identify eligible participants and connected us. Hence, there was no potential risk or pressure on the potential participants to participate in the study. Participants were informed that they had the right to refuse to answer any of the questions and they could withdraw from the research at any time if they did not wish to continue. The participants were informed that there might be no direct benefit to them in participating in the study. However, they might find it an opportunity to share their feelings related to their experience of menopause. In addition, they might be able to reveal some of their strengths and limitations concerning menopause. There had been an overall benefit of understanding Pakistani women's experiences of menopause in relation to their cultural and religious context. This will help in offering culturally relevant care to women in this specific context. There were no risks found for the women to participate in the study interviews. All the interviews were audio-recorded with the

participants' permission. Participants' autonomy, privacy, and confidentiality were always given importance.

Anonymity and confidentiality. I established a trusting relationship with the participants and assured them of the maintenance of their right to anonymity, privacy, and confidentiality. I achieved this by providing them with all the necessary information about the research as per their level of understanding, sharing my and my supervisor's contact details, ensuring that the place where the interview was conducted was safe and comfortable for both the interviewer and interviewee, and obtaining a confidentiality agreement from the data transcriptionist. I also used effective means of communication and interview techniques, took other possible measures required to establish the relationship, and maintained participants' anonymity throughout the study. I ensured anonymity at the stage of data collection, audio-recording the interview, and through verbatim transcription, as well as at the time of data analysis. I will ensure the same later in the phase of dissemination of the findings.

I excluded participants' names from the transcripts of the audio recordings. Participants' names were not represented in any information they provided. I took all possible measures to ensure that the participants' identities remain concealed. To conceal participants' identification, I replaced their actual names with pseudonyms to represent them in the analysis and discussion of the study findings (Appendix J). In addition, I allocated an identification number to each participant on the demographic information sheet and interview transcripts. I allocated an identification number to all the audio recordings of the interviews before I sent those to the professional data transcriber. I also obtained a confidentiality agreement from the professional data transcriber. Moreover, I provided my name and contact information as the principal investigator of the research as well as my University of Alberta doctoral supervisor's contact

details to the participants. They were welcome to contact either of us if they had any further questions regarding the research or if they wanted to request a copy of the final study results. Furthermore, I always kept the participants' information and research documents protected by using a secret password on the computer. I will keep the research data and consent forms safe for seven years as per the University of Alberta's policy. I will erase the electronic data from the audiotapes and shred the hard copies of the interview transcripts and analysis.

I managed the obtained data electronically on my personal computer by using different folders and using Microsoft Word for this purpose. I created separate folders to secure various aspects of the study. This includes demographic datasheets, interviews, memos, and analysis. I made sure that all the electronic folders were password-protected and only accessible by my supervisor or the research committee. Additionally, I secured all the paper copies of the study such as the interview transcripts and demographic data sheets of the study participants, in a drawer using a lock and key. Those were also accessible to the research team only. All the data will be kept secure and confidential for seven years, according to the university policy.

Chapter Four: Findings

In this chapter, I highlight the demographic information and main findings of my study related to the menopausal experiences of urban Pakistani Muslim midlife women using a focused ethnography approach. The following research questions guided my study:

- How is menopause perceived by middle-to-upper socioeconomic status urban Muslim midlife women in Karachi, Pakistan?
- How do urban Muslim midlife women manage symptoms associated with menopause in Karachi Pakistani cultural context?
- What are the various sociocultural, religious, familial, and other factors that influence Karachi, Pakistani women's experiences related to menopause?

The data were gathered from 20 educated urban Pakistani Muslim midlife women between December 2017 and March 2018. Participants in my study shared the experiences of their transition through menopause. Although each woman is unique and so are their experiences, I found many similarities and some distinctions in the way they perceived menopause and experienced the signs and symptoms and in the variety of ways and strategies they used to manage their menopausal symptoms. The robust sociocultural, religious, and familial ties strongly ingrained in the Pakistani setting, were associated with the women's beliefs, perceptions, and actions. Hence, the data obtained are presented in the light of the sociocultural and religious attributions; these are part of the overall findings and are an overarching theme rather than a separate section.

Demographic Profile of the Participants

I obtained the demographic information of the participants as soon as they gave their consent to participate in the study. The semi-structured interviews followed the demographic

data gathering process. Obtaining demographic data was valuable in two main ways. First, it helped me in getting to know the participants better. And second, it provided me with the necessary information about the participants to construct a profile of my study sample. The demographic data of my study included marital status of the participants and their family structure, age, religious affiliation, educational status, occupation, nature of work, menstrual history, menopausal experience, and family income.

The demographic characteristics of the study participants indicated that all the women were between 40 and 59 years of age. The marital status of the participants varied; out of a total of twenty participants, fourteen (70%) were married, four (20%) were unmarried, and one (5%) each was divorced and widowed. Three quarters (75%) of the women, i.e. fifteen, had children, while a quarter (25%) i.e. five, did not have any children. All the participants were Muslim; nine (45%) were from the Sunni interpretation of Islam, ten (50%) were from the Shi'a Ismaili interpretation of Islam, and one woman preferred not to identify her faith practice. All the participants were educated: four (20%) had completed baccalaureate degree, eleven (55%) a master's degree, three (15%) a doctorate, and two (10%) had completed post-doctoral fellowships. Fourteen (70%) women were engaged in full-time work, four (20%) were working part-time, and two (10%) were self-employed. These women were working in a variety of professions, namely education, health care, information technology, and journalism. Many were leaders in their fields: some worked for the government, private, or semi-government organizations, while others were self-employed in the megacity of Karachi. Fourteen (70%) women reported their age at menarche between 12 and 15 years. Ten (50%) women reported they were 43 to 47 years old at the time of their last menstrual period, while ten (50%) reported they were between 48 and 53 years of age. All (100%) women experienced symptoms of

menopause. In addition, some participants experienced chronic issues like weight gain, diabetes, hypertension, and hypercholesterolemia that had an impact on their menopausal experience. Relevant excerpts of participants are stated later in the chapter. The summary of the demographic data of study participants is illustrated in Table 2.

Table 2

Summary of Demographic Data of Study Participants (N=20)

Characteristic	Options	Response	Percentage
Marital Status	Married	14	70%
	Unmarried	4	20%
	Divorced	1	5%
	Widowed	1	5%
Children	Yes	15	75%
	No	5	25%
Age in Years	40-44	1	5%
	45-49	6	30%
	50-54	6	30%
	55-59	7	35%
Religious Affiliation	Sunni Muslim	9	45%
	Shi'a Muslim (Ismaili)	10	50%
	Not identified	1	5%
Education	Baccalaureate	4	20%
	Master	11	55%
	PhD	3	15%
	Post-doctorate	2	10%
Occupation/Employment	Full-time	14	70%
	Part-time	4	20%
	Self-employed	2	10%
Nature of Work	Professional/Skilled worker	19	95%
	Entrepreneur	1	5%
Age at Menarche	8-11 years	4	20%
	12-15 years	14	70%
	16-18 years	2	10%
Age at L.M.P	43-47 years	10	50%
(last menstrual period)	48-53 years	10	50%
Family Structure	Nuclear family	12	60%
	Extended family	7	35%
	Alone	1	5%

Experienced Symptoms of Menopause	Yes	20	100%
	No	0	-
Family Monthly Income Range (in PKR and CAD)	PKR 50,000 - 100,000 (CAD 581 - 1,163)	1	5%
	PKR 100,000 - 300,000 (CAD 1,163 - 3,488)	13	65%
	PKR 300,000 - 600,000 (CAD 3,488 - 6,977)	3	15%
	PKR 600,000 - 10,00,000 (CAD 6,977- 11,628)	2	10%
	PKR 10,00,000-25,00,000 (CAD 11,628- 29,070)	1	5%

The narratives of my study reflect the experiences of urban educated Pakistani Muslim midlife women regarding menopause. The findings of the study are grouped into three major themes, based on the research questions and the related findings. Each theme and their respective subthemes are delineated with supporting excerpts from the transcripts and relevant field notes. Following are the three main themes of the study:

1. Perception of menopause
2. Strategies for symptom management and
3. Factors influencing women's experience

Further sub-themes of each are elicited in the relevant tables.

Theme One: Perception of Menopause

In this theme, I discuss the important questions of the what, why, when, and how related to menopause. I have elaborated on how Pakistani educated Muslim midlife women perceived menopause, and what their thoughts, understanding, and concepts were related to menopause. I have also discussed how they experienced menopause, what it meant for them when it took place, and how it affected women's lives, both at work and personal/at home. Thus, the

perception of menopause is divided into sub-themes and categories for a better understanding of the reader, as outlined in Table 3.

Table 3

Perception of Menopause

Sub-themes	Categories
Beliefs and understanding related to menopause	It's a natural phenomenon that has to come
	It's a personal experience
	"No more machine" to reproduce
	Good news, no more bleeding
	Bloodstain, a disgrace
	"It has robbed me off"
	"Production of babies vs. production of career"
	It's debilitating
Struggles, challenges, and rewards of menopause	Physical and emotional challenges
	Educated vs. less educated
	Well-nourished vs. malnourished
	Compromised self-care
	High expectations
	Work-related challenges
	Time management: a tussle between necessities, work, and household responsibilities
	Too much to handle
	Fear of losing job
	"Symptoms masked by work"
	"I just go blank"
	Societal discrimination
	Clash of responsibilities
	Menopause combined with migration is awful
	Age-related challenges
	It's resource straining
	Lack of support in the culture
	Rewards of menopause
Symptom experiences	Physical
	Sexual/Reproductive
	Psychological/Emotional

Women's perception of menopause spanned over different phases of their life. It included their own perception about menopause throughout their lifespan, as well as the general perception of menopause that existed in the culture.

Beliefs and understanding related to menopause. I have divided the women's beliefs and understanding associated with menopause in sub-themes for better understanding.

It's a natural phenomenon that has to come. Women believed that menopause was a non-pathological and a natural phenomenon, and it was just another phase in the transition in a woman's life. One of the participants Fara, said: "Menopause is not a disease. Menopause is natural." Similarly, Safina believed that: "It is a normal part of the aging process."

Women believed that menopause was an interruption in regular monthly cycles and was inevitable. Faiza said: "I think menopause is just a cessation of menses." Kiran had a similar understanding and said: "Definitely a time comes when your hormonal level has to change in your body. So, this is what's going to happen, and it will definitely stop one day." Participants knew menopause was a permanent cessation of the monthly menstrual cycle due to hormonal changes, as Amber said: "It's a stoppage of periods."

Women shared that menopause was a phase of life, like puberty and reproduction, and one has to face its challenges. Meera said: "The things that happen to you naturally, it happens, and you can't help it." Likewise, Kiran said: "That's a phase of life, you know, menarche is a phase of life, production is a phase of life, and then post-production is a phase of life." However, they believed that the menopausal experience varied for each woman.

It's a personal experience. Women shared that menopause was a personal experience, and every woman would experience it in her own way. Ruby said: "I know that a period comes in some age that varies person-to-person, in which the monthly cycle is going to stop."

Likewise, Fara said: “Menopause, I believe, is a very personal experience. It’s, like, everybody experiences it totally differently.” However, women commonly believed that it brought with it a major change in their bodies.

“No more machine” to reproduce. Women had an understanding that after menopause they would not have regular menstruation and, as a result, they would be unable to conceive. Zara said: “I think that menopause is just early symptom of completing your menstrual cycle and also, it decreases your chances of fertilizing.” According to participants, menopause served as a natural solution to the problem of continuous human reproduction. They expressed their joy in not worrying about getting pregnant after menopause. Kiran said: “Menopause means, in very, very simple words that you are not burdened to produce any baby anymore.” Kiran shared her experience related to the regular menstrual cycle. She said:

> When it is there, you are expected to produce babies, and this has happened actually…my husband honestly, was always asking for a third baby and all my friends were saying, “When are you going to have third baby, third baby, third baby!” So, it was too much of a pressure. And everyone was saying, “before you have menopause, make sure that you have a third baby.”

Kiran added: “So, for me, if you are menopausing it means, you are actually telling the world, now I’ll be a successful person because now I do not have to produce babies for you. I’m no more machine for you.” Some women were pleased by this.

Good news, no more bleeding. Women expressed their happiness with the cessation of the menstrual cycle for reasons such as having the opportunity to achieve better hemoglobin levels due to no more depletion of red blood cells and achieving better health. For example, Fara said: “I’m very relieved that I don’t have to go through that loss of blood.” Similarly, Kiran said:

"It's kind of a relief, also, because a lot of people, when they are having menstruation, they are losing a lot of red blood cells and then they have to take a lot of good diet to cover that. So, the good part is that you don't have to lose blood."

Fara said:

> I can tell you that women in the third world countries are relieved because they are usually anemic. Their diets are not good, they are not given good food, [and] they always compromise on a lot of things in close families. And, usually, women are very anemic and that is something that, society like ours, they don't care about. So, the relief that women get; and also, we don't get a two-day break at home because we are menstruating, you know. I think when the blood stops, they take it as a blessing.

Women shared the additional relief that menopause, in their opinion, brought them regarding modesty in relation to the menstrual cycle.

Bloodstain, a disgrace. Women in the Pakistani context were concerned about getting bloodstains on their clothes because of sudden or heavy menstrual/perimenopausal flow. One of the Pakistani cultural dresses commonly consisted of kameez or kurta, which was worn as a top that may be short or long and trouser or shalwar. Although both men and women in Pakistan wore shalwar kameez, the material, pattern, colour, and style differed for both genders. In addition, women usually wore either a dupatta, scarf, or shawl.

Due to shyness and modesty, visible bloodstains on women's clothes were considered indecent and uncivilized, especially when men could see them. Participants were thus extra careful and conscious about that. Some women shared that they were glad that after menopause they did not have to worry about getting menstrual bloodstains on their clothes. Indicating to her attire, Kiran shared that after menopause:

> You don't have to worry that, that today, like, I'm wearing white today, and as soon as there is a first stain, I will get a little bit worried, "oh what is going to happen, the stain can be seen by others"… I'm happy that I won't be worried about that.

Likewise, Naila shared her experience, especially on the first day of her cycle: "In start, very heavy bleeding and my white clothes get all stained. It was a very, very difficult time at that time, for me." Meera said: "That's very shameful if your clothes get dirty."

On one hand, women expressed their happiness with the commencement of menopause, while on the other hand, they voiced their displeasure.

"It has robbed me off." Women considered menopause a bad thing that happened to them, as Fara said: "Perimenopause is the worst years of my life. It has robbed me off of so much that, sometimes I wish I had taken my uterus out and maybe I'd have a better life…menopause is not a good thing." It was believed that with menopause women's health starts deteriorating and their energy and vitality start to diminish. Aliya shared that menopause to her meant that: "The reproductive healthy life is coming to an end." Women believed that menopause would take away their splendour.

Menopause was also considered an indication that women were getting old and their active, youthful lives would end with menopause. Fara said: "It really scars us…fertility is something that is a symbol of acceptance and symbol of beauty and womanhood." Shirin shared similar thoughts: "Our really helping hormones, which have our beauty of skin and, like, estrogen, progesterone, so, they will drop, and childbearing age will be finished…impact on your sexual life also."

"Production of babies vs. production of career." Participants believed that menopause was the end of their reproductive years and the stage of child-rearing. They believed that it was

the time to focus on building their careers. As Kiran said: "Rather than saying [a] woman is becoming older, you know, we should say a woman is growing up…now she has already crossed that, her phase. It's now no more production of babies. So, now production of my career." Kiran continued describing how menopause was perceived in the culture: "People are thinking menopause is 'yeh to boorhi aurat hai, ab to yeh boorhi ho rahi hai' [she is an old woman; now she is getting old]. 'Ok, you are still menstruating! Oh, you are still jawaan' [young]." Kiran disagreed with this perception. She said: "That is a wrong understanding."

It's debilitating. Women shared their concerns with menopause. They also shared their family members' perceptions and concerns regarding their menopause. Meera shared her husband's unacceptance and apprehension about her menopause:

> He is actually not ready that menopause is going to be there. I think he is scared, that "once menopause is there then my wife will become old. She won't be active that much, and might be possible that she will start limping, that she will start having all bone problems." So, he has all these fears, not me, because I know that this is a part of life…it's a natural fact that after menopause, the women's health declines.

Women had mixed feelings and perceptions related to menopause. They believed that menopause brought certain struggles that women had to bear throughout the phases of pre, peri, and post-menopause.

Struggles, challenges, and rewards of menopause. This section focuses on women's perceptions and experiences related to the struggles and challenges of menopause. They believed that most women experienced some struggles while transitioning through the menopausal phase of life. To get an in-depth cultural understanding of the struggles of menopause that women shared, this section is divided into subsections.

Physical and emotional challenges. Participants in the study believed that women experience some challenges during menopause. The nature of their struggle differs from one woman to the other, and one situation to the other. These may vary based on their environment, family support, nature of work, support from friends and colleagues, and the social determinants of health such as level of education, age, health, and socioeconomic status of the women.

Women shared their struggles with 'marital responsibilities' during menopause. Sana said that it was hard to satisfy her husband's demands. She talked about her experience during the Islamic month of Ramadan when Muslims around the world fast, abstaining from food, drink, and bad deeds from dawn to dusk. Cleanliness holds the top priority in Islam. Every Muslim has to perform ablution before offering prayers. But after sexual intercourse, the couple has to take a complete shower from head to toe as part of their ablution for religious activities like praying, fasting, reading the Quran, or simply for activities of daily living. Sana said:

> Before Saheri [meal eaten before sunrise, prior to fasting], I can't take a bath and because, I slept after 1:00 am, how can I? I used to wake in the early morning, and I should take a bath, and send my babies to the school, then, I should go to my workplace; then, how it was possible? It was lack of time as well!

Sana said that because of the heavy and prolonged bleeding during her perimenopause she faced marital clashes due to her husband's matrimonial expectations. Sana blamed her husband for frequent sexual activity, as she believed that was the reason for her recurrent infections:

> My husband used to be irritated, "when will it stop?" because I was not available for him. I used to blame him that "this, the frequent intercourse you ask me, and this is why, I acquire infection." I used to tell him "I will avoid it" …during bleeding I had to avoid it.

> I used to do it again, then I had infection and again, acquired bleeding for long periods, and this was for one year.

Educated vs. less educated. Women said that the priorities in life and the struggles of menopause for literate women from the middle-to-upper socioeconomic classes would be different from the ones who were less educated and belonged to the lower socioeconomic class. Aliya shared a variation of women's behavior:

> Even within educated it's not the same, but if I go to… [an urban slum in Karachi] they are more open in talking; "oh, I'm not getting my cycle and therefore I'm not so attractive to my man. And therefore, I'm thinking of getting him married to a younger lady, so he gets off me." So, they are very open in terms of…even having her husband married again and having a good life, and then she will feel that "my good life will be that he is off my back." So, that is not same in the educated women. Educated women will not like the husband having an affair or marrying a second wife. But the women who are from the lower social income, less literacy level, they are comfortable if the men are requesting for sex again and again…Educated women or women in the workforce do different things to keep them active, in family life, in sexual life, in work life. So, I think their struggles are different. I don't think struggle of women… [from urban slum] would be about pigmentation, she has much bigger issues than pigmentation.

Sana shared how during menopause she struggled to maintain a balance between her studies, work, and household responsibilities:

> At the same time, I was doing my master's/MPhil. So, it was so busy time…my MPhil that is affiliated with…University of America, that was very tough. So, I used to go at 8:30 [am] and come at eight in the evening. My children were small, they were with my

> parents; my sisters and my driver picking them from school and all that, but I was busy there.

Well-nourished vs. malnourished. Participants shared that most women in Pakistan are poorly fed. Fara spoke about her views regarding the suffering of women in developing countries like Pakistan. She said that most women in Pakistan are anemic due to inadequate nutrition and heavy menstrual/perimenopausal bleeding, and have minimal to no family/societal support:

> Majority of women in third world countries are anemic, you know. So, we never dig deep, as to why they are anemic or what's happening? And, you know like, irregular bleeding, heavy bleeding is never again a talk and we are constantly anemic…In addition to everything that I just told you, and lack of support provided, they have to go through men and their infidelity and marriage, second marriages and all that, and unfortunately, it all happens at the same time.

Similarly, Kiran shared her thoughts on the challenges of menopause, especially for ill-informed women: "Poor women, those who are not aware, so they must be going through a lot in conflicts with their partners and many other things must be going on in their life."

Compromised self-care. Participants shared that when they were experiencing menopause, they simultaneously had high demands at work and home. Meera was also conducting private tutoring classes at home that are commonly known in Pakistan as tuition/coaching classes. Many children go to these paid classes for extra help with their studies. Meera said: "It's very hard for me that after job, I do housework, tuitions, and take care of my health; it's very difficult, especially visiting a doctor." One of the participants, Shirin, shared her experience:

> Body very stiff, muscular pains, and mood swings, irritable; so, I have to manage this all things with, what we say, struggling, trying to be calm and quiet, and be in happy mood, so, I can well manage my family…before that I was not tiring too much of these rounds [at work]…but physically, now, I feel tired…my feet and my legs pain at the end of the work.

Women played multiple roles during their midlife, both at work and at home, which contributed to their perception of menopause.

High expectations. Educated working women had greater self-expectations for the home and workplace. They also faced high expectations from society. In addition to unexpected and difficult symptoms of menopause, women shared that they had to face challenges related to daily living, both personal and professional, often with little to no family support. Regarding dealing with menopausal symptoms and coping with her professional responsibilities without quitting her job, Sana said:

> That is very difficult to go with heavy bleeding to my job and I used to work in a medical college in those days. So, I used to go to washrooms in between, just to change so, I do not get any spot on my clothes. I did not stop going to my job, I did not stop. I managed it by frequently going to toilet and change my pad and just to cope with the situation.

Meera shared her experience of prolonged and heavy menopausal bleeding and how it affected her ability to balance her work:

> Because family get irritated also that "yeh kya roz" [what is this every day] we are working for her, she has to work because our Pakistani mind, Pakistani culture is like…role of a woman is like a 'naukrani' [servant]. She has to work. She has to work for the house, she has to earn if she's educated like me, ok? She has to take care of the

> kids, she has to take care of husband, everything. And if she is sick, nobody is there to take care. Nobody is there to take care of her.

She added: "I'm glad that my kids are grown up, they understand, they help me. But sometimes even they, with life, they think [pause]". Likewise, Fara said: "Now that I have stopped menstruating, I'm suddenly not supposed to exist. I'm just supposed to go invisible in society. It's like you cease, you cease to be; sex is not your problem…"

Work-related challenges. In connection with high expectations, Naila shared that she was too particular about her performance at work and that she could compromise anything but her quality of work and her image at the workplace. She said that she could not tolerate being called out for silly mistakes and that she would go to any limit to prevent that. It placed her personal or married life at stake, but she would not settle for a compromised quality of her work. She said:

> I am that kind of a person, I try not to affect my work. Otherwise, affect my life, my personal life, but not work life…I don't want anybody pointing out to me that I'm not at that level. So, I affect my personal life, my married life but not the work-life.

Similarly, participants verbalized their distress at not being able to fulfill their professional responsibilities due to some of the disturbing symptoms of menopause. Meera talked about prolonged heavy bleeding during perimenopause:

> It is so heavy that I have to stay back at home, I can't go to my job or anything, because that's very shameful if your clothes get dirty. So, I have to stay back at home. It was not possible for me to go and do all my duties, so I took off. And I've discussed this with my principal also. She asked me to wear diaper and come to school (laughs) and I said "no, I'm not going to wear diaper, but you have to give me leave for two days."

Time management: a tussle between basic necessities, work, and household responsibilities. When talking about busyness at work, pursuing higher education, and fulfilling household responsibilities, all at the time of menopause, women mentioned that they struggled with managing their time. While describing her struggles with time management for home, professional advancement, and work, along with her menopause, Sana said:

> I am not that mobilized nowadays. I do not go for shopping, even my elder sister does every type of shopping. I am limited now, just as I am doing my PhD…I go home after 8:00 in the evening…Sometimes I cook, boil water, do some kitchen work…I used to clean my dining table, or some guests came, and the arrangement of sofa set and all. Actually, I had worker for this work as well, throughout. But I used to do extra work, sometimes I did cleaning…I never rested because of my heavy bleeding.

Too much to handle. Women expressed their distress with menopause. Rozy shared her challenges with her menopausal symptoms. She had discontinued some of her earlier work-related activities. She had joint pains and felt sleepy all the time. She just wanted to lie down and not get out of bed. She said:

> I want to take a nap and even sometimes I want to lie down, just put my head down, for half an hour, one hour…In the early morning, sometimes I'm forced that…for example, I come with my colleague, then I call my colleague and say I'm not coming today and then I sleep, I sleep.

Rozy added: "I was engaged in the part-time clinic…then due to my pain in the knees, I was not very interested to go there."

Fear of losing their jobs. Participants shared their struggles with managing their menopausal symptoms at the workplace, which they said, was challenging at times. They had to

control their emotions, keep calm, and stay active at work to keep their employment. Alina expressed anxiety about losing her job as her menopausal symptoms were affecting her work:

> I was managing with my workload, because if you don't do your work then your boss will say "tata, bye, bye" …Also, my boss told me once that… "now you are getting angry, your voice has become loud." So, I said, "OK, now I need to control, because boss is always right!" (laughs). And, I love my job very much and I don't want, you know, any effect on my job, that affect my boss and my relationship.

Amber, an entrepreneur and, a single woman, shared her distress due to menopausal symptoms when performing her tasks. She expressed that she had to manage with an extra workload and long working hours during this time:

> I was bleeding so profusely and it was hurting me and it was causing a lot of discomfort in terms of my professional activities…I've always been self-sufficient…At that point in time, I was working from seven o'clock in the morning till late in the night…

"Symptoms masked by work." The women said that it was not easy for them to keep up with everything that was going on during their midlife. In addition to having high expectations for themselves as well as from their family, coworkers, and superiors at the workplace, women expressed mixed feelings about their work outside of their household responsibilities. They sometimes thought that work helped them cope with menopause. While they also believed that busyness at work masked their feelings and emotions related to menopause, they either had no time to think about their menopause, or it was not their priority so, it was not concerning to them. Amber shared her experience with physical, mental, and emotional symptoms of menopause without realizing it while she was juggling her responsibilities at home and work:

> It would just be happening and, because I had too much work to do, I had no time to deal with all that. And, that probably helped me keep sane…I was so busy that I don't think it mattered to me except just the pain and, you know, the discomfort...There was a time when I used to, like, the servant was not there, so I would do their work too, when I would come back then make sure that my parents are well fed.

Participants believed that their work had masked their menopausal symptoms. They thought this might be due to the multiple roles that they were playing while managing to balance their personal, family, and professional lives. They said that because of the work-related stress they could not recognize or differentiate it from their menopausal symptoms. As a result, they said that they never or minimally experienced menopause-related symptoms. According to Sana:

> Problems like the hot flashes and depression, I did not experience because I am very busy in my professional life and then, that my children were also younger, and I used to spend time between my hospital job and the home. As I live with my family…and even I used to practice in the evening…so, I am too busy. So, I did not notice the problems which I may be having, not visualized it properly.

Likewise, Shifa said:

> I have no such experience, only hot flashes that I went through because I was busy in my duties. So, I have not noticed anything…I cook breakfast and lunch, dinner; also wash clothes, clean the house. And, here in the office I'm head of the department. So, all the time I'm busy.

Some women believed that "work helps." They shared their happiness at working outside of the home as it gave them some relief as well as was a diversion during menopause.

They said work keeps them active and engaged, and gave them courage, self-confidence, and the ability to cope with menopausal symptoms. It provided a means of socialization and support from their colleagues to share their problems with them and get ideas to help resolve or deal with menopause in a better way.

Women shared their opinion that despite all the stresses and challenges at the workplace, it helped them maintain a balance in life. Rahila said: "You are balanced because you are doing job." Aliya shared that she was working in a leadership position and had frequent work-related travels. She took that as an opportunity to give more quality time to herself, which she otherwise would not do:

> I travel a lot, and when I'm travelling, I have more time to myself…And, I have the luxury of nice bathrooms to myself. So, I like to do the night creams and day creams during that time, versus when I'm in the regular routine job, when I go home, I tend to forget.

Participants articulated that their work kept them functioning and offered them a chance to socialize, share, discuss each other's experiences, and stay connected. It also gave them the tools and valour to deal with menopause and other life challenges. Alina said:

> I'm managing because I said, "no, I have to be active." Because I know, once I will be on bed or at home, it is very difficult to come out of all those stresses; plus, you will be out of socialization. No matter working in the office the stresses are different, but if we are going to be at home, you know, I will end up with, uh, you know, psychiatric patient, that may be depressed or full of anxiety and all that. So, up till now, I am managing.

Alina added: "It may be because I am a working woman what I feel that, because we have so many…stresses in our office so, that helps us to deal with the challenges." Women also shared

that they tend to ignore whatever they were going through due to their busyness at work. Rozy said: "Once I'm engaged here, I'm too much busy…Then I forget all." Similarly, Tina shared: "I do my household work, plus my professional work. It has become very busy and plus, it activates me."

"I just go blank." Some women were concerned with what they called forgetfulness, brain fog, and being/feeling dumb. Participants expressed their disturbance with menopausal symptoms that directly affected their personality and work. They felt that they had to compete with the younger generation in the workforce. They had to prove that they were worthy and competent and that they had more experience to bring to the table. However, brain fog and forgetfulness blocked their thinking, which was disturbing and challenging for them at times. Faiza a university faculty shared:

> Thinking blocked means, in the school you require a lot of energy, you need to be motivated, you need to initiate new projects and…whenever I go to the meeting I was like a dumb, and I couldn't participate much…like you are expected to be more knowledgeable, more experienced, have more things, and sometimes we are not meeting the expectations. So, it might make people feel that we may be useless.

Another participant, Fara, a journalist, shared a similar experience:

> For me, my mind is the most precious possession. And some days, it just does not function. I've had such horrible brain fog…it can just happen at any time. One day I'm intelligent and next day I'm dumbest person. I just go blank.

Some women shared their experience with forgetfulness, lack of concentration or reduced attention span, absentmindedness, and feeling blank during their menopause. Kiran, who was

working in a leadership position, shared about a recent meeting: "I'm a multitasking person. I can take care of ten stuff at a time…And, I noticed today, I did not…"

Women shared their frustration with brain fog, which they said was difficult for them to overcome. Fara shared how it affected her work, and disturbed her routine:

> As far as brain fog, I still don't know what to do. That's one thing that I don't know what to do. So, I just take it as they come. I pray that I don't have it on days when I have major assignments or when I have a meeting…But if I do, I usually cancel out on things…because nothing, nothing is more annoying than you attending a meeting and not being able to participate fully and you come across as a dumb woman. So, I try to not go…I take a day off. And, I have the luxury that I can do that because I am alone, I'm not married, I work from home. And I'm an extremely independent woman. I just work at my convenience, you know, but still, it affects because it takes away the routine…

Societal discrimination. Some women said that it had been an overwhelming experience for them. According to Fara, menopause had jeopardized her personality and shattered her self-confidence. While talking about her profuse perimenopausal bleeding, she explained: "As much as I really wanted it because I did not want the heavy bleeding, but…it has taken that confidence that I had."

In addition, women felt that their society was prejudiced towards them, especially when they were not younger-looking and beautiful. Being a journalist, Fara shared her experience:

> The society is very, you know, discriminatory towards a woman…because she suddenly doesn't look good…she's not going to find a job if she loses this job. And starting a new career at, you know, 45, is very, very scary…I might not get jobs, you know.

Another participant, Shirin, talked about her physical looks, and compromised beauty with menopause. She said: "Appearance matter for you if you are a working woman. Then, there is more requirement for beauty things to manage, and very difficult to manage."

Because of losing her looks, Fara shared that she lost her job and had to find another type of work against her true will. She said: "This is not the time to give up my career of writing. Big channels are not hiring me. So, I have found my own niche. I'm writing freelance, you know."

Delving into the reduced support and societal bias that occurs during the transition phase of menopause, Kiran shared that people were not empathetic to what was happening with women; rather¸ they made fun of them when they acted unusually. She added: "It's not that everyone is happy, or everyone is concerned. People often laugh that 'look at her, what she is doing'."

Clash of responsibilities. In Pakistani culture, the family was greatly valued. Taking care of the family including husband, children, in-laws, and, at times, their parents, and siblings was the primary responsibility of a woman. For a working woman, this was in addition to her work-related responsibilities. Sara shared her experience and conflict of responsibilities at work and home during menopause:

> I'm a person like, I wanted to do something. And, I'm a person, who accepts challenges…In my in-laws, girls are not much educated…And I was a doctor…and…non-intentionally they just demanded…I was…managing home, and…I continued my teaching…it was very, very difficult for me, but I just continued it…my mother-in-law had Alzheimer's, she was bedridden. She…everybody gets cranky, I'm getting cranky too (laughs) after menopause…She passed away at 75…I used to run from

> here and back home to change her diaper…with my PhD…with my job…We are five brothers and sisters, all are doctors, 'MashaAllah' [by the grace of God], …settled outside Pakistan. My father refused to go outside Pakistan…I had to look after them as well…I had a very busy, very busy schedule.

She added:

> My mother-in-law…my father died three years back…around this menopause…my father was diagnosed with prostate cancer. My father was a doctor as well. He just came to my house…This is the stage when you have to look at your children, very vigilantly…I had to look after all these things so, I just held up myself that, this (menopause) is a normal thing; I have to pass through it. That is why I did not experience anything. I never thought of…I didn't have any time.

Sara added that her other responsibilities took priority, which masked her menopausal symptoms. With tears in her eyes, Sara shared:

> Three years back, my father died, two years back my nephew, my nephew [pause]; my brother-in-law used to live on the first floor, and we are living on the ground floor. His son, 24 years old son, suddenly died. He slept and never woke up… So…all are dying at my home… [pause] [crying]. And this was the time of perimenopause. So, I didn't have time…the only thing I noticed, that was prolonged bleeding. Just because I wanted to pray, I wanted to fast, just because of that…

The women shared that they did not care about themselves and were least bothered by what was happening in their lives and around them. And, what they did was just for the sake of doing it without much interest. Sara said that she had feelings of blame, guilt, and repentance, thinking that whatever happening was probably because of her own faults and sins:

> My nowadays activities are those which are done with no heart; since I have to do it so, I do it… So, I'm coping-up with it… I don't want to do anything. I just want to just sit at a quiet place with dark and everything [pause] I don't know, maybe Allah has… [crying] … I pray. I pray a lot. Don't know, maybe my faith is weak that's why Allah has [pause] [continued crying]."

Menopause combined with migration is awful. The women shared their challenges related to menopause and their migration for work or better prospects. They expressed that it was quite stressful for them to deal with multiple hardships at the same time. It was almost impossible for them to separate their menopausal symptoms with various other struggles that were part of their migration. Zuby shared that her menopause coincided with her and her family's immigration to a western country. She had several stresses related to work, financial instability, family responsibilities, and other things, in addition to her menopausal transition. She could not differentiate and identify the reason for her depression. According to her, she and her spouse were glad when she missed her period as they had only one daughter and were planning to have a second child. However, they were told that the missed period was not due to pregnancy but was a sign of her menopause. Since she could not continue to cope with the multiple stresses of menopause and migration, in addition to missing close family/relatives and social circles, she returned to her country of origin. Zuby said:

> I didn't know what was the cause [of depression] because everything was changed [after migration] …I used to do voluntary. I was like, maybe I don't have a job…because…I had such a busy life here, and I was a teacher, and full time socializing with people, and I was missing my family. So, so many factors were there. It was not only one factor, so I didn't even realize it [menopause] could be one of the reasons.

Another woman, Alina, had to go to a different country as part of her job while she was experiencing her perimenopause. She said that that was a very stressful time for her and her family since she was suffering from heavy perimenopausal bleeding. She was travelling and temporarily relocating alone; while her family was staying in Pakistan. She was going to a village in a developing country where she did not have any acquaintance. Also, there were insufficient and sub-standard healthcare facilities. Alina said: "…I still remember…I said, now what to do? Because…next day was my flight…I was stressful, if bleeding is going to occur then, then what will happen? Because that is a very backward area. That was a village …"

Safina, a single woman, who was travelling back and forth to another country for work, shared her challenges of menopause simultaneously with the overwhelming workload and expectations at work. Safina said:

> It's a lot of…stress and tension and all that at work, because like a lot of things are put on me and sometimes, I get irritated. When I don't do the thing…I get depressed, anxious…It was affecting my work and then at the same time, you know, I…go home late and... even though I go home late, I still bring the work at home so... I feel like it is continuous… it stops when I fall off to sleep..."

Age-related challenges. Participants shared experiences regarding their age at menopause and the challenges associated with aging. They talked about how they thought their age at menarche may be related to age when menopause starts. Some women spoke about their own as well as their cultural experience with their female friends' and relatives' age at menopause. In addition, they talked about the common practice in Pakistani culture of females hiding their age and the reasons for that in their opinion. They also shared their views, understanding, satisfaction, and disappointments of menopause in relation to age.

Participants shared that there was an 'early and unexpected onset of menopause'. Most of the participants said that they experienced menopause earlier in their lives than they had expected, i.e. in their forties. The women shared that they knew other women in their culture, who were experiencing menopause at a younger age compared to women in the western countries, and they were not sure why. Aliya, sharing her contextual experience with the west, said:

> Women of our culture get menopause very early compared to the women in western world. I don't know the reason yet, whether it's biological or environmental or our diet, but certainly, in Pakistan, I found…many at 40 are saying they are experiencing pre-menopausal or perimenopausal symptoms.

Similar to that was Sana's opinion, who said: "this happens in our country in the age of 40 or so. Even it can come earlier if there is any problem like nutrition deficiencies or etc." Participants expressed frustration when sharing their personal experiences with menopause at an early age. They said that it was sometimes hard for them to accept their menopause at such a young age and that it was challenging for them to convince their husbands and other family members that they were experiencing menopause. Fara said: "I'm just 45…Unfortunately, a lot of women are reaching their menopause early these days, because of the environmental toxins and stressful life and all that. Like…I didn't think I would just have menopause at my age…like, bloody hell!!"

Sharing both her husband's and mother's unacceptance, and her regret on having an unexpectedly early menopause, Meera said:

> I used to ask my mother that "I'm having all these symptoms so, what do you think it maybe?" So, she said, "No, it's too early for you, 'itna jaldi' [this soon] it's not possible

> that you get menopause at this age." Because she had menopause at the age of 55 so she said "No, you are going to have menopause at the age of 55 only" …I'm 47 now. My menopause started exactly at 46.

The women voiced their concern that they were not prepared to get menopause that soon. Samina said that she experienced excessive bleeding as her initial menopausal symptom at an early age: "When I was 39, 40 years old I had very heavy period." They also shared their experience of early menopause in the culture. Meera said: "My friend's youngest sister, she was just 30 years old and she has been through menopause. So, it is starting at such an early age." Likewise, Sana said: "This (menopause) happens in our country in the age of 40 or so, even it can come earlier if there is any problem like nutrition deficiencies or etcetera." Some women shared their confusion and uncertainty about the early onset of menopause and unanticipated menopausal symptoms. Naila shared that she mistakenly thought that she was pregnant: "I was 47, 48. I thought oh, I got pregnant"; whereas, it was due to her menopausal irregularity. Sarah said: "My mother got menopause much earlier, in her I think early 40s or late 30s she got menopause…My elder sister, she got menopause at 45." Safina said: "usually most women experience, you know, this menopause, in the ages between 40s to 50s."

In Pakistan, the age of a woman was generally not asked and women 'did not disclose their correct age'. The women expressed a common tendency in the culture, of not revealing their true age. Participants shared that in Pakistani culture women do not usually tell their actual age. They hide their age to portray themselves as younger since menopause in the culture is highly associated with old age/aging and associated beliefs that women become physically weak and inactive, mentally compromised, unable to reproduce, and less productive for society. The women shared their beliefs and opinions regarding this behaviour. Alina said:

> Sometimes I get surprised that the women of same age say different…like, I say I am 57 so it's like, so what? But maybe it's because the culture factor has come over here that you say, 'ab to budhi ho gai, ab to kisi kaam ki nahi' [now she's got old, now she's of no use/worth]. Or…they are working women, so they want to look young and all that. So maybe that's the requirement, I think. So, women my age, I know they are similar to my age, but they don't say, 'I am 50, 51' or maybe late 40s they say; they never say they are late 50s.

Alina shared a recent experience she had with one of her colleagues, saying: "I came to know one of my colleagues she said that:

> "I am at this stage", and after 2 years I heard that she was saying that now 2 years are left for retirement. I said, "2-years ago you told me you are 52 or something, so retirement?" She said, "it's personal" …So, I said "OK!" So, I don't know why they hide."

Alina added:

> Menopause means that you are old. This is what they feel, whether it is early 40s or early 50s. So, sometimes they don't accept themselves that they are having menopause because maybe people will feel 'oh she must be more than 40' and, you know, in our Urdu we say that "you don't ask age from a woman and salary from a man" (laughs). So, maybe it's one of the factors that they don't want to show; it's very personal also…They want to look young, especially at the workplace.

Alina said that hiding age was common in women of all ages. She shared one of her experiences:

> Even nowadays 70 or 75-years old women, we cannot say 'aunty'. Previously we used to say 'aunty'. Now if you say, they say "aapa bolo! Aapa hun main!" [call me elder sister!

> I'm elder sister!]. This is the change we have got in our culture. So… "I'm not your aunty" …Hiding age is not only for 40 or 45-year-old women, it's for 70, 80-year-old also, because, you know, if you ask them, they say, "nazar lag jai gi" [I'll get an evil eye]. Because I'm active "to mujhe buri nazar nahi lagay" [so that I don't get an evil eye].

Kiran accepted the common cultural practice that women hide their age to avoid themselves being called old, but she said:

> So, it's a post-production phase. So, we have to do something that people should not call this woman 'old woman'; and that's why they hide their age, that's why they don't share what it is they are going through. Because people will be labeling them as an old woman. That's a wrong kind of thing, isn't it?

Similarly, Alina said:

> I have seen in the community…I have seen women they are hiding their age. I don't know what the reasons for that are. I never hide my age. Whoever asks me, I tell them the truth. Because this is what we are! It's my age; it's nothing to do with others. So, if I am 57 years, I have 57 years of experience with me. So, why I should be ashamed of that!

Participants shared their disappointments with the early onset of menopause. While some women expressed their happiness on getting relief from the pain and discomfort of monthly menstrual cycles.

It's resource straining. The women shared their beliefs and experiences of menopause in relation to their financial status. Besides time, patriarchy, and reasons like lack of fundamental priorities in life, women believed that they generally did not seek help for menopause-related issues mainly due to financial reasons. This included consulting a healthcare provider locally.

One of the participants, Amber said: “that depends on their financial freehold; if they can afford it, then they will go and consult a doctor and follow their advice too.” For those women in the country, who lived below the poverty line and were unable to afford the healthcare expenses, Amber said:

> I have concerns, with many people, who cannot afford that kind of an expense in Pakistan, so they try not to go even to the doctors. At least, I went to not only to doctors but…specialists in different fields and wherever they recommended me. Any ultrasound, or any tests…they recommended, were done. And, even MRI was done…which is an expensive test over here; not many people can afford it.

Meera shared a similar experience. She said that she spent a high amount of resources and went from a general physician to a well-reputed gynecologist for her menopause-related problems: “The [menstrual] cycle was all disturbed, so I went to the doctor and she was not that knowledgeable, though she was a gynecologist.”

The women mentioned that the problems related to the diagnosis and treatment of menopausal symptoms may be because menopause was generally not considered significant, and women rarely talked about it or referred to healthcare for advice. They said that certain treatments and diagnostic tests were not available within the country even at the topnotch hospitals and healthcare facilities. If they needed care, they had to travel abroad which was highly expensive.

Amber said that since she was not satisfied with the treatment for her menopause-related symptoms despite spending a considerable amount of time and material resources within Pakistan, she had to travel abroad. She said that it was possible for her because she was well aware and economically sound: “The cost of having that procedure was equivalent to the cost

that I paid in England…Luckily, I got the visa and went, and got that done…" She said that she had to continue to travel abroad whenever she needed treatment: "I have to go to UK, but I don't have to go frequently."

The women said that most people in Pakistan are ill-informed and not economically well, to pursue healthcare for their menopause or to simply take care of themselves through proper nutrition and care during this time. Faiza said:

> People are not earning sufficient…one liter of milk comes in 100 Rupees. If people are earning around 200 Rupees so, how can they give milk to their children, and then woman who is menopausal? This is another issue in our country. Economically people are very poor. So, one, they don't have awareness…they don't have money; and…those who have money, they are lazy and not taking it…So, lot of things.

Amber said that in addition to the material resources, a lot of her and her family's time was wasted in the whole process: "I felt, the time that I went for procedures over here was terrible…Not to mention my family, who is driving me over here and will be with me." Despite spending a considerable amount of resources including time and money, women were unhappy with the services available for their menopause-related symptoms. As a result, they either suffered or if they could afford, they traveled abroad for their menopausal concerns.

Lack of support in the culture. In this section, I have discussed how participants thought menopause affected their lives as a result of its perception in the Pakistani society. Since menopause was not freely spoken about in the culture, silence on this important phase of life is mentioned. Additionally, I have discussed about the preparedness for menopause that the women talked about. I have divided this section into two sub-sections, i.e. silence and women's preparedness in the Pakistani setting.

Menopause was usually experienced in ‘Silence’. The women commonly talked about menopause as a silent phenomenon. They said that it was not considered appropriate in the culture to discuss anything related to women’s issues openly, menopause included. Some women said that they had never heard the word ‘menopause’ in their homes. Aliya said:

> Nobody talks a lot about menopause in our culture/society… mothers would not talk about it, sisters would not talk about it, so for example, both my elder sisters have gone through menopause before me and I never heard the term menopause at home; I started hearing at my workplace…nobody talks about it at all, it’s a hush hush phenomenon somehow.

Alina verbalized her ignorance about the situation when she believed her mother was perhaps suffering from the symptoms of menopause:

> I just, [pause] I watched my mother that something is going, uh, going wrong or something and that my mother used to be very upset. And, that just was my observation that because of some age there is something happening. But I exactly didn’t know and also because I’m of the same culture, I never asked my mother what is happening to her.

Sharing her own experience with menopause and remaining silent about it, Faiza, a healthcare professional working in academia, said:

> I got the menopause last year, uh, but, I had never discussed with anybody…I know about the issue and I know how to deal with it, so I have never discussed with anyone even not my sister not even my mother. My daughter is now 23-year-old…I told her about the menstruation when she was in pubertal age, but I never shared anything about my…whatever womanhood issues, with anyone… I’m a very reserved person

> so…anything with reproductive I think I never discuss, with anyone, not even my husband. I never discuss it!

The women shared that silence about menopause was also related to their workplace environment. They expressed that they had multiple roles and responsibilities, but they stayed quiet about their menopause-related problems. Fara said: "Women have to work outside, they have to work at their homes, their children and their large family setup; still be quiet." One of the participants expressed that she was surrounded by all men at her workplace and it was absolutely impossible for her to talk about this topic or to express what she was going through during her menopause. Amber said: "When this [menopause] was happening, the office was fully male-dominated. So, I was the only female. So, you know, sharing of this kind of information; so, office was out!"

The women shared that reproductive and sexual health or any related matter was considered a women's personal and private concern and was not discussed in the culture. Amber said:

> Many a times, I think, in the culture over here, especially in lower-income families, uh, a lot of people don't want to discuss anything, especially in connection to menopause, periods or sexual drives or anything related to these factors. So, you know, they just take it as it is.

Fara said that menopause was an unspoken phenomenon in the culture to the extent that it was not even discussed openly by the healthcare professionals: "In Pakistan, like I said, we don't talk about menopause, we don't talk about hormonal health; even the gynecologists don't talk about hormonal health."

The women believed that menopause was similar to menarche in terms of its perception and silence in society. Aliya said: "The same as a girl would not talk about her menarche and she would hide her cycle and sanitary pads and stuff like that. Similarly, is with menopause." Alina shared her experience with both menarche and menopause and how both of these phases of a woman's life in Pakistan were somewhat similar in terms of their disclosure: "My mother said yes, just to stay [at home, at menarche] because your father will come after two hours so, you don't have to show him also, that what's wrong with you. So, you should be ready, neat and clean…" Alina added:

> During menarche also, in the beginning, you get irregular, uh, menstrual cycle, so you need to adjust. Similarly, what goes here [at menopause] but here you are mature, sometimes you control yourself. You know where to express, where not to express. So, sometimes, you know, women, they hide…what they are feeling…after menopause, or during menopause [pause] and over there [at menarche], the girl is confused."

Aliya shared about the silence on the issue of menopause: "So, I think this entire thing of beginning of the cycle and end of the cycle is the same phenomenon here in our culture." Participants talked about the openness of discussing women's issues in some of the other cultures, particularly based on their experience of working, studying, and living in the western world. Sharing her experience of having lived both in Pakistan and abroad, Aliya said that western countries are more vocal in discussing women's concerns, like menopause: "I think other countries are very open, and I have lived 8 years in U.S."

The women shared that they were usually expected to deal with it in silence. At times women did not exhibit their menopausal suffering due to the fear that they may be perceived as getting old and less worthy. Sometimes, women did not share their feelings, symptoms or

anxieties related to menopause with their close family members, including their husband and female members like mother and sisters. The women indicated an overall lack of knowledge about menopause as well as insufficient literature and research on the topic in the Pakistani setting. Aliya said: "Nothing is being done in Pakistan, not much literature, not much systematic study has been done." Similarly, Amber said:

> Not too much documentation [research] I think would have been done over here. Even though… [referring to a university hospital] is supposed to be a good organization, but I think now they have started to venture into, uh, bio-medics. So, hopefully, they might want to think about it [menopause]."

The women mentioned that silence about menopause may differ in various socioeconomic strata, and on the level of literacy and awareness of women, their families, surroundings, and workplace, etc. Aliya said: "In different socioeconomic strata, if I look at school of nursing - educational area, health sector, it is talked openly but if I'm sitting in [a business institute] nobody talks about it." Comparing that with lower socioeconomic class, Aliya said: "I would say even within educated it's not…but if I go to [an urban slum in Karachi] they are more open in talking." The women shared that in most cases family would only know or would be involved when it comes to serious issues that are mainly related to health or finances. Amber said: "I don't think this is an issue that involves family until and unless it has some major financial repercussions or umm, health repercussions." Participants believed that due to the silence about women's issues like menopause, women did not seek help from anyone, including the healthcare professionals unless the symptoms were unbearable or life-threatening. Amber shared: "If they [women] don't feel something is wrong with them, then they won't go to the doctor."

Contrarily, some educated, working women were very bold and vocal in talking about their menopause and its symptoms with anyone. Fara a journalist, and a single woman said:

> I think few years into my perimenopause, almost everybody in my life knew that I was troubled by my hormonal imbalance. It was so, so, bad, that everybody in my life, be it a boyfriend, neighbour, even my driver knew… I would say, "please get me the supply." If my sister is not there, I'll call a friend. And, a few times I had to call a male friend…

The women, who were more open to talking about their menopause, said that it was not a norm in the society and that most women would not say a word rather, they would discourage any such discussions. While sharing her menopause experience, Fara said that it was almost impossible for her to go out of the house to buy basic necessities of life; on some days she could hardly get out of bed and had to phone other people to provide her with food and supplies:

> I'm a very vocal person, uh, you know, I would say, "can you please get me some sanitary napkins and drop by some food because, you know, it's that time of the month, and I'm not feeling well, and I've stomach pain"…in that like 5 years, I had asked almost all my friends to buy me sanitary napkins, all my sisters or even my neighbour… I'm very vocal, and this is my rebellion, and this is my way of challenging society and its norms.

She added:

> In Pakistan, girls don't do that, but I have [laughs] you know. So, maybe I'm not the right person to ask this because I'm a crazy rebellious woman, uh; so, people around me have to know what I'm going through, because I make it a point, uh, to tell them…I might one day actually write about it.

Fara said: “I’m one heck of a woman I’m not going to go invisible…now that I have stopped menstruating, I’m suddenly, not supposed to exist. I’m just supposed to go invisible in society.” Reflecting at her mother’s silence during this phase, while questioning her ignorance, and the male dominance and neglect on the matter, Fara said:

> I don’t know if my father knew what my mother went through. He just knew probably, that she stopped bleeding and that now she didn’t have the danger of getting pregnant; and maybe, he might [have] liked it. But did he understand what my mom went through?”

Fara blamed society for its prejudice; she called it an act of crime towards women since it suppressed women’s right of speech and freedom of expression:

> That is the time when a woman is going through a lot. To deal with your changing body, moods, and everything, you know, not being able to talk about it; this is so sad. And this is criminal. This is criminal!!

Similarly, Kiran expressed her fear of being labeled as aged if she shared anything related to her menopause with her husband:

> I don’t discuss the sexual stuff…The problem with our men is, which I have heard from other women…that they call you older woman, “aww, you are becoming older, aww you are old!” So, I would never tell him this is happening with me. So, I keep myself as me. So, even though he is my partner, but he is still a Pakistani man.

Some women were very open to sharing their ideas, opinions, and feelings. However, menopause was one thing that they hesitated to talk about. Naila had gotten married in her middle age and had no children, said:

> I feel very shy on this thing. So, I didn't discuss even with my husband… I didn't discuss it to anyone…Many of my colleagues and friends, even my family don't know I'm going through menopause…They are still praying that "you will get a baby" …No one speaks on it, like me. I'm very vocal person but even I didn't share this thing. Even my family, my mother, my sister don't know that…

Some women gave the existing shyness or modesty in the culture and religion as one of the reasons for their silence on menopause. Shifa said: "Because our 'muzhub' [religion] never gave 'ijazat' [permission] that you can share each and everything with the children… 'Woh hoti hai, sharam waghera' [there is this thing, modesty/shame etc.]." Likewise, Rozy stated:

> At that time due to 'haya' [modesty], I do not talk much about this, not with my mother and not with my elder sister-in-law. She is very friendly with me, but I do not want to discuss with them. Now, this is my maturity, I do not like to discuss on this topic with anyone…

Some women said that they did not share their menopause experience with others because they do not trust them. Naila said that she preferred keeping it to herself: "I don't think it's good to share, uh, because no one knows, who is your friend. I just don't like to share my personal things to everyone, not with my colleagues, my friends." Shifa said that women in the Pakistani culture do not share their menopause experience regardless of their level of education or any other factor: "Nahi karti hain, bilkul nahi kartin! [They don't talk. Not at all!]".

Silence related to menopause and its symptoms had an impact on women's support system and their readiness for this important phase of their midlife.

Pakistani 'women's preparedness' for menopause was a challenge. Since menopause was a silent phenomenon in Pakistani culture, participants said that it was hard for them to prepare

physically, mentally, emotionally, and sexually, for this phase of life. They were sometimes not told by anyone, including women in their close contact like, mother, sister, mother-in-law, sister-in-law, other women in their family and close relatives, friends, neighbours, colleagues or women in their community, about the symptoms, how to prepare for it, or what to do when they experience menopause. Faiza said: "I heard from friends, uh, but as you know in Pakistani culture, your parents even don't tell you about the menstruation, so not even about the menopause…" The women said that they faced the challenge of partial to total unawareness about menopause prior to their own experience. Some women learned about menopause through their formal education and work, particularly in the field of healthcare; while some were told by elder women in the family or significant others in their acquaintance.

The women or their close family members, who were affiliated with the healthcare industry, were more open to talking about their menopausal experience. However, they were more comfortable to talk about it with females, which helped women prepare for their menopause. Sara said: "Yes, we kept discussing, 'Yaar yeh ho gaya yaar' [this happened dear] …because we all are doctors; my father is a doctor, my elder sister is a doctor, I am a doctor, my brother is a doctor. We do not discuss it with my brothers and my father but!"

Some participants believed that each woman had to go through all the phases of life, and menopause being a personal experience, they would understand only when the time comes. They thought that every woman knows about different life stages like menopause thus, they did not need to be told about it. They believed that women need no prior preparation for that, and they would know when they get it. Naila said: "I think it is very personal. Every woman has to go through this cycle and period. So, what is good to share? Everybody will know." Participants shared their opinion that since the media was strong, they were more knowledgeable. They

believed that their families thought that they had enough knowledge from the internet or being a working woman, they were too busy to talk about it. Also, they said that sometimes women staying at home or the ones, who were housewives, somehow got the information from elder women in the house, neighbours, etc. Naila said:

> Everyone knows nowadays. It's a very fast and internet era. Everyone, who is working, knows. Even I think the people sitting inside [housewives]… they know a lot because the nani [maternal grandmother], dadis [paternal grandmother], mummies, aunties, tell them more, which we don't…My mother or aunties care… Because I am a working woman, I don't have time to spend with them and listen to this all things, which I already know. And they also know I think, that she knows everything because she is a [healthcare professional], she knows through net, books, maybe through the colleagues. So, they don't discuss...

Alina shared that women's preparedness and proper knowledge about their life events such as menarche and menopause was important. She said:

> This is very important that one should know what is menarche and what is menopause? This is what my life experience is that these two points are very important because that is very personal and sometimes, we don't know how to express ourselves."

The women explained that the symptoms of menopause were usually new to a woman. These were at times extremely uncomfortable, also because everyone was not experiencing it the same way. Alina said: "Why I am feeling so hot? It's nothing, nobody is feeling; why only that woman is feeling? And you feel that you are abnormal now." The women said that they did not tell their husband or anyone but because of the symptoms, they knew it. Naila shared: "I never

discussed with him [her husband], but he knows I am on menopause due to my physical problems…"

Some women thought that they were not prepared for menarche or menopause. But it was important to give proper information and prepare women about these important phases of life. They believed that the time had changed now, the new generation was relatively open to talking about such issues. They believed that exposure to media - both print and social media, were the main contributors to this variation. Alina said:

> But being a mother, I taught my daughter everything…again culture factor has a very important role that where this girl or woman is getting the information, and how she is getting. Now, it's very common, you know, you open YouTube, everything will be there. But at that time, mother's role was not very informative.

Similarly, some women shared their intent to prepare their sisters and significant other women for their menopause as they did not want them to experience this phase as a surprise. They also mentioned that this study had provoked them to do so. For instance, Naila said:

> I will maybe, prepare myself to tell, I'm thinking now; now, because of you, I will think, I have to prepare her [younger sister], and she will go through and maybe she will have a lot of problem, maybe she will not have a problem…I will provide her some information or pamphlet…a book; to tell her that it is a natural process and you will go through this and the symptoms will appear.

The women said that when they reached their menopause and experienced its symptoms, they did not get the required support from their family since menopause was a silent phenomenon due to the concept of modesty in the culture. Participants experienced multiple

symptoms of menopause. Safia said: “With menopause…I started like gradually…some kind of psychological feeling or physical feeling at the same time; like depression...”

Rewards of menopause. In addition to the challenges related to menopause, participants shared some of the relieving aspects of menopause. For example, the women expressed their feelings of joy from ending the chance of unintended pregnancy, after menopause. They were aware that they could not conceive if they were not menstruating. They considered it a big relief for them. Rozy said: “Now we are in advanced stage in the life, then we can be sure of that, now you cannot have a pregnancy. So, you can say “free from that burden” or free from that ‘khauf’ [fear]”.

The women viewed menopause as the time for the ‘production of their career’. Some participants perceived the time at menopause as positive for them. They said that this was the time of more freedom from childbearing responsibilities and to work towards achieving their professional goals. Kiran, on an optimistic note, declaring this stage as the one to build their career, said: “It’s now no more production of babies. So, now production of my career.”

The women shared that after menopause, they could concentrate on their professional growth; and work more comfortably and travel more conveniently. Some participants shared their relief from the earlier frustration when their work and work-related travels frequently coincided with their heavy menstrual and perimenopausal discomforts. They said that they could now pay more attention to their professional commitments with ease. Aliya said that she was happy and felt relieved from the menstrual cycles, especially the unpredictable and heavy perimenopausal bleeding while at work; and she was more comfortable and enjoyed her life and her travels, mostly work-related travels now than before:

> I feel much at comfort...always my travel would coincide with my cycle, so my travel bag was never without [sanitary napkins] pack…and I would hate it. And now I am always pad free, and travel is more fun. I'm enjoying more, I'm swimming more, and working more. Whatever I need to do at any time, I don't have to worry about keeping a pain killer or things like that.

Some women expressed their happiness in having menopause. In addition to sharing their 'feelings of relief' from the monthly menstrual cycle, they expressed their freedom from disturbing menopausal symptoms.

Sana said: "I am happy, because I was afraid of that heavy bleeding. I am happy not to have menstrual period and find any problem with that because I am just involved in my work." Sharing a similar viewpoint, Shifa said: "...and going to places, nowadays I'm free."

Naila also shared her satisfaction with menopause. She talked about profuse bleeding and extreme pain during menstruation, which made it difficult for her to go to work, at least on the first day. She either had to take a day off or take painkillers:

> During menstruation…I took a leave or…injection (analgesic), and then I feel very relief…but I suffered from heavy bleeding… Due to [painkiller], the pain was relieved… It was very, very difficult time for me, for having dysmenorrhea and this. The first day, I cannot work; it's very, very painful, and heavy bleeding. After menopause, I don't have any bleeding.

Ruby felt comforted after menopause since it was too disturbing for her to manage her responsibilities with her menstrual cycles. She didn't have the physical and mental energy and motivation to carry out her activities of daily living, which she felt she had after menopause: During menstruation, "I wanted to take rest and I didn't want to do any work. I wanted to stay in

bed, and I felt uneasy… Now I'm very much relaxed. I'm ready to do anything at home, for my kids." Similarly, Samina a college teacher, who had lost her eyesight after a childhood accident, shared her distress with the perimenopausal bleeding. She was working full-time and engaged actively in social work and community services. Samina said: "I faced problem because I am a working woman…I spend more time out of my home, that is why I feel very uncomfortable in heavy and irregular periods…I feel that in sitting position, the menses is very heavy."

In the next section, I discuss some of the symptoms that the women shared they experienced during menopause.

Symptom experiences. There were several symptoms that Pakistani Muslim midlife women experienced during their menopause. Most women experienced one or more symptoms. These were different for every woman as well as perceived and experienced differently. Also, the symptoms varied in intensity and frequency. The women reported a variety of symptoms ranging from hot flashes and irregular menopausal bleeding to tiredness, aches, and pains, thinning of hair, anxiety, distress, reduced self-esteem, and low sexual drive. However, it is hard to discretely list down these symptoms exclusively in any one category, as most menopausal symptoms that participants shared were interconnected and influenced multiple aspects of their life. For example, excessive perimenopausal bleeding, although more explicitly a physical symptom, had a significant impact on women's reproductive, sexual, and psychological aspects as well as on their personal, professional, and family life. However, for better understanding, these symptoms are divided into the following three categories: physical, sexual/reproductive, and psychological/emotional.

Physical. Physical symptoms are the ones that women experienced physically during menopause. These include symptoms like hot flashes, pigmentation of the skin, and fatigue.

Participants of the study often spoke about experiencing episodes of 'hot flashes' at different times of the day that affected their personal and professional life and had a psychological impact also. Aliya shared her experience saying: "I think I do feel hot flashes very often, every day, uh, almost…In the pre-menopausal…for last one year…I started feeling more hot flashes."

Aliya added:

> Hot flash is not only hot flash because I would say, it is temperature variation; so, I feel hot easily but at the same time I feel cold also. So, after half an hour or so I say, 'Oh, I am so cold!' and I'm looking for 'desi' [local] clothes or 'chadar' [a big shawl to keep warm]. So, I think it is thermostat variation within the body… So, I'm easily warm and I'm easily cold at the same time. It wasn't there before at all.

With menopause, women experienced bodily 'aches and pains.' Aliya said that despite taking good care of herself she experienced a few bodily complaints, as she said: "I still get sometimes like knee, joint aches and pains here and there." Shirin shared a somewhat similar complaint, saying: "I think when I'm worried and anxiety is due to my professional work so, it may increase stiffness of body… My knees, it's mild…but whole leg, and back-ache, and one ankle is very painful..." Shirin added, "…before that I was not tiring too much… now I feel tired. I have too much, my feet and my legs pain at the end of the work."

The women suffered 'chronic illnesses' with menopause. Participants perceived menopause as the main cause of their chronic diseases like high blood pressure, diabetes, and arthritis. This made them anxious about getting menopause, especially at an early age. Alina voiced: "…being more at the age of 57, now I am afraid that maybe I'll get diabetes or maybe

hypertension…I am afraid of getting all these, you know, chronic illness…" Likewise, Rozy experienced similar kind of anxiety, as she shared:

> You can say slight depression that now you are advancing towards the old age…one of the very common apprehension that after the menopause…the hormonal imbalance will lead to, because it's a protective covering to you…once it is stopped, then various disorders leading to…hypercholesterolemia and blood pressure, and the cardiovascular disorders can approach you very easily. So, this is one of the fears that you can say that, with the advancing towards the menopause.

Rahila complained of experiencing palpitations during her menopause. She got it checked by a foreign doctor when she was visiting her sister abroad. She said: "Palpitation…when I went to US my sister showed me to a big doctor, he had my ECG done and said, it's just [an] Adrenal rush." Shirin said: "I am thinking that this obesity is also due to my menopause." Faiza said: "I got the diagnosis of hypertension last year…so, I thought it may be related to hormonal changes or something…" Ruby said that when she had menopause: "I had diabetes at the same time…but…I did not relate this with it." Similarly, Fara said: "…my understanding now is that chronic illness somehow is related to hormonal issues…menopause has done a lot of horror…I just really resent menopause for osteoporosis…" She added: "My main concern in menopause is cardiac health and my bone health. I already am on cholesterol medication, uh, and again, you know, I never had the cholesterol issue and it's suddenly just popped up."

The women expressed concerns related to lack of physical attraction and 'compromised appearance' with menopause. The women spoke about the effect of menopause on their overall appearance. Fara said:

> Menopause has done a lot of horror, starting with, suddenly my hair is very thin…I had a good head of hair. So, I think it is, it's just the menopause; suddenly my hair is not thick anymore, you know, so, that is like one shock.

Fara expressed her frustration on how menopausal symptoms have had a negative impact on her career, i.e. media and journalism:

> My appearance has changed… I can tell you one thing, the minute you stop menstruating your body just changes within seconds and it changes to where you cannot, you can't explain. There is no rationale to it, it's like the minute your hormones take a dip, you lose your muscle tone, you suddenly have these tires around your belly…Things that I cherished, my hair, my skin and my muscle tone, and all three of them just gone.

Fara added:

> From looking like I was 27, within few months I look like I'm 50, and eyebrows turning grey, I mean, hello!! Vision, I had 6 plus 6 vision. I went to an ophthalmologist and he said, "Your near sight is weak." Things that I did not think could happen to me. My skin, no matter how much I take care of it… but it has changed, and… this is all menopause related.

Shirin shared a similar experience: "My appearance is still decreasing and not good looking…" Shirin said:

> It's very depressing that now my body…my skin is not charming now, and my hair is very dry. So, it's very hard feelings, that now I'm no more young, so it affects my social life and I feel down sometimes due to these feelings.

Aliya shared her distress with facial pigmentation during menopause. Indicating to her face, she said: "and the other thing is spots on the cheeks, the pigmentation. So, I think that

started coming from the pre-menopausal…my first sign was my pigmentation!" Aliya shared that that was one of the most troublesome problems of her menopause, considering her position at work she felt it was important for her to maintain her physical beauty. I could notice some dark spots on her face, especially on the cheeks, despite apparently attempting to conceal the pigmentation under facial foundation/creams and make-up.

The women frequently talked about 'gaining weight' during menopause. They perceived menopause as the primary reason for their weight gain. Rozy said: "I've definitely got an increase in weight in the last 3 years…I have gained about…10-12 Kg…in 2014 you can say I was 67 Kg and now in 2018, I am 78 Kg. So, that's a lot!" Similarly, Faiza also complained of gaining more weight during her menopause. Pointing to her body, Faiza said: "This weight gain was effect of menopause I think." Likewise, Meera said:

> It's not like that I'm over-eating, I'm taking normal meal; sometimes I skip my meals, I don't even get time from my busy schedule to take my afternoon meal, so I skip that meal and I just survive on 2 meals - breakfast and dinner. Even then I'm gaining weight; I don't know why!

Fara said that her food cravings had increased with menopause: "I'm a food lover. But one thing I can tell you, that my appetite for food and my love for food has grown since I've hit menopause." Fara added: "As much as I should be watching what I eat, I don't! I don't know why!!"

The women experienced fatigue and 'low levels of energy' during menopause. One of the reasons they mentioned was related to profuse and continuous perimenopausal bleeding. Amber said: "…the energy level that got reduced, really went way down. Because I was in pain, and, I didn't bother about anything…" Similarly, Shirin shared that she got tired easily; she said:

"Now I feel tired and think you can sit at home and do your prayers…Lazy and fatigue and tired. Tiredness is increasing day by day."

Sexual/Reproductive. The women shared symptoms like heavy bleeding and diminished sexual drive during menopause. These affected their sexual and reproductive health, as well as were most often the cause of their marital conflicts.

One of the common symptoms shared by the women was 'irregular, heavy perimenopausal bleeding'. It affected all aspects of women's personal and professional life with an impact on their physical, mental, sexual/reproductive, and emotional aspects. Amber a single businessperson, called menopause as one of the worst days of her life. She spoke about her excessive menopausal bleeding, which often lasted up to several weeks. During this time, she experienced pain, irritability, and physical and mental exhaustion. Amber said: "Like, literally my gut used to hurt even lying down or while moving, it was difficult at that point in time…the pain and, you know, the discomfort, I think I recall that more than anything!" Amber added: "It lasted, initially I think from 7 days to like 10 days, and then it was 15 days, and then it became 20 days, and it was continuous profuse bleeding, and with a lot of clots."

Similarly, Fara complained about profuse, irregular bleeding during her perimenopause, saying: "I had, uh, heavy bleeding, such irregular bleeding, and I'm an anemic by birth. Now I know that I am Thalassemia minor. So, I was always low on iron." Fara added: "What I experienced was that heavy bleeding, bleeding that was so bad that one day I ended up in hospital; and then, they had to do the blood transfusion; because my perimenopause was horrible." Fara shared a few accompanying symptoms as a sign of starting her perimenopausal bleeding; as Fara said:

> I would know a day or 2 before because I would have fever, I would have fatigue, my joints would swell…and my breasts would swell up, you know, that would give me a signal…they would just start like raining, you know, like thunderstorm, like, that bad.

Sometimes, women became agitated and irritable as a result of heavy menopausal bleeding. Amber said:

> My mood, perhaps, I was in pain umm I was irritant…I recall my brother saying "oh, don't exaggerate" and I said: "go, get out of here!", which I generally don't! I'm not abrupt, but I was at that point in time; because of the discomfort and pain, I said: "Just leave me alone!"

The women expressed that menopause was like "putting the men at a pause". Decreased sexual desire was one of the symptoms women frequently experienced during menopause, which was apparently bothersome for the men too. Aliya shared that she overheard some men joking about this issue saying:

> I think we should find out women…women for sexual partner and not as a companionship…because the women inside the house are always at menopause and they want to put men at a pause. So, they were making a joke of the word 'menopause'; put the 'men' at a 'pause'. So, they are never interested, they are not getting the sexual drive, and stuff like that.

Aliya further said that low sexual interest and diminished physical attraction were common during menopause but were dealt with differently by women in different socioeconomic status. According to Aliya, women from low socioeconomic status may obey their husbands if they ask for frequent sexual contact despite their disinterest. Moreover, they may not object if their husband had extra-marital affairs; or even getting their husband to marry a younger woman

because women would find their peace of mind and relaxation in that. While, she said that it may not be the same for educated women, from the middle-to-upper socioeconomic class.

Similarly, Meera shared her experience of diminished sexual desire and related it to her heavy menopausal bleeding:

> Sometimes we fight…because…he has desire for sex…and I don't feel comfortable during these days and I avoid all this, and he doesn't like. So, then we start to fight, and he says you have to do it and I say no, stay away from me, I don't want you to come closer to me. So, I don't know how long it's going to take, and for how many more times I'm going to have fight with my husband.

Meera added:

> Like this, it keeps on going and my husband says that "you become irritable when you get heavy bleeding…go and take consult with a doctor. I don't want that you should go through menopause. Uh, there are many things you can do to prolong your periods." I said no, I don't want to prolong my periods…it's happening naturally, let it be, and it's not necessary that when I get menopause, I won't be having any desire for sex.

While some women said that despite the decreased sexual drive, they compromised and followed their husband's desire; as Shirin said: "I cooperate with my husband. If I do not feel still my husband want to do the sex so, I compromise on that." And, Kiran said:

> Vagina becomes too much dry, very painful. I don't show him that I'm getting pain, but I do feel that pain sometime. And sometimes I really want to slap him, and in the middle of the thing [laughs], and say: "get lost, I don't want to see you!" But I don't do that because that is too rude, you know. It's not their fault. Our body is changing.

During menopause, women experienced some psychological and emotional symptoms in addition to their physical, sexual, and reproductive ones.

Psychological/Emotional. There were some mental/emotional symptoms that women experienced during their menopause. These were sometimes related to their physical and sexual/reproductive symptoms. The most common symptoms women shared were mood swings and forgetfulness. They noted that these symptoms have started around menopause.

'Mood swings' with menopause was a big concern for the participants. Aliya mentioned that she was bothered by her sudden mood changes, which was not there before. Due to her seniority and leadership position at work, people did not usually confront her or indicated to her about her attitude. However, she realized it on her own. She said: "People don't tell me on my face, but I do realize I get mood swings because the same small reason makes me angry than it would have previously or, uh, my self-reflection is telling me, that was mood swing!" Aliya added: "If a lot of women are feeling that, then maybe it is estrogen level going down…for last one year, I started feeling…more mood swings, and sometimes close friends would say, 'wasn't that an irrational behaviour?'."

Aliya looked quite concerned about her symptoms around the menopause period. She said that some of her symptoms were not present before and had emerged with her menopause, while some other symptoms had intensified: "It wasn't like, a very small thing would irritate me. It has to be a lot more than a small thing to irritate, earlier." Similarly, Shirin mentioned experiencing a frequent change in her mood around menopause: "I have menopausal mood swings and, this I think is related to my hormonal changes because it's very rhythmic per month..." The women indicated that both the pre-menstrual and menopausal symptoms were remarkably similar in nature. Shirin said that often her negative thoughts during menopause

were the cause of conflict with her husband: “We just fight; but it’s always me to start fighting. It’s from my side, not my husband, always, always!” Sometimes women had decreased interest in socializing with people or attending events and gatherings. Shirin said:

> I feel that what is the purpose to go and waste my time? Now, I mean, young feeling is not there. Nobody will look at me. So, why should I go and waste my time? I use this time for my home, my family, and my professional work, for religious.

Shirin added that sometimes it is also related to other symptoms of menopause:

> Especially, feeling of decreasing health is very hard feelings…You are not looking good and you are not participating as you want. For example, if you want to play ‘dandiya’ (a cultural dance with sticks) or you want to play something…which require your physique is fit, so…you are not able to take this…And…if you try too hard to participate then definitely, your legs will not support you.

Aliya shared that she experienced feelings of guilt and crying around her menopause time and that, these feelings did not exist before:

> I wasn’t crying much, before. But with the irrational behaviour and anger, after the anger burst, it’s always crying burst. And, then I would feel guilty that why did I get so angry on a small thing and then I would cry. So, previously the crying spells were not there. ‘Crying’ like somebody has to do something really drastic to make me cry [laughs].

Likewise, Shirin shared about getting upset during her menopause:

> Negative feelings, and sometimes too much crying and grieving, and sometimes I think about my previous delays what I have done and reflecting… Negative thoughts, that…everybody is trying to challenge me, degrading me…When I come in a normal

> mood then I realize that it's just my feelings, my mood; and my hormonal changes is making me so depress and so sad…

Women also shared the symptoms of anxiety and depression during their menopause. Rozy said: "When…I wake up in the morning, I am depressed. I think that whole day I have to work and…then one thing comes in mind, I should sleep…"

Another frequent menopausal symptom that the women shared was forgetfulness, brain fog or 'short-term amnesia'. Aliya said:

> And that new thing, which has come up is short term amnesia…Because, only in last 3 months I have forgotten my purse several times, which wasn't there [before]. My 'purse' I would never forget! I would forget the phone, the keys, or other things but my purse is almost like a hand trolley. It's as heavy as that. But I've left it now several times, in the meetings, classroom, inside the bathroom and outside. And, then I'll think "where have I kept my bag?" And, I will go and pick back…

Similarly, Fara also shared absentmindedness as a worrisome symptom for her, which did not exist before:

> Brain fog! See, I'm a writer. I'm a journalist. For me, my mind is the most precious possession; and some days it just does not function. I've had such horrible brain fog… it can just happen at any time. One day I'm intelligent, and next day I'm dumbest person. I just go blank. I would not remember where I've left the keys, I won't remember the names. I've become very bad with names. I've become very bad with, uh, numbers…

Fara added: "Vanity is something that is more troubling. As much as I really wanted it because I did not want the heavy bleeding, but it is just, it has taken that confidence that I had."

The women suffered 'low self-esteem' with menopause. In Pakistani culture, menopause was associated with old age in women. The women believed that they aged faster as soon as they experienced menopause. In addition, they held menopause responsible for a lot of problems related to aging. Faiza said:

> We have physical changes like we are losing turgor of our skin and we are not as beautiful as we were so, uh, sometimes your self-esteem goes down because you try, for example, if you want to go for photographs with students so, you feel that they are so beautiful, get away from them so, their pictures don't get spoiled.

Fara shared that menopause and aging are very closely related in the Pakistani culture, which is very frustrating:

> The saddest part is that the people tell you, not that they tell you that now that you're menopausal like I said, people don't talk about, people don't use the word 'menopause', but the doctor would say that "accept that you are old. Now accept that you are old. Accept! Accept this hair!" And I don't want to accept it! I'm just 40, 45, you know, Why?? This is just so sad because you can't have partners or, you know, because fertility is, it seems like that, you know, beauty and acceptability, it's just so, it's so, close, it's closely associated with your fertility.

Zuby said that they were planning to have their second child after some time but due to sudden and unexpected menopause, she was upset and stressed: "We were thinking that we have more time; so, like after a year we can conceive…But we didn't know that it [menopause] will happen, and then we will have no time to do that."

Meera shared her experience with menopause in the Pakistani culture: "some women also feel that they are becoming old now. There won't be any…valuable position of her in the

society. Because people are thinking 'buddhi ho gai hai chal baith ja' [you have gotten old, just sit down]". She added: "Our community, they are just focusing on cancer, cancer, cancer. I think this is a kind of cancer for women…All those women, who are facing this problem, and if the family is not cooperating with them, they are in big problem."

Pakistani Muslim women were using a range of strategies to manage their menopausal symptoms.

Theme Two: Symptom Management Strategies

This section is divided into sub-themes and categories based on the symptom management strategies that women used to manage their menopausal symptoms, in the Pakistani setting. These are illustrated in Table 4.

Table 4

Symptom Management Strategies

Sub-themes	Categories
Use of modern medicine	
Lifestyle modifications	Self-care
	Hygienic practices
	Simple measures
	Drinking water
	Teas
	Eating healthy
	Milk products
	Eliminating unhealthy habits
	Physical exercises
	Rest and sleep
	Relaxing and socializing
Self-medication	Painkillers
	Self-diagnosis and treatment
	Supplements
Non-pharmacological interventions/ complementary & alternative medicine/therapies (NPI/CAM)/home remedies	
Spiritual/religious practices	

Use of modern medicine. Not every woman in the study sought medical advice; nor did they reach out to modern medicine for minor symptoms, in their perspective, related to menopause. Almost none of the participants exclusively relied on modern medicine. However, the women shared using some medical advice, usually when they experienced severe/uncontrollable menopausal symptoms. For example, Amber sharing her experience with irregular heavy bleeding, said: "I've spent a whole year of going to specialists over here in Pakistan, starting from kidney, to general physician, to urologist, to gynecologist, and then having second opinions on each of them…" Amber added: "I was doing all the medical remedies…possible and, uh, no one was saying that it was menopausal but umm it was just, 'ok, let's wait and see'. Though, I feel that at least the gynecologist should have mentioned that."

The women were dissatisfied with the diagnosis and treatment related to menopause. At the same time, it was common to note that women discontinued their medications either due to the fear of side effects or other reasons. Samina, one of the study participants, who had consulted a gynecologist for her uncontrolled bleeding during menopause, said:

> Heavy and irregular periods so, I went to doctor. After checkup, she…informed me that I have cysts in my uterus, but I went to another doctor…One doctor asked me the treatment of this trouble is laser and one doctor told me that I have to go to surgeon. But the doctor, who suggested me for surgery, one day before my operation date, she told me that our board has decided…we give you medicine.

Samina decided not to use any more medications due to their side effects:

> I have experienced it before because one of my gynecologists kept me on medicine for 6 months but after the use of that medicine my ultrasound report told…there is no positive change in my case. After using these medicines, I face many problems…So, I decided at that time, that I do not use more medicines.

Similarly, for her problem of heavy bleeding, Alina said:

> They did my D&E…and at that time, I came to know that this mucosa was bleeding a bit and it was nothing to worry about…it's just that the size of the uterus at that time was 15 mm although, it should be 3 to 5 mm. So, they said maybe your endometrial has, you know, gone through lots of changes so, maybe it's due to that…doctor told me I can go for my travel and she gave me a 6 months hormonal replacement therapy.

Although, Alina was told that every time if the bleeding starts, she can take HRT for six weeks to six months, but Alina said: "I am not taking any medication and, uh, because I know there are side effects more than there are benefits."

Participants sometimes referred to modern medicine for problems associated with menopause like, bone loss and thinning of hair. Fara said: "I've just been offered bisphosphonate injections, uh, to you know, control the bone loss…I already am on cholesterol medication…I take, uh, lipid medication." Fara also said: "With hair, the doctor just gave me minoxidil. It's like an ointment that helps grow hair. So, I've just started that and I'm hoping to get half of my hair back."

For reasons like untreated, painful, and heavy uncontrolled bleeding, insufficient knowledge of healthcare practitioners and meagre healthcare services within the country, related to menopause lead the women to refer to internationally renowned healthcare facilities. Amber shared such an experience for the diagnosis and treatment of her excessive menopausal bleeding:

> In the meantime, my visa for United Kingdom came through and I went and had it there. And over there all they did was take one blood sample, one day of going to the hospital…and all it was, was probably a growth in my uterus which was causing me all the pain and the extensive bleeding…I didn't have to do anything, and my bleeding stopped casually. And another thing, in the procedure they also inserted Mirena [hormonal intrauterine device] …I had to take vitamin B injections and iron injections initially.

Most women, who used modern medicine, were not satisfied with the treatment strategies and the insufficient knowledge base of the healthcare providers, related to menopause. For this and other reasons, women chose to make some healthy lifestyle changes related to the management of menopausal symptoms.

Lifestyle modifications. The women used some self-care strategies and lifestyle modifications to manage their menopausal symptoms and to stay healthy. These ranged from

eliminating and limiting their unhealthy habits, adopting healthy habits, consuming a nutritious diet, practicing physical exercise, ensuring proper rest and sleep, and socializing. These strategies included intentional efforts to stay healthy, in addition to some of the routine cultural practices. The women believed that these practices had an effect on their menopausal symptoms and overall wellbeing.

Self-care. Sometimes, women performed simple measures to take care of themselves during menopause. Aliya strongly supported the idea of lifestyle modifications, as she said: "every life stage requires lifestyle modifications. And, if we do lifestyle modifications, I have so far not felt it as a burden."

Hygienic practices. Participants emphasized the importance of their habits to stay healthy, as well as doing simple things on a regular basis to eliminate or lessen the intensity of their menopausal symptoms. The women thought that proper hygienic practices were important during this time. Talking about simple hygienic measures and women's increased vulnerability to infections after menopause, Rahila said: "Healthy habits…sometimes you go to other toilets, you go, sit, and get an infection." Fara shared taking extra measures to keep well after experiencing menopause: "I have to now take extra care of vaginal, you know, hygiene, and cleanliness." Similarly, Alina said: "So, your hygiene becomes very important now and, you know, sometimes you feel that you are smelling something, which is not good, and you feel uncomfortable. So…when I take bath, I feel comfortable." Faiza, who was a healthcare professional, mentioned using a sanitary napkin on a daily basis, regardless of any bleeding or discharge. She also admitted her limited knowledge about HRT. Faiza said: "There is still spotting but I just use a sanitary towel every day so not to dirty my panties, so I can manage with

that. So, I don't go for hormonal therapy and I don't have much information on hormonal therapy."

Simple measures. Participants shared some simple measures to overcome their menopausal symptoms. One of the participants Safina shared how she managed her forgetfulness: "I keep the record all the time, notebook in my pocket like whatever I have done, whatever I have to do, like, I just tick mark…so, ok today I spoke to him, today I have done this."

The women also shared some of their strategies to feel better while experiencing an episode of hot flashes during menopause. Zara explained: "I usually open AC. When I get [hot flashes], I… go to my bedroom and do first this thing. And take bath, take shower, cold shower. For irritability…I go to, uh, room and I calm myself; I take deep breaths." Similarly, Alina said:

> You know, in Karachi we have load shedding [power outage] and all that; so, you don't have the luxury to have AC on, so I use to take cold water while going out or while taking bath, just to suppress all feelings. But sometimes it's very difficult to tolerate all these feelings especially the heat when you have hot feeling especially, it's very difficult, very, very difficult.

Drinking water. Participants shared drinking more water for multiple reasons during menopause. Naila said: "Just drinking water [laughs] nothing else, because I remember one of my master's teacher, she always carried her [water] bottle…And she told me that I am having hot flashes so, I have to drink a lot of water." She added: "So, I carry this thing in my menopause period, and I drink a lot of water and I carry my bottle all the time." The women spoke about making efforts to change their unhealthy drinking habits. Safina said: "…mostly I stopped taking cold drinks; just water...and not cold water, just plain water."

Teas. The women talked about eating more consciously. Shifa shared that she had started taking black tea with preferably, brown sugar. Speaking about the reasons for taking black tea she said that tea whitener was not healthy, rather harmful, as it was a chemical, not milk or cream. Whereas, her rationale for replacing white sugar with brown sugar was "to…decrease the weight; because the weight is also increasing after menopause." It was a customary practice in the culture that almost everyone, young and old drank the traditional black tea with milk and sugar, culturally known as 'chai', as an essential part of their everyday life. It was customary to offer tea to guests, regardless of the time of the day. There were tea breaks at the workplaces, instead of coffee breaks. Sometimes the tea was flavored with cardamom. While for medicinal purposes, like headaches, cold, flu, and other ailments, people made the tea with a mix of one or more spices like cinnamon, cardamom, clove, ginger, black pepper, and other herbs and spices.

Rahila said that she had reduced drinking tea since she had been experiencing palpitations during menopause. Rahila shared: "I only take one tea in the morning, one at 11:00 [am], one in the evening but very small quantity just with 2, 3 biscuits. Now I am stopping it because it gives me palpitation." Like most women in the Pakistani culture, Zuby also took tea, but she said: "I take [tea] with milk, but not too much sugar…You keep yourself like, uh, healthy and strong." Meera shared how tea works for her: "I'm so tired after my job that I really need tea. It gives me so much energy that it works like a rocket [laughs]; just a cup of tea!!" Safina mentioned switching from coffee to tea: "It's a tea with, uh, milk and honey. I don't use white sugar; I use only honey. And, now I'm putting pinch of pepper and a small piece of ginger… sometimes twice…" She shared that she had noticed changes: "…because I'm used to drinking…this kind of tea, now with weight gain, it's a little bit...reduced." Also, "I noticed that…with this tea, I take regularly…bowel movement for me it is like…normal, regular."

Participants also spoke about drinking different types of teas in addition to the traditional tea. This included green tea as part of their daily practice after menopause. Faiza said: "I do take some time green tea, maybe twice a week or 3 times." Fara said: "I do drink green tea a lot whenever I have headaches to soothe myself, and I put honey in it."

Eating healthy. The women made conscious efforts to eat healthy during menopause. Shifa said: "I have decreased eating sweet things." Safina said: "Sometimes; I eat cheese but not much because I'm conscious about…the issues of like, uh, the weight, the heart issues…" The women shared taking care of their nutrition for the purposes of health promotion and disease prevention, especially related to menopause and aging. Rahila said: "I…take balance diet." The women shared intentionally observing some of the other dietary restrictions, either to avoid getting a chronic illness or to stay well. Safina said: "I, uh, try to...to stop eating foods which are not good for the heart." Similarly, Alina said:

> I am afraid, that maybe I'll get, uh, diabetes or maybe hypertension. So, now I am decreasing few of the fats…And I am taking small meal, especially in the evening because at night I know there will be no activity…I am afraid of getting all these, you know, chronic illness…So, I am not taking…anything which has more salt so…not to get hypertension and all that.

Adding further to her dietary changes, Alina said:

> Still I am taking [sweets] but initially, I was taking, you know, 'wo jo rasgulla hota hai na itna bara!' [that big sweet confectionary called 'rasgulla'!], now I'm taking half, although the sweet is my 'kamzori', weakness [laughs]. But I say no, I should now control because…I want to be healthy.

The women shared a common cultural practice of reducing the consumption of rice, fats, and sugars if they wanted to stay healthy. Rozy said: "In diet, I have cut down you can say that, uh, in Urdu you can say the three 'ch: chawal, chiknai aur cheeni' [rice, fats, and sugars]. I've cut down on it!" Zara said:

> Basically, you know, after [menopause] now…we lack estrogen. So, there are more chances of, uh, bone issues and, uh, and weight issues. So…I make some dietary changes especially, I avoid rice and wheat…because once you get the weight, then it affects your bones and other areas. So, that, I have changed.

Similarly, Zuby said that she was health-conscious and consumed less oil in the food: "Why to take too much oil or anything which is like high cholesterol or bad cholesterol? So, we are finding more ways where we can lead happily and healthy life." Zuby added:

> We are not taking any bread or anything with like oil or sugar in the breakfast. What are we eating is like, eating apple or banana and then, like dates and figs in the morning, uh, with boil egg…So, rice, we are taking once a week, sometimes 2-3 days a week but sometimes, like, not even in 10 days.

Zuby added:

> I like to eat salad and stuff like chutneys…from coriander and mint, which I keep it like ready and we eat salad plus like we eat 'roti' [homemade traditional whole wheat bread] everyday…plus like, we prefer like, mostly vegetable, and like with, uh, animal product, like, chicken or meat. So, one vegetable plus one that, or either we go with pulses, and lentils, and stuff…

While Sara shared a different opinion:

> This is the only source of estrogen, after menopause. So, we can increase this source by eating cholesterol, you know. Everybody out there says cholesterol is bad, don't eat cholesterol, don't eat cholesterol, don't eat cholesterol. No!! Cholesterol is a vital molecule!

She added:

> If you go more towards nature, if you eat butter rather than margarine, then it will be absorbed in your blood directly…lipoproteins…LDL is dangerous for your heart…You can maintain your breast tissue, you can maintain your adrenal cortex by estrogens, and by giving food to adrenal cortex, and have estrogen…eat visceral fat and butter, but in a very nominal amount…not that you eat everything in butter or ghee, no!

Sara said that eating organ meats like, brain and liver in reasonable amounts were important during this life stage to produce estrogen in the body, and to ease menopausal symptoms. Moreover, women said that they now preferred taking white meat rather than red meat, for more nutritional benefits and less harmful effects. They talked about eating fish on a regular basis, in addition to fruits, vegetables, and pulses. They mentioned eating wisely. One of the major lifestyle changes Safina mentioned, was: "I have become more conscious about what I eat…Before I pick up something at the grocery, I look up at the nutrition facts and all, it's good or not good!"

Milk products. Participants had been more mindful of dealing with their menopausal symptoms with their diet. The women frequently used open, unpackaged milk for drinking, cooking, baking, and making yogurt. Open milk is delivered by milkman at their doorstep, directly in their saucepan or individually packed in a transparent plastic bag; as well as it is available at the milk shops. Milk is then boiled and cooled at home, after which, the thick layer

of cream is separated to eat as it is, with or without adding sugar or honey, with paratha, toast, rusk or bread, or added to a cup of tea, or it is collected in the freezer to make homemade butter and ghee, which is known as 'desi ghee' that is preferred on commercially prepared one. Most women in the context talked about using more natural stuff and avoiding artificial and processed food. Emphasizing on the importance of consuming milk during menopause and the unavailability of natural and pure foodstuff and artificiality, adulteration, and contamination in edibles like milk, Sara shared using natural, unpasteurized milk as much as possible: "You take fresh milk…when you boil it, all the bacteria die out. And whatever is mixed, gets evaporated…so, don't take tetra pack milk and things like that…go more and more natural! More and more natural!"

Most women shared they had regularly been consuming milk in their daily diet since menopause. They said that earlier, it was not necessarily a part of their daily routine, either due to lack of time or it was not their priority in life. But due to the considerable amounts of essential components like calcium and vitamin D to prevent problems like osteoporosis, they felt the necessity of adding milk and milk products to their diet. Participants believed that it was helping them to deal with menopausal symptoms and stay healthy. Rozy said: "One change I brought in life was that, taking milk daily…because I didn't have time to take milk. I've led a very, very busy and very difficult life; very busy! So, I didn't have time for myself." Naila said: "Now I take milk one glass a day, and a lot of yogurt in afternoon. So, this thing is helping me." Safina said: "at night I drink a glass of milk." Safina added: "I think it's important, especially for the women, who, uh, experience this menopause, post-menopause…because of the calcium in milk and some vitamins as well…It's good…for the bones." Similarly, Samina said:

> After the menopause, I feel joint pain, cramps, after that I thought that I have to drink milk and I have to take some calcium. I think milk is the major source of calcium so, I drink milk and... glass of milk I took daily after menopause, not before.

Eliminating unhealthy habits. The women shared making changes to some of their habits, which they considered unhealthy at menopause. They believed that these were causing more harm than benefit and aggravating their menopausal symptoms. Amber shared an unhealthy habit that she had developed about 30 years ago when she was abroad for studies and work, for a few years. She said that it was difficult for her to change. She considered quitting this habit during her menopause. Amber said:

> At one point in my life, I used to drink a lot of coke especially after coming from abroad to Pakistan. I could not even bring myself to drink water because water tasted funny. So, instead of water, I would have coke. Coke, I still feel, that it's an energy booster…I would have, you know, lot of cokes I would say, eight to ten cans perhaps…

She added: "I generally don't take sugar that much, but I'm fond of chocolates and, uh, coke…I've cut down on the coke content considerably…chocolate is something that I go on binges!" It was during her menopause when she cut-down her habit of consuming excessive amounts of coke and chocolates: "it has been a conscious effort to cut down coke and chocolates."

In addition, women shared that they developed some good habits. Naila spoke about adopting healthy habits in her routine, in addition to her dietary regime: "now, dietary pattern has changed. I take breakfast at seven or eight o'clock…and in evening time we take our dinner at seven o'clock, before 'Maghrib' [evening prayers], not very heavy, but balanced. That's changed…"

Likewise, Sara emphasized on her healthy habits, which she thought were helping her stay well during menopause. She mentioned setting her routine of both sleeping and waking early; having a good breakfast, "small lunch and good amount of dinner before 8:00 pm…go to sleep by 10:00 pm…wake up early at 5:00 am…offer 'Fajr' [morning prayers] at 6:00 am…"

Physical exercises. Participants also talked about doing various kinds of exercises for physical and mental fitness during menopause, to relieve symptoms, and to stay well. For example, they shared using stairs instead of elevators and walking indoors. In Pakistan, it was uncommon for women to go outdoors alone for a walk, jog, or any kind of exercise. It sometimes depended upon several factors such as, where they lived, their neighbourhood, the crime rate in the area, time of the day, and weather conditions. It also varied on circumstances like, if they have memberships at the gym or have facilities at home. Rahila said: "Take a small walk every day thirty minutes per day five to six days a week." Rahila added:

> Since it is winter, I stopped walking. When I start walk, I feel healthy…I have got a treadmill, but I find it very boring because it is available in my first floor it is very depressing there; so, I walk on the terrace that is more comfortable.

Rahila shared some of the benefits of walking for her: "If I walk, I usually feel I don't get sick and mentally also, you feel more fit, your mood is better because, you know, when you walk you get endorphins releasing from the brain so, they give beneficial effects." Kiran had a belief that exercise was the most beneficial of all, during menopause. Kiran said: "I believe strongly, that exercises can really take care of your health. It's a kind of your life assurance. You know, people talk about money as a life insurance. For me, exercise is the actual body life insurance." She added: "I'm not paying installment of my life insurance if I'm not exercising." Working in a management position Kiran had initiated a free exercise session at her workplace. It was open

for all women to join, regardless of their designation or role. She was leading and teaching the same to anyone interested. She also motivated and convinced other women to get involved. Kiran said:

> I have also started aerobic classes at [workplace] and then, I'm inviting all the staff and faculties to just come and get their exercises for 30 minutes. Honestly, I started not for them, I started for myself…because as a teacher, you have to be there and if I will not be there, others will not go. So, I have to go; I have no choice then! (she said, with a smile on her face).

Kiran welcomed me to attend, where I observed that some women had come voluntarily, while others she had brought with her on the way to join. Most of these women were middle-aged. It was late in the evening after working hours when people were still on their desks working; she was going around and gathering women to come for some physical exercise. All the participants enjoyed doing some stretching and aerobic exercises with music, for about half an hour. Participants felt relaxed, happy, and energized at the end of the session. A room was specifically booked for this purpose on the scheduled times of the week. Sharing her experience of being physically active and doing regular exercises and its effects on her frequency of micturition during menopause, Kiran said: "I have to urinate, you know, spasms are there. I don't feel these spasms anymore. Probably my exercises and all are helping me."

The women shared the importance of exercise for bone health, especially after menopause but complained about a busy schedule. Shifa said:

> I have no time, but walk is very necessary. Because after menopause…two cells are present in the body: osteoclast and osteoblast; osteoclast activity increases, that's why they say to walk, to decrease the osteoclast activity. And to decrease the osteoporosis.

Zara shared: “Frequently I start and then…I stop for few months and I again start. But now I’m continuously doing this…It’s just behavioural issue…when you…start aching and paining, then it gives a reminder that you have to start this thing.”

Rest and sleep. Participants spoke about ensuring proper rest and sleep, especially when experiencing menopause. Rozy said that she tried to take some extra rest during the day, which helped. Rozy shared: “Also, I take a nap…after I go home from (work), I must have 1-hour sleep.”

Likewise, Shirin said: “I love to have better sleep and I feel very fresh. So, my 6 to 8-hour sleep is not complete, then I feel very tired. So, I always complete my rest, all the time.” Safina also said: “I sleep early…at least 6 to 8 hours sleep.”

Relaxing and socializing. The women were making multiple lifestyle modifications to stay healthy and to eliminate their menopausal symptoms. Socializing, diverting their mind and staying happy were a few strategies that women used. Alina said: “I don’t take any medication…my coping is to watch TV.” And, Kiran said: “Talking to friends around, listening to music, it really helps, wearing nice clothes; probably I will go out in the evening to eat something spicy, you know…” Similarly, Shirin said: “Changing your mood so, watching TV…taking food and relaxing or talk with somebody, sharing things and crying.” The women shared some simple strategies to overcome their menopausal symptoms. Aliya said:

> Few things which have helped, so, for example in hot flashes, I quickly start drinking water and I realize that if I umm drink half a bottle, like about 200 ml or so, I quickly overcome it, and, uh, having the air condition and a fan on, and…most of the time it’s at night…I get hot flashes…usually, I like, uh, putting comforter on, so, putting comforter

> off would work. If I'm [at work] …drinking water and using a napkin or something would help.

Aliya said:

> And with the mood swings umm other than…reflecting and then thinking, "I'm not going to do this next time, what I've done", and spacing. So, like what you normally do for anger management…So, what I've done is getting up and moving out, going to the bathroom or saying I'll be back and not staying in the same place where I'm getting in the same situation where I am getting angry, so moving away from that spot or spacing.

Kiran shared the ways that she believed help relax and feel better during menopause: "Exercises and, you know, eating well, detoxifying and staying positive, laughing with your friends, have some outings, watch a nice movie with popcorns, you know, see some excited stuff, religious, classical, you know, artistic stuff…" Likewise, Safina said:

> I suffer with depression; I like to go out with friends or most probably it is just to wind up things like this. Sometimes go for a walk like that. And, uh, maybe sometimes listen to music when I'm depressed or when I'm irritable. Especially, when I'm irritable I try to get away from the issue as much as possible.

Hence, participants made a variety of changes to their daily routine to ease their menopausal symptoms and to stay well during menopause. This included eating less but more nutritious food, adding more fruits, vegetables, lentils, and pulses, and having less intake of oil, sugar, rice, and flour, as well as avoiding cold drinks even cold water, and drinking lots of water. The women shared about ascertaining proper rest and sleep, about 6-8 hours each day. With making these changes to their lifestyle in terms of eating, drinking, and sleeping habits, women noticed changes in their body and relief in menopausal symptoms. As Safina said: "It's been like

almost two years now that I felt like I'm a much better person than before… I really try to discipline myself in, you know, these things, because…I really felt, and I've seen the change."

Self-medication. In addition to taking supplements, self-medication without any prescription was common in most of the households. Rahila said: "For most things, I do my self-medication." Everyone did not consult a health professional for their menopausal problems for several reasons. Samina said: "Mostly healthcare professionals not listen carefully about our problem…the person, who can resolve our problem, but they can't understand our problem and don't listen to our problems carefully, how can they be helpful for us?"

Over-the-counter medicines. Participants commonly took over-the-counter drugs, including analgesics to manage pains related to perimenopausal bleeding and body aches, antibiotics to treat suspected infection of any sort, and other medicines to manage their menopausal symptoms. Shirin spoke about taking medications to help feel better; as she said: "supportive care like having pain killers…" Taking medications without a healthcare provider's advice, for minor ailments and symptom relief was quite common in the setting. Fara said: "Headaches are very hard to deal with. I take Panadol, uh, you know, pain killer." Similarly, Naila said: "…if I have a problem, very severe back problem, then I will take a Voltaren, Bruffen…" Fara said: "If you have too much of bleeding you take Ponstan Forte." Likewise, Shirin while sharing about her aches and pains during menopause, said: "…and then I again take pain killer and this. So, daily I take. Since my husband is also very worried about me so, today I had my x-ray ankle and lower back...Now I will go to orthopedic doctor…or general physician…consultant so, they can see me that what is happening."

Self-diagnosis and treatment. Additionally, the women, who were somewhat literate in the field of healthcare, tried to self-diagnose and treat themselves based on the combination of symptoms they were experiencing during menopause. Rozy said:

> In hypothyroidism, depression is a very common symptom…So, I diagnosed myself as a victim of thyroid due to these symptoms, increased sleep, increased weight…so, maybe depression is a mix effect of that, but…once I got depressed, I lost all the activities in life…Maybe it was due to hypothyroidism I don't know; I'm taking pills for that 'jis ki wajah say woh mask ho gaya hai' [because of which, that has masked]…that has very much relieved that symptoms and relieved depression.

Fara, who was not related to the healthcare profession, shared her experience with the healthcare system in Pakistan:

> Luckily, in Pakistan, you don't need a doctor's note to get some blood tests done. I took things in my hands. Because I had to make sense of what was happening to me, you know. I was going crazy…I just wanted some relief. If it was just by taking hormone replacement, then nothing like it. I'm on steroids, and I'm taking supplements, and doing all kinds of things, and still, I'm not getting the relief; so, that means my body needs some hormones.

Fara said that based on her knowledge of menopause through available resources, she contributed to her treatment. She asked her doctor:

> "Can we just do some corrective hormonal therapy?" So, now he has said that yes, and he has asked me to do a repeat test…if the reports are still the same, then now I will be put on hormone replacement therapy…a lot of them have said that they've gotten relief,

> their symptoms have relieved of menopause and chronic illness, you know. So, if just taking hormone replacement can give me some kind of relief, then why the hell not?

Since these were educated, working women, they said that they were aware of their menopausal symptoms and were able to partly find relief to those on their own, through a variety of available resources. Also, they were able to communicate and negotiate treatment with their care providers. Fara said:

> I'm educated, that I'm headstrong and I like to take things in my hands that I've educated myself…if I have any kind of discharges then, you know, I rush to my doctor and I press them to do a PAP smear or, you know, internal checkup…I deal as I go through the symptoms.

Supplements. The women frequently spoke about taking supplements, most commonly, vitamin D and calcium, as well as taking omega 3, 6, 9 and multi-vitamins. They took these on a daily basis to stay well during menopause. Just like, Fara said: "I do take vitamins." Kiran said: "I'm taking regularly my calcium and vitamin D… I wasn't like this before, just…from last year I started taking it." Similarly, Rahila spoke about using probiotics; she further said: "I got my level done; calcium was okay, but vitamin D was deficient so, I have started taking vitamin D3." Rahila gave her reason for taking these supplements, as she said: "…because naturally I entered 7, 8 years menopause so, precaution like muscular weakness and all so, it is better if you take calcium." Zara said: "when I was 40 so, I started taking calcium, omega-6, 3…I've recently started multi-vitamins." Likewise, Rozy spoke about using supplements and gave the reasons on how, in her opinion, these were helping her deal with menopausal symptoms. Rozy said:

> I am taking calcium from the beginning but since my knee pain has aggravated, I am very much, uh, bound to take these calcium supplements, and ligaments and cartilage

> supplements. I'm taking regularly, regularly! And maybe they helped, because I am now decrease in the intensity of that pain…Once a day I take multivitamins…

Meera shared that she took calcium supplements on her friend's advice, to regulate her menstrual cycle; she said her friend told her:

> 'Calcium 1000'…take one in the morning so it will help your menstrual cycle, you won't bleed heavily. I said ok fine, there must be some reason behind it so…this time, I started myself only and I'm taking it one in the morning. So, I don't know whether it affect or not, but I'm taking it because it's helping me with my back pain.

Hence, women took medication on their own for their menopausal symptom relief and to avoid related problems. In addition, participants commonly took other remedies for the purpose.

NPI/CAM/Home remedies. In the Pakistani setting, people widely used non-pharmacological interventions/complementary and alternative medicine/therapies. They used herbs and herbal medicine, natural/home remedies, physical exercises, cosmetic treatment, behaviour change, symptomatic relief, and diversion therapy like relaxing and socializing, which is discussed in the previous section. Midlife women heavily relied on these modalities to stay well and get relief from their menopausal symptoms.

Some of the most common natural ingredients or food items participants mentioned adding to their daily routine, included honey, turmeric, ginger, garlic, kalonji [nigella sativa or black seeds], milk and dairy products, dates, fenugreek leaves, and black pepper to stay well, prevent diseases and eliminate menopausal symptoms.

Aliya said: "So, having a water bath, bathtub, shifting your weight, doing small exercises with ball, balloon, towel, pillows, and with the rice pack, with the ultrasound therapy… I'm really in favor." She added: "Whenever I get more aches and pains, I look at the bone care and I

need to take more calcium." She denied using medications and relied more on home remedies and self-medication as much as possible. Aliya said: "The supplement I have started, but otherwise it is the diet…" Aliya shared that her reminder to follow her natural therapy is when she starts feeling aches and pains:

> That reminds me "oh I haven't taken my supplements, or I haven't taken enough milk or cheese or yogurt or something." So, I look at my diet and I follow that. But some people say that kalonji helps. And, this herbal helps or that herbal helps. So, people have given me ideas about herbals, which I haven't done but I've certainly increased yogurt, milk, and cheese.

Faiza talked about dealing with menopause, naturally. She believed that medications have harmful effects that outweigh the benefits:

> I think since the conception of humans, menopause is given, so why to go for artificial management and take more complications for self. Because once you are on medication, you may suffer from side effects of drugs; and because drugs they are beneficial, they are having some issues as well.

Likewise, most women in the culture did not believe in using hormonal or other therapies than the natural ways of dealing with it. Kiran said:

> It's better to cope without hormonal therapy but for some time…if somebody is having pretty earlier menopause…if I am 38 years old and I'm having menopause, for some time I will want to use the hormonal therapy. Some of the women, it's ok if they want to try, but we should tell them that the hormonal therapy means that you are basically, you know, disturbing your nature of body. Your ovaries…have already produced

> naturally...So, if you are going to disturb them, the chances of getting cancer and so many other problems are there…go for symptomatic management.

Alina verbalized dealing with painful sexual intercourse due to vaginal dryness as part of her menopause by herself at home, instead of referring to a physician; she said: "I am still feeling that painful intercourse…at that time I was unable to feel that why I am feeling this pain. Then I said, this is part of my life; then we used this lubricant…so, then it's fine." Similarly, Kiran said: "I wasn't using lubricant too much but now I have to, for sure, for every attempt I have to use lubricant." Also, Aliya used CAM in general and to relieve her menopausal symptoms like aches and pains:

> I don't like medications and therefore with my aches and pains what I do is 'rice packs'. Rice packs really helped me and it's easy…Take socks, put dry rice, just the uncooked rice and stitch it from top. Put it in the microwave for one minute and it is even better than the…gel pack and water bottle…So, I like that, it's easy and it's fluid, and so it's like a ball, so it's like flexible, and take the shape of your neck or back; so I've done that.

Zuby shared using a home remedy to make her menstrual periods regular especially, at the time when she had missed her periods due to menopause. But she had mistaken it as her pregnancy for which she and her husband were not prepared then. They decided to follow a cultural home remedy. Zuby said:

> I started eating some food like dates…to make it regular…we heard that when we get delayed periods so, it's like something warm we should eat; and then, there are dry dates…So, we used to boil it and eat it…My husband actually heard about that so, he was sharing…like this time we are not really prepared so, we need it [the cycle] to be

> regular…it was more than 20-30 dates we used to boil and make its consistency little harder and then, I used to eat it…I continued that for a week.

Alina shared the use of herbs in her food, both for taste and their beneficial effects on the body and mind: "In food when you cook…curry and all that, we put all these things…ginger, garlic, and chili paste…We don't use red chili, we use green chili paste…" Additionally, Alina spoke about using some of the home remedies. For example, Alina said: "When there is heat or when I feel constipated, I take honey, black pepper, and half glass of water, mix it. So, it helps with constipation…sometimes I take green tea with lemon…" Also, Meera said:

> Turmeric, so it's good for the bone pains and for everything. And turmeric, you know, is a natural antibiotic. So, it heals your body internally, that I know very well because I am from a family, uh, which follows all the home remedies. So, I, I admit that I do follow all the home remedies. Like… 'haldi wala doodh' [milk with turmeric], or honey and turmeric together, so that if there is any internal injury, they will be healed like this. We have this concept, and it helps a lot.

Meera added:

> For my bone pain…naturally, it's working! It's working! I take it at night, and I can sleep well. I don't take any medicine...Some of my friends...take Lexotanil. I said, "Why you take Lexotanil?" So, they say, just to get a peaceful sleep. It's weekend so, we can sleep peacefully and when we come back on job on Monday we are relax and fresh…I started milk with turmeric and I'm sleeping so nicely and I'm fresh [laughs].

Similarly, Naila said:

> Now, I boil turmeric with one glass of milk and then add honey, at nighttime… so, that I sleep nicely; and a lot of yogurt in afternoon. So, this thing is helping me. This is on

> regular basis, when we take dinner so, we make 'raita' [a side dish of yogurt, made by adding spices and condiments in yogurt] …I had a lot of problem due to season, bronchitis, cough, dry cough, and it lasted for a month so, doctors put me on antibiotics. So, now I'm used to take this and now no medicine anymore.

Describing the effects these had on her, Naila said:

> So, I get a sound sleep and I get up fresh in the morning. This, I noticed! … Maybe, this helped my mood, to decrease my aggression and all these things. And I'm very active…And, sometimes I add crushed almond in this, 5 almonds, every morning.

The women shared some of their eating habits that included consuming herbs and natural ingredients on a daily routine and how those were engrained in their lives intentionally or unintentionally since their childhood, as part of their daily living. They believed that these contributed greatly towards their health during midlife and their general state of wellbeing. Such as Meera said:

> I keep kalonji, honey, and dry fenugreek leaves. It's on my dining table. And, my children they have this habit that when they get up in the morning after breakfast, they take one spoonful of honey, and they take a pinch of kalonji every day. I and my husband, we take all 3 of these things in the morning…Since my marriage, for 23 years, I'm taking… If you take a spoonful of honey along with few grains of 'kalonji and methi' [black seeds and fenugreek], then you will remain healthy throughout your life.

Another participant, Naila, said: "This is a natural pain killer so, when I eat anything like vegetable or gravy, curry, anything, then I add raw ginger; and it's helped a lot. Because now I feel low back pain is not too much." Naila said: "Garlic is a routine, you know, in Asian dishes you add in vegetable, in a curry; garlic, ginger, and onion you will find in any curry, any Asian

and traditional dishes." Naila was a health professional; she said: "I don't believe on medicines!!" The women spoke about using herbs and herbal teas for their menopausal symptoms. Kiran said, "They try to take some herbs, tea, special type of herb tea, they bring from Italy, from Saudi Arabia, from Philippine, from China…Chinese medicine is becoming very common in Pakistan." Kiran added: "Somebody was telling me that if you really want to reduce weight go for Chinese treatment, if your bones are paining go to Chinese treatment and then special treatment are there for menopausal women." China being a neighbouring country of Pakistan, Kiran said: "…and, you know, that Pakistan is going to have this one route, right…till China, so, then that will give us the opportunity to travel to China to get the treatment done…so, I can easily go and get my treatment done there [laughs]."

In addition to making some overall lifestyle changes during menopause as mentioned in the previous section, the women spoke about some other interventions that they did to relieve their menopausal symptoms. Fara shared what she did when she had an episode of brain fog; she said:

> My mind feels very frozen. And so, what I do is I take a hot bath, you know, hot steamy bath, uh, which sort of provide some relief. I take green tea with honey and then I stay in bed. If it comes with fatigue, and fever and malaise then, all that day I'm just in bed watching TV and just cursing myself…

In addition to drinking the traditional tea, Kiran talked about consuming coffee for the relief of her menopausal symptoms:

> Coffee helps! Coffee really helps! Tea doesn't help that much. Especially these days, when you are going to have day-one, and then as time is progressing, I would like to have

more and more strong coffee probably. I don't know; I would really like to have the strongest, the black one, and strong one. But I'm just putting in milk to avoid ulcer.

Participants sometimes referred to herbalists, who treated their problems with herbs and traditional remedies. Samina said: "I go for some home remedies. I go to one 'Hakeem sahib' [Herbalist]…Now…I treat myself with food…" Sharing the effects of this change, Samina said:

I get pineapple, I get apple before having my breakfast daily. I drink powdered milk; I drink hot milk with turmeric. I think after few months like 3, 4 months my period has settled, and I feel there is no pain in my uterus and no pain in menstrual period. I felt these are good for me.

Kiran, a health professional, shared that she had recently started using an herb that is especially beneficial in relieving menopausal symptoms:

I also started one more thing. It's called Moringa…It is coming out from special kind of tree and then this Moringa seeds are having multiple benefits. It is having a lot of vitamin A, vitamin D, calcium, proteins, iron, and B12 also…I have started this, 4 seeds per day…And this really helps in fighting with the menopausal symptoms…It also prevents from cholesterol and improves the immunity system…you can get it from the market easily… it's a complimentary herbs' store… 'Pansari ki dukaan'… a lot of women have used it. It worked so well on them…

Kiran continued: "I think, we need to stick to herbs…And Chinese medicine is a good idea…It WILL be common...home remedies are VERY common…making some different coactions at home to detoxify." Describing a recent trend in the setting, Kiran said:

There is new trend coming in Karachi at least, that people are having…3 days of protein, 3 days or carbs, 3 days of this vegetable soup. They put in all the vegetables, boil it very

well and then drink it for 3 days. So, this is how they are maintaining their weight and detoxifying their body and whatnot. People are doing so many other things…

Fara added that even the physicians and other healthcare professionals favored and recommended the use of complementary and alternative medicine:

> What kind of, you know, relief a doctor offers here? Just anti-depressant, right? Because they understand only that…I did not want to take antidepressant…understand the level of apathy and level of ignorance of even the doctors in Pakistan. So, I remember that during my perimenopause I consulted my gynecologist…He did not ask me to have hormone test done, okay! He just said, "Deal with things", you know, "seek homeopathy." HE told me. HIM, being a major gynecologist in Pakistan!!

Fara favored the benefits of using different oils for a variety of symptoms: "I have tried what not! From evening primrose oil, you know, and trust me, evening primrose oil has helped me with my hormonal headaches and, vitamin E more for vanity…" Aliya spoke about using cosmetic modalities for her pigmentation:

> I've been using [name of brand] products very regularly, which are there for the pigmentation; or aging, or night cream or day cream, stuff like that, uh, so, I noticed that when I go for a professional presentation, I especially use good foundation, which I never needed before. So, that's changed, and the remedy is cosmetic!

Similarly, Kiran spoke about applying different creams on her face and some parts of her body to prevent hyperpigmentation, delay wrinkles and signs of aging, and to get a feeling of freshness: "before going to sleep…on most of the days…under my eyes…and on the neck…Herbal lotion is the best thing to do especially when rose water is there…"

In addition to the lifestyle changes mentioned in the previous section, the women spoke about doing yoga and meditation to help with their menopausal symptoms. Fara said: "A lot of women online swear by yoga…Yoga is one thing that, even though it was difficult during the periods but that is something, you know, deep breathing and all that, uh, to calm myself down." She added: "Now, I especially want to go into meditation because, uh, I've heard that meditation really helps women." Similarly, Zara shared that whenever she experiences symptoms like, hot flashes and irritability: "I understand, this is because of that reason [menopause]. So, I take some deep breaths and try to relax myself during this time."

Spiritual/Religious practices. Since Pakistan is a majority Muslim country, Islamic teachings were part of the people's daily living. The use of honey, kalonji [black seeds] and olives shared by the women were described in the holy Quran and 'Sunnah' [words/actions of Prophet Muhammad - peace be upon him]. Additionally, engaging in prayers at different times of the day would give them a break from the worldly matters. Islamic principles were followed in all matters of their lives. Hence, it was almost impossible to separate out culture and religion in most of their actions.

Allah was relied upon and thanked for everything. In addition, everything that happened was believed to be the will of God. Sara's first response to a question on how she managed her menopausal symptoms, was: "I don't know! 'Alhamdulillah' [All praise be to Allah] Allah ta'ala' [God] is with me. I manage it minute to minute." Rahila shared how she tried to control her stress with Islamic practices during menopause:

> It is better I remain calm. So, I avoid stresses even in job; I do not disturb people. I take the path of least resistance because it causes my heart rate to increase. I try to be calm. The best way I tell you, is forgiveness.

Rahila added: “I use to get calm, and mind my own business, this is the way I do. I am educated person. I do not have energy with all my menopause and age, to buy more stress…” And, Naila said: “I don't get involved in others’ business.” The women said that praying and remembering Allah was their foremost action to ease the menopausal symptoms. Shirin said: “at that time, I just…my prayers, my ‘tasbih’ [remembered/called the name of Allah].” Zuby added: “I believe it’s like praying a lot, especially, I used to pray and recite Quran…like that’s really helpful.”

Based on the teachings of the holy Quran and Sunnah, Meera shared following a habit of consuming natural ingredients on a regular basis to manage her menopausal symptoms and to stay healthy, as mentioned earlier: “If you take a spoonful of honey along with some few grains of kalonji [black seeds/nigella sativa] and ‘methi’ [fenugreek], then you will remain healthy throughout your life.”

Wearing different stones was believed to have varied effects on people and their lives. It was believed that wearing ‘Aqeeq’ [quartz] in a silver ring was Sunnah and that it affected the individual’s temperament by keeping the person calm. People generally wore it in a ring or as a locket to help control their anger and aggression; especially, by those who were short-tempered. Naila said: “I just put, uh, some stone on ring… I’m wearing this, and I think maybe due to this, umm as I used to be very aggressive, now I’m not that much aggressive… ‘Aqeeq’ [quartz]… It cools down your temper.” The women perceived menopause as an indication of getting old thus, getting closer to death and the Day of Judgment. They considered spending less time on social activities and worldly matters and more time in the remembrance of Allah by offering prayers more regularly, doing good deeds, charity, and other religious activities. They said that this way, they came out of menopausal depression and felt better. Shirin said:

> Socially, I have decreased my feeling to interact and go in weddings, and I don't feel to go…I spend more time for religious…I think old age is coming so these things [menopause]…it's normal I think, and you have to manage, and you have to accept this. It's fact that your life will go [is temporary], and your days will decrease, and your old age and your old appearance will increase…mostly I just keep myself busy, then it's [menopausal symptoms] resolved…

Shirin added:

> It's normally very mild symptoms, and irritating, crying mood and thinking of past feelings…and suddenly you are thinking about your negative things. So, at that time I just do my prayers, my tasbih [remembrance of Allah or repetitive utterance of short sentences in the praise of Allah] …if I'm very fatigued, feel tired to stand up. So, by lying down I do my tasbih…

Shirin sadly shared that she was regular in the practice of her faith by attending her religious place before menopause but since menopause, she was only attending occasionally: "I'm not, uh, going regularly…before menopause, I used to go every day." Alina said that practicing religion relieved all her tensions; she said: "Of course, we have a religious responsibility also; so, that gives you relaxation, of course!" The women found peace and relaxation in the practice of their faith. This included remembering Allah, praising Him for all His blessings, and uttering verses from the holy Quran helped in managing their menopausal symptoms to a great deal. Kiran said: "I just focus and then start saying some religious words and all; taking the name of God, or any religious thing, saying 'Kalima' [the confession of faith] or saying 'Durood Shareef' [salutation upon the prophet]." With that, she also shared practicing positive self-talk and having a strong belief in Allah: "Because we have a strong belief that 'it

will help', so, it helps. If I have a strong belief that 'it will not help', then, it will NOT help." She said that belief in Allah and practicing faith also work as a diversion of mind that helps, since it requires focus and concentration, Kiran added: "…I will be focusing on that [recitation]; you have to say it correctly, isn't it? You can't make mistakes. So, then you are focused on that. You completely forget about what is happening…"

Sometimes women did least on their part to relieve their menopausal symptoms or even consider that as an issue. They thought that menopause and its symptoms were given by Allah and they had to bear with it, so to stay calm and handle those patiently till those were over. Most of them spoke in gratitude for all the blessings of Allah, menopause being one of those. They thanked God for everything, the good and the bad in their lives, and believed that praying was the only/biggest solution to all their problems. They sometimes expressed no complaints or desire to do much to relieve their menopausal symptoms, unless those resulted in serious issue or complication. For example, despite the problems related to menopause, as discussed earlier, Alina said: "By the grace of Allah, you know, everything went well…thanks God they [children] understood, and they really were very supporting… 'Shukar Allah!' [Thank God!] up till now, I don't have any problem." Rozy said: "It's a part of life, uh, but luckily again, I can say that God has gifted me that [menopause], I can say that I have…less perimenopausal symptoms."

Similarly, staying positive was important for most women, as they believed that everything happened for good and by the will of God. For everything that happened to them or if they were able to find relief for their menopausal symptoms, they thanked God for granting ease in their difficulties. Amber, sharing about her experience with uncontrolled perimenopausal bleeding, said: "When it stopped [laughs] I thanked God…luckily, I got the visa and went [abroad] and got that [treatment] done; and thank God [laughs] now I'm able to get back to

normal." Amber added: "Thank God because not many people are fortunate enough to have the facilities that I did and the guidance that I did." Likewise, Naila said: "When I feel these things [menopausal symptoms], I just burst out to my husband and he is very cooperative, and he understand a lot of things about me. So, he doesn't say anything…so, this is a blessing I think." Naila shared related to her decreased sexual desire: "If I say no, he never insists, never forces me. He is very caring, which I think is a blessing. With all my problems this is a blessing. My husband is very supporting and caring." Participants believed that they had the strength to face their menopausal symptoms by praying and being hopeful that everything would be fine, and this time would pass too.

Theme Three: Factors Influencing Women's Decisions

There were several factors that influenced the women's perception and strategies to manage menopausal symptoms and to stay well during menopause. These include healthcare providers, family/friends/colleagues, and religion, as well as their worldview and available resources. This section is divided into sub-themes and categories based on the factors that influenced women's decisions. These are illustrated in Table 5.

Table 5

Factors Influencing Women's Decisions

Sub-themes	Categories
Health personnel	
Family, friends, and significant others	Family and friends Colleagues
Spiritual/religious factors	
Internet, media, and literature	
Worldview/learning and experience from abroad	
Other factors	

Health personnel. Healthcare personnel influenced some of the management strategies women followed. The women often consulted them for the severity of menopausal symptoms or to avoid complications. However, they followed some advice but tried to avoid taking medications. Rozy shared about her aches and pains: "I consulted many of the rheumatologists, and now I'm very much better and I've started my walk." Similarly, Safina said: "Previously I used to drink powdered milk, not full cream, it's less fat, and even now I'm taking the zero-fat powdered milk, but my cardiologist advised me to instead of taking powdered milk, to take liquid milk." She also said:

> Few years ago doctors used to tell me that, uh, do some exercise 5 times in a week and at the time I was always tied up with work…I felt like I was still really physically strong and all but later on I thought to myself that, it is really good for me.

Hence, healthcare personnel including physician, rheumatologist, orthopedic, physiotherapist etcetera, had an impact on various strategies women used to overcome their menopausal symptoms and to stay healthy during midlife. In addition, there were other factors in women's lives that greatly influenced their perception and decision related to menopause and the ways they managed those.

Family, friends, and significant others. In Pakistani culture, family, friends, colleagues, neighbours, and significant others were greatly trusted for their experience and advice. Their advice was equally valued for menopause and its management strategies. The women's choice of how they managed their menopausal symptoms, was widely influenced by various people in their life. The women frequently shared that their decisions related to their menopausal symptom management were widely driven by their mother, husband, parents, in-laws, cousins and other family and friends' advice and experience.

Family and friends. Meera shared the influence of her family for her strong belief in CAM/T: "…I am from a family, uh, which follows all the home remedies." Similarly, Meera mentioned the influence of her cousin on her decisions: "One of my cousin sisters and her husband…so, whenever I get sick, I don't go to any physician. I just give them a call, they give advice…" Another participant, Rahila, had a long-standing habit, which she quit during menopause, on her sister's advice: "I am not much into tea, because it gives palpitation. My sister advised me not to take tea…" Alina shared: "Mother's role was not very informative at that time, that mother should inform the daughter about menses and all that. So, my aunty, she told me everything." Kiran, who was a health professional, also talked about her decision of starting to use an herb on her friends' advice:

> I have just started a month back so, I really don't know the changes but all I could see from my friends, you know, they are 70 years old, 75 they are older than me, they have already gone through [menopause], they don't have a single wrinkle on their face, their heart…and everything is so much normal. This is what my research is going to be…So, probably we are going to bring this as an alternative/complementary therapy for the menopausal women…

Kiran added:

> Many of my friends, who are all either going through the menopausal stage or they have already crossed, they are the ones who have told…and they are all posh, very rich women. And they really believe in it…so, they told me…I have a friends' group…we are 25 or probably more…So, we are meeting sometime, and we discuss different matters…in a coffee shop and somewhere and talk; and from there I learnt it.

Meera started taking calcium supplements on her friend's advice, to regulate her menstrual periods when she had menopausal irregularity: "One of my friends at school, she just tells me that whenever we bleed heavily, we should take some calcium… so it will help your menstrual cycle…" Similarly, Zuby shared that: "It was like when you talk with people so, it gives you more dimensions." And, Samina said: "My family members and some of my friends asked me to go to Hakeem [Herbalist]." Also, Alina said that her behaviour during episodes of anger and mood swings was guided by her superiors at the workplace.

Colleagues. Safina, talking about the role her colleagues play in her decision making, said: "They say I am actually workaholic. I just want to do things right now and finish right now." Based on such feedback, she had made changes in her attitude, to manage her forgetfulness, anger and mood swings related to menopause. Safina said: "So what I do, I try to manage it like, for example, if it's 5:00 pm... I leave it like that…for the next day." Safina shared that she had recently started eating oatmeal in her breakfast on her friends' and colleagues' advice, Safina said: "People say that oats are good for reduction of weight and good for heart as well." She had recently started using honey instead of white sugar; and added pepper and ginger in her tea; she said that people around her influenced her decision: "people say that ginger is good for the body and pepper is actually good for the stomach, and your eyesight becomes more clear." Likewise, Faiza said: "We share many of the things with the colleagues…we are here 8:00 [am] to 6 or 5 o'clock; we share lot of things, so we do share our children issues, our health issues, help each other in giving the advices." Kiran said that she followed her colleague's advice for her psychological problems during menopause: "I have strong support, you know…I think I have no problems, facing [menopause], going anywhere…

I'm feeling very comfortable. Another good thing I have is the liberty to talk to mental health nurses around." Alina shared:

> Also, my boss told me once that "now you are getting angry, your voice has become loud." So, I said ok, now I need to control because [the] boss is always right [laughs]. And, I love my job very much and I don't want any effect on my job…that affect my boss and my relationship.

Thus, it was common that women's decisions related to menopausal symptoms were guided by a variety of people around them. This included friends, cousins, colleagues, and bosses in addition to siblings, husband, mother, and in-laws.

Spiritual/Religious factors. The women asserted religion as their biggest strength and a means for preparing and dealing with their menopausal symptoms. They said that religion had a great influence on most of their decisions. The women also believed that whatever had been revealed in the Quran and by the holy Prophet [peace be upon him] was now being proven by science. The women followed religion in every walk of their lives. Zuby said:

> Whatever holy Prophet said, it's mentioned in Quran…whatever he said, now science and researchers are showing that it has importance. Even like, what we pray, 5 times 'namaz' [prayers] it's also like when you put your head down [prostration] and your head is lower than your heart, it has like different significance and 'wazu' [ablution] we do, it has like different significance, and it's like, keeping you healthy. Like, fasting a month is considered now like very important for health you fast then it has like health benefits. I have even heard that it can protect you from cancer.

Similarly, Zuby said: "I started more praying as well. So that's the way I came out of that depression." Also, Shifa mentioned about a famous book on Islamic beliefs and practices

written by a Muslim scholar that describes Islamic rituals and morals. She said that the volume is especially aimed at educating girls and women. Shifa said that she referred to this book in addition to medical literature for her menopause and its symptoms: "And our religious book… 'Baheshti Zewar' [Heavenly Ornaments] [name of a book] …It solves all the problems… 'Nikah' [marriage], menopause, husband-wife relationship…" She said that the book has discussions and guidance on topics of daily life in the light of the Quran and Hadith of Prophet Muhammad (peace be upon him), which are very helpful.

Aliya shared her opinion and understanding about menopause that it is believed to be good in terms of freedom to practice religion at any time since a woman is considered clean at all times after menopause:

> Some people were enjoying. They said we don't have to worry about 'wazu' [ablution] in namaz, and not praying, and fasting, and not fasting. Because now we can dedicate ourselves to namaz, and to fasting, and to the God, and to connection with God. And, so, they enjoyed menopausal that now they are more pure, they are towards the purity and out of the reproductive part, and they can connect more with their Almighty Allah.

Similarly, Shifa said: "After menopause we have time, to give to our religion because whole month we are free…have no excuse." Contrarily, Amber thought that there was also cultural influence on some aspects of religious understanding that affected women's lives and their decisions during menopause; she said:

> Generally, in Pakistan, it's a taboo to talk about periods or menopause or anything relating to that…even like sometimes I don't understand why they say that when you have periods you shouldn't go to the mosque or read the Quran, because the way I see

> things is, ok, you have to be neat and clean and, you know, but this is something that God has given, you know…I think a lot of cultural values also dictate what you do…

It was important for Sara to pray and to connect with Allah, which was not possible for her due to prolonged bleeding; she said: "There was continuous bleeding for a month. Then I got very much disturbed…" At that time, her action was guided by a religious scholar. Her husband consulted a 'Mowlana' [religious scholar] because Sara wanted to pray: "I asked for a 'fatwa' [a legal pronouncement in Islam] that if I can perform my prayer or not? So, they said…The bleeding after 7 days becomes pathological, and then you can perform your prayers…" Religion had much influence on women's overall life decisions, including during menopause. Sara said:

> While the menstrual cycle, if you are married, you don't go to your husband…so, you avoid sexual relationship…And then, you must be in wazu [ablution] at all times…And, you can sit on the 'jae namaz' [prayer rug or mat]…You cannot say Salah [namaz], but you can recite what you have 'hifz' memorized; you can do that, you should do that! 'Allah pak ka naam lena' [taking the name of Allah], right! This is because, because this is a blessing; having menstrual period is a blessing, it's not a curse. Because your estrogen and progesterone are normal, that is why you are having menstrual bleeding. You must be thankful to Allah for that…

She added that women during perimenopausal bleeding:

> They can read Quran but not touching it and do 'zikr' [remembering/calling the name of Allah] and all that, ok! …So, it is a good thing. It helps you to fight with the symptoms. Some people get dysmenorrhea, right? So much of pain! You can fight it off like that. Because you see, our religion, uh, Quran is THE treatment of everything. It's THE

> treatment! There is no other treatment. It's not just the symptomatic one…Saying 'Alhamdulillah' [all praise be to Allah] is THE treatment!

Thus, religion had a great influence on women's decisions during menopause. This included referring to the holy Quran, Sunnah, religious books, and religious scholars. In addition, women referred to print and social media, medical books, and other literature to learn more about menopause and guide their decision.

Internet, media, and literature. Since the study participants were educated working women, internet, media both print and social media, as well as health-related books and articles had an influence on their decision to manage their menopause-related symptoms. The women had the knowledge and access to refer to and share these resources. They frequently used Google, YouTube, blogs, vlogs, and other media resources as well as medical/health-related books, newspapers, magazines, articles, etcetera, to seek information about menopause and its symptoms, and to find their solution.

The women shared that they did not prefer to consult for medical advice for their menopause. They rather tried to seek knowledge on their own, to understand what was happening. Shirin said: "I read all the things by myself and better understand…" Meera spoke about a book called "Health in your hands." Meera said that her mother also shared information through her learning from newspapers; she said: "My mother, she is a good reader of newspaper, Gujrati newspaper." Also, Meera said, she was fond of reading, especially about health-related topics including menopause; she said:

> I love human body. I want to explore that what is happening within the human body, why it's happening; so, I keep on reading all the health tips. It is my field of interest, so I know, I have awareness of all such things that these are the things that happen to a

> woman. Sometimes, when I go to library, I get books like that, or when my son, he is studying biosciences, I just pick up his books and if there is some topic on it, I quietly take his book and read.

Fara said: "as far as seeking knowledge, I went online, and I searched. I literally typed, you know, 'test for menopause'..." Similarly, Samina shared: "I go to internet and I learn, see the things, which are good for me. From internet, I see the benefits of turmeric powder, benefits of pineapple, benefits of apple…" Naila said:

> Now you get everything, every information from one click from net. So, you don't need to go to anyone to ask what will happen and what is going to…If you have, uh, symptoms you just click the net and you will get the answer.

Fara spoke about her experience of using social media and blogs a lot, to seek help with relieving her menopausal symptoms and related problems:

> I talk to a lot of women online because unfortunately, in my setup nobody talks about menopause; so, who do I talk to about it? And, whenever I've initiated the conversation it has not been received very well, uh, if I'm saying something, that doesn't mean other women are going to say, "Yes dear, I've experienced it too!" They'll be like, "Yeah, okay." So, that's like, one subject, women don't talk about. So, me, somebody who likes to talk, who likes to express, I take refuge in online groups.

She added:

> During my perimenopause, I was frantically going online and typing things, and I would hear these words like brain fog and all these things, I could never understand. But now that I'm experiencing, I still haven't started the hot flashes yet, and I dread, I'm literally

> dreading out because whatever I have read online, I'm freaking out that how the hell am I going to handle that?

Likewise, Zara said: "I have good resources. Then I used to read a lot, uh, especially I read Mayo Clinic, Harvard Literature and, reliable literature…" Hence, being literate and having access to the internet and other resources, most women referred to these to educate themselves about menopause.

Worldview/learning and experience from abroad. The women shared their experiences related to menopause in a foreign context, and its influence on the ways they dealt with their menopause. Most women talked about their experience of living in a western country for reasons like, studying, working, visiting or for their treatment. Amber visited the United Kingdom for her uncontrolled menopausal bleeding and got Mirena inserted, which helped control her bleeding. Her cousins were there, who supported and influenced her decision since she had a dissatisfactory healthcare experience in Pakistan. Similarly, Aliya, who frequently traveled to the United States for work and to visit her family said: "I had gone to physiotherapy a lot and I fell in love with the physiotherapy in U.S. and I brought many skills from the physiotherapist there." Many of her management strategies were influenced by that. Thus, women's worldview/learning and experience from abroad contributed to their decision related to managing their menopausal symptoms.

Other factors. The women also referred to other sources to help eliminate their menopausal symptoms. These included cosmetologists and beauticians. Aliya sharing about her management strategy for hyper-pigmentation during menopause; said:

> When I'm travelling, at the airports you find cosmetologists, who are selling the [name of cosmetic brand] product, and some are the [another name of cosmetic brand] product and

> some other good products…They have the doctors telling right there. Or, when I'm travelling and I go to a mall, the malls have places where the doctors are there, who look at your skin, and then they guide you that this soap, that soap will suit you, this lotion, that lotion…

Hence, there were multiple factors that influenced women's decisions on managing their menopause and its related symptoms.

In conclusion, the data collected from 20 urban Pakistani Muslim midlife women were aimed to answer the study questions. Participants shared experiences of their transition through menopause. There were similarities and differences in the way they perceived menopause, experienced the signs and symptoms, and used various strategies to manage their menopausal symptoms. There were robust sociocultural, religious, and familial ties firmly ingrained in the Pakistani setting, which were associated with the women's beliefs, perceptions, and actions.

Chapter Five: Discussion

In this chapter, I present the discussion of my study findings in relation to my research question, i.e. what are urban Pakistani middle-to-upper socioeconomic status Muslim midlife women's experiences of menopause? The question was further divided into three sub-questions. These were as follows: How is menopause perceived by middle-to-upper socioeconomic status urban Muslim midlife women in Karachi, Pakistan? How do urban Muslim midlife women manage symptoms associated with menopause in Karachi Pakistan's cultural context? And, what are the various sociocultural, religious, familial, and other factors that influence Karachi, Pakistani women's experience related to menopause? I used a focused ethnography design to answer my research questions. In this section, I relate some of the major findings of my study to an existing theory. I discuss some of the Pakistani cultural perspectives and the broader outcomes of the research by discussing the overall findings in view of the existing literature.

For readers' clarity and better understanding in this discussion, the words 'women' and 'participants', refer to educated urban Karachi Pakistani Muslim midlife women participants of the study. The terms 'midlife' and 'middle aged' are used synonymously; these refer to women in their pre, peri-, and postmenopausal phase of life. I have divided the discussion based on the major themes, i.e. women's perception of menopause, the strategies they used to manage symptoms associated with menopause, and factors that influenced women's experience related to menopause.

The theoretical approach that I found most relevant to my study is the concept of transition, as explicated in the Transitions Theory by Meleis, Sawyer, Im, Schumacher, and Messias (2000). The term menopausal transition is given to the period of transition of women from the reproductive to the non-reproductive stage of life (Elavsky & McAuley, 2009).

Transitions theory lists four main types of transitions, i.e. developmental, situational, health-illness, and organizational transitions. Pertinent to my study is the developmental transition that encompasses the different stages of the life cycle, for example, puberty in adolescence, parenthood, pregnancy and lactation in adulthood, and menopause in midlife. The theoretical framework helped me to understand that menopause is a transition phase of life and how it is an interlinked process of transition. Menopause cannot be experienced in isolation rather, its experience is based on multiple factors including, the women's cultural, religious, familial, and social beliefs and understanding. The model can help our understanding of the various transition conditions, i.e. its facilitating and inhibiting conditions that have an impact on how menopause is perceived and experienced.

Transitions Theory

Transitions theory is an emerging middle range theory. Transition is a process of change in circumstances, for example, of individuals or organizations. Transitions theory comprises the types and patterns of transitions, properties of transition experiences, transition conditions, i.e. facilitators and inhibitors, process indicators, outcome indicators, and nursing therapeutics (Meleis, 2010). Changes in the health status of an individual may result in positive or negative effects and trigger a transition process. Transition can be a cause or an effect as mentioned by Meleis, "Transitions are both a result of and result in, change in lives, health, relationships, and environments" (2010, p. 52). Clients may become vulnerable due to transitions. Vulnerability may be understood as the quality of life, based on a client's understanding of experiences and responses during the transition phase. Some examples may include illness experiences like diagnosis and surgery, developmental and lifespan transitions like aging and menopause, and social and cultural transitions like immigration and retirement. A person may go through

multiple transitions at any given time, for example, developmental and lifespan transitions like menopause, and social and cultural transition like migration. This may lead to increased vulnerability.

Transitions theory has great implications in nursing. Nurses are the primary caregivers that help individuals and families to transition through the life changes related to illness and wellness. They provide care throughout the transition process to help gain optimum health and wellbeing. Transition is used both as a perspective and a framework. The types of transition central to nursing practice when working with clients and families have been identified as developmental, health and illness, situational and organizational (Meleis, 2010). Transitions are usually not discrete or mutually exclusive, and it has patterns of multiplicity and complexity. For example, multiple structural transitions involved in aging maybe retirement, health status, role change, and socioeconomic status. Figure 5.1 demonstrates major connections of the middle-range theory of transition. Copyright permission has been obtained to reprint the figure (Appendix J).

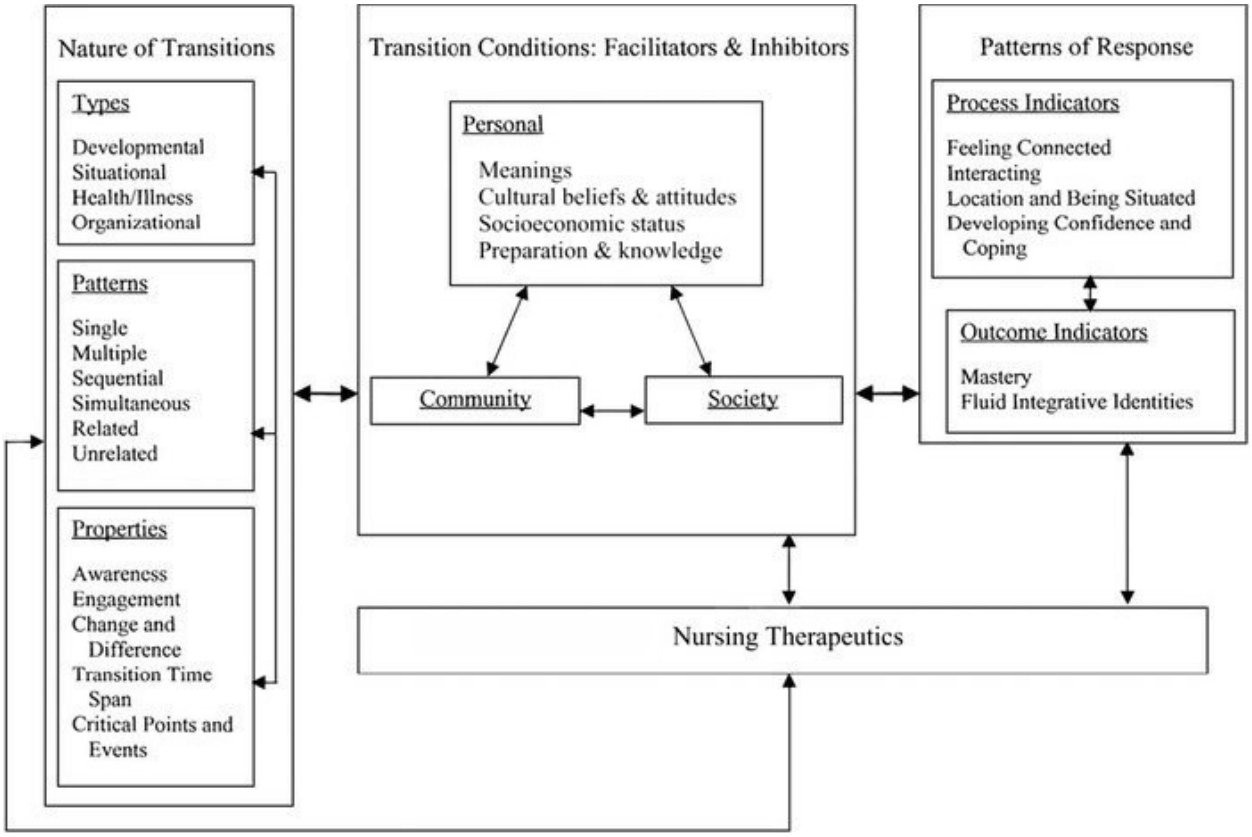

Figure 5.1. Transitions: A middle-range theory. Meleis, A.I., Sawyer, L.M., Im, E.O., Schumacher, K. and Messias, D.K. (2000). Experiencing transitions: An emerging middle range theory. *Advances in Nursing Science, 23*(1), 17.

Nature of transitions. The nature of transitions consists of the types, patterns, and properties of transitions. Types of transitions may be developmental, situational, health/illness and organizational. Patterns of transitions may be single, multiple, sequential, simultaneous, related, and unrelated. And, properties of transitions may include awareness, engagement, change and difference, transitions time span, and critical points and events (Meleis, 2010). I further discuss the types, patterns, and properties of transitions, and transition conditions related to my study.

Types of transition. In my study, menopause experiences of urban Pakistani Muslim midlife women were multiple and complex in nature and did not occur in isolation. These were

interrelated with other developmental, situational, and health and illness transitions. As the participants shared their experience of menopause, the connections of multiple transitions were intertwined throughout their descriptions. In addition to dealing with the developmental transition of menopause, participants were also dealing with other transitions related to aging and health/illness, for example, symptoms associated with menopause and chronic conditions. Developmental transition in conjunction with health/illness transition created a multiple and complex pattern.

Patterns of transition. Menopause has multiple, simultaneous, and related patterns of transitions. Menopause is a complex process as it brings changes in various aspects of women's life. My study participants experienced multiple transitions like change of roles and menopause simultaneously when they were moving towards aging; and some experienced one or more chronic problems like obesity, diabetes, and hypertension.

Properties of transition. Transitions have various important properties like awareness, engagement, change and difference, transition time span, and critical points and events (Meleis, 2010). These properties are interconnected components of a complex process (Meleis et al., 2000). For example, my study participants' awareness and engagement were based on their level of education and degree of freedom of speech or silence they observed concerning their sociocultural and religious understanding and experience of menopause, their role change and preparation, nature of their work, work environment and position at work, socioeconomic status, severity of menopausal symptoms, physical, mental and emotional health, and their social support system through family, friends, colleagues and significant others; their transition time span was based on their age at menopause and length of time they experienced menopausal symptoms; and participants' critical points and events were varied based on their personal,

familial, and societal circumstances. My study participants experienced menopause in their unique ways depending on several factors.

Figure 5.2. demonstrates a situation-specific theory of Asian immigrant women's menopausal symptom experience in the United States or AIMS theory by Im (2010). Copyright permission has been obtained to reprint the figure (Appendix K). This is a situation-specific theory developed from the middle range Transitions Theory on menopausal women in a specific context. It refers to the applicability of the Transition theory in my study. This situation-specific theory may be viewed as emerging rather than complete. Because of the inherent nature of situation-specific theories, it is more specific to a time and place, which may not be applicable at a different time and place due to its specificity (Im, Stuifbergen & Walker, 2010). Moreover, the development of a theory is an evolving, dynamic, and cyclic process (Im, Stuifbergen & Walker, 2010). This situation-specific theory aims to explain the menopausal symptom experience of women in a specific sociocultural context and is open for further development in different Asian contexts (Im, 2010).

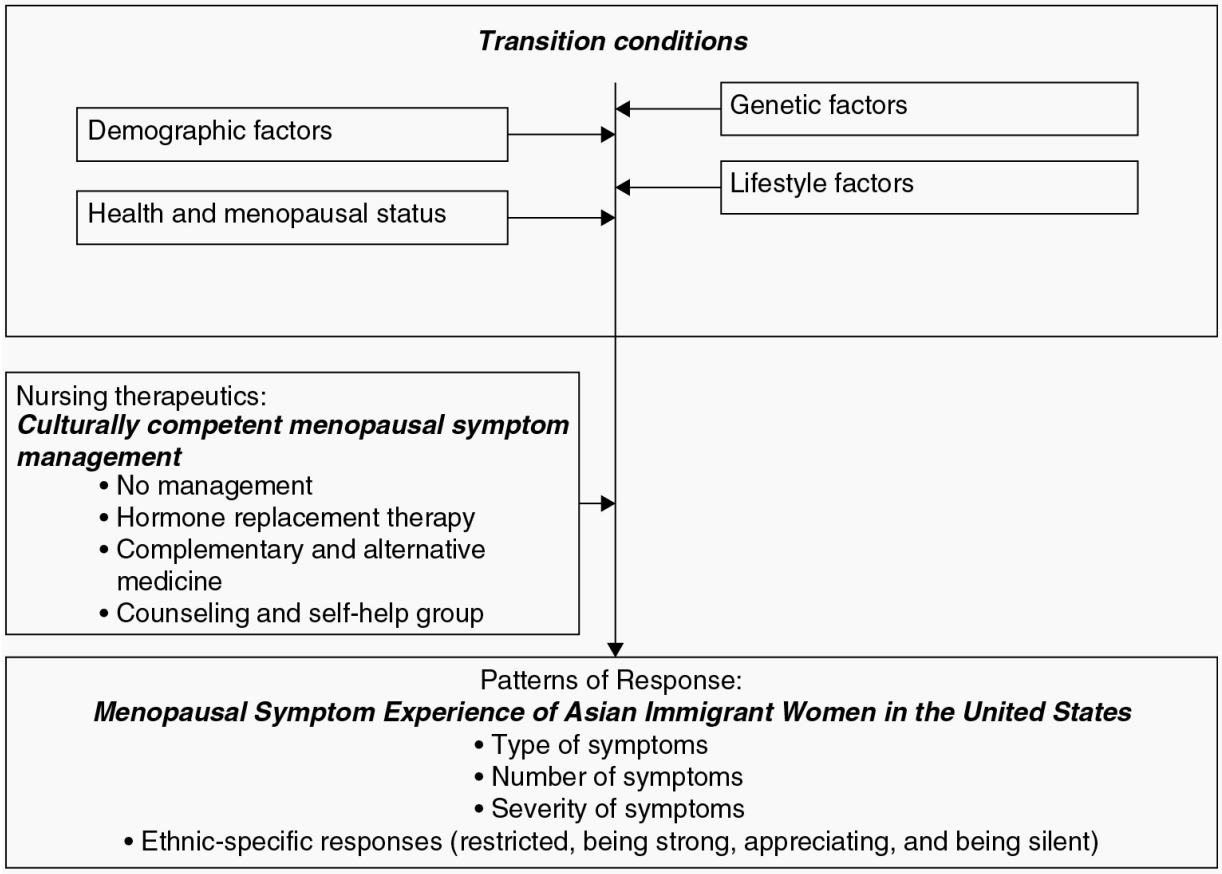

Figure 5.2. The AIMS Theory. Im E. O. (2010). A situation-specific theory of Asian immigrant women's menopausal symptom experience in the United States. ANS. *Advances in Nursing Science, 33*(2), 143–157.

Transition conditions. The Transition conditions mainly constitute the facilitators and inhibitors. These may be at personal, community, societal and other levels (Meleis et al., 2000) that may include factors such as demographic, genetic, health and menopausal status, and lifestyle (Im, 2010). In my study, some of the salient facilitators and inhibitors that contributed to participants' menopausal experience were mainly related to their culture that included health personnel, family, friends and significant others, spiritual/religious factors, internet, media and literature, and women's worldview/learning and experience from abroad.

Patterns of response. Patterns of response mainly include process and outcome indicators. The women's experiences were positive, neutral, and negative based on these indicators. The patterns of response in my study of Pakistani women's menopausal experience included the frequency of the menopause-related symptoms, severity and time period of symptoms, women's awareness, and their sociocultural responses to those symptoms.

Nursing therapeutics. Nursing therapeutics is another major concept in the theory. In my study, it is conceptualized as the cultural management of menopausal symptoms. These may be promotive, preventive and interventive (Meleis et al., 2010) in nature, based on women's experiences. It includes the use of modern medicine, lifestyle modifications, self-medication, non-pharmacological interventions/complementary and alternative medicine/therapies (NPI/CAM), and spiritual/religious practices.

Thus, transitions theory relates well to my study. The developmental transition includes various stages of the life cycle including menopause. Transitions theory emphasizes that menopause is a transition phase of women's life around midlife. In addition, menopause is an interrelated process of transition that is not experienced in isolation. Its experience is based on multiple factors. Transitions theory is valuable in understanding the various transition conditions, i.e. the facilitating and inhibiting factors that influence how women perceive and experience menopause. As my participants talked about their menopausal experiences, the connections and interrelations of various transitions were woven throughout their narratives. In proceeding with discussing the broader study findings, I continue to relate to the components of the Transitions theory and highlight some of the common cultural perspectives in the Pakistani context and their impact on my participants' menopausal experience throughout the discussion.

Perception of Menopause

In this section, I discuss the study findings related to how menopause is perceived by middle-to-upper socioeconomic status urban Muslim midlife women in Karachi, Pakistan. This section reflects the 'nature of transition' from the Transitions theory. This includes its patterns, which discuss that participants experienced multiple transitions simultaneously that were interrelated like menopause, aging, and chronic problems; and properties, which discuss participants' awareness and engagement with the phenomenon of menopause, the change and difference in their lives due to menopause, the impact of their age-at-menopause, and the critical points and events like role change and societal expectations. The nature of transitions is interconnected with the transition conditions, i.e. the factors that influenced participants' menopausal experience. It includes the participants' meaning and perception of menopause, sociocultural beliefs and attitudes, socioeconomic status, and preparation and knowledge of menopause. I discuss the relevant findings in view of the literature under three main sections as follows: (a) beliefs and understanding associated with menopause (b) struggles, challenges, and rewards of menopause and (c) symptoms experienced.

Beliefs and understanding associated with menopause. Pakistan is predominantly a patriarchal society. It is a widespread practice in Karachi, Pakistan, that a man is the head of the family. He is the primary bread earner and is responsible for working and earning outside of the home. A woman's primary responsibility revolves around childbearing and childrearing. Participants shared that they were required to look after the house and its members. They had high expectations to care for their families, especially their husbands and in-laws. Literature indicates that such viewpoints are stronger in rural and poorly educated communities than urban and literate families (Adhi et al., 2007; Awan, 2012; Hakim & Aziz, 1998; Qureshi, 2013). Yet

even in an urban context, women were voicing this. Similar expectations from women exist in other societies too, like in Niger, West Africa (Rasmussen, 2000). Gender roles in the culture contributed to influence women's beliefs and understanding associated with menopause.

Menopause is natural and unique for every woman. Participants were knowledgeable and aware that menopause is one of the phases of life that women experience around midlife. And, that, it was a natural phenomenon in the transition of women's life. They understood that it was not a disease process rather, an irregularity in the normal monthly menstrual cycle during midlife due to deficiency of reproductive hormones namely, estrogen and progesterone that lead to a permanent cessation of the menstrual cycle. Similar perceptions of women were found in a study conducted on less-educated middle-aged women from underprivileged families in Karachi, in which the author reports that almost three-quarters of the women perceived menopause as natural, while only about a quarter believed it was a disease (Khokhar, 2013). Iranian Azeri midlife women also believed that menopause was a natural phase and a fact of life (Hakimi, Simbar, Tehrani, Zaiery, & Khatami, 2016). Other pieces of literature note similar findings of women's perception of menopause as a natural occurrence (Malik, 2008; Im et al., 1999; Winterich & Umberson, 1999).

My study participants viewed menopause as a personal experience that may differ from one woman to another. They believed that every midlife woman experiences menopause and its associated symptoms in her unique way. Women's experiences may vary depending on their circumstances, for example, their physical and mental health, level of education and awareness, nature of work and financial status, the severity of menopausal symptoms, and support system. Likewise, studies conducted on midlife women in other cultural contexts report that women's experiences associated with menopause are not the same (Suka, Taniuchi, Igarashi, Yanagisawa,

& Ishizuka, 2016). Their experiences may differ based on their racial and ethnic background (Avis et al., 2015; Im, Chang, Chee, & Chee, 2019). Regardless, every woman in her midlife, experiences menopause and its symptoms. In some women, the symptoms may be mild to moderate, while in others, it may be severe and debilitating (Kopenhager & Guidozzi, 2015). My participants' experiences of menopause and its associated symptoms were more individualized and subjective. Since menopausal experience was perceived as personal, it differed from one participant to the other. Additionally, there were cultural, religious, and other perceptions and practices that played a part in shaping women's experiences of menopause.

Menopause, marriage, and reproduction. Pakistan being an Islamic state, marriage is valued (Saeed & Atta, 2018) and preferred over live-in relationships and extramarital affairs; and most marriages are heterosexual. All my married study participants were married to men. Polygyny is permitted in Islam, i.e. a man can marry up to four women. It is based on certain reasons including supporting women that are divorced, widowed or unable to fulfill their needs; protecting women and providing them good status in the society; when the wife is incapable of reproducing and avoiding people from going astray, and on conditions including the man is capable, and agrees to do justice to all his wives, and has the willful permission of his present wife to marry another woman. However, it was rarely seen in the urban Pakistani context that a man had more than one wife. All my married participants were the only wives of their husbands. Polyandry, i.e. a woman marrying more than one man, is not permitted in Islam, for reasons including to comfort women to maintain their optimum health, and, if the woman, who has multiple husbands, gives birth to a child, it is challenging to figure out, who the biological father of the child is. Divorce is regarded as a disgrace (Hussain, 2009). It is uncommonly found in Pakistan, and is a taboo, especially for a divorcee woman. It may be due to reasons like

permitted polygyny, and divorce as a taboo in the culture that some of my participants refrained from talking about their menopausal challenges with their husbands, family, or anyone at all. They preferred to stay calm and accommodating and remained obedient to their husbands and families. Yet one of my participants was divorced, she seemed sound, and independent.

In the Pakistani culture, having children and being able to conceive is thought of as a blessing and a gift of God. The same was asserted by my study participants. According to my participants, as well as the literature, in Pakistan, the family is given priority (Saeed & Atta, 2018), and childbirth is considered essential and fundamental in continuing the heredity of the family. Childbearing and childrearing are believed to be the primary responsibility of women (Khademi & Cooke, 2003) in addition to taking care of their families (Ahmad & Anwar, 2018), especially, in-laws. In Pakistan, the descent is traced patrilineal (Weiss, 2014). Literature reports that the birth of male children is given special importance in carrying forward the name and inheritance (Hakim & Aziz, 1998; Stotland, 2002). Women having more sons are valued highly in society (Awan, 2012). Sons are considered to be the strength of the family, caretaker of their parents later in their lives, and predominantly to carry on the name and heredity of the family; therefore, bearing male children signifies pride (Awan, 2012). In a study conducted in Karachi, Pakistan, less educated middle-aged women with lower literacy and socioeconomic status reported multiple pregnancies in the quest of giving birth to male children (Malik, 2008). Midlife women in my study believed that while women were menstruating, they were burdened to produce children. However, contrary to the literature, none of my study participants shared being pressured to deliver male children.

Participants experiencing menopause, linked menopause to being old and unable to bear children anymore. My study participants considered the phenomenon more mechanical as they

thought that the patriarchal culture viewed a woman as a machine to reproduce. They believed that this understanding was more common in underprivileged communities than in more literate and financially stable ones. Similarly, literature reports that rural women and those from less educated families are expected to give birth to multiple children (Awan, 2012; Qureshi, 2013). Participants considered frequent childbirth and sometimes not using appropriate family planning strategies (Hakim & Aziz, 1998) as risky for both the mother and the child. They believed that this resulted in high maternal and infant morbidity and mortality. Participants appreciated that after menopause they were not expected to reproduce because they were infertile due to the insufficiency or absence of reproductive hormones. Thus, they felt relieved from the burden to reproduce. However, they had other challenges including multiple responsibilities and expectations during midlife.

Views about menopause and work. In Pakistan, working women bear additional responsibility; they may or may not get support from their family. However, there are servants and helpers in most of the middle-to-upper socioeconomic class houses like: 'masi' [cleaner], maid, cook, and driver, primarily depending on people's affordability, need, and willingness. Despite the societal challenges, my study participants, who were educated and working women from urban Karachi, had a somewhat optimistic view of menopause. They believed that menopause was an indication for the production of their careers rather than the production of babies. They believed that they had more time and energy to focus on their careers and achieving their professional goals. Women's perception of menopause, however, varies in different contexts. For example, rural Iranian women have negative perceptions of menopause as childbirth is highly valued in their culture (Khademi & Cooke, 2003). They think that it takes away their worth in society as they cannot reproduce after menopause (Khademi & Cooke,

2003). Women that are highly reliant upon men for their physical, economic, and social providence tend to perceive menopause as a fear to maintain their relationship with their husbands, and keep their status in society (Aaron, Muliyil, & Abraham, 2002; Khademi & Cooke, 2003). However, my study findings were unique in that respect, as my participants were more independent in terms of fulfilling their basic needs. Since these were literate, working women from urban Karachi, they were financially sound, enjoyed better physical and material freedom, and were well-placed in the society. Hence, my participants had an optimistic outlook on menopause. Similarly, studies conducted on educated women report that they are more positive about menopause; they express their happiness in being able to accomplish their career goals after menopause as they are free from the monthly menstrual cycles (Stotland, 2002). A study conducted on middle-aged women in Karachi, Pakistan, reports that 36% of women were pleased, while 33% expressed displeasure on experiencing menopause (Khokhar, 2013).

Participants' beliefs and understanding about menopause varied based on several factors. Because of the disturbing menopausal symptoms, lack of family support, and negative societal perceptions about menopause, participants sometimes viewed menopause negatively. In addition, due to their multiple roles and responsibilities, they sometimes did not view menopause as their primary concern. They had to deal with several challenges simultaneously while they were experiencing menopause, their concerns, including menopausal symptoms, took the least priority. Some participants reported there was so much going on in their lives that they had no time to think about themselves and their menopausal symptoms. This finding is congruent with the literature, which informs that some immigrant women and the ones from the lower socioeconomic status have negative (Im & Meleis, 1999; Qureshi, 2013) or more neutral views about menopause (Im, 1999). They are engaged in multiple tasks at the same time; they earn for

a living, take care of their house, and immediate and extended families (Im, 1999; Khademi & Cooke, 2003). Thus, for them, menopause does not take precedence over other important matters of their life (Khademi & Cooke, 2003). Participants' perceptions were also driven by access to various facilities for women in the culture.

Midlife is linked with poor health and beauty. In Pakistan, there are few amenities like parks, playgrounds, gyms, and walking and biking tracks; and these are fewer for women. Participants shared that they had limited opportunities in terms of facilities, time, and energy, to keep well and practice physical activity and exercise. However, due to the negative perceptions present in the culture that associated menopause with weariness and ill health, participants tended to try different ways to portray themselves as young and admirable. They shared a common perception that exists in the culture about menopause that is thought of as the main contributor to women's compromised health in their midlife. They, as well as their husbands and families, believed that women suffer physical and mental problems and chronic diseases due to menopause. Some of the reasons for this cultural understanding may be improper nutrition, increased workload and time constraints, multiple pregnancies, the least priority given to physical activity and exercise, increased patriarchy, and due to other such factors, women in Pakistan experience multiple health issues and chronic problems around midlife. My participants were no exception to these cultural challenges. Despite coming from well-educated and middle-to-upper class families, women had to face some of these issues existing in the culture. Thus, menopausal symptoms were frequently linked to poor health and aging in Pakistani culture. Likewise, literature relates menopause to chronic problems like cardiovascular diseases and osteoporosis (Gutiérrez et al., 2015). Study participants and the available literature, link menopause with old age (Khademi & Cooke, 2003) and getting closer to death and dying.

Participants perceived menopause as the primary cause of losing their youthfulness and beauty. They understood menopause as an end to their vitality and worth in society. They believed that estrogen and progesterone were helping them stay young and beautiful, but the hormonal deficiency after menopause had caused them to look and be viewed as old and weary. Similar beliefs were found in the literature, a study conducted in Iran, indicates that mainly due to losing the ability to reproduce, rural midlife women perceived menopause as a step towards getting old, and they did not appreciate this change in their life (Khademi & Cooke, 2003). Study participants believed that reproductive hormones were mainly responsible for their vitality, which declines with menopause and results in women's poor health, lowers chances to conceive, and accelerates aging. This is consistent with the literature, which indicates that fertility and reproduction are linked to women's vitality and womanhood (Ahmad & Anwar, 2018). Participants blamed menopause for deteriorating their skin turgor and affecting their sexual life. Menopause was believed to be a cause of concern and apprehension for women and their families.

Menopausal age and aging. In Pakistani culture, most women regardless of their age, be it young girls or older women hide their true age. I initially faced challenges in recruiting my study participants as most women denied that they were in their midlife or were experiencing menopause. There may be several plausible reasons for that, for example, young women are valued more in the culture, and older women are considered less worthy and inefficient. Hence, women refrain from disclosing their correct age, perhaps due to the taboo attached to being older especially, as a woman, and to avoid being called non-productive, inactive, and old. This finding is comparable to a study on midlife women from different backgrounds, which informs that women feared to admit that they were experiencing menopause as it signified that they were

aging; and because menopause was associated with stigma, silence, shame, and aging (Nosek, Kennedy & Gudmundsdottir, 2010). Therefore, to be viewed as young and to maintain their status in society, women do not reveal their age. A study in Karachi, Pakistan, reports that women frequently hide their actual age as per their documented birth date (Adhi et al., 2007). Women tend to under-report their age, while they are indeed a few years older than what they say they are (Baig & Karim, 2006). Thus, young girls tell their age a few years younger than their real age and parents tell their daughter's age a few years less than they are. This may be because they fear that their daughters would not get good proposals for marriage as most people desired younger girls for marriage, who are preferably in their early or mid-twenties (Calder et al., 2017), and almost always a few years younger than their husbands-to-be. Besides other reasons, hiding age and early female marriages may be connected to higher chances of having a physically active, and longer and healthier sexual/reproductive life, since, in Pakistan, women were often menopausal at an earlier age. In addition, the overall life expectancy of Pakistani women is about 70.5 years (CIA, 2019), which is lower than in some other countries.

According to my participants' cultural understanding, Pakistani women experience menopause at an earlier age, i.e. in their forties, compared to women in the western world, who usually experience menopause in their fifties. For example, the average age of menopause reported by women in the U.K. is 51 years (Sarri, Davies & Lumsden, 2015). Participants perceived it as a stressful time since menopause was unexpected for them and their families. It was a challenge for the participants to reveal it to their husbands and in-laws, even to their natal families, that they were experiencing menopause at an early age. They knew that their menopause would not be accepted by their families, or at least it would be hard for them to admit it. For some women from the less educated and lower socioeconomic background it may be

difficult to perceive menopausal changes and to prepare for it at the right time as they may not know their age at menarche, or their actual age according to their date of birth (Adhi et al., 2007). My study participants were menopausal at different times during their midlife. Albeit, all the participants reported that they experienced the beginning of menopause between 43 and 53 years of age. This coincides with the available literature. According to a study conducted in Karachi, Pakistan, the average age of women at menopause as per their documents was 44.5 years (Adhi et al., 2007). An investigation conducted on midlife women with low literacy rates and poor socioeconomic background in Karachi, Pakistan, informs that the average self-reported age at menopause was 47.4 years (Malik, 2008). A similar average age of 47.4 years is also reported in a study carried out on 300 women from various parts of Pakistan (Noorani, Siddiqui & Farzana, 1998). Another study conducted on menopausal age women from different socioeconomic status in urban Karachi, reports the mean age of women at menopause as 47 years (Wasti et al., 1993). There could be several contributing factors for Pakistani women to experience menopause at an earlier age than in the industrialized world. Definite reasons for early menopause are not known; however, according to literature, menopausal age and symptoms may vary based on several factors, including health status, ethnicity, parity, socioeconomic status, lifestyle, level of literacy, and genetics (Adhi et al., 2007; Ara, 2018).

Struggles, challenges, and rewards of menopause. Every woman in my study experienced menopause differently. They experienced a variety of symptoms. Some participants believed that menopause brings struggles and challenges, while others perceived menopause as rewarding.

Struggles and challenges. Participants shared several challenges related to menopause and its symptoms. They had to maintain a healthy balance between their personal and work life.

In Pakistan, problems with access to necessities of life such as the supply of safe drinking water are common. My participants were no exception to these problems. In addition to facing their menopausal challenges, participants had to deal with these issues on a daily basis. For example, they had to take various measures to obtain safe drinking water, it was not readily available in their houses. Affluent and knowledgeable people in Pakistan either buy mineral water bottles or containers with dispensers/coolers or boil tap water in large pots/vessels at home for at least 20 minutes and then cool it down to make it consumable for drinking and sometimes cooking purposes. It is done almost every day, either by women or servants in the house, most often on 'sui' [natural] gas stoves; it is uncommon to see electric burners in Pakistan. People use ready potable water or other methods of water purification as per their affordability, convenience, and level of awareness, to obtain the consumable quality of water. There is frequent electricity load shedding or power outage for several minutes to hours, sometimes days especially, during peak summertime. This was cumbersome for participants experiencing hot flashes. They could not enjoy the luxury of turning on the air conditioner or even fan at times. They managed their hot flashes by drinking cold water, wearing light clothing, and taking showers, which was again not so easy because the water supply is limited; affluent people store water in overhead/underground reservoirs and tanks. In addition, there are internet issues; and not all houses in Pakistan have automatic washing machines, dishwashers, and other luxuries of life. This added to participants' challenges of daily living and information-seeking through the internet.

Working women are overburdened. Most participants shared that it was their responsibility to make sure that food was prepared every day and served on 'dastarkhwan' [tablecloth spread on the floor] or on the table to the whole family. Including breakfast, food in

Pakistani houses is usually prepared fresh for the household once or twice a day, with typically one to two main dishes mainly curry and rice dishes for lunch and dinner with most frequently 'roti/chapati' [homemade whole wheat round flatbread] and/or rice, along with salad, chutney or pickle, and an optional sweet dish. However, eating out, family gatherings, social events, and entertainment are common in Pakistan in the evenings and over the weekends and public holidays. Dining out gives women some relief from cooking, while inviting friends and family to the house increases their workload. Elders are greatly respected and obeyed in Pakistani culture especially, parents, grandparents, and in-laws. In addition, hospitality is highly valued. Serving guests both planned and unplanned at any time of the day is welcomed and viewed as a blessing. It is typically the responsibility of the women to serve them in the best possible way. Additionally, women are expected to make sure that the children are tidy and well dressed, the elderly members in the house are well taken care of, the house is clean, and everything in the house is in order at all times. Needless to mention that educated women have higher expectations for their children's upbringing, secular and religious education, better grades in school, attending parent-teacher meetings, etcetera. Most of these societal expectations were reflected in participants' descriptions. Similarly, literature states that a working woman has to deal with her household responsibilities along with the patriarchy, with or without help at home, and high demands at the workplace (Calder, Noureen, Rakhi, & Imtiaz, 2017).

My study participants sometimes found it challenging to manage their work and household responsibilities due to the severity of their menopausal symptoms. Some of them were working at high-level roles and had the responsibility to take care of the sick and elderly at home while they were experiencing menopause. Literature notes that women perceive their busyness at work and home, challenging. They struggle with balancing the household and

professional responsibilities, which are equally demanding (Khurshid, 2016). Similarly, my participants had to take care of their household, family, husband, kids, and in-laws, cook food for them, keep the house clean, and serve the guests at all times. In addition to the challenges of basic needs of life in Pakistan that were expensive yet not easily accessible, participants shared the concerns of gender discrimination that prevailed in the society. As most of my study participants were working in leadership or senior positions, which were stressful and demanding, they perceived menopause had elevated their physical and mental stress. They often had to face their menopause-related symptoms in silence since the phenomenon is not freely talked about in the culture. Likewise, literature reports that women are expected to stay silent, patient, and tolerant (Ahmad & Anwar, 2018; Qureshi, 2013). Studies carried out in other parts of the world are also consistent with the cultural understanding of menopause as a silent phenomenon (Rasmussen, 2000). Additionally, in other male-dominant societies like India and Korea, women do not always experience an increase in status when aging, nor can they talk about their views and challenges related to menopause with their husbands. Instead, they are expected to stay calm and tolerant (Aaroon, et al., 2002; Qureshi, 2013).

Sharing menopausal experiences with others differs from one woman to the other. Some of my participants shared their menopause-related experiences only with their husbands; some shared it with their female family members, friends, and colleagues; some with healthcare professionals, and some did not disclose it to anyone. This finding is consistent with other studies that mention that women from educated backgrounds and well-to-do families discuss their menopausal experience with their close relatives, friends, co-workers, and health care providers (Memon et al., 2014). Some of my participants openly talked about it with anyone around them. However, they said that it was not customary to have discussions on menopause

freely in the culture and it is not looked upon positively. Participants struggled to cope with the challenges they experienced with menopause, gender discrimination, and extraordinary demands on women set by society. This finding is congruent with other studies, which state that the expectations on women and the challenges they face are overwhelming and physically and mentally straining (Khademi & Cooke, 2003). A study conducted in Karachi, Pakistan, on women from different literacy and socioeconomic class reports that besides other expectations, the recent social and cultural expectations from women to attain a certain level of education is increasing (Hussain, 2009). These expectations are higher for young women for better chances in the marriage market (Hussain, 2009). However, the author writes that there still exists a gender difference in society. Similarly, some of my study participants expressed feeling less important and less productive for society in midlife and encountered gender inequality. They believed that this was exacerbated by menopausal symptoms like hot flashes, fatigue, and absentmindedness that they experienced during this time.

Participants expressed their apprehension and annoyance on losing their beauty and youthfulness with menopause, which made it difficult to sustain their work in some instances. They said that they did not get the necessary support from their employers and coworkers during this time. Some of my study participants strongly opposed the idea and believed that societal biases against women in midlife were not right. They believed that women at this age had more life experiences; they had a lot to share with others, especially with the younger generation. Consequently, they were able to contribute to society in a better way. Participants widely argued that gender biases are prevalent in the culture. Literature reports that Pakistani television channels, which are extensively watched by all age, gender, and class, have started playing a role in promoting gender-based discussions through TV dramas since the liberalization of media in

the early 2000s (Cheema, 2018). This change is reflected in a book written by Hussain (2009). The author informs that Pakistani women are now moving towards more innovative and non-traditional roles and white-collar jobs that were previously viewed as exclusively male employments (Hussain, 2009). This is consistent with my study findings where my participants were from an assortment of professions and occupations. They worked at highly prestigious positions like a university professor, dean, nurse leader, doctor, information technologist, journalist, head of department, and entrepreneur. Many of them were outspoken, they expressed their experiences and concerns related to menopause openly; some even called themselves 'rebellious' to the cultural norms for women. In addition, most of my participants were married, while some were unmarried, and one had gotten married recently. This was again, not a norm especially, in the past in Pakistani culture and even in the present times in many parts of the country where early female marriages are common. This study finding is consistent with a fairly recent study conducted on working women in Karachi, Pakistan, from different class and educational levels, in which the author reports that around 42% of her participants were married, while almost 55% were unmarried (Hussain, 2009), which is an exceptionally large number.

High matrimonial expectations. My study participants experienced concerns related to the high matrimonial expectations in society that continued during midlife. They shared that in addition to taking care of their family and in-laws, they had to satisfy their husbands, which meant that whenever their husbands demanded sexual intercourse, they were expected to be available. Some women shared their annoyance and became agitated and angry. Others believed that it was their duty and obligation to obey their husbands and to please them. This finding is similar to a study conducted on midlife women from various ethnic backgrounds that report that women felt their duty to take care of their house, children, and husband, as well as the sick and

elderly family members (Im, Stuifbergen & Walker, 2010). However, it was challenging for women due to several reasons including perimenopausal bleeding, aches, and pains, tiredness, mood swings, and decreased sexual drive during their midlife. Moreover, in Islam, cleanliness is of utmost importance; both the man and the woman should take a complete shower after sexual intercourse and prior to performing any religious or worldly activity. My study participants found it distressing because of the multiple responsibilities. Moreover, they had to not only maintain their employment but to perform their best at work.

Some of my participants found their lives overwhelming during midlife. Due to various responsibilities, they did not notice the changes and challenges of menopause and its symptoms. Due to the heightened expectations and responsibilities, menopause was either not their priority or was simply masked by the workload. Their menopausal changes went unnoticed unless those took a considerable amount of time and energy or negatively disturbed their life and caused hindrance in carrying out their usual work. These findings are consistent with the literature that in some developing countries, women do not pay much attention to menopause. They either do not see it as a problem, or they perceive it as a natural occurrence, or lavishness of life for those who have time and resources for themselves, as they have multiple responsibilities and problems to attend to than menopause (Malik, 2008; Im et al., 1999; Winterich & Umberson, 1999).

Symptoms like forgetfulness or brain fog were expressed by participants as one of the biggest challenges that they experienced with menopause. They suddenly went blank in the middle of their thoughts, which was, at times embarrassing for them especially, at work. Their thinking was blocked and sometimes it was hard for them to remember certain things or events. For example, they were bad at remembering names and numbers or whom they met, and when or what they talked about. This was very disturbing and challenging for them as they could not

participate efficiently at work or social gatherings. They experienced a lack of attention and focus, and absentmindedness. As a result, they felt 'dumb' as stated by a participant, and worthless at their workplace and in society. Similar findings are reported in the literature. A study conducted on Karachi Pakistani women reports that in addition to other menopausal symptoms, over 20% of their participants experienced poor memory (Khokhar, 2013).

Rewards of menopause. My study participants believed that menopause ceases the ability to reproduce. They expressed their happiness over this fact and perceived it as a relief from the burden and fear of reproduction. They were glad that they did not have to worry about getting pregnant after menopause, which was earlier a source of stress every month. In addition, they did not have the monthly pain and discomfort as when they were regularly menstruating.

Some participants mentioned that after menopause, they had more time and energy to take care of their family and look after themselves. They could also focus more on their work and career goals. Participants viewed menopause as a more opportunistic time of their lives to develop themselves personally, financially, and professionally. They believed that after menopause, they could excel in their professional endeavours. The above findings coincide with the empirical evidence that educated working midlife women view menopause as an opportunity to enjoy freedom from the monthly menstruation, and time and ability to pursue their professional undertakings (Stotland, 2002). A vast majority, i.e. 87% of the highly literate professional midlife women in Hyderabad, a neighbouring city of Karachi, reported a positive attitude towards menopause, and several of them experienced an easier and calmer life (Memon et al., 2014). Better literacy and socioeconomic status are notably associated with an optimistic outlook of women and their improved knowledge and management of menopause, as indicated in a study conducted in three different cities of Pakistan (Mallhi et al., 2014). Similarly,

researchers in a study on Iranian women report that urban women have a positive attitude towards menopause, while rural midlife women have a more negative perception of menopause mainly due to the inability to reproduce (Khademi & Cooke, 2003). A study on less literate middle-aged women from the lower socioeconomic status from Karachi Pakistan reports that a majority of them either had a positive or neutral attitude towards menopause, i.e. 47% and 39%, respectively (Malik, 2008). Another study conducted in Pakistan reports that menarche and menopause are similar to some extent, for example, menarche is a turning point in a woman's life when her freedom as a child ends, her mobility decreases, and household responsibility increases (Calder et al., 2017); menopause is another turning point in her life. Women perceive menopause as freedom and independence from the regular menstruation (Malik, 2008).

Participants believed that with menopause, the fallacies and stereotypes associated with menstruation in the culture end such as pickles turning bad on touch, and refraining women to pray, fast or touch the holy book, and participate in religious activities. Im, Stuifbergen and Walker (2010) report that women from various cultures face traditional patriarchal restrictions while they are menstruating. This includes not washing hair, refraining from sitting on cold floors and limiting physical activity like running and bike riding (Im, Stuifbergen & Walker, 2010). Similarly, literature notes that women could only continue religious practices once their menstruation has ended (Bari, 2000). Thus, participants perceived menopause as a relief from these restrictions and misconceptions. They were happy that they could perform their religious activities whenever they wished after menopause.

Some literature from the western context informs that midlife women experience the 'empty nest syndrome'. This is when their children depart and move on with their lives, women experience aloofness and emptiness (Hall et al., 2007), as they miss their children. Family is

valued; however, in the western context, it is normal that children leave their parents' house for reasons like better prospects. In my study, family and relationships are highly treasured in Pakistani culture, which is usually expressed by living in multi-generational households. The family is the fundamental social organization that provides identity, protection, and sustenance to its members (Weiss, 2014). My participants were either living in extended families or close connections with their families. Likewise, the literature confirms that the joint family system is strongly rooted in Pakistani culture (Cheema, 2018). Most married participants had ties with natal families too, which is also consistent with the studies conducted in Pakistan (Weiss, 2014). This could be a reason, almost none of my participants expressed their concerns related to feelings of emptiness. Rather, participants perceived midlife as the period to redefine their roles such as taking care of the elderly and grandparents in their house. Their roles were transitioning to becoming mother-in-law and grandmother from the earlier roles of daughter-in-law and mother. Similarly, in Japan, there is a common concept of a joint family. Japanese women in their midlife take on an active role as a mother-in-law. They are responsible to take care of their daughter-in-law, especially after she has given birth (Zeserson, 2001). If the daughter-in-law is not well-rested or gets sick, the society blames and demeans the mother-in-law (Zeserson, 2001). Nonetheless, one of the reasons for my participants to not experience emptiness may be related to their age at menopause. Most studies that report women's feelings of emptiness are conducted in the western context where life expectancy is higher, and women experience menopause at a later age. This oftentimes coincides with children departing their parents' house to move-on in their lives. While in the Pakistani context, as mentioned elsewhere, life expectancy is lower and women experience menopause earlier in their midlife, their children are still young and living

with them. This could be a reason my participants did not report feelings of loneliness or emptiness while experiencing menopause.

Symptoms experienced. My participants reported several menopausal symptoms. These symptoms varied from one woman to the other in frequency and intensity, as well as in their perception and experience. Most women experienced more than one symptom related to menopause. My study participants reported experiencing a wide range of symptoms with menopause including hot flashes, disturbed menopausal bleeding, bodily aches and pains, fatigue, sleep disturbance (sleepiness and insomnia), and psychological issues like depression, brain fog, forgetfulness and absentmindedness, and low self-esteem. Similar findings are commonly mentioned in the literature. A study conducted on 437 midlife women in a developing, neighbouring country, Bangladesh, listed generalized body ache as the most prevalent menopausal symptom, followed by lower back pain, muscle and joint pain, tiredness, hot flashes, genitourinary symptoms, insomnia, and irritability (Ara, Alam, & Yusuf, 2018). In a study in Karachi, hot flashes were the most commonly reported symptom by menopausal women (Adhi et al., 2007). In addition, forgetfulness, weight gain, mood swings, vaginal dryness, decreased physical beauty and appearance like pigmentation and wrinkles on the face, loss of muscle tone, thinning of hair, and poor eyesight were some of the common complaints expressed by my study participants. Similar menopausal symptoms are reported by women in the other studies (Adhi et al., 2007; Chattha et al., 2008; Daley et al., 2006; Khokhar, 2013; Yeh & Chang, 2012). In addition to hair loss, memory loss and other symptoms, urinary incontinence was also reported by midlife women in a study in Karachi (Baig & Karim, 2006). Additionally, irritability, dyspareunia, and frequency of micturition were indicated as menopausal symptoms in another study on 650 midlife women in Karachi (Wasti et al., 1993). Some midlife women in

Hyderabad informed experiencing stress incontinence and growth of facial hair with menopause (Nisar & Sohoo, 2009). Also, skin changes and decreased vision during menopause was reported in a study of midlife women in Karachi (Karim et al., 2013). Participants commonly expressed being anxious about getting bone and joint problems like osteoarthritis and cardiac and other chronic illnesses like hypertension, hypercholesterolemia, and diabetes. Participants also reported irregular menstrual cycle and heavy and sometimes prolonged perimenopausal bleeding, which caused physical and mental exhaustion, pain, irritability, and social disconnection. Some participants informed decreased sexual drive, while others reported joy and increased libido. Conversely, in a study in Karachi, women did not report any change in libido (Adhi et al., 2007). There was a significant impact of menopausal symptoms on all aspects of participants' lives including personal, professional, and familial. A study conducted on midlife women in Hyderabad Pakistan reports that urban women experienced more frequent and severe symptoms of menopause compared to rural women (Khaskheli et al., 2009). The researchers also report that rural versus urban women were more comfortable with menopause. They accepted and managed menopausal symptoms well (Khaskheli et al., 2009).

In summary, participants' roles and perceptions of menopause varied widely based on several factors including their employment and socioeconomic status and family support. They viewed menopause as a positive, natural, and personal phenomenon; while due to busyness and disturbing menopausal symptoms some did not notice any change or perceived it negatively. On one hand, women were glad that menopause has relieved their worry of getting pregnant and they had more time to accomplish their career and financial goals. While, on the other hand, they were unhappy about their diminishing youthfulness and vigor due to hormonal insufficiency with menopause. In Pakistan, there is an increased concept of extended family and bearing

children is valued. Hence, midlife women are often viewed as old and incapable of reproducing. As a result, women do not reveal their actual age. Participants experienced a wide range of symptoms associated with menopause. Menopause is widely considered a women's private matter. Most participants did not discuss menopause openly, as they were expected to stay silent about this (personal) life experience. Due to access to print and electronic media, some participants discussed their menopausal experience, preferably with their female family members, friends, colleagues, health professionals, and sometimes online.

Strategies used to Manage Menopausal Symptoms

In this section, I discuss the study findings related to my second research question in the light of literature, i.e. how do urban Muslim midlife women manage symptoms associated with menopause in Karachi Pakistan's cultural context? This section reflects the 'nursing therapeutics' component of the Transitions theory, I discuss the culturally competent menopausal symptom management of the participants. It includes the use of modern medicine, lifestyle modifications, self-medication, non-pharmacological interventions (NPI)/complementary and alternative medicine and therapies (CAM)/traditional home remedies, and spiritual/religious practices as drawn from participants' narratives.

Use of complementary and alternative medicine/therapies. People in Pakistan widely use a variety of strategies for the prevention of disease and promotion of health (Wasti et al., 1993). Most of my participants did not prefer using medicinal approaches for their menopausal symptoms. This finding is consistent with the literature. A study conducted in Pakistan informs that Pakistani women practice various strategies for coping with menopausal symptoms (Wasti et al., 1993). Pakistanis use home remedies, homeopathy, and natural ingredients in addition to various other approaches to stay well (Qidwai et al., 2012; Shaikh & Hatcher, 2005). Traditional

healing, natural/home remedies, and other complementary and alternative medicine/therapies are considered as the inherent component of the Pakistani society (Shaikh et al., 2009). Participants commonly used these strategies to relieve their menopausal symptoms and to lead a healthy and graceful life. Similarly, multiple studies inform that people widely use CAM and self-care practices for better health and wellbeing (AlRawi et al., 2012; Butt et al., 2009; Hunter & Rendall, 2007). In addition to the severity of the health problem, time and money were some of the major influencing factors for participants' choice of management strategies. Unlike Canada, in Pakistan, healthcare expenses are out of pocket payments. Well-aware people and those from higher socioeconomic status prefer to utilize private facilities since government facilities are sub-standard. Participants sought medical attention only when it was urgent, uncontrollable, or unmanageable by other means. Likewise, a study conducted in Karachi reports that less than a third of the women consulted a physician for menopausal issues (Khokhar, 2013). A study conducted in Hyderabad informs that just over half of their study participants consulted healthcare providers for menopause (Memon et al., 2014). Similarly, my participants generally referred to CAM/T or NPI to manage their menopausal symptoms, resolve minor ailments, and to stay healthy. The reasons for their preference may be related to high healthcare expenditure in the private sector, substandard public healthcare system, distrust in the healthcare professionals due to their inappropriate knowledge and understanding about menopause, improper treatment, and fear of unwanted consequences of medications and hormonal therapies.

Participants believed that medicines had side effects and adverse effects, and hormones like estrogen and progesterone were not safe. They believed that hormonal therapy may lead to cardiac problems and cancers. Likewise, literature suggests that midlife women treated with hormone replacement therapy are prone to suffer from coronary heart problems, stroke, venous

thromboembolism, and breast cancer (Daley et al., 2006; Dog, 2007; Hall et al., 2007). However, some menopausal women are treated with hormonal therapy with more caution where its benefits outweigh the risks (Dog, 2007). Nonetheless, there are multiple studies conducted globally on the wide use of CAM/NPI. Most of my study participants believed that traditional remedies were more effective in relieving their menopausal symptoms and had less to no side effects. For example, participants commonly consumed different beverages and coactions and other ingredients on a regular basis to relieve or lessen their menopausal symptoms. Studies inform that some of the therapies have shown positive results in improving these symptoms (Chattha et al., 2008). There is a wide range of modalities that people commonly use in other contexts, that include therapeutic herbs, Ayurveda, traditional Chinese medicine, spiritual healing, acupuncture and acupressure, homeopathy, naturopathy, traditional healing, manipulative and body-based therapies, biological-based therapies and dietary prescriptions, and mind-body practices (Davis et al., 2011). These methods are mainly used either to complement conventional medicine or as an alternative for the treatment or merely for health promotion and self-care purposes (Davis et al., 2011). In India, midlife women frequently practice yoga (Chattha et al., 2008), which is believed to help relieve the depressive symptoms related to menopause (Streeter et al., 2007; Pilkington et al., 2005).

Herbs and spices. The use of herbs and spices is commonly seen in Pakistani culture as part of their daily practice. These are frequently used for minor ailments like headache, toothache, menstrual pains and menopausal symptoms, bone and joint problems, and chronic illnesses, as well as to simply prevent diseases and to stay well. Some of these mentioned by participants include but are not limited to garlic, ginger, turmeric, cinnamon, clove, honey, black seeds, fenugreek seeds, cumin seeds, coriander, dates, olives, cardamom, black pepper, and figs.

The benefits of some of these are widely mentioned in the holy Quran and Hadiths (AlRawi et al., 2012).

It is a common practice to consume traditional ‘chai’ tea or ‘doodh patti’, i.e. loose tea leaves well-brewed in milk and some water on the stove. At some offices, the tea is made by peons (person who performs odd jobs) in the same way. There are special tea shops/café or street hawkers called ‘dhaba’ or ‘chainak’ where people go to enjoy the hot tea, just like most Canadians go to certain coffee shops to enjoy the variety and flavors of coffee, and for informal meetings/gathering with friends and family. At offices where there is self-serve, people make tea with tea bags. People drink this tea once a day to several times during the day and its quantity ranges from a cup to inordinate amounts per day. Such tea is part of the daily lifestyle of most people of all ages and gender in Pakistani culture. This traditional tea is consumed by almost all my study participants. These findings are consistent with the literature that indicates tea as a popular beverage in Pakistan (Adnan et al., 2013). Participants believed that the tea offered a lot of benefits to them during menopause. It was good for heart health, relieved their fatigue, and gave them freshness. In addition, it provided them strength, rejuvenated their energy, and kept them active and healthy, and capable of functioning all day. Most participants consumed it at least once a day, mostly a cup in breakfast. Some participants additionally consumed it in the evening or more than twice a day. Some took it with milk and sugar, some with honey or brown sugar, while some participants consumed black tea without milk or sugar. Similarly, literature informs that tea plays an important role as a nutraceutical and pharmaceutical agent and its consumption has numerous medicinal effects (Adnan et al., 2013). Another study reports that tea has vital properties including antimicrobial, antioxidative, anti-inflammatory, anticarcinogenic, cholesterol-lowering and anti-hypertensive (Hayat, Iqbal, Malik, Bilal & Mushtaq, 2015).

Moreover, it has beneficial effects like prevention of many diseases including diabetes, arthritis, obesity, and stroke (Hayat et al., 2015). Participants sometimes brewed the tea and consumed it in different ways by adding certain herbs and spices for different purposes and effects. For example, 'masala chai' is commonly consumed. In that, one or more herbs and spices like, clove, cinnamon, ginger, and cardamom are brewed for different desirable effects like headache, cold, and indigestion. Additionally, some participants preferred drinking coffee and green tea to relieve their menopausal symptoms and to stay well.

Self-medication is also common in Pakistan. Participants reported taking self-medication to relieve their menopausal symptoms and to stay well during this time. These mainly included painkillers and vitamin supplements, which have been reported to be used by women in other studies (Qidwai et al., 2012). Participants most commonly used vitamin D, calcium, omega-3, 6, 9, and multi-vitamins. Most participants took these regularly after they experienced menopause. This finding is similar to a study conducted on midlife Pakistani women, which reports that about a fourth of the women commonly used herbs and supplements (Nusrat et al., 2008). Participants believed that these were good for maintaining muscle and bone health, preventing health issues, and remaining healthy. In addition, participants used therapies based on oils, for example, evening primrose oil for hormonal headaches, and used cosmetic interventions for reasons like facial pigmentation, wrinkles, and signs of aging. Participants used different creams and products for these purposes. Similarly, literature reports aromatherapy and the use of essential oils to relieve menopausal symptoms like depression, hot flashes, and pains, and to regulate blood pressure (Hur et al., 2007).

Lifestyle changes. Most study participants tried to make healthy lifestyle changes, maintain self-esteem, and embrace this life process. Similar lifestyle changes were reported by

midlife urban women in a study in Iran (Khademi & Cooke, 2003). Participants relied more on home remedies, self-care, self-medication, and religious interventions on an everyday basis to manage their menopausal symptoms. According to the conclusion of a narrative inquiry, more midlife women with high financial and educational status use CAM compared to men (Bishop & Lewith, 2010). Some of the common modalities reported in literature that midlife women use for their menopausal symptom management include nutritional therapy, yoga and exercise, relaxation and stress management, naturopathy, and homeopathy. Women have reported these to be effective (Daley et al., 2006). Similarly, my study participants mentioned eating a healthy diet and avoiding the use of certain foods. They increased the intentional intake of vegetables and fruits, whole grains, pulses and lentils, nuts, milk, and milk products like yogurt and cheese, and eating more white meat like fish and chicken than red meat. Participants believed that it was more important for them to eat a nutritious diet that is rich in essential nutrients, calcium, and fiber for better health during midlife. They believed that eating a healthy and well-balanced diet would help them manage their menopausal symptoms. In addition, it would reduce their risk of chronic illnesses since participants believed that the chances increase after menopause due to hormonal deficiency. They were more conscious of what they ate to maintain their body weight, regulate bowel movement and to lead a healthy and happy life that is free from complications and chronic illnesses. Thus, participants limited their consumption of junk foods, sweets and sugary foods, excessive salt, carbonated drinks, oils and, fatty foods. They tried to eat healthy homemade food as much as possible and refrained from eating food from outside. Participants believed that acquiring healthy eating habits would lessen the intensity of menopausal symptoms and prevent chronic diseases.

Participants mentioned that since they started experiencing menopause, they deliberately started paying more attention to increasing their physical activity. Some of them had dedicated times during the week for physical exercise, while some talked about performing yoga and meditation. They most often increased walking and taking stairs instead of elevators on a regular basis. Participants believed that increasing physical activity was more important after menopause than before. They believed that it strengthens their bones and joints as a result, it prevents bone and joint problems like osteoarthritis. In addition, they believed that it prevents them from chronic illnesses like diabetes and hypertension since their protective hormones were diminishing and improved their overall physical and mental health. Similarly, literature informs that traditional mind-body practices like yoga, tai chi, and qi gong have demonstrated to aid in reducing insulin resistance syndrome-related risk factors for cardiovascular diseases in menopausal women; it helps in elevating their mood, improves well-being and sleep, reduces sympathetic stimulation, and augments cardiovagal function (Innes et al., 2008; Yeh & Chang, 2012). Mind-body therapies are proven to lower autonomic stimulation resulting in enhanced perceived quality of life in midlife women, while with physical exercise, this could be achieved through improved circulation of beta-endorphins and possibly as a diversion from stress and anxiety (Posadzki et al., 2011). Literature states that yoga is one of the popular forms of mind-body medicine (Pilkington, Kirkwood, Rampes & Richardson, 2005). In addition to relieving stress and anxiety, it has positive effects on fatigue, sleep disorders, depression, and low back pain, and improves overall health, energy, and quality of life (Chattha et al., 2008; Kelly, 2009). Additionally, yoga has been shown to lower the neuro-hormones and electrophysiological changes of sympathetic arousal (Streeter et al., 2007). It is also found to reduce the depressive symptoms of menopause by increasing the levels of gamma-aminobutyric acid in the brain

(Streeter et al., 2007; Pilkington et al., 2005). Literature also reports that midlife Indian women widely practice yoga (Chattha et al., 2008). Its effectiveness in improving their menopausal symptoms, however, depends on the frequency, intensity, and length of their practice (Chattha et al., 2008).

My study participants also paid more attention to taking proper rest and sleep especially, after experiencing menopause. Participants complained of disturbance in their sleep routines, some felt too sleepy throughout the day. This finding is consistent with multiple literature, which report that menopausal women commonly experience sleep disturbance (Khokhar, 2013; Yeh & Chang, 2012). Most participants, however, elucidated that they tried their best to complete at least six to eight hours of sleep per day for better health and wellbeing.

Work helps. Some participants viewed working outside of the home as directly or indirectly helpful in managing their menopause and its associated symptoms. Participants shared that their work helped them by diverting their minds from the challenges of menopause and improving their self-confidence to enable them to better manage their symptoms. It gave them a way to socialize with their colleagues and friends at work and share their problems with them. They sometimes used diverse ways to manage their menopausal symptoms and felt better by simply ventilating their feelings related to menopause. Participants believed that their work-life gave them the courage and endurance to bear with their menopause and deal with it in a better way. Additionally, it helped them stay physically and mentally active and able to deal with other life challenges at this time. Participants believed that their busyness at home and work helped them balance their life at menopause. These findings are consistent with the literature that reports midlife women consider their employment and household responsibilities part of their physical activity (Im, Stuifbergen & Walker, 2010). Another study conducted on 336 Polish

climacteric women concludes that women having high physical activity due to work and other daily activities experienced significant reduction in climacteric symptoms by improving overall health and well-being, preventing weight gain, reducing the prevalence of chronic illnesses, and improving mental health and sexual functioning, as well as maintaining a better quality of life (Skrzypulec, Dąbrowska & Drosdzol, 2010).

Religious practices around midlife. Religion is a major part of Pakistani culture. Pakistanis commonly have strong belief and connection with religious and spiritual understandings (Anwar et al., 2015). Most follow the teachings of the holy Quran and Hadiths/Sunnah (Anwar et al., 2015). My study participants practiced their religion in every walk of their lives including to manage their menopause and its associated symptoms. They believed that life is mortal. In some faith practices, menstruation was connected with impurity (Bhartiya, 2013) and posed limitations to performing religious practices. While after menopause, participants felt free to practice their religious activities. They prayed more regularly after menopause since they associated menopause with old age and getting closer to death. A similar perception of menopause is also reported in a study on midlife Iranian women (Ayatollahi, Ghaem & Ayatollahi, 2005). Participants believed that in addition to multiple benefits, regular praying was beneficial for their physical and mental wellbeing. They regularly offered prayers, performed recitation of the holy Quran, read religious scriptures, practiced ‘zikr’ or ‘dhikr’, i.e. the repetitive calling of any or all of the (99) names of Allah with or without using a rosary, performed recitation of certain ‘dua’, i.e. prescribed prayers or verses from the holy Quran and Sunnah. For example, ‘Surah Fatiah’, the beginning verses of the holy Quran was strongly believed to possess the power to cure, which is also mentioned in the literature (Anwar et al., 2015). Participants also performed other religious practices. Some of these were

performed communally and some individually, some at specified times of the day, while others at their own discretion. Participants tried to carry out virtuous deeds and become more involved in voluntary and charitable activities that were thought to be part of their religious and moral obligation. Practicing these acts gave them a sense of pleasure and satisfaction, which in turn helped minimize the intensity of their menopausal symptoms. Engaging in these practices sometimes provided participants a diversion from their menopausal symptoms and helped relieve their anxiety and depression. It gave them the inner courage to bear with the challenging times. Participants staunchly believed that practicing religion helped them in unimaginable ways. Moreover, participants kept religious scriptures with them and wore amulets. Likewise, literature reports that keeping religious scriptures and wearing amulets and gems is common in the Pakistani culture (Farooqi, 2006), and holds religious significance. Participants used certain gems like 'Aqeeq' [quartz]. They kept the gem with them or wore them in a silver ring or locket. These were trusted as part of Sunnah. Participants wore these stones for purposes like managing their mood swings, to stay calm, and to control their temperament. This finding is similar to the literature, that the use of gems and vitamin supplements is primarily thought to protect against harm and to stay well (Qidwai et al., 2012).

In conclusion, based on their sociocultural and religious understanding, familial practices, level of literacy, and financial stability, participants used a variety of ways to manage their menopausal symptoms, prevent diseases, and stay well. Most of these are consistent with the available literature.

Factors that Influenced Women's Experience

In this section, I discuss the study findings related to my third research question in the light of available literature, i.e. what are the various sociocultural, religious, familial, and other

factors that influence Karachi, Pakistani women's experience related to menopause? This section mainly reflects the 'transition conditions' component of the Transitions theory that includes the facilitators and barriers related to participants' menopausal experience. These influencing factors are interrelated with the participants' patterns of response in terms of their perceptions, actions, and an overall experience related to menopause.

In addition to the level of literacy, socioeconomic status, and other socio-demographic factors, my study participants' menopause experience was driven by various sociocultural and religious facilitators and barriers. These also influenced Pakistani women's agency. Multiple studies confirm that several factors contribute to influencing the beliefs, understanding, and behaviour toward health and illness (Ara et al., 2018; Sluijs et al., 2013; Malik, 2008; Yosef, 2008). In addition to multiple factors, silencing of women about the phenomenon of menopause and the relationship of menopause with old age and aging in the culture affected Pakistani midlife women's agency. It created a hindrance for the women to be able to act independently and make wilful decisions about their health choices. Despite that the study participants were highly learned, working, and independent women, the perception of menopause in the increasingly patriarchal society negatively impacted women to fully practice their agency. As nursing is a female dominating profession, they also experienced silence on the topic of menopause and spoke least about the phenomenon in the culture. Patriarchal dominance illegitimately hinders women's agentic skills (Meyers, 2002). The women faced challenges related to gender discrimination and prejudice. As a result, women directly or indirectly suffered reduced power, subordination, and oppression to varied extent that interfered with practicing their agency. By acknowledging these and other factors that influence women's agency in a negative way, nurses and healthcare providers can play a crucial role in facilitating women to

empower and practice their agency to their fullest. This could be addressed by advocating and providing awareness to the women and men about the phenomenon and women's rights to their free choice to decide for their holistic health and wellbeing. Silencing and ageism were intertwined part of other factors in the culture as discussed further.

Religion and culture as the driving forces. Pakistan is a majority Muslim country, which means that Islamic teachings are part of the people's daily living. Both religion and culture are strongly intertwined and had a great impact on participants' lives and their perceptions and experiences of menopause. Participants widely practiced religion in all matters of their life. Similarly, Hussain indicates that women practice religion more than men, and they play important roles in religious activities (2014). Islam is instrumental in every Pakistani's life. It is a major part of society both for 'deen', i.e. religion or religious matters, and 'dunya', i.e. world or worldly matters. Everything people do is mainly based on the principles and preaching of Islam, while some practices are originated from the family traditions, culture, and diverse interpretations of Islam. Overall, people commonly follow the teachings of the holy Quran and 'Hadiths' or 'Sunnah', i.e. the words/actions of Prophet Muhammad (peace be upon him). Islam being a monotheistic religion, people believe in the oneness of 'Allah' [God], the holy Quran as the last revelation of the four holy books, and Prophet Muhammad (peace be upon him) as the last messenger of Allah. There are 'masjids' [mosques] i.e. Muslims' gathering place for prayer, located at almost every few hundred meters. 'Azan/adhan' [the Islamic call to worship] could be heard from the masjids' loudspeakers five times a day, with the first one starting before sunrise and the last one after sunset. We could see framed Quranic scriptures and hear the Quranic recitation in Arabic and its translation played in some houses and shops, especially in the morning time. It is thought to bring grace, blessing, and prosperity to begin the day in the name

of Allah. There are designated areas at most workplaces for worship, and to perform prayers and religious activities. In most workplaces, extra time is allocated with the lunch break to allow time to perform 'namaz-e-Zuhr', i.e. the midday prayer, especially on Fridays, when they have special 'namaz-e-Jumma' [Friday prayers], which is preferably performed in congregation. In some places, it is a half working day on Fridays. I could witness empty workspaces at namaz times and my participants performing 'wazu' [ablution] offering prayers and practicing religion in their usual activities like reciting words/phrases to praise and thank Allah for everything they did including when drinking water, eating food or simply getting up from the chair. Similarly, literature states that Islam has taught us many etiquettes of drinking and eating, and stressed on hygienic practices (Hossain, 2014). Spiritual and religious aspirations are, therefore, deeply rooted in the Pakistani setting. It can not be separated from the culture, many of the people's actions are based on Islamic laws and principles. For example, alcoholic beverages and pork are 'haram' or forbidden in Islam (Hossain, 2014) and the country. As part of their religious understanding, my participants often used dates, honey, figs, kalonji, and olives in their daily lives including to manage menopausal symptoms. This finding is consistent in the literature that informs most of these ingredients are mentioned in the holy Quran and Hadiths (AlRawi et al., 2012). In addition, participants thought that offering prayers at various times of the day gave them a break for physical and mental peace and relaxation from their busy lives. It gave them a chance to exercise/relax their body and mind for about 5-7 minutes with each of the five or three prayers, based on their Islamic interpretations and faith practices, performed by the participants during the day. This was approximately 30 minutes a day, seven days a week. Practicing religion gave participants a sense of satisfaction and relief from their menopausal symptoms. Likewise, literature states that according to Islamic interpretations there is a strong connection

between physical body, soul, and spirit (Hossain, 2014). Thus, in Pakistan, teachings of Islam are followed in every walk of people's lives, from cradle to grave, including, in matters related to adolescence, matrimonial, family and relationship issues, childbearing and childrearing, as well as in matters of business, hospitality, and health and illness. This finding is congruent with the literature that informs religion is deeply rooted in the culture and is inseparable from the Pakistani context (Anwar et al., 2015). Similarly, another article points out that religion plays a significant role in various aspects of people's lives, including health, lifestyle, society, business, and administration (Hossain, 2014). Additionally, social ties and relationships are highly valued in Pakistani society.

People's influence. In Pakistan, family, friends, and colleagues are an essential part of people's social life. Participants were closely connected with their family, friends, neighbours, co-workers, and other social and religious groups. Participants considered their family extremely important. They cared for, loved, respected, and trusted them. The family had a significant impact on most matters of participants' lives. This finding is consistent with multiple studies, which state that family is greatly cherished in Pakistani society (Hakim & Aziz, 1998; Saeed & Atta, 2018). However, participants either did not discuss or preferred to discuss concerns related to menstruation, menopause, and other sexual and reproductive health issues with the female members of the family. They often discussed these matters confidentially with their mothers, sisters, cousins, and aunts, mostly elder to them. Husbands were part of discussions related to their wife's menopause experience to some extent, and so were the in-laws. Participants usually found value in their family members' experiences and opinions. In most cases, they followed their advice related to menopause.

Friends were a noteworthy part of Pakistani women's social support system. They played an influential role in participants' lives. In Pakistani culture, close friends are most often from the same gender. Friends from the opposite gender are less frequently seen and are rarely found in the less educated and lower socioeconomic class. Most of the time, friends were the ones from women's family, school, workplace, and neighbourhood, and sometimes from family friends and religious community. Participants felt more comfortable talking with them about their personal issues like menopause, which was associated with aging and a phenomenon of silence in the culture. Similarly, literature reports that midlife women express feelings of silence, stigma, and embarrassment related to menopause and its symptoms; people in their intimate relations also avoid the discussion because of its association with sexuality (Nosek, Kennedy & Gudmundsdottir, 2010). Thus, participants commonly referred to their female friends, colleagues, and significant others for anything related to their daily living including their menopausal issues. Participants valued sincere friends and followed their advice on managing menopausal symptoms and staying healthy.

My study participants sometimes consulted healthcare personnel for their menopause-related concerns, mostly in case of urgent need, complication, or uncontrolled health circumstances. They usually preferred to use non-medicinal approaches to manage their menopausal symptoms and to stay well. This could be due to reasons including expensive healthcare facilities and preference to use CAM/traditional remedies. This is consistent with the literature, which reports that Pakistanis prefer to use home remedies (Wasti et al., 1993).

Since my study participants were educated working women, they had numerous opportunities to approach well-educated social groups and healthcare providers, as well as access informative resources to recognize, discuss and manage their menopausal symptoms. This

finding is consistent with multiple studies, which report that women use social connections to manage their menopausal symptoms (Awan, 2012; Vanwesenbeeck et al., 2001). Participants frequently referred to scientific articles, books, and journals, both online and paper copies, to seek appropriate and timely knowledge on matters of their concern. In addition to their international experience of living and working in diverse global contexts, participants' exposure to mass media and the internet, had a huge impact on shaping their perception and decisions about menopause. Similar findings are reported in the literature that educated women widely use various resources to seek information (Memon et al., 2014). Participants often referred to a wide array of resources to learn about menopause and used an assortment of ways to manage their symptoms. Participants practiced some of those approaches based on their effectiveness, scientific evidence, and others' experiences. They commonly used social media and a variety of internet search engines in their daily routine. As menopause was not freely talked about in the Pakistani context, participants even used blogs and other such platforms to put forth and discuss their menopausal concerns in the hope of getting a satisfactory reply/solution.

In summary, multiple factors influenced my participants' experiences related to menopause. Some of these included their level of literacy, access to media, financial status, social support like family, friends, and acquaintances, healthcare providers, culture, religion, and international exposure. These factors played a significant role in persuading women's perceptions, their use of multiple strategies to manage menopausal symptoms, and decisions they made related to menopause. Thus, participants' overall experience associated with menopause was driven by several influencing factors.

Chapter Six: Strengths and Limitations of the Study

Introduction

In this chapter, I highlight my reflections, and implications of the study findings to nursing knowledge: practice, education, research, and policy, followed by recommendations and suggestions for further research and strategies for disseminating the study findings.

There are several strengths as well as some limitations to my study. This study was the first focused ethnography research conducted in Pakistan to explore urban Pakistani Muslim midlife women's experience of menopause. There is an overall scarcity of research in developing countries like Pakistan, where healthcare resources are limited and expensive, and people tend to use non-pharmacological, self-care, and traditional ways to maintain health.

Menopause, like other reproductive and sexual health matters, is deemed a women's personal issue, which means that women do not ordinarily talk about their menopause experience. They do not customarily disclose their age or that, they are menopausal, to avoid being called old. Therefore, it was initially a challenge to recruit women for the study. Nevertheless, I was able to recruit my study participants by using alternative, less socially sensitive, and more subtle terms like midlife experience, rather than menopause experience.

Recruitment of participants in the study was confined to educated working midlife women who consented to participate and were willing to share their menopause experience. Less educated, non-working women from the lower socioeconomic group were not included in the study. This was specified earlier in the literature review and some other sections of methodology.

Personal Reflections

Being knowledgeable about the culture and environment of the study setting as an insider, was a great strength. However, I had no to little personal knowledge and experience about the phenomenon under study as an outsider, which may have resulted in misinterpretation of some of the narratives. Thus, to obtain rich and credible findings, I used multiple data gathering strategies, followed necessary ethical considerations and transparent analytic techniques as elaborated in the relevant sections. In addition to data triangulation and cyclical analysis of data, I used a pre-designed interview guide to lead my interviews and to acquire appropriate, rich, and in-depth data for the study. All interviews were conducted at a time and place that were agreed upon by the participants. I established rapport with the research participants, exhibited respect, used effective communication techniques, and maintained appropriate ethical practice throughout the study.

The findings of my study present a novel perspective on the experiential knowledge of educated, working, urban, midlife women in the Pakistani context. Since it is a qualitative study with a focused ethnography design, there is no intention to claim the generalizability of the findings. However, the data acquired through this research methodology would allow transferability in other contexts and settings.

Having limited knowledge as a novice researcher in the field and conducting such a study for the first time, presented angsts and challenges. It was my first time to conduct an ethnographic study and using a qualitative design. Timely guidance, support, and encouragement of my supervisor and committee throughout the process, along with my inquisitiveness to learn enabled me to remain optimistic and perseverant, and meet my academic and personal expectations. I am not an expert and never will be because I believe there is no end

to learning, knowledge, and growing academically. It was valuable learning throughout the course of this study. To conclude, I believe the contribution of this inquiry to the pool of nursing and healthcare knowledge far outweighs its challenges.

Implications

The findings of this study illuminate midlife women's perception and experience of menopause in the Pakistani cultural[2] perspective. Based on these findings, some implications are suggested in the areas of nursing practice, education, research, and policy.

Implications for practice. It is imperative that healthcare providers understand the significance of cultural influence on individuals' and families' health. By recognizing the heterogeneity in cultural beliefs, nurses can avoid stereotyping, and foster client-centred interventions for women under their care (De Chesnay, 2014). In my case, it impacts midlife women's health concerning menopause. Culturally specific understanding of menopause can be a helpful resource for nurses and other healthcare providers to care for midlife women. In addition, there are a variety of other factors that influence women's perception, choice of ways for management of their symptoms and overall experience of menopause. Healthcare professionals need to be knowledgeable, culturally sensitive, and respectful to women's values, beliefs, understandings, and preferences for their menopausal issues. Moreover, healthcare providers need to have appropriate knowledge and understanding regarding culturally acceptable language related to menopause and use effective communication and interpersonal skills. It is vital to align the associated management approaches to women's sociocultural, religious, and other influential backgrounds like cultural patriarchy and gender-based discrimination. This

[2] Glossary of terms including culture, cultural safety, cultural sensitivity, and culturally competent care is added in Appendix A

would ensure improved coping of midlife women at this important transition phase of their life. It would help enhance their self-esteem and confidence in dealing with their menopausal symptoms. Nurses' and healthcare professionals' cultural cognizance and respect and appropriate knowledge about menopause would empower women to feel more comfortable and confident in seeking help from them. Nurses are well placed in the healthcare setting to advocate for women's needs that are more culturally constructed and to collaborate among other healthcare providers to work towards midlife women's health requirements related to menopause. Appropriate health education materials regarding menopause and its effective management strategies may be prepared. Written materials like pamphlets should be developed in both English and Urdu languages. These informative resources should be displayed at women's clinics, and sexual and reproductive health clinics, and family planning clinics, which are usually visited by both genders. These health education materials should be distributed and made freely available and accessible for both women's and men's referral at the clinics and community health centres. Such gender-based interventions can help educate women and involve their husbands in supporting them in their experience of menopause. In cultures like Pakistan, husbands and mothers-in-law play an influential role in women's lives. Thus, involving them in discussing women's menopause-related issues will help break the gender-based barriers to midlife women's health and facilitate women to practice their agency. It will offer some support in attaining a better quality of life of midlife women during menopause.

Implications for education. It is important to cultivate cultural sensitivity in nurses and health care professionals to enhance cultural safety in the care they provide. Cultural sensitivity can be cultivated by equipping health care providers with relevant education and skills in undergraduate programs about cultural diversity among and within the Pakistani culture. In

addition, health care professionals must acknowledge their perceptions and influences on aspects of health and illness and become cognisant of how those may affect the care they provide. Cultural knowledge is a vital component in midlife women's health and should be included in nursing and health professionals' curricula. It is growing increasingly important now because of the overall rise in the longevity of the people of Pakistan in particular, which means that women would spend more time in their menopausal phase of life. The findings of this study demonstrate the significance of cultural sensitivity, and application of cultural knowledge by nurses and other health care providers to improve discussions around personal and sensitive health issues around menopause, with women and their families. Consequently, it is recommended that cultural perception and practices around menopause should be addressed as part of the health syllabi, particularly in nursing and medicine. This should be done within Pakistan and abroad, specifically in countries with diverse populations, like Canada and the U.S. It is, however, significant to integrate cultural knowledge across the syllabus rather than just a small portion of a course as it may be more beneficial. Cultural immersion in a different cultural context may help develop cultural sensitivity in nurses that may result in fostering a lasting impact, improving sustainability, and growing personally (Ruddock & Turner, 2007). Culturally competent and knowledgeable health care professionals would be able to provide culturally safe care and assist midlife women to cope with the critical period of menopause more efficiently. Seminars, workshops, and other training sessions should be held about the different perceptions and practices related to menopause in Pakistani culture. Also, discussions on topics related to midlife women's health especially, menopause should be organized at community levels. The findings of this study imply that there is a strong need to communicate women's health issues like menopause and its management strategies in the Pakistani context at the level of understanding

of the people, to create awareness within the community. Since the family is greatly valued in the Pakistani culture, such knowledge and understanding would assist families in supporting women to deal with their menopause in a better way. As Pakistani society is highly patriarchal (Murshid, & Critelli, 2017), such educational sessions would be more fruitful if both men and women, especially, husbands and mothers-in-law were included.

Implications for research. There is a need in the Pakistani context to explore midlife women's health, cultural perception of menopause, common practices for its symptom management, major influencing factors, and an overall menopause experience of Pakistani women. A range of issues has been identified as a result of this study, which may be useful for further research and scholarship in the field of nursing. My study on midlife women's menopause experience was limited to one context. However, it should be extended and replicated to more heterogeneous settings and religious and cultural backgrounds to gather broader perspectives. It would be useful to explore sociocultural barriers and misinterpretations about menopause and its symptom management. In addition, future research should focus on women's perception, values, beliefs, and understanding of menopause. More research should be conducted to explore the variety of strategies women use to manage their menopausal symptoms. Research should also be conducted to investigate the multiple factors that drive women's understanding, practices and experiences related to menopause. Pakistani midlife women use a variety of complementary and alternative therapies, non-pharmacological interventions, self-care practices and lifestyle modifications to prevent illness and maintain health and wellbeing. Hence, more studies need to be conducted on the common ingredients and practices used to explore their individual and synergistic effects. Scientific knowledge about these modalities would result in more evidence-based interventions and recommendations associated with the

benefits or inadvertent effects produced by these remedies. Related researches on a diverse set of populations and settings, for example, midlife women in other cities of Pakistan, as well as in rural areas, with varied socioeconomic, and literacy levels; and, using different study designs would be worth conducting. This would help gain broader perspectives on women's cultural experience of menopause, navigate their healthcare needs, and plan to provide the best possible information and support to maintain optimal health during this phase. It is equally important to disseminate the knowledge of such research to healthcare professionals and the general public, especially the concerned population.

Policy implications. There is no magical formula or a 'one size fits all' kind of an approach for menopause-related issues. Understanding cultural values and norms is fundamental in bringing about a policy level change. By taking certain actions, WHO's Sustainability Development Goals number 3, i.e. good health and well-being, 5, i.e. gender equality, and 10, i.e. reduced inequalities, may be achieved to some extent. Empowering women by allowing autonomy and freedom in decision making during midlife would be instrumental in accomplishing gender equality (Alidou & Verpoorten, 2019). However, interventions need to be focused on the more individualized needs of midlife women in society (Alidou & Verpoorten, 2019). Some of the policy implications to my study may include offering seminars and workshops related to midlife women's cultural health needs as a compulsory part of continuous education, to nurses and healthcare employees working in the areas of women's health or reproductive health. In addition to knowledge development in nursing, it is vital to facilitate and help people in a culturally appropriate way to benefit them to achieve better health (De Chesnay, 2014). Additionally, setting up "women's health clinics" or more specifically "menopause clinics" could be a good source where women could discuss their menopause-related issues in a

safe environment. These clinics could further focus on dealing with women's individual menopause experience that is specific to help them transition through this phase according to their level of understanding, anxiety, and stage of menopause, i.e. pre-, peri-, or postmenopausal. Involving husband, in-laws especially, mother-in-law and other significant people in such discussions would greatly benefit women to smoothly transition through menopause. Culturally congruent care would contribute to culturally applicable research development, knowledge translation, and health policies, and compliance to interventions would be triumphant (Ross, 2014).

Recommendations

In some cultures, like Pakistan, women may be reluctant to talk about their menopause perceptions, experiences, and feelings, or to seek assistance to manage its associated symptoms. Thus, creating midlife women's interest groups or peer support groups may prove beneficial. This may aid in improving the quality of life of women by getting support from other women experiencing similar menopausal symptoms as them and discussing some of the facilitators and barriers to managing those.

As there has been a gap in the knowledge about effective strategies to manage menopausal symptoms, it leads to the necessity to develop and explore the effectiveness of alternative therapeutic possibilities, which has shown some positive results in improving these symptoms (Chattha et al., 2008). There is a need for safe, economical, wide-ranging therapies that minimize menopausal symptoms with minimal to no negative health consequences, promote adherence, and lower the risk of major chronic conditions linked with menopause. There is an increased need for management strategies since due to the rise in the overall life expectancy, more women are expected to spend about one-third of their life in perimenopause to

postmenopausal state (Khokhar, 2013). It is recommended that despite inadequate scientific evidence of the effectiveness of complementary and alternative medicine/therapies and self-care practices, its use should not be discouraged if women personally find it beneficial and it poses little to no harm (Dog, 2007).

Dissemination of Findings

I will use various methods to disseminate the findings of my study. I have already presented the research protocol and parts of my study findings at various conferences. I will continue to deliver both oral and poster presentations where possible in relevant conferences within Pakistan and internationally. Some of the well-attended conferences in Pakistan, Canada, and globally include National Health Sciences Research Symposium in Pakistan, Women and Children's Health Research Institute Conference in Canada, and Sigma Theta Tau International Nursing Research Congress, and Global Health Research Conference held internationally. I intend to publish the research findings in highly accessed international peer-reviewed journals. Potential journals may include the Journal of Obstetric, Gynecologic, and Neonatal Nursing; Journal of Women and Aging; International Journal of Nursing Studies; Health Care for Women; Journal of Women Studies; Journal of Public Health; International Journal of Social Science and Humanity; The Journal of Alternative and Complementary Medicine; Journal of Religion and Health; International Journal of Nursing Practice; International Women's Health Issues; and Journal of Transcultural Nursing; as well as in local and national publications within Pakistan and abroad like Journal of Pakistan Medical Association; Journal of College of Physicians and Surgeons Pakistan; The Express Tribune. Presentations and discussions about the findings with healthcare workers, employed and volunteer members of the government and non-government organizations dealing with women's health may also be organized. In Pakistan, the most popular

social media among its people of all ages, class, and gender are Facebook and YouTube channels. Thus, some of my other knowledge translation strategies may include posting a YouTube video, a blog, and a Twitter or Facebook account discussing the topic and findings of the study.

Conclusion

In conclusion, menopause, just like menstruation, is inevitable in a woman's life. Every woman passes through this important phase of life. Women have a variety of beliefs and understanding related to menopause and its symptoms, based on multiple factors. They experience and manage their menopause symptoms accordingly. In addition to numerous factors, women's level of education, employment, financial status, and religious and sociocultural attributes play a significant role in influencing their experience of menopause.

My intent of this study was to understand the experiences of urban midlife women in the Pakistani Muslim cultural context related to their menopause, and how they managed their symptoms to sustain health and wellbeing. This study adds substantive novelty to the pool of healthcare knowledge, predominantly to the discipline of nursing. Taking a qualitative path using an ethnographic approach for health research was new for me. However, I became more aware and comfortable after exploring similar studies about the lived experiences of people related to health in a wide range of contexts in all age and gender. Focused ethnography fitted well with the aim of my study since it had a defined purpose and was conducted in the context that was known to me as the principal investigator and could be accomplished within a certain period (De Chesnay, 2014).

Some of the distinct findings of my study include that Pakistani midlife women preferred using more non-medicinal interventions, traditional remedies, and self-care, to manage their

menopause symptoms and to stay healthy. They had both negative and positive views of menopause. For example, on a negative note, women believed that lack of reproductive hormones after menopause leads to uncomfortable symptoms, it takes away their youth and vitality and increases their risk of bone and cardiac problems as well as other chronic diseases. While on a positive outlook, they viewed menopause as the time to focus on their career goals and enjoy the freedom to work, travel, and pray more freely.

This study contributes to nursing knowledge in some additional ways. First, this research specifically focuses on educated working midlife women's menopause experience. These women were Pakistani Muslims, residing in the metropolitan city of Karachi, which is less studied. Second, the results of this study provide an insight into the role culture, religion, familial, and other factors play in Pakistani women's understanding and practices related to menopause. And, third, it offers nurses and other health care professionals to view women's experience of menopause using Transitions Theory that is beyond the biomedical concepts of care to a more holistic perspective of health and illness management. Knowledge generated through this study is valuable for nurses and other healthcare providers to better care and advocate for Pakistani Muslim women experiencing menopause. Overall, it is an important study that brings a unique dimension to women's experience of menopause and intrigues further exploration with more variation in the area of women's health during menopause.

References

Aaron, R., Muliyil, J., & Abraham, S. (2002). Medico-social dimensions of menopause: a cross-sectional study from rural south India. *National Medical Journal of India, 15*(1), 14-17.

Adhi, M., Hasan, R., Shoaib, S., & Tauheed, S. (2007). Age and symptomatology of menopause in Karachi, Pakistan. *Pakistan Journal of Physiology, 3*(1), 41-44.

Adler, S. R., Fosket, J. R., Kagawa-Singer, M., McGraw, S. A., Wong-Kim, E., Gold, E., & Sternfeld, B. (2000). Conceptualizing menopause and midlife: Chinese American and Chinese women in the US. *Maturitas, 35*(1), 11-23.

Adnan, M., Ahmad, A., Ahmed, A., Khalid, N., Hayat, I., & Ahmed, I. (2013). Chemical composition and sensory evaluation of tea (Camellia sinensis) commercialized in Pakistan. *Pakistan Journal of Botany*, *45*(3), 901-907.

Agar, M. H. (1996). *The professional stranger: An informal introduction to ethnography.* New York: Academic Press.

Ahmad, A., & Anwar, H. N. (2018). Femininity, Patriarchy and Women Political Representation in Pakistan. *Pakistan Journal of Peace and Conflict Studies*, *3*(1), 23-37.

Alam, K. (2015, October 16). Pakistan has 18th largest 'middle class' in the world: report. *The Express - Tribune*. Retrieved from https://tribune.com.pk/story/973649/pakistan-has-18th-largest-middle-class-in-the-world-report/

Ali, T. S., Azam Ali, P., Waheed, H., & Memon, A. A. (2006). Understanding of puberty and related health problems among female adolescents in Karachi, Pakistan. *Journal of Pakistan Medical Association*, 56(2), 68.

Alidou, S., & Verpoorten, M. (2019). Only women can whisper to gods: Voodoo, menopause and women's autonomy. *World Development, 119*, 40-54. https://dx.doi.org/10.1016/j.worlddev.2019.03.005

AlRawi, S., Fetters, M. D., Killawi, A., Hammad, A., & Padela, A. (2012). Traditional healing practices among American Muslims: perceptions of community leaders in southeast Michigan. *Journal of Immigrant and Minority Health, 14*(3), 489-496.

Anwar, M., Green, J. A., Norris, P., & Bukhari, N. I. (2015). Self-medication, home remedies, and spiritual healing: Common responses to everyday symptoms in Pakistan. *Health Psychology and Behavioural Medicine, 3*(1), 281-295. http://dx.doi.org/10.1080/21642850.2015.1088387

Anwar, M., Green, J., & Norris, P. (2012). Health-seeking behaviour in Pakistan: A narrative review of the existing literature. *Public Health, 126*(6), 507-517. http://dx.doi.org/10.1016/j.puhe.2012.02.006

Ara, R. F., Alam, M. J., & Yusuf, M. A. (2018). Menopause-Related Symptoms and Help Seeking Behaviour among Women Attended at a Tertiary Care Hospital in Bangladesh. *Open Journal of Obstetrics and Gynecology, 8*(04), 376-384. https://dx.doi.org/10.4236/ojog.2018.84042

Avis, N. E., Crawford, S. L., Greendale, G., Bromberger, J. T., Everson-Rose, S. A., Gold, E. B., . . . Tepper, P. G. (2015). Duration of menopausal vasomotor symptoms over the menopause transition. *JAMA Internal Medicine, 175*(4), 531-539.

Awan, S. Z. (2012). Role of civil society in empowering Pakistani women. *South Asian Studies, 27*(2), 439.

Ayatollahi, S. M. T., Ghaem, H., & Ayatollahi, S. A. R. (2005). Sociodemographic factors and age at natural menopause in Shiraz, Islamic Republic of Iran. *Eastern Mediterranean Health Journal, 11*(1), 146-154.

Baig, L. A., & Karim, S. A. (2006). Age at menopause, and knowledge of and attitudes to menopause, of women in Karachi, Pakistan. *The Journal of the British Menopause Society, 12*(2), 71-74.

Bari, F. (2000). *Country Briefing Paper: Women in Pakistan. Asian Development Bank, July 2000.* Retrieved from https://www.adb.org/sites/default/files/institutional-document/32562/women-pakistan.pdf

Berg, J. A., & Lipson, J. G. (1999). Information sources, menopause beliefs, and health complaints of midlife Filipinas. *Health Care for Women International, 20*(1), 81-92.

Bhartiya, A. (2013). Menstruation, religion and society. *International Journal of Social Science and Humanity, 3*(6), 523-527.

Bishop, F. L., & Lewith, G. T. (2010). Who Uses CAM? A narrative review of demographic characteristics and health factors associated with CAM use. *Evidence-Based Complementary and Alternative Medicine: ECAM, 7*(1), 11-28. http://dx.doi.org/10.1093/ecam/nen023

Boadu, N. Y., & Higginbottom, G. M. (2014). Using malaria rapid diagnostic tests in Ghana: A focused ethnography. In M. De Chesnay (Ed.), *Nursing Research Using Ethnography: Qualitative Designs and Methods in Nursing* (pp. 139-169). New York: Springer Publishing Company.

Burrows, A., & Johnson, S. (2005). Girls' experiences of menarche and menstruation. *Journal of Reproductive and Infant Psychology, 23*(3), 235-249.

Butt, M. S., Sultan, M. T., Butt, M. S., & Iqbal, J. (2009). Garlic: Nature's protection against physiological threats. *Critical Reviews in Food Science and Nutrition, 49*(6), 538-551. http://dx.doi.org/10.1080/10408390802145344

Calder, R., Noureen, I., Rakhi, A., & Imtiaz, F. (2017). *Pakistan Girl Landscaping Report.* (Research paper).UK Department for International Development. Retrieved from https://assets.publishing.service.gov.uk/media/58f9cce240f0b606e70001af/Pakistan_Girls_Landscaping_Report_Apr2017.pdf

Carolan, M. (2000). Menopause: Irish women's voices. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 29*(4), 397-404.

Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research, 17*(10), 1316-1328. http://dx.doi.org/10.1177/1049732307306927

Chattha, R., Raghuram, N., Venkatram, P., & Hongasandra, N. R. (2008). Treating the climacteric symptoms in Indian women with an integrated approach to yoga therapy: A randomized control study. *Menopause (New York, N.Y.), 15*(5), 862-870. http://dx.doi.org/10.1097/gme.0b013e318167b902

Cheema, M. (2018). Women and TV culture in Pakistan: Gender, Islam and national identity. Bloomsbury Publishing.

Cheema, D., Coomarasamy, A., & El-Toukhy, T. (2007). Non-hormonal therapy of post-menopausal vasomotor symptoms: a structured evidence-based review. *Archives of Gynecology and Obstetrics*, *276*(5), 463-469. http://dx.doi.org/10.1007/s00404-007-0390-9

Central Intelligence Agency (CIA). (2019). The World Factbook. Retrieved from https://www.cia.gov/library/publications/the-world-factbook/geos/pk.html

Creswell, J. W., & Miller, D. L. (2000). Determining Validity in Qualitative Inquiry. *Theory into Practice, 39*(3), 124-130. http://dx.doi.org/10.1207/s15430421tip3903_2

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Thousand Oaks. CA: Sage publications.

Cruz, E. V., & Higginbottom, G. M. (2013). The use of focused ethnography in nursing research. *Nurse Researcher, 20*(4), 36-43. http://dx.doi.org/10.7748/nr2013.03.20.4.36.e305

Daley, A., MacArthur, C., McManus, R., Stokes-Lampard, H., Wilson, S., Roalfe, A., & Mutrie, N. (2006). Factors associated with the use of complementary medicine and non-pharmacological interventions in symptomatic menopausal women. *Climacteric, 9*(5), 336-346. http://dx.doi.org/10.1080/13697130600864074

Davidson, C. (2009). Transcription: Imperatives for qualitative research. *International Journal of Qualitative Methods, 8*(2), 35-52. http://dx.doi.org/10.1177/160940690900800206

Davis, M. A., West, A. N., Weeks, W. B., & Sirovich, B. E. (2011). Health behaviours and utilization among users of complementary and alternative medicine for treatment versus health promotion. *Health Services Research, 46*(5), 1402-1416.

De Chesnay, M. (2014). *Nursing Research Using Ethnography: Qualitative Designs and Methods in Nursing*. New York: Springer Publishing Company.

Dillinger, J. (2017). Countries who spend the least on healthcare. Retrieved from https://www.worldatlas.com/articles/the-countries-with-the-lowest-health-expenditures-in-the-world-relative-to-gdp.html

Dog, T. L. (2007). The role of complementary and alternative medicine during the menopausal transition. *Menopause, 14*(3), 347-349. http://dx.doi.org/10.1097/gme.0b013e318053e792

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods, 8*(1), 54-63. http://dx.doi.org/10.1177/160940690900800105

Elavsky, S., & McAuley, E. (2009). Personality, menopausal symptoms, and physical activity outcomes in middle-aged women. *Personality and Individual Differences, 46*(2), 123-128.

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of Convenience Sampling and Purposive Sampling. *American Journal of Theoretical and Applied Statistics, 5*(1), 1-4. http://dx.doi.org/10.11648/j.ajtas.20160501.11

Farham, B. (2008). What is midlife? *Continuing Medical Education, 24*(11), 666.

Farooqi, Y. N. (2006). Traditional healing practices sought by Muslim psychiatric patients in Lahore, Pakistan. *International Journal of Disability, Development and Education, 53*(4), 401-415. http://dx.doi.org/10.1080/10349120601008530

Foronda, C. L. (2008). A concept analysis of cultural sensitivity. *Journal of Transcultural Nursing*, *19*(3), 207-212.

Friedlander, A. H. (2002). The physiology, medical management and oral implications of menopause. *The Journal of the American Dental Association, 133*(1), 73-81. https://dx.doi.org/10.14219/jada.archive.2002.0025

Greendale, G. A., Lee, N. P., & Arriola, E. R. (1999). The menopause. *The Lancet, 353*(9152), 571-580. https://dx.doi.org/10.1016/S0140-6736(98)05352-5

Gutiérrez, C. V., Rodrigo, J. R., Alguacil, M. M. O., Caravaca, M. Á. S., Lechuga, M. J. A., & Villaverde, A. R. (2015). Overweight obesity and cardiovascular risk in menopausal transition. *Nutricion Hospitalaria, 32*(4), 1603-1608. http://dx.doi.org/10.3305/nh.2015.32.4.9380

Gul, R. B. (2007). *Competence of Graduates of the Four-year BScN Program at Aga Khan University: Experiences and Perceptions.* (Ph.D. Nursing). University of Alberta, Edmonton, Canada.

Hakim, A., & Aziz, A. (1998). Socio-cultural, Religious, and Political Aspects of the Status of Women in Pakistan. *The Pakistan Development Review, 37*(4), 727-746.

Hakimi, S., Simbar, M., Ramezani Tehrani, F., Zaiery, F., & Khatami, S. (2016). Women's perspectives toward menopause: A phenomenological study in Iran. *Journal of Women & Aging, 28*(1), 80-89.

Hall, L., Callister, L. C., Berry, J. A., & Matsumura, G. (2007). Meanings of menopause: Cultural influences on perception and management of menopause. *Journal of Holistic Nursing: Official Journal of the American Holistic Nurses' Association, 25*(2), 106-118. http://dx.doi.org/10.1177/0898010107299432

Hayat, K., Iqbal, H., Malik, U., Bilal, U., & Mushtaq, S. (2015). Tea and its consumption: benefits and risks. *Critical Reviews in Food Science and Nutrition*, *55*(7), 939-954. https://dx.doi.org/10.1080/10408398.2012.678949

Higginbottom, G. M. (2011). The transitioning experiences of internationally educated nurses into a Canadian health care system: A focused ethnography. *BMC Nursing, 10*(14) http://dx.doi.org/10.1186/1472-6955-10-14

Higginbottom, G. M., Pillay, J. J., & Boadu, N. Y. (2013). Guidance on performing focused ethnographies with an emphasis on healthcare research. *The Qualitative Report, 18*(9), 1-16.

Hossain, M. Z. (2014). What does Islam say about dieting? *Journal of Religion and Health*, *53*(4), 1003-1012. https://dx.doi.org/10.1007/s10943-013-9698-x

Hunter, M., & Rendall, M. (2007). Bio-psycho-socio-cultural perspectives on menopause. *Best Practice & Research Clinical Obstetrics & Gynaecology, 21*(2), 261-274. http://dx.doi.org/10.1016/j.bpobgyn.2006.11.001

Hur, M., Oh, H., Lee, M. S., Kim, C., Choi, A., & Shin, G. (2007). Effects of aromatherapy massage on blood pressure and lipid profile in Korean climacteric women. *International Journal of Neuroscience, 117*(9), 1281-1287. http://dx.doi.org/10.1080/00207450600936650

Hur, M. H., Yang, Y. S., & Lee, M. S. (2008). Aromatherapy massage affects menopausal symptoms in Korean climacteric women: A pilot-controlled clinical trial. *Evidence-Based Complementary and Alternative Medicine: ECAM, 5*(3), 325-328. http://dx.doi.org/10.1093/ecam/nem027

Hussain, I. (2009). *Problems of working women in Karachi, Pakistan*. Cambridge Scholars Publishing.

Ignacio, J. J., & Taylor, B. J. (2013). Ethical issues in health-care inquiry: A discussion paper. *International Journal of Nursing Practice, 19*, 56-61. http://dx.doi.org/10.1111/ijn.12017

Im E. O. (2010). A situation-specific theory of Asian immigrant women's menopausal symptom experience in the United States. ANS. *Advances in Nursing Science, 33*(2), 143–157. https://dx.doi.org/10.1097/ANS.0b013e3181dbc5fa

Im, E. O., Stuifbergen, A. K., & Walker, L. (2010). A situation-specific theory of midlife women's attitudes toward physical activity (MAPA). *Nursing outlook*, *58*(1), 52-58. https://dx.doi.org/10.1016/j.outlook.2009.07.001

Im, E. O. (1999). Neglecting and ignoring menopause within a gendered multiple transitional context: Low income Korean immigrant women. *Journal of Korean Academy of Nursing, 29*(6), 1336-1354. https://dx.doi.org/10.4040/jkan.1999.29.6.1336

Im, E., Chang, S. J., Chee, E., & Chee, W. (2019). The relationships of multiple factors to menopausal symptoms in different racial/ethnic groups of midlife women: The structural equation modeling. *Women & Health, 59*(2), 196-212.

Im, E., & Meleis, A. I. (1999). A Situation-Specific Theory of Korean Immigrant Women's Menopausal Transition. *Image: The Journal of Nursing Scholarship, 31*(4), 333-338.

Im, E., Meleis, A. I., & Lee, K. A. (1999). Symptom experience during menopausal transition: low income Korean immigrant women. *Women & Health, 29*(2), 53-67.

Innes, K., Selfe, T., & Taylor, A. (2008). Menopause, the metabolic syndrome, and mind-body therapies. *Menopause: The Journal of the North American Menopause Society, 15*(5), 1005-1013. http://dx.doi.org/10.1097/01.gme.0b013e318166904e

Jafar, T. H., Haaland, B. A., Rahman, A., Razzak, J. A., Bilger, M., Naghavi, M., ... & Hyder, A. A. (2013). Non-communicable diseases and injuries in Pakistan: strategic priorities. *The Lancet*, *381*(9885), 2281-2290.

Karachi population: World population review. (2019). Retrieved from http://worldpopulationreview.com/world-cities/karachi-population/

Karim, F., Ghazi, A., Ali, T., Jabbar, S., Naz, S., & Aslam, R. (2013). Women's perception towards menopause. *Journal of Surgery Pakistan (International), 18*(3), 143-147.

Keen, D., & De Chesnay, M. (2014). State of the art in nursing research using ethnography. In M. De Chesnay (Ed.), *Nursing Research Using Ethnography: Qualitative Designs and Methods in Nursing* (pp. 15-36). New York: Springer Publishing Company.

Kelly, Z. (2009). Is yoga an effective treatment for low back pain: A research review. *International Journal of Yoga Therapy, 19*(1), 103-112.

Khademi, S., & Cooke, M. (2003). Comparing the attitudes of urban and rural Iranian women toward menopause. *Maturitas, 46*(2), 113-121. https://dx.doi.org/10.1016/S0378-5122(03)00182-8

Khaskheli, M., Baloch, S., & Sheeba, A. (2009). Health profile of post-menopausal women in rural versus urban population in Sindh province of Pakistan. [Abstract]. *Maturitas, 63*(1) S124. http://dx.doi.org/10.1016/S0378-5122(09)70499-2

Khokhar, S. (2013). Knowledge, attitude and experience of menopause. *Pakistan Journal of Medical Research, 52*(2), 42-46.

Khurshid, A. (2016). Domesticated gender (in) equality: Women's education & gender relations among rural communities in Pakistan. *International Journal of Educational Development, 51*, 43-50. https://dx.doi.org/10.1016/j.ijedudev.2016.08.001

Knoblauch, H. (2005). Focused ethnography. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 6*(3), 1-10. http://www.qualitative-research.net/index.php/fqs/article/view/20/43

Komesaroff, P., Kafanelis, B., Black, C., Cable, V., Sudhir, K., & Daly, J. (2002). Experiences at menopause of women in a non-English-speaking community: a qualitative study. *Climacteric, 5*(1), 78-86. http://dx.doi.org/10.1080/cmt.5.1.78.86

Kopenhager, T., & Guidozzi, F. (2015). Working women and the menopause. *Climacteric, 18*(3), 372-375, https://dx.doi.org/10.3109/13697137.2015.1020483

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy*, *45*(3), 214-222.

Kurji, Z., Premani, Z. S., & Mithani, Y. (2016). Analysis of the health care system of Pakistan: lessons learnt and way forward. *Journal of Ayub Medical College Abbottabad*, *28*(3), 601.

Lee, M. B., & Saeed, I. (2001). Oppression and horizontal violence: The case of nurses in Pakistan. *Nursing Forum, 36*(1), 15-24. https://dx.doi.org/10.1111/j.1744-6198.2001.tb00236.x

Leininger, M. M. (1999). What is transcultural nursing and culturally competent care. *Journal of Transcultural Nursing, 10*(1), 9.

Lincoln, V., & Guba, E. (1985). Naturalistic Inquiry. Beverly Hills, CA: Sage Publications.

Malik, H. S. (2008). Knowledge and attitude towards menopause and hormone replacement therapy (HRT) among postmenopausal women. *Journal of Pakistan Medical Association (JPMA), 11*, 164-167.

Mallhi, T. H., Qadir, M. I., Khan, Y. H., Khan, A. H., & Adnan, A. S. (2014). A survey of knowledge and attitude of menopause among post-menopausal women in Pakistan [Abstract]. *Value in Health, 17*(7), A731. https://dx.doi.org/10.1016/j.jval.2014.08.083

Maselko, J., Bates, L., Bhalotra, S., Gallis, J. A., O'Donnell, K., Sikander, S., & Turner, E. L. (2018). *Socioeconomic status indicators and common mental disorders: Evidence from a study of prenatal depression in Pakistan.* https://dx.doi.org/10.1016/j.ssmph.2017.10.004

McFarland, D. M. (2014). How to do ethnography. In M. De Chesnay (Ed.), *Nursing Research Using Ethnography: Qualitative Designs and Methods in Nursing* (pp. 95-102). New York: Springer Publishing Company.

Meleis, A. I. (2010). *Transitions theory: middle-range and situation-specific theories in nursing research and practice*. New York: Springer Pub. Co.

Meleis, A.I., Sawyer, L.M., Im, E.O., Schumacher, K. and Messias, D.K. (2000). Experiencing transitions: An emerging middle range theory. *Advances in Nursing Science, 23*(1), 17.

Memon, F. R., Jonker, L., & Qazi, R. A. (2014). Knowledge, attitudes and perceptions towards menopause among highly educated Asian women in their midlife. *Post Reproductive Health, 20*(4), 138-142.

Meyers, D. T. (2002). *Gender in the mirror: cultural imagery and women's agency.* Oxford University Press on Demand.

Miaschi, J. (2019). Religion in Pakistan. Retrieved from https://www.worldatlas.com/articles/religious-beliefs-and-freedoms-in-pakistan.html

Milgate, M. (2006). Handbook of Ethnography. *Australasian Marketing Journal (AMJ), 14*(2), 47-50. http://dx.doi.org/10.1016/S1441-3582(06)70060-X

Miller, A. M., Sorokin, O., Wilbur, J., & Chandler, P. J. (2004). Demographic characteristics, menopausal status, and depression in midlife immigrant women. *Women's Health Issues, 14*(6), 227-234. https://dx.doi.org/10.1016/j.whi.2004.08.004

Moyad, M. A. (2002). The placebo effect and randomized trials: analysis of conventional medicine. *Urologic Clinics of North America, 29*(1), 125-133. https://dx.doi.org/10.1016/s0094-0143(02)00039-3

Mumtaz, Z., Sivananthajothy, P., Bhatti, A., & Sommer, M. (2019). *"How can we leave the traditions of our Baab Daada" Socio-cultural structures and values driving menstrual hygiene management challenges in schools in Pakistan*. https://dx.doi-org./10.1016/j.adolescence.2019.07.008

Munhall, P. L. (2007). *Nursing research, a qualitative perspective (4th Edition).* Sudbury, Massachusetts: Jones & Barlett Publishers.

Murshid, N. S., & Critelli, F. M. (2017). Empowerment and intimate partner violence in Pakistan: results from a nationally representative survey. *Journal of Interpersonal Violence, 35*(3-4), 854-875. https://dx.doi-org/10.1177/0886260517690873

Nag, O. S. (2019a). Countries with the most people living abroad - Emigration rate by country. Retrieved from https://www.worldatlas.com/articles/countries-with-the-most-emigrants-living-abroad.html

Nag, O. S. (2019b). What languages are spoken in Pakistan? Retrieved from https://www.worldatlas.com/articles/what-languages-are-spoken-in-pakistan.html

Naseem, S., Khattak, U. K., Ghazanfar, H., & Irfan, A. (2016). Prevalence of non-communicable diseases and their risk factors at a semi-urban community, Pakistan. *Pan African Medical Journal*, *23*(1), 1–8. https://dx.doi.org/10.11604/pamj.2016.23.151.8974

Nisar, N., & Sohoo, N. A., Sikandar, R. (2012). Age and symptoms at natural menopause: A cross-sectional survey of rural women in Sindh, Pakistan. *Journal of Ayub Medical College Abbottabad, 24*(2), 90-94.

Nisar, N., & Sohoo, N. A. (2010). Severity of Menopausal symptoms and the quality of life at different status of Menopause: A community-based survey from rural Sindh, Pakistan. *International Journal of Collaborative Research on Internal Medicine & Public Health, 2*(5), 118-130.

Nisar, N., & Sohoo, N. A. (2009). Frequency of menopausal symptoms and their impact on the quality of life of women: A hospital-based survey. *Journal of Pakistan Medical Association (JPMA), 59*(11), 752-756.

Nishtar, S., Boerma, T., Amjad, S., Alam, A. Y., Khalid, F., ul Haq, I., & Mirza, Y. A. (2013). Pakistan's health system: Performance and prospects after the 18th constitutional amendment. *Lancet, 381*(9884), 2193-2206. http://dx.doi.org/10.1016/S0140-6736(13)60019-7

Noorani, K. J., Siddiqui, N., & Farzana. (1998). Age of natural menopause in Pakistani women. *Journal of the College of Physicians and Surgeons Pakistan, 8*(5), 227-229.

Nosek, M., Kennedy, H. P., & Gudmundsdottir, M. (2010). Silence, stigma, and shame: A postmodern analysis of distress during menopause. *Advances in Nursing Science, 33*(3), E24-E36.

Nusrat, N., Nishat, Z., Gulfareen, H., Aftab, M., & Asia, N. (2008). Knowledge, attitude and experience of menopause. *Journal of Ayub Medical College Abbottabad, 20*(1), 56-59.

O'Neill, S., & Eden, J. (2014). The pathophysiology of menopausal symptoms. *Obstetrics, Gynaecology & Reproductive Medicine*, *24*(12), 349-356.

Pakistan Bureau of Statistics, Government of Pakistan. (1998). *Population and Housing Indicators.* Retrieved from http://www.pbscensus.gov.pk/content/population-and-housing-indicators

Pakistan Ministry of Finance. (n.d.). *Pakistan Economic Survey 2015-16: Annex-III: Poverty.* Retrieved from http://www.finance.gov.pk/survey/chapters_16/Annexure_III_Poverty.pdf

Pal, S. A. (2017). Premarital health and social issues in Pakistan. *Journal of Pakistan Medical Association (JPMA), 67*(7), 973-974. Retrieved from http://www.jpma.org.pk/PdfDownload/8261.pdf

Pawson, R., Boaz, A., Grayson, L., Long, A., & Barnes, C. (2003). *Types and quality of social care knowledge. Stage two: towards the quality assessment of social care knowledge.* (pp. 1-31). ESRC UK Centre for Evidence Based Policy and Practice: Working Paper 18.

Pilkington, K., Kirkwood, G., Rampes, H., & Richardson, J. (2005). Yoga for depression: the research evidence. *Journal of Affective Disorders, 89*(1), 13-24.

Porter, S. (2007). Validity, trustworthiness and rigor: reasserting realism in qualitative research. *Journal of Advanced Nursing*, *60*(1), 79-86.

Posadzki, P., Ernst, E., Terry, R., & Lee, M. S. (2011). Is yoga effective for pain? A systematic review of randomized clinical trials. *Complementary Therapies in Medicine, 19*(5), 281-287.

Pradhan, N. A., Ali, T. S., Hasnani, F. B., Bhamani, S. S., & Karmaliani, R. (2018). Measuring socio-economic status of an urban squatter settlement in Pakistan using WAMI Index. *Journal of Pakistan Medical Association (JPMA), 68*(5), 709-714.

Qidwai, W., Samani, Z. A., Azam, I., & Lalani, S. (2012). Knowledge, attitude and practice of vitamin supplementation among patients visiting out-patient physicians in a teaching hospital in Karachi. *Oman Medical Journal, 27*(2), 116-120. http://dx.doi.org/10.5001/omj.2012.24

Qureshi, K. (2013). Sabar: body politics among middle-aged migrant Pakistani women. *Journal of the Royal Anthropological Institute, 19*(1), 120-137.

Rao, M. A. A., & Hussain, M. (2019). Women in Different 'Societal' Roles and Responsibilities: An Investigation through Islamic Connotations and Teachings. *The Islamic Culture "As-Saqafat-Ul Islamia" Research Journal-Sheikh Zayed Islamic Centre, University of Karachi, 41*, 55-74. http://dx.doi.org/10.2139/ssrn.3468834

Rashid, T. (2011). Empowerment and subordination of Pakistani women through patriarchy; elitism; class gender discourses. In R. Kalia (Ed.), *Pakistan: From the Rhetoric of Democracy to the Rise of Militancy* (pp. 85-104). New Delhi: Routledge.

Rashid, M., Caine, V., & Goez, H. (2015). The encounters and challenges of ethnography as a methodology in health research. *International Journal of Qualitative Methods, 14*(5), 1-16. http://dx.doi.org/10.1177/1609406915621421

Rasmussen, S. J. (2000). From child bearers to culture-bearers: Transition to post childbearing among Tuareg women. *Medical Anthropology, 19*(1), 91-116.

Reynolds, F. (2002). Exploring self-image during hot flushes using a semantic differential scale: associations between poor self-image, depression, flush frequency and flush distress. *Maturitas, 42*(3), 201-207.

Richards, L., & Morse, J. M. (2013). *Readme first for a user's guide to qualitative methods*. *(3rd Edition)* Thousand Oaks. CA: Sage Publication.

Rizvi, N., & Ali, T. S. (2016). Misconceptions and Mismanagement of Menstruation among Adolescents Girls who do not attend School in Pakistan. *Journal of Asian Midwives (JAM), 3*(1), 46-62.

Rodriguez, A. (2007). Migration and increased participation in public life: the case of Pakistani women in London. *Frontiers: A Journal of Women Studies, 28*(3), 94-112.

Roomi, M. A., & Parrott, G. (2008). Barriers to development and progression of women entrepreneurs in Pakistan. *The Journal of Entrepreneurship*, *17*(1), 59-72.

Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research.* Thousand Oaks, CA: Sage Publications.

Ross, C. A. (2014). Camindando mas cerca con dios (A closer walk with thee): An ethnography of health and well-being of rural Nicaraguan men. In M. De Chesnay (Ed.), *Nursing*

Research Using Ethnography: Qualitative Designs and Methods in Nursing (pp. 52-94). New York: Springer Publishing Company.

Ruddock, H. C., & Turner, D. S. (2007). Developing cultural sensitivity: Nursing students' experiences of a study abroad programme. *Journal of advanced nursing*, *59*(4), 361-369.

Saeed, A., & Atta, G. (2018). Women's Empowerment, working women and Islam. *Al-Qalam*, *23*(2), 24-34.

Sampselle, C. M., Harris, V., Harlow, S. D., & Sowers, M. (2002). Midlife development and menopause in African American and Caucasian women. *Health Care for Women International, 23*(4), 351-363.

Sarri, G., Davies, M., Lumsden, M. A., & Guideline Development Group. (2015). Diagnosis and management of menopause: summary of NICE guidance. *BMJ (Clinical Research Ed.), 351*, h5746. http://dx.doi.org/10.1136/bmj.h5746

Schwandt, T. A. (1994). Constructivist, interpretivist approaches to human inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 118-137). Thousand Oaks, CA: Sage.

Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching, 5*(9), 9-16. http://dx.doi.org/10.5539/elt.v5n9p9

Shaikh, B. T., Haran, D., & Hatcher, J. (2008). Women's social position and health-seeking behaviours: Is the health care system accessible and responsive in Pakistan? *Health Care for Women International*, *29*(8-9), 945-959.

Shaikh, B. T., & Hatcher, J. (2005). Health seeking behaviour and health service utilization in Pakistan: challenging the policy makers. *Journal of Public Health (Oxford, England), 27*(1), 49-54. http://dx.doi.org/fdh207

Shaikh, S. H., Malik, F., James, H., & Abdul, H. (2009). Trends in the use of complementary and alternative medicine in Pakistan: A population-based survey. *The Journal of Alternative and Complementary Medicine, 15*(5), 545-550. http://dx.doi.org/10.1089=acm.2008.0232

Skrzypulec, V., Dąbrowska, J., & Drosdzol, A. (2010). The influence of physical activity level on climacteric symptoms in menopausal women. *Climacteric*, *13*(4), 355-361.

Sluijs, C., Lombardo, F. L., Lesi, G., Bensoussan, A., & Cardini, F. (2013). Social and cultural factors affecting complementary and alternative medicine (CAM) use during menopause in Sydney and Bologna. *Evidence-Based Complementary and Alternative Medicine: (eCAM), 2013*(Feb 1), 1-6. http://dx.doi.org/10.1155/2013/836234

Speziale, H. S., Streubert, H. J., & Carpenter, D. R. (2011). *Qualitative research in nursing: Advancing the humanistic imperative (5th edition)*. Philadelphia: Lippincott Williams & Wilkins. http://dx.doi.org/10.3109/13697131003597019

Spiers, J. A., Williams, B., Gibson, B., Kabotoff, W., McIlwraith, D., Sculley, A., & Richard, E. (2014). Graduate nurses' learning trajectories and experiences of problem-based learning: A

focused ethnography study. *International Journal of Nursing Studies, 51*(11), 1462-1471. http://dx.doi.org/10.1016/j.ijnurstu.2014.03.002

Stotland, N. (2002). Menopause: social expectations, women's realities. *Archives of Women's Mental Health, 5*(1), 5-8.

Streeter, C. C., Jensen, J. E., Perlmutter, R. M., Cabral, H. J., Tian, H., Terhune, D. B., . . . Renshaw, P. F. (2007). Yoga Asana sessions increase brain GABA levels: a pilot study. *The Journal of Alternative and Complementary Medicine, 13*(4), 419-426.

Suka, M., Taniuchi, A., Igarashi, S., Yanagisawa, H., & Ishizuka, B. (2016). *Menopause-specific health literacy in Japanese women*. https://dx,doi-org/10.1016/j.maturitas.2016.06.004

The Economist Intelligence Unit - Country Profile: Pakistan. (2008). Retrieved from http://www.eiu.com/FileHandler.ashx?issue_id=1603760545&mode=pdf

The World Bank, IBRD, IDA. (2019). Pakistan. Retrieved from http://data.worldbank.org/country/pakistan

UN data: A world of information (n.d.). Retrieved from http://data.un.org/CountryProfile.aspx?crName=PAKISTAN

United Nations Children's Fund (UNICEF) Pakistan. (2013). Retrieved from https://www.unicef.org/pakistan/OSC_UNICEF_Annual_Report.pdf

Vanwesenbeeck, I., Vennix, P., & Van de Wiel, H. (2001). 'Menopausal symptoms': associations with menopausal status and psychosocial factors. *Journal of Psychosomatic Obstetrics & Gynecology, 22*(3), 149-158.

Wall, S. S. (2015). Focused ethnography: A methodological adaptation for social research in emerging contexts. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 16*(1), 1-15. http://dx.doi.org/10.17169/fqs-16.1.2182

Wasti, S., Robinson, S., Akhtar, Y., Khan, S., & Badaruddin, N. (1993). Characteristics of menopause in three socioeconomic urban groups in Karachi, Pakistan. *Maturitas, 16*(1), 61-69.

Weiss, A. (2014). *Interpreting Islam, modernity, and women's rights in Pakistan*. Palgrave Macmillan, New York: Springer.

Williams, R. (1999). Cultural safety—what does it mean for our work practice? *Australian and New Zealand Journal of Public Health, 23*(2), 213-214.

Winterich, J. A., & Umberson, D. (1999). How women experience menopause: the importance of social context. *Journal of Women & Aging, 11*(4), 57-73.

World Health Organization (WHO). (2007). Health Systems Profile, Pakistan. *Regional Health Systems Observatory (EMRO).* Retrieved from http://apps.who.int/medicinedocs/documents/s17305e/s17305e.pdf

Yeh, S. J., & Chang, M. (2012). The effect of qigong on menopausal symptoms and quality of sleep for perimenopausal women: A preliminary observational study. *The Journal of Alternative and Complementary Medicine, 18*(6), 567-575. http://dx.doi.org/10.1089/acm.2011.0133

Yosef, A. R. (2008). Health beliefs, practice, and priorities for health care of Arab Muslims in the United States. *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society, 19*(3), 284-291. http://dx.doi.org/10.1177/1043659608317450

Zeserson, J. M. (2001). Chi no michi as metaphor: Conversations with Japanese women about menopause. *Anthropology & Medicine, 8*(2-3), 177-199.

Zimmermann, K. A. (2017). What is culture? Definition of culture. Retrieved from https://www.livescience.com/21478-what-is-culture-definition-of-culture.html

Ziring, L., & Burki, S. J. (2019). In *Encyclopædia Britannica online.* Retrieved from https://www.britannica.com/place/Pakistan

Appendices

Appendix A: Glossary

A glossary of some terms that are commonly used in/related to this research, with the most relevant and applicable definitions to this study and its context are given below for clarity:

Culture: The shared patterns of behaviours and interactions of a group of people, and their cognitive constructs and understandings through socialization is referred to as culture; it may encompass anything including religion, clothing, food, language, art and music, rituals and ceremonies, perceptions of right and wrong; a way of sitting, greeting, behaving, and much more (Zimmermann, 2017).

Culturally competent care: It is the kind of care that is meaningful to the people and that fits with their cultural beliefs and lifeways. Culturally competent care is provided by using insiders' (emic) knowledge in an appropriate manner that fits with the outsiders' (etic) knowledge to help specific cultures (Leininger, 1999).

Cultural safety: Cultural safety refers to the environment that is free of challenge, assault, or denial of people's identity; hence it is physically, socially, emotionally, and spiritually safe for people (Williams, 1999).

Cultural sensitivity: "Cultural sensitivity is employing one's knowledge, consideration, understanding, respect, and tailoring after realizing awareness of self and others and encountering a diverse group or individual." Moreover, "cultural sensitivity results in effective communications, effective interventions, and satisfaction" (Foronda, 2008).

Eastern culture: Eastern culture is mainly referred to as the societal norms of Far East Asian countries, including the Indian subcontinent; where there is less of a distinction between religious philosophy and secular society than in the West (Zimmermann, 2017).

Islam: Islam is the religion that teaches that there is only one God and that Muhammad (peace be upon him) is his prophet. Followers of Islam are called Muslims, and the holy Quran is Islam's sacred scripture (Collins English Dictionary).

Menopause: The permanent cessation of a menstrual period in women for twelve consecutive months is referred to as menopause (Adhi et al., 2007). It may occur naturally, or artificially due to reasons such as surgery (hysterectomy and oophorectomy), chemotherapy and radiotherapy (Baig & Karim, 2006).

Midlife: Midlife or middle age is defined in literature as the age between 40 and 60 years (Farham, 2008).

Reflexivity: In ethnographic research, reflexivity refers to reflecting upon the research process to see how the researcher's presence and research techniques used have made an effect on the nature and extent of information collected. Reflexivity involves researcher reflecting upon the extent of required information obtained by the participants, and if the format of data collection enhanced or restricted the information gathered (Harvey, 2017).

Reflective practice: Reflective practice is a process that involves one's thinking, actions and emotions where the thoughtful practice is turned into potential learning, trying to ascertain that the result of an action is close to or better than the one anticipated by theory/similar experience; thoughtful reflective practise leads to better performance over time (Jarvis, 1992).

Religion: Religion is the belief in the existence of a divine or superhuman power/s as the creator and ruler of the universe, that is to be obeyed and worshiped (Collins English Dictionary).

My perception of menopause

I believe that menopause in most cases is a normal and natural phenomenon or life stage in a woman's life during her middle age. Artificial menopause may, however, result due to health status, contraception, and other reasons. The menopausal transition is the time when a woman is transitioning from reproductive to non-reproductive stage of her life. I believe that every woman is unique physically, mentally, emotionally, spiritually, intellectually, and in other ways; she is also unique in her experience of menopause. At this stage of my life, I am lucky enough to have visited a few countries around the world, and lived and experienced the lifestyles of both, the east and the west. Based on my education and life experience, I believe that women's culture, religion, lifestyle, level of education, health status, socioeconomic status, familial and other factors play a significant role in their perception and understanding of menopause. Each woman's menopause may start at a different age; and how they experience and manage, ignore or bear-with their symptoms may be unique too. I learned about menopause, for the first time, in my nursing education. Before that, I had not come across any discussion around this topic at home, probably because I had never lived in an extended family; neither did I have elder sisters nor did I have older female members in the house, other than my mother, to generate any such discussion. In general, I had never heard discussions around menopause among relatives, friends, or neighbours. In my personal experience, sex education and gender-related knowledge and discussions such as menopause, are common in some cultures and subcultures, while in others, such discussions are strictly prohibited and thought of as inappropriate and personal. In my opinion, awareness related to sex education and gender related knowledge are important to be discussed in culturally appropriate ways; for example, separate sessions may be organized for males and females in less educated, rural, and urban slums of Pakistan. In my clinical and

community experience, less educated women from rural areas or the ones living in urban slums were most often hesitant to talk openly about topics like menopause or other gender-specific ones as they considered these topics personal, private, and confidential, which cannot be talked openly and with or in front of male members of the family. They, however, sometimes had closed (limited) talks, if needed, in low volumes, with only female friends or close female relatives in confined spaces like home. In such cultures, the only exception to discuss such an issue may be in situations where it is urgent and important due to health reasons. In that case, it was often discussed with an elderly woman in the family or acquaintance, or a female health care provider, with the permission of the head of the family, which in most cases was a male member. Nonetheless, I also observed open discussions, on topics such as menopause, among more literate women at workplaces and in community gatherings of more educated women from literate, liberal, and upper-class families. The above is my observation and over two decades of professional experience as a nurse in various settings and capacities in the context of this study. However, it is worth noting here that as mentioned above, it varies greatly in different cultures and subcultural groups due to the factors including, but not limited to, level of literacy and independence of women/family. Having said that, I believe it is women's individual choice (to some extent, in some cases) how they decide to manage their symptoms of menopause.

Appendix B: Script for Verbal Information Giving (for Consent to Contact)

Title of Study: Exploring Pakistani, urban, Muslim, Midlife women's experiences of menopause: A Focused ethnography study

Principal Investigator: Amynah Mevawala, RN, RM, PhD student

Salam.
I am contacting you on behalf of Amynah Mevawala. She is conducting individual interviews regarding midlife women's experience of menopause. She will be conducting this interview as part of her PhD research. She is working under the supervision of her professor at the Faculty of Nursing, University of Alberta, Canada.

She will ask you questions related to your menopause experience. For example: what symptoms you experience, how you manage those symptoms etc. All the information you provide to her during this study will be kept confidential.

If you have any questions about the study or would like more information you can call the researcher directly any time at: +1 587 3340353 or her supervisor at: +1 780 4927953.

Appendix C: Consent to Contact Form

Title of Study: **Exploring Pakistani, urban, Muslim, Midlife women's experiences of menopause: A Focused ethnography study**

Principal Investigator: Amynah Mevawala PhD student
Supervisor: Dr. Solina Richter

I **…….**
[name of potential participant]
give permission that my name be forwarded to the researcher conducting the study related to exploring Pakistani, urban, Muslim, Midlife women's experiences of menopause. The University of Alberta, Edmonton, Canada, Research Ethics Board has given permission for this study to be conducted. You are cordially invited to be part of this study. You will be invited for one to two individual conversations of approximately 60 minutes each. The conversations will focus on your experiences of menopause. You are free to choose the time that will be the most convenient for you. If you are interested in the study, can you kindly sign this form and give your contact details. It will be forwarded to the researcher. She will contact you to set up an appropriate time and location to talk to you.

I give my consent to be contacted by the researcher of the research project: exploring Pakistani, urban, Muslim, midlife women's experiences of menopause. I would like to know more about this study. However, this is not my consent to participate in the study.

Name _____ Signature _____

Phone number _____ Email _____

Appendix D: Information Leaflet (for email)

Midlife Women's Experience of Menopause

You are cordially invited to be part of a study on Pakistani midlife women's experience of menopause. The study has ethics approval by the University of Alberta, Edmonton, Canada, Health Research Ethics Board. You will be invited for 1-2 individual conversations with the researcher. The conversations will focus on your experiences of menopause. You are free to choose a convenient time.

You are **eligible** to participate if you are:

- from any faith practice of Islam
- experiencing natural menopause
- educated to a minimum of post-secondary level
- professional/working
- from the middle-to-upper socioeconomic status
- living in Karachi, Pakistan
- proficient and comfortable in English language
- interested to participate in the research, and
- willing to share your experience related to menopause

If you are interested in participating or need more information, please contact Amynah Mevawala, PhD Candidate and Principal Investigator of the study at:
Phone: +1-587-334-0353 or **Email:** mevawala@ualberta.ca

Appendix E: Information Poster (to post)

Midlife Women's Experience of Menopause

You are cordially invited to be part of a study on Pakistani midlife women's experience of menopause. The study has ethics approval by the University of Alberta, Edmonton, Canada, Health Research Ethics Board. You will be invited for 1-2 individual conversations with the researcher. The conversations will focus on your experiences of menopause. You are free to choose a convenient time.

You are **eligible** to participate, if you are:

- from any faith practice of Islam
- experiencing natural menopause
- educated to a minimum of post-secondary level
- professional/working
- from the middle-to-upper socioeconomic status
- living in Karachi, Pakistan
- proficient and comfortable in English language
- interested to participate in the research, and
- willing to share your experience related to menopause

If you are interested in participating or need more information, please contact Amynah Mevawala, PhD Candidate and Principal Investigator of the study at:
Phone: +1-587-334-0353 or **Email:** mevawala@ualberta.ca

Menopause study
Amynah Mevawala
+1-587-334-0353
mevawala@ualberta.ca

Appendix F: Demographic Data Sheet for Study Participants

Title of Study: Exploring Pakistani, urban, Muslim, Midlife women's experiences of menopause: A Focused ethnography study

Please provide me the following information:

It will take approximately five minutes to complete this information sheet. I will handle all the information provided in a confidential manner.

Identification #: _____

Marital Status: Married ☐ Unmarried ☐ Divorced ☐ Separated ☐ Widowed ☐

Do you have children? No ☐ Yes ☐ How many? _____

Age range in years: 35-40 ☐ 40-44 ☐ 45-49 ☐ 50-54 ☐ 55-59 ☐ 60-65☐

Religious Faith: Sunni ☐ Shi'a ☐ Ismaili ☐ Barelvi ☐ Deobandi ☐
Ahl-e-Hadiths ☐ Other☐ _____ Don't prefer to respond ☐

Education: Bachelor ☐ Master ☐ PhD ☐ Post-doctorate ☐
Technical/vocational training ☐ Other ☐ _____

Occupation: Full time ☐ Part time ☐ Casual ☐ Self-employed ☐
Other ☐ _____

Nature of work: Labor ☐ Professional/Skilled Worker ☐ Entrepreneur ☐
Other ☐ _____

When did you have your first menstrual period? Date: _____ Age: _____

When did you have your last menstrual period? Date: _____ Age: _____

Do you live in…? Nuclear family ☐ Extended family ☐ Alone ☐

Do you experience symptom/s related to menopause? Yes ☐ No ☐

If yes, list the most common symptoms _____

How frequently do you experience the above symptom/s?

Everyday ☐ 1-2 times/week ☐ 1-2 times/month ☐ Other ☐

Please specify _____

How do you manage your menopausal symptoms?

Please specify _____

_____

Family Monthly Income Range (in PKR): <50,000 ☐ 50,000-100,000 ☐

100,000-300,000 ☐ 300,000-600,000 ☐ 600,000-10,00,000 ☐

10,00,000-25,00,000 ☐ >25,00,000 ☐

Thank you for completing this data sheet!

Appendix G: Proposed Interview Guide

Following is the proposed interview guide for the study:

- What do you know about the permanent cessation/stopping of monthly menstrual cycle, also known as menopause?
- How/where did you learn about menopause?
- Tell me about your experience of menopause.
- What are some of the common menopause symptoms that you experience?
- What do you do to manage those symptoms?
- What strategies have helped you in your menopause experience?
- How do you think it affects your work and household life?
- What factors influence your decision about managing your symptoms?
- With whom do you discuss your menopause symptoms and experience?
- Where do you seek information related to menopause?
- How do you think health care professionals can help you in this life process?

Probes will be used in the interview process where necessary, to get more detailed information of the phenomenon under study such as:

- What do you mean by that?
- Tell me more about that.
- Could you please elaborate on that?
- Would you please explain or clarify it for me?
- Give me more detail about it please.
- Why do you think so?
- I would like to hear more.
- Could you please share some examples?
- What makes you feel that way?

Appendix H: Information Letter for Participant Consent

Title of Study: Exploring Pakistani, urban, Muslim, Midlife women's experiences of menopause: A Focused ethnography study

Principal Investigator: Amynah Mevawala, RN, RM, PhD student
Tel: +1 587 3340353
Email at: mevawala@ualberta.ca

Supervisor: Dr. Solina Richter, PhD, RN
Professor and Academic Director of the Global Nursing Office,
Faculty of Nursing,
University of Alberta,
5-238 Edmonton Clinic Health Academy (ECHA)
11405-87 Avenue,
Edmonton, Alberta, Canada. T6G 1C9
Tel: +1 780 4927953 (office)
Email: solina.richter@ualberta.ca

What is the reason for doing this study?
Women during middle age generally experience a number of changes. These are mainly related to the symptoms related to the permanent stopping of menses (menopause). This has an impact on women's physical and mental health, as well as the general quality of life. I am conducting research to find out about middle-aged women's experience of menopause, and the strategies women use to manage its symptoms in Karachi, Pakistan. This study will provide knowledge for nurses and healthcare providers to care for Pakistani women going through menopause.

What will I be asked to do?
This letter contains all the required information to help you decide if you would like to participate in this research. If you agree to take part in the study, I will ask you to participate in 1-2 individual interviews. During the interview, I will ask you to answer questions related to your experience of menopause. Each interview will take about 60 minutes of your time. The interviews can take place at our mutually agreed time and place, which is safe and convenient. For the purpose of the study, I will also ask you to give me some basic information about yourself such as age, marital status, and occupation.

What are the benefits to me?
Your participation in the study will allow you to share your menopause experience openly and confidentially. This study may help researchers and health care providers to understand and support Pakistani women going through menopause. However, you may not get any benefit from participating in this research study.

What are the risks and discomforts?
There are no known risks to participate in this study, however, you may feel uncomfortable talking about your menopause experience. At any point, if you feel that you cannot continue, you

can let me know. We can take a break or stop completely. We can continue talking when you feel comfortable. However, it is not possible to know all of the risks that may happen in a study, but the researchers have made all reasonable efforts to minimize any known risks to a study participant.

Will my information be kept private?
The interviews will be audio-recorded and then typed word by word. All the information you provide during interviews will be kept confidential. Your name will not be used in the tape recording, written notes, or typed interview scripts. You will be assigned an identification number, which will be known only to the research team members. Your name will only be recorded on the consent form. All the consent forms will be locked in a separate place. All the study information will only be accessible to me and my supervisor or the ethics team on request. Your records will be kept for at least five years after the study is complete. I may contact you again if I need to clarify any information that you give to me.

No information of this study that has your name will be released outside the researcher's office or published by the researchers. Sometimes, by law, we may have to release your information with your name so we cannot guarantee absolute privacy. However, we will make every legal effort to make sure that your information is kept private.

Do I have to take part in the study?
Your participation in this study is voluntary. You are free to refuse to answer any question or part of the study. You can ask me to stop the interview at any time to take a short break or to stop completely. You may also withdraw from the study at any time without giving me a reason. You can do so up to six months after the interview has been conducted.

Future Use of Data
The study data collected will be used for publications and presentations. The information of this study may be used for future research. Your identity will be kept confidential and your name will not be disclosed in any situation. In any publication or presentation, study data will be combined for all the participants, and participants' names will not be disclosed.

Additional Contacts
If you have questions about the study, you may contact the following at any time: Amynah Mevawala at Tel: +1-587-3340353 or email at mevawala@ualberta.ca. You may also contact Dr. Solina Richter at Tel: +1-780-4927953 or email at solina.richter@ualberta.ca

If you have any questions or concerns regarding your rights as a study participant, you may contact the Health Research Ethics Board of the University of Alberta at +1-780-4920459. The office has no direct affiliation with the study investigators.

Please keep a copy of this letter.

Participant initials: _____ Witness initials: _____

Appendix I: Consent Form

Part 1 (To be completed by the researcher)

Title of Study**:** Exploring Pakistani, urban, Muslim, Midlife women's experiences of menopause: A Focused ethnography study

Principal Investigator: Amynah Mevawala Phone Number: +1 587 3340353

Supervisor: Dr. Solina Richter Phone Number: +1 780 4927953

Part 2 (To be completed by research participant)	Yes	No
Do you understand that you have been asked to take part in a research study?	☐	☐
Have you read and received a copy of the attached information sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to leave the study at any time, without having to give a reason?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand that the conversations will be audio-recorded?	☐	☐
Do you understand that portions of the research may be published in professional journals, presented at conferences, or used in future research/es?	☐	☐

Who explained this study to you? _____

I agree to take part in this study:

Signature of Research participant _____

(Printed Name) _____ Date _____

Signature of Witness _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of Investigator _____ Date _____

Appendix J: Copyright License for Figure 5.1 - Transitions Theory

Thank you for your order!

Dear Ms. Amynah Mevawala,

Thank you for placing your order through Copyright Clearance Center's RightsLink®service.

Order Summary

Licensee:	Ms. Amynah Mevawala
Order Date:	Mar 17, 2020
Order Number:	4791500329230 - License Number
Publication:	Advances in Nursing Science
Title:	Experiencing Transitions: An Emerging Middle-Range Theory
Type of Use:	Dissertation/Thesis
Order Total:	0.00 CAD

(Original Order Number: 501553889)

View or print complete details of your order and the publisher's terms and conditions.

Sincerely,

Copyright Clearance Center

Tel: +1-855-239-3415 / +1-978-646-2777
customercare@copyright.com
https://myaccount.copyright.com

Appendix K: Copyright License for Figure 5.2 - AIMS Theory

Thank you for your order!

Dear Ms. Amynah Mevawala,

Thank you for placing your order through Copyright Clearance Center's RightsLink®service.

Order Summary

Licensee:	Ms. Amynah Mevawala
Order Date:	Mar 17, 2020
Order Number:	4791510286629 - License Number
Publication:	Advances in Nursing Science
Title:	A Situation-Specific Theory of Asian Immigrant Women's Menopausal Symptom Experience in the United States
Type of Use:	Dissertation/Thesis
Order Ref:	501553893
Order Total:	0.00 USD

(Original Order Number: 501553893)

View or print complete details of your order and the publisher's terms and conditions.

Sincerely,

Copyright Clearance Center

Tel: +1-855-239-3415 / +1-978-646-2777
customercare@copyright.com
https://myaccount.copyright.com